Thinking about Identification with the Aggressor:

A way out of impasses, self-hatred, and isolation.

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Abstract

People who have been victimized or traumatised often become aggressive and domineering in their relationships with others. This occurs frequently in the analytic relationship where the analyst may come to feel traumatised by his patient. Some therapeutic approaches would propose that focusing analytic work on the underlying injury and vulnerability is most likely to be effective. Aggression is seen, in this formulation, as an epiphenomenon, rather than an important aspect of the patient's experience, which needs to be understood and explored. The concept of Identification with the Aggressor is explored from its historical origins to more contemporary understandings. Infant research will be used to demonstrate that a relationship structured by domination and submission is at the core of this phenomenon. It is proposed that the concept is a useful way to think about and work with the emergence of aggression in the analytic relationship, as it can open a reflective space in which aggression can be thought about. Further, it is suggested that Identification with the Aggressor may be at the core of intractable self-hatred and isolation. Accordingly, analytic progress will be limited or may even become mired in impasses, if the analytic couple is not able to think about aggression, specifically Identification with the Aggressor . The analyst's relation to his own aggression is seen as an important aspect of this process. Clinical examples will be utilized to demonstrate the kinds of toxic impasses which can occur when a therapeutic stance based solely on close attunement to injury and vulnerability is utilized. This stance may in itself be an enactment of domination and submission where the subjectivity of the patient dominates that of the analyst. Clinical material will demonstrate a way in which these aspects of the analytic couple's relationship can be explored. The ways in which this can open up analytic exploration as well as how it may be problematic will be illustrated. In some cases, it may be necessary for both patient and analyst own their aggressive identifications and acknowledge how they are structuring the current therapeutic impasse.

Analysands come to the analytic situation not only with good intentions, but also with bad and destructive intentions. The latter always feel subjectively necessary and may be plausibly justified, yet to regard that aggression as simply a defense against frustration of more fundamental, benign motives may draw the patient away from some of the deep roots of his being. A full, rich struggle with the dialectic between love and hate in human experience entails not a dissolving of hate no longer necessary to allow love to emerge, but an appreciation and reconciliation of the victim, the lover, and the villain in us all. (Mitchell, 1998, p.29-30)

One can go so far as to say that we cannot perceive a movement or an expression in another without unconsciously duplicating it in ourselves, although the duplication will be well below the threshold of overt expression or of conscious experience...it is the psychological basis upon which more permanent identifications are built...[These] identifications are based on...earlier perceptions which have aroused a sort of subthreshold echo of behavior in the child. (Sandler, 1959, p. 17)

Introduction

I am no stranger to aggression. It permeated my family and my peer experiences at school. In that confusing world, my decision to become a psychiatrist stood out like a beacon. The psychiatrist in my imagination at that time deeply understood suffering, was wise and patient, and most importantly, benevolent, probably even altruistic. Prioritising the other as a way of being was already deeply known to me. It was in my bones, as it was how I connected to my mother. Medical school, psychiatric residency and then psychotherapy training gave me a frame within which to work, however the organizing fantasy I had developed remained unchanged.

I had found myself in a psychiatric residency program that offered an extensive concurrent psychotherapy training whose clinical model was Self Psychology. The way I made use of this experience was shaped by my convictions about how to be most helpful to others. Empathy, understanding, a focus on the needs of the other, patience, and acknowledgement of failure were key elements of what my training taught me. I began my work as a therapist in this way and found that many patients formed intense connections with me. However, after many years of tireless attention and commitment, I felt that we were stuck and it was no longer possible to keep negative feelings about my patients out of my awareness.

Tina

Tina came to see me after her long-standing intimate relationship ended and because she had became increasingly unable to function. She quickly became very dependent on our sessions and struggled with very frightening and overwhelming feelings during breaks and

separations. I offered her more and more sessions, and phone contact on the weekend if

needed. She was highly sensitive to my presence and the slightest misattunement could

precipitate a crisis between us. When something like this occurred, she would come to the

session sullen and withdrawn, and would tell me that she could no longer trust me and that I

had become dangerous and unpredictable. She often struggled with suicidal feelings at these

times. We had a protracted period where she could give me no assurance that she would be

back tomorrow, whilst at the same time telling me she knew how hard this must be for me.

With every crisis, every disruption, I would focus on her sense of injury, acknowledge how I

had hurt her, we would link it to her past traumas, and things would temporarily calm down.

This continued for years.

My experience of working with certain patients began to shift from a sense that I was

working with someone who had been severely traumatised, to an increasing awareness that I

was feeling traumatised by aspects of my engagement with these patients. How was I to

understand this experience and how could I utilize it without traumatizing my patients even

further? Through extensive consultation and my own personal analysis, something which had

been unformulated began to crystallise. The patients I was struggling with, clearly deeply

injured and traumatised, were engaging with me in ways that were aggressive and sometimes

even cruel. Up until this point, my own disavowal of aggression and my choice of theory,

namely Self Psychology, had coalesced so that all I was aware of was how injured my

patients were, and how I so often, and apparently unwittingly, re-injured them.

The traumatised who traumatise

How is it that people who have been victimized/traumatised/terrorized can come to be victimizing/traumatizing/terrorizing towards others? Some contemporary psychoanalytic theories have largely bypassed this question and focused almost exclusively on the profound injury that can be a consequence of trauma of various kinds. Aggression is often seen as an epiphenomena and not a central aspect of the experience of trauma. The perspective perhaps most strongly associated with this view is that first articulated by Kohut (1977) and then in later iterations of Self Psychology (Stolorow, 1984; Ornstein & Ornstein, 1993; Fosshage, 1998; Lachmann, 2001; Shane, 2006). Kohut (1977) believed that aggression arose as a result of a failure of the relational surround, a "self-object failure" and that:

> the deepest level to which psychoanalysis can penetrate when it traces destructiveness…is not reached…when the analysand becomes aware of the fact that he wants (or wanted) to kill. This awareness is but an intermediate station on the road to the psychological 'bedrock': to the analysand's becoming aware of the presence of a serious narcissistic injury, an injury that threatened the cohesion of the self, especially a narcissistic injury inflicted by the self-object of childhood. (pp. 166-117)

This was the frame in which I understood what it was that I was trying to do with my patients until in some cases, toxic transference-countertransference developments (Ehrenberg, 2006) occurred. In my experience these developments could not be worked through by continuing to try to understand the patient's subjective experience, the approach to disruptive experiences recommended by Self-Psychology and Intersubjective Systems Theory (Jacobs, 2010).

The focus of this paper is to investigate one of the sequelae of trauma, which is often less attended to than the states of vulnerability, terror and helplessness that we frequently associate with survivors of trauma. This paper will explore the phenomenon of trauma-related aggression using the concept of identification with the aggressor as a lens. I will argue that it is essential in some cases to specifically attend to the nature of the aggression that emerges in the analytic relationship, in order that the treatment move forward. I also suggest that aggressive enactments contain important data that would not be accessible by empathy alone (Bromberg, 1998, 2006; Stern, 2010; Ringstrom 2010)

Kohut (1977) saw aggression largely as a signal that an injury has occurred, and as a way to restore self-cohesion. While I in no way disagree with this formulation, I see it as one dimension of what may be going on, and am of the view that this perspective necessarily excludes others. Kohut does not attend to the specific shape and form of the aggression, the particular way the aggression is expressed, or the impact of the aggression on the other. In his focus on the "psychological bedrock" of injury, he rapidly moves past specifically what it is that the person does when he feels injured. Angry responses to self-object failure, or injury, for me contain at least two fundamental groups of questions: Firstly, what is it that I experience when injured, and what kinds of intersubjective contexts evoke this experience? The second, and I believe equally important group of questions is: what is it that I do to myself and to others when injured? Who do I become? What do I enact? What are the intersubjective ramifications of this reaction?

The two fundamental groups of questions pertain to two complementary aspects of human aggression: domination and submission, or, sadism and masochism. I will argue that

both domination/sadism and submission/masochism are states of mind that are sequelae of trauma in most, if not all cases. There is, however, a bifurcation amongst psychoanalytic theories in relation to this issue. Is aggression simply a signal, a "breakdown product", as Kohut suggested, so that it alerts us to locate the injury and underlying vulnerability which led to the aggression? Or is the form, content, and relational impact of the aggression an important and rich source of clinical information which needs to be explored and understood in the same close detail that we might explore states of vulnerability and injury?

