



Since becoming 50, I find myself more aware of the value of small, simple moments. Planning for a "right" future seems less important than living the present as fully as I can. This unexpected change makes my work and my personal life easier and more enjoyable.

After four years of intensive therapy, Gloria felt safer and much less frightened and was beginning to experience her primitive rage. Uncharacteristically, she began one of her twice weekly group sessions rather than waiting for someone else to do so. Staring directly at me with no outward manifestations of anger and none of her typical hysterical gesticulations, she said with cold rage:

I hate you. You haven't done enough for me. You have not helped me enough. There is no point in my going on. And if I go, you are going with me. In fact, I think I will buy a gun. I know where I can get one. I will put it into my purse and bring it to an individual session. And after the session starts and the door is closed, I will take the gun out of my purse and I will shoot you. And after I shoot you, I will shoot myself.

Then Gloria turned to my co-therapist Dr. B., whose office adjoins mine, saying, "You'll hear the shots, Dr. B., and you will probably come running, but it will be too late because she will be dead and so will I."

I am a psychotherapist working in a group practice where we share the tremendous responsibility with which our patients entrust us—that of helping them release the powerful hold their emotions have over them. Among these emotions is rage, an intense form of the basic feeling of anger. Rage is usually an outgrowth of the primitive fear of abandonment of the infant who must often have a "subjective sense of having been forgotten or perhaps even abandoned forever. . ." (Bar-Levav, 1988, p. 341). When acted on, intense rage can be the force behind terrible atrocities and destruction. When repressed or denied, it can lead to harsh self-imposed limitations and waste of human potential. When closer to the surface and threatening to break through, it can lead to suicide. Most people, including many therapists, are very frightened of their own rage, not realizing that it does not have to lead to action. One can truly want to injure and even wish to kill another human being, including actually feeling muscular

power in one's hands and arms, without any reality danger existing. When rage is worked with in a setting where the safety of all participants can be reasonably assured, it becomes clear that most of the accompanying fear is a distortion and is based on past, rather than present, experience.

The alternative to strong and sincere expressions of rage such as those that will be provided by example in this paper is for patients to only talk about irrational anger they *used* to feel. Such talk leads to greater intellectual understanding but not to real working through, not to true character change.

It is possible to successfully work through rage of even murderous proportions in a course of long-term psychotherapy. Certain clear conditions must exist, however, and this paper will illustrate specific parameters within which rage can be experienced safely again and again in ever-increasing levels of intensity. Then it can be traced back to genetic material and slowly worked through. Throughout this process the patient must be in charge of his or her feelings rather than the other way around when feelings rule. This paper deals with a lapse in this condition and how it was handled.

Let us now return to the group session with Gloria which even years later stands out clearly in my memory. I had never been threatened like that before in my practice and because of what I learned from this experience such threats have never been directed at me since.

For a few weeks shortly preceding this group session both Dr. B. and I had been away from the office. When Gloria spoke it was clear to me that this "abandonment" had triggered her strong emotional reaction. While I was used to working with strong feelings, I was completely unaccustomed to such a threat.

Gloria's cold rage frightened me. Her unflinching demeanor stunned me. She was serious and I knew it. Once I recovered from my initial fear and shock, I was furious at this person with whom I had worked so hard for four years. She had not been an easy patient. She was manipulative and provocative and had challenged me countless times in an attempt to test me and find out if ours was really a safe relationship for her to be involved in. Her disappointment in me and criticism of me alternated with attempts to please me like a good little girl so that I would love her. After all my hard work, suddenly she was threatening my life! I pictured myself sitting in my office in an individual session with Gloria sitting across from me with a gun pointed in my direction. While my anger was not altogether unreasonable, I knew that my feelings were simply too strong to allow me to work with her at that time. The incident had, of course, had a strong impact on the other group members and I knew that I would have to be clear-headed for their sake as well as for my own and Gloria's before I could attempt to deal directly with this matter. From the start, however, it was clear that I would have to do something before the end of the session. I worked with other patients and inwardly continued to observe myself and my reactions. My ability to remain clear with others and do with them what they needed at the time was reassuring to me.

Dr. B. and Mr. H., my other co-therapist in the group, tried to engage Gloria thoughtfully but she did not respond to them. She seemed to be involved with me in a transference reaction of near-psychotic proportions and her observing ego was not operating. Other patients in the group spoke of their reactions to this frightening incident and some of them also tried to help Gloria. Listening to and working with them helped me re-establish my own equilibrium. About halfway through the session I was clear-headed enough to know what I had to do.

