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Original Contribution

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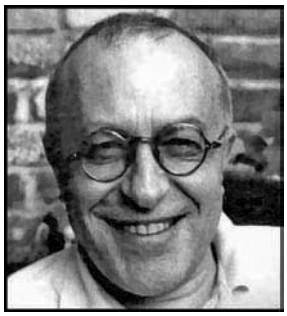

Editor's Note:
In the short article that follows, Dr. Hill describes a clinical course about which any of us might be quite proud, and from which report all of us can benefit. Yet I wish to call your attention to a deeper issue brought into focus by such cases. In the early days of psychoanalytic psychology, such rapid resolution of symptoms was the rule, rather than the exception. Many, if not most of Freud's case reports involved similarly brief interactions made possible by the clinician's ability to apply theory to practice. Such accounts made up a large fraction of the cases presented for many years in our journals and texts.

What happened next is typical of the history of the healing arts, for whenever a new technique is discovered, it is applied rapidly to a wide range of clinical conditions. Following the success seen in those early cases is always a period of failure as the treatment modality turns out not to be a panacea. The early experience of psychoanalytically-oriented therapy parallels precisely our later encounters with miracle drugs like penicillin, lithium, and cortisone. Human illness is occasionally simple and often complex; treatment is occasionally simple and often complex. I am old enough to have watched a succession of novel therapies carve their swaths through the waving fields of disease, bringing large harvests of healthy patients even though the borders of the swaths call to our attention the truth that patients with apparently identical illnesses often respond differently to treatment. It is from these failures that we begin to appreciate the subtle differences between those who got well and those who did not, and from which we develop ever-new therapies.

Psychoanalysis was made all the more urgently important by the limited success of suggestive therapies, yet it, too, shifted from pride and joy at its own rapid cures toward the darker matters of deeper illness. Resistance analysis, object relations theory, self psychology, and other modalities proved their own worth as techniques that made our approach both deeper and longer. As we learned more, we felt obliged to use these systems of depth therapy for fear that symptom relief might not afford the patient adequate change. Eventually, we therapists felt shame whenever we allowed a patient to leave treatment when any sign of psychopathology might remain visible. Supervisors and teachers of all sorts viewed with contempt any of our cases in which patients got well quickly, and all of us learned not to present such cases to those who held authority above us. Cognitive therapy worked swiftly and wonderfully when first introduced; now no training in this system of thought can be considered complete unless it offers new techniques for those who require long-term treatment. Unless the winds of change have blown away the almost inexorable shift toward long-term cognitive therapy, I suspect this field, too, will follow the lead of the psychoanalytic movement its practitioners so often deride.

Only in this era of meticulous attention to the cost of therapy has the validity of brief therapy returned to vogue. What on earth can possibly be wrong with a treatment approach that applauds the patient's success, celebrates the desire to leave patient status whenever comfortable, and welcomes the patient back to work on the next issue when it becomes salient? In our era, as Dr. Hill points out, it is affect/script theory that can now provide clues for rapid resolution of illness. Dr. Hill's short communication about a highly successful brief therapeutic interaction becomes all the more important when viewed in terms of the history of our field. DLN

Survivor Rage

As the October 1996 SSTI colloquium on "The When, When Not, and How of Brief Psychotherapy" rushes upon all of us who will present at it, we think a lot about those cases in which things went both swiftly and well. One of the factors that predisposes to effective therapy is a solid understanding of the issues involved—in other words, it helps to know what you're doing. My own work with angry patients has been improved significantly by Don Nathanson's (1992) contribution of the compass of shame, which is helpful because it clarifies how rage, common at the *attack-other* point on the compass, can substitute for feelings of shame or humiliation. As a therapist, I have been surprised by the ease with which a patient can now be relieved of seemingly compulsive raging, as well as an apparent "identification with the aggressor." I don't often meet a patient as well prepared for the emotional work at hand as "Rhona," so without holding her up as a norm by which to measure others, I present the following encouraging story of short-term psychotherapy.