Thinking about trauma-related aggression as "identification with the aggressor" may be one of many "royal roads" to help unpack this phenomenon. The concept certainly dates back to the earliest psychoanalytic theorists who were struggling to understand aggression as being a response to the surround, rather than emerging from within as a drive that pushed for discharge, the way Freud conceptualized it (Freud, 1930). Sandor Ferenczi (1933) and Anna Freud (1936) were the first to write about "identification with the aggressor", however, what they each highlighted was very different. Nevertheless, both saw it as a response to actual, anticipated or fantasied attack.

Ferenzci, on the one hand, described a process in which the patient identifies with the aggressor primarily to know him inside-out, so that the aggressor's needs can be pre-empted and responded to. He described a form of exquisite hypervigilance and accommodation. Anna Freud, on the other hand, described a phenomenon in which the aggression in question is taken in (identified with) and then enacted towards the other in what is fundamentally a replication of what was originally done to the victim. These differing views articulated by Ferenczi and Anna Freud seem to articulate the two dimensions of a larger relational response to trauma I wish to explore.

These apparently different dimensions in some ways parallel the apparent binary within the field of psychoanalysis in relation to whether injury and submission, on the one hand, or aggression and domination, on the other, are the key sequelae of trauma on which analytic attention should be focused. Fundamentally this determines whether the individual is positioned as passive or as an active contributor to his own experience. I have come to believe that this binary is artificial, and that both dimensions of experience, that of victim as well as that of victimizer, are almost always present, side by side. One dimension may be more foregrounded and conscious, while the other may be enacted or disavowed, with both shifting in prominence depending on the relational context.

For example, a patient's accommodation may on the one hand be a form of submission to the analyst, yet it may also be a way to control and subjugate the analyst, by pre-empting his responses and "managing" him, in fact controlling the interaction. Or, the analyst may feel held captive by the patient's vulnerability to injury, with a sense that the wrong word or tone of voice could have disastrous consequences. On the other hand, aggression in the patient may emerge as an expression of the rage associated with more covert accommodation and submission.

Major theoretical perspectives

Laplanche and Pontalis (1973) offered the following definitions of the phenomena which are the subject of this paper:

IDENTIFICATION:

Psychological process whereby the subject assimilates an aspect, property or attribute of the other and is transformed, wholly or partially, after the model the other provides. It is by means of a series of identifications that the personality is constituted and specified. (p. 205)

and

IDENTIFICATION WITH THE AGGRESSOR:

Defence mechanism identified and described by Anna Freud (1936): faced with an external threat (typically represented by a criticism emanating from an authority), the subject identifies himself with his aggressor. He may do so either by appropriating the aggression itself, or else by physical or moral emulation of the aggressor, or again by adopting particular symbols of power by which the aggressor is designated. According to Anna Freud, this mechanism predominates in the constitution of the preliminary stage of the super-ego: aggression at this time is still directed outwards and has not as yet been turned round against the subject in the shape of self-criticism. (p. 208)

Identification with the aggressor is perhaps mostly associated with Anna Freud's understanding of this idea. In 1936, she defined it as one of the ego's most powerful defences where "by impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself into the person who makes the threat" (p. 128). In *Beyond the Pleasure Principle*, Freud describes a similar phenomenon in which passive is turned into active, and in the process of doing so, the child "hands on the disagreeable experience to one of his playmates and in this way revenges himself on a substitute" (as cited in Freud, A. (1936) p.128). The aggression she refers to and with which the child identifies, is in the form of parental prohibitions and criticisms. The aggression,which is internalized, could also be fantasied, i.e. it could be an imagined aggressive response from the parent. The child will then become aggressive toward the parent or other whenever the shameful/bad/prohibited thoughts or impulses occur, because of the intense anxiety the child feels in relation to an anticipated prohibition from the parent. In this way identification with the aggressor is a potent defense against anxiety.

What is striking in her theory is that there is no mention of anything we might consider trauma. Abuse or domination does not figure at all in her formulation. One of her case examples involves a child who accuses the analyst of being secretive. It is then determined that it is actually the child who is secretive, harboring shameful masturbatory fantasies. The child anticipates criticism from the analyst and "the moment the criticism is internalized, the offense is externalized" and the other is blamed for whatever the wrongdoing may be. One of the consequences of her model is that the analyst is protected from being implicated in reality by the patient's accusations.

This understanding is profoundly different from that proposed by Sandor Ferenczi (1933) in his paper *Confusion of Tongues*. His theory emphasises lived trauma, particularly sexual trauma. It was this emphasis which resulted in his eventual split from Freud and exile from psychoanalysis. He saw in most of his patients a "helpless compliance" (p. 158) with "an exceedingly refined sensitivity for the wishes, tendencies and antipathies of the analyst" (p. 158). Instead of accusing the analyst of errors, they identify with him and come to know and anticipate his preferences and needs in profound detail. The identification is so profound that the patient replaces his own thoughts and responses with those of the analyst. It is protective but not in the way Anna Freud described, as a kind of pre-emptive strike. Ferenzci's model is more nuanced and complex.

Ferenczi (1933) felt the psychological experience of traumatic victimization was so devastating that it could be likened to a kind of death. The child feels intense anxiety when the overpowering force of the adult is more than can be tolerated. This anxiety "compels them to subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious of themselves, they identify with the aggressor" (Ferenzci 1933, p.162). He proposes that the immature personality is unable to maintain itself in the face of such overwhelming feelings and it can only continue to function through a form of mimicry. It is almost as though the psychological death he describes leads to a kind of psychic merger with the traumatiser, or that the psychic merger is the only option other than psychic death. The trauma now ceases to exist as an external reality as it is now intra-psychic. The erasure of the external reality of trauma allows the child to maintain a "situation of tenderness" (Ferenzci 1933, p. 162) with the adult.

Ferenczi saw repetitions of this in treatment when patients steadfastly refused to follow his advice to react to unkind treatment in the analysis. And unkind treatment in analysis was ubiquitous, in his view. The restrained coolness and professional hypocrisy of the analytic method often concealed a dislike of the patient, and these aggressive or negative feelings towards the patient are not dissimilar to the parents' negative feelings towards the child. In this way the analyst will "repeat with his own hands the act of murder previously perpetrated against the patient" (Ferenczi 1932, p.52).

Ferenzci felt that the patient's accusations toward the analyst, in contrast to being projections, probably had some basis in truth. He felt it was vital to seek out in the material any clues which might suggest that the patient may feel angry with the therapist, as mostly patients are not able to speak these thoughts themselves. Here Ferenczi appears to be alluding to the fact that there is likely to be more going on than is immediately apparent in a situation of compliance and submission.

Ferenczi (1933) referred to a wide range of range of potentially traumatizing experiences. On the one hand, trauma can occur in the form of excess punishment or in the withdrawal of love. On the other, if excessive or inappropriate intimacy is forced on the child, this is also traumatic. He also referred to the adult who terrorizes the child with his own suffering and complaints. As a consequence of trauma of any kind, the adult will turn

> the child…. into a psychiatrist, and in order to become one, and to defend himself
> against dangers coming from people without self-control, he must know how to
> identify himself completely with them (p.165)

If there has been a "complete identification" or psychic merger with the traumatiser, however, is it not possible that the traumatiser now exists internally as a self-state (using contemporary language) that can be embodied and enacted? Ferenzci does not seem to address this directly. He appears to focus mostly on the ways in which the patient's experience of traumatization is repeated in the therapy, and how the identification with the aggressor exonerates the analyst.

Fairbairn's (1952) concept of internalized objects and object-relations is central to the issue being explored. He firstly replaced the motivational primacy of drives, proposed by Freud, with the proposition that the relationship with an object is the supraordinate human striving. Further, he proposed that what is repressed does not consist of drives, but of "bad" objects. He made these observations and formulated his theory based on his work with sexually abused children.

Fairbairn (1952) proposed that relationships with bad objects are intolerable. Further, they are shameful for the child. Fairbairn explained this on the basis that in early childhood, all object relationships are based on identification. If a child is treated badly, the child feels bad as he has identified with the parent. So if a child feels bad or behaves badly, it means he has bad objects. His investigation of delinquent children revealed that invariably, these children had no recollection of what had been established to be "bad" homes. Fundamentally, Fairbairn is describing how we come to have an identification with those who hurt us.

He took the explanation of this process one step further with his "moral defense" (Fairbairn, 1952). It is not simply that we identify with our early bad objects and so become

"bad" ourselves. But by becoming bad, in effect taking on the parent's badness, we make

them good. This creates a sense of security as now the child can feel he is living in a world of

good objects, however, it comes at the price of internal security. There is now an internal

array of persecutors, and the child has in effect joined with the parents and subjects himself to

the anger and punishment he feels he deserves. In many ways, his theory is a development of

Ferenczi's ideas, where the internalization functions to maintain a relationship that feels

loving and safe, a "situation of tenderness". It also explains how individuals who have been

mistreated develop self-hatred, as they are persecuted by their internalized bad objects.

