

WORKING WITHIN THE NEGATIVE TRANSFERENCE

By Reuven Bar-Levav, M.D.

Not only clinical observations but also any cursory review of societal affairs strongly suggest that the suppression and repression of anger is perhaps a most common phenomenon. Since there are so many realistic reasonsⁱⁿ every society and in every family for experiencing anger, political, economic and sociologic explanations and solutions are much more commonly available and accepted than psychologic ones. Religion is but one of the many social institutions that all played an important role at keeping anger below the surface. Religious, national and class wars as well as the ever present multitude of irrational inter-personal struggles and conflicts among individuals have always served as the safety valves for the excess rage that has been expressed, often with disastrous results. In face of so much real injustice the experience of anger often seems rational, and therefore, not of concern to psychotherapy.

Even a superficial view of man's condition in most modern societies shows that while much injustice remains real progress has been made in dramatic proportions but frustration and rage have nonetheless increased to a point that violence in small or large proportion has touched the lives of practically all of us. Slavery and the plague were practically extinct, hunger and illness have been minimized although hundreds of millions continue to suffer. But, although it is of little consolation to those suffering, their fate is at least of some small concern to others, as it was not so in the more distant past when life in general was much cheaper. We are justly insensed at the brutalities of our own age, and we forget often that similar and greater brutalities have been accepted without protest as part of the human condition only a few short hundred years ago.

The reasons for the universal anger that bubbles just below the civilized veneer may well have a far greater psychological component than either social

scientists or psychologists have been willing to accept in the past. It deserves a separate and detailed discussion. Regardless of the origins of the anger with which patients come to us, the failure of psychoanalysis and psychotherapy in general to work with these powerful affects within the therapeutic setting may well be the greatest shortcoming that is largely responsible for the less than desirable results that are obtained in spite of diligent efforts. Many of the so-called newer psychotherapies have altogether abandoned the task of working-through pre-verbal rage which all too often is made permanent by channeling it at anger at supposedly adult injustices. But, psychoanalysis and serious psychotherapy have also neglected to recognize the central importance of working with irrational anger and its ubiquitous presence in every psychotherapeutic setting. Even the very use of the terms positive and negative to denote different aspects of the transference as if it were analogous to a series of neutral integral numbers maybe an indications of unconscious discomfort on Freud's part and on those who followed him with such affects as hate, anger and rage. Most people, and this specifically does not exclude psychoanalysts and psychotherapists, find situations of loving and accepting as less threatening, they prefer them over situations of hate and rage, and the term "negative" may denote, therefore, more than just an opposite direction. It would probably be more useful to define the so-called negative transference as a positive transference of hate and anger, while the absence of a strong transferential involvement would simply be denoted as a negative transference. In order to minimize confusion, however, the terms will be used in this paper in their usual meaning.

A Few Basic Assumptions

The five assumptions upon which the following discussion are based are spelled out next. These assumptions are generally not in dispute among psychoanalysts and serious psychotherapists, and they will therefore only be mentioned and very briefly discussed.

1. Cognition alone is not enough to achieve results from a psychotherapeutic process, insight is not the same as intellectual understanding.
2. Absence of manifest anger in a long-term psychotherapeutic relationship indicates the presence of resistance.
3. The presence of manifest anger in the psychotherapeutic relationship is not usually merely a legitimate reaction to social injustice.
4. A therapeutic alliance exists between the therapist and the observing part of the patient's ego, and this therapeutic alliance is steadily being firmed up so it may withstand even extreme pressures upon it.
5. A strick non-acting-out contract exists between patient and therapist, and this is constantly being checked out and firmed-up to minimize the chances of the patient leaving therapy when the negative transference intensifies.

