THE TREATMENT OF PREVERBAL HUNGER
AND RAGE IN A GROUP

By

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THE THERAPIST AND THE individual members in an intensive psychotherapy group are experienced in a variety of changing perceptions by each patient. This series of internalized images reflects changing phases of the transference as well as changes in the other persons as real objects. Similar transformations also occur in relation to each patient's perception of the group-as-a-whole. Here, too, the changes in perception reflect not only changes in transference projections but also the real changes that occur in the group as a unit as old patients leave and new members join.

The concept of the "mother-group" was reviewed by Scheidlinger (1974) who found increasing awareness of the perception of the group by its members as a symbolic maternal figure. Scheidlinger hypothesizes that an individual's identification with the group-as-a-whole represents an unconscious wish to restore an earlier state of unconflicted union with mother, a return to a "need-gratifying relationship," which is postulated as occurring between the third and the eighteenth month of a child's life. Gibbard and Hartman (1973) reported that splitting the group transference into "good" and "bad" mother images sometimes occurs spontaneously to facilitate continued repression of "the more frightening, enveloping or destructive aspects of the group-as-mother," thus holding in check forbidden oedipal feelings of a libidinal or aggressive nature.

These and similar studies enlarge our understanding of what happens to individuals in the course of psychotherapy in a group setting. Yet further refinements of such understanding are needed.

Since the personal history of each individual patient is entirely different from that of any other, it is quite likely that in addition to the more generalized reactions described, both diagnostic and therapeutic benefits may be derived from better understanding *individually* determined vicissitudes in the perception of the group-as-a-whole, which also change over time. This was recognized in principle by Durkin (1964), but it has not been considered in detail and its import has yet to be appreciated. Whenever the character of the group is not intentionally or unintentionally manipulated by its leader or therapist, individuals are likely to experience the group-as-a-whole in a manner that in general parallels modes of reacting to the real mother of childhood. Such perceptions of the group by individual patients can be changed in both a "positive" or a "negative" direction, as well as intensified or attenuated, depending on the degree of deprivation or gratification of infantile needs. The underlying psychotherapeutic philosophy and the design of specific psychotherapeutic tactics determine how the group-as-a-whole is perceived by any one patient at any one moment even more than do the transference distortions that reflect the quality of the original relationship with mother.

Grotjahn (1972) suggested, for instance, that "as a general rule, the group is a truly good and strong mother, not only in fantasies of transference but also in the reality of the group process." Slater (1966), on the other hand, while describing the group-as-a-whole as "a source of succorance and comfort, even a refuge," also recognized that at other times this mother image was "a frightening one . . . of being swallowed and enveloped." The nonpatient components that contribute to the formation of such perceptions, especially the personality and the philosophy of the therapist who plays a major role in shaping such perceptions, have generally been overlooked.

Scheidlinger (1974) understandably wonders why most psychotherapy groups are experienced in the same way as good and supportive mothers would be experienced. Attention is thus drawn to an often unrecognized bias that is introduced into the group psychotherapy setting by the therapist, and which determines the degree of gratification or deprivation of infantile dependency and other needs of patients. Individual perceptions of the group as a nourishing or

non-nourishing mother are largely the result of such a bias. Individual patients still act in different and sometimes in opposite ways to the same bias, depending on their personal histories, but the therapist's bias in itself is a manipulation of the therapeutic relationship and affects the nature of each patient's transference. Different aspects of the transference are highlighted and brought into focus when the therapeutic relationship is manipulated, as it always is to some degree. Such general unconscious and unintentional manipulations of the transference occur no less in individual therapy and even in classical psychoanalysis, for even in the face of complete clinical-analytic neutrality, the personality of the therapist and his typical modes of being greatly affect the nature of the transference at any one point.

Crisis Mobilization Therapy, C.M.T. (entirely unrelated in any way to Crisis Intervention), is a recently developed system of psychotherapy in which conscious and deliberate manipulations of the therapeutic relationship, and therefore of the transference, occur. Such manipulations, as well as various other provocative techniques, are designed to mobilize affective crises within the therapeutic setting which are repeatedly resolved, until feelings associated with such crises lose their grip on the patient. Crisis Mobilization Therapy cannot be discussed fully in this paper, but selected aspects that relate to the topic will be dealt with here.