In *Object Relations in Severe Trauma: Psychotherapy of the Sexually Abused Child*,

Stephen Prior (1996) outlines further consequences of this internalization:

> the child knows he has internalized and identified with the bad object and fears that he
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> will be "possessed" (Fairbairn 1952, p. 67) by the bad object with which he is so
>
> thoroughly identified. This identification with the aggressor is desired (as an antidote
>
> to aloneness and vulnerability), is repellant (as terrifying and devouring of the good
>
> self), and is punishable (to the degree that it takes hold of the personality). The child
>
> cannot live without this complex introject but lives in agonizing conflict with it (p.
>
> 88)

Because the child has internalized the object relationship, he is "both aggressor and

victim….. internally" (p.88). Prior here alludes to the idea that the experience of "possession"

by a bad object leads to self-hatred.

Throughout subsequent theorizing, beginning with Bowlby, the idea is developed that it is relational sequences or procedures that are internalized, not simply objects per se. Attachment theory began to elaborate Fairbairn's concepts with the notion of "internal working models" (Bowlby, 1969). The central concept is that the infant will adaptively develop ways of maintaining an optimal level of proximity and felt security to the caregiver, within the limitations of what is available in the relationship. These ways of being with the caregiver are internalized and form a template, which organizes not only the anticipation of the quality of future relatedness, but also the strategies with which the infant will navigate and negotiate other close relationships.

Sroufe and Fleeson (1986) refer specifically to the internalization of working models related to abuse. They state that

abused children learn not only the role of the exploited but the role of the exploiter…Each partner 'knows' all 'parts' of the relationship and each is motivated to recreate the whole in other circumstances, however different the required roles and behaviors might be (p. 61)

This would suggest that it is not possible to have the experience of victimization without also in some way internalizing the experience of being victimizing.

Beebe and Lachmann (2002) refer to a similar phenomenon based on their extensive mother-infant observation data. They state that "mother and infant jointly construct a patterned sequence of movements and establish the 'rules' for regulating these movements through the dimensions of time, space, affect and arousal" (p. 116). These are "schematized"

(p.116) interaction patterns and form the basis of future behaviors and expectancies. These "presymbolically" (p.116) encoded interaction patterns contain expectations for mutually regulating arousal with the partner, expectations of affective matching and interpersonal coordination, and expectations of misregulation and interactive derailment.

What is represented is not an object, but the inter-relatedness as a whole, something which is a coconstruction and not a simple summation of the contributions of both partners. Describing how victimizing states might become part of these internalized sequences, they state the following:

> The inherently dyadic nature of these representations implies that both roles in an interaction are known to the person. This may explain why, in adult treatment, the patient knows both roles in the interaction intimately and in some cases may exchange them eg. masochist-sadist, predator-prey, dodger-chaser, abandoner-abandoned. One side or the other may be disavowed, repressed, embroiled in conflict, ascribed to the partner, or sought at any price. Restoring access to the missing side may be necessary in treatment. (Beebe and Lachmann 2002, p.118).

More recently, Lyons-Ruth (2006) has investigated the sequelae of disorganized attachment in infancy. Disorganised attachment was developed as a fourth category by Main and Solomon (1990) when they observed that infants of high-risk families displayed odd, disoriented and conflicted behaviours in the presence of the caregiver. Main and Hesse (1990) suggested this occurred in a situation where the infant was seeking comfort from the parent who was at the same time the source of his fear. This created an insoluble dilemma. It

was later determined that it was lack of caregiver regulation of fearful arousal which was the aetiological factor in disorganized attachment (Lyons-Ruth, Bronfman, and Parsons 1999).

Lyons-Ruth (2006) found that the mothers of disorganized infants fit one of two profiles. They were either "helpless-fearful" or "hostile-self referential". She subsequently stated the following:

> We view these two maternal profiles, hostile and helpless, as complementary stances in a two-person dyadic system, a dyadic system where one person's needs predominate and the other person feels helpless to exert initiative. We think, then, that the diversity in maternal profiles [where the infant is disorganized] occurs because different parents identify more strongly with one or the other pole of this unbalanced dominant–submissive dyadic pattern. However, theoretically we view these different stances as related aspects of a single internalized representational model" (Lyons-Ruth 2006 p. 608).

By age 3-5, many disorganized infants display controlling attachment behaviours through either caregiving or coercive strategies. This is seen as an attempt to control the parent's attention, as it has become clear that to turn to the parent and expect appropriate responsiveness at times of need is unworkable. Lyons-Ruth (2006) concludes:

> These observations underscore how disrupted forms of parental responsiveness can lead to a profound overriding of the child's voice and initiative around attachment needs and to role reversal in the parent–child dialogue. (p. 612)

It is implied in this explanatory framework that a relational experience structured by a pattern of dominance and submission becomes internalized. Where the parent violates the infant's attachment strivings, autonomy, and ultimately her subjectivity, the infant is forced into a place of submission within the dyad. These infants then respond in one of two ways: they either become caretaking and submissive, or they turn the tables on the caregiver, by becoming controlling and/or domineering and attempting to override the subjectivity of the parent. This is compelling evidence for the centrality of sadomasochistic patterns of relatedness, even in covert form, as the foundational core of the phenomena this paper seeks to investigate.

In another publication, Lyons-Ruth (1999) refers to the experience of collaborative and coherent communication/dialogue in the mother-infant dyad. Coherence primarily refers to an overriding principle of cooperation between participants, involving openness to the other's initiatives and the other's states across the whole range of affective experience (Lyons-Ruth, 2008). It involves an attempt to comprehend and respond to the experience of the other, with the ability to negotiate similarity and difference and to repair disruptions. In many ways, this concept is similar to Jessica Benjamin's (2004) concept of mutual recognition.

Non-coherent or less coherent dialogue will lead to the internalization of "enactive relational procedures" (Lyons-Ruth, 1999) that are not structured by the principles of coherence or collaboration. These will likely involve some form of dominance and submission in which only one person's subjectivity is acknowledged and the other is overridden. The point most relevant to the central theme of this paper is that it is the enactive relational procedure of dominance and submission (rather than collaboration) that is

internalized. And as it is the procedure, rather than the role, which is internalized, it follows

that this procedure could be activated in a reversible fashion, from the position of the

dominator or from the position of submission.

Domination is arguably the foundation of most, if not all, forms of aggression. Does

not most aggression, ranging from certain forms of persuasiveness, attempts to coerce or

control, to violence or abuse, consist fundamentally of an attempt to subjugate the

subjectivity (including the embodied subjectivity) of the other? In this way, experiences of

submission to a subjugating other may simultaneously create the potential for controlling,

domineering, or abusive behaviours and relational strategies. In this formulation, it does not

seem possible for one to occur without the other.

This explanatory model based on enactive relational procedures seems to provide a

powerful developmental explanation for how the phenomena encompassed within what we

call identification with the aggressor come about. It is the experience of being a participant in

a dominant-submissive or sado-masochistic relational dynamic that creates the capacity or

potential to re-enact this relational configuration regardless of whether one occupies the

dominant or submissive pole. Thus just as 3-5 year olds whose subjectivity was overridden in

infancy become controlling, patients who have experienced domination or abuse may display

domineering or controlling relational moves in treatment. I am suggesting that it is vital to

attend to this phenomenon as well as the relational context within which it occurs.

Contemporary theorizing, especially that based on infant research, clearly supports

the idea that sadomasochistic relational procedures are internalized and can be activated in a

reversible fashion. But what about the specific form and shape that the

controlling/domineering/abusive behavior takes? It has been my experience that it is not just that people who have been dominated become dominating, but sometimes the particular way domination is enacted bears a very close similarity to what the original abuser did to them. This phenomenon seems to be compelling evidence for the descriptive accuracy of the concept of identification with the aggressor.

Jody Davies and Mary-Gail Frawley (1994), in their seminal work on the treatment of survivors of childhood sexual abuse, propose a detailed model largely based on the idea of internalized object relations, and therefore encompassing an internalisation of, or identification, with the aggressor. They state:

> Always juxtaposed alongside the survivor's identification as victim, running parallel to it – though less consciously available – is her equally strong identification with the perpetrator of the abuse. The ruthlessness and icy sadism survivors display toward their own bodies, minds and emotions are shocking to witness…The enacting survivor takes up where the perpetrator left off, turning fury and frustration against herself in appallingly vicious way. (p. 132)

But it is not just that identification with the abuser is turned against the self. At the core of their model are eight transference-countertransference positions: unseeing parent and neglected child; sadistic abuser and helpless enraged victim; omnipotent rescuer and entitled child; seducer and seduced. These 4 matrices are enacted in the transference-countertransference and it is often only through the analyst closely tracking her countertransference, that the rapidly shifting and reversible nature of these positions will become conscious (Davies and Frawley, 1994).

