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Lauren D. Walther
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Abstract

This is a theoretical thesis focused on aggression in countertransference for the purpose of increasing clinicians' awareness and understanding of aggressive feelings and actions towards patients. Firstly, this research examines the evolution of theories about countertransference in psychoanalytic literature with attention to the experience of hate and aggression. Secondly, this research presents contemporary understandings of the behavioral features of aggression and considers a methodic examination of the behavioral manifestations of aggression in countertransference. Acting out one's aggressive instincts towards a client is potentially damaging to the therapeutic relationship. A classification system of aggressive behavior is outlined and applied to therapists' experiences of aggression toward a patient within the context of a therapeutic relationship. In this way, therapists may garner more precise information about themselves by becoming more observant of the ways their behavior discloses their aggressive instincts toward patients.

**When Therapists Attack: An Aggressive Instinct in the Countertransference and
Aggressive Behavior in Technique**

A project based on an independent investigation, submitted in
partial fulfillment of the requirements for the degree of Master of
Social Work.

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2011

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Chapter One

Introduction

Insane patients must always be a heavy emotional burden on those who care for them. One can forgive those who do this work if they do awful things...However much he loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients (Winnicott, 1949, p. 69).

The HBO series, *In Treatment*, allows an audience to peek behind the curtain of confidentiality to observe a most intimate relationship between a psychoanalyst and his patients. Even if viewers are familiar with the process of therapy through their own psychotherapy sessions, the show reveals the reticent mind of the therapist. Within an actual therapeutic alliance, a therapist's reaction to patients and sessions is often only explored through patients' fantasies about the therapist's thoughts, but *In Treatment* allows for the audience to consider a therapist's vulnerability. A therapist's encounters in life and internal structures contribute to behavioral manifestations of conflict. Frequently, the more subtle behavioral signs of these conflicts are unnoticed. It is not until the behaviors become injurious to the therapeutic alliance that a clinician may realize he or she needs to attend to their own process. In the fourth episode of *In Treatment*, the audience observes the clinician, Dr. Paul Weston, played by Gabriel Byrne, respond to the aggressive badgering of one of his clients, Jake, in a questionably pugnacious

manner. Paul starts to scratch the surface of his hostilities toward his clients with his own therapist, Gina, in the fifth episode,

Um, Gina, I, uh, I called you last night because I really felt that I needed to talk to somebody. It's, um, actually it's something that's been bothering me a lot lately, but only yesterday I felt the need that I had to, to talk about it. I feel that, (sigh) I don't know how to put this but I feel like I'm, I'm just losing my patience. (Small laugh and smile) I'm losing my patience with patients. I, there are session where I can barely retrain myself from having just, from an outburst. I want to just lock the door some days and wish everybody would just go away. I have this; I had this couple who've been coming to me for marriage counseling. They have one child. They have been trying for five years to have another baby, so she gets pregnant and now she wants to have an abortion. I think what she really wants is to get rid of the husband, if you ask me. But anyway, this guy really got on my nerves yesterday. He cornered me. He, he badgered me until I made a decision. "Should we have an abortion? Should we not have an abortion?" I finally said, "Yes! Good! Have an abortion!" As soon as I said it of course I regretted it because I knew that I had spoken in anger, but I couldn't help it. This guy, he just, he said some really nasty things to me. He called me... a murderer. I knew he was right the second it came out of my mouth. Of course he was right. I was sitting there telling him to kill his baby. But still I was... I know I'm not making much sense, but anyway.

Paul recognizes that he has been feeling frustrated with his clients for some time, but the manifestation of that frustration into an overt act of aggression necessitates an examination of his animus. The therapeutic value of Paul's response to his client is contentious. The damaging

effects of Paul's response appear to have been effectively managed by demonstrating the couple's process of interacting; however, the session also effectively ended prematurely. Paul's description of his attitudes towards his patients and his actions toward this couple show the need for a therapist to understand not only the psychic motivations for aggression, but also the behavioral characteristics of aggression to formulate therapeutic interventions. Paul would be able to have a more comprehensive understanding himself if he was more able to fully illustrate the connection between his countertransference and resulting aggressive behavior.

Aggression is unavoidable in its ubiquity. The instinct for aggression is to have existed before the very existence of the human species in our genetic predecessors. Its ubiquity is matched by its influence. From birth to death, it drives individuals. From establishment to destruction, it is in the foundation of civilizations. As intrinsic as aggression is to society, an examination of its formations, motivations, and operations in the human psyche is complex. Societal acceptance of violence, genetics, temperament, disposition, upbringing, modeling, gender norms, and myriad other factors affect an individual's tendency to aggress.

Research demonstrates how strongly the nature of a relationship impacts whether one person will aggress against another. Kelly and Thibaut (1978) say that an interdependency of outcomes and behavior between people with an established relationship inherently increases the likelihood of aggression. Also, repeated interactions between individuals and intertwining of relational goals create circumstances for outcomes to be threatened. A therapist and client establish a relationship by meeting for sessions and agreeing to collaborate. The desired outcome for the client may be to reduce symptoms, increase insight, or work on relationships, etc. The desired outcome for the therapist may be to utilize his or her repertoire of techniques to facilitate change in the client. Whatever the desired outcome for each, the therapist and client begin to

interact with an expectation of some designated outcome, which may not always act in conjunction. Frequently, the course of treatment does not follow a linear path to improved wellness. In any given session, the behavior of either therapist or client may diverge from the desired outcome. In fact, clinicians anticipate clients will digress from their stated goal as a course of therapy, which, in turn may cause the therapist to react. Throughout this interplay of action and reaction by the therapist and client, each will undoubtedly perpetrate aggressive acts as a normal gambit of human behavior. Outcomes in conflict and personalities create occasions to act aggressively.

The purpose of this study is to examine aggression in countertransference to increase clinicians' understandings and awareness of their aggressive feelings and actions towards patients. Firstly, this research will examine the evolution of theories about countertransference in psychoanalytic literature with attention to the experience of hate and aggression. Secondly, this research will present contemporary understandings of the behavioral features of aggression and consider a methodic examination of the behavioral manifestations of aggression in countertransference. Acting out one's aggressive instincts towards a client is potentially damaging to the therapeutic relationship. A classification system of aggressive behavior will be outlined and applied to therapists' experiences of aggression toward a patient within the context of a therapeutic relationship. In this way, therapists may garner more precise information about themselves by becoming more observant of the ways their behavior discloses their aggressive instincts toward patients. Bridging the discourses on the experience of aggression in countertransference and behavioral modes of aggression may enable professionals to reduce their acting out of aggressive instincts by increasing their awareness of the numerous modes of aggressive behavior.

In order to comprehensively relate behavioral manifestations of aggression within the countertransferential experience of therapists, one must have a familiarity with the historical and theoretical development of two contrasting approaches to the concept of countertransference. Representing the distinctive concepts illustrates the evolution of professional thought with respect to countertransference and demonstrates how that evolution has advanced an acceptance of constructive exploration into the emotional reaction of therapists to their patients. An outline of these concepts highlights the understatement of constructive exploration into the behavioral reaction of therapists to their patients. Reviewing the progression of multiple viewpoints concerning countertransference establishes a platform on which to discuss a therapist's experience and possible actualization of aggressive instincts toward patients.

