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The Intersubjective Perspective
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8

AGGRESSION IN THE PSYCHOANALYTIC SITUATION

Robert D. Stolorow, Ph.D.

IN THIS CHAPTER I APPLY THE conception of the psychoanalytic situation as a continuously shifting intersubjective field to the problem of aggression in the psychoanalytic situation.

Our thesis, elaborated in detail in *Structures of Subjectivity* (Atwood and Stolorow 1984), is that psychoanalytic treatment seeks to illuminate phenomena that emerge within a specific psychological field created by a dialogue between two subjectivities—that of the patient and that of the analyst. In this conceptualization, psychoanalysis is not seen as a science of the intrapsychic, focused on events presumed to occur within one isolated "mental apparatus." Nor is it conceived as a social science, investigating the "behavioral facts" of the therapeutic interaction as seen from a point of observation outside the field under study. Rather, psychoanalysis is pictured by us as a science of the *intersubjective*, focused on the interplay between the differently organized subjective worlds of the observer and the observed. The observational stance is always within, rather than outside, the intersubjective field or "contextual unit" (Schwaber 1979) being observed, a fact that guarantees the centrality of introspection and empathy as the methods of observation (Kohut 1959). Psychoanalysis is unique among the sciences in that the observer is also the observed (Stolorow and Atwood 1979). In our earlier work we explored the implications of this inter-

subjective perspective for the understanding of transference and countertransference, negative therapeutic reactions, psychopathology, and therapeutic action. I now extend this intersubjective viewpoint to a consideration of aggression in the psychoanalytic situation. My particular focus will be the intense hostility that is often found to pervade the treatments of severely disturbed patients.

The intersubjectivity concept that we have proposed is a direct outgrowth of the psychoanalytic understanding of transference and countertransference. The concept of transference may be understood to refer to all the ways in which the patient's experience of the analytic relationship becomes organized according to the configurations of self and other that unconsciously structure his subjective universe. The transference is actually a microcosm of the patient's total psychological life, and the analysis of transference provides a focal point around which the patterns dominating the patient's existence as a whole can be clarified, understood, and changed. Countertransference, in turn, refers to how the structures of the analyst's subjectivity shape his experience of the analytic relationship and, in particular, of the patient's transference.

From the continual interplay between transference and countertransference two basic situations repeatedly arise: *intersubjective conjunction* and *intersubjective disjunction*. The first of these situations is illustrated by instances in which the configurations of self and other that structure the patient's experiences give rise to expressions that are assimilated into closely similar central configurations in the psychological life of the analyst. Disjunction, by contrast, occurs when the analyst assimilates the material expressed by the patient into configurations that significantly alter that material's actual subjective meaning for the patient. Repetitive occurrences of intersubjective conjunction and disjunction are inevitable accompaniments of the analytic process and reflect the interaction of differently organized subjective worlds.

Whether or not these intersubjective situations facilitate or obstruct the progress of analysis depends in large part on the extent of the analyst's reflective self-awareness and capacity to decenter (Piaget 1970) from the organizing principles of his own subjective world and thereby to grasp empathically the actual meaning of the patient's experiences. When such reflective self-awareness on the part of the analyst is reliably present, then the correspondence or disparity between the subjective worlds of patient and therapist can be used to promote analytic understanding. In the case of an intersubjective conjunction that has been recognized, for example, the analyst may become able to find analogues in his own life of the experiences presented to him, his self-knowledge thus serving as an invaluable adjunct source of information regarding the probable background meanings of the patient's expressions. Disjunctions, once they have become conscious from a decentered perspective, may also assist the analyst's ongoing efforts to understand the patient, for then the analyst's

emotional reactions can serve as potential intersubjective indices of the configurations actually structuring the patient's experiences.

In the absence of decentered self-awareness on the part of the analyst, such conjunctions and disjunctions can seriously impede the progress of analysis. The most common situation in which conjunction leads to an interference with treatment is when the region of intersubjective correspondence escapes analytic inquiry because it reflects a defensive solution shared by both patient and analyst. In such instances, the conjunction results in a mutual strengthening of resistance and counterresistance and, hence, in a prolongation of the analysis.

It is my view that intense, pervasive aggression in the psychoanalytic situation most often arises as a result of protracted, unrecognized intersubjective disjunctions. In such instances, empathy is chronically replaced by misunderstanding, as the therapeutic interventions are repeatedly directed toward a subjective situation which, in fact, does not exist. Such persistent disjunctions contribute to the formation of vicious countertherapeutic spirals, which serve to intensify rather than alleviate the patient's suffering and manifest psychopathology. It is in these spirals that analysts can find the source of what they have euphemistically termed "negative therapeutic reactions" and the unrelenting hostility that accompanies them.

