Transforming Aggression

Psychotherapy with the
Difficult-to-Treat Patient

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Self Psychology Strikes Back

A university professor sought analysis because of his inability to control his temper, especially his critical and destructive outbursts toward his students. Although his preparation of lectures is extensive, his ambivalent relationship with his students and colleagues deprives him of the professional status to which his competence entitles him. He described similar flare-ups of rage toward his friends, wife, and children, usually prompted by his sense that they were less competent, reasonable, or conscientious than he expected them to be. Afterward, he would feel remorseful, contrite, ashamed, and guilty. Many years of prior analysis with another analyst diminished this pattern considerably, but not sufficiently to enable him to function better. His unsuccessful attempts at self-control continued to evoke painful self-reproaches and prompted him to try analysis again. After our initial consultation he told a friend who knew him well that he was going to begin analysis with me, a self psychologist. His friend said, "How could you? They don't know anything about aggression."

My patient's friend turned out to be a Kleinian psychoanalyst. He voiced one of the many criticisms of self psychology that have been spread
in the psychoanalytic literature and by word of mouth since Heinz Kohut published *The Analysis of the Self* in 1971. However, although the comment that self psychology does not deal with aggression is a misconception, it does point to clinical and theoretical questions with respect to self psychology that demand clarification.

I use the term aggression as it is used in ordinary language and defined as “the first attack in a quarrel; an assault, an inroad, the practice of setting upon someone; the making of an attack or assault” (Oxford English Dictionary 1982). From the dictionary entry I left out the first definition—“an unprompted attack”—because that is the specific aspect of aggression that self psychology challenges. The attack is not unprompted when understood from the vantage point of the aggressor's subjectivity. Kohut (1972) proposes that aggression is not a primary motive, but is reactive to a narcissistic injury. Thus, the circumstances in which a person acts aggressively may appear to an observer to be unprompted, but when understood from within that person's perspective or within his subjective experience, a context for the attack can be discerned. This view of aggression does not excuse the attack in a normative sense, but makes it understandable in a psychological sense. Psychoanalytic treatment then focuses on the context in which aggression is evoked and the injury, deprivation, and/or frustration to which it is reactive.

Kohut came to his views on aggression through his study of narcissism and his experience as clinician, supervisor, and teacher. The first generation of self psychology patients included many who had been traumatized in prior analyses where their narcissism was relentlessly confronted. When narcissism is diagnosed as a defense or an ego-syntonic character trait, treatment often entails confronting the patient's self-centeredness, arrogance, and self-aggrandizement, and focusing on the patient's inability to relate to other people as separate objects. From some theoretical perspectives, the rage with which patients react to such confrontations is seen as confirmation that aggression underlies narcissistic defenses. However, from the vantage point of self psychology, when confrontation constitutes a narcissistic injury, then rage is a plausible response.

Merton Gill's (1994) description of his experience as an analysand in one of his classical analyses illustrates the kind of treatment approach that Kohut addressed in his theory and in his technical innovations. Gill reported, “One of my analysts once said that if my parents' behavior accounted for 95% of my troubles and it was my experience of their behavior that accounted for the remaining 5%, it was only that 5% in which he was interested. I see his point more clearly now than I did then, but I still think I was right to become enraged” (p. 31). Gill did not reveal how his rage reaction was interpreted. However, if his analyst applied the same principle to the analysis of transference as he did to the shaping of Gill's early experience, then he may have focused on Gill's rage rather than on the context, the analyst-patient interaction, from which the rage emerged. Placing rage, or other expressions of aggression, into the past and current context in which they were evoked reconnects them with the patient's broader affective life. Furthermore, it enables the patient to appreciate and understand the totality of the experience that motivated the rage, rather than feeling himself to be defined as rageful.

Self psychology is not alone in claiming that it is essential to place aggressive reactions into the contexts in which they were evoked. However, the central focus placed by self psychology is on understanding the patient from within the patient's subjectivity, that is, the patient's frame of reference, which is co-constructed by analyst and patient and provides the context for the patient's reactions of rage. By "co-constructing" I mean that both participants, analyst and patient, contributed to the organization of the interaction, but not similarly or equally. For example, by dismissing 95 percent of the contribution of Gill's parents to his troubles, the analyst dismissed, out of hand, Gill's perception of his childhood experience. In this way the analyst made a contribution to the context in which Gill became enraged.

Gill's vignette captures the connection between injured narcissism and rage. However, the differences between the self psychological view of narcissism and aggression and other psychoanalytic views point to fundamental questions about human nature: Is aggression an innate drive that must be mastered? Is the task of managing sexual and aggressive drives a basic challenge that we must be helped to face? Is the task of
facing one’s infantile anxieties, and overcoming the propensity to attribute one’s painful and conflicted affect states to others, the position from which we must move? Or is aggression a reaction to massive deprivation, frustration, and narcissistic injuries that obstruct self-development? Is striving toward self-integration the fundamental human task?

I believe that these positions, innate versus reactive aggression, are mutually exclusive and fundamentally irreconcilable. Posed in these extreme terms they also revive the bankrupt nature-nurture controversy. For example, the fetus in utero can change its state, dampen its arousal, and put itself to sleep to cope with aversive stimulation (Brazelton 1992). Already in utero “the fetus can regulate the level of arousal and responsivity as a function of the nature of the stimulation provided” (Beebe and Lachmann 1994, p. 138). We know now that nurture, environmental influences, begin in utero, and that nature, biological and genetic influences, may emerge at varying times in a person’s life (see, for example, Field 1981, Thelen and Smith 1994). However, the innate versus reactive aggression controversy is relevant with respect to the guiding theory used by a psychoanalytic clinician. The clinician who adheres to a theory that aggression is innate will make clinical choices that differ from those of the clinician who adheres to a theory that requires searching for the context in which aggression has been triggered in reaction to a narcissistic injury, frustration, or disappointment.

From my point of view, a person’s rage, hostility, contempt, or other variant of aggression is a reaction. However, the observation of drive theorists and object relations theorists of rage outbursts that appear unprovoked or proactive captures aspects of how aggression can be experienced by some people. The phenomenology of ragefulness or unprovoked anger, disdain, or contempt is thus of interest to self psychology. Later, I will elaborate on these varieties of aggression, with special attention to patients whose outbursts of rage, contempt, and murderousness evoke more rage when the analyst searches for the patient’s subjective context that can house the aggression. But first, I review Kohut’s formulations about aggression and self-development along with the criticisms and attacks from the psychoanalytic community that his proposals brought forth.

Kohut proposed that obstructions in self-development were derived from disruptions in a child’s needed connection to a caregiver. As one consequence of chronic disruptions in this connection, the sense of self remains vulnerable and is prone to breakdown. Rage as well as sexual pathology can be a consequence of that breakdown, of that self-disintegration.

Nowhere is the distinction between Freud’s and Kohut’s theories of development clearer than in their differing formulations of the Oedipus complex. Kohut (1984) contrasted oedipal conflicts with an oedipal phase. He distinguished between two paths of development that centered on how the oedipal child experienced his or her parents. If the parents are experienced as supporting the developmental achievements of this phase, then a normal, joyful oedipal period follows. If the parents are experienced as responding seductively or with counteraggression to the child’s phase-appropriate oedipal exhibitionism and sexual strivings, then castration anxiety and oedipal conflict follow.

Kohut’s postulation of a normal oedipal phase that can become conflicted due to parental pathology and misattunement stands in stark contrast to the Oedipus complex postulated by Freudian theory, in which the way the person manages powerful erotic and aggressive feelings toward the parents, that is, the characteristics of the Oedipus complex, is basic to subsequent personality organization. These differences point to irreconcilably different visions of human nature that lead to diverging clinical theories. To a large extent, different treatment approaches have evolved from these distinctions, with different conceptualizations of narcissism and aggression and different theories of therapeutic action in the treatment of pathology derived from aggression.

THE DEBATE OVER THE SELF PSYCHOLOGICAL TREATMENT OF AGGRESSION

There have been numerous excellent reviews and summaries of the literature on aggression (for example, Leider 1998). Hartmann and colleagues (1949) provided an early review and elaboration of Freud’s theory
of aggression. Although they did consider aggression a reaction to deprivation and frustration, they attributed entirely internal sources to these two triggers. In an illustration of their theory, they described the state of the child when fed and when not fed, when gratified and when frustrated.

Food intake permits gratification of libidinal needs both through zonal pleasure and ... through the libidinal significance of the incorporation of the "source" of satisfaction; giving of food at this stage also means giving of love.... The biting of food, its disappearance, its incorporation, affords aggressive satisfactions early in development. ... The absence of food deprives the child of an opportunity to discharge aggressive tension in its incorporation. [p. 29]

In this view, deprivation leads to a buildup of aggressive tensions and a frustration of the aggressive drive. The child's angry response is then not a reaction to having been deprived, but an accumulation of anger that did not have the usual or normal channels for discharge. This theory of aggression as an internal accumulation of tension has lingered in psychoanalytic practice. It is exemplified in treatments that encourage the outward expression of aggression as a way of divesting oneself of it.

