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Leon Hoffman

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## VICISSITUDES OF AGGRESSION: THEORETICAL AND TECHNICAL APPROACHES TO PSYCHIC TRAUMA

**I**t is now almost fifty years since Leo Stone (1954) wrote his classic paper, "The Widening Scope of Indications for Psychoanalysis." As readers of *JAPA*, particularly during the recent past, we have been privileged to learn more about this broadened reach of psychoanalytic ideas. This issue, with its wealth of clinical material, focuses on the value of psychoanalytic principles, old and new, in understanding and treating very difficult patients, particularly those who have undergone severely traumatic experiences.

Encountering another's clinical material, particularly when it involves complex clinical situations, leads inevitably to an influence (conscious and unconscious) on our own clinical work, as we compare and contrast the other's theory and technique with our own. Are they consonant with each other or divergent? Which approach is more consonant with our actual practice? Is the novel theoretical construction helpful in organizing our own clinical data? Studying the difficult clinical situations described in this issue, and the theoretical discussion they inspire, can help all of us apply the successes (and failures) of these authors to our own clinical work.

In 1927 Freud described the nonpsychotic disavowal of reality of two young men who had lost their fathers in childhood. In these men, two mental states existed side by side: one comported with a wish, the other with reality. In the posthumously published "An Outline of Psycho-analysis," Freud (1940) discussed further the idea that splitting, as a mechanism, is ubiquitous in childhood. Children, he stated, in addition to coping with undesirable instinctual demands by repression, often find themselves needing to fend off distressing demands from the external world. They do this by disavowing certain perceptions from

reality. “The disavowal is always supplemented by an acknowledgment; two contrary and independent attitudes always arise and result in the situation of there being a splitting of the ego” (pp. 203–204).

The papers in this issue present patients who have been traumatized by the external world and whose lives have been dominated by the kinds of splits alluded to by Freud. We hear about abusive parents, abusive environments, and external traumas such as the genocide of the Holocaust. One group of papers addresses the problem of trauma from a broad perspective, and another group addresses how particular theoretical understandings and psychoanalytic treatment approaches, some novel, can help us with more severely disturbed patients.

The first group includes papers by Harold Blum, Andrea Celenza and Glen O. Gabbard, Dori Laub and Susanna Lee, and Steven Reisner. The second group includes papers by Stanley Coen, Irwin Hoffman, Marvin Hurvich, Otto Kernberg, and Andrew Lotterman.

Blum reminds us that “psychoanalysis began with the study of psychic trauma, and that investigation remains altogether relevant to the contemporary scene.” Given the current state of the world, we, as citizens as well as psychoanalysts, must recognize the impact of external trauma on our patients and communities, as well as on ourselves. As Blum adds, “When trauma involves an entire community, it has a public character. Group identification occurs—with victims, with rescuers, and with the perpetrators. Even those not directly traumatized are collectively and symbolically injured.”

Reisner wonders why suffering and trauma have been so elevated over the last century, both in the psychotherapeutic sphere and in the culture generally. Reisner stresses that to understand the current trauma discourse, which he considers problematic, we must distinguish traumatic events from traumatic responses and trauma symptoms from trauma-avoiding behavior. He contrasts two conceptions of trauma: as an exceptional event and as a formative one.

Reisner would disabuse us of the notion that Freud “abandoned” the seduction theory. Rather, he stresses, Freud shifted his emphasis away from insisting that hysterical symptoms can be caused *only* by direct childhood sexual abuse; instead he enlarged our understanding of the complex interaction of self and environment and came to view trauma not as exceptional to the ego but as formative of it.

In contrast, Laub and Lee underscore the exceptional nature of trauma, noting that it “causes a profound destructuring and decathexis.”

Reisner stresses the ubiquity (and even necessity) of trauma. He discusses quantitative distinctions between traumatic events and stresses the nature of the individual response and the adaptive use one can make of potentially traumatic stimuli. In contrast, Laub and Lee stress the "inexplicability and unrepresentability" of trauma, which "forces psychoanalysis to explore and transcend the usual limits of its conceptual framework." Reisner, in essence, normalizes trauma and our psychoanalytic understanding of its impact. Laub and Lee stress that trauma "creates a strong impulse to repeat destruction" and that "understanding traumatic consequences as death instinct derivatives can create a conceptual framework in which treatment can be initiated."

Celenza and Gabbard address a problem that has long been traumatic to the psychoanalytic profession: the prevalence of boundary violations. They describe the great variability in the individual psychopathology of a group of two hundred professionals who have transgressed boundaries with their patients. From the perspective of the professional analytic community, Celenza and Gabbard's conclusion is of profound significance because of its hopeful note. They "are convinced . . . that many transgressors, perhaps even most, are amenable to rehabilitation efforts and that it is misguided to dismiss every analyst who has made a serious error in judgment. If these analysts are always a lost cause, then so are we all."

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Kernberg provides clinical material on the use of the transference-focused therapy that he and his colleagues have developed for the treatment of borderline patients, particularly addressing their affect storms and profound defenses against them. With this technique the therapist can understand that what appear to be rapid and chaotic shifts in the patient's relationship with the therapist turn out to be "the systematic repetition of the relationship between a persecutory, scolding, and derogatory object, and a rejected, depressed, and impotent self, the roles being rapidly assigned and reassigned to the patient and the therapist. The role reversals repeat the same relationship again and again." Interpretation of these transferences leads to an integration of the mutually dissociated transferences.