With about 15 minutes remaining I firmly told Gloria that I was cancelling her individual sessions indefinitely, that her threat had given me good reason to be frightened and that I would not take a chance with my life. Even though I cared about her and was trying to help her, my life was more important to me than hers and I would not consciously put myself in danger. I told her that I needed time to work with myself, to sort out what was rational and irrational on my part. I would let her know whether I could continue to see her as a patient. She was welcome to come to her group sessions and to the upcoming marathon session for which she had already been scheduled. But, for the time being at least, I would not be alone with her.

My taking this stance for myself had an impact on her. She cried and then spoke with remorse about what she had done. She saw her irrationality clearly and understood what a big risk she had taken with her therapy. She knew why I would not see her. She even thanked Dr. B., Mr. H. and several group members for having tried to help her. A frightened, sad, thoughtful woman left the session that evening.

During the weeks in which Gloria had no individual sessions she took part in a previously arranged 28-hour marathon session. All our patients participate in these about twice each year as part of their on-going therapy so Gloria had already been to several. By previous design many hours of that particular session were videotaped, allowing us to capture verbatim much of the dialogue in the vignettes which follow (Torraco, 1979b).

Gloria and her whole therapy group were at the marathon along with patients from other groups. Ten hours had elapsed and Gloria had barely spoken. In these sessions we often use structured exercises and then work in depth with the strong feelings they trigger. One of these exercises is called "The Lifeboat." Patients are randomly assigned to groups of four or five and are asked to assume that they are in a lifeboat which can support only the number of people in the group minus one. They have a half hour to deal with this dilemma. If one person is not figuratively eliminated from the boat, the boat will sink and the entire group will drown. To make the experience as real as possible, attempts on the part of participants to reduce their understandable anxiety such as giggling, joking, calling it a "game" or "a stupid exercise" are curbed. The real difficulty of involving oneself in such an exercise, the genuine horror that would accompany such an actual experience, and the hope that none of us will ever be faced with such a circumstance are openly and seriously discussed. With this structure in place, each small group deliberates independently and both healthy and pathologic

character traits have room to emerge. Then what happened in each "boat" is openly processed in the large group (Torraco, 1979a).

Gloria practically volunteered to be the victim in her group. Ron, a member of her group, had been speaking with pain about his own determination to survive in this exercise while Gloria was so willing to be "tossed overboard" by her companions. He had speculated that her self-destructive behavior might be a fear-based reaction to her recent threat to me.

Gloria: Today I don't care if I'm in the lifeboat and I don't understand. I'm tired; I don't want to be here. I'm angry and I'm hurting. Sometimes death could be an answer. And today I didn't want to fight. I knew I would be the victim before we started the exercise.

Dr. B.: What is your death called?

Gloria: Suicide.

Dr. B.: Ron would think it was a murder and he was a murderer. Each of the participants would live with your suicide as their murder.

Gloria: I told you I'm tired today. I don't care. I overslept today.

Dr. B.: (addressing her resistance to activating her observing ego) Are you going to talk thoughtfully now about what just happened to you? (Pause, sullen silence from Gloria) If not, lie down on the floor and be a victim.

Gloria: Goodbye. (she lies down dramatically)

Dr. B.: Goodbye. (Then speaking to the whole group) She is in a delusional state. She lives as if after she is dead for a while she will come back and have a nice dinner tonight. She will really have dinner tonight along with the rest of us, but living with this attitude under other circumstances could lead to her really ending up dead.

Gloria had barely spoken all day. This self-imposed silence along with her joking and her seeming lack of concern about her own "death" in the exercise were all resistances to experiencing her rage. So far nothing had shaken her. A few minutes later Dr. B. tried a more provocative technique, presenting himself as a target for her anger.

Dr. B.: Would you hold this lily please? (presents her with a paper cup which happens to be white like the flower) If you are going to be dead, then you can hold a flower like a dead person. That is how you treat yourself today for whatever reason.

Miss T.: She remains a nameless person in this room. (Unlike the other twenty-or-so participants in the marathon, she had never introduced herself by name.)

Dr. B.: She said that she felt hurt today and because of her hurt she decided that she does not want to take good care of her life. The least I can

do for such a person is to give her a lily. (smiling, directing his comment to the larger group but obviously mostly meant for Gloria's ears)

Susan: I don't understand that kind of thing.