Freud's view of aggression was already questioned by Bernfeld (1935, cited by Stepansky 1977). He disputed "Freud's claim that biology was at the source of his drive theory," and that the "final drive theory in no sense originates from biological considerations" (p. 188). Nevertheless, an insistence on the biology of drives, specifically as related to aggression, has been a central canon of the critics of self psychology. The publication of The Restoration of the Self (Kohut 1977) provided the critics with a field day. Although the hand-to-hand combat that followed Kohut's three major publications has died down, the smell of gunpowder has remained in the air. Volleys of criticism expectedly came from drive theorists, interpersonals, and object relationalists. For example, Rothstein (1980) faulted Kohut for "de-emphasizing the instinctual bio-

logical underpinnings of the aggressive drive." Such de-emphasis ran counter to Rothstein's conviction that "a well of basic rage... is part of every human being" (p. 433). Years later, at a symposium on the centrality of aggression in clinical psychoanalysis, Rothstein (1999, cited in Singer 1999) reiterated that "a successful analysis will necessarily need to have patients take 'responsibility for their sadistic, vengeful, and murderous desires'" (p. 1184). In a similar vein, Curtis (1985) faulted Kohut for ignoring "the child's drive-motivated fantasies and distortions of parental behavior" (p. 361).

The number of published attacks has indeed diminished, but lone critical voices can still be heard. Even fifteen years after the first assaults, Raphling (1998) criticized a self psychological treatment by reiterating that aggression is innate, that it is "an intrinsic psychic motivation: a primary, obligatory appetite of an instinctual nature modified by the ego into complex drive derivatives" (p. 100).

To attack the theoretical underpinnings of self psychology for not recognizing instinctual drives is bizarre. Of course, self psychology is not based on a dual drive theory. That is exactly what it aims not to be. But implicit in this critique of the role self psychology accords to aggression is this question: If there are no endogenous, biologically based drives, how does self psychology account for motivation? And, even more to the point, how can a person come to terms with his or her destructiveness? Even this frequently reiterated question assumes that destructiveness, a derivative of aggression, is an entity, is there, and must be accepted as part of oneself.

By not considering aggression and sadistic behavior to be biologically rooted, self psychologists are depicted as abdicating individual responsibility in favor of traumatically induced, and environmentally produced, deficits and reactions. In fact, Kramer (1994) specifically argued that because self psychology uses a deficiency model, it is confined to dealing with "surface material and fails to recognize the necessity for frustration, rather than the avoidance of frustration for development" (pp. 9–10).

In the background of these debates is this question: What kind of evidence can sway the adherents of either view, reactive or innate ag-
gression, to consider the other's perspective? When we buttress our arguments with clinical illustrations, we are usually applauded by the partisans of the approach illustrated, and dismissed by those who hold another opinion. Research evidence could help, but there is the problem of formulating studies that do justice to the complexities of a theory and simultaneously avoid the potential bias of the investigator. And even then, Raphling (1998) held that research evidence is inadmissible in addressing these controversies. He specifically dismissed infant observation and other research methods as incapable of revealing the complex verbal meaning encoded in aggressive behavior. In dismissing research evidence, Raphling implicitly dismissed the seminal studies of Henri Parens (1979), whose conversion from drive theory to a view of aggression as reactive will be considered later.

From a clinical standpoint, the self psychological view of aggression has also been contrasted with treatment approaches derived from Kleinian object relations theories. While Fairbairn (1952) considered aggression reactive to frustration, aggression as a basic constituent of human nature was central to the work of Melanie Klein. This emphasis has been continued by modern Kleinians, for example, Betty Joseph (1985, 1992).

About the origin of aggressiveness, Melanie Klein (1975) asserted that "some babies experience strong resentment about any frustration and show this by being unable to accept gratification when it follows on deprivation" (p. 249). She contrasted children who she believed show strong innate aggressiveness and greed with children whose outbursts of rage were occasional. In addition, she believed that an innate aggressive component in a child would also result in strong persecutory anxiety, frustration, and greed. These predispositions contribute to the child's difficulty in tolerating frustration and dealing with anxiety. Finally, she concluded that the interaction of the strength of the destructive impulse with libidinal impulses "provides the constitutional basis for the intensity of greed" (p. 62).

Both Klein and Joseph accepted Freud's (1914b) seesaw relationship between narcissism and object love. As one increased, the other would decrease. In their view, narcissism and problems with aggression noted in a patient were closely linked. A similar connection between narcissism and aggression is found in the theories of Kernberg (1975) and other object relational theorists. They hold to the traditional psychoanalytic dictum that an increase in narcissism, an early libidinal stage, is linked to a failure to achieve the developmental level of object love. The treatment they espouse attempts to reverse this situation—to diminish archaic narcissism and thereby raise the person to the level of object love.

The treatment implications of a link between narcissism and aggression are clear in non–self psychological approaches. The analyst confronts and analyzes the patient's negative transference, the repository of the patient's aggression and narcissism, and confronts and analyzes the patient's resistance and the inability to relate to the analyst as a separate object. These treatment strategies share a common emphasis: to identify and analyze the negative transference.

FAILURES IN EMPATHY AND SELF-OBJECT RUPTURES

In presenting his views on aggression, Mitchell (1993) criticized both drive theorists and those who have abandoned drives, among whom he includes self psychologists. Specifically, he attacked self psychology for portraying aggression as though it is always "provoked and therefore as avoidable and peripheral to the development and structuralization of the self" (pp. 157–158, italics added). In contrast, he believes that aggression is spontaneous, inevitable, and central in human interactions. Mitchell is among those analysts (see also Harris 1998) who have distanced themselves from a drive version of aggression but have embraced aggression as central to an understanding of human nature, and central to the analytic enterprise. That is, they do not believe that aggression should be given the status of a drive, but they do argue that it is a central human motivation.

The problem with Mitchell's depiction of self psychology is the word therefore. To claim, as self psychologists do, that aggression is reactive and provoked does not mean it is avoidable. It does not mean that
analysts are advised to walk on eggshells to avoid stirring up a patient's aggression. It does mean that the context in which aggression has been experienced by the patient requires exploration. Mitchell, as have other critics of self psychology, also erroneously equates failures in empathy with selfobject ruptures. Before distinguishing between the effects of empathic failures and ruptures of selfobject transferences, a word about selfobject transferences.

Selfobject Transference

Selfobject transference pertains to "that dimension of our experience of another person that relates to this person's functions in shorting up our self" (Kohut 1984, p. 49). Developmentally, selfobject transferences derive from the ties between the infant and his or her parents. To the extent that the child's longings for needed experiences of feeling mirrored and being included within the protective orbit of an idealized parent are met, these longings evolve into a set of guiding ideals and ambitions and a cohesive sense of self. In treatment, the patient may derive selfobject experiences in which the analyst is felt to be a source of self-coherence, affect regulation, and self-continuity. That is, the analyst is experienced as a "function" that maintains and organizes the sense of self, and not used as a target for the patient's affects, or to work over projected fantasies and displaced experiences with significant people from the past. Rather, the selfobject experience is a vitalizing, affective, self-restorative, or self-enhancing experience. It can be derived from a variety of sources, not necessarily only from the analyst, or from "good-enough" parents. A selfobject experience is defined by the positive, self-sustaining, self-maintaining, or self-restoring quality of a person's subjective experience and is distinguished from the interpersonal or environmental context in which the experience is evoked. A variety of contexts may be the breeding grounds of selfobject experiences. Not all of these contexts would be considered positive or healthy. These contexts include sports, love, fantasies, and friendships, as well as sources such as sadomasochistic relationships, drugs, addictions, and violence.

Empathy

Kohut considered empathy as a mode of observation, the way in which we gather information about the subjective life of another person. Through vicarious introspection, what it feels like to live in that person's shoes, the analyst grasps the subjective life and experiences of the patient. To be so exquisitely attended to and understood, to be the object of this "empathic listening perspective" (P. Ornstein 1985, p. 43) is felt to be a beneficial experience by many, but not by all patients, as I will illustrate in Chapters 8 and 9. However, Kohut was clear in not giving empathy a value. He exemplified the dark side of empathy by referring to a hoodlum standing at a street corner and sensing who would be a good mugging prospect (P. Ornstein, personal communication, 2000), and in the Nazis adding sirens to their buzz bombs when they bombed London during World War II, knowing that these sounds would increase the terror and confusion of the populace (Kohut 1981). They were using empathy, sensing themselves into the subjective experience of other people and attacking where they sensed the greatest vulnerability. In Shakespeare's Othello, Iago's empathy enables him to manipulate Othello because he is able to sense with uncanny accuracy just how and where Othello is vulnerable (A. Lachmann 1999).

Although failures in empathy and selfobject ruptures may coincide, failures in empathy can be traced to aspects of the therapeutic relationship where there has been a misunderstanding, a misinterpretation, or a tactless response by the analyst (see Stolorow et al. 1987). The extent to which this disruption was due to the analyst's insensitivity or the patient's specific hypersensitivity can then be investigated. In these instances, the therapeutic interaction in the here and now is explored more fully. Identifying the empathic failure restores the therapeutic interaction. The patient's specific vulnerability contributes to the occurrence of these failures.

In selfobject ruptures the accent falls on the specific vulnerability and sensitivity of the patient to a greater extent. The presence of this vulnerability makes such ruptures an everyday event of treatment. Investigating the basis for the rupture constitutes its repair. In neither case
can failures and ruptures be avoided. In both instances the patient may provide the crucial signal. This signal may be a verbal recognition that something went awry, or an increase in symptomatology that may range from a slight cold withdrawal to a flare-up of flamboyant behavior.

Exploration of failures of empathy and selfobject ruptures accrue to the stability of the patient's self organization. Such exploration and interpretation can lead the patient toward expectations of being understood and the further expectation that when a dialogue is disrupted, the patient can expect the analyst to be motivated to try to understand the basis for the disruption and thereby restore the dialogue.