A therapist's feelings of anger or an aggressive instinct toward a patient requires monitoring alongside scrupulous observation of one's actions toward a client. A review of behavioral literature will demonstrate how cognitions, affects, and arousal mediate aggression in the social context of the therapeutic relationship. A proposed classification system of aggression will be submitted as a tool for professionals to become more cognizant of their aggressive actions within the therapeutic dyad. While it may be uncomfortable or unpopular to subject one's actions to such inspection, knowledge and appreciation for all the subtypes of aggression will aid in a therapist's ability to become more aware of moments when he or she may not respond therapeutically due to acting out on aggressive impulses. Dominic Parrott and Peter Giancola (2007) propose a paradigm of aggressive behavior based on a more precise definition of aggression and a classification of behavior reflecting the various routes of expression for aggression. A summary of this classification system of aggressive behavior will be illustrated

through examples of behavior relevant to therapeutic practice. In this way, readers may increase perceptiveness in recognizing the various ways to act out aggression.

In summary, an explicit framework for aggression will allow therapists to become aware of the ways their aggressive instincts in countertransference may be subtly expressed through their behavior. Becoming more observant in this capacity can help professionals recognize their own aggressive behavior brought about by the countertransference. By being able to recognize these behaviors more clearly, therapists may be able to improve or employ better techniques with their patients. These observations can also lead to more in-depth explorations of the therapist's feelings if he or she notices a pattern of overt aggression with particular clients or the utilization of particular subtypes of aggression within certain circumstances. Looking at aggression through these lenses may be particularly beneficial to the field of social work in addressing issues of race and racism in treatment. Racism's history of violence and aggression in Western culture can create unspoken tension within a therapeutic dyad, so this research may also enable clinicians to identify when microaggressions occur in therapy. It is essential for clinicians to be willing to investigate their aggressive instincts as well as their aggressive actions to provide the healing relationships that their patient's desire.

Chapter Two

Aggressive Instincts

If the object is a source of unpleasurable feelings, there is an urge which endeavors to increase the distance between the object and the ego...we feel the “repulsion” of the object, and hate it; this hate can afterwards be intensified to the point of an aggressive inclination against the object- an intention to destroy it (Freud, 1915a, p. 137).

Self-Analysis

While Freud developed his theories of the human mind through observing his patients' neuroses, his ideas about the development and structure of the psyche apply to the internal psychic composition of all humankind. Freud was obviously aware that analysts were subject to the same psychic pressures as the rest of the population; thus, he suggested that prior to practicing analysis with patients an aspiring analyst “should have undergone a psycho-analytic purification and have become aware of those complexes of his own which would be apt to interfere with his grasp of what the patient tells him” (Freud, 1912, p. 116). In Freud's view, an analyst's break from the calm and disinterested stance through the experience of intense or passionate emotions toward a patient was an intrusion in the psychoanalytic process. In the beginning of psychoanalytic practice it was presumed that an analyst would be able to induce “emotional coldness” (Freud, 1912, p. 115) toward his patient. An analyst's emotional reaction to the therapeutic relationship was a display of unresolved neuroses and necessitated further

personal analysis for the analyst. The most ideal conditions for psychoanalysis would be one where an analyst would take on the emotional qualities of a surgeon, who concentrates solely on the skills of surgery for successful outcomes. Emotional coldness provides, “for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help that we can give him” (Freud, 1912, p. 115). The emotional life of the analyst was compartmentalized and kept completely isolated from interactions with patients.

As psychoanalytic technique developed, the experiences of patients in Freud’s time demonstrated that neuroses could and did resurface if an ego is incapacitated through trauma, illness, etc. (Freud, 1937). Certainly, psychoanalysts themselves were subject to the risk of a faltering ego as much as their clients. Freud recognized early on that psychoanalysts,

Who can appreciate the high value of the self-knowledge and increase in self-control thus acquired [through psychoanalysis] will, when it is over, continue the analytic examination of his personality in the form of self-analysis, and be content to realize that, within himself as well as in the external world, he must always expect to find something new (Freud, 1912, p. 117).

An ego that had previously been brought into harmony with the instincts through a “successful” analysis could decompensate giving rise to new or prior neuroses. Freud states definitively that environmental and internal processes are transitory. This fact assures the inevitability of the emergence of fresh and recurrent conflicts within an analyst’s psyche. Evidence of an analyst’s drives and instincts necessitated scrutiny through self-analysis. Freud believed that it was possible for an analyst to remain affectively stoic throughout an encounter with a patient, so it is

assumed that he would not have considered the therapeutic relationship to be a source of useful information for an analyst's emerging neuroses or for the therapeutic relationship as a whole.

Instincts

People's daily encounter with the impermanence of their environment is an easily comprehensible premise whereas the inconstant nature of people's internal processes is not as conspicuous. The activity of a person's internal processes frequently occurs below the surface of one's consciousness. In *Instincts and Their Vicissitudes*, Freud (1915a) characterizes an instinctual stimuli arising from one's mind as a need that operates as a constant force. While the force of the instinct is ever-present, Freud indicates his belief in the unpredictability and variation of instincts with the use of the word "vicissitude" in the title. In an effort to begin to locate and describe mental forces that are inherently erratic, Freud postulates that instincts may be "regulated by feelings belonging to the pleasure-unpleasure series" and a biological framework suggests, "an 'instinct' appears to us as a concept on the frontier between the mental and the somatic" (Freud, 1915a, p. 120-121). The pleasure principle proposes that, "the course taken by mental events is automatically regulated by the pleasure principle...[that course] takes a direction such that its final outcome coincides with...an avoidance of unpleasure or a production of pleasure" (Freud, 1920, p.). The increase and decrease of external and internal stimuli are in an effort to produce the most satisfaction for an instinct. A consideration of the biological is necessary in this effort because both the mind and body are required to expend energy in satisfying an instinct's needs. If Freud considered instinctual energy to be constant, it is a wonder that he might expect psychoanalysts to be able to keep tabs on their own instincts enough to keep them out of therapeutic practice.

In order to more easily discuss the concept of instincts, Freud defines terms that are used in reference to the components of instincts' energies. The *pressure* of an instinct is the “motor factor, the amount of force or the demand for work which it represents” (Freud, 1915a, p. 122). The pressure of an instinct pushes for some kind of activity whether it is in the physical or mental realms. Every instinct has an *aim* and that aim is always satisfaction. This aspect of an instinct is unchangeable; however, the pathway to satisfaction is varied. An instinct must have an *object* through which it is able to achieve the aim of satisfaction. Unlike the aim of an instinct, the object is the most variable feature in the concept of instincts as one instinct can have any number of objects or any number of objects can be used to satisfy one instinct. The *source* is the, “somatic process which occurs in an organ or part of the body and whose stimulus is represented in mental life by an instinct” (p. 123). Due to the limitations of contemporary science, Freud was unable to determine how an instinct located its source, but he rightly postulated some sort of chemical or mechanical process in the body. The components of Freud's concept of instincts will help further the discourse on current understandings of aggression later in this discussion.