Miss T.: Susan, have you ever heard anybody protesting, shouting "damn you!" out of the morgue?

Dave: Or seen a suicidal person who was content?

Susan: You've heard the joke about the casket? You make sure that, just in case, you have a phone in there so you can call out. People don't want to cut off all ties. (some laughter and a few anxious, hopeful looks at Gloria who remains tight-lipped and silent).

Dr. B.: Let Gloria play with this fantasy. I think that the way she looks she might as well have a rehearsal for being dead. She might soon be there unless she is basically different and much more careful.

As the exercise continued so did Gloria's silence. None of the therapists addressed her or her "suicide" further although we watched her, hoping that she would find the strength to emerge from her withdrawal, a suicidal equivalent. She witnessed the work of four other groups and listened to the stories of four other "victims". When the exercise was over and people were continuing to process their experiences, Gloria finally spoke. Her facial expression had changed—there was no longer a numb mask or an inappropriate smile. The flippant attitude was gone. She no longer joked. At times she sounded somewhat theatrical and imitative, aspects of her character presentation which she still tended to adopt when frightened. But she clearly recognized her fear and could talk spontaneously about herself and her feelings, respectfully and without shame, making connections with genetic material.

Gloria: I'm so mad at you, Dr. B. I've been so mad, I haven't spoken to you for weeks. (Her throat tightens up as she speaks.)

Dr. B.: Don't cut your throat now.

Gloria: I've been through so much more therapy than Tom, [a relatively new patient who had earlier discussed a serious episode of acting out at home] but I'm acting up the same way he is. I don't know what to do. I'm so mad that I'm afraid I could come over and kill you. I'd like to smash you. But yet I love you so much I really don't want to do that. I know damn well I'm lonely. I mean this is my group; these are my people. I know just about everyone here. And this has been pure hell for me. Pure hell. I've been quiet for a long time and I didn't care. That scares me. I haven't done this in a long time. Three years probably. Do you realize I would be dead? It's not a game. It's not a joke. You and Miss T. left me for all that time. When you came back three weeks ago, I'd grown up. I looked at you and I was enraged at you both. When I saw you in the hall I couldn't even speak because I was so mad and yet I love you. You know that. I could kill you.

Believe me, I would like to take a spike heel right through your face. I told Miss T. I would kill you in a second. But yet I love you so much. It is a terrible conflict. It makes me scared. To think I've got these strong feelings of murder and I want to kill you and hate you. It's a danger signal for me. It scares me.

Miss T.: So you killed yourself instead.

Gloria: So I killed myself instead. I'm not dead yet and I am talking about it, but that frightens me, so I don't want to act. I feel like I want to punch you and make you suffer. In my cold war you will come crying back to me, "My darling Gloria, I love you. Please talk to me. Please darling. Please baby." That's what I'm waiting for. As I see it, you are bad. You are a bad man and you are going to come back into my life. I can't allow it. I can't be shit on like that. Somebody can walk in, walk out, come back, shit on me, come back, shit on me. I can't allow it any more, and I won't. Not from you or anyone else.

Dr. B.: Let me ask you a question. Who shit on you in reality? Walked in, walked out, shit on you, come in, come out, shit on you. . . Who did that?

Gloria: My father. He used me and abused me. He'd give me some money—give me a present and then leave. Come back and leave. Came back and left. But that's all bullshit. My father conflict is resolved. He is dead.

Ron: Bullshit.

Gloria: He is dead!

Dr. B.: That's right.

Gloria: But you're not.

Dr. B.: When did he start doing such terrible things—walk in, walk out?

Gloria: Always. Always. He was in prison for the first few years of my life. He would go to jail; he would do all sorts of things. He would leave. He would come visit us late at night. He would only come to use me or exploit me or get something from me.

Dr. B.: He may have also loved you.

Gloria: I loved him. There was nothing that I wouldn't do for him.

Dr. B.: You had only one father.

Gloria: That's right; I loved him. I could have killed him too. So I don't like this idea of you coming in and then leaving me.

Dr. B.: Well I've got to think over my plans. But there is one slight dissimilarity between your father and me. While I may come and go, I don't think I shit on you.

Gloria: I know all the reasons. My head knows everything.

Dr. B.: I'm just trying to tell you that I deserve almost the same treatment, but not quite. I didn't try to talk myself out of my situation. As a matter of fact, what happened today may help save your life. Because I would like to remind you of what happened today. You wanted to slit my throat, take a spike heel and drive it through my face. Instead of doing that, and of course I don't want you to do it, for the last 12

hours or so you did it to yourself. You can be angry with me. You don't have to actually drive anything through my face. You can hate me and we can still be together.