Discussion

1. Marked differences unfortunately exist between the theories of various psychotherapeutic approaches and typical modes of their practice. While there is very little disagreement that intellectual understanding in itself is not of sufficient force to bring about basic changes within the personality, in fact, much of psychoanalysis and psychotherapy consists of expanding and enlarging the scope of understanding, of making the unconscious conscious, of lifting the repressions, a process which is often devoid of strong affective involvement. Process rather than content, interpretations of developments within the therapeutic relationship are often useful in this sense, but intellectualization is probably the commonest resistance to real personality change. The classical psychoanalytic and psychotherapeutic approach which uses language and interpretations to overcome resistances is uniquely unsuitable for overcoming this difficulty for it consists of the same approach. ~~Science~~ ^{Silence} on the part of the therapist is a more useful device, but it presents a different set of technical problems that cannot now be discussed in full. Only rarely will silence provoke an uninhibited expression of strong feelings

in the classical psychotherapeutic settings. What is required is a total involvement of the patient in the psychotherapeutic process to the point of affective involvement which also stimulates major physiologic parameters.

2. In actual practice, many long-term psychotherapeutic relationships, psychoanalytic and otherwise, are practically devoid of any raw expression of anger except for brief flashes of minor intensity. Although there is wide-spread theoretical acceptance of the fact that mothers absence in early infancy often provokes panic and tremendous pre-verbal rage that are soon repressed and then re-repressed during the oedipal period, very little of any of this rage ever finds full expression in psychotherapy as it is classically practiced. As I have postulated elsewhere (Bar-Levav, 1977) such preverbal rage can and must be worked with repeatedly over time for it is responsible for symptom formation and blocks the expression of true love and the formation of intimate relationships.

Since the framework of psychoanalysis and psychotherapy as commonly practiced provide very few opportunities for full experiencing and full expression of the universal preverbal rage, it is not commonly observed in psychotherapy, and the absence of such manifestations all too often erroneously are misinterpreted as indicating their absence. When therapist and patient both continue in their mutual efforts as if such an all important element in the patient's psychological being simply does not exist, they are involved in a collusion, usually unconscious, that dooms their efforts to eventual failure.

3. What happens to the preverbal rage when it does not find open channels of expression within the therapeutic setting? The unconscious collusion mentioned earlier often involves then a misdirection of this anger away from the psychotherapeutic setting and on toward external objects that therapist and patient both agree upon as deserving of such rage, anger and hate. The wide-spread blindness within psychiatry to the dynamic components of this phenomenon constitutes, in my opinion, a major current tragedy. Black and other minority psychotherapists

often fail to recognize that their patients' rage at the injustices of the white majority, while often having reality justifications, may well represent a resistance to experiencing the preverbal rage which is much more frightening. When female psychotherapists openly champion women's rights or engage in consciousness raising activities with their patients, they channel their women patients rage against the male chauvinistic establishment, and in effect substitute a political relationship which may or may not be meritorious for a psychotherapeutic one. More commonly, when psychoanalysts and psychotherapists fail to recognize as resistances the strong expressions of anger by their patients at big business and big government, representing autocratic and often abusive authority figures, important opportunities for working-through of preverbal rage are missed altogether. Since many psychotherapists share political evaluations of their patients in regard to such powerful institutions, they often fail to recognize soon enough that the timing and the place of such expressions within the therapeutic setting almost always represent an effort to avoid directing this rage at the therapists representing the original rage provoking object. Such counter-transferential identification with the objects of the patient's rage interfere with the psychotherapeutic process even when the therapist eventually directs the patient's attention to possible similarities between the hates social institutions or political figures and the powerful forces that played major roles in the patient's early life. When this happens, patient and therapist together observe what happened in the patient's life, which strengthens the positive transference and diverts the patient away from a negative transferential relationship with his therapist.

As shown later in this paper, the bulk of the psychotherapeutic work that brings about real character re-organization is achieved within the negative transference. Attempts on the part of the therapist divert the patient away from the negative transference and back to the positive one are, therefore, counter-productive and delay the psychotherapeutic process, for this is nonetheless a common practice since ways and means of working within the negative transference are usually not

to be found within the armamentarium of most psychoanalysts and most psychotherapists.