They give multiple examples of interactions in which the patient invades the

therapist's boundaries, or attacks the analyst's sense of reality, or attempts to seduce the

therapist. These are seen as interactions in which the patient is enacting the role of the abuser

and creating an interactive form of pressure to induce in the analyst the experience of victim.

The concept of enactment is central to their model and they state:

it is the therapist's willingness to embrace and enact…the relevant transference-

countertransference positions that eventually allows the patient to identify, tame and

integrate long split-off elements of her self and relational world…[and] we stress that

enactment alone is not enough. It is the enactment and interpretation of transference-

countertransference phenomena combined that facilitate integration and healing.

(Davies and Frawley 1994, pp. 167-168)

Another contemporary formulation which articulates a similar theory, based on

enactment and multiple states, is that of Donnell Stern (2010). Central to his model is

Sullivan's notion of "not-me" states. "Not-me" is an experience that has never been

formulated, it is a dissociated state that has never been symbolized. He sees "not-me" as

originating as a response to unbearable fear or humiliation when one is the object of a

powerful other's sadism. He states:

It is the sense that one is once again that stricken person: terrorized and terrified,

sometimes to the point of….helpless, destructive rage; contemptible, sometimes to the

point of self-loathing that yearns for the destruction of self and other; shamed and

horrified, sometimes to the point of losing the desire to live or creating the desire to

kill. (p. 119)

Stern proposes that dissociated experience is unformulated. It cannot be thought about

or articulated, it can only be enacted. "The child, and then the adult, enacts the traumatic

states and lives his "known" life inside the bearable ones" (p. 85). He describes enactment as

the "interpersonalisation of dissociation" (p.86) and explains:

I will "play out" the state of self I cannot tolerate experiencing directly, and I will

thereby unconsciously influence those with whom I relate to adopt a variation on the

same dangerous response that led me to dissociate in the first place. In one variety of

enactment, I embody the traumatized self, in a continuous and futile attempt to make

everything happen differently, thereby healing myself; but instead I provoke the other

person to experience and behave in ways that, tragically, simply keep traumatizing

me. In the reciprocal version of this enactment, in a similarly unconscious attempt to

wrest control of the situation, I traumatise the other just as I myself have been

traumatised but I have little or no appreciation of my role in doing so. (Stern 2010,

p.84)

Finally, what of the phenomenon of identification itself? Is there any basis for its

continued use as an explanatory concept? Contemporary neuroscience appears to indicate that

there is. Olds (2006) in his exploration of the concept of identification, illuminates how

emerging understandings of mirror neuron systems appear to validate this psychoanalytic

concept. Iacaboni (2008) and Ramachandran (2011) have recently published extensive

expositions incorporating this newly discovered neurological system. Fundamentally, researchers have found that when a primate research subject watches another primate perform an action, neurons in his premotor cortex fire in exactly the same way as if he were performing the action himself.

Interestingly, at first the mirror response does not occur if the action being observed is novel (Olds 2006 p.33). However, after a few repetitions, the mirror neuron response will occur. Olds goes on to explain that this system is how we recognize actions, as opposed to objects: "the only way we can recognize an action is to play it out in the brain" (p. 33). And:

> Perception is "being there". Especially with interpersonal perception and recognition, one does not simply perceive, one *becomes.* In this model the visible actions and expressions of the other seem to some extent *invasive* and *controlling.* One replicates or simulates the external world internally, and only in this way can one understand. (p. 34).

One does not have to extrapolate very far to imagine how this might play out in a situation where a child is being abused repeatedly. In Ferenczi's model, where the child becomes hyper-skilled at pre-empting the abuser, the mirror neuron system will have encoded multiple records of action sequences in the child's own pre-motor cortex, so that they can be recognized. And in the enactment model of identification with the aggressor, where the individual acts out a replication of what was done to him, mirror neurons provide a powerful mechanism by which this phenomenon might come about.

Wolf, Gales, Shane and Shane (2000) articulate a similar hypothesis when they state:

> In addition, one can see from this implicitly-procedurally based mirror neuron system how experiencing trauma and witnessing trauma might profoundly affect an individual throughout life— how, based on repeated trauma, an individual might repeat these patterns, and how, even if on a conscious level an individual "knows better," he or she can involuntarily be drawn into repeating traumatic behavior with their own children, hence the intergenerational transmission of trauma. This transmission of trauma is often done via identification with the traumatic aggressor (i.e., turning passive into active) and is implicitly-procedurally based. The mirror neuron system provides one neurobiologic mechanism whereby an observed action becomes automatically non-consciously self-generated. (p.421)

Clinical Implications

Arriving at a sense that "I am a basically loving person who sometimes, atypically, gets angry and hateful when threatened" is not an ideal ending of an analysis. Such an ending leaves out too much, and smooths over a great deal that is potentially vitalizing and enriching in aggressive experience. A more ideal ending involves a sense that "I exist in different states of mind at different times, some loving, some hateful." A more meaningful sense of continuity and integrity of experience over time entails not a tucking in or concealment of aggression into a preferred, loving view of self, but an increased ability to recognize, hold, and work through aggressive states. What changes is one's ability to contain destructive states of mind and to recognize them as one among many expressions of a distinctively subjective and potentially constructive personal experience. (Mitchell, 1993 p. 379)

Is it important or even necessary to attend to aggressive states in the patient? More specifically, is it important to think about how patients may be identified with the aggressor? And if it is important, why is it? As previously mentioned, my experience has been that in some cases, a focus on the patient as traumatized, without a co-existing focus on the patient as traumatizing, will lead to limited analytic progress, and, potentially, even toxic impasses.

In my work with Tina, for example, one aspect of her experience, which we could not reach or modify analytically, was her self-hatred. No amount of empathy, understanding, challenging, or reassurance seemed to have much of an impact. Many patients like Tina, who have experienced trauma, present with intense self-hatred as one of the most damaging

aspects of their difficulties. This self-hatred is often very resistant to change and can be one of the most difficult aspects to open up and transform. I believe that some, possibly many, patients are on some (unconscious) level aware of their own aggression (or identification with the aggressor) and its traumatizing impact on others. I am proposing that this is an important aspect of why they hate themselves so intensely.

I have found in many of my conversations with colleagues that it is a common experience to feel that nothing one does as an analyst can shift some particularly toxic forms of self-hatred. In these conversations, I have often observed that the clinical approach is to show the patient that her experience of herself as "bad" or "revolting" or "ugly" is basically incorrect and that she has taken on negative attributions from the surround, or taken on excessive responsibility for the traumas and difficulties in her own life. In its extreme, this approach can frame the patient exclusively as victimized and focus solely on the impact of trauma and abuse on her sense of value.

This kind of approach, whilst fundamental and necessary, may on some level also be a collusion in which the more difficult aspects of the patient are not explored. It may unconsciously contribute to the patient's feeling that the "bad" parts of herself are so "bad" that not even the analyst wants to acknowledge or talk about them. In fact, intense self-hatred may initially elicit a powerful pull in the analyst to reassure the patient in one form or another that she is not "bad". This may inadvertently confirm that the "bad" states/parts are so powerful that the analyst is too frightened to go anywhere near them, ultimately reinforcing a feeling of terrifying intrinsic destructiveness.

I am not suggesting that these approaches are incorrect, in fact I would argue that they are essential aspects of unpacking the devastating psychological constellation of self-hatred. Like most psychological phenomena, self-hatred is likely to be overdetermined and contain multiple meanings and functions. I think it is essential, therefore, for us as analysts to wonder whether there might be some kernel of truth in the patient's often excessively vicious allegations against herself. Whilst recognizing the patient's experiences of victimization at the hands of others, perhaps we need to also consider that there may really be something "bad" that this person does interpersonally. This may potentially result in terrible shame and guilt, and, possibly, even then the turning of aggression against the self in ongoing self-denigration or even self-harm.

