The Aggression of Patients: Between the Kleinian and Kohutian Approaches

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Abstract

This article presents two approaches concerning the aggression exhibited by patients. The Kleinian approach views aggression as innate and destructive, thus playing a crucial role in shaping personality. Consequently, a significant part of Kleinian therapy focuses on confronting the patient's aggression. In contrast, the Kohutian approach perceives aggression as always reactive. According to this perspective, the therapist should meet the patient's aggression not through confrontation "from the outside" but through an "inside" view. This perspective seeks empathetically, and from the patient's point of view, to explore the chain of events that led to their aggression. I will argue that the Kohutian approach allows for a multidimensional, comprehensive, diverse, and more exploratory engagement with aggression, and its therapeutic goals are more far-reaching. I will provide clinical examples to illustrate the principles described.

Keywords: aggression, approach, personality, Kohut, Klein

1. Introduction

The transformation that Freud made in his understanding of aggression, from a constructive view of aggression as serving life and libido (Freud, 1915) to viewing it as destructive and an expression of the death drive (Freud, 1937), characterizes the polar debate in psychoanalysis regarding the engagement with the patient's aggression. Klein (Klein, 1957) expresses the view that aggression is destructive, stemming from the death drive, with the aim of eliminating the object. This, primarily in her opinion, is due to envy (Klein, 1957). According to her understanding, aggression is always innate, constitutional, and exists prior to any experiences a child has with their surroundings. Kohut (Kohut, 1978), on the other hand, views destructive aggression, which can escalate into revenge, as a response from a narcissistically vulnerable individual, arising from the failure of the self-object to meet their narcissistic needs. The purpose of this article is to indicate that the Kleinian approach, characterized by emphasizing the destructiveness of the patient's aggression (at least according to Klein's written theory, as it changed slightly towards the end of her life), is much more limited and less sufficient in treating aggression than the Kohutian approach. In my opinion, Kohut's approach, which is accused of downplaying the patient's aggression, allows for a broader and deeper engagement with the patient's aggression.

Until 1915, Freud attributed a constructive role to aggression, viewing it as a primary importance in maintaining existence, as a promoter of control, and as a means of distinguishing between self and non-self (Freud, 1937). Aggression was regarded as a component subordinate to the sexual drive. In 1968, Adler (Adler, 1908) proposed that aggression might be a primary drive, not subordinate to any other drive. For this, he received a cold shower from Freud, which contributed, among other things, to their disconnection. The radical change in Freud's view of aggression began only in the 1920s and 1930s (Freud, 1923) (Freud, 1930) (Freud, 1937) with the dual instinct theory, Eros and Thanatos. According to his perception, the death drive is biologically driven and geared toward the destruction of life. He returns to his position that the tendency toward aggression poses the greatest danger to the destruction of culture.

The idea that a person has an instinct that compels them to be destructive, as a derivative of a drive to return to an inorganic, dead state, has provoked many psychoanalysts. Among them are Fromm (Fromm, 1973), Guntrip (Guntrip, 1969), and Fairbairn (Fairbairn, 1952). Fairbairn argued that there is no such thing as an aggressive drive. Aggression is always a product of frustration. Similarly, Guntrip views frustration and the need to live and love as the triggers for one of two responses: fight, which leads to aggression, and flight, which leads to schizoid withdrawal (Guntrip, 1969).

Klein (Klein, 1946) (Klein, 1957), who agreed with Freud's position on the death drive and further expanded and deepened this position until it became central, posits that the basic anxiety in the infant, an unbearable anxiety

that they cannot bear, is projected outward (thus stepping beyond Freud) and results in a splitting within themselves and the object. When they are anxious about being pursued by the bad object, they turn it into a pursuit of that same bad object. Thanks to this splitting, the infant feels secure due to the existence of a good object, which also projects its goodness onto them through the investment of libido. The important aspect of Klein's assertions is that the entire emotional world of the infant is actually created before they have any experiences with objects. Experiences from the external world may influence, but they do not decisively create the feelings of the human infant.

Cohen (Cohen, 1990) notes that Klein (Klein, 1957) places aggression at the center of the theory of character formation, placing almost complete responsibility on the infant with an innate individual level of anger and greed. According to Cohen's explanation, the mother has a marginal role in shaping or channeling these aggressive experiences of her children, and her responses contribute insignificantly to their ability to accept their own aggression.