4. Patients often come to psychotherapists with an already established positive transference, especially in cultures where psychotherapy and psychoanalysis are known and accepted at least within certain social strata. Such positive transferences contain magical expectations of the psychotherapist that are similar to those that the infant has of his mother, and they should not be confused with the firm therapeutic alliance between the therapist and the observing part of the patient's adult ego. The therapeutic alliance that Sterba first elucidated plays a minor role during the honeymoon period of long-term psychotherapy and psychoanalysis, when the positive transference alone can hold the patient within the therapeutic setting. Since the life of the psychoanalyst and the psychotherapist is relatively uncomplicated in his relationship with his patient during such a honeymoon period, it is often prolonged unnecessarily, especially when the therapist is unsure of his grounds in working within the negative transference. The real value, however, of the honeymoon in psychotherapy as in marriage is that it provides opportunities for establishing reality-based alliances and clarifying the community of interests of the partners for such time when the going gets rough. Marriages and psychotherapeutic relationships commonly fail when real reality-based alliances are not developed during such honeymoons, and if the relationships do not actually break at that point, it is only because fear keeps the partners together. The work of psychotherapy basically involves mourning for unfulfillable dreams of childhood, and it is, therefore, a painful and difficult process during which a great deal of frustration, disappointment and rage are always experienced. The therapeutic effect of experiencing such difficult affects is that they are being experienced in relationship to another human being, the therapist, who does not react in kind but, instead, is willing and able to tease out reality distortions that emanate from past experiences that no longer apply in the present. Such repeated corrections of reality distortions within the

therapeutic setting test the real alliance between the patient's observing ego and the therapist, and the stronger the reaction the stronger the test. Although these theoretical statements are rather basic and generally accepted, in practice the positive transference is all too often used to seduce the patient away from experiencing so-called negative transference feelings of an intensity that might surpass the strength of the therapeutic alliance. If this is not to happen, the therapeutic alliance must be established early in therapy and it must be nurtured and strengthened repeatedly during the entire course of therapy if it is to withstand the enormous stress that must be put upon it.

5. While the principle of non-acting-out is clearly established in a theory of psychoanalysis and Crisis Mobilization Therapy, C.M.T., a great deal of confusion exists in regard to it in many of the newer psychotherapeutic approaches. The clear and non-ambiguous distinction between feeling and acting is often blurred, and many psychotherapeutic attempts fail in the name of "doing one's thing". When in some of these psychotherapeutic approaches strong feelings are elicited such as in the screaming therapies, bioenergetic or gestalt therapies, such feelings are always directed at inanimate objects that can be beaten, twisted and yelled at without dangerous consequences. Although useful up to a point, the weakness of these approaches is that when conditions are created that allow patients to experience such strong affect in the relation to a non-living object, they frequently protect themselves from the fear of experiencing such affects by merely just going through such exercises mechanically. The intended projection of a patient's fantasies upon such objects commonly fails to occur with the result that the patient becomes proficient in the specific techniques while relatively only small changes occur in his character organization and his modes of functioning. The recent appeal of T.A. to an acting-out generation was similarly based on the easy premiss that therapeutic goals can be determined by the patient's feelings, which serve as the basis for the therapeutic contract. Since feeling and acting are not clearly demarcated and separated from each other in all of these therapies,

a patient feels that he is about finished with therapy, which usually is when the positive transference is over or when the patients is experiencing affects that are too frightening to him, he is not discouraged from acting upon such feelings. Claims of feeling good are equated with being well when the existence of the unconscious and of resistances are altogether ignored.

The next section of this paper describes several conditions that seem optimally suited for working within the negative transference. Such conditions are commonly found in Crisis Mobilization Therapy, C.M.T., not to be confused with any crisis intervention techniques. C.M.T. is a system of intensive psychotherapy based upon basic psychoanalytic principles that have been enlarged upon expanded and modified to conform with clinical observations which were not obvious in Freud's days. Only those aspects of C.M.T. that deal with working within the negative transference will be discussed. Since very strong affects are elicited and since such affects are always directed at the therapist in an immediate I-thou sense, a strick non-acting-out contract is absolutely essential in C.M.T., even more so than it is in psychoanalysis. Like all contracts and long relationships, it cannot be made just simply once, but it must be evolved, nurtured, developed and strengthened throughout therapy. While non-acting-out contracts serve in psychoanalysis to keep patients from discharging affects that should be available in the therapeutic setting, in C.M.T., additionally, the contract is necessary to prevent patients from acting-out within the therapeutic setting, even under extremely provocative conditions.