Focusing exclusively on the patient as victim also positions the patient as passive. The patient's defensive maneuvers or identification with her traumatiser may significantly contribute to ongoing experiences of alienation and relationship dysfunction. Not attending to this dimension is not consistent with contemporary notions of reciprocal mutual impact and intersubjectivity, as it frames the patient as a passive recipient of negative experiences over which she has no control. Helping the patient think about how she may be implicated in her ongoing experiences of suffering, that her power is being denied or disavowed, also has the potential to be liberating as it helps her experience a sense of agency and the possibility of choice (Ehrenberg, 2010; Ringstrom, 2010).

How then should we work with these traumatizing states in our patients? Can we have any certainty that a particular approach will be helpful? What are the many differing impacts that drawing attention to the patient's aggression and her identification with the aggressor may have? Could it be liberating if it leads to an amelioration of shame and feelings of

badness? Can it be destructive, confronting the patient with the intolerable, and lead to

psychic collapse, and, possibly even therapeutic ruptures?

And what is the role of the analyst's relation to his own aggressive states, and his own

history of trauma and exposure to aggression? This relation can powerfully structure the

analytic field. It can determine the analyst's choice of theory, which will likely be

concordant with his own psychological organization around aggressive experiences and states

of mind. How does the analyst's specific relation to aggression impact what emerges in the

analytic relationship? How does it potentially either open up or foreclose certain areas of

exploration when it comes to aggression?

Tina

Over time, I began to notice that I felt exhausted by endlessly trying to provide the response

and availability Tina seemed to need from me. I felt less inclined to offer extra sessions, and

began to resent text messages I received on the weekend. On one occasion, I had forgotten to

remind Tina that we were approaching a public holiday and so would miss a session. Tina

phoned me on the day and was extremely angry with me, shouting at me that it was clear that

I did not care about her. I attempted to stay with her experience of being forgotten about, of

being discarded, but I felt indignant. After all I had done for her! After all of the extra time,

text messages, and emotional investment and care – this was the thanks I got! In a very

heated exchange, I told Tina that if she was going to be like this to the people that cared

about her, she would be alone forever. The following week, she was sullen, uncommunicative

and told me that it was no longer possible for her to trust me. She felt very hurt by my

comment, and I acknowledged it had been a hurtful thing to say. As we processed it, she felt I

had said it because I felt guilty about forgetting to warn her about the public holiday. I

acknowledged this was probably correct and the intensity between us seemed to settle. We

focused on how this was a replication of childhood experiences of abandonment. At the time,

I had no awareness of why I had forgotten the public holiday. The following weekend, Tina

phoned me to say goodbye after having taken a massive overdose. I called an ambulance and

she was admitted to the intensive care unit and ventilated. Afterwards she told me that on the

day after our last session for the week, she had gone "crazy" and had become convinced that

she needed to die.

Up until this point, I had been convinced that if I just provided the requisite

responsiveness and helped Tina understand how her distress was linked to current

experiences that were analogues of childhood injuries, she would eventually feel better about

herself, and be less vulnerable to interpersonal disappointments. In retrospect it is obvious

that Tina was not only hurt by this event, but that she was also hostile and punitive towards

me. I wonder what the outcome would have been if we had been able to acknowledge not

only her injury, but her aggression and punitive treatment of me. Did my sustained attempt to

be empathic and "good" contribute to her feelings of "badness", and hence her conviction

that she must die? Could a different response have averted her suicide attempt? Was her

suicide attempt fuelled by guilt about her hostility toward me, whilst at the same time being a

further hostile act?

I have come to hypothesise that my fear of aggression, my own and that of others,

helped to construct a relational system with Tina in which I required myself to be endlessly

giving and never frustrated. In this system, I consciously experienced Tina as vulnerable and

helpless, and it seemed understandable that she couldn't help it if she sometimes lashed out

when she was hurt. I have come to realize that aggression has for me been a "not-me" state,

and so it probably suited me to experience Tina as the difficult, angry one, whilst I was the

benevolent carer. Further, I think it is highly likely that my disavowal of aggression may have

contributed to Tina's suspicion of me, and also probably heightened her feelings of badness

because she was the only one who continued to "lose it" on a regular basis. I had adopted a

stance of being "empathic", for a range of reasons, and I suspect that this was a way of

distancing myself from Tina rather than truly making contact (Ehrenberg, 1996). This may

have contributed to her isolation and fuelled increasingly desperate attempts to reach me.

Perhaps if I had been able to acknowledge my anger and talk with Tina about her

impact on me, my own anger would not have escalated to the point that I enacted it by

forgetting a public holiday or retaliating with an interpretation that was designed to hurt. This

would have been more truly "related" than the cautious and benevolent stance I adopted. In

retrospect, I now see that I had colluded in setting up this enactment by occupying a

masochistic position in relation to Tina. This was fuelled by a conflation between my own

need to avoid aggression and a theoretical stance that seemed to prioritize a kind of self-

effacing attunement. This created increasing feelings of resentment and rage, which remained

unconscious, "not-me", and so ultimately were enacted in what transpired between us.

Steven Mitchell describes the consequences of a similar kind of submission in the

relationship between a parent and an infant, and how the consequences are very different if

the parent feels in some way coerced to perform this function:

> What I am describing is best understood…..as a transition of modes of
>
> interaction *in a relationship*. This transition can be disastrous when the original
>
> adaptation on the parent's part is done through a sense of obligation or an intellectual

determination of the child's "needs." In such cases the subsequent reclaiming of the

parent's needs and interests is accomplished with deep resentment and often sadistic

retaliation for the previous masochistic surrender. Yet even under the best of

circumstances, the negotiations between parents and children over desires and

adaptations are complex, last a lifetime, and are inevitably conflictual. I regard the

position sometimes found in the psychoanalytic literature suggesting that sensitive

parents can make the frustrations of childhood less conflictual and generally joyful, as

a kind of grandparents' theory. On occasional visits it can *seem* as if gratification or

sympathetic understanding of disappointments is the simple answer; actually living

together, however, requires continual negotiation. (Mitchell 1991, p.156)

I believe here Mitchell is referring to a model of treatment which holds that sensitive

attunement can bypass conflict, and that sympathetic understanding of disappointments is all

that is needed. He seems to be pointing out that negotiation, and therefore conflict, are part of

the fabric of human relatedness, and smoothing over these issues, because we believe this is

what the patient needs, will only result in the emergence of conflict in another form. I

nevertheless accept that one can only respond and work from within the limitations of one's

own subjectivity and psychic organization. I am not sure that I would have been able to

respond to Tina in the way Mitchell recommends at the time we commenced working

together as much of what unfolded between us was, I believe, unconscious. Ultimately, Tina

and I found a way to talk about what had been unacknowledged or even unformulated. Could

we have gotten there via a less traumatic route? Probably. I believe, however, that ultimately

where we got to was transformative for both of us.

As I gradually began to acknowledge that I was fed up with having to be so careful all the time, with every little mis-step or misattunement being pounced on, I became able to formulate an aspect of my countertransference. I had been feeling for some time that it was bad to be separate from Tina, to have my own separate life, ultimately my own separate needs and subjectivity. Anything which highlighted to Tina my separateness from her, resulted in difficult and prolonged periods during which I experienced an urgency to repair the relationship. Seeing me arrive "from somewhere" in my car, taking a vacation, wanting to have a day off on a public holiday rather than see Tina – all of these things, and countless others, felt more and more like I was bad and uncaring for feeling this way. I had associations to my own struggle to move out of home, and how telling my mother that I wanted to live somewhere else, other than with her, felt like I had killed her.

Tina began to articulate her need for us to be "melded", or "inside the bubble". She explained this was the only form of relatedness that felt safe to her and anything which represented a boundary between us was actively denied or ignored. Tina was able to articulate at one point that when I made observations, rather than being aligned with her experience, it was intolerable for her. "It puts you outside, over there. Don't you understand that you are in here, inside me?". I was much helped to understand the subtleties of our interaction by the approach described by Darlene Ehrenberg (1992). Attending to the subtleties of our interaction helped illuminate for me why I often felt both imprisoned and enraged. There was a powerful pull from Tina for me to remain in this position with her, and a complementary terror of breaking free, which triggered my own associations to the consequences of having a boundary with my mother.

On the one hand, I understood that because Tina had been left multiple times by those she depended upon, she experienced any sign that I was moving away, especially that I wanted to move away from her, as terrifying and catastrophic. In this transference-countertransference configuration, I was the parent who was more interested in my own needs than hers, and she was the discarded child. Another competing transference-countertransference configuration began to coalesce, as if it were taking shape out of a fog. I was the child who wanted to have my own space, my own life, my own thoughts, my own self, and Tina was the narcissistically absorbed mother who required that I be of one mind with her, or else face terrible consequences. Tina's mother had subjected her to devastating emotional abuse and contempt when she was not fused with her mother's needs and wishes.

