

## **Unlocking the Unconscious: Collected Papers of Habib Davanloo (1990)**

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merely *very little* but *no* working through takes place—nothing is drained from the reservoir. If this were true the therapist could go on making interpretations and receiving responses indefinitely, without any appreciable therapeutic effects whatsoever. In that way therapy becomes endless.

It follows from this that the patient can use *response to interpretation as resistance*. He keeps the therapist happy by giving the impression that his problems are being worked through, whereas in fact nothing of the kind is taking place at all.

The mistake the therapist is making is not to realize that he is operating below the threshold at which true working through takes place, and therefore to work with the component of *response* to his interpretations, or the component of communication—which indeed is present—rather than the component of *resistance*. Only when he systematically works with the resistance and eventually brings the patient to a point above the threshold, where there is sufficient true experience of the underlying feelings, can genuine therapy begin.

Moreover, it appears from Davanloo's work that merely *interpreting* resistance is not enough. On the contrary, first the resistance has to be systematically *challenged*, and then the consequent transference feelings have to be brought into the open and truly experienced. Only by this means can most patients be brought above the threshold where interpretation becomes therapeutically effective. It is these twin interventions that constitute the core of Davanloo's technique and his most important and most original contributions.

These early phases usually need to be followed, as in the above interview, by a phase in which the residual resistance is systematically dissolved by interpretation, including many links with other relationships in the patient's life. When this has been done an immensely important consequence follows, which is an observed fact but which traditional therapists may have difficulty in believing. This is that the reservoir does not contain a huge volume of pathogenic conflict which has to be drained drop by drop over a long period. Nor is it under such pressure that weakening the defenses causes it to erupt in uncontrollable explosions of affect such as occur in many encounter groups. On the contrary, it can often be drained quickly and relatively smoothly, with quiet yet intense experience, each component being dealt with once for all. The final result is total resolution—the reservoir is left permanently empty.

Perhaps we may end with two statements that sum up one of the main points in the above argument: "The most devastating and pernicious form of resistance is response to interpretation;" and "The greatest mistake a therapist can make is not to recognize when response to interpretation is being used as resistance."

## References

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# Intensive Short-Term Psychotherapy with Highly Resistant Patients. I. Handling Resistance\*

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This is the first of a series of articles describing a powerful technique of short-term dynamic psychotherapy. The essential initial stages are: (1) challenging the resistance, which appears in the form of a series of defenses, (2) bringing into the open the consequent intense transference feelings and enabling the patient to experience them, and (3) showing the patient the parallel with similar patterns in other relationships, both current and past. This leads to a final stage in which there is direct access to the unconscious and it is possible to expose the core neurosis. Some aspects of the technique are illustrated by the early stages of an initial evaluation interview. The remainder of the interview will be described in later articles.

## Introduction

One of the main aims of all forms of dynamic psychotherapy is to enable the patient to experience his true feelings, but this can only be accomplished by overcoming resistance. The phenomenon of resistance is almost universal and indeed was present in the earliest cases treated by Breuer and Freud between 1880 and 1900. As we now realize, it is the inevitable consequence of the basic mechanism underlying neuroses, namely the repression of feelings because they are painful or unacceptable. As a result, the patient puts every obstacle in the way of having these feelings brought to the surface. Resistance is a very powerful force, and the therapist's problem is concerned with the forces that he can mobilize against it. Breuer's solution, later adopted by Freud, was to use the force of hypnotic suggestion. When Freud found this unsatisfactory, largely because many patients could not be hypnotized, he replaced it by suggestion in the waking state. But this method too he found unreliable and exhausting, and it was here that he took what proved to be a fateful step.

It has to be remembered that the forces supporting resistance are not the only ones operating in the therapeutic situation. On the other side are the repressed feelings and memories struggling for expression, which are, so to speak, the therapist's allies. Freud came to realize that if the patient was simply asked to say whatever came into his mind, these feelings and memories returned in a disguised form and with some help could be brought into consciousness. This led, by steady develop-

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ment, to the fundamental rule of free association and the psychoanalytic technique used today. Here the therapist initially hands over control to the patient, and though he certainly does not cease to direct the session he does so in a far more subtle and unobtrusive way. He pays particular attention to trying to weaken resistances by interpretation, thus aiming to allow repressed material to enter consciousness.

What Freud could not possibly have foreseen were the complications to which this increasingly passive technique would lead. Some of these are the transference neurosis, regression, dependence on the therapist, endless over-determination, and "analysis interminable."

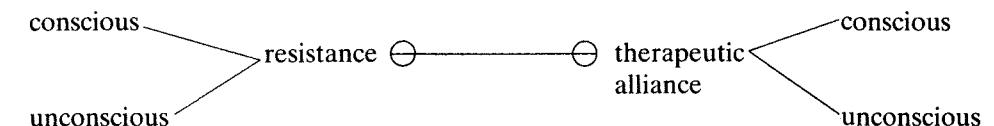
Almost all attempts to reverse this trend and develop an effective technique of short-term psychotherapy have been based on taking back some of the control and putting more of the motive power into the hands of the therapist. Instead of following wherever the patient's associations lead, he actively directs his attention towards a particular problem, making it into the "focus" of his therapy. Malan has pointed out that the word "focus" has come to be used, often quite independently, by a number of different writers on this subject. Malan also makes clear, however, that the ability to maintain a focus depends very largely on the careful selection of responsive and highly motivated patients with an underlying simplicity of psychodynamics. The same applies to the technique developed by Sifneos. The result is that such techniques are applicable to only a small segment of the patient population. The fact remains that the bulk of patients suffer from longstanding, complex psychoneurotic disorders and character neuroses and are neither well motivated nor responsive but poorly motivated and highly resistant. It is this problem that must be solved if short-term psychotherapy is going to have any impact on the psychotherapeutic services and the mental health of the community. Therefore it was this problem above all to which I addressed myself and to which I believe I eventually found a solution. The present article is the first of a series in which different aspects of this form of therapy will be described and discussed.

### Principles of the Technique

As a result of my own experience, I take an uncompromising stand on many issues which are still a matter of widespread controversy and confusion. I believe that dynamic psychotherapy can be not merely effective but uniquely effective, that therapeutic effects are produced by specific rather than nonspecific factors, and that the essential factor is the patient's experience of his true feelings about the present and the past.

The aim of the technique is, therefore, to enable the patient to experience his true feelings as rapidly as possible and to the maximum degree that he can bear. Almost every patient arrives at a therapeutic session in an ambivalent state, which has both conscious and unconscious components. On the therapist's side is the *therapeutic alliance*. The conscious component of this consists of the patient's will to get well, to collaborate with the therapist, to tell the truth even if it is painful, to face disturbing feelings. The unconscious component consists of the tendency to make communications that enable the therapist first to infer what is happening beneath the surface, and then to bring this into the open and enable the patient to experience it. Ranged in opposition to this is the patient's *resistance*. The conscious component of this consists of deliberately withholding information which the patient knows is

important, while the unconscious component consists of the whole range of defensive maneuvers with which every therapist is familiar—vagueness, distancing, silence, intellectualization, the whole range of obsessional defenses, and a wide range of regressive defenses, etc. Almost every moment of every interview shows a mixture of these components, and there is a continuum from complete alliance to complete resistance, both of which in turn also show a continuum from being wholly conscious to wholly unconsciousness.



The therapist's function is to probe for feeling and to monitor continuously the balance between resistance and therapeutic alliance. There are, of course, a few patients who show hardly any resistance and can be put in touch with their feelings very easily, but these represent a very small proportion of the psychotherapeutic population. The vast majority of patients either start in resistance from the beginning or rapidly become resistant the moment painful areas are approached. In the classical technique resistance is handled by *interpretation*, and if this repeatedly fails, by waiting for something further to develop—for pressure to build up within the patient, often through the transference, which enables the resistance to be overcome. But what if this does not happen? Then the therapeutic process starts going round in circles, as is shown by the many failed patients who are referred to yet one more course of therapy.

What I have discovered is that resistance, even if extreme, can be handled by a process of challenge and pressure. In the classical technique resistance is a serious impediment; in my technique it is to be welcomed as an indicator that painful conflicts are not merely being approached but can be brought to the surface and resolved. Each time resistance is penetrated there is a marked and unmistakable increase in the strength of the therapeutic alliance.

The whole process begins in the initial interview, which can therefore be used for illustration. The only differences between the initial interview and sessions in the main body of therapy are that the patient must be watched even more carefully for his reactions, and in addition careful psychiatric, medical, and social histories must be taken. If at any point he shows signs of becoming seriously disturbed by the therapist's interventions, or gives a history which indicates he is likely to become so, then the therapist must modify his technique accordingly. Provided the therapist shows this vigilance, in my experience adverse consequences of the initial interview are not observed.

### Overall Description of the Process

I have worked out standard types of intervention adapted to each move on the patient's part. These interventions have often been reached intuitively, and it is then only in retrospect that I have been able to describe theoretically what I have been doing. Each intervention is quite specific and usually leads to an equally specific reaction from the patient. The result is that it is possible to describe a general course

of the therapeutic process, divided into a number of stages. Of course the exact order varies from one case to another; not all stages necessarily occur in every case, and certain stages may need to be repeated. Nevertheless the following scheme represents a good framework within which to describe actual events, and it can be used as a guide for anyone wishing to understand the technique and hoping to learn how to apply it.

A major difference from the classical technique is that the motive power of the interview lies to a greater extent in the hands of therapist rather than the patient. In both techniques the process consists of an interaction between the two partners in the therapeutic process; but whereas in the classical technique the sequence is material, interpretation, response, in my technique the sequence is far more accurately described in the form of active intervention, response, followed by a further active intervention. Heavy emphasis is put on the patient's experience of the ongoing interaction with the therapist. Thus each segment consists of a characteristic couplet of intervention and response.

Central to my technique of Short-Term Dynamic Psychotherapy are challenge to the resistance and extensive use of the transference, which need to be considered in the context of the whole process of dynamic interaction between the therapist and the patient.

The various phases of an initial interview may be described as follows:

#### Pressure toward Feeling

As already mentioned, almost every patient arrives in an ambivalent state, on the one hand wanting help, and on the other hand wishing to conceal and avoid issues that cause him pain. In an initial interview the therapist usually opens with a simple question such as "Can you tell me what seems to be the trouble?," "Do you want to tell me about your problems?," to which the patient makes an opening statement, which is often about symptoms or some current situation in his life. In a therapeutic session the patient usually makes such a statement without needing to be questioned. In either case the stage of pressure toward feeling begins. This starts with simple requests for elaboration, "Can we look at that?," "Can you say more about that?" In response, the patient allows a little of the truth to be seen, but usually he keeps a very great deal concealed. Sooner or later he describes some situation which either does arouse feelings or ought to do so. The therapist first asks the patient what he feels. In response, the patient very often glosses over the truth by speaking in relatively innocuous terms such as "anxious," "uncomfortable," "confused," and even if he speaks in stronger terms such as "annoyed," "angry," or "sad," he is often really just using words to avoid the true experience of his feelings, thus seeming to answer the therapist's question while not actually doing so. The therapist tries to penetrate this defense: "What do you *experience* when you feel anxious, uncomfortable, annoyed, sad?"

All these questions are seemingly innocent and straightforward; but in fact they convey a powerful hidden message, namely that the therapist wishes to understand any given situation in depth, wishes to know exactly what the patient experiences, and will not be put off by evasions and half-truths. The patient picks up this message very quickly and sooner or later—usually sooner—becomes unconsciously alarmed that his most painful areas are going to be investigated. This brings the next phase.

#### Intensification of Resistance

Resistance takes the form of a series of defenses. Some of those most commonly encountered are: tactical defenses such as vagueness, tentativeness, evasiveness, diversionary tactics, etc.; a wide range of obsessional defenses such as intellectualization, rationalization, isolation, and rumination; or a wide range of regressive defenses such as projection, introjection, and weepiness, etc.

#### Clarification of Defenses

The therapist's first approach to the defenses that are used in the service of resistance is to clarify each one as it arises, while continuing to exert pressure toward the experience of feeling. This has the effect of further intensifying and crystallizing the resistance, bring it into the open where it can be further challenged. This clarification gradually goes over into the next phase:

#### Challenge to the Resistance

This technique is radically different from psychoanalytic technique, and of all its elements it is probably challenge and pressure to the resistance that is the most foreign to the traditional psychoanalytic approach in which most therapists have been trained. There is no space here for a comprehensive presentation of the vast subject of the different kinds of challenge. A few examples will have to suffice to convey their quality and flavor:

##### *Challenge to Tactical Defenses; Asking for a Decision as a Challenge to Vagueness*

PT: *Perhaps I do have resentment toward my husband.*  
TH: *Why do you say "perhaps?" Either you do or you don't.*

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PT: *I think my sex life was not satisfactory.*  
TH: *You think? You are not sure?*

##### *Confronting the Patient with the Selective Nature of Inability to Remember*

PT: *That is too long ago to get in touch with.*  
TH: *How is your memory usually? You have difficulties with your memory?*

##### *Striking Descriptions of the Patient's Defensive Manoeuvres*

TH: *You leave everything in limbo, hanging in the middle of nowhere.*

It is crucial to emphasize that these words are directed not toward the patient himself but toward his defenses, and they initiate a process of turning the patient against his defenses and making him realize how counter-productive or crippling they really are.

#### **Challenge to the Therapeutic Alliance; Pressure to Give up the Defenses**

During or after a period of challenge it is often important to make a direct and challenging appeal to the patient's therapeutic alliance to abandon his resistant position, with the rhetorical question: "What are we going to do about it?"