Optimal Conditions for Working Within the Negative Transference

With the previous discussion in mind, it might be easier to consider the optimal conditions for working within the negative transference around the following five topics:

1. A direct face-to-face encounter.
2. Alternating individual and group psychotherapy sessions.

3. More than a single therapist involved with each patient.
4. Split and multiple transferences
5. The use of provocative and evocative techniques.

1. Although the classical psychoanalytic position of lying on the couch as other well-known origins, it had been stated that it does resemble the physical condition of the infant in a crib, and it might be evocative of early genetic material and help with planned regression. This rarely happens in practice, and in a few reported cases in borderline patients, it was a warning that ego fragmentation was not far behind. More typically, unable to gage themselves by their facial and other reactions of the analysts sitting behind them, patients further associate and the lack of visual input increases the relative importance of the patients fantasies over his real relationship to the therapist. Sadness hurt and yearning are more easily felt under these circumstances rather than rage. To the extent anger is experienced, it is more commonly a feeling that is talked about and reported, rather than experienced with full intensity in the here and now. It is physically and psychologically almost impossible to explode with rage at a target that is not visible, and even very young infants are most convincing in their expression of preverbal rage before they become aware of the existence of externality. Later on in their development, once they realize that they have the ability to summon another person to care for them, their indignant demands soon often contain elements of whimpering and self-pity when no one shows up, and before they find their thumb or another transitional object to give them solace. Similarly, the empty-chair technique of gestalt therapy or the regressive techniques used in the various screaming therapies offer the patient no aim to direct their rage against. As indicated earlier, strong feelings can nonetheless occasionally be elicited with these latter techniques, which could be very useful if cognitive working-through would follow.

The direct I-thou encounter that Martin _____ wrote about extensively allowed even the simplest of Jews such as Tavia, the milkman of Fidler on the Roof, to speak to God directly, almost as an equal. God was no longer an omnipresent power enveloped in glory and grandeur and reached through a hierarchy of intermediaries but instead he was a very real and human-like presence to whom one can complain and with whom one can rejoice and celebrate with. Rather than humble God, such a relationship raised an enobled man, who has now assumed God-like qualities. In similar fashion, the eyeball-to-eyeball encounter between patient and therapist places the patient physically in a more powerful and more equal position, and it legitimizes the right to demand, even if such demands are not to be gratified. Rather than talk about anger, patients can actually be angry and moreover they have opportunities to express such anger directly at another person without inhibition. Such self-assertive acts serve as corrective emotional experiences for they are in sharp contrast to what was possible or permissible in infancy when the repression was set in.

2. When patients are seen regularly both individually and in group settings several clear advantages accrue to them. As I have described more fully in a separate discussion (Bar-Levav, 1978), patients in properly conducted psychotherapy groups directly witness difficult struggles of others with frightening powers within them, and they can usually judge without difficulty whether provocative and evocative techniques used by therapists to elicit rage are in fact abusive as the involved patient often experiences it, or whether they are helpful in bringing up material that would otherwise not be available for working-through. Repeated exposures to such situations allows patients to experience the group as a safe framework in which they too may sometimes reluctantly take frightening risks that they would not do in another setting. Alternating such frightening and difficult experiences with individual psychotherapy sessions that are conducted more along traditional lines makes it possible to clarify and work through some of the more disturbing experiences of the group, thus helping to cement the

therapeutic alliance between the therapist and the patient's observing ego on a regular and repeated basis.

3. In the C.M.T. model, more than a single therapist is regularly participating in group psychotherapy sessions, although every patient works regularly and continuously with one therapist in individual sessions. It would obviously be economically unfeasible and psychologically intollerable for more than a single therapist to work with a patient individually so that the clear advantages of having more than a single therapist are limited to group therapy situations as described. Patients as well as therapists not familiar with the group therapy setting might at first find such a seemingly confusing situation as totally undesirable, and they would surely have a great deal of difficulty seeing its advantages. Yet, the very qualities that patients and psychotherapists with different backgrounds sometimes object to, namely the greater exposure and the increased fluidity in the psychotherapy setting are helpful in working with and in overcoming character resistances that are usually not amenable to psychotherapeutic interventions. All individuals, psychotherapist included, prefer the homeostatic state and are reluctant to move into strange and unknown areas that appear to be frightening. The orderliness and clear structure of the one-to-one-psychotherapeutic setting that is often comforting to psychotherapists and to patients is often responsible for the limits of psychotherapeutic progress.