Coen stresses that "for those who expect hurt, disappointment, and rejection, negativism, with its safety and control, is much safer than caring, with its vulnerability and anxiety." He explores the defensive functions of negativism for both analyst and patient when they are caught up in transference-countertransference enmeshment. Coen

stresses that the psychoanalyst, by using a degree of playfulness instead of being “blown away,” can “offer the negativistic patient the opportunity to integrate hating and loving feelings as occurring simultaneously rather than sequentially.” Self-analysis clearly plays an important role in Coen’s approach to severely provocative patients, allowing him to extract himself from their negativism. He views playfulness with these more disturbed patients “as a way to acknowledge the positive in the negative, to welcome the patient to the possibility of enjoying the interaction with the analyst.”

Hoffman also discusses patients’ profound negativism and, like many of the authors in this issue, cites André Green, especially noting his idea of the internalization of a “dead mother,” which leads to patients’ emotional unattachment. Hoffman concludes that “affective distance is fundamentally an attempt to preserve a fragile psychic equilibrium from intrusion by wished-for, but primitively internalized, object identifications and identity.”

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He describes individuals who experienced a mother “who seemed unable to sustain an interest in them, or to accept much of their libidinal strivings.” Like the patients described by Lotterman, such patients have a difficult time autonomously defining themselves and instead rely inordinately on a self-definition in which they are part of a symbiotic whole. Hoffman draws on the work of Heinz Lichtenstein, who, in his work on identity, was among the first to stress the importance for the developing infant of mirroring experiences with the mother.

Lotterman proposes that “there exists a particular form of pre-oedipal guilt that consists of guilt about simply existing at all.” He says that “we seek to know what is expected of us so that we do not incur the wrath of our creators.” In other words, guilt as a defense against retaliatory aggression is a self-preservative device. Patients with whom he has worked have the pervasive fantasy that they owe a great debt to their parents for having been created.

Hurvich, in contrast, theorizes that annihilation anxieties, residuals of psychic trauma, constitute a basic danger that can be a strong motive for defense. He proposes that the likelihood of annihilation anxieties is increased as a result of traumatic experiences, ego function weakness, and threats to self-cohesion.

In all of these papers, the role of trauma, persistent overstimulation, and preverbal experience is stressed. How do we evaluate their competing conceptualizations? When an author presents a novel theoretical

formulation, he or she is in essence saying, "I have a new and better way of organizing and understanding patients' phenomenology." Hurvich maintains that annihilation anxiety is central, while Lotterman stresses that guilt about existence is a central motivating mechanism. Both provide excellent clinical material to substantiate their conclusions—that these formulations are clinically and theoretically more advantageous than the "usual" formulations. How does the outside reader evaluate (clinically or empirically) these different clinical and theoretical perspectives? Can they be integrated? If so, how?

It seems to me that understanding the vicissitudes of aggression (directed toward the subject and/or directed outward by the subject) is a unifying theme in this issue. Many of the authors, in fact, describe aggressive interactions in the transference-countertransference and in real life (leading to traumatic effects). In fact, the role of aggression is highlighted in the two panel reports, "Dangerous Behavior in Children and Adolescents" and "Aggression and Women."

However, it is striking to me that many of the authors here do not stress enough the concepts of "identification with the aggressor" and "turning passive into active," despite the fact that many of their clinical descriptions are consistent with such mechanisms. Perhaps this is a result of the ease with which object relations theories can be used in theoretically organizing the clinical phenomena observed when treating "sicker" patients—patients who seem disorganized and fragmented. The concepts of "identification with the aggressor" and "turning passive into active" are of course central to conflict / compromise formation theory.

For example, Kernberg compares his object relations orientation to the orientation of Matte-Blanco, as well as to that of Kleinian and British contributors, to the ego psychological approach of Peter Fonagy ("mentalization" and "self-reflectiveness"), and to the theories of André Green. But he does not compare and or even contrast his theories with those of conflict / compromise formation theory.

Are ideas that arise from that perspective, then, to be considered less applicable to the understanding of these "sicker" patients? Psychoanalysts need to evaluate which theoretical formulations lead to more effective interventions. A paper that has been virtually forgotten (cited only six times in the PEP-CD ROM) is to me a paper that not only helps us understand "sicker" patients through the lens of conflict / compromise formation theory but also provides a bridge between that body

of theory and the various object relations theories. In that paper, Michael Porder (1987) states “that projective identification can best be understood as a compromise formation that includes as its major component an ‘identification with the aggressor’ or a ‘turning of passive into active,’ in which the patient unconsciously acts out in the transference the role of the major pathological parent or both parents and, via this re-enactment, induces feelings in the analyst similar to those that the patient experienced as a child” (p. 432).

From my perspective, it is important that we try integrate the approaches of conflict / compromise formation theory with those described in this issue. An integrated approach can help us better conceptualize the role of aggression in normality and pathology, the manner of adaptation to outside aggressive actions, and the degree of expression and control one possesses over one’s own aggression.

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167 East 67th Street  
New York, NY 10021  
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