#### **Intensification of Transference**

Beneath the surface the effects of this repeated challenge are intense, wide-ranging, and profound, and take the form of a rapid rise in transference feelings. These feelings are extremely complex and may contain any or all of the following components. The first layer is usually the patient's anger with the therapist for not allowing him to use his customary defenses. This links with all the past situations that have made him angry, and with it usually comes considerable anxiety. Beneath the anger, however, there often lies a quite opposite feeling: warm appreciation that another human being is going to such lengths to sweep aside his facade and get close to his true self. Finally, side by side with this unconscious anxiety-laden guilt feeling about closeness there arrives the realization of its devastating consequence—missed opportunities and destroyed relationships throughout the patient's life. The consequent feelings of grief and remorse are likely to be even more painful, and the patient may use the anger as a defense against them. The result of the potential mobilization of all these mixed, painful, and anxiety-laden feelings is therefore a further intensification of resistance, but resistance of a new kind, namely transference-resistance.

#### **Direct Question about the Transference**

The therapist needs to be well prepared to recognize signs in the patient indicating that the resistance contains a major transference component. These often come from nonverbal signs of tension, such as gripping the arms of the chair, taking deep breaths, smiling involuntarily, or simply becoming increasingly passive and immobile. At the right moment, when the tension has become sufficiently manifest, the therapist breaks in with the question, "How do you feel right now?" This initiates a further cycle of resistance and challenge.

#### **Challenge to Resistance in the Transference**

What happens now usually consists of a series of defenses against the patient's transference feelings. These feelings are complex, having elements of anger, anxiety, sadness, and painful feelings. The defenses are challenged in much the same way as before; but the therapist also needs to be extremely alert to the fact that the defenses may be as much against closeness, sadness and painful feelings as against anger, and to switch his approach accordingly.

#### **The Head-on Collision with the Resistance**

The further intensification of resistance in this phase may result in the interview seeming to go round in circles or threatening to grind to a halt. Here the therapist may bring in his most powerful intervention. This is to point out the reality of the situation, namely, that the patient is trying to defeat the therapeutic process and that if he continues to do this and ultimately succeeds then the therapist will be useless to him. This intervention contains three important elements. First, it puts the responsibility firmly where it belongs, that is on the patient himself. Second, it is a confrontation directed at the conscious therapeutic alliance, with the implication that unless the patient makes a supreme effort to be honest he cannot be helped. And third, it contains a crucial message to the patient's unconscious, an implied interpretation of destructive impulses both in the transference and directed by the patient toward himself.

#### **Direct Experience of Transference Feelings**

The result of all this pressure and challenge is finally that the defenses become exhausted and the patient is able to experience his transference feelings directly. This does not come with any explosive outburst, but with a quiet, inner intensity.

#### **Mobilization of the Unconscious Therapeutic Alliance**

The effect is dramatic. There is an immediate drop in tension and a feeling of relief, there is a rise in true motivation and the emergence of strong positive feelings for the therapist, the patient's unconscious becomes unlocked, the unconscious therapeutic alliance is mobilized, and there often appears some major communication which throws light on important aspects of the patient's core neurotic structure.

#### **An Empirical Observation and a Note on Patient's Feelings in the Transference**

Here I need to bring in an observation of immense practical and theoretical importance. On reviewing the transcripts of many initial interviews I find the following: that where a therapist has achieved a major breakthrough with a resistant patient, this has almost invariably followed a passage in which the patient has been confronted with his feelings in the transference and has been able to experience and acknowledge him. In turn, these feelings might contain the element of anger. This anger may also be a defense against underlying painful feelings, and beneath it we always see very strong positive feelings. The way in which the anger is aroused is crucial. It obviously is not therapeutic just to make the patient angry, for instance by taunting him. This would result in an immediate misalliance. On the contrary, the patient becomes angry within an atmosphere in which he senses, both consciously and unconsciously, that the therapist is directing him toward his most painful buried feelings out of a genuine and compassionate concern, a determination not to spare him pain but to make him face it, with the sole purpose of freeing him from the self-defeating patterns that have spoiled his life for so many years. It is essential for the therapist to create this atmosphere from the beginning. The total situation, in

which the patient experiences and can acknowledge his mixed feelings with a therapist who he knows is facing him with pain out of a determination to help him, seems to contain something specific which mobilizes crucial conscious and unconscious processes. These lead in turn to the greatly increased possibility that the patient's unconscious will respond by revealing in depth some of the feelings, situations, and events that have led to his neurosis.

#### The Phase of Analysis of the Resistance—The Use of the Two Triangles

The reader may have noticed that so far there has been no mention whatsoever of *interpretations*. This is not an oversight—until the breakthrough has been achieved there is no place for interpretations in this technique. However, they now come into their own. The breakthrough is usually followed by a long and complex phase in which exploration of relationships outside the transference alternates with the use of interpretation. The patient needs to be given insight into the *ways in which he has been defending himself against his underlying feelings* and the *anxieties* that have led him to do so. These three elements constitute the “triangle of conflict.” Moreover, the therapist can now begin to explore meaningfully the same triangle in the patient’s other relations. It is only too likely that the patient has been defending himself in the same way in his current relations, e.g., with spouse or boss, and that this pattern has been laid down in the distant past with parents or siblings. The therapist thus begins the process of completing a second triangle, transference/current/past (TCP), which we may call the “triangle of person.” The freeing produced by the experience of the triangle of conflict in the transference leads to the de-repression feelings that have been buried for many years. TCP interpretation, that is interpreting the triangle of conflict in the transference and then making the link with the same pattern in current and past relationships, is of crucial importance. Experience has shown time and again that completing these two triangles can result in rapid and major therapeutic effects. The sooner the process can be completed, the more complete and the shorter therapy will be.

TCP interpretations are directed toward further analyzing the residual resistances. By this means the residual resistance is weakened to the point at which it is no longer operating, and now the therapist is able to enter the next phase.

#### Direct Access to the Unconscious and the Exposure of the Core Neurosis

The therapist can now explore the past directly. It is true that resistance may temporarily return when painful areas are approached, but now it can be relatively easily swept aside, usually without reference to the transference. As a result, the central neurotic structure responsible for all the patient’s disturbances can at last be meaningfully explored and interpreted, and the process of freeing him has begun.

#### Recapitulation

To sum up, the complex process of trial therapy described above can be grouped into two over-all phases. The first is the pre-interpretative phase, which consists of challenge and pressure on the resistance accompanied by a rise in transference and culminating in the first experience of transference feelings. This results in the unlocking of the unconscious and the mobilization of the unconscious therapeutic

alliance. The interpretative phase can now begin, first with the analysis of residual resistance, and finally with the exploration of the past and the exposure of the core neurosis.

All these processes will now be illustrated with a clinical example.

#### The Case of The German Architect

At the time of the initial interview, he was in his early thirties and suffered from disturbances in interpersonal relationships characterized by distancing and inability to get emotionally close to anyone in his life orbit, conflict over closeness and intimacy, and longstanding conflicts with his family, particularly his father and one of his brothers. His relationships with women he described as disastrous, and his last relationship had been with a woman who had a nervous breakdown and he ended up being her caretaker. In all his relationships he had had a self-defeating and self-sabotaging pattern. He suffered from episodes of depression with no suicidal ideation.

Longstanding characterological problems, shifting from a detached, withdrawn, distant pattern of behavior to being stubborn and defiant, which had permeated all his relationships.

The initial interview started with the evaluator questioning him about his difficulties.

#### Descriptive Phenomenological Approach, Immediate Resistance

*TH: Could you tell me what seems to be the problem that you want to get help for it?*

*PT: Uh . . . no, not exactly. This is one . . .*

*TH: So you don't know exactly what the problem is, hmm?*

*PT: I'm here, ah, I only have ah, some hazy idea what might be the problem.*

*TH: Now if I question you what seems to be the difficulties that you have, what then you would say there? Because you are saying you have a hazy idea about your difficulties which is . . .*

*PT: Which I'm not even sure whether those difficulties are my re . . . normal part of being a human being, ah, however . . .*

*TH: So you have several difficulties that you question if is normal or . . .*

In answer to the question, “Could you tell me what seems to be the problem?,” what emerged was that the patient is vague, ruminates, and wants to intellectualize about whether his difficulties are normal or abnormal.

It became evident immediately that a descriptive phenomenological approach would not be meaningful.

#### Clarifying Defenses—Some Degree of Communication

The patient clearly wanted to intellectualize about the causes of his difficulties.

*TH: Yeah, but you see, let me to question you this. You are now moving to the cause of it before you tell me what the problem is. Do you notice that?*

PT: *Oh, yeah, I understand that, umm . . .*  
 TH: *You see my question was, what are the difficulties that you have? But now you are moving to the issue of the cause.*  
 PT: *No, I'm not, I'm simply explaining that umm . . .*  
 TH: *Now you are becoming slow.*  
 PT: *I beg your pardon? No, I'm trying to say that umm, it becomes a more plausible thing, ah, with a more plausible cause when you realize . . .*  
 TH: *Yeah, but you see this is very vague, you see you say the, still the question that I had was what seems to be the difficulties and so far you are in a sense ruminating in a vague fashion on the . . .*  
 PT: *No, I'm not, I've definitely said I have a problem with commitment, and that very much came home when I discovered the same problem elsewhere in people related to me who have the same background, ah . . .*  
 TH: *So one problem that you have has to do with commitment.*  
 PT: *Yes, but don't forget that of course it took me many, many years to even realize that I had a problem there. I mean I've been plodding in the dark for almost as long as I've been alive. Ah, which brings up another point, maybe I have a problem with feelings.*

The therapist has clarified with the patient his vagueness and his tendency to ruminate. What emerged was that he has a great many characterological problems. He made two significant communications: "plodding in the dark" and "problems with feelings," but both of these communications are themselves vague. The therapist follows the line and focuses on the patient's problems with feelings, at the same time pointing out the defense.

From now on the patient's responses, and particularly his bodily movement, took on an increasingly provocative and insolent quality; when he turned his head, for instance, it expressed a feigned long-suffering patience with the therapist's approach. Throughout the whole of this passage the therapist handles this simply by drawing attention to the movements, without either being provoked or even pointing out the provocation.

#### Probing for Feelings, Increased Resistance

TH: *Problem with feelings. Could you tell me about that? That is merely a sentence.*  
 PT: *Yes, it is a sentence. Umm, maybe my reactions to things that I should feel are . . .*  
 TH: *Yeah, but that again is vague. "My reaction to things . . ."*  
 PT: *Okay.*  
 TH: *Now you turn your head on the other side, do you notice that?*  
 PT: *I beg your pardon?*  
 TH: *You move your head on the . . . do you notice that in a sense your head moved?*  
 PT: *Yes, I'm looking for ah, another tack you see.*  
 TH: *Another?*  
 PT: *Tack.*

TH: *What does that mean?*  
 PT: *Ah, another approach.*  
 TH: *Uh hmm.*  
 PT: *Umm.*  
 TH: *Another approach to what?*  
 PT: *To explaining maybe why I'm here.*

#### Challenge to Resistance

In a passage that has been omitted the patient continued vaguely, which the therapist pointed out once more. The patient now seemed content with his state of affairs, so the therapist began challenging the patient's resistance:

PT: *Yes, I know but I am vague. I mean I'm very vague about . . .*  
 TH: *So the first question for us, what are we going to do about the vagueness? Because up to the time you are vague then we wouldn't have a clear picture of what seems to be the problem.*  
 PT: *Umm. . .*  
 TH: *Do you see what I mean?*  
 PT: *Yes, I see what you mean.*  
 TH: *Because up to the time you are vague then ah, we wouldn't understand what seems to be the nature of your problem.*  
 PT: *Uh hmm. Well, I can't tell you why . . .*  
 TH: *Yeah, but you say uh hmm, but that doesn't solve our problem here because our problem here is first to establish what seems to be the difficulty that you have. But now if you want to be vague, then we wouldn't understand even what is the difficulty. Now, that is the first step.*  
 PT: *Well, of course, if, maybe if I knew what the difficulty was I wouldn't be here.*  
 TH: *Yeah, you see again you move to this, maybe . . .*  
 PT: *Yeah.*  
 TH: *. . . in other words again, limbo state.*

As there was an increase in the patient's movements in the chair and he turned his head away in another gesture of hidden insolence, the therapist for a moment focused on his feelings. The patient now began to be almost openly insolent in his verbal responses, using the device of sarcasm:

TH: *How do you feel?*  
 PT: *How do I feel?*  
 TH: *Right now here.*  
 PT: *Umm (little pause)*  
 TH: *You are holding your hand over each other and . . .*  
 PT: *I find that comfortable.*  
 TH: *Uh hmm.*  
 PT: *Ah, do I need to comfort? I don't know.*  
 TH: *How do you feel? My question is how do you feel?*

PT: Ah, warm, but otherwise fine.  
 TH: Warm means what?  
 PT: Warm means I might start sweating any minute.  
 TH: You mean you are not sweating yet?  
 PT: No, I'm not.  
 TH: And what else do you feel?  
 PT: Umm (little pause and he laughs a little) limbo if you like.  
 TH: Now, you smile. Okay, but that is a sentence.  
 PT: Yes.  
 TH: But that doesn't describe how you feel.

Here the patient, unconsciously, is using the defense mechanism of isolation, while consciously he is being deliberately and provocatively evasive. It is clear that the resistance has crystallized in the transference and that the time has come to try and bring this into the open. Here the therapist intensifies the provocativeness by concentrating on the defensive element in the situation, the avoidance of a direct relationship. This leads us in the direction, not of the patient's aggressiveness but his pain—something that he least expects the therapist to see.