4. In the group setting in which more than a single therapist is to be found multiple transferences usually exist, and the different therapists sometimes assume by design different positions vis-a-vis a patient in order to elicit different aspects of such transferences. Such transference splits make it possible for patients to experience one therapist as totally bad and unacceptable, experiencing the full range of intense anger, hatred and rage toward him without having to leave therapy since the therapeutic alliance with the other therapist and with other patients is in force. As shown elsewhere (Bar-Levav, 19 & Bar-Levav, 1977) such splitting of the transference parallels the early splitting in the psychic life

of every infant when mother was perceived as all-good or all-bad, depending on her availability at that moment. When patients have repeated opportunities to experience and express such primitive rage in the therapeutic setting and then they reflect on such experiences, such powerful affects eventually lose their gripping hold on them, a hold that is often crippling and severely limiting the very functioning of a person.

5. As already indicated earlier, with a viable therapeutic alliance in place a variety of provocative and evocative techniques are used to reproduce within the psychotherapeutic setting situations that might bring up very strong affects. Such techniques are not based on any role playing on the part of the therapists, but instead the real experiences of patients within the therapeutic setting are used. Once such technique, dredging for affect, is described elsewhere (Bar-Levav, 197) and some techniques are borrowed from other psychotherapeutic systems. Since patients are assumed to wish to maximize their comfort and to minimize their pain in C.M.T. as es elsewhere, verbal pressure with consent is applied to push patients beyond the point where they might go otherwise. One therapist may push the patient to continue working while the other may encourage him to resist such pressure, thus placing the responsibility for the patient's progress in therapy squarely upon his own shoulders. While each patient is deeply respected as an individual, their psychopathology is not.

The sum total of such provocative and evocative techniques often produce storms of rage directly at the therapist of an intensity that involves various physiologic parameters such as blood pressure, pulse rate and respiration. Such intense reactions are obviously out of proportion to whatever stimulation may have been present, and repeated clinical observations over time strongly suggest that in many instances storms of preverbal rage have been tapped in this fashion.

The Effect of the Real Relationship on the Transference

Regardless of any clinical or practical considerations, the real relationship between therapist and patient largely determines to what extent the negative

transference can be worked with. The personality characteristics of the therapist are almost completely overlooked in the so-called newer psychotherapies as a topic that deserves specific and careful attention. In psychoanalysis on the other hand the assumption is made that after completion of one's analytic training and after having undergone the rigors of a personal and training analysis the instrument of therapy, the therapist, has been perfected to the point that the real relationship will no longer interfere with the work that any patient needs to do for himself. The disturbing fact is, however, that not sufficient work within the negative transference occurs in any of the various psychotherapeutic approaches, including C.M.T., and that the personality of the therapist, the degree of his continued discomfort with hate, anger and rage are always the limiting factors that determine how far patients can go in the direction of working with their preverbal rage.

Because psychoanalysts generally undergo the longest and most difficult period of training among all psychotherapeutic approaches they are generally the ones who are least receptive to this type of reasoning. And yet, disappointing as it must be, here in a superficial examination of the issue strongly suggest the need for instituting major changes in the training and therapy of analysts that would make it easier for their patients to work within the negative transference. John Dorsey () describes in some detail his personal analysis with Sigmund Freud, and his description is basically similar to similar reports by others. No patient can go beyond the point where his own therapist or analyst dares to go, since all therapists send conscious and unconscious messages to their patients when the latter trespass the limits of the therapist's fear. Freud was not always kind and gentle in his professional dealings with colleagues in the Vienna Psychoanalytic Society and elsewhere, and he is reported to have been autocratic and impatient from time to time. But in his work with patients, he apparently came through as understanding, gentle and kind, and very much there with the patient. In addition, most of his analysants, like John Dorsey himself, came