Based on these components, Freud formulated the hypothesis that the primal instincts were the ego, or self-preservation, instincts and the sexual instincts. The sexual instincts are at first, “attached to the instincts of self-preservation, from which they gradually become separated” (Freud, 1915a, p. 126). The state of narcissism in a child's early development is such that the ego is able to satisfy the instincts to some extent, which is pleasurable. The ego and instincts are indifferent to the external as it is not required to produce pleasure. Eventually, the instincts of self-preservation begin to acquire objects from the external world. The objects that produce pleasure are taken into the ego and the objects that produce unpleasure are relegated to the external world, which has now become associated with unpleasure rather than indifference.

Through the process of developing from the narcissistic stage to the object-stage, the ego instincts and sexual instincts begin discerning the pleasurable and unpleasurable objects instead of dividing reality into the pleasurable internal world and unpleasurable external world. It is from this arrangement that hate emerges. Freud (1915a) stated that,

Hate, as a relation to objects, is older than love. It derives from the narcissistic ego's primordial repudiation of the external world with its outpouring of stimuli. As an expression of the reaction of unpleasure evoked by objects, it always remains in an intimate relation with the self-preservation instincts (p. 139).

The external world imposes unpleasurable stimuli on the internal world of the ego, which the ego instinct is compelled to avoid in order to preserve itself. Objects of unpleasure are repulsed by the ego just as the external world once was so that the ego may preserve its pleasurable state.

Repression

There are a number of methods the ego can utilize to manage unpleasurable stimuli and one device in particular supports the inevitability that psychoanalysts will not be able to be aware of their internal worlds continuously. Freud (1915b) began his paper entitled *Repression* with the statement, "One of the vicissitudes an instinctual impulse may undergo is to meet with resistances which seek to make it inoperative" (p. 146). Unlike the response to an external stimulus, an ego cannot escape an internal stimulus, or instinct, by fleeing, because the instincts are within the ego. Instead, an instinct seeks release to be satisfied. Repression is a method by which an impulse that would normally find pleasure in attainment of its single aim (satisfaction) changes course. When "the motive force of unpleasure shall have acquired more strength than the pleasure obtained from satisfaction" (Freud, 1915b, p. 147), repression manages the

unreleased energy of the impulse. Satisfying an aggressive impulse towards one's client by kicking them out of session and locking the door would be satisfying in one sense, but create a considerable amount of displeasure in other areas including the therapeutic alliance and one's sense of professionalism. To enable a person to continue to engage with another despite a potentially negative instinctual impulse towards that person, repression confines the instinct's energy to the unconscious, preventing release.

The relegation of an instinct to the unconscious does not destine the instinct to extinction. Freud stated that, "the essence of repression lies simply in turning something away and keeping it at a distance, from the conscious," (Freud, 1915b, p. 147) which indicates a continuation of the instinct's energy in the realm of the unconscious. Additionally, Freud admits that repressed energy cannot be totally locked up in the unconscious because "derivatives" of the repressed material can be reached through associations, which can elude the filter of the conscious. Freud asserted that, "repression in fact interferes only with the relation of the instinctual representative to one psychical system, namely, to that of the conscious." (Freud, 1915b, p. 149). The repressed energy can also leak through to the conscious, but the motive of the energy may still be out of the person's awareness. The instinctual impulse, "proliferates in the dark, as it were, and takes on extreme forms of expression, which when they are translated and presented to the neurotic are not only bound to seem alien to him, but frighten him by giving him the picture of an extraordinary and dangerous strength of instinct" (p. 149). If a person is repressing an instinct, the energy is liable to burst through the defensive barrier and manifest in a way that is conscious to a person. A person may be alarmed by such a release of psychical pressure because the source of the energy remains obscured. To say that psychoanalysts do not repress instincts or experience

unexpected spews of psychical energy in relationship to their patients may be too confident a claim.

While Freud never denied the existence of these instincts for all persons including clinicians, the expectation that psychoanalysts should be able to squelch the influence of these energies during analysis with a patient wasn't as easily accepted. Given the defensive mechanisms available to the ego such as repression, one might be hard-pressed to ever definitively say the instincts are not affecting one's thoughts and actions. As the field of psychoanalysis developed, various views about how the clinician's instincts, personality, and emotions enter the process of analysis have emerged. Additionally, a multitude of perspectives have arisen as to the utility a clinician's emotional reaction to patients and the appropriate management of insertions of an analyst's psyche.

Chapter Three

Countertransference

Analytic therapy ... makes claims on the doctor that seem directly selfcontradictory. On the one hand it requires of him the free play of association and fantasy, the full indulgence of his own unconscious ... on the other hand the doctor must subject the material submitted by himself and the patient to a logical scrutiny, and in his dealings and communications may only let himself be guided exclusively by the result of this mental effort... This constant oscillation between the free play of fantasy and critical scrutiny presupposes a freedom and uninhibited motility of psychic excitation on the doctor's part, however, that can hardly be demanded in any other sphere. (Ferenczi, 1926, p. 189)

Classical Countertransference

The term “countertransference” originally referred to residual pathological features of the analyst’s psychological world that hindered the therapeutic process by interfering with the analyst’s functioning (Abend, 1989). Otto Kernberg (1965) refers to this original approach to countertransference as the “classical” one, which will be adopted for the remainder of this discussion. The classical notions of countertransference maintained that an analyst could not facilitate transference expressions and interpret a patient’s unconscious material without sufficient lowering of his own resistances. It was believed throughout the psychoanalytic community that emotional reactions to patients decreased an analyst’s sensitivity and ability to accurately listen to patients, rendering analysis less effective. Despite the apparent liveliness of

an individual's unconscious in the management of instincts as described by Freud, the classical notion of countertransference maintained that "insight into the patient's problem is achieved via the analyst's own unconscious" (Reich, 1951, p. 25). Supporters of this school of thought instructed psychoanalysts to keep their mental energies out of the therapy room so that he may be able to "turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient (Freud, 1912, p. 115). In this way, an analyst would use his own unconscious to experience a short-lived identification with the patient's unconscious and make an objective evaluation of the patient's material. The required neutrality is marred and the analyst is unable to listen properly when his unconscious is splitting its energy between repression and a patient. Reich (1951) stated:

If the analyst has some reasons of his own for being preoccupied, for being unable to associate freely, for shrinking back from certain topics, or if he is unable to identify with the patient, or has to identify to such a degree that he cannot put himself again outside the patient—to mention only a few of the possible difficulties—he will be unable to listen in this effortless way, to remember, to understand, to respond correctly (p. 25).

In her view, these were the ways an analyst would be signaled that he needed to seek his own analysis to resolve active conflicts. If an analyst noticed he was unable to "listen in this effortless way" to be able to make appropriate interpretations, he was to seek his own analysis. The overwhelming and unexpected burst of psychical energy that sometimes happens as a result of repression is not considered.