An intense involvement in therapy by both patients and therapists is basic to C.M.T., as is the old principle of non-acting-out and non-acting-in. Patients must thoroughly understand, as part of the therapeutic contract, that feelings of whatever intensity do not in themselves justify any action at any time and under any circumstances, and that contemplated action must always first be mediated and coolly evaluated by the patient's cognitive process. With this principle firmly established, patients are helped to experience the full range of emotions at the highest tolerable level of intensity. Resistance to experiencing such intense feelings, some of which are very painful, frightening or embarassing, naturally follows. Patients often understandably perceive such affects as actual threats to their very lives and to their integrity

When physical comforting and even verbal solace and advice are discouraged in a group setting, as they often are in C.M.T., anxiety

rises and the "good and strong mother" qualities of the group that Grotjahn (1972) describes do not materialize. The group is, instead, often experienced as a cold, distant, non-nurturing, and sometimes nonprotective mother. Patients' reactions to such a "bad" mother matrix depend to a large extent on the nature of the incorporated mother image that they bring with them to therapy. They may react with fear, helplessness, confusion or rage, which are then analyzed and worked with. The greater the resemblance of the "real" or incorporated mother to the "mother-group," the faster the transference neurosis develops and the more directly can internalized conflicts be reached and worked with. Patients who experience their "real" mother in basically different ways than they do the group matrix may not immediately be uncomfortable in a basically non-gratifying group, for they often find solace and security by mere association with other human beings in a common effort of great importance.

To facilitate working-through of different aspects of the internalized conflict the therapeutic setting must not be allowed to become uniform in nature. A more supportive, "good" mother matrix is sometimes also provided by the therapist's being less challenging and less provocative and by offering more solace and support. Themes of loss and separation are common in such sessions, surfacing spontaneously or raised intentionally. Active efforts by the therapist are usually required to overcome resistance to the experiencing of sadness, tenderness, or loving feelings with sufficient intensity.

Patients with diffuse ego boundaries, borderline or schizophrenic, cannot usually acknowledge or work through dependency needs and yearnings until after they have openly experienced with full intensity their internalized rage, against the eruption of which they may have developed their entire pathology. Such threatening repressed rage is never expressed or experienced spontaneously as long as the defensive structure of the patient is reasonably stable, and it must be mobilized by provocative techniques that may include silence, sarcasm, exaggeration, and even ridicule of pathological character traits. This is a delicate, dangerous, and prolonged task in itself, but only after it is well under way can such patients hesitatingly begin to experiment with trusting-loving

relationships. The splitting of the transference between the group-as-a-whole and the therapist proves most useful in this context.

Three major fears are often felt by patients in basically nongratifying and noncomforting groups that are experienced as "bad" mothers:

1. Fear of erupting rage.
2. Fear of being swallowed or engulfed, damaged or mutilated.
3. Fear of starvation and abandonment.

As patients are helped to work through such fears, slow but gradual relief occurs. When patients begin to know that rage need not be destructive, either to themselves or to others, they feel less frightened, less compulsive, less rigid, less phobic, less depressed, and more spontaneously free. Similarly, as fear of being swallowed or engulfed, damaged or mutilated is slowly found to be based not on a present reality, its dimensions shrink and patients become more assertive, less aggressive and less combative, more reasonable and less bigoted, more flexible and more humane. These are expected concomitants of more sharply delineating ego boundaries. None of these statements is meant to imply that such highly desirable results are easily or quickly achieved. On the contrary, the sailing is never smooth or continuous, but always rocky, prolonged, discouraging at times, and most tedious. Even the results cannot be guaranteed.

The third fear, that of starvation and abandonment, is different from the previous two in that no relief occurs as it is being worked with; instead, patients go through a continuous series of most painful experiences. Working-through and resolving this fear is probably the one most difficult task of psychotherapy. As Mahler (1975) recognizes, individuation cannot occur without resolution of the process of separation. She points out that "in the normal course of developmental events, real physical separations (routine or otherwise) from mother are important contributors to the child's sense of being a separate person, but it is the sense of being a separate individual, not the fact of being physically separated from someone, that needs to be achieved." The many incomplete "cures" and questionable results of psychotherapy in general can probably be attributed mostly to a failure in this part of the task. The fear of starvation and abandonment stands like a formidable rock at the

entrance to a harbor where the water is peaceful and serene, and many psychotherapeutic voyages have tragically ended on it.