Finnel (Finnel, 1987) reviews the literature regarding negative therapeutic responses. She is concerned that the primary interpretive work of Kleinians is directed toward confronting the patient’s aggression, especially concerning expressions of envy toward the therapist, without the theory upon which they rely allowing for the experiences of the environment and their influences. These shape the derivatives of anxiety and aggression stemming from the death drive.

Klein (Klein, 1957) explains that envy exists within a person, who seeks an object in the external world to project it onto. It seems that Guntrip (Guntrip, 1969) conducts the most comprehensive attack in the literature against Klein's position. His focus is precisely on these points regarding the placement of the patient's aggression and envy toward the therapist, including their derivatives from the death drive, and their determination even before any experience in object relations. Guntrip writes that the self, according to Kleinians, splits itself due to fears of its own death drive, and this occurs without and before experiencing interpersonal relationships with the object. Therefore, the evil of the object is determined not from experience with it, but according to the projection of the death drive. The evil of the self is felt and experienced not from regard for the object, but is built by the death drive. Everything, Guntrip continues and attacks, begins from the fears of the self regarding its own death drive. The self is inherently split, not by poor object relations in real life, but by its biological inheritance. Every experience of the infant with objects automatically and inevitably becomes split, not due to the nature of the objects, but due to the infant's nature. The infant cannot experience objects simply based on how they care for it. All Kleinian psychopathology, Guntrip argues, could be constructed metapsychologically by an external world that is nothing more than a screen for projections. Guntrip is aware of Segal's (Segal, 1973) attempts to show that Kleinians do recognize the influence of the external environment, but Segal's clear and gentle writing allows him to see clearly how little space Kleinians leave for the influences of the environment.

Winnicott, in his article about the analysis he underwent with Klein, alongside much appreciation, writes about her contribution (which he questions), such as the theory of the death and life drive and her attempts to see the destructiveness that appears in infants in terms of inheritance and envy (Winnicott, 1975). Aggression is related to the needs for growth and development. It cannot stem solely from destruction and the death drive. He ascribes great importance to aggression in promoting the separation between the infant and the mother, as it allows for a departure from symbiosis and advances individuation.

Kerenberg (Kerenberg, 1992) (Kerenberg, 1975), at least regarding the etiology of the development and formation of borderline and narcissistic disorders, sees eye to eye with Klein regarding the perception of aggression. Intense and uncontrolled aggression, which is constitutionally determined even before birth, is, according to him, the etiological basis for the formation of narcissistic and borderline disorders. The immense aggression causes anxiety that the internalized negative objects will dominate the internalized positive objects. The ambivalence, conflicts, and anxiety stemming from this are concealed and repressed by reliance on splitting mechanisms. Kerenberg repeatedly emphasizes Klein's contribution (Kerenberg, 1992) in pointing out envy as a key factor in the destruction of intimate interpersonal relationships (including the envy of a patient toward their therapist). According to that article, a person's envy and hatred toward others is not caused by the behavior of the other. Sometimes envy and hatred are particularly heightened in encounters with an object that is not internally controlled by similar hatred.

Kohut's most significant contribution to understanding and treating patient aggression is encapsulated in his view that aggression is always etiologically reactive! Overwhelming aggression may occur, characterized by an unrelenting drive for revenge through all means, which any observer recognizes by name: narcissistic rage. In contrast, mature aggression serves under the control and direction of the ego. According to Kohut, the goal of treatment is to alter the narcissistic structure of the personality so that narcissistic rage transforms into mature aggression. The narcissistically wounded individual responds to an actual or anticipated narcissistic injury with either a shameful withdrawal or narcissistic rage. The need for revenge, for rectification of the distorted, for the

annulment of the injury, without discrimination of the means, and out of an unrelenting drive, leads the narcissistically wounded individual to act without rest. Kohut argues that sometimes a simple fact, such as the therapist or the other being independent or different, is enough for the narcissistic individual to experience them as attacking or harmful. Narcissistic rage arises when the self-object fails to fulfill the functions and expectations placed upon it by the narcissistically wounded individual. Such a response may occur in a child at an appropriate developmental stage who demands recognition of the grandiosity of the self and insists on the omnipotence of their self-object. Such a response may also arise in an adult whose archaic narcissistic structures remain fixed after their narcissistic demands, adapted to their childhood development, were traumatically frustrated.