WHAT ABOUT PROJECTION AND DISTORTION?

The place accorded to frustration as the impetus for aggressive reactions is a distinguishing factor in contrasting self psychology with other psychoanalytic approaches. For self psychologists, attention given to frustration is closely connected with the attention given to the investigation of empathic ruptures in the transferences. This emphasis places the patient's frustration-generated anger into a context through which the threat, the disruption that triggered the anger, can be understood. Placing frustration-generated anger into a context in which the patient's reaction becomes understandable has led numerous critics such as Kernberg (1974) and Bromberg (1989) to claim that self psychology fails to deal with the extent to which patients distort their experience of the analyst and contribute to the failure of the analyst to understand them (Tuch 1997). Kernberg argued that the self psychological focus on the patient's disappointment, whether in the analyst or in other people, fails to recognize how narcissistic patients will "totally devalue the transference object for the slightest reason" and that the self psychology perspective "fails to recognize the narcissistic patient's intense, overwhelming . . . aggression against the object" (p. 232). These arguments between proponents of innate and reactive aggression resemble political debates. One side accuses the other of being soft on aggression, and the other retorts, "You are hard on the vulnerable."

Some critics of self psychology see the emphasis on the analyst's empathic immersion in the patient's experience as a deprivation for the patient. That is, Bromberg (1998), from an interpersonal point of view, argues that in a self psychologically informed treatment the patient does not get to hear from the analyst what it feels like for another person to be the target of the patient's needs and demands. Curtis (1983), from the position of classical Freudian theory, faulted self psychology because he believes that a focus on "empathic responses to build the self crowds out other experiences and affects of anger, sexuality, and sadism" (p. 284). Modell (1986) joins this line of criticism by faulting Kohut for not acknowledging the "dark side to empathy" and thereby "seriously inhibit[ing] the patient's own creative powers" (p. 375).

In essence, self psychology is being criticized for not according patients the powers of projection and distortion. These mechanisms play a major role in both understanding psychopathology and in analyzing transference resistances in other psychoanalytic approaches. When the accent is placed on the reactivity of aggressive motivations and the co-construction of the analytic process, a burden is placed on the analyst. Nothing can be explained as residing solely within the patient. Rather the analyst investigates what in the analyst-patient interaction may have contributed to triggering the patient's aggressive reaction. Of course, whatever the trigger, rage is certainly not the only possible response a patient can have. The patient's potential for reacting with rage, rather than reacting in another way, can then lead to an investigation of the roots of the patient's vulnerability to rage reactions.

The close association between narcissistic pathology and aggression, captured in Kohut's term narcissistic rage, will dog us throughout these chapters. Both theoretically and clinically we know that narcissistic pathology provides a fertile field for the growth of aggressive reactions.

Freud's (1914b) proposal of a seesaw relationship between narcissism and object love is central to numerous treatment approaches to narcissism, not only that of Melanie Klein and her followers. In contrast, one of Kohut's earliest contributions was to unlink this connection between narcissism and object love and argue that narcissism and object
love follow independent lines of development—independent but certainly not unrelated to each other. In un linking this connection, Kohut voted against the imposition of a "relationships are healthy" morality as part of a mental health ethic. As a separate sector of the personality, Kohut proposed that narcissistic pathology can be explored without simultaneously imposing a goal.

Kohut also challenged the assumption that narcissistic patients are unable to form analyzable transfersences. He proposed that these transfersences reflect the patient's striving to (re)establish or restore necessary, sustaining ties to parental figures, ties that had been traumatically and repeatedly disrupted in childhood. These disruptions led to the failure of these ties to become abstracted and depersonified as symbolic processes. In consequence, as such a child becomes an adult, the literal absence of another person is required to sustain a cohesive sense of self and to feel attended to and loved. Conversely, even the temporary absence and certainly the loss of that person can lead to anxiety and despair, emotional coldness, or bodily symptoms.

Inevitably, a patient's strivings to establish selfobject ties to the analyst are prone to be disrupted through (1) failures of empathy on the part of the analyst, (2) selfobject ruptures, (3) the patient's requirements for exquisite attention, or (4) the slings and arrows of everyday life. Sustaining the ongoing selfobject tie and the analysis of ruptures promote self restoration and self integration. In a therapeutic milieu informed by this vision of narcissism, a patient can develop a more cohesive, temporally continuous, and affectively more positive sense of self (Stolorow and Lachmann 1980). In turn, as a consequence of a better integrated sense of self, an increase in the capacity to regulate strong affects, such as rage, follows. Increased affect regulation links the treatment of narcissistic pathology with the diminution of rage outbursts.

NARCISSISTIC RAGE, AMBITION, AND ASSERTION

Although narcissistic rage, ambition, and assertion are discussed in greater detail in subsequent chapters, some preliminary comments are in order.

Kohut distinguished between rage, which he labeled narcissistic rage, and healthy aggression. By healthy aggression, he meant ambitious and assertiveness as expressions of a cohesive sense of self. He considered narcissistic rage and hostile destructiveness to be breakdown products of an enfeebled self. That is, the fundamental pathology lay in the lack of self-cohesion or, put differently, in ready self-fragmentation. Under these conditions, in the absence of a responsive milieu, narcissistic rage and pervers or driven compulsive sexuality would predominate. The therapeutic implication of this proposal is to restore the sense of self and the selfobject ties by addressing the transference ruptures that inevitably occur, and as they occur, in the course of treatment. The restored sense of self can then become a functional unity, an independent center of initiative (Kohut 1977).

I believe that Kohut's illumination of narcissistic rage constituted one of his major contributions to the analysis of the pathology associated with aggression. However, theoretical and clinical problems are also introduced into psychoanalysis in this contribution. First, he distinguished healthy aggression and pathological aggression not on the basis of subjective experience. A person may feel assertive or may be expressing aggression in a healthy way, but others may view him or her as a pathologically aggressive bully. Or, the reverse, a person may feel like, or, in his or her eyes, act like, a bully, but others may be admiring of the display of force and determination. Thus, the distinction between healthy and pathological aggression is based on the judgment of an outside observer. The distinction thus overrides the subjectively experienced similarity between healthy and pathological aggression. Second, assertion and aggression are provided with a common origin. Kohut's distinction between healthy and pathological aggression gives healthy aggression a proactive status. It is linked with ambitions and assertiveness, whereas pathological aggression or narcissistic rage is deemed reactive. Third, pathological aggression is linked to and is indicative of a lack of self-cohesion. Linking pathological aggression to a breakdown of the self does not do justice to the extent to which feeling enraged, hostile, or fantasizing sadistically can enliven the sense of self. That is, in Kohut's formulation, aggression is not credited with maintaining a person's sense
of cohesion. These are important issues to which I will return later in this book.

From Kohut's vantage point, narcissistic rage is always a consequence of self pathology. And indeed, clinically, in many instances, therapeutic restoration of self-cohesion does address the underlying basis for rage outbursts. When the sense of self is strengthened through analysis, eruptions of narcissistic rage decrease. Healthy aggression, assertion, and ambition can then become expressions of a cohesive self. Indirectly then, healthy aggression rather than narcissistic rage becomes the handmaiden of a cohesive self.

In psychoanalytic treatment, narcissistic rage is diminished by attention to disruption and repair of the transference tie. The context for the patient's rage is addressed when the analyst tries to understand the patient's need to have grandiosity mirrored, and the patient's need to have idealizations of the analyst accepted. When these needs remain unfulfilled, aggressive reaction can coagulate on the surface of the analysis. Recognition of these needs, and recognition of disappointment at their nonfulfillment, constitute meeting necessary developmental requirements. Thus, according to Kohut's theory of development, these "arrested" structures, the patient's archaic grandiosity and idealizations, can then resume development and mature on their own.

Earlier I cited references to highlight the theoretical positions from which self psychology has been criticized, and the nature of these criticisms. The differences noted between Kohut and his critics delineate a great divide that is unlikely to be bridged. These differences have distinct clinical corollaries that can be illustrated through a summary of Kohut's contributions to psychoanalytic practice. Particularly relevant in the treatment of aggressive pathology, these contributions are "(1) the unwavering application of the empathic-introspective mode of observation as defining and delimiting the domain of psychoanalytic inquiry, (2) the central emphasis on the primacy of self-experience, (3) the concept of self-object function and self-object transference" (Stolorow 1986, p. 388).

The critics of self psychology have claimed that the analyst's empathic focus on the patient's experience, and thus on the patient's subjectivity and self-experience, deprives the patient of an experience of the analyst as another, a separate observer/interpreter of the patient's experience. Since there are circumstances when experiencing the analyst in this way is instrumental in furthering the treatment, Kohut has suggested that interpretations be framed with leading and trailing edges (Miller 1985).

THE LEADING AND THE TRAILING EDGE OF INTERPRETATIONS

In the framing of interpretations, Kohut described leading-edge interpretations that capture the patient's strivings, the quality of self-experience the patient is attempting to attain or maintain, and trailing-edge interpretations that refer to the dynamic and historical basis underlying the patient's motivations and defenses. Complete interpretations contain both of these edges. A leading-edge interpretation can stand alone for a considerable time in treatment. A trailing-edge interpretation, without recognition of the leading edge, can be experienced as confrontational and injurious by the patient, as an iatrogenic injury. At its best, a trailing-edge interpretation can offer the patient a feeling of being understood, can be felt as relieving and enlightening, and can construct a broader current and historical context for an experience.