came to a man whose reputation preceeded him, a man of real genius and a master from whom one learns and who one does not question very much except most obliquely. Surely, it is difficult even to imagine an eyeball-to-eyeball confrontation with the gentle Dr. Freud, towards whom one would express with full vehemence, frothing from the mouth, the full extent of one's preverbal rage. Personal experiences with Richard Sterba who was one of Freud's followers in Vienna and a member in his study circle, confirmed the same impression. Dr. Sterba always appeared as a deeply sensitive, humane individual, genuinely meaning well, _____, bright and inoffensive. In Freud's own case, such qualities obviously do not represent the whole picture, but such a view is not atypical to how psychoanalytic patients often see their analysts. The rigid structures of psychoanalytic training programs closely follow not only the content but also the style of the early analytic pioneers, and the long scrutiny of candidates encourages conformity to this model.

The importance of working within the negative transference is obviously lost in psychoanalytic theory. Greenson, for instance, cautions his readers not to ask patients too early about the meaning of rage expressions, which much have a 'chance to be expressed' when they are most intense. Even beginners know that premature interpretations should be avoided for they tend to increase the resistances and interfere with the formation of a transference neurosis. But, how intense is "most intense" and at what point are interpretations "premature"? The answers to these most important questions are obviously determined in subjected ways that reflect the tolerance of the psychoanalyst or psychotherapist at that point. Since no two individuals are ever likely to react in exactly the same fashion to the same stimulus, such seemingly objective and scientific statements can obviously not be independantly calibrated. Rather than answer the question they beg it. Even after the completion of training, and after personal therapy or personal analysis, patients will continue to be able to work within the negative

transference only to the point where their therapists or analysts is himself beginning to experience some anxiety. This is the point that is likely to be called "the point of greatest intensity", and here the analyst or therapist is likely to make an interpretation to ask the question. When a spontaneous expression of feelings is interrupted in such a fashion, the process stops and content analysis begins. Ideally this should happen at the point just before the patient's anxiety tolerance is exceeded, but in fact it unfortunately happens all too often when the therapist's anxiety tolerance is being approached. Training and personal therapy within the C.M.T. model is described earlier inevitably raises the anxiety tolerance of prospective therapists who are then more comfortable with working within the negative transference at higher levels of intensity.

Patients invariably get the message from their therapist as to how much anger, hatred and rage are to be tolerated. Such messages are consciously and unconsciously delivered as the following few examples will demonstrate:

1. A very disturbed young man, who is seemingly very scared of losing impulse control is seen for an initial interview by a sedate, respectable and very proper therapist to experience some discomfort during the interview. The patient is being told before the end of the session that obviously he is in need of continuing help, but that the therapist is unable

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But that the therapist is unable to continue seeing him in the future for personal reasons. The patient may need hospitalization, drugs, and regular appointments, all of which the therapist does not have to offer. A proper referral to another therapist is made.

COMMENT: The therapist has not hospitalized anyone in the last few years, and he does not prescribe drugs except most rarely. He really does not have much free time, but he could accept the patient who does not make as many demands on the therapist's skill and time as this one probably would, at least in the beginning. More importantly, the therapist is aware of his own discomfort in the presence of this young man, and his own integrity would not permit him to enter into any relationship that would require some conscious or unconscious collusion between therapist and patient as described earlier. The question whether the therapist is actually afraid of the patient and his impulsivity is not consciously addressed.

The patient who believes he is nearing the point of losing control of his tremendous rage experiences the encounter as a rejection and of the confirmation of his own dangerousness. His panic is increased and he is grateful for being seen by a less competent therapist who drugs him heavily. This need to be drugged also confirms to the patient the fact that he is dangerous to himself and to others, since two physicians have found it necessary to stay away from him except when he is in chemical restraints. The impact of these experiences have the affect of increasing his anxiety and lowering the anxiety threshold and tolerance. He is constantly worried about the storms that rage within him, continuous dependence on drugs and exerts marginally. He delays for several years any attempts to work with what afflicts him, proceeds very carefully and slowly, not believing than anyone would be willing to tolerate his explosions without rejecting him.