Kohut explains (Kohut, 1978) that everyone tends to respond to narcissistic injury with embarrassment or anger; however, the intense experiences of shame or the intolerable violent reactions (fury) that overwhelm those sensitive to narcissism are immense in their intensity. For these individuals, a sense of control over their environment is essential, as the existence of their self-esteem, and indeed of the self as a whole, depends on the unconditional accessibility of the affirming reflection of the self-object or merging with an ideal self-object. Since Kohut perceives the sources of aggression as a response to the failure to meet the desperate needs of the individual, his view of aggression is much more diverse in each case.

The self-psychology movement would argue that there is no narcissistic or borderline pathology in and of itself. There is only that which is caused in the intersubjective field, meaning, between a wounded self, which archaically needs its narcissistic satisfactions, and a self-object that fails to fulfill them. The borderline symptomatology that appears in therapeutic sessions is such whenever the therapist fails as a self-object for their patient. They are, of course, aware that the borderline symptomatology began outside the therapy room and will continue beyond it. However, in the therapeutic session itself, whenever symptomatology appears, it will be the therapist's failure. Their inability to understand the patient's perspective and their attempt (to impose externally) their perspective. Schwaber (Schwaber, 1984) also shares with Brandchaft and Staloro the recognition that there is a need to interpret from within, from the required perspective of the patient, rather than from the outside.

It is clear that such a Kohutian perception of aggression opens up much broader listening possibilities than a fixed view of aggression and envy arising innately. This form of listening, from the subjective experience of the patient, seems to me to be more faithful to the psychoanalytic approach, as it is more exploratory, encouraging a much broader unfolding than merely reaching the constitutional source of aggression, which must only be confronted with the patient and helped to accept.

2. Example to Clarify the Kohutian Approach

A 51-year-old academic man, engaged in a freelance profession, is characterized by very high levels of anger and aggression that appear during therapy toward the therapist. The therapist notes that after each successful therapy session (where good dialogue occurred and interpretations were accepted with understanding), the patient bursts forth with intense complaints about the quality of the therapy. The therapist attempts several times to interpret this pattern "from the outside," using the understandings characteristic of Kleinian thinking: she tried to draw his attention to the fact that after a good session, his complaints increase. These interpretations only intensified his anger. She shifted her perspective and interpreted his behavior "from the inside." She said that perhaps what she provided was not enough for him and only frustrated him, hence his increased anger... After these comments, the patient felt a great sense of relief and said: "I have always begged therapists to connect with where I am, and then I am willing to grow." This intervention by the therapist led to a breakthrough in therapy that lasted for many months afterward. The patient added: "I know I have a tendency to trample on others' warts, but how I do it, I don't exactly know; all I want is to gain their attention and love".

It is clear that the aggression here is not innate - destructive aggression that stems from the death drive. The Kohutian view allowed for the exposure of the chain of context that led to his aggression, as well as a distinction between hostile aggression, aimed at harm, and instrumental aggression aimed at achieving a non-aggressive goal, as in this case, recognition, love, and care.

Example 2:

A 30-year-old female patient spent several hours hurling accusations at her therapist: "You don't understand me, you are too young." She also questioned the therapist's intelligence. In supervision, it was noted that behind this patient's aggression, there was a desperate examination in which she tried to ascertain, out of fear, whether she would find what she hoped to find—a therapist who could serve as an "ideal parental figure".

Example 3

In the following example, I will present several junctions of possible responses to the patient's aggression. Some allow for interventions in a Kleinian direction; however, the listening possibilities opened by the Kohutian approach are much more comprehensive and exploratory. In our case, the aggression is not directed toward the therapist or others in the environment but arises in dreams, images, and fantasies: Yael (a pseudonym) is a