Therapists usually tend to avoid this dangerous area altogether, knowing the difficulties and sensing that it may endanger the continuation of their work. Patients also understandably resist entering this painful area, for it seems that the struggle there is endless, hopeless, excruciatingly difficult and painful, with no final victory in sight. Yet, these dangerous waters cannot be avoided if one wishes to complete the trip successfully. Several special techniques are used in Crisis Mobilization Therapy to help the working-through of this basic fear.

One such technique, Dredging for Affect, involves the use of language in a basically different way than usual. In addition to using words for conveying meanings in interpersonal transactions and in free association, words are also used for the elicitation of strong affect. The patient repeats a short sentence judged by the therapist to be possibly helpful in reaching repressed feelings which are reasonably close to the surface. If the judgment and timing of the therapist are correct, such words soon lose their usual dictionary meaning and a storm of feelings comes forth. The words assume an esoteric meaning given them by the patient, based upon his or her emotional experiences of the past. Depending on the readiness of the patient and on the skill and intuition of the therapist in evaluating the therapeutic moment accurately, such an exercise of verbal repetition often helps the patient experience *specific*, previously repressed, emotions with a great deal of affective intensity. These emotions can then be worked with cognitively. Clinical observation has repeatedly shown that true personality change requires the undergoing of psychological experiences with enough emotional intensity to involve and change previously established physiologic patterns. As explained in greater detail elsewhere (Bar-Levav, 1976) more is needed than merely increasing the scope of conscious understanding.

Patients frequently do not cognitively know why they experience such storms of affect. It is yet unclear whether, and to what extent, it is necessary for an individual to possess such cognitive knowledge each time preverbal pain, rage, or fear are worked with. Biofeedback and hypnosis studies as well as the scream therapies

suggest that physiologic parameters mediated by the autonomic nervous system are changeable in the adult, as they are in infancy, without cognitive involvement. But C. M.T. aims at changing such parameters in response to symbolic representations of reality and psychological stimuli, and cognition is considered, therefore, to be an essential ingredient.

Lowen (1975) and others have clearly demonstrated that affects which have become physiologically bound in the tissues of the body before the development of language and symbolic thinking must first be converted into "free" feelings before any attempt to modify them is made. Only after the emotional storm has blown over and the gestalt has been completed, does the intellectual task of integration begin. Such integration can sometimes be dispensed with in advanced phases of therapy, as patients usually possess by then the necessary tools to perform this task unassisted.

The affect that is reached and that becomes available for working-through as a result of Dredging for Affect is by far more specific than that reached by the scream therapies or by bioenergetic and other direct manipulations of the body. Its very specificity gives it unique qualities that allow for focusing on a sharply delineated segment of the internalized conflict. This, in turn, allows for the intensification of feelings all the way to tolerable limits, just before anxiety takes over and overwhelms the patient.

Poorly timed or premature sentences offered to patients as aids in their effort to dredge for affect are usually rejected or fail to produce effective results. This is akin to the fate of premature interpretations in psychoanalysis, which are of little use. But in this case they do no harm, for the powerful and provocative techniques of C.M.T. can usually overcome any temporary increase in the resistance and the tendency to repress.

The mere existence of the group at times of mobilized affect provides a benign matrix for the experiencing of storms of feelings since the willingness of members to participate in such an undertaking is obviously voluntary and therefore an expression of support. The patient usually experiences the group-as-a-whole at such times as being, at least passively, "with him" and for him, although such perception of the group as a "good" mother may only be of a transient nature if the patient's basic transference needs of the moment

are different. The active manipulation of the therapeutic relationship in C.M.T. allows for rapid transitions in the transference in close succession.

Patients in all psychotherapeutic modalities eventually learn to use the specific language and idiom of their own therapists and therapy. Such idiom is frequently used in the service of resistance, and is a very effective resistance indeed since the patient usually appears to be cooperating in the therapeutic task when in fact he is not. This type of resistance, resembling in some ways the usual forms of intellectualization, is essentially imitative in nature, and although it is becoming increasingly common, it frequently goes unrecognized. This resistance is often found among patients of the newer modalities of psychotherapy, such as Encounter, T. A., and Gestalt, but it is also present in the more conventional modalities and in psychoanalysis. Patients mouth the language of their therapeutic milieu, sometimes in an almost flippant and self-assured way, without real emotional involvement. "Experienced" patients learn to say what their therapist expects to hear, in order to minimize their pain and hurt. Such intellectual self-deception is generally not fully conscious, but it can be fully successful in prolonging and diluting the therapeutic effort if overlooked by the therapist.