A combination of a leading-edge and trailing-edge interpretation, and its consequences, can be illustrated in a case described by Peter Fonagy (1999).

His patient was a depressed, anxious man with pervasive feelings of inadequacy and an arrogant manner. Fonagy found the arrogance enraging. In a session before a weekend break, the patient spoke in a particularly baasful manner, "listing the properties he owned and suggesting that my consulting room could be moved with advantage to one of the large houses owned by the patient" (p. 4). Fonagy interpreted that the patient wanted "me to be close to him over the weekend (the leading edge) and also under his con-
trol, so he could avoid the humiliation of having to miss me" (p. 4) (the trailing edge). The patient responded contemptuously that if that had been his intention he would simply have bought the house that Fonagy was in. He said he was quite fed up with Fonagy's monotonous whining—and was considering an extended break from the analysis during the coming week.

In addition to providing an illustration of leading- and trailing-edge interpretations, Fonagy's example highlights the difficulty in choosing one or both of these edges at any given point. Would a more productive interchange have evolved had Fonagy only made the leading edge part of the intervention? The situation would certainly have been different. But would the patient have become so engaged and enraged? And was it to the patient's benefit or detriment that he became so enraged? Was the patient's hostility and contempt, although present from the first moments of the analysis, also called forth and even reinforced by the trailing-edge portion of the interpretation? Was the patient's hostility a reaction to Fonagy's confrontation of the patient's needs and shameful exposure of his vulnerability? Was the patient's contempt an ever-present latent aspect of his manner that would have emerged under any circumstances? Or was it a refreshing experience for the patient to be tacitly recognized as a contender? These are clinical questions and decisions that are relevant to the place accorded to aggression, contempt, and hostility in the therapeutic dialogue.

Leading-edge interpretations have a shady reputation in the psychoanalytic community. At best they are viewed by some analysts as useful in a preparatory phase of analysis, providing support for the patient or temporarily siding with the defenses or the resistances. In self psychology they are positioned on a par with interpretations that aim toward reconstructing childhood experiences, as well as feelings, memories, and contents that have been disavowed or repressed. It is self psychology's use of leading-edge interpretations that has contributed to its reputation among classical, Kleinian, and relational psychoanalysts as avoiding a patient's aggression and as failing to deal with a patient's devaluation, rage, or withdrawal from the analyst.

COMPARING TREATMENT APPROACHES

A case report by Gail Reed (1996) can illustrate the clinical implications of the many differences between self psychology and classical defense analysis, particularly in treating psychopathology rooted in aggressive conflicts. These differing organizing concepts and beliefs point to basically and irreconcilably different assumptions about human nature. In making these principles explicit, I believe, differences can be clarified and sharpened. Furthermore, I believe that at present such comparisons can only be impressionistic and anecdotal. Until such evaluations have been systematically applied, who knows which theory produces the better outcome?

In contrast to self psychology, Reed (1996) adhered to the classical psychoanalytic theory and treated her patient's narcissism as a defense against aggression. "For the better part of five years," her patient "came to each session precisely on time, lay down and recited, in detail and impegnably, the facts of her work situation" (p. 74). The patient spoke little about her private life, brought neither dreams, daydreams, nor for that matter, any irrational thought or behaviors to the sessions. Reed reported that this patient made "no acknowledgment that I existed" (emphasis added). "If I questioned the meaning of this dry recital as an action, she reacted with high-handed but ever polite frustration. She was doing what she was supposed to do, wasn't she, saying what came to mind?" (p. 74, italics in original). Reed interpreted the patient's behavior as "doing something" to her. This interpretation did not alter the patient's behavior in the analysis, making Reed "feel helpless, frustrated, bored, and trapped by the unending march of details, a victim pinned to the wall by her words" (p. 75). Reed realized that her patient's behavior had "aroused my hostility. . . . If I did intervene, my interventions led to labyrinthine, rationalized discussions during which I felt like a rat trapped in the maze of her narcissistic defenses. . . . I was aware, of course, that these intense reactions were data, something she wanted me or needed me, at some level, to feel" (p. 75).

Contained in Reed's description, understanding, and treatment of her patient is a theory and treatment that provides a clear contrast to the
self psychological perspective. First, the patient is described and evaluated from the analyst's perspective. In contrast, self psychology would propose attempting to see the patient and her complaints from her frame of reference, a perspective within her subjectivity. From the vantage point of the primacy of the patient's self-experience, a leading-edge interpretation of her dry recital might emphasize her effort to secure her safety. Furthermore, she might be understood as dreading to be pulled into a perhaps all-too-familiar irrational world. Reed's wish that the patient present dreams and irrational material could be understood as Reed's contribution to the dry recital, a possible demand that veered the patient even further into her dry retreat. Hence, a stalemate may have ensued. The analyst's pull toward the expression of unconscious material would contribute to the patient's retention of her dry-recital resistance. The repetitive dry recital, although no doubt a behavior with which this patient was quite familiar in other circumstances, has thus also been co-constructed by analyst and patient in the analytic setting.

Second, in her report, Reed emphasizes what the patient does not provide for the analyst. The patient fails to adhere to her analyst's expectations. In contrast, a leading-edge interpretation would mirror the patient's desperate strivings and necessary attempts to protect her vulnerable sense of self.

Third, Reed expected her patient to acknowledge her and thus form an object-related transference. Thus, the selfobject dimension of the transference that the patient is attempting to establish is not recognized. The patient attempts to provide the analyst with what she understands the analyst to require of her. It comes across as a compliant, dry recital. But, from the vantage point of the leading edge, the patient's presentation requires acceptance. Not to criticize or dismiss the dry recital but to accept it as the patient's participation in the analytic dialogue constitutes the analyst's contribution to the mirroring selfobject experience. Through its recognition and noninterference, the patient may feel understood, as a totality, rather than having aspects of herself subjected to scrutiny and criticism. The analyst's acceptance of the mirroring selfobject tie constitutes the analyst's participation in its transformation, its depersonification, and its abstraction. The safety and security that is part and parcel of the establishment, and the repair of disruptions in the selfobject tie, then opens up possibilities for the revival and establishment of other affective relationships in the analysis.

Fourth, Reed described her countertransferences of feeling hopeless, frustrated, trapped, and bored. She interprets this as the patient's attempt to arouse the analyst's hostility. The countertransferences she described are typical of those felt by analysts who believe that what they experience is not only a clue to the transference but has been evoked in them by the patient. When an analyst resents being experienced by a patient as fulfilling a selfobject function, the patient's need for the analyst may then be interpreted as an attempt to control, devalue, or negate the presence, aliveness, or goodness of the analyst. From a self psychological perspective, the analyst's ability to tolerate being experienced as a selfobject function is posited to be crucial for the eventual transformation of pathological narcissism.

Fifth, although Reed (1996) states that "classical theory puts us in the humbling position of not knowing anything about the patient's meaning from the manifest content, including the manifest content of the transference" (p. 142), she equates her own manifest experience of feeling "trapped like a rat" as indicative of the patient's motivation. She assumes that how she feels is how the patient made her feel or intended her to feel. However, from the assumption that any experience of the analyst or the patient in the context of the analysis has been organized by both, though not similarly or to an equal extent, the contributions of each participant would be investigated.

Sixth, Reed views narcissism as a defense to be analyzed and resolved. In contrast, self psychology views narcissism as serving vitally needed self-sustaining and self-restorative functions. In the context of the sustained selfobject transference, the patient's narcissism would be expected to evolve from concrete forms to more abstract and depersonified forms. For example, one might anticipate that the patient's rigid self-protection would eventually yield to a greater resilience in her perception of herself and others.

Seventh, from Reed's vantage point, the patient's protestations that she was trying to do what was required of her in analysis were viewed as
resistive and an aspect of her character pathology. In contrast, from the standpoint of the leading-edge strivings of the patient, the patient's concretized (Atwood and Stolorow 1984) efforts to comply with and connect with her analyst require recognition. Subsequently, trailing-edge interpretations derived from her associations and the meaning and implications of her specific method of complying and connecting could be investigated.

Eighth, according to classical psychoanalytic theory (Freud 1914b) narcissistic patients are assumed to be unable to form genuine interpersonal relationships. Thus, the patient's positive feelings were suspect. Reed understood her experience of frustration and hostility as a consequence of the patient's projections. In contrast, when these strivings for self integration and selfobject experiences are understood and affirmed as legitimate efforts on the part of the patient to maintain or sustain herself, other (leading-edge) motivations can be investigated with less potential iatrogenic resistance and defensiveness.

Reed concluded her account of this analysis by stating that the patient became aware of who she was, developed stable relationships, married, and gave birth to a child. Numerous somatic symptoms (e.g., dermatitis) decreased or disappeared. Just as classical Freudian or relational analysts cannot argue that a patient treated by a self psychologist would have received a better analysis from a treatment guided by their position, self psychologists cannot argue the reverse. As I will discuss later, in any treatment, analyst and patient form a system, and it is this analyst–patient system that can reveal the processes that account for therapeutic change. My point in contrasting Reed's treatment approach with a self psychological one was to highlight the major differences in assumptions, both theoretical and clinical, and spell out the domain of self psychology, which I explore and enlarge as well as modify.