The classical framework of countertransference believes that a departure from a position of neutrality and an admittance of an analyst's own unconscious energies in the therapeutic dyad

greatly hinders the psychoanalytic process. The solution to the problem of experiencing countertransference in psychoanalysis was to reenter analysis for oneself. Freud believed that “laying oneself open to another person without being driven to it by illness is amply rewarded” because psychoanalysis provides insights not accessible by traditional modes of learning such as school and books (Freud, 1912, p.116-117). Freud believed that gaining insight about oneself through psychoanalysis could be beneficial for anyone outside of it being essential to prepare an analyst to do the work of analysis. Freud admonished analysts who refused their own analysis, warning that “he will easily fall into the temptation of projecting outwards some of the peculiarities of his own personality, which he dimly perceived...as a theory having universal validity” (p. 117). Without proper personal analysis, a clinician was in danger of allowing his own neuroses to guide interpretations instead of psychoanalytic techniques. The “peculiarities” of a person’s personality were not considered desirable or useful to the therapy. More importantly, there is an assumption that a clinician’s peculiarities actually *could* be kept out of the therapeutic relationship.

One line of thinking extending from Freud is that an analyst examining his or her feelings in relation to a patient within the context of the therapeutic dyad is too great an insertion of the clinician’s own personality on interpretations. The quote at the opening this chapter by Sandor Ferenczi, a contemporary of Freud, reveals how competing notions about the presence and utility of countertransference emerged in the infancy of the field of psychoanalysis. In the classical understanding of countertransference, the internal process of an analyst is assessed, but not considered useful for technique. The idea that repressed instincts might become evident through the behavior of the analyst would be framed as a gross encroachment on the process of analysis. This creates an atmosphere where the stirrings of emotions from an analyst toward a patient

might be seen to reflect an analyst's failure. Such an atmosphere may cause the discharges of an analyst's emotions toward a client to go unexamined. The classical view of countertransference may have discouraged discussions of emotional reactions towards patients, as one might have appeared unprofessional. As psychoanalysis continued to develop, incompatibility of clinicians' experiences and behavior with this classical definition of countertransference became more apparent and the discussion on the matter of countertransference broadened.

Totalistic Countertransference

Freud's contemporaries within the psychoanalytic profession began questioning the idea that countertransference could be managed to a point as to never enter the therapy room. While Freud strived to model the psychoanalytic process on scientific principles of controlled variables and uniform procedure, it began to be understood that an analyst would never be able to remain as emotionally removed as an inanimate object. Alice and Michael Bálint (1939) illustrate how even the set-up of an analyst's office or the clothes he chooses to wear gives his patients information about his personality and mood. Even more significantly, how analysis is performed is different from analyst to analyst such that, "the choice of one or the other of the many synonymous possibilities, the accentuation or non-accentuation of certain words, even their cadence or intonation" (p. 226-227) reveals parts of each analyst. Additionally, variations in technique are required to provide sound psychoanalysis to special cases such as children or persons with psychosis. There will exist a personal element to these adaptations and depending on an analyst's internal and external world, these personal elements will manifest differently.

Within a decade, Paula Heimann (1950) stressed the relational component of the analytic situation and defined countertransference as "all the feelings which the analyst experiences towards his patient" (p. 81). Otto Kernberg (1965) refers to this perspective of

countertransference as the “totalistic” approach, which will be adopted for the remainder of this discussion. Heimann purported that countertransferential feelings constituted an important investigative tool to aid a therapist’s understanding of a patient’s unconscious. Heimann stated that feelings arising from the analyst were expectable because the therapeutic relationship is no different than other relationships in that it involves two egos. Like Freud, Heimann and other proponents of the totalistic approach to countertransference encourage an analyst to explore his feelings toward a patient with his own analyst to maintain professionalism, but the utility of self-analysis was somewhat different. She states that,

The aim of the analyst’s own analysis, from this point of view, is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him, to *sustain* the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to *subordinate* them to the analytic task in which he functions as the patient’s mirror reflection. (Heimann, 1950, p. 82)

This line of thinking about countertransference situates emotional reactions of the therapist as arising from a number of sources including the therapist’s past, the patient’s unconscious process, the therapist’s reaction to a patient’s characterological structure, and the patient’s reaction to the therapist’s characterological structure. An analyst’s emotions are allowed a space in the therapeutic dyad in which the analyst is encouraged to contemplate, but still not release his instincts into the room.

The varied sources of emotions identified within the totalistic approach to countertransference allowed for clinicians to attempt to name and qualify their reactions, which in this conceptualization, aids analysis. However, much of the literature about

countertransference discusses only the therapist's conscious emotional reactions. Menninger (1958) affirms that, "manifestations of the countertransference may be conscious although the intrapsychic conditions resulting in its appearance may be unconscious." Kernberg (1965) further states that unconscious aspects of countertransference remain blind spots until the therapist's emotional reaction is brought to the open. It is not assumed that Menninger is implying that therapists are unerringly mindful of the manifestations of their countertransference, but the literature has perhaps focused too much on uncovering the intrapsychic underpinnings of countertransferential reactions without assessing the multitude of manifestations including the behavioral. It may be possible to fill in the blind spots referred to by Kernberg through more careful discernment of one's actions towards patients.

Perhaps the idea that a therapist might actually act out aggressive impulses towards his or her client is as unscrupulous as the dominating idea of Freud's time that a therapist might have feelings towards a client. The fact that the concept of countertransference originated from being judged as a professional misstep may account for clinicians' reluctance to attend and openly discuss behavioral reactions to clients. However, in order to provide the most beneficial treatment, it is essential that professionals openly acknowledge and confer about their actions towards clients. The "manifestations" mentioned by Menninger most frequently refer to the emotional reactions of therapists to their clients, however it may be too great an assumption to believe that all therapists simply observe their emotions and appropriately shut down any behavioral manifestations of those feelings. Appreciating the behavioral component of aggression may better inform professionals' conceptualizations of countertransference and aid clinicians in becoming more conscious of their actions.

Chapter Four

Behavioral Lens of Aggression

There is no such thing as an absolutely good technique, to be followed by every analyst in the world. But on the other hand the analyst must be required to make himself conscious of every emotional gratification brought about by his individual technique, in order that he may keep a better control upon his behaviour... Every advance in psychoanalysis has had to be paid for by an ever-increasing conscious control over the investigator's emotional life. We believe that our technique can be still further improved, if we are able to bear still further conscious control over our everyday analytical behaviour (Bálint, 1939, p. 229).

General Aggression Model

As the field of psychoanalysis developed, the image of the stoic therapist has transformed. Many professionals believe that a clinician's personality enters therapy much more than originally thought. Additionally, Freud's theories of the unconscious and instincts illustrate how aspects of a therapist's personality may intrude upon the therapy without the therapist's awareness. This fact is becoming less a stigma and more a fact of clinical work. However, the expectation that clinicians should monitor and address their lapses in therapeutic technique has not changed. If a therapist notices her own neuroses or personality intruding in the therapy in unsuitable ways, she must address those issues outside the context of therapy with the client. As explained in a previous chapter, the instincts that all human beings have in common, whether

mentally healthy or disturbed, carry a constant force of psychological energy. The focus of this discussion is the constant force of aggressive instincts. One way this psychological energy can be monitored is through attention to thoughts and emotions, but a description of ways to conceptualize therapists' *behavior* may facilitate even better understanding of these psychological forces.