A colleague referred Rhona as an impossibly enraged woman who was making her husband's life a world of misery, and whose behavior threatened their marriage. She had tried therapy twice before, but to no avail. Could I help her? "I'm willing to try," I said, "but no guarantee. I first have to find out what is going on." Rhona wore a shame-faced expression when she entered my consultation room. "You know why I'm here?" she asked, "Did my husband's therapist tell you?" "He said your husband was having a problem with your expressions of rage," I replied, being careful not to shame her. "I don't know what comes over me," she said, "but it happens more and more frequently. I fly into a rage at my husband, and lately I have been doing it in front of the children, even though I realize this is terrible for them to see. But I can't stop myself."

Prior to having a family, Rhona and her husband had planned their life to accommodate children. "I did not want to stop working, so we agreed on how we would divide up the work in the household and take care of our children." Rhona is an intelligent and ambitious university administrator who enjoys her work and is also devoted to her family.

I asked why she had come back to therapy. "I hear you're an expert on rage and I am willing to put in the time to find an answer. Life has become impossible." I was glad to enjoy her confidence, notwithstanding its questionable basis, but was brought up short as she added "I know that psychotherapy can take years, and I am willing to stay in for the long haul because I am sure this is a deep-seated problem and I don't expect you to be able to solve it for me in a hurry." In an age of managed-care-driven short-term therapy, a practitioner can be forgiven a momentary lapse into countertransference—at last a patient who will guarantee me an hour for the foreseeable future! Training won out, and I managed to reply "you seem too relaxed with the prospect of years of useless therapy, especially after your recent experiences. Is it more important for you to keep this problem than to find a solution?" She laughed out loud "Yes! But I don't know why."

As I tell you about Rhona's therapy I am reminded how a therapist learns about the patient's present condition at the same time as learning about her past. It would take a verbatim transcript to convey the sense of this back-and-forth process of uncovering Rhona's current and historical scripts for shame and rage. Instead, all I can tell you is a short story about her ongoing script, and then a bit about its original version.

It did not take much sleuthing to pinpoint Rhona's pattern of behavior. The problem was that even though he professed to love her and the children, her husband was not living up to the terms of their agreement. If she reminded him of his share of their duties, it seemed to take him even longer to get around to them. Often the end of the week arrived and she would simply fill in for him so that the children would not have to suffer; when he did not do the laundry on time, they did not have clean clothes to wear. When she spoke to

her husband about this, he would insist that it was up to him to decide how and when he would fulfil his obligations. When she pointed out that he was not fulfilling them at all, he insisted that she was not allowing him to follow his own schedule, and that if she chose to take up his duties it was in no way his fault. Unable to penetrate his obfuscations, and lacking a clear enough perception of what she experienced as his passive provocation, Rhona would simply fly into a rage at him. This gave him ample reason to accuse her of being crazy, after which he would come home from therapy sessions supported fully by his therapist, who had been told goodness knows what.

By the end of the second session, Rhona had realized that she felt both betrayed by her husband and trapped in a situation that required of her more work than she had time or energy to undertake. In response to my request for the emotion accompanying this sense of being cheated, manipulated, and exploited, she said that she felt totally humiliated. Despite her pride at having negotiated a fair division of labor with her husband, he had nonetheless managed to trick her into the very thing she had wanted to avoid. On top of that, by becoming enraged at him, she provided him with an excuse to avoid further negotiation, for now *she* was defined as the problem—an irrational, enraged wife who was victimizing her poor husband and terrifying their kids. Once she had put all of this together, Rhona said to me "That's it! No more rage. I am going to talk to him! I am sure he doesn't know what he's doing." And to my surprise, after this second session she reported that they'd had a successful conversation and apologized to each other. The marital crisis was over.

I need to emphasize two points: The first is that Rhona had been terribly confused about this recurring interaction with her husband and that this confusion had made their interactions impenetrable to her. All she knew was that she flew into a blind rage whenever their household duties became an issue. This fluster was itself part of her shame experience—what Nathanson (1992) calls the "cognitive shock" associated with the physiology and psychology of shame affect—and it made her rage appear all the more out of control and so frightening to both of them that they labeled it "irrational."