Reed's treatment of her patient illustrates a theory of narcissism and therapy in which hostility is inferred, and assumed to be concealed beneath positive, idealizing feelings. This inference constitutes one of the traditional analytic assumptions; others are that beneath feelings of inadequacy there is unbridled grandiosity, beneath grandiosity there lies inadequacy, and beneath love there lurks hate. Within this perspective, good psychoanalytic treatment demands that the message is never the message (compare to Lichtenberg et al. 1996, principle of technique, “the message contains the message,” p. 94). These assumptions that the patient has concealed rage, envy, and grandiosity, require stringent application. They place the analyst in the role of explorer at best, and in the role of surgeon, onion peeler, or sledgehammer wielder at worst.

In the view of some treatment approaches to narcissism, a patient's self-centeredness and infantile sense of entitlement constitutes an attack by the patient on his or her love objects—past, present, and transferenceal. On Kohut's couch, such meanings are not ruled out, but must be arrived at in each particular case. However, a patient's expectation of perfection and feelings of defectiveness are not, a priori, viewed as defensive and to be analyzed and relinquished, but as analyzable selfobject transferences. An emphasis on the reactive nature of aggression and on the self-maintaining function of narcissism leads to the view that self-centeredness constitutes a person's striving to attain or maintain a sense of self-cohesion, continuity, and vitality.

Especially when it comes to problems with aggression, there is a close connection between how treatment is conducted and how aggression is understood. However, I do not believe that there is only one treatment approach that emerges from a particular theoretical perspective. The exquisite varieties of human nature, specifically, the variations of aggression, challenge any treatment approach that presents itself as cast in stone. Thus, I believe there is validity to the criticism that self psychology needs to put forward a more comprehensive, coherent view of the variety of functions, meanings, manifestations, and expression of, and defenses against the expression of, aggression in analysis.

The controversy between those following a theory of treatment that assumes innate aggression and those following a theory of reactive aggression will reemerge in the chapters to follow. However, to conflate the legitimate debate over the clinical application of the theory of reactive versus innate aggression with attacks on and criticism of the theory and clinical application of self psychology is a different matter.

Contrary to the opinion of the analyst who said to my patient that self psychologists don’t know anything about aggression, self psychol-
ogy as a theory attempts to neither minimize nor ignore rage. Rather, in its clinical application, the self psychologist strives to place rage into the context of self-experience. Though as a group, we are often accused of needing to be nice and empathetic, I react badly to having my theoretical views misunderstood, or worse, distorted. Therefore, I offer a final word to the critics of self psychology, illustrating my reactive aggression. In a footnote in Civilization and Its Discontents, Freud (1930) quotes the German poet, Heinrich Heine:

Mine is a most peaceable disposition. My wishes are: a humble cottage with a thatched roof, but a good bed, good food, the freshest milk and butter, flowers before my window, and a few fine trees before my door; and if God wants to make my happiness complete, he will grant me the joy of seeing some six or seven of my enemies hanging from those trees. Before their death I shall, moved in my heart, forgive them all the wrong they did me in their lifetime. One must, it is true, forgive one’s enemies—but not before they have been hanged. (p. 110)

The Aggressive Toddler and the Angry Adult

Armed with the fundamental principles of self psychology, the centrality of self experience, empathy, and introspection as tools of observation; the selfobject dimension of the transference; repairing of empathic ruptures and selfobject failures; and the twin edges, leading and trailing; we are prepared to examine the development and analysis of aggressive reactions. When aggression is seen as the well of rage that is part of every human being, there is a parallel assumption that at birth the well is already well supplied. The case for aggression as an innate drive in full swing in toddlers, and the case for aggression as reactive, are illustrated in two vignettes, one from a paper by Anna Freud and the other from the work of Gerald Stechler. Each analyst illustrated aggression in a toddler. First, Anna Freud’s vignette from her 1972 critique, “Comments on Aggression”:

Toddlers are not easy to control in groups, since they are extremely aggressive towards each other. To take hold of a toy, food, sweets, to get attention, to move an obstacle whether human or material, or for no obvious reason at all, they will bite, scratch, pull hair, throw
over, hit out, kick, etc. Nevertheless what emerges is not a physical
fight between two hostile partners as it would with older children.
Instead, the victim of attack dissolves into tears, runs for protection
or stands helpless and needs to be rescued. What puzzles the ob-
server is the fact that this attacked child may have been an aggres-
sor himself a short time previously or may be soon afterwards, i.e.,
that he is by no means without aggression and its tools himself. He
has both but is unable still to employ them in the service of de-
fence. [pp. 169-170]

From these observations Anna Freud inferred that aggression de-
velops in a sequence, a developmental line along which the ability to
attack others is primary and a direct expression of the aggressive drive.
Defending oneself is an acquired response, a defense mediated by the
ego.

To Anna Freud toddlers appeared to be extremely aggressive. The
primacy of their aggressive attacks is evident in their taking hold of a toy
and “for no obvious reason at all” (p. 169, italics added) biting, scratch-
ing, or hitting another child. The sequence of aggression dissolving into
tears is seen as indicative of aggression as primary, whereas aggression as
a defense is reactive, learned, and therefore secondary. In contrast, I quote
the following vignette offered by Gerald Stechler (1987):

We are in an infant and toddler day care center. On the floor, in the
center of a well-lighted playroom, a young but experienced child-
care worker is sitting with a newly enrolled eight-month-old girl,
Laura. About three feet away a 14-month-old girl, Jane, is also sit-
ing on the floor looking at the other two. Jane has a push-toy with
a musical wheel at the end of it. She is moving it with her left hand,
slowly and then more forcefully advancing it toward Laura. The
worker responds by first positioning her body to protect Laura,
and then by reaching out and removing the toy from Jane’s hand.
As she does this, she says to Jane, “Why don’t you do it with your
other hand?” At that point she brings the toy around and puts it in
Jane’s right hand. Jane has plenty of open space on her right side,
and starts to push the toy in that direction with increasing vigor.
Her facial expression becomes more joyfully excited. Finally she
stands up and walks the toy across the room, pleasantly vocalizing.
[p. 348]

Stechler described the act of moving the toy as primarily joyful,
assertive, and exploratory. Should Laura have appeared as an obstacle in
Jane’s path, had there been no child-care worker present, Jane would
surely have pushed the toy into Laura. At that point Jane and Laura
might have pushed each other or cried, as Anna Freud described. To
Stechler, however, self-protection is primary and an aggressive attack is
a consequence of a misregulated infant-caregiver system in which nor-
mal assertion becomes attack aggression.

DIFFERENCES IN HISTORICAL CONTEXTS

Among the numerous differences between these two vignettes are the
different models of early development. Stechler’s illustration dates from
the era of Sander (1977) and Stern (1985), when the empirical studies
of infancy had already made an impact on psychoanalytic theorizing. In
contrast, at the time of Anna Freud’s writing, the most important em-
pirical contributions to early development came from Spitz’s (1965) work.
In the developmental theory of Spitz, the neonate lived in an “objectless
stage, a world in which there is neither an object nor an object relation”
(p. 35). Spitz contended that not until about age 3 does a rudimentary
ego organization coalesce. Prior to that time, as the neonate is stimu-
lated, energy is discharged in a random and diffuse manner.

Beginning at about 3 months, according to Spitz, the neonate is
able to “discharge energy” through more controlled action. Then “di-
rected action proper becomes not only an outlet for the discharge of
libidinal and aggressive energy, but also a device to acquire mastery and
control. The infant shifts from passivity to directed activity at the stage
at which the smiling response appears. The emergence of the smiling
response initiates the beginning of social relations in man” (pp. 106-
107). Spitz emphasized that aggressive energy is not limited to the expression of aggression, but serves as the motor of every movement and activity, and of life itself.

This is the essence of the model of aggression from which Anna Freud observed her toddlers, and which still, implicitly and explicitly, underlies much psychoanalytic theorizing and treatment. The crucial assumptions of this model are that aggressive energy refers to a life force and is also linked to the expression (discharge) of hostility, rage, sadism, anger, and destructiveness. Furthermore, according to Spitz, aggression as a driving force predates the organization of an ego. It also predates attachment to objects since for Spitz social relations began with the smiling response, not at birth.

When aggression is seen as the motor of life itself, a life force, and is conflated with destructive aggression, survival requires aggression (and sexuality). In contrast, Kohut proposed that survival hinges on the quality of the selfobject tie between the infant and its parents. Kohut thus singled out inborn attachment motivation as necessary for ensuring survival. Although it may be argued that these two visions of human nature do not have to be either/or, I believe a more encompassing question is: Are these motivations sufficient to capture the panoply of human motivations? In the next chapter a number of other basic motivations will be described that are implicated in survival.

Mahler and colleagues (1979) entered the nursery with assumptions similar to those of Anna Freud and René Spitz. They attributed children’s early severe temper tantrums and ambivalent reactions, especially upon loss or separation from the mother, to a too sudden and too painful deflation of their omnipotence. They proposed that trauma from external sources is certainly implicated, but ego development must be such that drive discharge is regulated and effective. They held that ego immaturity characterized by infantile grandiosity can eventuate in the discharge of aggression as a tantrum. For Mahler and colleagues, development hinged directly on the deployment of the aggressive drive and the fusion of libido and aggression.