Tina

Tina had been struggling with self-hatred and had tried to make contact with me via text on the weekend, but I had forgotten to get back to her. This precipitated her angry withdrawal, including having thoughts about terminating treatment. We worked on this in the usual way, trying to understand why my forgetting to respond was so catastrophic, and it made sense to us in terms of her childhood experiences. Things settled between us after two very difficult weeks. One evening shortly after, I received a text message from Tina, telling me she was not doing well. Usually, I would respond with an acknowledging and reassuring text but some hours later, I realized I had forgotten her message. Perhaps because of my own personal analysis and my growing capacity to own angry states, I was shocked to become aware of a part of me that thought "If I don't respond, I will be in deep trouble... again. I don't want to respond. And I am not going to! She can go to hell! She has been so demanding and difficult, she deserves everything she gets". Realizing that something complicated was going on, I

responded to her text briefly, expressing my concern and my hope that we could talk about it tomorrow.

It became clear to me that I needed to explore the transference-countertransference configuration which had only recently become apparent to me, as it was clearly leading to retaliatory enactments in which I was aggressive towards Tina. The following day, I decided to share with Tina my internal process in response to her text message, including that it had shocked me to observe that there was a part of me that could be cruel. I told her that this realization had prompted me to reflect on what was going on. I had become aware that I had been feeling a kind of coercive pressure that if I did not respond in a certain way, I would pay dearly for it with either withdrawal, suicidal threats or indeed self-harm. She asked me whether I perhaps had residual feelings about the period in which she had been chronically suicidal, that perhaps it had been exhausting. I told her that I thought it had been more than exhausting, that the thing that had made it most difficult was that it felt so cruel for her to come here almost every day and tell me that she might kill herself, and to leave me in a position where every morning I would wonder if I were going to see her that day.

We continued to explore this over many sessions and I was able to eventually ask Tina whether perhaps sometimes when she thought she was protecting herself from me by withdrawing or threatening to leave, when she saw me as dangerous and untrustworthy, that she might also be acting in a way that was cruel to me. She was unsure, however she acknowledged that she knew that I experienced those things as punishing. She also said that in the past she had been cruel to people close to her in ways that scared her. This opened up a painful exploration of how Tina had been demanding and verbally abusive to co-workers or even her partner when she felt she was not being treated with respect. She owned that

anything that left her feeling that she was not important could potentially trigger this

reaction.

Tina's family had always compared her to her mother, describing her as too demanding and

too difficult. Any exploration of whether there was any truth to this had been impossible in

the past as it flooded Tina with shame. Now we were able to cautiously wonder whether there

were in fact some ways that she could be like her mother, and that we experienced this by

living through certain interactions in the therapy. There were many associations to her

mother's need for recognition, how she would lose it if Tina had bought the wrong brand of

cookies at the store, and how important it was to constantly make sure that her mother felt

like she was the most important, or else suffer the wrath. Many painful memories emerged of

her mother's rage, and how "she would keep going until she had destroyed you and you were

on the floor, begging for forgiveness."

This is just one of many sequences in which Tina and I were either enacting a sado-masochistic coupling, or were attempting to talk about it after the fact. Attending to what was going on between us interactively (Ehrenberg, 2010) was fundamental for moving the treatment forward. Tina became increasingly able to, and in fact wanted to explore how she was being controlling with me. This enabled her to become increasingly aware of how difficult she had been with me. It then became possible for her to hold in mind that there was the potential inside her to be like her mother, mostly at times when she was feeling extremely vulnerable and threatened. Tina said that this part of our work transformed a sense that there was something "hideously bad, gross, disgusting" inside of her, to a sense that it was "just ordinary, everyday bad". She continues to struggle with her responses to disappointments and her punitive behavior towards those around her, despite this awareness. However it has now

become accessible to analytic exploration and no longer leads to violent enactments of self-hatred. Tina's self harming behavior completely stopped around this time. I believe that becoming aware of how cruel she was to me, allowed her to begin to consider how cruel she was being to herself.

Despite how painful and difficult it was for us to talk about this, I believe what made it transformative was that the experiences were "live" (Ehrenberg, 1992) right now, between us. Tina expressed genuine sadness about what she had put me through. Through the recognition of the experience of subjugation and the attendant rage I was experiencing, Tina became more aware of how in her own relationships, she was often in a similarly masochistic position. Just as I felt I had to go along with what Tina wanted, this was how Tina positioned herself in her relationships, "melding" herself to the other person's subjectivity. This allowed us to understand the depth of her rage at being so dominated and used and led to the development of a capacity to have a boundary, and to articulate some of her own needs in relationships. It was like I had to go first and change the way I was in our relationship before Tina could make similar changes in her own life.

We began to make sense of one of the other issues that had been seemingly resistant to change, namely Tina's extreme isolation from any intimate involvement with others. She was able to acknowledge that she was frightened of how she would lose herself entirely in masochistic compliance if she made contact with another person. At the same time, she was equally frightened of how angry and punishing she could become if others did not match her expectations exactly. It was therefore better to isolate herself than risk causing damage to anybody else. She had previously attributed her isolation to feelings of repulsiveness and ugliness. Now, she struggled with an increasing awareness that she could become

masochistically "melded" with others, or alternatively aggressive and punishing if they failed to meld with her. On another level, we began to explore how much her feelings of repulsiveness were associated with the enormous reservoir of need and desire that was rarely, if ever was directly expressed.

These are just some examples of how attending to Tina's identification with her mother opened up multiple areas of exploration that had previously been foreclosed or inexplicable. In retrospect, I feel one of the most important functions of this concept was that it helped me to retain a capacity to think at those times when I experienced Tina as being aggressive. It helped me to remain present rather than slide into a dissociated state of masochistic compliance. I also think a central aspect of this whole process was the reversibility of the sado-masochistic integration between us, where we swapped roles frequently, and sometimes rapidly. This is the kind of phenomenon outlined by Davies and Frawley. It is also consistent with Lyons-Ruth's premise that it is the entire procedure, and not just one role, that is internalised. And clearly both Tina and me were no strangers to domination and submission.

Mitchell (1988) articulates very clearly an aspect of what I believe occurred between Tina and me:

> If he is open to the nuances of his experience and the analysand's impact on that experience, he sometimes finds himself enacting the patient's old scenarios, speaking in a voice not wholly his, and sometimes enacting his own old scenarios, as various parallel or complementary voices from his own past and his own dynamics are evoked within the complexity of the interaction with each analysand. (p. 295)

It also seems to me that a central aspect of the process was that I occupied and embodied a cruel "not-me" self-state, that subsequently became accessible to consciousness for me. This is one of the central ways in which my work with Tina was transformational for me. I am convinced that it was not possible for me to become fully conscious of how cruelty existed between us, and particularly to perceive that Tina was being cruel to me, until this had happened. Davies (2009) articulates this phenomenon when she writes:

> experience that seeks to avoid meaning can lodge itself well within the unconscious or unformulated experiences of either the patient or the analyst. Where, via projective identification and other projective mechanisms, meaning is subjected to such defensive extradition, it becomes incumbent upon the analyst to represent actively – even embody – that aspect of the split-off internal self and object world of the patient that so elusively defies acknowledgement and integration. It becomes part of the analyst's essential function to recognize and maintain such disavowed experiences until such time that the patient can know them and integrate them without the threatening precipitation of debilitating anxiety and psychic regression. Within such a scenario, the analyst oftentimes must speak the dangerously charged words for the first time. (p. 168)

Bringing aggressive states into awareness does not always lead to an opening up of exploration. It can, as Davies says, lead to psychic collapse and extreme anxiety, as initially occurred when I attempted to explore this with another analysand, Grace.

Grace

I had been working for many years with Grace, who was physically abused by her mother and sexually abused by her grandfather. A climate of cruelty seemed to pervade her early life. She consciously identified as victimized and was frequently in states of fear/vulnerability/terror. She often felt abused and attacked by people around her, including me. After many years of work focusing on these experiences, there seemed to be very little shift in the intensity of her self-hatred. In a way that was very similar to my work with Tina, I had hoped that persistent, attuned, responsiveness would result in a shift in her self-experience. Before any apparent shift in her experience occurred, however, there was a shift in my countertransference.