#### Clarification of Resistance in the Transference, Pressure toward Transference Feelings

TH: Now your eyes also avoid me.  
 PT: Well, I mean I can't look at you all the time, one hundred percent of the time.  
 TH: Do you notice that you avoid my eyes?  
 PT: No, I don't avoid your eyes. I look at your eyes when you talk to me.  
 TH: Uh hmm.  
 PT: But then I look away so I can, ah, think for myself where I don't have to concentrate on your eyes, umm . . .  
 TH: And how do you feel when you look at my eyes?  
 PT: Fine, I . . .  
 TH: Fine means what, I mean fine is another vague . . . you smile now.  
 PT: Is that okay, I mean I smile?  
 TH: Uh hmm. Now your eyes go toward the ceiling.  
 PT: Right, that's quite right.  
 TH: Right, huh?  
 PT: Umm, how do I feel when I look at you.  
 TH: You are avoiding me. This is the real issue.  
 PT: I'm avoiding you?  
 TH: Yeah, is it or isn't it? I mean you can tell me.  
 PT: No, I don't think I'm avoiding you particularly.  
 TH: Now, look, you have been vague so far . . .  
 PT: No.  
 TH: . . . you have not been specific so far and now we are focusing on your feeling, you say fine . . .  
 PT: Well, that's what everybody in this country says, ah . . .

One of the major features of all patients suffering from character neuroses of this kind is using a wide range of defenses to distance themselves in interpersonal relationships. They have a major neurotic conflict over intimacy and closeness which is deeply rooted in very early traumatic experiences in their lives. This conflict over closeness becomes immediately manifest in the transference, avoiding eye contact, looking at the opposite wall; and an important aspect of my technique is constantly monitoring and drawing attention to the patient's body movements, particularly when they have transference implications. This mobilizes a great deal of unconscious anxiety with further intensification of resistance. The therapist then constantly watches for non-verbal cues indicating tension and anxiety, e.g., taking deep breaths.

#### Head-on Collision with the Resistance

TH: And obviously you have some problem that so far we don't know anything about it, okay?  
 PT: That's right.  
 TH: But if you stay like this, vague, and nonspecific and withholding as you are . . .  
 PT: Ah . . .  
 TH: Now let's to look at it—and withholding, then we will depart from each other, hmm?  
 PT: Uh hmm.  
 TH: . . . without we get to the core of your problem.  
 PT: Uh hmm.  
 TH: Hmm? then I would be totally useless to you. Now, you have set up a goal, obviously to come here to understand your problem.  
 PT: Uh hmm.  
 TH: Hmm?  
 PT: Yeah.  
 TH: That is your goal.  
 PT: Yeah.  
 TH: But then if I become useless to you and we would not get to the core of your problem . . .  
 PT: Uh hmm.  
 TH: . . . then you walk out of here, me being useless to you and you carrying your own problem, whatever it is, with yourself.  
 PT: Uh hmm.  
 TH: So who is defeating? So obviously what immediately is coming to the focus is that you have a self-defeating pattern. This is very clear right now. My question is why an intelligent person like you wants to do that?  
 PT: I'm not aware of . . . I'm not aware of defeating it . . .  
 TH: But look at it. Isn't there defeat in this?  
 PT: No, I mean not that I, I don't feel that way.  
 TH: You tell me, I mean look, we have spent fifteen minutes, you tell me what have we accomplished?  
 PT: My goodness, many people come to psychiatrists for years on end . . .

*TH:* Uh hmm.

*PT:* . . . and ah . . .

*TH:* So what you say is this, that we have to come for years until we understand.

*PT:* No, I, I hope not.

In the above passage there has been further systematic challenge to the patient's resistance; and the therapist has brought into focus another aspect of the neurotic mechanism with its transference implication, namely his need to defeat the process. This is a self-defeating pattern which is becoming very clear in the transference. At the end of the session the therapist will have been useless, something which obviously has repeated itself in all the patients interpersonal relationships. The therapist by experience knows that this has its roots in the past. But at no time does the therapist make any reference to current or past; he tightly maintains the focus on the transference. Nor so far has the therapist referred to the patient's sarcastic smile.

Pointing out the reality of the situation, the consequences of defeating the therapeutic process, and making the therapist useless contains three elements:

- (1) Putting the responsibility firmly where it belongs, that is, on the patient himself.
- (2) Confrontation directed at the conscious therapeutic alliance.
- (3) A message to the patient's unconscious about his destructive impulses.

#### Rise in Transference Anxiety, Continued Head-On Collision; Gradual Mobilization of the Therapeutic Alliance

The above pressure on the transference resistance has begun to have an effect, for now (1) the patient begins to give repeated nonverbal signals indicating increased anxiety, and (2) these are the first glimmerings of therapeutic alliance in the words "you are a total stranger," which contain a sort of appeal to the therapist not to try to get too close. Sensing these signs of progress the therapist redoubles his challenge.

*TH:* Now you took a deep sigh.

*PT:* . . . you are a total stranger to me.

*TH:* Uh hmm.

*PT:* Umm . . .

*TH:* So then I am a total stranger, uh hmm.

*PT:* Yes, ah . . .

*TH:* And you are erecting a wall with this stranger.

*PT:* Not necessarily.

*TH:* What do you mean not necessarily?

(Patient laughs and sighs frequently)

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*TH:* Now my question is this. Up to the time you keep this wall . . .

*PT:* Uh hmm.

*TH:* . . . then we are not going to get to understand your problem; we would not be able to get to the core of your problem, then it is useless.

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There are more glimmerings of therapeutic alliance:

*PT:* There is a wall which can probably be broken down, I don't know, I mean . . .

*TH:* Okay, so the first job that we have is to see how we are going to break the wall, and if we cannot break the wall then it is useless. Let's see what we are going to do about the distancing and the wall, it is your own will to come here, to understand your problems, and we can get to the core of your problems.

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*TH:* Yeah, but that is in another vague sentence.

*PT:* Well, I mean I'm sure you can reduce everything to vagueness . . .

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*TH:* . . . it is your will to come here. If I can be of help to you fine, but if I cannot what can I do? So then let's see what are we going to do about the wall. Now you are smiling now. And your eyes . . .

*PT:* Yeah, well of course . . .

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This process of challenge and pressure on the resistance continues, and the patient smiles frequently and sighs deeply and frequently. This is pointed out to him, and he becomes more passive.

*TH:* Now you are putting your hand over your mouth.

*PT:* That's right.

*TH:* What does that mean?

The patient actually gives his own interpretation—further signs of therapeutic alliance:

*PT:* I guess, I have no idea what it means, but it's probably something like well, I'm about not to say anything anymore.

*TH:* Uh hmm. Becoming more passive.

*PT:* Uh hmm.

(The patient smiles frequently, which is pointed out to him)

PT: Yes, I know because I can, I'm, I'm sort of picturing what your mind is saying, you see.  
 TH: Now you are ruminating further, what my mind is going to say.

The patient makes an important communication:

PT: All I can say if something is expected of me I don't know what and I don't know how to . . .  
 TH: Now, let's to look, you see the subject of the something is expected of you.  
 PT: Uh hmm.  
 TH: Hmm? The main implication is that I am demanding from you. Hmm?  
 PT: Yes.

The therapist has picked up the patient's communication. As a result the patient immediately becomes alarmed at the threat of increased closeness and becomes quite openly defiant. He puts his legs up on the table between the two of them.

PT: Well, thank God, I mean there is nothing else I can do.  
 TH: And we see the movement of your legs.  
 PT: They're still active.  
 TH: Uh hmm. But it is not clear how you feel inside. (There is a pause and the patient continues his denial):  
 TH: Silence and passivity.

The patient continues his denial:

PT: It's not a bad feeling actually.

He now becomes openly sarcastic, which the therapist dismisses:

#### Further Rise and Experience of Transference Feelings: Head-On Collision in Transference; First Emergence of Unconscious Therapeutic Alliance

PT: Well, you'll have to admit my smile is very warm and inviting.  
 TH: Yeah, but that is another way of ruminating, that "my smile is warm and inviting."

The patient now makes another communication:

PT: You wouldn't want to risk your neck walking through the wall with my smile, I mean you need more than that.

TH: Could we look into that, because what you say to break my neck . . .  
 PT: No, I didn't say break the neck, ah, risk I said.  
 TH: To risk my neck.  
 PT: Yeah.  
 TH: That means that if I pass through the wall then my neck is going to . . .  
 PT: No, not at all, but you might feel that, I don't know. Ah, I mean I don't wish people any harm, thank you very much.  
 TH: The ideation is that there is something negative there, you mean?  
 PT: A wall, yes, I think a wall is very negative.  
 TH: I mean there is something negative in you.  
 PT: Oh, definitely.  
 TH: When you say negative in you definitely, you smile immediately.

Suddenly the patient makes the most important communication yet, linking the transference with the relation with his father (an example of the T-P link):

PT: Ah, well, it's the one thing (He clears his throat) that was pointed out to me a long time ago ah . . .  
 TH: Uh hmm.  
 PT: . . . I was negative, ah, much less now than I used to be, I presume.  
 TH: So you were told that you were a negative person?  
 PT: Yes, actually by my father.  
 TH: Uh hmm. In what way he implied you were a negative person? (Pause)  
 PT: Umm, well this is almost like child stuff, it's probably ah, I'm not interested in that or I'm not interested, I don't want to do that, well, I think in that sense he called me a negative person.  
 TH: You mean you were defying your father in a sense?

Here the therapist has used a word about the relation with the father that highlights an aspect of the transference. The patient immediately becomes resistant again using the defense of vagueness. It is absolutely essential that this residual resistance should be challenged. As long as it is still present the unconscious is still locked and the unconscious therapeutic alliance is insufficiently in operation. If the therapist ignores this and pursues "content" prematurely, the process becomes cognitive and intellectualized.

PT: That could well be.  
 TH: Now, let's look at it. It is very important to look at it.  
 PT: Yeah, but it's . . .  
 TH: You see you leave things in a state of "may well be."  
 PT: Well . . .  
 TH: "May well be" is a sort of the state of limbo. You are usually an uncertain person?  
 PT: Okay.  
 TH: You know what I mean, in a sense you . . .  
 PT: No, not about most things but about myself I sure, I sure am.  
 TH: But this is very important we look at it.

PT: Well, that's why I'm here.  
 TH: Is it with me you are leaving things in a state of limbo, this is only with me and is not in others?  
 PT: No, no this is not with you, this is period.  
 TH: A pattern of you?  
 PT: Right, I don't know. That's why I'm here.  
 TH: Uh hmm. Yeah, but "I don't know" and then also you use often "maybe" because what you say is . . .  
 PT: Cause I don't want to make any definite statements on my psyche, I mean I know very little about it, so I say maybes.  
 TH: So you make always the indefinite statement?  
 TH: So I question you, in that incident that you were talking about, that your father told you that you are a negative person, the question was that you were defying your father, in a sense not doing the way he wanted you to do?

#### Direct Experience of Anger in the Transference

Hitherto the patient has been expressing hostility by defiance and detachment, which are ways of expressing anger without the true experience of anger. Now suddenly he becomes involved in his anger, raising his voice to the therapist. This is a crucial moment, but when the therapist focuses on it he begins to deny that it is happening, necessitating further challenge:

TH: This is very important. Again you leave it in the state of limbo, "I think so."  
 PT: Well I do think so! Goddamn it, I'm not a psychiatrist, I mean I . . .  
 TH: How do you feel right now?  
 PT: I feel fine, I'm getting belligerent, ah . . .  
 TH: Now, just a moment, you said "Goddamn it." I said how you feel. You said belligerent.  
 PT: Yes.  
 TH: Obviously you have been belligerent all through.  
 PT: No, I don't think so.  
 TH: "I don't think so." You, yourself, say you are getting belligerent.  
 PT: Okay, I'll say no, I didn't feel belligerent all through but . . .  
 TH: No, when you said "Goddamn it," how you felt inside?  
 PT: Ah, fine.  
 TH: Now, you said fine.  
 PT: Oh yeah, that's the wrong word.  
 TH: Did you feel irritated at any time, if you be honest with yourself? When you said "Goddamn it," did you feel irritated at the moment?  
 PT: Yeah, because ah . . .  
 TH: So you felt irritated.  
 PT: No, I was just trying to make a point and ah . . .  
 TH: No, you see again you water down the whole thing.  
 PT: Ahhh . . .  
 TH: And a smile.  
 PT: Yes.

Now there is a further rise in the pitch of patient's voice.

PT: Oh, I can damn well tell you when I'm irritated, but that was nothing to be irritated about.  
 TH: Oh, you mean that you didn't get irritated?  
 PT: No, I'm getting irritated now.  
 TH: You are getting irritated now, you mean you are getting, you are now you mean?  
 PT: I could be easily irritated.  
 TH: Okay, are you irritated or aren't you?  
 PT: I'm getting there.  
 TH: You are getting there. Now what is the way you experience this irritation right now? You took a deep sigh . . .  
 PT: Hmm, thinking again.  
 TH: How you, how did you experience this irritation? Did you feel that you wanted to lash out?  
 PT: No, I raise my voice instead.  
 TH: Uh hmm. But did you feel that you wanted to lash out?  
 PT: No.  
 TH: What are you like when you get angry?  
 PT: I raise my voice.

#### Mobilization of the Unconscious Therapeutic Alliance

Since the patient has been raising his voice to the therapist he has really acknowledged his anger. Of course we must not forget that this anger is also a defense against the emergence of many other painful feelings.

The therapist senses that this open experience and acknowledgement of feelings in the transference is probably enough to have unlocked the unconscious and brought access to similar feelings in other relationships. He decides to put this to a crucial test by asking for an example of anger in some other situation. If he is right, a significant communication will emerge from the unconscious.

At first it seems that he may not be right, since the patient manifests further resistance which has to be challenged. However, a quite crucial communication soon emerges.