Using empirical studies of infants and viewing Mahler’s films as a point of departure, Karlen Lyons-Ruth (1991) challenged Mahler’s formulation and thereby the entire theoretical edifice upon which they were built. Lyons-Ruth concurred with Mahler’s stress on the clinical significance of the ambivalence she noted in toddlers. After separation from the mother, Mahler observed, the toddlers would shriek and push away from their mother, bang on the door through which the mother left, collapse on the floor, and cry. But, Lyons-Ruth questioned, “Are these behaviors tied to the mother’s ‘too sudden deflation of omnipotence’ or failure to remain available to the child as a source of comfort and ‘refueling’ after toddlerhood begins?” Lyons-Ruth suggested that “the anger, distress, and avoidance directed by these infants toward their mothers at 18 months is part of a more deep-seated disturbance of the caregiving relationship” (p. 8).

Lyons-Ruth’s (1991) challenge to traditional psychoanalytic thinking about early development goes even further. She noted the conceptual contradiction in the traditional developmental theory of psychoanalysis that infants lack the ability to organize separate psychological representations of self and other, but can keep separate their representations of good mother/self and bad mother/self. She reasoned that it would follow that the ambivalent, angry behaviors of infants alternating with positive behaviors would underlie such early psychological organizations. However, such behavior is not prevalent among infants prior to 15 months of age during the time when split object representations are hypothesized to exist. It is specifically among children at serious social risk that ambivalent angry behaviors become increasingly prominent. Thus, Lyons-Ruth argued that the developmental evidence is more congruent with the notion that, under conditions of adequate caregiver regulation, the infant develops smoothly integrated behavior patterns and representations, involving both positive and negative components. By contrast, when caregiver regulation is inadequate, the infant develops increasingly well-articulated and distinct negative representations of self and other, which are poorly integrated with representations of positive interactions. “Poorly integrated positive and negative representations are not intrinsic to early infant functioning, but a gradual developmental acquisition under conditions of disturbed regulation” (p. 13).

Lyons-Ruth stated that the central difficulty with Mahler’s theory
of infant behavior during the rapprochement period lies not with her rich behavioral observations but with her failure to distinguish clearly between normative and deviant developmental pathways. In retrospect, that Mahler saw disturbed behavior as normative for a particular developmental period was consistent with the psychoanalytic developmental theory of her time. Typically, early developmental periods were seen as having characteristics of adult psychopathology.

GENDER DIFFERENCES

In addition to the differences in historical contexts and in the theoretical perspectives underlying Anna Freud’s and Gerald Stechler’s vignettes, there are other noteworthy differences. They embody different philosophies of human nature, different theories of motivation, and different assumptions about the relationship between assertion and aggression. Differences in the gender of the toddlers in the two vignettes may also be implicated. Anna Freud seemed to be describing boys, whereas Stechler’s illustration is of two girls.

In discussing the cases included in this book, I do not make gender comparisons. I use selected cases to illustrate specific points, and to do so I use more illustrations from the analyses of men than of women. Although it is possible that inferences about the varieties of aggression are gender linked, I hesitate to use my highly selected anecdotal material to generalize about the relationship between expressions of aggression and gender difference. This is clearly an area in need of rigorous empirical and clinical studies.

I will also leave aside differences in temperament, such as different predispositions to various affective responses. For example, in Stechler’s illustration Jane might simply have been a particularly cooperative toddler. In similar circumstances another toddler might have responded more aggressively to Laura and to the child-care worker. However, the point of this discussion is not how to produce happy, cooperative toddlers, but to recognize that whatever transpires in the playroom has been co-constructed. Whatever transpires is an emergent behavior, organized between the toddlers and the present or absent child-care worker.

Anna Freud tells her story from the vantage point of a noninterfering, neutral observer. Gerald Stechler includes the active participation of the child-care worker. In fact, a toddler playroom without an intervening child-care worker might indeed come to resemble the situation described by Anna Freud. In the absence of such an observer-participant, an attack scenario might have been played out. From Stechler’s vantage point, however, the attack would not be an indication of primary aggression, but a consequence of an unregulated or misregulated toddler-caregiver system. For example, if the child-care worker’s attention to the new girl, Laura, had prompted Jane to try to draw the child-care worker’s attention, Jane might have attempted to attack Laura. However, that expression of aggression would then have been reactive and a product of the child-caregiver system.

In Stechler’s illustration, Jane was interested in exploring her environment, in her efficacy, and in the pleasure of her adventure. Territory and self-assertion did not seem to be top priorities for her. Another toddler, with a different history or temperament, might have been more intent on asserting her dominance in that situation, and a different interaction would have been organized. However, the presence and interventions of the child-care worker would still be crucial in the interaction. She contributed by directing Jane’s activities toward exploration and enabling her to enjoy her efficacy, rather than toward facing an obstacle and dealing with a potentially competitive, aggressive scenario. The difference between the two vignettes that I want to focus on is the presence of the intervening observer who co-constructs and regulates the interaction.

The intervening observer makes a crucial difference, both in the playroom and in psychoanalysis, and both in theory and practice. It follows that what is labeled “aggression” and what is observed to be aggressive is crucially dependent on interventions made or not made, their context, and the theory in the mind of the observer, whether child-care worker or analyst.
DESTRUCTIVE AND NONDESTRUCTIVE AGGRESSION

The intertwining of normal and pathological behavior has been a continuing vexing problem in the evolution of psychoanalytic theory and practice. This problem is particularly evident in the theories of aggression so that destructive and nondestructive aggression must be phenomenologically distinguished, and assertion and aggression require disentangling. I now consider the distinction between nondestructive and destructive aggression in the context of Henri Parens’s (1979) work. (The relationship between assertion and aggression is considered in the next chapter.) Generally, analytic observations express the preferred theory of the observer. An exception is provided by Parens, who assumed, when he began to study toddlers, that aggression was an innate drive. In the course of his observations, he changed his mind. He emerged from these studies with the conclusion that destructive aggression is reactive for both boy and girl toddlers although expressed differently by these two groups.

Parens wrote within a psychoanalytic tradition that required him to consider the range of “aggression from self-assertiveness through mastery, rage and hate” (1979, p. 99). He reported that his findings were consistent with the reports of psychoanalysts who have argued for an inherently nondestructive trend in human aggression. He recommended that aggression be considered to range from inherently nondestructive to destructive.

Parens characterized nondestructive aggression as “compelling peremptory exploration, examination and manipulation of everything. Its aim [is] the exploration, asserting oneself upon, control, assimilation, and mastery of the self and environment” (p. 101). In contrast to destructive aggression, nondestructive aggression “has a spontaneous origin. From the first weeks of life, the awake, satiated infant explores, searches visually more or less intently, in what may be inferred to be his first efforts to control and assimilate the environment” (p. 102).

In his discussion Parens linked the nondestructive form of aggression to self-assertion. A further discussion of the relationship between aggression as reactive and assertion as proactive will be found in the next chapter. Destructive aggression or hostile destructiveness, however, according to Parens, “requires an underlying, excessively felt displeasure experience for its mobilization” (pp. 110–111).

SELF- AND INTERACTIVE REGULATION

The question of how aggression emerges from a regulated or misregulated interaction is at the heart of studies of self- and mutual regulations. Understanding the bases for assertiveness and reactive destructiveness requires a prior discussion of the regulatory processes that provide the context for these varieties of aggression and assertion. Self- and mutual regulations depict a basic level of interaction patterns that underlie the organizational experience in infancy as well as in subsequent development (Beebe and Lachmann 1988,a,b, 1994).

Optimally, self- and interactive regulation between infant and caregiver, toddler and parent, and patient and analyst are in some balance (Beebe and McCrorie in press, Lachmann and Beebe 1996a). In the absence of needed parental responsivity, the developing child may turn to solitary self-regulation. Then the child’s expectations may become organized around distinct positive images of self and other. Poorly modulated expressions of aggression will then predominate, as illustrated by Lyons-Ruth (1991).

In infants, self-regulation refers to the capacity to regulate arousal; to activate arousal to maintain alertness and engagement with the world, and to dampen arousal in the face of overstimulation; and to calm or soothe oneself or to put oneself to sleep. Self-touching, looking away, and restricting the range of facial expressiveness are examples of infant self-regulation strategies during face-to-face play. In adults, self-regulation includes symbolic elaborations, fantasies, identifications, and defenses. In infancy as well as adulthood, self-regulation is a critical component of the capacity to pay attention and to engage with the partner (Beebe and Lachmann 1994, Lachmann and Beebe 1996a,b).

Sander (1977) was the first to introduce the idea that self-regulation in the infant is successfully established only through adequate
mutual regulation between infant and caregiver. The ease and intac-
ness of the infant's self-regulation, and the particular patterning of
mutual regulation, both develop hand in hand, each affecting the suc-
cess of the other.

Mutual regulation is often misconstrued as referring to positive
interaction and mutuality, and as implying a desirable outcome. Instead,
mutual regulation means that each partner's behavior affects, that is,
can be predicted by, that of the other. My colleague Beatrice Beebe and I
thus prefer the term interactive regulation since it is less likely to be mis-
used as implying a positive or desirable interaction. Patterns of self and
interactive regulation come to be expected by the infant (Beebe and
responsivity, as well as anticipating nonresponsivity, and expecting an
optimal range of closeness and distance in one's interactions, as well as
being, or fearing to be, intruded upon, are all interactively regulated.
Furthermore, interactivity organized expectations as well as
disconfirmations of the expected are all represented and internalized.
The processes of self- and interactive regulations lead to developmental
transformations and to therapeutic transformations (Lachmann and Beebe
1996a).