30-year-old woman. Then single, now married. An artist by profession and a university graduate. The second daughter in a family of three children. An older sister two years her senior and a younger brother two years her junior. She was born in Israel to parents of European descent. Her father is a lawyer, and her mother is a housewife who tried to engage in art but stopped after her husband dismissed and rejected this pursuit. Yael's parents gave her a name that, to my understanding, is a boy's name. When she called me, I was surprised to hear a girl's voice identifying herself with a masculine name. She sensed my surprise, and it later became clear that such encounters are very characteristic of her first meetings, always experienced as traumatic by her. Yael associated this experience with an imagined picture that accompanied her throughout her life: her father standing by her crib saying, "Daughter, too bad, I really wanted a son." Most of Yael's childhood was spent in an endless longing for love and appreciation from her parents. They conveyed countless messages to her at various levels that she was unwanted and unloved. Her parents were filled with disappointment that they did not have a son, and hence, in her feeling, also the name chosen for her, along with the hairstyle and clothing dictated to her by her mother. Her father preferred her sister over her, and her mother preferred her brother. In sibling fights, Yael was always considered the "bad child." She painfully recalls how her mother, unbeknownst to her, sent a letter to relatives in London, where she stayed when she was ten years old, preparing them for the arrival of an annoying and disruptive child.

On her birthdays, when she expected loving treatment from her family, her father bought her gifts that were actually intended for him, such as radio kits to assemble. Yael entered therapy with the desire to enhance her ability to connect with people in general, but particularly with members of the opposite sex. Her meetings with friends were always accompanied by long and awkward silences. This characteristic was of course evident in therapy (except for the last year and a half of therapy, during which her conversations became much more fluent). Yael had three love stories over the ten years preceding her therapy. Each relationship lasted about a year and ended at the initiative of the men.

The last months of therapy were characterized by her great caution. Directly or indirectly, Yael described therapists who were not sensitive to their patients' needs. She conveyed to me the message of how vulnerable she is and how careful one must be in a relationship with her. She often likened her long silences to a vendor offering a yard of fabric and cautiously checking if the buyer is interested. If not, he hurriedly withdraws his merchandise.

During the second half of the first year, material surrounding her relationships with men arose, including her feelings toward the men in her family: she spoke about her brother and father, and alongside these emerged dreams and imagery rich in aggression. Yael described a dream in which she sees a hand with a knife cutting her brother's genitals. Only after considerable work in therapy did she raise the possibility that the hand holding the knife is her own. Memories in which she felt anger towards her brother because he is a boy and she is a girl. Her aggression toward men also manifested in the metaphor where she depicted herself as an animal (a bug that digs a tunnel in the sand and waits for an ant to pass by, fall into its tunnel, and then devour it).

This segment of therapy illustrates a first junction where one could deliberate between a Kleinian or Kohutian intervention when encountering the patient's aggression. Kleinians would approach such therapy with the assumption that the aggression and envy arising in the patient are foundational facts of therapy. Beyond that, one cannot go, and therefore, one can only confront the patient with her aggression. In her important article about envy (Klein 1957), Klein repeatedly demonstrates how she hopes to reach a point in therapy where the patient will acknowledge their aggression, accept it, and engage with it.

In this segment of therapy, a Kleinian intervention could be formulated roughly as follows: "There is envy in you that he has and you do not; if you cut him, he will not have it either, which will calm you." By the way, Freud (Freud, 1937) would also see this segment as a foundational fact (bedrock). He writes that female penis envy is a foundational fact in therapy and that one cannot go beyond it.

The self-psychology approach, on the other hand, attempts to show the patient the chain of origin for her aggression, the source of her pain, and the lack of acceptance of her femininity. According to this view, merely confronting the patient with her aggression will not diminish the experience of destruction, whereas recognizing the chain of events that led to this aggression will lessen the experience of destruction. Therefore, the interpretation arises: you could not accept the difference between you and your brother—the son, to rejoice in who you are, to enjoy a connection with a boy, that he is as he is, and you are as you are. This is because your whole life you have lived with the feeling that you are not like what your father wanted, and not like what your mother loved and rejoiced in.

During the first two years of therapy, listening to Yael was very difficult. In addition to her long silences, when she spoke, it was often in a quiet voice, with fairly complex expressions and metaphors. During this period, I was particularly struck by the feeling that I needed to be careful with every interpretation or reflection, as well as a difficult inner discomfort whenever I "missed" or hurt her in my interpretations. It should be noted that these

two elements, the sense of vulnerability that characterized her and the difficulty in listening to her, almost completely disappeared in the last year and a half of therapy.