For the next two months Gloria had no individual sessions. In addition to the marathon, she attended all her group sessions. She remained sad and thoughtful. She often made excellent contact with me, sensitively identifying with the difficult situation I was in, describing clearly why it might not make sense for me to ever be alone with her again. At the same time she hoped I would find a way since I had helped her so much over the years. Her experiences in the marathon and the genetic connections she had made had brought her to a sobering awareness of her serious character pathology.

I worked hard with myself. My colleagues listened to me and tried to help me separate my thoughts and feelings. I came up with all kinds of ideas. I thought perhaps I could see Gloria individually, but only on the condition that she leave her purse in the waiting room with the secretary. Or I could see her but I would not allow her to come to sessions carrying any bags or wearing dresses with big pockets. I both laughed and cried as I realized that these ideas made no sense. If I couldn't trust this woman or feel safe in a session, then I couldn't work with her. Finally, after many weeks of painful struggle on my part and on Gloria's, I decided it was safe—that Gloria again had enough observing ego and that I could work with her without being scared or in actual danger. We started individual sessions again and she never made another threat. Her considerable progress was particularly evident in the areas of separating thinking and feeling, exercising her observing ego, and limiting her use of dramatic measures in an attempt to prevail. Careful investigation of Gloria's history in light of her choice of such terms as "use," "abuse" and "exploit" suggests that she was not physically mistreated, sexually or otherwise. It appears that she used these strong terms to emphasize the depth to which she felt deprived of needed emotional resources and the insensitivity she experienced to her childhood needs for security and consistency.

Utilizing the clinical material with Gloria, let us now explore in more depth the conditions necessary in the therapeutic setting for work with rage to be both safe and productive. They are:

1. An intense relationship with the therapist consisting of a real-relationship and a parallel therapeutic relationship.
2. Clear separation of actions and feelings.
3. Regular individual and group sessions.
4. Splitting of the transference through the regular involvement of several therapists.
5. Active use of therapists as targets for both positive and negative transference reactions.
6. Resolution of the therapists' own primitive rage.

Patients usually come to us in panic or despair, unable to resolve some real or emotional crisis in which they find themselves. Nonetheless, we must not overlook the fact that therapist and patient are first and foremost two real, adult people who come together by mutual agreement. The scope and limitations of this real relationship are defined clearly by the contract.

Within the real-relationship it is the therapist's responsibility to shape the therapeutic relationship. And it is within the therapeutic relationship that transference experiences can play themselves out. In the clear contract which must exist between patient and therapist they both agree to continually strive to separate their thoughts and feelings and to base their actions on rational judgement and never on momentary feeling states. Such a contract gives patients room to experience and to reality-test intense feelings with everyone—therapists and patients—being physically safe. Patients who are unwilling or unable to commit to such a contract (which includes no spontaneous physical touching) cannot be safely permitted to work with strong affects in therapy. By blocking the "action" avenue of discharging feelings, we open the road to clearer vision and to evaluation of the sense or non-sense of momentary emotional experiences in the context of current reality. (Even though the feeling in Gloria's case was rage and the accompanying action potentially dangerous to me, the same principle should hold for all feelings. Thus a "hug" when one feels loving is no more acceptable than a punch when one feels angry.)

No threats of any kind can ever be permitted to pass in psychotherapy. Even though a threat is not an action in itself, it is a statement of an intent to act based on a feeling. Statements of wishes, yearnings or fantasies, on the other hand, make no implications about actual behavior and, therefore, involve no actual danger to anyone. The experienced threat to one's current safety, whether on the part of a patient or a therapist, is then clearly a distortion of current reality. Such a contract asserts the importance of the observing ego always being operational since without it the potential for violence exists.

The fact that for four years Gloria had had weekly contact with me three times and with Dr. B. twice allowed her to become deeply emotionally involved with actual people who remained dependably present. Her group sessions had allowed her to witness the struggles of others, to experience and observe her idiosyncratic reactions to peers and theirs to her, to live with the frustrations triggered by having to share the limited resources of the group, particularly time and therapists' attention, and to survive the emotional crises precipitated by the character confrontations which can be more effectively undertaken outside of the dyadic setting. At the same time, the exclusivity and more supportive, mothering climate of Gloria's individual sessions made room for her to feel safe enough to intensify her relationship with me, to try to differentiate her real needs from her childlike yearnings, to examine her lonely life, and to process behavior and strong reactions from her group sessions and from other areas of her life. The combination of individual and group sessions "repeatedly evokes irrational fears and other feelings very intensely in an environment which is known to be safe. Patients often flinch, but only rarely do they give up and leave" (Bar-Levav, 1988, p. 250).