TH: Could you give an incident when you are angry?  
 PT: Yeah.  
 TH: Uh hmm. Could you give me a specific incident? Could we look at one of the incidents when you got angry?  
 PT: Umm, it has to be a plausible one, I guess, umm . . .  
 TH: You see I question you could you give an incident that you were angry and then you had to make a certain move, change of position and you become slow and you repeatedly also keep your hand over your mouth.  
 PT: I'm learning a lot.  
 TH: Learning a lot of what?  
 PT: I'm learning a lot about the things I do.  
 TH: Uh hmm. But still you have not been able to say . . .

PT: I'm trying to give, ah thinking of a good example, hopefully that involves people rather than anything else, I mean there's no point telling you about ah, you know, walking into a chair and picking up a chair and throwing it which I've never done anyway, ah, umm well, (Frequent sighs), I guess . . .

TH: Guess?

PT: Well, who in the hell am I to know? I guess that the . . .

TH: Again you say you guess.

#### A Council Communication From the Unconscious

PT: . . . most ah, angry moment was many years ago in a pub and . . .

TH: How many years ago?

PT: (Frequent sighs) Downtown here, ah, and somebody insulted constantly a woman, incessantly.

TH: What was the situation?

PT: Oh, we were sitting in the pub and . . .

He described an incident that took place in a pub. He was there alone having a drink. A woman was sitting nearby and a drunken man was constantly needling her. The patient did not know the woman. The man was quite drunk and the patient emphasized that he is not a fighter. He went into such a rage that he lost control, but only hit the man on the shoulders. The result was that this very mild attack merely served to provoke the man into beating him up:

PT: . . . needling her.

TH: In what way?

PT: He was quite drunk.

TH: He was drunk.

PT: I think so.

TH: Uh hmm.

PT: And ah, I'm not a fighter but, ah, I did get up to do something and I'm not sure what I did.

TH: What do you mean, you got up to do something?

PT: Well, I got very angry and . . .

TH: Very angry.

PT: . . . I hit him in the shoulders I mean.

TH: Uh hmm.

PT: And ah, I'm not a fighter but, ah, I did get up to do something and I'm not sure what I did.

TH: What do you mean, you got up to do something?

PT: Well, I got very angry and . . .

TH: Very angry.

PT: . . . I hit him in the shoulders I mean.

TH: Uh hmm. What was the way you experienced the anger at that moment?

PT: Oh, very physical.

TH: You mean there was internal rage?

PT: Oh yeah.

TH: And then ah, you were aware of the way you were hitting him on the shoulders?

PT: (He laughs a little) Well, not very good because he got up so fast he knocked me out.

TH: He knocked you out?

PT: I didn't hit him where it would hurt too much I'm sure, which was my mistake.

TH: Uh hmm. Where did you . . .

PT: Probably his shoulders, not in his face anyway.

TH: Uh hmm.

PT: But he hit me right in the face.

TH: With fist you mean?

PT: Hmm.

TH: And then what happened to you?

PT: Umm, I think ah, a twisted and bleeding nose and black eye and bleeding . . .

TH: Ah, was he bigger than you?

PT: No, just, ah, stouter.

TH: Uh hmm.

PT: He was good at it.

The patient ended up badly hurt and across another table. He is very disturbed while describing this incident and in an emotional turmoil, becoming increasingly sad.

TH: Uh hmm. You don't have memory of this incident you mean?

PT: No, not particularly, not particularly.

TH: So then he beat you up.

PT: That was it. Yeah, he beat me up, yeah.

TH: Uh huh. But you have difficulty to describe this incident. Do you notice that?

PT: Yeah, I don't particularly like it.

(The patient has become increasingly sad, with tears in his eyes.)

TH: When you say you don't like it . . .

PT: I mean I, I'm proud of the fact that I stood up for her; and it didn't do me any good, I mean I didn't even get any thanks.

TH: Uh hmm.

PT: But umm, other than that I, I could have done without it, I mean I don't like the violence, ah . . .

TH: So you say you don't like violence, but here there was violence on you as well.

PT: Oh, well absolutely.

TH: So my question is this. How badly did he beat you up? Because he must have been really in rage . . .

PT: I think I still have a scar here and ah . . . ah, well, my nose bleeding.

TH: Bleeding nose. Uh hmm. And you were black and blue you said or am I . . .  
PT: No, I had a big black eye for a long time, yes.  
TH: Black eyes, uh huh. How did you feel during the fight? Did you feel that you wanted to go strong at him? Because you said that with the first strike you could have done it better than you did.  
PT: Yeah, I could have really hurt him.  
TH: Hmm?  
PT: I could have really hurt him I guess the first time.  
TH: When you were in rage and you had the first strike on him did you feel that you wanted to be very violent at that moment? Beat him up to the level that he would not move? You felt that way inside?  
PT: You mean I want to kill, I want to kill.

(The patient remains sad)

TH: In terms of thoughts I mean.  
PT: Yeah, yeah, I know what you mean.  
(Pause)  
PT: Well, I don't know what the thoughts are, were . . . but . . .  
TH: But you have . . .  
PT: I mean, I mean if you have that kind of a thought, geez I could kill him, it's immediately superseded by another thought, no, you can't, you don't want to . . .  
TH: I know, but this is very important we look at it because you see if there is the impulse in you, that one part of you wants to go to the level that you might want to kill the guy, and the other part of you is frightened of this, then you might put yourself in the disadvantage and beaten position in a sense.  
PT: Hmm.  
TH: Do you see what I mean?  
PT: I know exactly what you mean.  
TH: Uh hmm. Do you see what I mean that in a sense the impulse is so powerful that it frightens you and then you get yourself in a situation that you get beaten up actually. Do you see what I mean by that?  
PT: Yeah, it's fascinating.  
TH: What is fascinating?  
PT: The thought.  
TH: Do you think that was in operation there? That in a sense your beating was only provoking him and then ah, you see this is very important we look at it, that in a sense you only provoked him to the position that he beat you up to that level. How do you feel when we talk about this rage and anger and . . . how do you feel about that? I have a feeling that you feel very uncomfortable to talk about the anger or rage.  
PT: No, no, no, not at all. I actually find it very fascinating, I find it fascinating.  
TH: But you see you are . . .  
PT: This little story, this little story and God knows why the hell I picked on it.

TH: How do you feel? How do you feel right now?  
PT: Ah, that, that the way you keep talking about it, you know, and . . . It brings something out on me, it makes me cry, I find it fascinating, I find it beautiful, I find it beautiful.

(The patient is crying and very sad.)

Here it is worth while to pause and take stock. First of all, there has been an amazing change of atmosphere, from one of belligerence, insolence, and lack of involvement to intense communication, highly positive feelings ("I find it beautiful"), and great sadness. We may ask two questions. First, how is it that this has happened? Many years of observing similar phenomena enable us to say categorically that it is the result of the patient's direct experience of his feelings in the transference (T), expressed by his moment of irritation and other complex feelings and his ability to acknowledge it. Of course this in turn has only been made possible by the relentless pressure on the defenses.

This systematic challenge and pressure on the resistance accompanied by an intensive rise in transference feelings led to the de-repression of feelings that had been buried for many years in relation to both of the other categories of persons; namely current (C) and past (P).

In the present case "current" involves relatively recent past. De-repression occurs of the patient's feelings about an incident of several years ago. This leads to the second question: What on earth is the significance of this incident and the intense feelings that it arouses in him?

At this point in the interview it was only possible to speculate, as follows: the situation that he describes is his rage in a triangular situation in which he is witness to a man ill-treating a woman.

We may speculate that this situation activated his feelings about his parents; that his father had been aggressive to his mother and had aroused rage in him that was laden with anxiety and guilt. This would explain why he had been unable to express the rage effectively and has ended up simply by being punished for it.

But what of the word "beautiful" and the intense sadness. "Beautiful" must express the extraordinary relief of this moment of being freed from his defenses and put in touch with part of his inner self. About the sadness we can only say that it is probably concerned with the relation with a father—or both parents—that he wished he could have had, and his remorse and regret about his own contribution to whatever it was that went wrong.

It is evident, however, that he is far from realizing very much of this consciously, and the therapist actively focuses on his feelings.

TH: Yeah, but there is something important there.  
PT: I find it beautiful, okay? What else I feel, I don't know.  
TH: Your tears are there, okay?  
PT: I know. I know.  
TH: But then you avoid my eyes as well when your tears are there.  
PT: Well, Goddamn it, wouldn't you if you had tears in your eyes?

TH: Uh hmm. But there must be some ideation that comes to your mind that in a sense . . .  
 PT: No, nothing comes to my mind but it's ah . . .  
 TH: But you are intelligent, you know that in a sense you yourself say that talking about the story of that, like that then mobilizes all kinds of the feelings in you so obviously there must be something there that in a sense mobilizes these feelings in you.  
 PT: It really makes you wonder about the mind.  
 TH: But you are very strongly touched by it aren't you?  
 PT: Yes, I am.  
 TH: And there is the idea of killing in it. And you are avoiding to experience the full impact of your painful feelings.  
 PT: I don't know.  
 TH: And that is very important we look at it.  
 PT: Whatever it is it's not deliberate I can tell you.  
 TH: I know but you know to put the facade is not going to . . .

(The patient continues to cry, fascinated by this incident)

PT: I don't lie to you.  
 TH: I didn't say you do.  
 PT: No, no I know you didn't.  
 TH: Because must be very . . .  
 PT: I'm not doing anything.  
 TH: Yeah, but this strong feeling in you . . .  
 PT: Except to, except just going with it that's all I'm doing. And it's very nice.  
 TH: Why do you want to fight this strong feeling?  
 PT: I'm not wanting to fight anything. I have to congratulate you just the same.  
 TH: Congratulate in what way?  
 PT: For putting your finger on things pretty quickly.

This further pressure on the defenses has paid dividends for now the unconscious therapeutic alliance leads the therapist toward the past:

TH: But you see you are talking in terms of congratulating me.  
 PT: I don't know.  
 TH: But how about, I mean . . .  
 PT: Why should I congratulate me?  
 TH: Hmm?  
 PT: Why should I congratulate me? I mean I didn't even put the problem there. Maybe you should congratulate my parents or something for bringing the problem to you.  
 TH: Your parents, you say?  
 PT: Uh hmm. My parents.  
 TH: Which one, I mean your mother or your father?  
 PT: It doesn't matter I don't think, ah, mostly my father but I mean that has always been how I understood it.  
 TH: He is alive?

The therapist now decides that resistance has been weakened sufficiently for meaningful exploration of the past to be possible. He embarks on fact-finding.

Both parents are living. They are celebrating their anniversary. They want to pay for his trip to go home. His father wants badly to see him before he dies. His father is in his seventies as is his mother. He said his father is more in his mind, "and it was always my father I fought." The focus is on his father's wish to see him and the patient's ambivalence about going. He said that for his parents every year is going to be their last. His father suffers from pulmonary and heart diseases. He refers to his mother as a "vegetable" as she was knocked over by a car and had a head injury. The focus is further on his father's reference to this year as the last of his life. His letters refer to this and how badly he wants to see his son. He is a minister. In talking about his father he sighs deeply and frequently and becomes anxious. The focus is on the patient's last visit with him. He referred to his father as a pain in the neck.

What emerged was his ambivalence, that his father might die. The focus was on his father's characteristics. He was extremely rigid and the patient repeatedly referred to him as a "pain in the neck" and was very critical of him. In talking about his father he becomes tense and then stretches his legs and once more puts them on the table. He tilts the chair back.

#### Analysis of the Resistance in Terms of the Past (the T-P link)

The interview now enters the next phase. The unconscious therapeutic alliance is now so strong that the first T-P interpretation of the resistance is given by the patient himself.

PT: I mean I'm not comfortable talking about my father because . . .  
 TH: You mean that putting your feet on the table is the way that you fight the discomfort that you have?  
 PT: No, when I see something in front of me I put my feet on it, sorry.  
 TH: Uh hmm. Why you are sorry? Because it has some significant . . .  
 PT: Because if you were my father he would tell me to take my feet off it.  
 TH: Uh hmm. So could we look into that because obviously there is something here that in a sense . . .  
 PT: You're my father, and I'm defying you.  
 TH: Uh hmm. Now could we look into that because you say if your father was here he would not want your feet to be up there.  
 PT: That's when I would put them up there, of course.  
 TH: Uh hmm. So then you do it in order to defy your father, you mean?  
 PT: Because all these little things that he has rules about . . .  
 TH: I know, but there is something there. Let's to look at it. You said that if your father was here would demand that you not put your foot there.  
 PT: That's right.  
 TH: And now you are defying me . . .  
 PT: No, actually . . .  
 TH: . . . as if . . .  
 PT: . . . it might be.  
 TH: Let's not to get to "might be." You are doing it and then you are saying that you are defying me, obviously that is becoming very clear, that you are in defiance with me, but who are you really in defiance with?  
 PT: Well, obviously now you.

The therapist embarks on a further head-on collision with the residual resistance:

*TH: Okay, but let's to look at it, because this is very important we look at it this moment. Because the picture is very clear about certain issues, a little bit clear about you and your father, but obviously what is taking place between you and me is colored by that and we should . . . look at it. Now, it is something like this, if he is going to get after my feelings, I am going to fight it. If he is going to be demanding I am going to defy. If he is going to focus I am going to . . . okay? So then obviously it is becoming very clear the problem here with me. Now if you continue that way, then what happens here with me? The same thing that happened with your father, hmm?*

*PT: Yeah, I know, I mean do . . .*

*TH: In a sense, in a sense then I become useless to you as your father has been useless to you. The picture is very clear, you don't have any use for your father. He has to drag you to be there, he has to drag you and to see you before he dies. Hmm? He has to drag his son to see him before he dies.*

(Pause)

The patient is again charged with feelings—anxious, talking about his father. Again he puts his feet against the table and tilts his chair back. This enables the therapist to make a link with the incident in the pub, thus leading in the direction of linking this in turn with the past (the T-C-P link):

*TH: Now again you see your position. Your feet are against this.  
PT: Oh boy, let me to tell you, I'm defying everything in the row right now.  
TH: Uh hmm.  
PT: Ah . . .  
TH: And if you further push it, what happens?  
PT: I'll fall backwards.  
TH: Uh hmm. And what happened there in the fight with that man in the pub?  
PT: (He takes a deep sigh . . .) Ah . . .  
TH: You were knocked down. You said you had a black and blue eye.*

### Recapitulation and Conclusion

In the introduction to the present article I described an initial phase of *pressure toward feeling* which leads to *resistance*. With this particular patient hardly any such pressure was needed—it was obvious from the patient's vagueness and intellectualization that he was in resistance from the beginning. It was also obvious from his manner and bodily movements—which took on a covertly insolent quality—that his resistance very soon involved the *transference*.