During the first half of the second year, Yael often spoke about her need for a complete alignment of my interventions with her needs. She expressed her desire to be understood without speaking, and she also associated this with her silences. She spoke about her fears of taking up space in the world. Then, alongside the wish to be understood accurately, she asked that I know exactly at the right moment, not before, not after, to invite her out of her silences. Then another need also arose: "I do want you to miss sometimes. I do not want to be surrounded by people who can precisely hit the mark, like snipers, exactly what I need; it is unrealistic, and it cannot be." During that period, she remarked on a segment where I did not understand her: "There is something relieving and amusing about not being understood, like a couple who have not fought for 20 years and finally do".

I saw in her words a second junction. Should I intervene in a Kleinian or Kernbergian style, encouraging and seeking expressions of aggression from the desire to argue? Another way would be to progress in the style of the empathetic reflection she so desperately needs. I saw in her words progress from the first stage of empathetic reflection, in which the patient needs a complete alignment of the self-object's attunement to her needs, to the third and final stage according to Kohut (Kohut 1970). Yael moved toward greater separation from the self-object. From here, in my understanding, her desire to be less understood and more separate arose. By being more separate, Yael was able to notice additional components in the therapist that differed from her, such as her femininity. This trend intensified .

In this process, there is progress in the stages of empathetic reflection because it contains a willingness, or her desire, to shift me from a more nurturing role of providing close empathetic reflection to a more paternal role, according to Kohut (Kohut, 1977).

Near the end of the second year of therapy, Yael brought, in several sessions, with much pain, the loneliness in which her life unfolds. She told a touching account of how she hiked in the mountains on a Saturday for work, saw families hiking, could not bear her loneliness, and returned to the city to her apartment. At home, she heard how her neighbors' families came for Saturday dinner and again felt her loneliness. During those hours, her silences in the therapy room multiplied and intensified beyond the usual. Apparently, I struggled to contain the pain of her loneliness, and instead of offering an interpretation such as: "even here in therapy, she feels lonelier than usual," I interpreted the opposite (which, of course, turned out to be a complete mistake), interpreting, "It is pleasant to be in your silence today." In our next meeting, she said that when I said it was pleasant for her to be in silence, she felt bad. On a Saturday evening, watching television, she saw an Israeli soldier smashing a Palestinian's head against a wall, and for a moment, she replaced the soldier's figure with mine... She felt that the interpretation I gave to her silence resembled smashing her head against a wall. This connected with associations from her childhood, where, after fights with her mother, she would typically isolate herself in her room. When her father returned from work and asked about her, the mother would say that she was resting in her room, conveying to him the message that Yael was enjoying her privacy there. Yael was in great pain then and always hoped that her father would not respect the closed door and would not believe that she was happy there in her solitude.

In the last year and a half of therapy, her silences diminished to the point of complete disappearance; her quiet, unclear, and complex speech also ceased. Alongside these, my feelings toward her changed, from a sense that I needed to protect a vulnerable infant to the feeling that a mature partner sits with me in the therapy room. In Yael's artistic work, a significant flourishing began. Her creations received much praise. She exhibited in exhibitions and even published books. In her relationships with men, there was also a drastic change. She met a partner and lived with him for several months. She shared that although she felt he loved her, she was the one who ended the relationship because she felt he was "not sufficiently generous and not giving her enough." She added, "I will not jump into the arms of the first man who wants me, just because I have longed for someone to love and want me for so many years." Toward the end of therapy, Yael met another man, and in a phone conversation, about a year and a half after the end of therapy, she told me she had married him.

In Yael, there was a fundamental experience of gratitude toward the therapy. She expressed it clearly and loudly. She linked her professional success to therapy. Another important development in the fourth year of therapy was her acceptance of her femininity, which manifested in her clothing, appearance, internal feelings, and creativity.

However, alongside all this, in the last year of therapy, a thread emerged that connects to the broader issue I discussed in this article. Yael complained several times that year that the therapy involved "too much understanding." She also stated that the therapy had not sufficiently prepared her for the confrontations outside in life. She said, "Understanding is like giving discounts." It does not advance enough. I was a bit like being in a greenhouse here. In one of our last sessions, Yael complained that I was a "carrot" to her in terms of 'stick and carrot.' I asked if she felt a sense of loss because there was only 'carrot' between us? Yael replied, "Out of my 35

years, I needed 4 years of acceptance." To my question, "Would you like me to be here with both the stick and the carrot?" she answered, "I never imagined you in uncomfortable areas, but maybe, I don't know".