Intense feelings of all kinds, including rage and its accompanying wishes and fantasies to actively inflict physical injury, must have room to surface in any therapy which aims to alter character pathology. Otherwise, patients will hide their most primitive affects. Gloria experienced a real sense of danger and injustice in Dr. B.'s and my "walking in and out" of her life. Thus, her wishes to shoot me and to drive a spike heel through Dr. B.'s face were appropriate. That she attached such wishes to us rather than to family members or other people outside her therapy made it possible to work with them in the heat of the moment and then later on in the context of a therapeutic alliance and contract. This requires that the involvement with therapists be frequent, durable over time, focussed in intensity, and safe with well-defined parameters.

Patients' relationships with their therapists must be sufficiently real in the present and of sufficient emotional intensity that primitive feelings can actually be experienced in the current relationship, not role-played or only cognitively discussed. The therapist must, therefore, be willing and able to present him or herself as a transference target toward whom affective reactions are directed. Thus when anger is the affect being experienced, graphic fantasies will emerge and vocal spears need to be hurled at this therapist-target, always under the watchful eye of the observing ego. When hurt is the experience of the moment, the pain of the past will be felt as emanating directly from the therapist's insensitivity. When old fears surface, the resulting sense that the patient's safety may require leaving therapy must be patiently reality-tested. And when deep yearnings are stirred, the therapist becomes the focus of "love that has the purity and innocence of little children" (Bar-Levav, 1988, p. 229).

Obviously any therapist who has not sufficiently worked through his or her own rage and other affects will not be able to tolerate the intensity of such work and is likely to withdraw or in some other way sabotage the patient's best efforts. Even under ideal circumstances such work is not possible for therapists laboring alone. The presence of an able co-therapist both eases the clinical burden and gives the patient room to split the transference, experiencing rage or some other strong affect toward one therapist while sensing another as a steady, safe and welcomed support. A patient such as Gloria is then not all alone with both her own feared rage and also the hated object. Even though in the group session where Gloria's threat occurred she eventually responded thoughtfully to my taking a strong stand, she had benefitted from Dr. B.'s and Mr. H.'s earlier work with her. And while I was struggling with my decision as to whether or not I could continue as Gloria's individual therapist, in the marathon she continued her work (without threats), now using Dr. B. as her transference target. This time she was able to use both of us to help her trace her reactions to some of their genetic roots and to begin to sadly view the high price she had been paying for her distortions.

Therapists who work together with the same patient can not only multiply the benefits to the patient but can also provide essential help and support to each

other in such intense work which regularly strives to alter basic character pathology (Torraco, 1993). Without the help of my colleagues in examining reality and my own fears I would probably have actually terminated Gloria's therapy or at least diluted it considerably.

In light of my current understanding of the essential ingredients for successful psychotherapeutic work with rage, I can trace Gloria's threat to my insufficient work in two of the six above-mentioned areas, #2 and #6. First of all, I had apparently not clearly enough helped her to separate actions from feelings. Had I established and maintained a tight enough contract, Gloria might have spoken in that group session about her *fantasy* of bringing a gun to a session and shooting herself and me, but she would not have made an actual threat.

Secondly, I had not sufficiently worked through my own early fear and rage. Otherwise, as soon as Gloria made the threat I would have experienced appropriate signal anxiety since a potential danger did exist, but I would have had my wits about me enough to quickly recognize the weakness in the contract and to *immediately* speak to Gloria the way I finally did at the end of the session. My feelings and their clouding of my ability to think clearly would not have interfered with my patient's needs.

Because anger and rage involve force, thrust and power, inhibition of rage often leads to inhibition in living, to a holding back of one's potential force and power in life. In Gloria's case, her desperate attempts to contain her rage had led her to place severe limitations on herself which had been reflected for years in her superficial relationships and in her being seriously underemployed. Like countless others, she restrained much of her creativity, resourcefulness, love and joy. The fear that she was a monster because she was so angry pervaded her whole life.

Fortunately such fear and rage can be successfully worked with and eventually resolved when we understand the context in which such work is not only effective, but also safe for everyone involved.

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