A previous chapter described the intrapsychic processes of the unconscious to acknowledge the constant presence of such forces on the therapist. According to Freud, this energy has a constant pressure, the aim of satisfaction, and an object through which the aim is achievable. If the ego utilizes repression to relegate this energy to the unconscious, a build-up of psychological force may cause the instinct to be expressed in extreme ways. One of the ways the energy may be discharged is through a person's actions. The various perspectives in the fields of psychoanalysis and psychotherapy agree that a therapist must manage his own psychological energy, even if they disagree on how it presents in the therapeutic dyad. Each perspective expects that a clinician should strive for conscious control over his behavior to provide the most therapeutic intervention for patients. A description of a contemporary behavioral model of aggression will bridge the intrapsychic understandings of aggressive instincts with the behavioral manifestations of those instincts.

A model of aggression that captures the dynamic of a therapeutic session is Anderson and Bushman's (2002) integrative framework of aggression known as the general aggression model (GAM). This model combines elements of a number of theories of aggression and focuses on the "person in situation" or a single cycle of ongoing social interaction (see Appendix A). These researchers call this single cycle of ongoing social interaction an episode, which in a clinical context is a session. Kelley and Thibaut (1978) determined that the likelihood of aggression

increases with higher frequencies of interaction because the growth of dependency in the relationship creates more opportunities for aggression. The GAM emphasizes the interaction between inputs, routes through which these inputs have variable impact, and outcomes of appraisal systems and decision processes. The foci of the GAM are intentionally broad-based because so many factors influence aggressive action. Stimulus inputs, personal factors, situational factors, internal states, personality processes, and decision processes within an individual all contribute to behavioral manifestations of aggression.

Knowledge Structures

The GAM builds its theoretical foundation on literature about the development and use of knowledge structures for perception, interpretation, decision-making, and action (Collins & Loftus, 1975; Fiske & Taylor, 1991; Higgins & Kruglanski, A., 1996; Wegner & Bargh, 1998). Knowledge structures are based on people's experience, influence a person's perception, become automatic with use, can be linked to affective states, behavior, and beliefs, and guide one's interpretations and behaviors in response to stimuli in one's environment. Consistent use of knowledge structures forms personalities. Knowledge structures that are particularly relevant to aggression are perceptual schemata, person schemata, and behavioral scripts. These impact how a person interprets their environment, what beliefs one holds about a particular person or group, and how people are supposed to behave. An individual develops knowledge structures to interact with the environment successfully. These assumptions about schemas and scripts set a foundation to talk more specifically about how a particular person in a particular situation may act more or less aggressively.

Inputs

Person inputs. The GAM firstly considers how information, or input, about the person and about the situation can influence aggressive behavior. Beginning with these features is an attempt to consider all the psychological, biological, social, and environmental factors of an episode. The seven person factors that Bushman and Anderson (2002) detail are traits, sex, beliefs, attitudes, values, scripts, and long-term goals. Traits refer to certain characteristics about a person that affect aggression such as an inflated self-image or susceptibility towards hostile attribution (Crick & Dodge, 1994; Baumeister, Smart & Boden, 1996). Research has repeatedly demonstrated the sex differences in aggressive tendencies and also how sex impacts the type of aggression used by individuals (e.g. Oesterman, Bjoerkqvist, Lagerspetz, Kaukiainen, Landau, et al 1998). Beliefs, particularly regarding self- efficacy and aggressive behavior in general, prepares one to aggress or not (Bandura, 1977; Huesmann & Guerra, 1997). The evaluations that people hold about other people, objects, groups, issues, and themselves are known as attitudes and these can increase a person's readiness to aggress (Petty & Cacioppo, 1986, p. 4). Further, if a person holds positive attitudes about aggression in general, use of aggression may increase (Malamuth, Linz, Heavey, Barnes & Acker, 1995). A person's values also influence aggressive tendencies as some groups regard violence as an acceptable method of conflict resolution (Nisbett & Cohen, 1996). Long-term goals of a person color episodes in such a way as to affect whether a person will utilize aggression (Bushman & Anderson, 2001). Scripts for interpretation and behavior, which may be composed of many of the elements just discussed, impacts a person's preparedness to aggress. Person factors are developed and reinforced throughout a person's life and are brought by the therapist to every session. All of these elements comprise a

personality and influence a person's preparedness to aggress. The other input the GAM considers influential to a person's aggressive behavior is the situational factors. Similarly to the person factors, situational factors can influence an individual's cognition, affect, and arousal.

Situation inputs. The situational factors the GAM details as affecting a person's likelihood to aggress are aggressive cues, provocation, frustration, pain and discomfort, drugs, and incentives. While there is some crossover with person factors (e.g. what a person considers provocation will depend on her schema), the situational factors examine social and environmental elements in priming for aggression. These are aspects of the therapeutic interaction that Freud did not contemplate as extensively as affecting proper therapeutic technique. Aggressive cues are objects and images that recall aggression-related memories in a person (Carlson, Marcus-Newhall, & Miller, 1990). Provocation, which can include insults, interference with goals, slights, verbal aggression, or physical aggression, is probably the most important causal factor for aggression (Berkowitz 1993, Geen, 2001). Many provocations can be seen as a type of frustration, which is essentially blockage of goal attainment (Dill & Anderson, 1995). Research has shown that aversive environmental conditions such as hot temperatures or loud noises can increase aggression (Berkowitz, 1993). Drugs, including caffeine, can increase aggression and facilitate other factors that affect aggression, such as provocation. Incentives can be somewhat related to goal attainment because the value of an object or relationship can influence a person's likelihood to aggress (Kilbourne, 1999). Based on this framework, it is possible that anything from too much caffeine to watching a violent news-clip before a session can affect whether a therapist will act out aggressively in a session. No matter how well analyzed a psychotherapist might be, any combination of person factors and situation factors can create an episode for aggression to occur.

Routes

Cognition, affect, and arousal. The person and situation inputs create present internal states by affecting a person's cognitions, affects, and arousal. Put another way, the input variables can influence a person via several routes, through an individual's thoughts, affects, and behavior. Inputs may "prime" hostile thought networks and scripts and prepare someone to evaluate and act aggressively (Bargh, Lombardi, & Higgins, 1988; Sedikides & Skowronski, 1990). Expressive motor responses and emotions are related to affect. Negative emotions triggered by person or situational factors may contribute to aggressive behavior. Additionally, aggression-related motor programs, such as automatically responding with an angry facial expression to a threat, appear to affect aggressive feelings (Berkowitz, 1993).

Physiological and psychological arousal affects aggression in a few ways. A person may become physiologically aroused even by irrelevant stimuli, which activates ingrained aggressive tendencies causing a person to prepare to act aggressively. Non-aggressive physical arousal, such as exercise, may also lead to mislabeling the arousal as anger (Zillmann, 1988). Further, physical arousal may stimulate aggression if it is experienced as an aversive state, similar to painful stimuli. While each of these routes is distinct, the GAM emphasizes the interconnectedness of cognitions, affects, and arousal in activating aggressive states and actions. It may sometimes appear that these processes occur simultaneously, but in actuality one's thoughts, feelings, and body are simply closely linked.