Kohut's (1971, 1977) concepts of selfobject and selfobject transference have immeasurably deepened our understanding of human intersubjectivity and of the meaning of aggression in the psychoanalytic situation. In the selfobject transferences, the patient revives with the analyst the early idealizing and mirroring ties that were traumatically ruptured during the formative years, and upon which he comes to rely for the restoration and maintenance of a sense of self and for the resumption of arrested psychological growth. In my experience, intense hostility in the psychoanalytic situation is most often produced by prolonged, unrecognized intersubjective disjunctions wherein the patient's selfobject transference needs are consistently misunderstood and thereby relentlessly rejected by the analyst. Such misunderstandings often take the form of erroneous interpretations of the revival of an arrested selfobject tie or need as an expression of malignant, pathological resistance. When the patient revives an arrested selfobject tie or need within the analytic relationship, and the analyst repeatedly interprets this developmental necessity as if it were merely a pathological resistance, the patient will experience such misinterpretations as gross failures of attunement. These traumatic, repeatedly inflicted injuries are similar in their impact to the pathogenic events of the patient's early life (Stolorow and Lachmann 1980). Such chronic, unrecognized disjunctions, wherein vital developmental requirements revived in relation to the analyst meet with consistently unempathic responses, constitute the intersubjective context in which intense and sometimes violent hostility is produced. Such aggression is not a manifes-

tation of a primary, inherent, instinctual viciousness. It is, in Kohut's (1972) terms, the expression of intense "narcissistic rage"—a secondary reaction to severe threats or injuries to a vulnerable self-organization in the context of chronic selfobject failure. I turn now to a clinical illustration.

CASE EXAMPLE

When the patient (discussed previously in Atwood and Stolorow 1984, and Stolorow and colleagues 1983) entered treatment at age 25 his florid manifest psychopathology included many features that typically are termed borderline. He suffered from severe, agitated, lonely depressions, and experienced a desperate, devouring hunger for closeness and physical contact with women, whom he perceived as awesome in their idealized qualities. At the same time, his relations with others, especially women, were extremely chaotic and sadomasochistic, marked by violent rage, envy, and destructiveness directed both against others and himself. He frequently engaged in bizarre, ritualized enactments of a sadomasochistic and sexually perverse nature.

After several months of treatment, I began to focus my interventions on what seemed to be the patient's unmistakable pattern of phobic avoidance of intimate contact with women. I consistently interpreted this pattern to the patient as reflecting his intense fear of women, based on his images of them—including the maternal prototype—as terribly powerful, sadistic, and dangerously destructive. The patient's fear of women was well documented in the analytic material. Indeed, he had disclosed that he consciously pictured the sexual act as a situation of mutual destruction and mutilation, in which his penis would inflict damage to the woman's body, and her vagina, lined with razor blades, would cut off his penis in retaliation against him.

The patient reacted to my repeated interpretations of his phobic defense and underlying fears and fantasies by becoming intensely paranoid within the transference. He began to believe, with increasing conviction, that my sole motivation in making interpretations was to humiliate him, lord it over him, and ultimately destroy him. As a result, he became obsessed with fantasies of revenge and wishes to attack and destroy me. During the sessions he seemed just at the brink of enacting his aggressive fantasies. He would pace menacingly about my office, gnashing his teeth and screaming violently, often picking up objects and gesturing threateningly, as if he wished to hurl them at me. My interpretations of projective mechanisms only exacerbated his rage and belief that he was being victimized, which eventually became entrenched in the form of full-fledged persecutory delusions.

This paranoid transference psychosis and the accompanying primitive aggression persisted for several weeks and was alleviated in large part as a consequence of two serendipitous circumstances. The first was an incident that occurred when the patient inquired about a day hospital program with which he knew I was familiar. I responded spontaneously and nonanalytically, saying that I believed he was "too together" for this particular program. The patient became utterly elated and revealed that he experienced my comment as an unexpected vote of confidence, a longed-for expression of approval. Shortly thereafter, he reported a highly illuminating dream, in which the symbols pointed to the emergence of archaic grandiosity and its deflation:

> I was telling people I was going to jump from a very high altitude, off a building or window sill. I wasn't going to commit suicide; I was going to jump and *live*! It would have been the first or second time in the history of the world! Then the big day came. I crawled up on the window sill and I looked down. I was scared. I couldn't jump. I saw a rope ladder and couldn't even go down that. It was *incredibly humiliating*, telling people I could do something and then being too scared to do it.