2. A 17-year-old teenager is finally able to overcome his timidity which was always interpreted as life-long shyness and his increasingly complaining to his relatively inexperienced therapist about his shortcomings. Theoretically understanding the importance of the patient's behavior the therapist reports that development in supervision with obvious satisfaction. In one of the next few session, apparently, when the therapist's own anxiety threshold was being approached, he asks the patient, "Why are you so angry at me?" Soon thereafter the patient misses sessions and is increasingly interested in leaving therapy.

Comments: Recognizing only partially his own anxiety, the therapist believed that the question was well-timed and aimed at helping the patient connect his rage with its genetic origins. He did not hear the slight annoyance that crept into his voice and the fact that he emphasized the word "me" in a way that almost suggested that the patient should get angry at "them".

The relatively unsophisticated, young patient, nevertheless, understood his angry expressions were as unsafe in the therapeutic context as they might have been in his original family, seriously threatened the therapeutic alliance and the continuation of therapy altogether.

3. The same young patient, later on in this therapy, is standing in front of his therapist, white with rage, and refuses to talk. But, if looks could kill, the therapist's survival would have been in danger. Finally after a few minutes, such an intense, if silent, confrontation the therapist asked the patient, "are you so angry at me?" The patient continues to remain silent in an obvious attempt to save face, but within a few minutes he speaks with a great deal of hurt about a painful life experience that had happened to him several years prior to that time.

Comments; Although the words of the question were exactly the same as those in example #2, the different emphasis conveyed a totally different meaning. There was no annoyance, no complaint in the therapist's voice, but instead, obvious concern positive regard and acceptance of the patient and of his anger. It was as if the

therapist was speaking for and giving a voice to the observing part of the patient, as if the patient himself was asking "why indeed was he so angry at the therapist". Having asked the question of himself, the patient was able to proceed beyond it and engage in the important work he was doing with himself.

A crude attempt to illustrate these points graphically is shown on the next page. The fear of losing control of anger, hatred and rage leading to aggressive actions cripple all human beings to functioning well below the perceived limits of danger. These subjective projections of anxiety tolerance and of anxiety thresholds are changeable by psychotherapeutic interventions. The real relationship between therapist and patient determines the limits of the transference projection upon the therapist of material that is perceived by either as being dangerous. When the therapist's own fear of regression is greater than that of the patient, or when the patient perceives it as being so, it will tend to lower the perceived tolerance level and increase the patient's disability. If the healthy part of the patient's ego is strong enough they would leave the therapist and seek another, but this obviously is a frightening and time consuming process at best. When the therapist's own fears do not interfere with a patient's needs to work within the negative transference with rage and hatred at high levels of intensity, these experiences prove to the patient that such strong affects do not necessarily have to lead to dangerous actions, and they raise the perceived anxiety tolerance and anxiety levels over time.

The evaluation of patient's impulse control is taught in psychiatric residency programs and in other training programs for psychotherapists as if such determinations are dependent on clues that are given to therapists by patients. In reality such determinations of patient's impulse controls depend to a larger extent on the therapist's own fears of their own unresolved preverbal rage and hate, for this always interferes with what can objectively be seen. Such distortions in the vision of therapists as they view and evaluate their patients must first be recognized and then be corrected with fear-free areas in patients' lives are to be expanded.

CONCLUSION

The following chart attempts to summarize how four different parameters that are important in working within the negative transference rate in five different psychotherapeutic approaches. The screaming, feeling and direct body approaches to psychotherapy that were developed largely as a reaction to the over-intellectualized approach to psychoanalysis generally lack an appreciation for the importance of long-term working-through of feelings that are successfully elicited. Psychoanalysis, on the other hand, must examine some of its basic premises, as indicated, if working within the negative transference is to be facilitated.

Full expression of raw feelings (physiologic parameters)	-	-+	-+	+	+
Eyeball to Eyeball (I-thou)	-	+	-	-	-
Transference Split (group, multiple therapists)	-	+	-+	-+	-
Long-term working-through. (Unconscious resistances)	+	+	-	-	-

PSYCHOANALYSIS

CRISIS MOBILIZATION THERAPY (C.M.T.)

GESTALT

BIOENERGETIC AND Direct body

SCREAM & feeling Therapies