I started to experience Grace as cruel to me. I experienced this in the way she would sometimes ignore me, or accuse me of finding her hideous, or send me emails stating only the one line "I hate myself and want to cut myself" after a session. I had a sense that talking about my emerging experience of her, involved taking an enormous risk, the nature of which I could not formulate. I felt terrorized by the potential for violent retaliation, even though Grace had to this point not demonstrated any violent or threatening behavior towards me. When I felt brave enough to talk to her about the fact that I felt she was being cruel to me, her response was something like this: "you are making me feel crazy! I don't know what you are talking about! I don't know who you are talking about! That is not me! Why are you saying that? Why are you being so awful to me?" Grace was clearly frightened and became increasingly distressed and disorganized. It rapidly became clear that she was unable to process what I was saying, and only experienced it as yet another attack on her. She later told me that it felt like I was doing exactly what her mother did, accusing her of something

she didn't do. Even when the intensity of the enactment had passed, Grace was not able to see my actions as anything other than hostile and punitive.

Twelve months later, I was aware that I had "forgotten" to respond to Grace's frequent distressed emails over the weekend. I became aware that I was feeling angry about her relentless intrusion into my space and time. I attempted to explore with Grace what might be going on that I was having a negative response to her emails. She became highly distressed in a way that was very similar to the session outlined above and I began to feel I should not have opened my mouth. It felt like we had touched on something explosive and that she was likely to storm out of the room like she had in the past. The following session, she arrived in a state she experienced as very depressed. She reported that she was feeling paranoid, as though everyone around her had hostile intentions towards her. This obviously included me. She appeared "crazy", with her long hair pushed forward over her face, through which she would peer at me out of the corners of her eyes. I asked if she was angry with me and she acknowledged that she was very angry about the fact that I was not there when she was in her highly depressed states, the times she needed me most. Was she supposed to pretend that was ok, she asked? I was aware at this point that I had a choice: to obfuscate and distract from the rage she was feeling, by saying something reassuring or reminding her that I did care, or focusing on how this was a repetition of her experiences of abandonement. Alternatively, I could try to open a space for her anger so that it could be dealt with here and now between us.

I responded that it was not OK that she was alone at these times, and I did not expect her to pretend that it was. Sbe then asked me how she was supposed to hold on to the relationship at those times, as my not being there proved to her that our relationship meant nothing, and it

left her with nothing. I said I understood how desperate she became, but I wondered how that led to the relationship becoming "nothing". Further, I said that this was all I was able to provide, as I needed my own space and time in which I could "close the door to my room for a while" (here I was spontaneously using an image related to her own childhood experience of having no privacy). She acknowledged that she killed me off when I was unavailable by vowing that she would never allow me to get close to her again. We saw how doing so actually destroyed any sense that there was something good in the relationship.

She subsequently became reflective and had many associations including that what happened between us was like when her mother punished her by sending her to her room for long periods, or how she would run away and hide outside after her mother had beaten her, but then secretly hope that her mother would come and find her and help her. I said I was moved by what she was telling me, and was aware of another aspect of our interaction. That sometimes I felt like I was not allowed to have my own space and time and that it was like I was in a room which had no door and no privacy, very much like her own childhood room to which her mother had complete access at any time she wanted. I was also aware, but did not articulate, that the sense of penetration into my personal space might be an enactment of the physically and sexually abusive interactions she experienced. Grace left the session in a completely different state, coherent and no longer paranoid. I commented on the profound change and Grace said she felt dramatically better now than when she had arrived.

It is sometimes suggested that some particularly traumatised patients require a long period of close attunement where the analyst puts his subjectivity into the background, before anything resembling mutual recognition can begin to develop in the relationship (Slochower, 1996; Bass, 1996; Mermelstein, 2002). Indeed, Kohut (1977) wrote about the need for a

prolonged understanding phase with a particular type of patient who had experienced

profound self-object failure. Both the cases of Tina and Grace involved toxic impasses that I

believe were a result of taking this stance. Sometimes the impasses that result from such a

perspective may be harmonious, with a sense that much work is being done, however, little

fundamental change is occurring when it comes to deeply help self-hatred.

Samantha

Samantha and I had a very good working relationship and sessions always seemed

productive. Our relationship was notable for the absence of disruptions or anger of any kind.

This seemed consistent with how Tina saw herself: as kind, patient, caring, self-sacrificing.

After a protracted period in which we had explored her experience of vulnerability and

helplessness, we began to work on some of the less than kind ways she treats her husband

and colleagues. I had also become aware that even though she is extremely friendly and

polite, there is a way that I feel subtly frozen out, and that no matter what I do, I will never

really be allowed to be close to her.

Recently, she had been upset by the actions of her boss and was trying to enlist my agreement

that her boss was a cold, awful woman, and that Samantha was totally justified in treating

her with complete disregard. I responded that I was having a reaction to the way she was

talking about this, and I wasn't sure what I was reacting to. She said it's as if she has become

cold as ice, evil, relentless, wanting her to suffer. I said I think that's what it is I am noticing,

that there is something punishing going on.

She said "I do want her to suffer. Actually I think of all kinds of ways to get to her, and I

enjoy it! Isn't that awful! I can't believe that I am like this! I thought I was a kind person but

in the last few months, I have realized that's not true. I think I did the same thing to my husband for many years when I froze him out". I asked her what she thinks evokes this kind of reaction. "It's betrayal, when I feel someone has betrayed my trust, they are out! Never to return. And I will punish them for what they have done to me. I remember I did that with my mother. She was so horrible and cruel to me. I would let myself trust her again and then she would hurt me again, and eventually I discovered I could upset her by being very cold and distant. I took great pleasure in hurting her". I responded: "That makes sense. But the thing that I am struck by is now you are being like your mother, and you are also treating your colleague the way your mother treated you. You are persecuting her and terrorizing her with your coldness in a way that is cruel. I know its awful to think about, but we all take on aspects of our parents, especially the things that we were traumatised by". She was devastated and said "That makes me feel terrible to realize I am like her!" During the following session she said she had gone home feeling that I must be appalled and disgusted by her and that the whole thing was very difficult for her to process.

Some months later, after further work on Samantha's aggressive states, work that she clearly wanted to pursue, she appeared to come to a devastating recognition of the extent of her passive hostility to her husband over many years. She had never cried before during our sessions, but now she began to sob with grief in a very moving way. I felt an impulse to remind her that she was only reacting to her husband's insensitivity most of the time. However, based on my experiences with other patients, it felt to me like this was a profound moment in which she was not berating herself for being "bad", or hating herself, but truly grieving the consequences of her aggression, which may make it possible for her to grieve the enormous losses associated with her childhood in a way that she had not yet been able to. Many months later, Samantha was able to articulate how tormented she had felt most of her

life, by feelings of toxicity related to a sense that she was destructive to others.

Acknowledging how she could actually be hurtful by being cold, had ameliorated the sense of

intrinsic (and hence beyond her control) toxicity she had felt. This made it possible for her to

choose other ways of responding when she felt hurt.

For people whose subjectivity has been subjugated by that of a dominating other, it makes sense on one hand, that an experience of having their subjectivity recognized may be transformative. However, at what point does the analyst's act of placing his subjectivity into the background become a masochistic enactment, where he is now the child who was subjugated? Is it not possible that what we think is a new relational experience is actually a repetition of the original traumatizing configuration, except in reverse?

The phenomena I have attempted to describe, just like any aspect of the analytic encounter, are fundamentally ambiguous (Hoffman, 1992) and open to multiple interpretations. I propose that the concept of identification with the aggressor gives us a frame within which to think about aggression within the analytic relationship. It is a concept that has extensive support in both early and contemporary psychoanalytic writing, and now neuroscience. It appears to have receded out of mainstream psychoanalytic discourse, and I would encourage us to re-evaluate its utility as a concept that is highly relevant to contemporary relational psychoanalysis. At the very least, it may be a way to open a space of "thirdness" (Benjamin, 2004; Aron, 2006) so that what is being enacted can be thought about, ideally making it possible for both members to "play" with the material at hand (Ringstrom, 2007).

Aggression in the analytic relationship can be both elusive and threatening, and the concept of identification with the aggressor gives us a way to have some traction on this phenomenon. It inherently contextualizes aggressive states by immediately placing them within the current transference-countertransference situation. It gives us a way to think about what may be being enacted in the relationship when aggression is present. It also links aggressive states to their historical relational contexts. When aggression is disavowed or unformulated, important domains of exploration can be foreclosed. Further, such disavowal can lead to subtle or toxic impasses which can stifle analytic progress. Dealing with this phenomenon may also help individuals who have been victimized reclaim a sense of agency and find a way out of self-hatred.

References

Aron, L. (2006). Analytic Impasse and the Third: Clinical Implications of Intersubjectivity

Theory. *International Journal of Psychoanalysis, 87*, 349-368

Bass, T. (1996). Holding, holding back, and holding on: Commentary on paper by Joyce

Slochower. *Psychoanayticl Dialogues, 6*, 361-378.