When self- and interactive regulation are in balance, neither pre-
dominates or is exclusive in organizing the dyad's interactions. In this
balance there is a flexible foreground-background relationship between
the two, and interactive regulation is in the midrange, neither excessive
nor insufficient. This balance can be tilted toward either pole. At one
extreme there may be excessive interactive vigilance at the expense of
access to the person's inner state. At the other extreme there may be pre-
occupation with self-regulation at the expense of engagement with the
partner. When the balance between self- and interactive regulation tilted
toward solitary self-regulation, drastic efforts were required to compen-
sate for the tilt, as in the case of David, below. His treatment illustrates
the necessity for understanding a fundamental problem in self-regula-
tion as a central factor in the development of his hostile, sullen, angry
state, and his propensity to provoke and react angrily.

THE TREATMENT OF DAVID:
SELF- AND INTERACTIVE REGULATION

The treatment of a young adult, David, can illustrate the consequences
of an early tilt in development toward solitary self-regulation. Problem-
atic interactive regulations veered David's development toward a singu-
lar reliance on self-regulation, and sullen, angry, provocative behaviors,
especially toward authority figures.

My first meeting with David was at my last session before my sum-
mer vacation. I had informed him of that, and offered to refer him to a
therapist with whom he would be able to start to work immediately,
should that be indicated. Nevertheless, he wanted to make an appoint-
ment. When we met, he was surly, demanding, depressed, and belliger-
tent during the consultation. He asked me to charge him a higher fee
than the one I quoted so that he could submit that bill to his insurance
company. They would pay 50 percent of the fee, which would then cover
the total bill and he would not have to pay anything in addition. When
I refused this request he became furious, and called me a hypocrite be-
cause he did not believe that I was always this honest.

I suspected that he might have been on drugs. He described his
depressions as cyclical and that he was at the moment in one of his
lowest troughs ever. He then mentioned his heavy marijuana use, but
that he did not consider it a problem.

David was angry at his employer, who pressured him about the
deadlines that he had been failing to meet at his work. He thereupon
informed his boss that he was quitting, but his boss suggested that he
find another job before quitting the present one. He advised David that
it was not prudent to quit a job until you have another. Angered, David
called his boss patronizing. As the session drew to a close, I suggested
that because he was so visibly angry, depressed, clearly unable to func-
tion, and suffering, he should have a consultation with a psychophar-
macologist. I told him to call me in the fall. Privately, I did not think we
had made a great connection, and I did not expect to hear from him
again.
When I returned in the fall, I received a call from David asking me whether I would be willing to work with him. Not to be undone by his sadomasochism, I agreed. At our next meeting a strikingly different David appeared. He was well related, civil, more relaxed, and clearly sober. We agreed to meet twice a week.

This dramatic change in David's manner lasted throughout the entire time we worked together. I discovered later in his treatment that this change coincided with the decrease in his use of marijuana. What remained evident outside of his treatment, however, was a provocative version of his hostile manner. In the sessions, I could only see subtle, passive-aggressive manifestations of his angry, sullen side. For example, as we explored his tendency to procrastinate, it became clear that he would almost finish a paper for school and then go through a series of requests for deadline extensions and failures to comply with the extensions, through which he would taunt his professors. In the sessions he reported these "successes" in maintaining his passive-aggressive stance as a way of indicating to me that our work had not altered this pattern.

When David was 11 years old he made a discovery that profoundly affected his life. He, his parents, younger sister, and older brother usually had Sunday lunch at the house of his paternal grandparents. One day as the family sat around the dining room table and talked, David explored the house. He came upon the room that had once been occupied by his uncle, his father's younger brother. The room, long vacant, had been left intact just as his uncle had left it when he moved out many years ago. In it he discovered a treasure trove of pornography, including bondage and sadomasochistic literature. After that, visits to Grandpa and Grandma were never the same. David would sit quietly waiting for lunch to be over. Time passed slowly until he could, unobtrusively, make his way up to his uncle's room to spend the afternoon. Then time flew as he thumbed through the books and magazines.

No one in the family noticed David's absence or seemed concerned about where he spent the afternoon. Typically, no one paid attention to him, and his secret was never discovered. These visits continued until his early teen years. They provided a seamless transition into a fantasy life to which masturbation was added. His masturbation fantasies were derived from the imagery of the books and magazines he read.

In his fantasy life, David identified with the women. He imagined himself dressed in silk clothes, highly desirable, and subjected to torture, bondage, and discipline. His view of himself as an alluring, sadistically treated woman stood in stark contrast to his daily life. There he felt and appeared masculine, although he increasingly became a severely depressed, angry, and rebellious young man. His academic potential and intellectual resources were constantly imperiled by his debilitating depression and obstinate procrastination of academic requirements, but mostly by his sullen, angry defiance toward authority.

David was born with impaired hearing, which was not recognized by his parents. It was not corrected until he was about 5, when the impairment was recognized in school. Until that time he also had speech problems. David stated that, according to his mother, she and he developed a private sign language. This communication did not develop into a substantial intimacy with his mother, but was probably more associated with her neglect of his actual problem. When David recounted this material, halfway through the first year of therapy, we characterized his early life as isolated and lonely. In addition to his hearing and speech impairments, he had to make sense out of his experience and feelings, mostly on his own. As a result of the school's attention to his problems, he was given speech lessons and reading remediation, and a myringotomy was performed, in which a hole is created in the tympanic membrane to drain fluid from the ear. His hearing and reading improved rapidly, as did his speech. To this day a very slight speech impairment is noticeable. However, most important, regulation of states of over- and underarousal, and organizing his experience became his task, alone. A tilt toward solitary self-regulation in the absence of participation by his family characterized his early development. Solitary self-regulation was reinforced and repeated throughout his later development and eventuated as his characteristic seething, hostile withdrawal.

Going to school had been anxiety arousing for David from the start. He recalled daily, early morning stomachaches. To deal with his anxiety, he developed a "curative" self-regulatory ritual. He would set his alarm
clock to awaken him two hours before he needed to get up in the morning. A portion of these two hours would be spent watching the clock. By watching the clock he felt he could slow down the passage of time. He said, “You know it works. When you watch the clock, time seems to pass more slowly.” Watching the clock, slowing down time, succeeded in restoring his sense of mastery. His anxiety decreased and his stomachaches vanished.

David’s experience in his uncle’s room brought together a number of prior themes, which reinforced his solitary self-regulation. That is, David had found a way of arousing and stimulating himself, and escaping from his feelings of resentful isolation and loneliness. The extent to which he felt that time dragged as he waited to enter his uncle’s room and the speed at which time raced as he examined the pornographic literature contributed to his feeling that he could control time.

In the opening weeks of therapy, before I had learned of his visits to his uncle’s room, David questioned my trustworthiness. At this early time in the treatment, I could only connect his question about my trustworthiness with his concern that he would be left alone. Could he trust me to watch out for him, and make sure that he did not undermine treatment? Later, I could understand his worry about me: Would I get off my chair at the dining room table and find out what he was doing upstairs? Would I offer him some concerned engagement, or would he repeat with me his experience of abandonment to his own strained resources? Yet, his characteristic defiant stance, it seemed to me, also expressed some hope of countering abandonment by provoking others to attend to, react to, and thereby acknowledge him. I understood him to be striving to engage me in his solitary, massive self-regulatory efforts.

The leading edge of David’s sadomasochistic fantasies pointed toward their function as self-regulators of affect and arousal, as attempts to self-stimulate as well as self-soothe, and attempts to dispel his isolation, chronic anger, and gloom. In singling out and interpreting David’s self-regulation, the more familiar trailing-edge dynamic formulations, for example, the presumed unconscious implications of his behavior, are placed into the background. These include his subtle expressions of contempt for and hostile behavior toward authority figures. In the foreground are aspects of self- and interactive regulations that are often taken for granted.

The salient needs that evoked no response from his parents are depicted in his fantasies. That is, the fantasies depicted a highly responsive interactive engagement in which David as a provocative woman evoked hostile attention, which he found sexually arousing. At the same time the fantasies provided David with the means for self-regulation of arousal. In fact, they provided him with a readily obtainable self-administered antidepressant. The fantasies contributed to David’s sense of himself as unique, important, and desirable. They served as David’s precondition for functioning in the world, outside of his uncle’s room.

David had spent most of his childhood in states of friendless withdrawal, angry depression, and preoccupation with regulating his equilibrium by himself, slowing time to stave off anxiety. We believed this to be the precursor of his sudden withdrawal states characteristic of his later years. Once he found his uncle’s pornography, the “cure” for his depression resulted in overwhelming, unmanageable overstimulation. Maintaining some separation between the uncle’s room and the outside world became urgent. How to deal with the intensified swings in his feelings, always by himself, became his ongoing, self-regulatory challenge.

David reported that his parents were primarily self-absorbed; secondarily they were absorbed with each other. The children came last. By the time he reached adolescence, David was not sure that obtaining his parents’ interest was preferable to being ignored. However, his description of his family reflected the extent to which his relationship with his parents left him feeling very much alone. He expected to be unseen, unheard, and abandoned to his withdrawn and isolated state.

David’s pattern of solitary self-regulation organized our relationship as well. He anticipated that I, like his parents, would be primarily self-absorbed, and if I did think of him, it would be to criticize him. In light of this, he spoke in a reportorial manner, observing himself without what I would have thought of as self-reflection. I think of self-observation as characterized by a colder and more dispassionate self-view. Self-reflection would be more affectively varied. In fact, the most visible
affects in David were depression, chronic unhappiness, and a low level of anger.