During this early phase the therapist made interventions both *clarifying* the resistance and *challenging* it. The patient avoided the therapist's eyes and now it became possible first to *point out* his resistance in the transference and then to exert pressure toward the acknowledgement of transference feelings. Resistance increased and brought about the *head-on collision*. This resulted in increased manifestations of anxiety, together with the first indications of therapeutic alliance. The

therapist redoubled his challenge and the patient then showed his therapeutic alliance by spontaneously linking the transference resistance with his defiance of his father. The therapist concentrated on the defiance and suddenly the *resistance broke down*, and the patient—who had been trying to maintain a facade of noninvolvement—raised his voice and *openly expressed anger with the therapist*. The therapist concentrated on the patient's feelings, the patient became more irritated, and eventually he was able—almost—to acknowledge it.

At this point the therapist put the unconscious therapeutic alliance to the test, asking about other incidents in which the patient had become angry. This led to a *major communication* in which the patient described an incident of immense—though at present also obscure—symbolic significance, throwing light on important aspects of his neurosis. During this description the whole atmosphere of the interview changed and the patient became deeply involved, very sad and tearful.

Then the session focused on the meaning of this incident, and the patient eventually mentioned his parents, particularly his father.

The therapist now embarked on some factual enquiry about the past. However, as the patient spoke about his father he became tense, resistant, and again openly defiant. It was now very easy to make the link once more between defiance in the transference and defiance of the father, which represented the continuation of *analyzing the resistance in terms of other relationships*.

Here we break off the interview, which will be continued in the next article. One thing seems certain, that this kind of breakthrough could not have been achieved so quickly or so completely with interpretation alone.

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# Intensive Short-Term Dynamic Psychotherapy with Highly Resistant Patients. II. The Course of an Interview after the Initial Breakthrough

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This is Part II of a two-part article describing a powerful technique of Intensive Short-Term Dynamic Psychotherapy, which is used in the initial evaluation interview as a form of trial therapy. The present article completes an account of the interview used as an example in Part I.

## **Recapitulation**

In Part I of the present article I gave a general account of the phases of trial therapy in an initial interview, which may be summarized as follows:

- Pressure toward the experience of feeling, leading to increased resistance.
- Challenge to the resistance, leading to a rapid rise in transference feelings and an intensification of resistance.
- Challenge to the resistance in the transference, leading to the direct experience of transference feelings, which leads in turn to an initial breakthrough, unlocking the dynamic unconscious, and the mobilization of the unconscious therapeutic alliance.
- Exploration of current (or recent past) and distant past relationships, enabling the therapist to undertake a systematic analysis of residual transference resistance in terms of these relationships (the use of the two triangles).
- Direct access to the unconscious, with transitory return of resistance which is now relatively easily penetrated, with massive de-repression in relation to the current (or recent past) and the past and having a direct view of the unconscious and the core neurotic structure.

As an illustrative example I used a patient who showed intense resistance from the outset, and I have an account of the interview as far as the initial breakthrough.

In summary, what happened was as follows:

The patient's initial resistance took the form of extreme vagueness distancing, and intellectualization. The therapist began his challenge immediately, and the resistance became intensified and took on an unmistakable transference quality with covert defiance and insolence. This enabled the patient to express hostility without actually being emotionally involved in it. Repeated challenge disrupted this defense,

and the patient became actively angry with the therapist and raised his voice. The therapist used this direct experience of feelings in the transference by asking the patient to describe another situation in which he had become angry.

Suddenly there emerged a crucial communication from the patient's unconscious therapeutic alliance—the description of an incident which had occurred some years before and contained the following elements:

- (1) A man is being repeatedly provocative to a woman (both strangers to the patient—the incident occurred in a bistro).
- (2) The patient gets in a state of rage and attacks the man, but
- (3) His attack is such as to be quite ineffective and only results in his getting beaten up himself.

Although the exact significance of this incident was not immediately obvious, experience suggested that it must represent a situation between the patient and his parents. The therapist succeeded in bringing out that the patient had really been afraid of his own violence and this was why his attack had been so ineffective. As the patient spoke of this incident, the whole atmosphere of the interview changed and he became intensely involved, fascinated by what had emerged from his unconscious, and very sad and tearful.

He now spontaneously mentioned his parents. Exploration of the relation with his father led to a reactivation of transference resistance, and the therapist was now able to begin the systematic analysis of this resistance in terms of other relationships, both the relation with his father and with the man in the bistro.

At this point we may resume the detailed account of the interview:

### **The Case of the German Architect (Cont'd)**

The patient has just put his feet on the table between himself and the therapist, tilting back his chair. This gesture expresses a complex set of feelings and impulses: first, there is obviously defiance in it, but the defiance serves not only to express his hostility toward the therapist but to put distance between the two of them, thus reducing the anxiety produced by the systematic challenge to his defenses and the threat of emotional closeness. Further, by tilting back his chair he puts himself in danger of falling over backwards, which carries the potential of causing damage, not to the therapist, but to himself, which in turn shows parallels with the incident in the bistro.

*TH: With your feet you are pushing it toward my direction, and if you push it further it might knock me down; or the other way, you might knock yourself down.*

The patient uses the defense of detachment, which the therapist questions:

*PT: That would be fascinating.*

*TH: Fascinating?*

*(The patient laughs)*

*TH: Now you are smiling. Could we look at your defiant position, your foot up there?*

The patient intellectualizes, "lying the truth," which again the therapist calls in question:

*PT: Well, I mean, who am I defying? I mean, presumably it is my father, but I mean...*

*TH: You see again "presumably" and...*

*PT: Okay, so it is my father.*

This gives an opportunity to open up the next phase of the interview:

### **Analysis of Transference Resistance in Terms of Other Relationships**

The therapist takes the patient by surprise with a fresh parallel between the transference resistance and the relation with his father (a T-P interpretation). He combines this with a further head-on collision with the resistance, in which he speaks directly to the therapeutic alliance:

*TH: So let's see, let's look to see what we are going to do about that first. Your father wants to drag you to see him. Now the question for us is, am I dragging you to come here to understand your problems and to get to the core of your problem, or is it that you come here on your own will?*

*PT: We know the answer to that.*

*TH: Okay, you come on your own will, then let's look and see what you are going to do about this defiant position.*

*PT: (He clears his throat) (Pause) I don't know where to start.*

The therapist now reminds the patient of the mechanism underlying his self-defeating attack on the man in the bistro: that he got himself beaten up as a defense against (and punishment for) his murderous impulses. Since this interpretation is made in the context of defiance directed both toward the father and the therapist, it implies—though it does not explicitly spell out—the following major interpretation of the transference resistance: "You are now engaged in active self-defeat of the therapeutic process as a way of dealing with your murderous impulses toward me. This is the same self-defeating mechanism you used in relation to the man in the bistro, and it originated in your relation with your father." The therapist thus clarifies defence and impulse (two corners of the triangle of conflict) in relation to all three corners of the triangle of person—Transference, Current (or recent past), and distant Past—i.e., he gives a T-C-P interpretation of the resistance:

*TH: Mm hmm. And we know that in the bistro you could have struck badly on the neck of the guy, wouldn't you have been able to?*

*PT: Yeah.*

*TH: But you managed to be beaten, had a black eye, and a bleeding nose. You were the defeated, beaten man; and as I said before you took the defeated, beaten position as a mechanism to deal with the impulse which had a murderous quality—that in a sense you could have knocked him down with the first strike, but defensively you managed to be the beaten man with the bleeding nose.*

*PT: Well the...*

*TH: And humiliated in front of the woman.*

The technique of STDP which I am describing in this article has led to many empirical observations of immense importance. The present case illustrates three of these:

- (1) After the initial breakthrough in which the patient directly experiences his transference feelings, the therapeutic alliance is mobilized to such a degree that T-C-P interpretations of the kind just given produces a major response.
- (2) Direct experience of the patient's complex transference feelings is a triggering mechanism to a massive de-repression of the Current and the Past (Davanloo, to be published).
- (3) This will lead immediately to direct access to the unconscious, the unlocking of the unconscious, in which the past can be explored in a highly dynamic and meaningful way, often with little or no further reference to the transference; and any reactivated resistance can be easily swept aside. In the present case, however—as will be seen—the father-transference was so intense that it had to be brought into the open on two occasions.

#### Major Response, Leading to Direct Access to the Unconscious

*PT: Okay, the closest I have come to murder is when my father was in...I think he went for a lung removal operation.*

*TH: How old were you then?*

*PT: Umm, God, about eleven or something.*

*TH: Mm hmm.*

*PT: And I expressed a wish out loud that, ah, he would die, ah, I may have said it in front of my mother but I don't know. I hope... I had enough sense not to do that, but certainly in front of a brother or sister or something.*

*TH: The wish that he would have died.*

*PT: Yep.*

*TH: Mm hmm.*

The patient is becoming increasingly sad and anxious and has taken his feet off the table.

His therapeutic alliance was now so much in operation that he spontaneously brought up a fresh memory in which he had tried to slash the wrists of one of his brothers, Gustave, who was their father's favorite (the patient is the eldest). This highly significant memory both underlines the patient's violent impulses and introduces an entirely new issue, namely his longing for a closer relation with his father.

*TH: What was the incident in which you slashed the wrists of your brother?*

*PT: Oh, actually that was before, that was before.*

*TH: Mm hmm.*

*PT: There was extreme provocation of some kind or another.*

*TH: You mean he provoked you?*

*PT: Oh yeah, oh yeah, it was a table knife.*

The patient is very uncomfortable describing this.

*PT: I am very relieved that it wasn't sharp.*

The therapist faces the patient with the underlying impulse:

*TH: Mm hmm, and if it was sharper?*

*PT: Well, God knows.*

*TH: Mm hmm.*

*PT: Anger is anger.*

#### The Relation with the Father

The therapist now embarks on a systematic exploration of the patient's relation with his father. It is important to note the degree of spontaneous communication in this passage, which is in marked contrast to his early intense resistance:

*TH: So then your relationship with your father has been a very negative one.*

*PT: Yep.*

*TH: Mm hmm. You say it like that, "Yep."*

*PT: Well, that is such an established fact in my mind.*

*TH: Mm hmm. And if he had died when you were eleven during his operation, what would have happened in your life?*

*Pause*

*PT: Well (pause), ah, by that time I had had most of my physical punishment. I wasn't going to get much more of that.*

*TH: You mean your father was very physically violent with you?*

*PT: Yeah.*

*TH: How far back does that go?*

*PT: As far back as I can remember.*

The patient, with frequent deep sighs, described his early life with his father. He told how his father had a ruler with brass knobs on it, and how he would frequently put the patient over a table and would use this ruler to beat him severely on his rear end. With repeated sighs he said that this was a frequent procedure. He then brought out a new memory, that whenever he did something wrong at the dining table, his father would hit him over the knuckles with the blunt edge of a knife, and that this went back to the age of five, as far back as he can remember. He said that he was the target of all the punishment because he was the oldest. This was followed by yet another fresh memory, that after such a punishment his father would often lock him up in a dark cellar. Throughout this description the patient showed many signs of anxiety, and the therapist therefore focuses on his feelings:

*TH: How do you feel when we focus on your early life with your father?*

*PT: Ah, that is quite all right, ah, I had forgotten most of it.*

*TH: Because when you want to talk about these memories of your early life with your father, do you notice you are anxious, do you see the posture of your body and the way you move your body around in the chair?*

The patient said that he does not feel comfortable talking about his father. The therapist asked if the father was a basically aggressive person, to which the patient said, "Oh, no he's a coward like I am."

*TH: So, you mean that you have features like your father? You have similarities to your father, you mean?*

*PT: Oh, I think so.*

### History Taking

All initial interviews need to contain long passages in which essential information is gathered, but with such a highly resistant patient it is essential to carry this out after the breakthrough has been made. If this is not done the information obtained will be full of evasions and dynamically useless, whereas if it is done the information will be much more complete and presented with much greater honesty, and will lead naturally into further exploration of the dynamics and ultimately to exposure of the core neurotic structure.

It was therefore at this point that the therapist, knowing that the therapeutic alliance was strongly in operation, decided to explore the following: the patient's areas of disturbance, his recent relationships, and his medical and psychiatric histories.

He has suffered from disturbances in interpersonal relations with both men and women throughout his life, which are characterized by his being detached and withdrawn and often taking a belligerent, sarcastic, defiant position, particularly with males in authority. He distances himself from his feelings and has a conflict over intimacy and closeness. There are many masochistic traits in his character, and in his personal relationships there is self-defeat and self-sabotage. All these features, of course, were seen in the transference in the early part of the interview.

His relationship with women have been very disrupted. His last relationship, with a much younger woman, ended disastrously. Shortly after she moved in with him she had a nervous breakdown, and for four years she was in treatment and he could not put her out as she had no place to go—her father had run away, her mother was an alcoholic, and her grandparents who had brought her up were both dead. Before that he had had a number of relationships, but he terminated them all because his feelings changed. He was well aware of his problem over commitment.