Yael's words allow for a renewed discussion around the central theme of this article - Klein's approach and, at this point, also Kerenberg's (Kerenberg, 1992). Both would argue that I should have mobilized persecuting elements in transference and confronted her with them. Thus, they would surely understand her words about my being too understanding and providing her with a sort of greenhouse.

In contrast, the self-psychology perspective sees things from a different angle. Kohut (Kohut, 1977) (Kohut, 1984) would certainly argue that the patient is stating in these words that she is satisfied with empathetic understanding, that she is growing now, which was very necessary for her over four years, but now it is enough!

It can be understood from Yael's words that her perception of me as a therapist has changed and also progressed along the direction I pointed out above. That is, from a close need for my precise empathetic understanding to a desire to see her as more separate. The need relates to her words of seeing me as an object, and reducing her needs to see me as a self-object. This developmental course in therapy allows for two processes: one is a more classical interpretative work, and the other, made possible by her viewing me as an object.

It is essential for my understanding that a self-psychology therapist, when encountering a patient who tells them: "I am satisfied with empathetic understanding," will consider that it is developmentally appropriate and will not hasten to think that the patient is actually activating defense mechanisms against empathy (Newman, 1980).

3. Discussion

Observational research (Buss, 1996) (Fesbach, 1977) typically divides aggressive behavior into two categories: 'hostile aggression' and 'instrumental aggression.' The actions of instrumental aggression are aimed at achieving a non-aggressive goal. While there may be harm to another in the course of the action, this is not the primary objective. In contrast, 'hostile aggression' aims to harm another. Cohen and Fesbach (Cohen, 1990) (Fesbach, 1977) argue that aggressive behavior can be considered instrumental even though it may harm another person if its basic purpose is to restore the self-esteem of the assailant, which was previously undermined by the victim.

Such flexibility in the perception and conceptualization of aggression is made possible by the Kohutian approach but not by the Kleinian one. The latter sees all aggression as inherently destructive, stemming from a singular basic source—the innate death drive. It seeks external confirmations and opportunities for expression of what is already experienced internally. This is a theory that posits that envy comes from within, and we search for an object outside to project our envy onto. Klein (Klein, 1957), when encountering the patient's aggression, can only confront them with it and seek to achieve their acknowledgment of it. In contrast, an approach that sees aggression as always a reaction to prior injury will search for the chain of events that led to this aggression and will also be empathetic toward it. There are many chances that the self-psychology approach will be better able to discern and identify aggression as instrumental rather than merely unidimensional or hostile. Patrick (Patrik, 1991), who is associated with the self-psychology movement, describes a patient of his with narcissistic rage, who threatened the therapist with a knife. Based on his familiarity with the patient, he knew to assess her aggression not as hostile and destructive but rather as instrumental—in her attempt to secure the continuation of treatment. Only after she restored her self-esteem, which had been damaged by a previous unsuccessful intervention from the therapist, through this disruptive behavior could she continue in therapy, and this she even requested tearfully.

Here it is important to emphasize that this does not mean that the therapist must always respond to the patient with empathetic understanding from their perspective as a self-object (Willock, 1987); rather, the theoretical conceptualization of self-psychology regarding aggression allows for a broader perspective, a richer listening potential and responses, and a more curious stance. This contrasts with a unidimensional view of aggression as always destructive and innate.

Even Klein at the end of her life, and her successors from the 1970s onward, have slightly altered their perception of the patient's aggression. Although they did not change the general theoretical perspective toward aggression, and perhaps not even the basic method of treating it, they emphasized confrontation less and exhibited more trends toward differentiation in encounters with the patient's aggression.