In treating David, I had in mind certain assumptions that have been proposed by Loewald (1980) and Kohut (1971) and that were later articulated from a different theoretical perspective by Fonagy (1991). I believe that each of these authors contributed to an elaboration of the interactive context that is crucial for understanding the extent to which solitary self-regulation can lead to aggressive reactions becoming dominant in a person's life. What Fonagy has added to Loewald and Kohut is the importance of feeling oneself to be in the mind of the other as a constituent of interactive regulation.

Loewald held that the mother, in interactions with her child, maintains a somewhat more organized picture of the child than characterizes the child at that particular moment. She thereby furthers the developmental process. With respect to analyst and patient, Kohut suggested that the analyst must necessarily hold a slightly more organized, better integrated view of the patient than the patient holds. In the eyes of Kohut and Loewald, the mother as well as the analyst provides a context of responsibility in which a sense of direction and a feeling of self-integration can develop. In Kohut's and Loewald's terms, David needed a partner who could see him, hold him as he is, and simultaneously hold a somewhat more cohesive, continuous, and positive picture of him (Solorow and Lachmann 1980).

At the time I treated David, I was not yet familiar with Fonagy's (1991, 1999) work on the link between having experienced oneself in the mind of one's parents and the development of a self-reflective capacity. That David felt his parents did not hold him in their minds emerged implicitly in the course of his treatment. His desperate attempts to counter his anxiety and depression by himself from an early age on, through fantasy and pornography, can be linked to his sense that he was neither felt, seen, nor heard by his parents. A deadening of self-experience followed, leading him to attempt to buttress a sense of visibility and to provide self-cohesion through aggressive outbursts and sexualization.

When David began therapy, he also began graduate studies. He described involving his professors in his very private struggle. He succeeded in evoking their concern: Would this bright student who participated in class get his work in on time? David explained that indirectly he would be saying to the professors, "Fuck you," but simultaneously, to himself, "Work!" He added, "I always need to find the Achilles heel, and provoke. I can't survive in a context in which the right response to 'jump' is 'How high, sir?"' The similarities between this behavior and the sadomasochistic fantasies became obvious to David and me. That is, he provoked his professors so as to engage them in a sadomasochistic relationship, just as he tried to do at various times in the therapy. His professors had the power to discipline him and he, as the student, was tied up in a helpless position. He then regulated his heightened arousal, anger, and defiant triumph through his withdrawal and by calming himself through detachment. Eventually, the arena shifted to an internal struggle in which he defied authority and would become depressed and self-loathing. To combat his depression and isolation, he would once again try to enliven himself by calling upon his sexual fantasies.

David and I noted the parallels between his behavior with his professors, his sexual fantasies, and his presentation of his provocative procrastination in the therapy. I focused on his need to maintain self-control and his dread that were he to relinquish it, he would be ignored. I said to him that to ignore the sexual fantasies implicit in this pattern with his professors would smack of a repetition of his earlier experience that no one cared what he was up to. Now, as then, he would be abandoned to solitary overstimulating experiences. But to link his behavior and his sexual fantasies too closely by assuming an underlying well of rage that has been sexualized as well as turned against the self would place the fantasies at the root of his difficulties in school. The extent to which he relied on his fantasies as his major or perhaps sole source of excitement might then be in jeopardy. Through his fantasies, David felt alive, passionate, and, at least temporarily, not depressed. I interpreted the sexual fantasies, their role in his procrastinations, and their function in his affective life.

Had I stayed only with the sexual fantasies, David and I would have come close to enacting either his sadomasochistic fantasies or his early abandonment experiences. I would have become the authority who
deprived of his self-control as well as the sadistic figure to whom he wanted to submit. We would have come close to his feeling sexually gratified, enraged, and humiliated. As I learned later, this is what he had expected, and it would have led us into a stalemate with which he was familiar. Had I pursued the fantasies without acknowledging the dilemma that we were facing, we might have tumbled headlong into an enactment that would have iatrogenically evoked aggression.

David could appreciate the dilemma I outlined. He thought that to pursue the issue of his fantasies might be “interesting, and would probably not affect the fantasies very much.” Through my description of our dilemma, I attempted to convey to David my sense of him as potentially capable of setting priorities for his sexual and academic needs and motivations, in short, able to initiate, organize, and integrate his experience in the context of our dialogue. That is, I attempted to convey my sense of his potential self-regulatory capacity in the context of our ongoing interaction.

A thread of continuity can be drawn from David’s lonesome clock watching and procrastination in grammar school, and his solitary self-regulation in his uncle’s room, to his current writing blocks. David concurred, “I have to do it alone. That was certainly true then.” Amplifying on the extent to which he felt neither seen nor heard by his parents, he added, “I could not have risked involving my parents because they might not have responded and I couldn’t risk finding out.” David was clear in his expectations of nonresponsivity. He had resolved to handle things on his own so as not to risk being disappointed.

For David, expectations of nonresponsivity led to his reliance on self-regulation of affect and arousal. Repeatedly he felt unattended to, exploited, and manipulated. In reaction, he sharpened his argumentativeness, an asset when he engaged in controversy, but a liability when his argumentativeness shaded into hostility and led to defiance or procrastination, as occurred in his oral presentations in school.

Toward the end of the first year, David’s finances were still quite limited. He had counted on a one-year teaching assistantship for the following year. In spite of “shooting myself in the leg” by delaying applications past the deadline, David was offered a one-term assistantship.

His procrastinations were not as blatant as they had been, and although he had handed in his application for the position past the deadline, it had not been unreasonably late. The one-semester assistantship he received was in recognition of the good work he had done in the class of the professor he would be assisting.

With regret, David spoke of having to cut down to one session per week, but promised to “run the figures again” to see if anything could be done. When I raised the issue a few sessions later, he told me that he could only come once a week; more frequent sessions would not be financially possible. I said, “Well, we’ll have to talk as fast as we can.” He responded by telling me that he felt criticized. My comment ruptured the selfobject tie that had slowly been engaged. By this time in the treatment, however, David could initiate restoration of the tie by telling me that he felt hurt. He heard me say that I thought he had not been making good use of the time. We explored his reaction. He was reminded of his unpleasant experience with the psychiatrist whom he had seen briefly before he began treatment with me. I told David that I was glad he could tell me directly how he felt, rather than handle his hurt feelings as he did with the psychiatrist, by leaving precipitously.

In a subsequent session David and I came back to the interchange that had left him feeling criticized. I had not wanted to explain or excuse my comment. Nor had I wanted him to feel his response was inappropriate or excessive. When I felt that we had restored our dialogue, I told him the context of my remark. I had thought he might have known it, but he did not. “A man and a woman were dancing at a resort and one says to the other, ‘Do you know this is costing us $18 per hour?’ The other answers, ‘I’m dancing as fast as I can.’”

David laughed and said he enjoyed my telling him this story. He then proceeded to tell me about the origin of a Yiddish word. I asked him about the meaning of his story. He told me that he had just learned about this derivation and thought I might be equally interested. He added, since I told him a story, gave him a present, he wanted to give me one. He called it a “reciprocal communication.” In my story I alluded to David and me dancing together. In his story he indicated that we share a common background. We are both Jews. David’s treatment ended after about
two and a half years when he received a fellowship for graduate studies that required his relocation to another city.

AFTERTHOUGHTS

In retrospect, David's difficulties could have lent themselves to the theory that narcissism precludes a capacity for object relationships. He was a loner and very much engaged in a fantasy world in which he was an object of intense desire. The treatment implications of this view would have pointed toward an essentially confrontational stance vis-à-vis his fantasies and behavior. David actually had expected me to take that path, and we discussed that he was prepared to stymie me had I done so. But, more important, since I do not believe that a link between self-absorption and social withdrawal coupled with a private grandiosity is invariably found, I saw no basis for assuming such a connection in David's treatment. Rather I assumed that the more competent he felt about managing his own states, the less he would feel compelled to withdraw into his fantasies and defiant behavior. I had not used the language of interactive regulation in working with him, so his "reciprocal communications" came as a surprise to me. He formed a relationship with me without my having directly pushed for it.

David's life was suffused with the consequences of his propensity to react provocatively and to withdraw. In his life he provoked anger and disappointment toward himself through procrastination and his pointedly defiant behavior, by shooting himself in the leg, as he termed it, by inevitably just failing to meet deadlines, work requirements, and school assignments.

As in the nursery described by Anna Freud, I noted the absence of intervening observers in David's development. The therapeutic process itself became the crucial carrier of a necessary interactive engagement. In this process, through establishing a balance between self- and interactive regulation, self-regulation became somewhat less burdensome for him.

Following Kohut's theory, I kept track of David's self-destructive, passive-aggressive, and provocative behaviors, by consistently exploring what he needed to do to enliven and soothe himself. I focused on his difficulty in maintaining self-control and his struggles in self-regulation. Without mentioning it in the course of our work, David had clearly cut down on his use of marijuana considerably. His self-regulatory problems were probably increased by his decision no longer to use marijuana as an affect regulator.

Shifting the balance between self- and interactive regulation was not directly addressed in the treatment. Rather, the quality of our engagement was a nonspecific aspect of the treatment process and served as a context for his increasing self-regulation of affect. David's social withdrawal diminished as he joined schoolmates in sports and other activities. Thus, by the end of the second year of therapy, David was able to offer me a "reciprocal communication."