A technique that strips language of its content value clearly obviates the effectiveness of such a resistance. A recent patient in Crisis Mobilization Therapy who had been in therapy for many years, including ten years in two separate psychoanalytic experiences, and who had also worked with Eric Berne, Virginia Satir, Carl Rogers, and others, serves as a good example. The patient, himself a professional in the field, tended to isolate his feelings consistently and with success, for he feared both his great dependency and the erupting and threatening rage. Being bright, he was adept in the use of all psychotherapeutic idioms, but was bewildered and frightened as none of these proved useful to him in C.M.T.

The patient sat silently in the group on one occasion, listening intently as another person was working, his face reflecting very deep hurt, sorrow, and sadness. When called upon, he agreed to repeat the sentence, "I am a very lonely man; please see me." He walked slowly from person to person, making deliberate eye contact with each. His usual flippant cleverness and dodging remarks, which he

used to defuse affect-laden situations, were useless under the new circumstances. His voice deepened, his furrows became more prominent and his speech slower as he struggled to keep the impact of the oft-repeated statement from breaking through his elegant and well-tended defenses. As the threshold of his anxiety was reached and exceeded, a faint smile appeared on his face. The exercise was terminated for the moment, to be continued on a future occasion. He was able and willing, however, to examine his mounting anxiety, a fact that would allow him to go beyond this point next time.

The threshold of anxiety and the anxiety tolerance of patients are not accepted as fixed limits in C.M.T.; instead, they are consciously and deliberately worked with, with the aim of raising the threshold and increasing the tolerance over time. Character defenses must be recognized as such and repeatedly tackled in order for such anxiety tolerances and thresholds to be modified.

Crisis Mobilization Therapy requires the existence of a very strong and viable therapeutic alliance between the therapist and the healthy part of the patient's ego. Compensated schizophrenia without psychosis and the various borderline states are conditions in which certain ego functions are either underdeveloped, stunted, or missing while others are intact. Defective regions of the ego are avoided by patients who experience panic as they get close to situations which require their intact presence, and entire life styles are constructed to ward off involvement in such frightening situations. C.M. T. aims at repairing such ego defects, not just at shifting the ego's defenses. Patients are placed in therapeutic settings that enable defective areas in the patient's ego to be repeatedly stimulated, thus bringing about selective development and strengthening of such defective ego functions.

Since ego function differentiation occurs very early in life, it follows that if attempts to repair ego defects are to offer any promise of success, it is necessary to repeatedly reach and modify preverbal affects that have become fixed before the formation of conscious memory or language. No real cure is achievable unless and until patients have a chance to re-experience emotionally such early phases of their development in order to resolve separation reactions and individuation failures. The repeated experience of "loving" and "stroking" to provide an adult patient with "corrective emotional

experiences," so commonly in use in the newer modalities of psycho-
therapy, obviously has no relevance to basic repair of the ego.
Psychoanalytic theory, on the other hand, correctly understands the
nature of the required work but its verbal and highly intellectual-
ized nature, the nonmanipulation of the transference, and the non-
intrusiveness of the analyst, who in the attempt to remain neutral
often remains anonymous, all make for a relatively tenuous thera-
peutic alliance. In this setting, deprivation of infantile needs leads
to subclinical depression, not to rage. The experience with a non-
giving, although benign, "mother" often results in frustration and
bitterness but not in true resolution.

The treatment of the unsatisfied hunger for good mothering is a
special concern of C.M.T., and the techniques developed for this
purpose are somewhat special. The yearning for the erstwhile
mother is expressed by patients as a wish to be given "more" in a
variety of forms. Patients ask questions, wish direction or advice,
make themselves confused or stupid, develop psychosomatic symp-
toms, and in general appear helpless and therefore in need of help.
This multifaceted yearning for help and the desperate desire to be
given to and to be taken care of are openly recognized in C.M.T. as
legitimate but are repeatedly frustrated, except when the requests
for help represent adult needs. These are gratified when possible.

Biologic hunger of the infant, expressed in adulthood as a mul-
titude of demands for gratification of oral and other drives, cannot
be directly satisfied no matter how hard we try. All such efforts are
always doomed to failure. But by steadfastly and repeatedly frustra-
ting such demands, *in a setting that holds clear and close promise of
gratifying adult needs*, such demands are turned first into dissatis-
faction and eventually into rage. This rage in its myriad forms is
treatable. The longing for reunion with an erstwhile symbiotic
mother can thus indirectly be resolved, and both separation and in-
dividuation more completely achieved.