His parents are in their seventies and, as mentioned above, the patient is the oldest. He has had lifelong conflict with all the members of his family, particularly his father, and he still has a very hostile relationship with his brother Gustave, who is six years younger.

As far as his psychiatric history is concerned, he has suffered from episodes of depression with the feeling that life is futile, but has never been actively suicidal. He has had no previous psychiatric treatment. His medical history is insignificant.

### The Transition to Further Dynamic Work: Death Wishes toward the Father and the Link with the Man in the Bistro (a P-C Link)

This transition occurred as follows: he described his father as in some ways good-looking, but his own face is similar to his mother's. He described his father as

thin, very energetic in his movements, very fast in action, always thinking about his next book or his next sermon. He then became involved once more in his memories of being punished "by the beautiful copper studded, brass studded ruler." Apparently there was also another rule for making parallel lines—"you take your pants off and he beats you on your bare ass." As he spoke of this he again became anxious and very uncomfortable.

*PT: Oh, I can still feel it.*

*TH: Uh hmm. When was the last time that he did it?*

*PT: Oh, God, I don't know, possibly before he got sick, before lung tuberculosis.*

*TH: How did you feel about his tuberculosis?*

*PT: That was actually a relief, ah, the old TB thing. It was a great relief.*

*TH: So his tuberculosis in a sense was on your side, hmm?*

*PT: Yeah, mm hmm, it certainly was.*

*TH: And his death would have been...*

*PT: On my side, but by that time I was so close to leaving Germany to come to this country that it did not matter in a way.*

*TH: But that doesn't make any difference, he had to die in order for you to have your freedom, hmm? That is quite a conflicting situation...*

*PT: That certainly is, and I have never thought of it and you may well be right.*

*TH: You said you wished out loud that he dies...*

*PT: Yes I did.*

*TH: So if you wished out loud that he dies, this means that you had been in such a painful state with your father, that he was such a pain in your neck...*

*PT: Mm hmm.*

*TH: ...that if he would have died then you would have had total freedom?*

*PT: Right.*

*TH: So this must be a very conflictual issue, that someone, in order to get his freedom...*

*PT: Mm hmm.*

*TH: ...has to have his father dead.*

*PT: Jesus, it's almost back to Christianity, hmm? Christ on the Cross.*

This remark of the patient's is not just a piece of defensive intellectualization, for it also contains a major communication from his unconscious therapeutic alliance. It is a sort of "slip of the intellect," for Christ on the Cross is God the Son, not God the Father, who suffered and died for Man's sins. The implication is that *some* of the patient's sufferings, i.e., those which—almost certainly—were brought upon himself by deliberate provocation of his father, were a self-punishment for murderous feelings against his father. The key to this is the fact that he provoked the man in the bistro to beat him up.

The therapist began by challenging the defensive element in the patient's communication:

*TH: You can sarcastically shuffle what I say, but that doesn't help. The pain and the agony is going to be there. And it's important that we look at the incident in the bistro. The man who beat you up, you describe him as energetic, highly mobile (i.e., like his father); but he wasn't physically stronger than*

*you. You gave him a mild blow and ended up to be beaten by him, black eyes, bleeding nose.*

PT: *Mm hmm.*

TH: *But you could have killed him.*

PT: *Yeah, I could.*

TH: *But you managed to be beaten by him, hmm?*

PT: *Mm hmm.*

TH: *Hmm? And if you had killed him who would you have killed?*

PT: *I can see that. I would have killed my father.*

### Further Exploration of the Relation with the Father and the Family Situation

During the next part of the interview the therapist focused on bringing the patient to the direct experience of all his complex and painful feelings toward his father. The first layer consisted of fear and anxiety; beneath this lay aggressive and sadistic impulses; and, most deeply buried of all, there was his tremendous craving for a tender father-son relationship, and the pain and sadness that this had never materialized. Each time the patient tried to move away from the subject of his father the therapist brought him back. Because by now the breakthrough had been made, the patient became more and more deeply involved as his feelings were de-repressed. At the same time it was possible for the therapist to include a great deal of history-taking, which was necessary in order to clarify the family situation, without spoiling the atmosphere of deep communication.

The interview unfolded as follows:

With frequent deep sighs the patient described his fear of his father. "I was deathly afraid of him most of my life." "I was aware of his presence all the time." "I was aware of him sitting up there in his study, shuffling his feet trying to keep warm." "I was aware of the typewriter stopping; I was aware of him coming down the stairs."

The therapist continued with history-taking. As mentioned above, the patient is the oldest. The brother next to him was two years younger and deaf and died at a very early age. There was another brother three years younger; and his brother Gustave was six years younger. There was also a younger sister.

With more sighs he said that neither his brothers nor his sister were punished by their father. It seems that the patient got all the punishment because his parents had a very high expectation of him—"I was to follow in my father's footsteps." The end result was that he became the black sheep of the system.

He brought out new memories underlining his tremendous rage against Gustave and further memories of his father's brutality. The latter gradually eased when his father developed tuberculosis.

### Return to the Transference

The therapist now focused on the patient's rage toward his father. This led to an extremely important transition passage involving complex transference feelings. As the patient spoke of further memories of the dark cellar he became both anxious and sad, once more tilting back his chair and looking at the ceiling. The therapist pointed out that transference-resistance: "You are avoiding me, looking up at the ceiling."

The patient used a symbolic communication which probably revealed anxiety about disclosing his feelings to the therapist (representing his father): Referring to the acoustic tiles in the ceiling, he said, "Yeah, I look at all these little holes; they are all listening to me."

### Positive Transference, Leading to Memories of Important Parent-Substitutes

There was then a dramatic transition. The patient became increasingly sad and began questioning the therapist about the brand of pipe tobacco that he is smoking, saying that the smell is very familiar to him. The therapist reminded him that he had asked a question in the corridor about the therapist's nationality, and the patient acknowledged his curiosity and interest. He then sighed several times and spontaneously spoke of his very close relation with his paternal grandfather, adding that the patient's father hated the grandfather (his own father). His grandfather died when the patient was about 20.

He talked sadly about how different his grandfather was from his father—"He was very nice to me, and I had a very close relationship with him." His earliest memory of his grandfather is from about the age of four. His grandfather built him toys and allowed him to work with him in his workshop. "I loved being with him; we played chess a lot, checkers." The therapist focused on the triangle of the patient/his Father/and his paternal grandfather, contrasting the close relationship with his grandfather with the murderous feelings toward his father. The patient spoke with sadness of his grandfather as a "refuge."

He then moved on to speaking about his paternal grandmother, with whom he also developed a very close relationship. This led from his search for father-substitutes to his search for mother-substitutes. His grandmother was very different from his mother. He went on to speak of an aunt on his father's side, "who was very close to me." He said that each time the family moved, "I would always find some kind of a substitute for parents, a mother and father, whom I would then call aunt and uncle."

The therapist focused first on the triangle of the patient/his mother/and his paternal grandmother—trying to reach his feelings for his helpless mother, and pointing out the contrast with his warm relationship with his paternal grandmother—and then on two further triangles, one involving his mother and his *maternal* grandmother, and the other his mother and his paternal aunt. The therapist summed up:

TH: *The way you talk about your mother is as if she never existed.*  
 PT: *That's right, that is what puzzles me...I never thought about my mother much.*  
 TH: *Mm hmm?*  
 PT: *I don't remember ever being touched by her. She was never demonstrative.*

### Negative Feelings for the Mother

It emerged that neither his father nor his mother was physically demonstrative. He described his mother as always busy, utterly subservient to his father, with a lot of children to look after, doing everything in accordance with the demands of his father, and in addition having to get through a war. However, this relatively sympathetic

view of his mother then changed into resentment toward her and memories of anger with her—she never stood up to his father, never did anything when his father punished him severely and put him the dark cellar. The therapist again summed up: his helpless mother and aggressive and brutal father, his search for refuge, and his turning to his paternal grandfather and the three women in his early life.

#### Final Breakthrough, Intense Mobilization of the Unconscious Therapeutic Alliance

At this point the patient becomes extremely sad and tearful, though still trying to avoid both the impact of his feelings on himself and the emotional closeness that would result from sharing them with the therapist. For this reason it is necessary for the therapist's interventions to include challenge to the transference resistance. After the first challenge the patient begins to sob, de-repressing with intense sadness one of the central issues in his pathology: that his suffering and messing up of his own life have unconsciously served the purpose of punishing his parents:

*TH: You see, you somehow don't want to experience the full impact of your feelings.*

*PT: No. Wait a second. I do this perhaps for the same reason that...  
(Pause)...*

*TH: You see, when your tears come then you move your head away from me.*

*PT: (Sobbing) Well, it is too late. (He is sniffing)*

*TH: I know there is a lot of...*

*PT: I don't... (He is crying very loudly) I don't want to punish them anymore.*

The therapist knows that he must bring in the other side of the coin:

*TH: But obviously you are punishing yourself as well as them.*

*PT: (He continues to sob) You mean...*

*TH: In punishing them you are punishing...*

*PT: (He continues to sob) I just want to let sleeping dogs lie as far as they are concerned.*

*TH: Yeah, that is one way of going about it; but the other way is the fact that you are punishing yourself and punishing them as well.*

The therapist now begins to sum up:

*TH: You have a lot of mixed and painful feelings about them. There are a lot of mixed feelings there, and you yourself know that you are messing up your own life—and then there is a part of you also that has a lot of bitterness about it. And obviously there is a part of you that has a lot of craving for an affectionate relationship that you wish you could have had with your father. Do you see what I mean?*

*PT: (He continues to be very sad and tearful) Yeah.*

*TH: And obviously it is very painful when you want to look at it at this time of your life. (Pause) It must be very painful.*

At this point the therapist detects the nonverbal cues that the transference resistance is still in operation, and he returns to challenge:

*TH: But when this moment of sadness and tears comes, you also avoid my eyes as well.*

*PT: (He continues to be tearful) I can't see very well.*

*TH: You don't want me...in a sense it has to do with closeness, doesn't it? In a sense...as if you have decided that you are not going to allow anybody to get close to you in your life...*

*PT: Come on, I would have been out of that door long ago.*

*TH: Hmm?*

*PT: I would have been out of that door long ago if that was true.*

*TH: I know...maybe a part of you wants to get close to me, but a part of you says the other way around, the part of you...*

*PT: Oh, no.*

*TH: ...might say that you are not going to allow anybody to get close to you; but another part of you says the other way around.*

*PT: Well, maybe, maybe so. I wouldn't know.*

The therapist continues with his summing up, "flag-labelling" some of the important areas of conflict revealed by unmistakable evidence in the interview so far:

*TH: But that is something to look at. It has to do with intimacy and closeness vis à vis distancing and the wall—which I pointed out to you when we met. There is a major conflict over intimacy and closeness, and as we can see you have a lot of unresolved issues and feelings about yourself and your life in relation to the past, particularly with your father, with your mother as well; and obviously there are a lot of unresolved issues in relation to your brothers and sister. We have only touched on one of your brothers, Gustave. Obviously, there must be a lot of mixed feelings about your grandfather—because as we have seen he stands very strongly in your life—who at very difficult moments in your life...Obviously there are a lot of mixed feelings about the women in the early phase of your life. I refer to your grandmothers and your aunt. What do you think? Am I right that way, or is it different?*

#### The Grandfather's Death, Leading to Thoughts about the Father's Death

Although the patient had thus been invited to talk about the women in his background, he seemed to want to talk about his grandfather. The therapist decides to go along with this, exploring another area that may well be a source of unresolved feelings, the grandfather's death:

*PT: Ah, you are. I am sure my grandfather was a great help.*

*TH: How did he die?*

His grandfather died of old age. The patient used to write to him and went to see him before he died. He sighed frequently when talking about this. He said that he

doesn't even know the color of his father's eyes, or his mother's. "I remember the eyes of my grandfather much better than my father's," he said.

In talking about his grandfather's death he spontaneously moved to his realization that sooner or later his father will die, and his thoughts about his father's death. The therapist focused on this. It seems that his father had never learned to drive and that his mother used to do the driving for the two of them. However, she suffered serious brain damage after being knocked down by a car and now cannot get around. His father therefore learned to drive at age 65, but he is a terrible driver and is likely to have an accident at any time. His brothers and sister have expressed the hope that if their parents died they should die together. "If one of them is left for one reason or another, it is going to be terrible 'cause my father can't live alone and neither can my mother." Asked to portray the death of his parents, he said they are asleep, eyes closed; his father has his glasses on. He said he portrays it like that because from his childhood he remembers that the most peaceful times were when his parents were asleep together. "Of course, I would hardly ever see that; one wasn't allowed in their bedroom."