Limentani (Limentani, 1981) refers to the editorial note by Klein (Klein, 1957) appended to her own article, in which she herself remarked that, although envy can be addressed analytically - to one degree or another - it nonetheless sets a limit on analytic success. Limentani (Limentani, 1981) observes that, despite this partial disavowal on Klein's part of the effectiveness of treating aggression through confrontation with envy, many Kleinians continue to rely on the interpretive work of the patient's envy toward the analyst as a means of withstanding the patient's destructive attacks on the analyst and on the analyst's work. Spillius (Spillius, 1983) notes of Klein that, in the later years of her work, she conveyed a markedly supportive stance toward the patient when negative feelings were exposed. Spillius regards this shift in Klein's tone as one of the factors that brought

about a change among practitioners of the Kleinian school in their clinical encounter with aggression. Spillius (Spillius, 1983) surveyed a large number of papers submitted by candidates for membership in the Institute of Psychoanalysis who were identified with the Kleinian school. She examined papers from the 1950s, 1960s, and 1970s and identified a shift in the later papers of the 1970s. The shift is manifested not in any diminished emphasis on the death drive or on destructiveness, but rather in the manner in which these are interpreted to the patient: less confrontation and a greater search for differentiation. Spillius (Spillius, 1983) attributes this shift, beyond the change in Klein herself, to additional sources as well. She cites the position of Betty Joseph (Joseph, 1987) - herself a Kleinian - who warns that, in the absence of differentiation on the part of the analyst in the face of the patient's aggression, a wholesale confrontation by the analyst may come to constitute the analyst's collusion in the patient's sadomasochistic operation. According to Spillius (Spillius, 1983), Bion (Bion, 1969) also contributed to this shift by enabling a distinction to be drawn between patient behavior arising from the projection of destructiveness and that arising from the projection of hopelessness.

Alvarez (Alvarez, 1983), a modern Kleinian, estimates that the distancing from interpretations regarding destructiveness among Kleinians was also caused by observational studies like those of Bick (Bick, 1964) and Melzer (Meltzer, 1975). Both were Kleinians. These studies examined children with severe psychopathologies. They indicated a lack of integration in this population due to the functional failure of mothers (primarily maternal failure), and did not point to destructive processes of disintegration arising from within as the source of the disturbance.

Parens (Parnes, 1979), who belongs to the Mahlerian stream, notes in his observations that aggression in infants, even when accompanied by sadistic pleasure, is reactive in origin. Willock (Willock, 1987) from the self-psychology perspective found, after observing children defined as "overly aggressive," that their aggressive outbursts occurred after these children felt rejected by those who were supposed to care for them. Lovental (Lowenthal, 1986) suggests separating the discussion of the death drive from aggression entirely. This is because one of the key factors in Freud's theory about the death drive, namely "nirvana," has nothing to do with aggression.

It is also stated that every therapeutic method carries within it disadvantages and dangers. Modell (Modell, 1986) even warns us against prolonged and consistent use of empathy. This is because it may be experienced by the patient as a threat to their own autonomy.

From the clinical examples provided in this article, it seems that particularly in example number 3, greater alertness was required on the part of the therapist. She needed to consider the degree of empathy given to the patient in light of the developmental processes they are going through and not to hurry to interpret the matters as a defense against empathy.

In light of the prejudices regarding the appropriateness of self-psychology to confront the patient's aggression, there were, of course, differences in the comparison of the treatment goals regarding aggression, as Kohut presents them, compared to the Kleinian approach. Klein, who attributes a central role to aggression in character formation and gives a central place during therapy to confrontation with the patient's aggression, hopes essentially for the treatment outcomes to be: softening or even elimination of aggression. She expects the patient to acknowledge their aggression after repeated confrontations with the therapist, and then to transform it into gratitude (Klein, 1957).

Kohut, in contrast, does not ask the patient to relinquish their aggression for the sake of an ambiguous concept like "gratitude." Aggression, in his understanding, is always reactive, and frustrations from the outside will always exist. The Kohutian approach expects that as a result of therapy, the narcissistic structure will change in such a way that frustration from the environment will not provoke narcissistic rage, which enslaves the self to its needs. Instead, mature aggression will emerge in the service of the self and the ego. Since, as mentioned above, the Kohutian approach allows for a distinction between destructive aggression and instrumental aggression, it is clear why the approach does not wish to relinquish aggression altogether and seeks for the person to remain equipped with it.

The opening positions and differing perceptions of the source of aggression and its treatment between the two approaches lead to profound and surprising differences both in understanding aggression and its sources and in the goals and methods of treating it.

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