Borderline and compensated schizophrenic patients, or those
with moderately severe character disorders, frequently have his-
tories of an original mother-child relationship characterized by pa-
rasitic and engulfing symbioses. The fear of re-engulfment in such
anxious and hungry individuals presents serious difficulties in the
formation of stable therapeutic alliances. If the original trauma was

not so extensive as to interfere with the ability to form lasting relationships altogether, these patients are treatable by psychotherapy, with the aid of various parameters, as discussed by Kernberg (1974) and others. The splitting of the transference between the therapist and the group-as-a-whole, both of whom represent different and rapidly interchanging aspects of mother, is one ideal parameter of this type.

Mahler (1975) defines the ego defense mechanism called "splitting" as one found in the rapprochement subphase of separation-individuation, which lasts from approximately fourteen to fifteen months of age to about twenty-four months. "The toddler cannot easily tolerate simultaneous love and hate feelings towards the same person," the rediscovered mother who is now a separate individual. "Love and hate are not amalgamated; mother is experienced alternately as all good or all bad."

Since patients in C.M.T. are seen regularly both individually and in groups, the transference can frequently be manipulated so that the group-as-a-whole is experienced as a "bad," non-nurturing mother, while the therapist is experienced as potentially overflowing and capable of providing much solace if he or she only chose to do so. Patients commonly experience in the group setting tremendous frustration as they are forced to compete for the "good" mother-therapist with all the "others" in the group. Such a useful crisis is completely avoided when patients are seen in individual sessions only, where even a completely silent and depriving therapist is at least physically present in the same room, exclusively for the patient and with the patient. The presence of an *active* therapist in C.M.T. groups, who is often helpful to "others" but may be experienced as ignoring or not addressing himself to a particular patient, conjures up extremely potent feelings of hurt, love, and rage.

As infants do when they go through the rapprochement crisis, so do many patients become acutely aware of their inability to control the potentially "good" therapist-mother. The remaining, unresolved aspects of the infant's omnipotence in the adult patient are severely threatened, just as they normally are during the real rapprochement crisis in infancy. Like the infant, so also patients in C.M.T. groups make repeated and desperate attempts to coerce the environment. Temper tantrums, whining, sad moods, and intense

separation reactions are experienced by adult patients in the same way and for the same reasons that they are experienced by toddlers. Such reactions can finally be experienced in a safe environment where the "good" therapist-mother keeps optimal distance, being available when needed but not otherwise. Such conditions were usually absent during the infancy of most patients. The mobilized rage is eventually turned against the therapist, either spontaneously or through the manipulation of the therapeutic relationship, and he assumes a "bad" mother role. The group-as-a-whole may or may not change in the perceptions of any one patient simultaneously with the changed perception of the therapist. As the rapprochement phase is passed, love and hate can dwell more comfortably together. The observing ego is usually capable of keeping the patient in therapy even as hate predominates, although not without repeated and active effort on the part of a skilled therapist.

On other occasions, the group-as-a-whole is helpful to patients as they so desperately attempt to satisfy their hunger for good mothering. Near the end of a recent twenty-eight-hour marathon session, a very tired and hurting patient who had been in therapy for several years and who felt overlooked and ungiven-to during the marathon stood up, walked from patient to patient slowly, establishing eye contact and holding it for a moment. "Good morning, John; I am Seymour." "Good morning, Ruth; I am Seymour." "Good morning, Dave; I am Seymour." "Good morning, Adele; I am Seymour," and so on. Tears began running down his checks as he proclaimed his existence over and over again, in a low but firm voice for all to hear and see. He was sobbing, shoulders shaking, as he continued his agonizing trip around the room, his tears running down his unshaven face. No one spoke to him, but no one refused to make eye contact with him, either. In the setting of the group, by now no longer either "bad" or "good" mother, he was able and willing to no longer ask others for anything but instead to supply his own needs.

As he finished going around, a trip that took some ten minutes but seemed forever, he straightened up, took a deep breath, was silent for a little while and then added, matter of factly: "Good morning, Seymour; I am Seymour."

"This is the first time in forty years," he added, "that I truly can say hello to myself."

The task was obviously not finished at that point; it was only finished for the moment. Working-through of preverbal hunger and rage is a tedious process that often seems endless. But it really has an end, and a happy end at that, when therapist and patient have the endurance, commitment and courage to see the task through.

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