My second point is that it would have been easy to assume that humiliation was an inevitable reaction to her husband's success in shirking his duties. But was it? I could imagine that she might have responded differently—and much more effectively—right from the start. After all, this is what had worked after the second session. Why was it that she could not allow for the possibility that he might respond well to an earlier appeal for fair play? Had I left this question unanswered, I might have kept the managed care operation thrilled with my performance—a 2-session cure! But it was exactly this question that opened up the nuclear script that if unattended would have left Rhona in its grip. So we were extravagant. It took us three more sessions to get to the bottom of her story.

There were two themes to the plot. The first was straightforward. At a very tender age, Rhona lost all her hair to alopecia. Since the family was too poor to afford her a wig, for several years she was forced to attend school with a cloth wrapped around her head. The first wig they bought was cheap and obvious; during her school years Rhona was ridiculed and shunned by her classmates, and she came to think of herself as a freak who was unworthy of friendship. Her parents believed it would be only fair to prepare her for life as a spinster by telling her that no man would want to marry her. Throughout her adolescence, Rhona was extremely shy around boys and did not date.

But what about the confident Rhona who appeared in my office? Where did she come from? When high school came to an end, she got so fed up with her situation that she realized she had to make a significant change or accept a life not worth living. She decided that the alopecia was genetic and therefore not her fault, and that people who rejected her on that account were not worth the trouble they caused. The choice seemed simple to her. Rhona decided to associate only with people who knew about her hair and could still enjoy being with her. She made a practice of lifting her wig and explaining her condition right off when she met someone she liked. She used their reaction as a new way of testing people. Soon she had a social life and a boy friend, and she married shortly after leaving college.

Now we knew that the humiliation of her childhood and adolescence accounted for one part of her sensitivity to shame. But this still did not explain why she had begun to react with rage to her husband when, for all these years, she had coped with humiliation by withdrawal or direct confrontation. And this is how we came to the final question that was to engage us.

Rhona's discomfort became acute. At times she could hardly speak. She reported that her parents had fought bitterly. Her father was verbally abusive to her mother, who showed no visible reaction. Rhona could not bear her mother's passivity, and began to challenge her father as soon as she was old enough to muster an argument. As she became angry at him on her mother's behalf, his rage would subside. "But I could never understand him," she said, "because he loved my mother so much. They were inseparable. And she adored him."

As happens so often in therapy, Rhona's understanding came to mind as soon as she lamented the lack of it. Both parents were Holocaust survivors who had endured unspeakable suffering and humiliation at the hands of the Nazis. When her father dealt with the outside world, he would cower rather than confront anybody; this was how he had survived the camps, and this had become his adaptation to the world. At home, where he felt safe, he imagined all kinds of insults and would fly into a rage. Her mother apparently understood the basis of this script and accepted his conduct. But this was the first time Rhona had understood her late father's tirades. Now she knew where she had learned her own *attack-other* defense, and could empathize with her father. This allowed her to complete her mourning for him because she understood the correspondence between his trauma and her own more minor version of it. By the end of her fifth session, Rhona announced "I think we have accomplished what I came here for. Now what am I going to do with all those years I was going to spend in therapy?" We both had a good laugh.

In psychoanalytic terms, I might have been concerned with Rhona's transference of her father onto her husband, and with her struggle against a feminine identification with her mother. I suspect that would have kept both of us busy for a number of years on a fascinating wild goose chase. By following the basic principle of affect theory—that the clues come from the affect—we were able to tap into her motivation immediately, to clarify what she had missed in her marriage, and to resolve the marital conflict. In the end, she became clear about her father's *attack-other* behavior, and could see beyond it to the vicious environment that had threatened his life and in the context of which the defense had been formed. Near the end of our last session Rhona said "Now I feel free to let my mother know how much I love her."

References:

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