#### The Relation with His Brothers, Leading to Grief about the Relation with His Father

The therapist now focused on the patient's relation with his brothers. His relation with Gustave has always been negative and hostile. He went on to speak of another brother who managed to have a good relation with their father, "he was the most politic of all, always played both sides, always stayed on good terms." Then back to Gustave who still has a very good relation with the father. The patient became very anxious and uncomfortable and said, "thank God I didn't cut his artery." The therapist focused on the triangle of the patient/Gustave/and their father, and spoke of the patient's craving for closeness in relation to his father. He became increasingly sad, sighed frequently, and cried:

*PT: I don't want to continue to punish my father. (Pause) You know, I don't want to tell them that they have been terrible parents, which they have been. I am sure they have been told.*

*TH: You see, you have a lot of painful feelings. And the most important thing is what goes on in your own head; that is the most important issue because really if they die that doesn't solve your problem.*

*PT: No. I think it makes it worse, maybe.*

*TH: Maybe?*

*PT: Maybe.*

*TH: Now you want to...*

*PT: Well, I had some faint hope when I applied here that I might be able to do something about what goes on in my head before I went back.*

*TH: Mm hmm.*

*PT: Whatever that will happen to be, I don't know.*

*TH: So, in a sense a part of you senses that if your father dies as well as your mother then you would have left something unresolved in the back of your mind. And then a part of you wants to resolve these issues. That is, what I am*

*saying is this, that you are not at peace with yourself in relation to your father as well as your mother. I am not talking about your father being alive or dead—but you are not at peace with your own self. You see...*

*PT: I realize that.*

*TH: But that is very important because from what we have seen today that is the key to the whole core of your problem. From what we have covered so far there are a lot of unresolved and complicated feelings and issues with your father, a lot of complicated feelings with your mother, and Gustave, and others we have not touched, which are the sources of many of your difficulties. We know that clearly they are interfering with your interpersonal life, but I forgot to ask you if they are interfering with your functioning in your professional life.*

*PT: Yes, they are.*

*TH: Do you think that you are functioning at the level of your potential?*

*PT: No, I don't think so.*

*TH: So then they are interfering...*

*PT: Mm hmm.*

#### Final Phase: Recapitulation, Exploring Motivation

The therapist now moved to further summing up, preparing the ground for bringing the interview to a close:

*TH: From what we have gathered so far, you have been suffering from diffuse and a wide range of problems, problems in interpersonal relationships with both men and women, and your life with women has been disastrous. You suffer from episodes of depression with times when you feel life is futile and you have a tremendous need to get yourself into a passive, helpless, beaten position at one level and a stubborn, sarcastic defiant position that everything has to be a certain way, at another level. Have you ever given thought to these two sides of yourself?*

*PT: You mean passive, helpless...*

*TH: And on the other hand highly demanding and sarcastic.*

*PT: I can see how I switch. Even without knowing.*

*TH: At another level is a tremendous need for you to put on a facade, to portray yourself as insensitive and non-feeling while we have seen today that underneath the facade is a sensitive man. Do you see what I mean?*

*PT: I can see that, and I know that I can portray myself as absolutely insensitive.*

*TH: On the other hand and in spite of your professional achievements you have a very empty life.*

*PT: Absolutely, absolutely.*

*TH: You left your country and came here to find your freedom, but obviously the shadow of the past is chasing you.*

*PT: Mm hmm. I can see that.*

*TH: As I said, we have covered the surface of some aspects of your problems, and part of you might want to avoid the painful issues in relation to your father, your mother, and many figures in the early part of your life; but another part*

*of you might want to get rid of these suitcases, to get rid of the shadow of the past which requires putting all your feelings in relation to all these issues in the right perspective, to see the truth as it is.*

*PT: I realize that.*

*TH: Do you think if what we did today, if we do it in much more detail, this would be of help to you? To get rid of this shadow of the past, these suitcases you are carrying with you, and find your way to freedom?*

*PT: Are you asking me...*

*TH: Do you think this might be of help to you?*

*PT: Are you asking me whether I think continuing this procedure would be of help to me?*

*TH: Mm hmm. If we continue in more detail, obviously. We only touched on the surface.*

*PT: Oh, I have no doubt.*

*TH: Do you think that would be of help to you?*

*PT: Absolutely.*

## Discussion

### The Patient's Psychopathology

From this single interview it is now possible to reconstruct a large part of the patient's central neurotic structure and to relate it to his history.

It seems that the patient's father hated his own father, and that much of this hostile father-son relation became transferred to his eldest son, in such a way that the other siblings escaped. In response to this the patient clearly became defiant and insolent, setting up a vicious circle with his father which resulted in repeated, very severe, sadistic punishment. The patient was unable to turn to his mother for warmth and protection, since she apparently was cold, passive, and completely under the domination of her husband. He therefore turned to his paternal grandfather, his two grandmothers, and an aunt. This probably made his father jealous and hostile and intensified the vicious circle.

The patient's underlying feelings in this situation consisted of hostility against both parents, intensely guilt-laden murderous feelings toward his father, and jealousy and hatred of his siblings, with overtly expressed murderous feelings toward his brother Gustave. Underneath this lay a grief-laden craving for the closeness that he had never experienced with either parent, and unresolved grief about the loss of all the parent-substitutes throughout his life, particularly the death of his grandfather.

The defenses against these feelings have laid down the pattern of his behavior and relationships in adult life. He now defends against all these painful and guilt-laden feelings by denial, isolation of cognitive and affective processes, intellectualization, and the pretence of being uninvolved and insensitive. He has a craving for closeness but cannot allow himself any true involvement or commitment for fear of the pain and rage that would result from his being rejected. In his relations with people of all kinds, but particularly male authority figures, he alternates between insolence, provocativeness, and defiance on the one hand, and passivity on the other. His insolence serves to distance himself from other people; and in addition it brings retaliation, which serves as punishment for his guilt-laden violent feelings. He also

expresses his need for self-punishment by sabotaging his own potential in every area of his life, both relationships and work. This serves the additional purpose of his becoming a living reproach to his parents, thus expressing his need to punish them as well. Finally, we see the important role that superego pathology plays in this patient's character neurosis.

### Recapitulation of the Course of the Interview

We are now able to describe the whole interview in the light of these concepts.

At the beginning of the interview the patient expresses his lack of involvement and uncooperativeness by appearing quite unable to describe his problems. When this is challenged he rapidly becomes provocative, defiant, and insolent, at first hidden and then overt (e.g., putting his feet on the table). This serves the purpose of expressing hostility without actually becoming emotionally involved in it, and clearly illustrates a current pattern in his relation with male authority figures, originating in his relation with his father. Systematic challenge eventually leads to penetration of this defense when the patient becomes overtly angry with the therapist and raises his voice. When he is able to experience and to acknowledge this, there follows the first breakthrough. The patient's strongly mobilized unconscious therapeutic alliance now produces a crucial "cover memory," the incident in the bistro, which clearly crystallized essential elements in his relation with his parents.

The essence of the incident is that he witnessed a man repeatedly provoking a woman, who appeared unable to prevent this from happening. His own first reaction was intense rage and he attacked the man, but his attack was "unconsciously deliberately" ineffective and resulted only in his getting beaten up himself. We can now clearly see the significance of this incident in terms of the past: the aggressive man and the helpless woman representing his father and his mother; and his own reaction consisting of murderous rage which was so guilt-laden that he needed to provoke the man into punishing him for it—just as in his childhood he had provoked his father. As he speaks of this incident he becomes intensely involved, fascinated by it without knowing why, and overcome by sadness, breaks into tears—which he does not yet know is concerned with the past situation that it represents.

He now spontaneously mentions his parents, but as he speaks of his father the transference resistance becomes reactivated in the form of further defiance. With mobilization of the therapeutic alliance that has already occurred, this resistance can now be dealt with by analysis rather than challenge. The therapist is able to perceive in the patient's act of putting his feet on the table and tilting back his chair many of the main elements of his relation with both his father and the man in the bistro—defiance, aggression, distancing, and putting himself in danger of physical injury. Interpretation of these elements leads to a major response, the patient speaking first of death wishes toward his father and then of overt murderous feelings toward his more favored brother Gustave. This in turn enables the therapist to make the link with his father and with the man in the bistro—murderous feelings for which the patient needs to bring punishment on himself. This passage has thus completed the triangle of person, transference (T), the father(P) and the man in the bistro (C), and therefore constitutes a major T-C-P interpretation of the resistance.

This leads to a long account, in which the patient becomes deeply involved, of the early relation with his father and the severe punishment which he had received at

his father's hands. Speaking of this again reactivates the transference resistance, and this time the therapist interprets the patient's avoidance of emotional closeness in the interview itself. This again produces a major response. The patient first acknowledges his positive feelings for the therapist, and then goes on to an account of the positive relations in his life—the grandfather as father substitute and various female relations as mother substitutes. This leads in turn to the patient's resentment against his mother for never giving him warmth or protecting him from his father.

When the therapist helps to make all this explicit the result is the final breakthrough into the unconscious. The patient becomes intensely sad as he realizes that much of his self-sabotage has served the purpose of punishing his parents. Behind this he becomes conscious of protective feelings toward his parents—"I don't want to punish them any more"—and the craving for the warm relation that he never had.

The evaluation is now completed and the therapist is able to bring the interview to a close.

#### Consequences of the Initial Evaluative Interview

The trial therapy model of initial interview I have developed and have described in these two articles brings about a major breakthrough into the dynamic unconscious, no matter how resistant the patient is. One sees a number of major consequences of such an interview:

- (1) The patient has been able to withstand the impact of his own unconscious, which indicates that he/she is a candidate for Intensive Short-Term Dynamic Psychotherapy.
- (2) The patient shows an unmistakable increase in motivation to start therapy.
- (3) Over the following days or weeks patients experience an upsurge from their unconscious in the form of vivid dreams and fresh memories which throw further light on their central neurotic structure.
- (4) Patient reports therapeutic effects.
- (5) After such an interview the therapist can be quite certain that in skilled hands the patient is suitable for Intensive Short-Term Dynamic Psychotherapy of up to forty sessions' duration.
- (6) Finally, our systematic studies of patients suffering from depression with severe characterological problems, patients with characterological depression, and those suffering from functional disorders in a setting of severe characterological problems show that a single trial therapy of 3–5 hours' duration can bring about a major unlocking of the unconscious with massive de-repression with major therapeutic effects both symptomatic and characterological.

#### Conclusions

In this two part article I have described a powerful technique of Short-Term Dynamic Psychotherapy which I refer to as Intensive Short-Term Dynamic Psychotherapy. I outlined my technique of trial-therapy model of initial interview which can bring a major breakthrough into the unconscious with every patient who suffers from character neurosis and comes to the interview in a state of high resistance. My work

has made clear that in every such patient the royal road to the unconscious is based on the technique I have discovered to handle resistance and the patient's direct experience of his transference feelings.

Systematic pressure on and challenge to the resistance brings about intensification of resistance and with further challenge to and pressure on the resistance we see the creation of an intrapsychic crisis and the phenomenon I have described, turning the ego against its own defenses. This process mobilizes complex impulses and feelings in the transference (T), and when these transference feelings reach a specific threshold and are both experienced and acknowledged there occurs a massive unlocking of the unconscious with de-repression of a similar feeling in the patient's current (C) and past (P) relationships.

During this work I have been able to reformulate some aspects of the classical psychoanalytic theory of neurosis. This is in the process of preparation for publication and has been presented in many symposia, courses, and core training programs. I have outlined my metapsychological conceptualization of the triggering mechanism responsible for the unlocking of the unconscious. I have described a number of metapsychological issues, but the one major element in the structure of the human neurosis as applies to this article is a major invasion of ego functions by a punitive superego structure. The case presented in these two articles is an example of the crucial role that superego pathology plays in this patient's severe character neurosis.

The crucial part played by transference in this process will probably come as no surprise to dynamically trained therapists, and the breakthrough can be achieved completely and within a short time with every patient suffering from character neurosis, no matter how resistant. It is an observation that can no longer be denied, and it offers great hope for the future development of psychotherapy throughout the world.

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# Intensive Short-Term Dynamic Psychotherapy with Highly Resistant Depressed Patients: Part I—Restructuring Ego's Regressive Defenses

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This is the first part of a series of articles describing the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of patients suffering from depressive, functional and psychosomatic disorders. These patients suffer from a deep-seated inability to experience the Impulse/Feeling component of the triangle of conflict, mistaking various defensive manifestations for the impulse itself. If they are challenged too strongly their anxiety level is raised and the result is a serious exacerbation of their condition. However, by the use of carefully graded pressure and challenge it is possible to restructure the defensive mechanism, and it is now safe to use unremitting challenge in order to achieve a breakthrough into the unconscious. The article concludes with a clinical example of this phase of an interview with a chronically depressed patient.

Scholarship has discovered many aspects of unconscious mental processes. Throughout his life Freud was searching for better ways of achieving access to the unconscious. In "The Psychopathology of Everyday Life" he outlined many ways in which unconscious mental processes manifest themselves at a conscious level, such as jokes, slips of the tongue, parapraxes, daydreams and dreams; and he considered the interpretation of dreams as his most important contribution, referring to it as the royal road to the unconscious. One can say that Freud's constant search was for ways of overcoming the phenomenon of resistance, which was considered a very powerful force and which as we know is the inevitable consequence of the basic mechanism underlying neurosis, namely the repression of feelings and impulses because they are painful or unacceptable. In his struggle with this force Freud first employed hypnosis, and when he found this to be unsatisfactory he moved to the technique of suggestion in the waking state, which in turn he found exhausting and unreliable. He then realized that if the patient was simply asked to say whatever came into his mind, the repressed feelings, memories, and impulses would return in a disguised form; and if he translated the disguise he could gain inroads into the unconscious and bring the pathogenic forces into consciousness. This finally led him to the fundamental rule of free association and the development of the classical psychoanalytic technique as practiced today. Freud and generations of analysts have satisfied themselves that the only way to work with the powerful force of resistance is the technique of free association, which is followed first by the development, and then the analysis, of the

transference neurosis. This has finally been accepted as the only way to work with patients' resistances. Perhaps it never dawned on Freud and later generations of analysts that it might be possible to achieve a rapid major unlocking of the unconscious, making possible a direct view of the core neurotic structure responsible for all the patient's neurotic suffering. In my previous publication I have outlined what I consider to be my most important discovery and contribution, namely the technique of handling resistance and transference in such a way as to trigger the unlocking of the unconscious in a single interview. I have demonstrated that this is not an event that happens with a few—or even a dozen—patients, but that it can be achieved with every patient suffering from structural neurosis, with the sole exception of those with severe fragility of the ego. As a result of this discovery, during the course of more than twenty years I have developed a system of Short-Term-Dynamic Psychotherapy which is highly effective over the whole spectrum of structural neurosis. As I have described elsewhere, this begins with trial therapy in the initial interview, the most important aspect of which is the unlocking of the unconscious through the direct experience of transference feelings, leading to a direct view of the core neurotic structure. I consider this to be the true royal road to the unconscious. It must be obvious that this has profound implications for the future of psychoanalysis and all dynamic psychotherapies.