Beebe, B. and Lachmann, F. (2002). *Infant Research and Adult Treatment.* Hillsdale, NJ:

Analytic Press

Benjamin, J. (2004). Beyond Doer and Done To: An Intersubjective View of Thirdness.

Psychoanalytic Quarterly, 73, 5-46

Bowlby, J. (1969). *Attachment: Attachment and Loss Volume 1.* New York: Basic Books

Bromberg, P. (1998). *Standing in the Spaces: Essays on Dissociation, Trauma and Clinical

Process*. Hillsdale NJ: The Analytic Press

Bromberg, P. (2006). *Awakening the Dreamer: Clinical Journeys*. Hillsdale, NJ: Analytic

Press

Davies, JM. & Frawley, MG. (1994). *Treating the Adult Survivor of Childhood Sexual

Abuse: A Psychoanalytic Perspective*. New York, NY: Basic Books

Davies, JM. (2009). Love in the Afternoon: A Relational Reconsideration of Desire and

Dread in the Countertransference. *Psychoanalytic Dialogues, 4*, 153-170

Ehrenberg, D. (1992). *The Intimate Edge: Extending the Reach of Psychoanalytic Interaction.*

New York: Norton Press

Ehrenberg, DB. (1996). On the Analyst's Emotional Availability and Vulnerability.

Contemporary Psychoanalysis, 32, 275-286

Ehrenberg, DB. (2006). The Interpersonal/Relational Interface: History, Context and Personal

Reflections. *Contemporary Psychoanalysis, 42*, 535-550

Ehrenberg, DB. (2010). Working at the Intimate Edge. *Contemporary Psychoanalysis*, *46*,

120-141

Fairbairn, W.R.D. (1952). *Psychoanalytic Studies of the Personality.* London: Tavistock

Publications

Ferenczi, S, (1933). Confusion of Tongues Between Adults and the Child, in *Final

Contributions to the Problems and Methods of Psycho-Analysis (1955),* London:

Karnac

Ferenczi, S. (1932). *The Clinical Diary of Sándor Ferenczi*, J. Dupont (ed.) (trans. M. Balint

& N. Z. Jackson). Cambridge, MA: Harvard University Press, 1988.

Fosshage, J. (1998). On Aggression: Its Forms and Functions. *Psychoanlytic Inquiry, 18,* 45-

54

Freud, S. (1930). *Civilisation and its Discontents.* London and New York: Standard Edition

Freud, A. (1937). *The Ego and the Mechanisms of Defence.* London: Karnac Books

Hoffman, I.Z. (1992). Some Practical Implications of a Social-Constructivist View of the

Psychoanalytic Situation. *Psychoanalytic Dialogues, 2*, 287-304

Iacaboni, M (2008). *Mirroring People: the new science of how we connect with others.* New
    York, NY:Picador

Jacobs, L. (2010) Truth or What Matters: Commentary on a Paper by Philip A. Ringstrom.
    Psychoanalytic Dialogues, 20, 224-230

Kohut, H. (1977). *The Restoration of the Self.* New York: Int. Univ. Press

Lachmann, F. (2001). *Transforming Aggression: Psychotherapy with the Difficult-to-Treat*
    Patient. Northvale, NJ: Aronson

Laplanche, J. & Pontalis, J. (1973). *The Language of Psychoanalysis: Translated by Donald*
    Nicholson-Smith. London: The Hogarth Press and the Institute of Psycho-Analysis

Lyons-Ruth, K. (1999), The two-person unconscious: Intersubjective dialogue, enactive
    relational representation, and the emergence of new forms of relational organization.
    Psychoanalytic Inquiry, *19*, 576-617.

Lyons-Ruth, K. (2006). The Interface Between Attachment and Intersubjectivity: Perspective
    from the Longitudinal Study of Disorganized Attachment. *Psychoanalytic Inquiry, 26*,
    595-616.

Lyons-Ruth, K. (2008). Contributions of the Mother-Infant Relationship to Dissociative,
    Borderline and Conduct Symptoms in Young Adulthood. *Infant Mental Health*
    Journal, 29, 203-218

Lyons-Ruth, K., Bronfman, E. & Parsons, E. (1999), Atypical maternal behavior and

disorganized infant attachment strategies. Frightened, frightening, and atypical

maternal behavior and disorganized infant attachment strategies. In Vondra, J and

Barnett, D. (Eds), *Atypical patterns of infant attachment: Theory, research, and*

current directions. Monographs of the Society for Research in Child Development, 64,

(3, Serial No. 258

Main, M and Hesse, E. (1990), Parents unresolved traumatic experiences are related to infant

disorganized attachment status: Is frightened and/or frightening behavior the linking

mechanism? In Greenberg, M. Cicchetti, D. & Cummings, EM. (Eds.), *Attachment in*

the Pre-School Years: Theory, Research and Intervention, (pp.161-184). Chicago:

University of Chicago Press

Main, M. and Solomon, J. (1990). Procedures for identifying infants as

disorganized/disoriented during the Ainsworth Strange Situation. In M. Greenberg, D.

Cicchetti, & E. M. Cummings.(Eds.), *Attachment in the Preschool Years: Theory,*

Research and Intervention, (pp. 121-160). Chicago: University of Chicago Press.

Mermelstein, J. (2002). Kohut's Understanding and Explaining Steps: Clinical

Considerations Influencing the Need for a Prolonged Understanding Phase. *Progress*

in Self Psychology 18, 63-75

Mitchell, S. (1988). *Relational Concepts in Psychoanalysis: An Integration*. Cambridge

Massachusetts: Harvard University Press

Mitchell, S. (1991). Wishes, Needs and Interpersonal Negotiations. *Psychoanalytic Inquiry, 11*, 147-170

Mitchell, S. (1993). Aggression and the Endangered Self. *The Psychoanalytic Quarterly, 62*, 351-382

Mitchell, S. (1998). Aggression and the Endangered Self. *Psychoanalytic Inquiry, 18*, 21-30

O'Leary JV. Watson RI. (1995). Paranoia. In M. Fiscalini, J. Mann, C. Stern, D. (Eds.), *Handbook of Interpersonal Psychoanalysis,* (pp.165-188). Hillsdale, NJ. The Analytic Press

Olds, D (2006). Identification: Psychoanalytic and Biological Perpectives. *Journal of the American Psychoanalytic Association 54*, 17-46

Ornstein, A. & Ornstein, P. (1993). Assertiveness, Anger, Rage and Destructive Aggression. In Glick, R. & Roose, S. (Eds.).. *Rage, Power and Aggression,*(pp. 102-117). New Haven, CT: Yale University Press

Prior, S (1996). *Object Relations in Severe Trauma: Pychotherapy of the Sexually Abused Child*. Maryland: Rowman and Littlefield

Ramachandran, V. (2011). *The tell-tale brain.* London: WW Norton and Co

Ringstrom, P. (2010). Meeting Mitchell's Challenge: A Comparison of Relational

   Psychoanalysis and Intersubjective Systems Theory. *Psychoanalytic Dialogues, 20*,

   196-218

Ringstrom, P. (2007). Scenes that Write Themselves: Improvisational Moments in Relational

   Psychoanalysis. *Psychoanalytic Dialogues, 17*, 69-99

Sandler, J. (1959), Identification in children, parents and doctors. In MacKeith, R & Sandler,

   J. (Eds.). (1961) *Psychosomatic Aspects of Paediatrics.*, (pp. 16-26). London:

   Pergamon Press

Sroufe, LA.and Fleeson, J (1986). Attachment and the construction of relationships. In

   Hartup, W. and Rubin, Z. (Eds.) *Relationships and Development,* (pp. 51-71)

   Hillsdale, NJ: Erlbaum

Shane, E. (2006). Developmental Systems Self-Psychology. *International Journal of

   Psychoanalytic Self-Psychology, 1*, 23-45

Slochower, J. (1996), Holding and the fate of the analyst's subjectivity. *Psychoanalytic

   Dialogues, 6*, 323-353

Stern, D. (2010). *Partners in Thought.* New York, NY: Routledge

Stolorow, R. (1984). Aggression in the Psychoanalytic Situation: An Intersubjective

   Viewpoint. *Contemporary Psychoanalysis, 20*, 643-650

Wolf, M, Gayles, M, Shane, E. and Shane, M. (2000). Mirror Neurons, Procedural Learning

   and Positive New Experience: A Developmental Systems Self-Psychology Approach.

Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 28,

409-430