Outcomes

Immediate appraisal. The outcome is the last consideration in the GAM and it includes the appraisal and decision processes as well as the action that is taken in a social encounter

(Anderson & Bushman, 2002). As has been explained, inputs enter a person's consciousness through the routes of cognition, affect, and arousal, which creates a particular internal state in a person. This internal state interacts with decision processes that determine the action taken. The decision and appraisal processes range from somewhat automatic, known as immediate appraisal, to self-restrained, known as reappraisal (Krull, 1993; Krull & Dill, 1996; Uleman, 1987). An immediate appraisal is more spontaneous and includes information from one's affect, goals and intentions. A person's resources, such as time or cognitive capacity, will determine whether an immediate appraisal will result in an impulsive action or an effort to reappraise.

Reappraisal. If a person has sufficient resources, she may be able to reappraise her internal state and inputs and formulate an alternative view of the situation. Reappraisal may include a number of cycles of thought as causes for the event, information from the environment, and relevant memories are sifted through to conceive of multiple possibilities. At some point, the process of cycling through the alternatives will cease and a person will take action. The reappraisal can serve to increase or decrease aggressive acts depending on the factors that are considered in the reappraisal. For example, a person may cycle through previous harms done to her by the other person in the encounter and decide that aggression is the next appropriate action. Reappraisal delays whatever action and allows for a person to reconsider all the factors that are influencing the situation.

Related Factors

Anderson & Bushman (2002) were deliberate in their naming of their model of aggression as the "general" aggression model because a number of phenomena intersect to produce acts of aggression. To remain thorough, these authors discuss how opportunity, overriding inhibitions, shared motivations, and the role of anger affect aggressive tendencies.

Opportunity refers to the rules of the social situation; some social situations restrict aggression while others create good opportunities (Goldstein, 1994). A restrictive situation might be a formal dinner, whereas a bar might create a “good opportunity” for aggression. Overriding inhibitions refers to instances where aggressors employ moral justifications and victim dehumanization to override self-standards that would normally stop someone from acting aggressively (Bandura, 2001; Keltner & Robinson, 1996). The concept of shared motivations covers acts of aggression that are perpetrated to protect basic human social needs such as self-esteem or social esteem (Baumeister & Leary 1995; Hogan, 1998).

Finally, anger affects aggression in a number of ways that are not always directly causal. Anger can affect all the routes previously discussed and may be embedded throughout a person’s knowledge structures. Aggressive thoughts and scripts are primed by constantly active anger-related knowledge structures. Anger can decrease higher-level cognitive processes and reduce inhibitions (Berkowitz, 2001). Anger also enables a person to be able to maintain a hostile internal state over time with no current threat in the moment. This may cause a person to act more aggressively when actually threatened. As is the same with other emotions, anger is used as an information cue that informs about people, causes, culpability, and appropriate ways of responding. Given that anger can underlie all these mechanisms of one’s internal state, aggressive behavior can certainly be energized by anger.

The GAM integrates numerous theoretical perspectives about aggression into a comprehensive framework. It considers the cognitive, physical, and social elements of a person’s experience to provide a holistic view of the mechanisms influencing aggressive action. In an attempt to consider all the elements that comprise aggressive behavior, the GAM certainly demonstrates that no one element can be deemed causal for aggression. The complexity of

aggressive actions as presented by the GAM reflects the complexity of intrapsychic instincts as described by Freud. An understanding of contemporary ideas about aggression can aid a clinician in connecting her internal psychic process to her physical experience of emotions and behavior. It is essential for a clinician to have as full a grasp as possible on the motivations behind her technique. A comprehensive categorization of aggressive behavior can enable a psychotherapist to track her behavior and hopefully gain more insight into her unconscious psychic process.

Chapter 5

Aggressive Behavior

How are we to arrive at a knowledge of the unconscious? It is of course only as something conscious that we know it, after it has undergone transformation or translation into something conscious... the data of consciousness have a very large number of gaps in them; both in healthy and in sick people psychical acts often occur which can be explained only by presupposing other acts, of which, nevertheless, consciousness affords no evidence (Freud, 1915c, p. 166).

Taxonomy of Aggression

The general aggression model serves to couple a therapist's internal psychic experience with an understanding of how that internal world can become transparent through behavior. It is possible for therapists to use their behavior as clues to their unconscious processes. All the aspects of aggression described in the previous chapter give a context for the personal and environmental elements that contribute to an aggressive action. Clinicians can better equip themselves to monitor technique by having a clear classification system of aggressive acts as a reference. Such a classification system is necessary because behavior aimed at harming another living being can take a multitude of forms. The elements of aggressive behavior discussed in the GAM do not produce one style of aggression. Personality and social situations may create preferred modes of aggressive actions for individuals and it is important for clinicians to be able to reflect on their preferred styles of aggression to accurately assess their actions with clients. A

comprehensive framework for categorizing aggressive behavior may aid a clinician in interpreting his or her actions more accurately so that he may be able to recognize when bursts of destructive energy break through from the unconscious. Further, comprehending the multiple modes and subtypes of aggression will allow clinicians to better assess and control their behavior toward a client. In order to provide sound treatment to patients, it is essential that clinicians effectively evaluate their behavior.

Modes of Expression

Parrott and Giancola (2007) devised a comprehensive system of aggressive acts, which therapists can use to increase consciousness of their behavior. The taxonomic system states that there are different modes of expression: direct versus indirect actions and active versus passive actions. Direct aggression indicates face-to-face interactions between the perpetrator and target of aggression, so a client would be able to identify the therapist as an aggressor. Indirect aggression indicates a circuitous delivery of aggression, which would allow a therapist to avoid accusation, confrontation, and counterattacks (Buss 1961, Richardson & Green, 1997; 1999). Active aggression involves active engagement with the target of aggression, so the therapist would engage in some kind of behavior. Passive aggression reflects a lack of active responding to a target of aggression, so a therapist would display aggressive intent by failing to perform some behavior. For example, a therapist may refuse to answer a patient's phone call despite assuring the patient she was going to be available. An aggressor may employ a combination of these modes of expression: direct active aggression, indirect active aggression, direct passive aggression, indirect passive aggression. The mode of expression depends on the personality of the aggressor and the situation in which the aggression takes place.

Subtypes of Aggression

Once an aggressor decides which combination of the four modes to utilize, there are five distinct ways to display aggression. Each of the subtypes of aggressive behavior may be delivered directly or indirectly and most can be delivered actively or passively. The five subtypes of aggression are physical, verbal, postural, damage to property, and theft. The delivery of each type of aggression will appear differently depending on the mode of aggression (i.e. direct, indirect, active, or passive). Physical aggression is noxious stimuli that inflict physical pain or injury on a victim. Verbal aggression is noxious stimuli communicated orally, inflicting psychological pain. Postural aggression includes non-verbal acts that do not require physical contact. Aggression through damage of property is the destruction of another's goods to inflict pain. The final subtype of aggression is theft, which is labeled aggression to the extent that someone possesses another's goods for the purpose of inflicting harm. It may be important to note that while expression of aggression is inevitable in the therapeutic relationship, certainly some forms are gross violations of ethics. While this fact may make some expressions of aggression less likely, it certainly does not disqualify the possibility of its occurrence however uncomfortable that may be to acknowledge. Hypothetical illustrations of the modes of expression and their subtypes within the context of the therapeutic session will enable a therapist to better imagine how aggressive impulses can be displayed to patients.