The second fortunate circumstance occurred because I was becoming acquainted at this time with Kohut's early papers on the understanding and treatment of archaic narcissism. This material made a deep, personal impact on me, enabling me to expand my reflective self-awareness to include a greater knowledge of my own narcissistic vulnerabilities and needs. This expanded awareness, in turn, made it possible for me to find in my own psychological history analogues of the patient's archaic states. As a result, I began to understand the nature of the patient's selfobject transference needs and the intersubjective situation in which the transference psychosis, with its violent hostility, had developed.

The patient's sense of self had been extremely vulnerable and subject to protracted fragmentations. Indeed, I later understood that the principal purpose of his sadomasochistic, perverse enactments was to restore a tenuous sense of integrity and stability to his crumbling self-experience. What he needed was an opportunity to solidify a more cohesive sense of self around archaic images of perfection and omnipotence. What he needed most in the transference was to feel that I appreciated and admired the grandeur of this brittle archaic self-experience. In this specific context, he experienced my repeated interpretations of his fears of women as unendurable mortifications. The transference psychosis and violent aggression developed as a result of a prolonged, unrecognized intersubjective disjunction in which my interpretive approach persistently

obstructed the archaic mirroring tie that the patient urgently needed to sustain the organization of his precarious sense of self. When I recognized and interpretively clarified the disjunction and replaced it with an empathic comprehension of the nature of the patient's selfobject transference needs, the transference psychosis dissipated, never to recur during the long course of the treatment.

In the months that followed this critical period of the treatment, the patient and I were able to explore analytically the meaning and function of his intense rage reactions, which would recur episodically throughout the course of treatment. Without exception, these rage reactions were found to occur in the context of events that disrupted the archaic mirroring tie that the patient was attempting to establish with me and that therefore posed a severe threat to the integrity and stability of his precariously consolidated grandiose self-organization. At times such disruptions originated in "empathic failures"—that is, situations in which the patient perceived me as failing to understand and respond appropriately to his need to see his grandiose self-experience reflected by my admiring gleam. At other times, however, the disruptions were triggered by failures, disappointments, or rebuffs that the patient encountered in his life outside analysis—experiences that he believed would make it impossible for me to continue to appreciate and esteem him as he so desperately needed. In either case, the disruption of the mirroring tie posed a deadly threat to the patient's psychological integrity, and he responded invariably with narcissistic rage and hostility. In such instances, it was learned, he would purposefully conjure up images of injustices, past and present, parading them before his mind's eye, in order to fan the flames of his outrage to violent levels of intensity. He would then "luxuriate" (his word) in the violence of his rage and in the accompanying fantasy that he was frightening me, both of which enabled him to feel omnipotently powerful once again. His rage and aggression thus served a critical restitutive function, restoring his grandiose self-organization when disruptions of the selfobject transference bond threatened it with dissolution.

Invariably, when the disruption and resulting injury were analyzed and understood, thereby mending the broken archaic transference tie, the aggression would subside without having to be confronted directly. As these inevitable disruptions and injuries were repeatedly analyzed and worked through, the selfobject transference bond became progressively more solidified, along with the patient's sense of self-cohesion, and concomitantly his rage reactions gradually diminished in both frequency and intensity.

CONCLUSION

Intense, violent hostility in the psychoanalytic situation, I suggest, is not to be viewed as a manifestation of an excessive pregenital aggressive drive (Kernberg

1975) or other primary instinct. Instead, it must be recognized as a *psychological product*, whose meanings and functions the analyst and patient must seek to investigate and comprehend. In my clinical illustration, the intense aggressive reactions always signaled obstructions of or disturbances in the selfobject transference bond, posing serious threats to the patient's self-organization, and the aggression served a restitutive function in restoring an urgently required feeling of omnipotence. When violent rage and destructiveness become pervasive and chronically entrenched, this is most often the result of protracted, unrecognized transference–countertransference disjunctions, wherein the patient's revived archaic needs are consistently misunderstood and rejected by the analyst. The case exemplifies the broader therapeutic principle that the meanings and purposes of aggression cannot be understood psychoanalytically apart from the intersubjective contexts in which it arises and recedes.

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