Active Aggression

Active aggression can be directly or indirectly delivered through each of the five subtypes of aggression. The nature of the therapeutic relationship being highly dependent on verbal exchanges and body language make active postural aggression and active verbal

aggression the more likely used of the five active subtypes. Descriptions of these forms of aggression are presented first. Active direct verbal aggression is one of the forms of aggression most commonly pictured in relation to aggressive behavior. A therapist may employ this style of aggression by criticizing, speaking harshly, or cursing at her patient. Active indirect verbal aggression is something that probably happens much more frequently in the therapeutic setting, as it is less overt. Spreading rumors or gossiping about a patient, for example to colleague in a hospital setting, can inflict psychological harm. Active direct postural aggression, which is an act that does not require physical contact, might include a therapist rolling her eyes at a patient, leaning forward aggressively, or invading a patient's personal space. Active indirect postural aggression might look like a therapist using her body to indicate a cutting off of the patient, such as turning away while the patient is talking. These modes and subtypes of aggression may be used more frequently due to the therapist's role and bounds of the therapeutic session.

Active physical aggression, damage to property, and theft are always options for ways to express aggression, but might be utilized less frequently than active verbal or active postural aggression due to the restrictions of the therapeutic relationship. Although the context of therapy and its ethics may make the use of active direct physical aggression less likely, it is possible a therapist may become so angered as to hit or punch her patient. Further, it is possible for a clinician to experience sustained anger and utilize active indirect physical aggression, which involves the hiring of another individual to deliver physical harm. While it is hard to imagine that anyone in the therapeutic profession would allow herself to become so unbound, one must remember the GAM and its innumerable factors influential to aggression. If one's personality or instincts predispose aggression from the start, a perfect storm of environmental factors may push someone to engage with a client in a physically aggressive manner.

Theft and damage to property also present some difficulty in the therapeutic relationship because patients frequently come to the offices of professionals, so opportunities to handle a patient's property might be limited. While stealing a patient's property to injure them might prove challenging, theft through payment is a possibility. The example of theft described by Parrott and Giancola (2007) is a husband taking his wife's keys either in her presence (i.e. directly) or without her knowing (i.e. indirectly) to prevent her from going to work, which would cause her harm. A therapist could utilize active indirect theft by charging a higher rate for a particular patient than any other patient without the patient's knowledge. Active direct theft might occur if a therapist raised the fee for a patient for no other purpose than to harm in some way. In these ways, the therapist would effectively be stealing from the patient through manipulation of the fee.

Damage to property is less likely to be utilized for the same reason as theft in that a clinician may not have easy access to a patient's property. Active direct property destruction would require a therapist to destroy something of the patient's with the patient present. Perhaps, more likely a therapist may utilize active indirect destruction of property and avoid confrontation by keying a patient's car in the parking lot. While direct and indirect forms of active physical aggression, theft, and damage to property may be less likely utilized within a treatment relationship, it is valuable to be informed of all the forms of the routes and subtypes of aggression. Active aggression is more overt form expression of aggression. A therapist would have to be fairly disconnected with herself to engage in some of these active modes. However, the use of verbal and bodily communication in therapy makes it more likely that a clinician might utilize active verbal and active postural aggression.

Passive Aggression

Passive aggression is distinguished by inaction. Similar to the active mode, passive aggression may be expressed directly or indirectly. Therapeutic technique is such that a clinician may choose to not respond to a patient for any number of beneficial reasons. These illustrations of passive aggression within the therapeutic context demonstrate how actions have the potential to hold many meanings. It is important for a clinician to consider whether a particular technique has an aggressive motivation, so reviewing behavior through this lens of aggression is simply an additional evaluative tool a therapist may use when improving her practice. Passive aggression is not applicable to postural because by definition posturing is an active form of non-verbal aggression, so an illustration is not provided.

Passive verbal aggression may be the most likely utilized forms of aggression for clinicians, but determining whether the behavior is motivated by aggression may prove tricky because such actions sometimes have therapeutic merit. For example, a therapist may choose to remain silent in a session for therapeutic purposes. However, the “silent treatment” is also a form of passive direct verbal aggression. Certainly, this is not a proposal that the choice of silence is an aggressive act toward a patient in every case. One must be aware, however, that it is possible for aggression to be expressed in this way and a therapist should be very mindful of her choice of technique. A clinician may also be engaging in passive indirect verbal aggression when she decides to not speak up on a patient’s behalf, for example at a meeting with a treatment team. Given that verbal communication is a large part of therapy, verbal forms of aggression may be a common mode of aggression for clinicians; it’s just a matter of remaining attune with one’s motivations of actions within the therapeutic alliance.

While active modes of physical aggression appear extreme within the therapeutic dyad, the passive mode of physical aggression may be more readily utilized. A clinician might enact passive indirect physical aggression by “forgetting” to mail a letter of attendance to a probation officer, which would cause the patient harm. Similarly, by refusing in a face-to-face interaction to produce proper paperwork, perhaps for court purposes or insurance issues, a therapist would be engaging in passive direct physical aggression. Each of the examples described above is characterized by physical inaction, which causes harm to the patient. Whereas active forms of physical aggression are so overt to be rarely used in the therapeutic dyad, passive physical aggression allows for subtlety, which is more fitting in a therapeutic setting.

Passive modes of theft and damage to property prove challenging to utilize for clinicians for the same reason as the active modes of these subtypes. A therapist does not frequently have access or responsibility for a patient’s property, so causing harm through this way is unlikely. A patient’s fee is the most feasible way a therapist could be a party to passive theft. In the case of passive theft, a therapist might not act on behalf of the patient in an unfavorable insurance dispute or unfair agency policy. If the therapist simply doesn’t step in and the patient doesn’t know the unfairness is happening, it would be a case of passive indirect theft. If the patient knew the therapist could advocate, but witnessed the therapist’s inaction, it would be a case of passive direct theft. In these cases, some other party is stealing the patient’s property and the therapist is doing nothing to prevent the theft.

The illustration provided by Parrott and Giancola (2007) for passive direct damage to property is a husband intentionally neglecting to water his wife’s plant while she is away. In this way, the husband’s inaction causes damage to the wife’s plant by allowing it to die. An indirect form of passive damage to property, according to these researchers, is if the son in this family

does nothing to assure the plant gets watered; thus, also not acting, which causes destruction to the plant. The access to property in the relationship between a therapist and her patient makes theft and damage to property less likely choices for expression of aggression.

It is important for clinicians to be familiar with all the modes of aggressive expression and their subtypes to ensure that they are best equipped to monitor their behavior in a session. It is also helpful to have an understanding of all the modes and subtypes of aggression to recognize what types of aggressive behavior one decides to utilize in different situations. The therapeutic session makes some forms of expression of aggression more likely than others and other situations allow for utilization of other aggressive acts. This can be important if a clinician is displacing aggressive instincts onto other people in different relational contexts. This taxonomy of aggression demonstrates how aggressive forces bursting forth from the unconscious can take on a variety of manifestations. Working from this broad framework of aggression, a therapist may be able to make a more efficient examination of aggressive instincts in the unconscious. In this way, she can become more aware of her technique and ensure its therapeutic value.

Chapter 6

Discussion

One important force active in neutralizing and overcoming the effect of aggression and self-aggression in the countertransference is the capacity of the analyst to experience concern... One might say that concern involves the recognition of the seriousness of destructiveness and self-destructiveness of human beings in general and the hope, but not the certainty, that the fight against these tendencies may be successful in individual cases (Kernberg, 1965).

Professionals' understandings of the therapeutic relationship and the interactions that take place within the therapeutic relationship have diverged and transformed since the inception of the field of psychoanalysis. The classical orientation of countertransference gave emotional reactions toward a client the tone of transgression. The totalistic orientation of countertransference may lack specificity in description, but opened up a space for therapists to be able to discuss the emotions they were having toward patients. This paper attempts to demonstrate how the historical evolution of countertransference created an atmosphere of censure for clinicians' natural emotional and behavioral reaction to clients. While the totalistic definition of countertransference allows for more open discussion of one's emotional responses to patients, the atmosphere of censure still surrounds negative behavioral reactions therapists have toward patients.

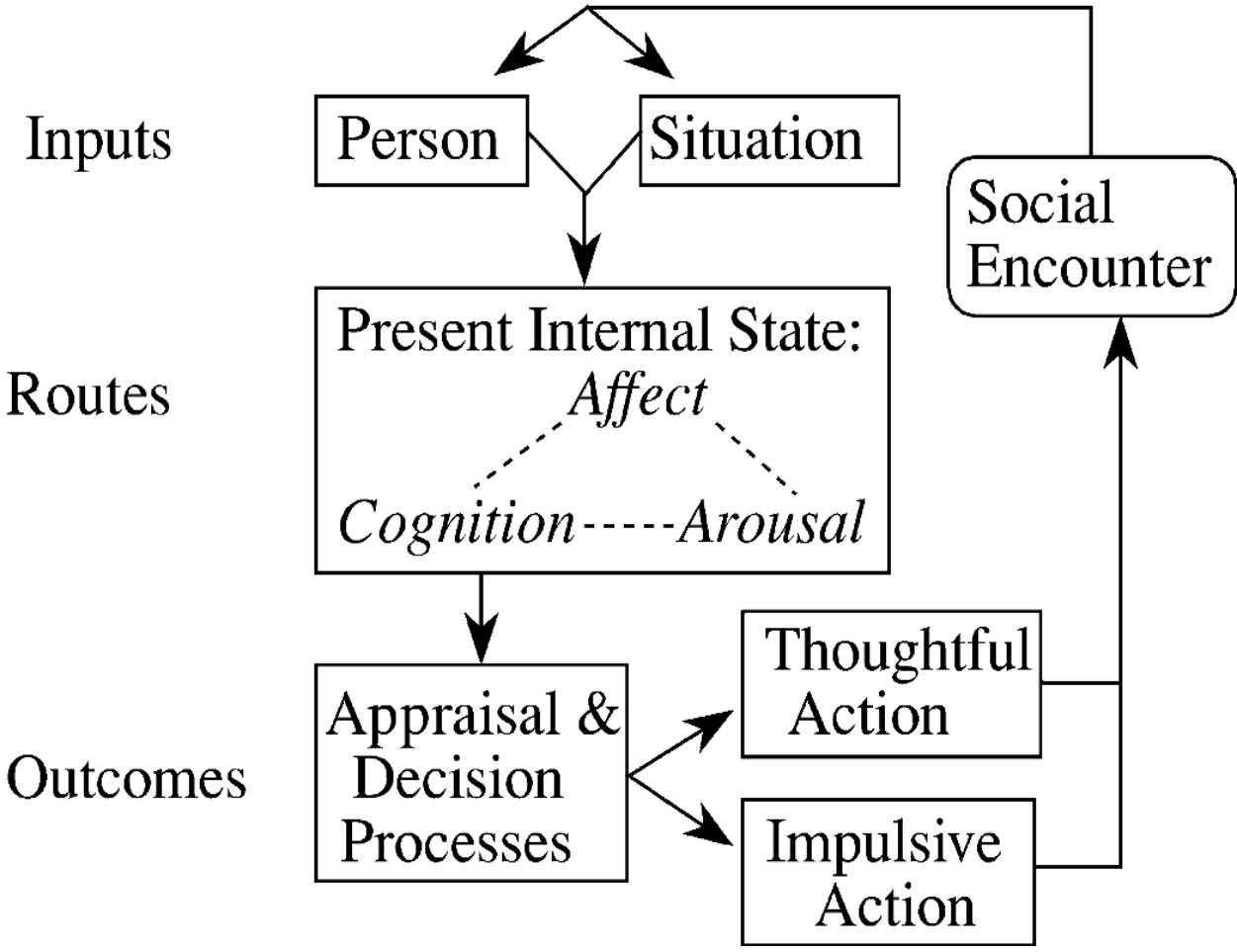
A presentation of a behavioral lens of aggression, applicable to all human beings, establishes aggressive behavior as a natural human process. This perspective serves to normalize aggressive actions and open up the conversation about improper behavior toward patients. The GAM demonstrates how aggressive actions are a complex series of mutual personal and situational processes that “ready” a person to aggress. The consistent frequency of sessions common in the therapeutic relationship heightens opportunities for aggression. Linking aggressive impulses experienced in countertransference with an understanding of behavioral models of aggression can aid a clinician’s awareness of his or her manifestations of aggression. The presentation of four routes of aggressive expression with various subtypes allows for therapists to pinpoint particular behaviors and broadens one’s understanding of behaviors that constitute as aggression.

To conclude, associating these bodies of literature and introducing a classification system of aggressive behavior to clinicians has a number of implications for clinical practice. Therapists can construct a more informed portrait of their countertransference and become more aware of their unconscious processes with increased knowledge of aggressive action. Extending the discussion of countertransference and technique only points an arrow to a possible direction for further discussion about how therapists experience themselves with their patients and how they interact with their patients. The taxonomy was originally created for this purpose of providing a precise and concise way to categorize and discuss aggression, so the field of clinical social work and therapy may easily utilize it to further knowledge about this area of the field. This information may be particularly useful in helping to identify biased reactions in cross-cultural dyads where microaggressions frequently go unnoticed. Further, while this paper focuses on the behaviors of the clinician, the classification system of aggression can also be helpful in

recognizing and conceptualizing client's actions. While this paper provides possible hypothetical scenarios of each of the modes and subtypes of aggression, the taxonomy might best be used to explore actual examples, provided by therapists. Additionally, the writer only speculated which forms of aggression might be most likely utilized within the therapeutic dyad, so further research needs to be conducted to soundly determine which modes are used with the most frequency. In this way, it is hoped that examining this natural, but somewhat unflattering behavior for professionals will increase awareness about how aggression manifests for each person. Perhaps, this insight may allow for more space for the therapist to experience the "neutralizing" effect of concern within the dyad, but more research is required before such conclusions can be proffered.

APPENDIX A

The general aggression model episodic processes (Bushman & Anderson, 2002, Figure 2)



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