In summary, my standard technique for handling highly resistant patients is as follows:

Pressure toward the experience of repressed feelings, which leads to an intensification of resistance.

Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of resistance.

Systematic pressure and challenge to the transference-resistance leading to a further intensification of resistance.

Head-on collision with the transference-resistance. Creation of intrapsychic crisis with turning of the ego against its own defenses.

Direct experience of the complex transference feelings—the "triggering" mechanism.

Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious.

Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.

Major de-repression of current or recent past (C) and distant past (P) conflicts, leading to a direct view of the dynamic unconscious and multi-focal core neurotic structure.

I have outlined the details of handling the resistance, with the analysis of clinical examples, in a number of publications (see Davanloo, 1978, 1980, 1986a and b). As indicated above, this concept of unlocking the unconscious is not based on generalization from a few observations. It is based by now on large series of audiovisually recorded interviews by myself as well as by many clinicians trained by me in my technique. Almost all these patients were suffering from severe neurotic disturbances and major character pathology.

The standard technique as described above is used with the majority of highly

resistant patients, including those suffering from ego-syntonic characterological disorders, i.e. those in which the patient does not recognize certain character patterns as a problem, as long as these disorders are not complicated by any of the following conditions to be mentioned below. In these uncomplicated cases the therapist employs constant pressure toward the underlying feeling or impulse (e.g. "how do you experience your anger with me?"), and then steadily increases challenge to the defenses, and does not take the pressure off until the unlocking of the unconscious has taken place.

However, there are a number of conditions in which this technique has to be modified, namely clinical depression, chronic and characterological depression, functional disorder such as common migraines and irritable bowel syndrome and psychosomatic disorders.

Our extensive clinical data show that these patients suffer from a wide range of character pathology, which may be ego-syntonic or ego-dystonic. One of the major features of all these patients is a deep-rooted inability to distinguish between the corners of the triangle of conflict, particularly the *impulse* of rage and the *anxiety*. In both depressive and somatic patients the unconscious defense mechanism instantly internalizes the rage, with the result that they do not experience the repressed sadistic impulse, but instead experience an exacerbation of symptoms, which may or may not be accompanied by an increase of anxiety. In many depressive patients the impulses are homicidal, and when these impulses are internalized in this way the result is depression with suicide. Further, it seems that the explanation of psychomotor retardation is that is a defense mechanism designed to prevent the patient from acting on his impulses.

What I have systematically demonstrated is that with these depressive and somatic patients it is possible to bring about a total restructuring of the unconscious regressive defense responsible for their symptoms, and moreover that this is an essential step before proceeding to the complete unlocking of the unconscious. Trial therapy then becomes divided into two phases:

1) The phase of restructuring the ego's regressive defense mechanism by means of graduated pressure and challenge, and

2) The phase of unlocking the unconscious by means of intensified and unremitting pressure and challenge.

It is very important to state that if the therapist does not employ this two-stage technique, and instead maintains his pressure and challenge too strongly or too persistently, the result will be an intensification of depression or an exacerbation of somatic symptoms. If he does employ the two-stage technique, on the other hand, the result after a single trial therapy will be in the opposite direction, consisting of a marked lifting of depression or the complete disappearance of the functional disorder.

In the first part of this series of articles I will focus on the technique of restructuring the depressive defense mechanism.

### **The Technique of Restructuring the Depressive Defense Mechanism**

If the therapist has any reason to suspect that the patient suffers from depression, he must create an early opportunity to explore its nature and history. If the depression turns out to be chronic or characterological, then he will institute the

restructuring technique. An entry into the patient's problems will usually be provided by some incident or situation involving current relationships which has been associated with an attack of depression. The therapist employs gentle pressure toward the patient's underlying feelings, followed by gentle challenge to the defenses, and will very soon confirm that the patient cannot differentiate between the corners of the triangle of conflict. Instead of describing the feeling or impulse, which almost always involves anger, the patient will describe anxiety or defense, and will quite often fail to understand that this is happening. The aggressive impulse is directly and instantly internalized so that it never reaches consciousness at all, but instead manifests itself as an increase in depression.

The therapist's aim is then, by graduated pressure and challenge, to bring the impulse gradually into consciousness, so that the depressive defense mechanism is undone. Moreover, since pressure and challenge invariably produce a rapid rise in transference feelings, the area in which this is accomplished is the transference. The patient's ego now becomes able both to experience the anger in the transference and to understand the mechanism by which it had formerly been avoided. The aggressive impulse is no longer instantly repressed, but passes the repressive barrier. Now the ego can clearly distinguish between impulse, anxiety, and defense—the three corners of the triangle of conflict—and the whole defensive system has been restructured.

This may of itself lead to a breakthrough and the unlocking of the unconscious, and if it does so, well and good. If it does not the therapist can then proceed to the second phase, the unlocking of the unconscious by means of unremitting pressure and challenge. This is possible because now the ego has the capacity to withstand the impact of the dynamic unconscious.

A description of the technique in further detail is as follows. As the therapist employs pressure and challenge he monitors signs of anxiety in the patient with the utmost vigilance. He is very careful never to arouse more anxiety than the patient's ego can bear. When necessary he can reduce the pressure in three main ways, (1) by turning back to enquiry, (2) by switching his pressure to another area, or (3) by asking the patient to describe the actual experience of anxiety. He can then return to pressure and challenge, this time increasing it from, say, "one plus" to "two plus," again monitoring the patient's response, and so on.

Pressure will be concerned at first with current relationships. (In the following pages these will be designated by the letter C, which term is used to include recent relationships though these may not necessarily be still current.) As the pressure mounts the patient's complex transference feelings (T) will be rapidly activated, and—as mentioned above—will almost always include anger. The therapist awaits his opportunity and now begins to exert pressure and challenge in this area (T). Once more, he is very careful to take the pressure off as soon as he observes that too much anxiety is being aroused. He increases the pressure gradually, as before, and it may be necessary to deal with other aspects of transference as well as anger, e.g. the patient's resistance against acknowledging positive feelings or allowing emotional closeness. Finally the impulse is experienced directly instead of being instantly internalized.

The restructuring process has now begun, but it is very important to state that it does not end there. It must be followed by a long phase of *consolidation*, in which every aspect of transference, whether already touched on or not, is systematically analyzed, over and over again, in a way that sometimes may seem repetitious.

Nevertheless, extensive clinical research data has shown that this repetition is absolutely necessary, in order to ensure that the patient both experiences the underlying feelings and understands the way in which they were formerly instantly internalized. Thus there is a considerable didactic element in this phase, and the therapist repeatedly draws the parallel, and points out the contrast, between the transference and current relationships (the T-C link). If all this is not done, what is inevitably observed is that the defenses reestablish themselves almost as inflexibly as before. If analysis of transference is done, on the other hand, the restructuring can finally be completed; and the therapist can now proceed to the full unlocking of the unconscious, if necessary by means of unremitting pressure and challenge.

The technique will now be illustrated by a clinical example.

### **The Case of the Woman with a Machine Gun**

This was a single woman of 30. She suffered from characterological depression which had intensified into three major depressive episodes. Each of these had lasted from six months to a year, two in adolescence, and one had been severe enough for the patient to describe it as a nervous breakdown. In addition she suffered from the following: Chronic anxiety: which has permeated all aspects of her life. Severe disturbances in interpersonal relations, in which she was unable to allow herself emotional closeness and constantly took the role of victim, letting herself be used and abused.

Severe sexual difficulties: severe pain during intercourse and totally anorgasmic. A pattern of constant self-defeat and self-sabotage throughout her life. Self-directed aggression: on a number of occasions she had banged her hands against the wall to the point of severely bruising them. Long-life characterological problem, characterized by distancing, detachment, shifting from passivity and compliance to defiance, inability to assert herself.

### **Initial Contact**

The session started with the therapist focusing on the circumstances of her referral. She said that she was self-referred, and then the therapist focused on the nature of her previous treatment. She said that she had been in psychotherapy with a psychologist on a once a week basis. She went to him for her depression, but he had focused on her sexual difficulties and her being anorgasmic. The following passage refers to the set-up in her previous treatment, which immediately reflects on aspects of her characterological problems.

*TH: So you were separated from each other by a curtain?*

*PT: Yeah, yeah.*

*TH: And you said he would play music?*

*PT: Musical tape. I don't even remember what the tapes were, and he would just say just let yourself fantasize and tell me what are you thinking.*

*TH: Fantasize?*

*PT: Yeah, and tell me what you are thinking.*

*TH: Uh hmm. And you said there was also a curtain?*

*PT: He had me doing various exercises I guess.*

*TH: What do you mean guess?*  
*PT: I was clothed, but I was touching myself.*  
*TH: Touching yourself where?*  
*PT: Well, sexually.*  
*TH: You would masturbate yourself you mean?*  
*PT: Yeah, but clothed, I . . .*  
*TH: With clothes on?*  
*PT: Yeah. (Laughs). It was you know, his idea, not mine.*  
*TH: How did you masturbate with clothes on?*  
*PT: Well it was more a question of fantasizing, he was saying. You know just like to touch.*  
*TH: Touch your genital? But then fantasize?*  
*PT: Yeah. But then just. . .*  
*TH: And what was your fantasy?*  
*PT: It was. . .it was more tied into the tapes and I can't remember what the tapes were. I found the whole thing silly.*  
*TH: But now let us not call it silly. You went for the treatment.*  
*PT: The treatment was focusing to help me to overcome my inhibition and I didn't get anywhere really.*

What emerged is that she finally terminated the treatment with her therapist. She was very uncomfortable describing this experience.

One of the major components of a comprehensive trial therapy is transference and countertransference evaluation. The format in the majority of cases is that the therapist first obtains a phenomenological description of the patient's difficulties, which in turn is followed by transference/counter-transference evaluation. However, in patients such as this—especially where transference has been activated by previous therapy—transference/counter transference evaluation is done first, and this by itself gives important data regarding the patient's areas of disturbance and especially the area of her characterological problems.

At this point in the interview the therapist knows that the patient suffers from depression and sexual difficulties, and he makes the following inferences:

(1) that her depression is of the kind that calls for the technique just described, in which transference-countertransference evaluation is carried out first;

(2) that the situation that developed in her previous therapy, in which she passively complied with her therapist's choice of focus, and ended up by being exposed to humiliation, was itself an expression of characterological problems, one being an inability to assert herself and the other a tendency to enter into situations in which she is used and abused.

### Focusing on Some Aspects of the Patient's Characterological Problem

*TH: You go yourself on your own will but then the focus is on sexual problems which you have, okay?*  
*PT: Uh hmm.*  
*TH: But you say that you have had other major difficulties but the focus is on sex and you go along with it.*

*PT: Yeah, I know. It sounds funny.*  
*TH: Let's not to call what it sounds. It looks like this: that you have gone for many major difficulties, most important of all your depression, but he decides to treat your sexual difficulties and you follow him without raising any question.*  
*PT: Uh hmm.*  
*TH: Are you a follower type? Do you have problems with assertiveness? Hmm?*  
*PT: Yes, I don't follow, I back off. . .if I am having a confrontation with someone and one of us has to assert, and one of us has to follow, I will do neither, I will just back away.*  
*TH: You mean you take flight.*  
*PT: Yeah from the situation. . .rather than say no, this is not. . .*  
*TH: So you are the type of person that you take flight.*  
*PT: Yeah I am not assertive.*  
*TH: Is this a problem for a young woman? I don't know, I am questioning you.*  
*PT: Yeah.*

### The Transference Implication

So far the process has focused on some aspects of the patient's characterological problems, her inability to assert herself, her inability to say no, and particularly her tendency to take flight, as manifested in her previous treatment, and now the therapist brings into focus their implications for the present transference relationship.

*TH: My concern here is this: are you going to follow me or are you going to. . .*  
*PT: No, because I have been through that and I. . .I want to get the most that I can get out of this session.*  
*TH: You have problems with assertiveness, either you don't assert yourself or you take flight from the scene.*  
*PT: Right.*  
*TH: Which is similar.*  
*PT: Yes basically the same thing but uh. . .*

What emerges is that her inability to assert herself is much more pronounced with men. "I will either go along or I will run away from the situation completely".

*TH: Which is worse?*  
*PT: Neither is worse, they are both bad.*  
*TH: And you smile and say it is.*  
*PT: Well running away is lonelier in the long run, but being too compliant is uh. . .uh. . .is not satisfying on any level, it may not be as lonely.*  
*TH: So either you take flight from the scene or you bend over backwards to please the other person.*  
*PT: Yeah, yeah.*  
*TH: You have any hesitation about that?*  
*PT: No, that is pretty much what I do.*

*TH: Are you saying that to agree with me?*  
*PT: No, I'm . . . I'm . . . at the same time I'm learning the difference between running away and complying, uhh, I'm not. . .*  
*TH: You see in every relationship you say you are either very passive, compliant or you take flight.*  
*PT: Right.*  
*TH: Now my question is this. How would that apply here? Is it going to be compliant in relation with me or are you going to take flight from here?*  
*PT: No, I am not going to run out because I have made up my mind.*  
*TH: That there would not be a flight.*  
*PT: No. . . no. I won't do that. I want to work these things out.*  
*TH: How about the other side, submissiveness and bending over backwards to please, how that would apply here with me?*  
*PT: That would be something I have to fight, if I did not agree I would have to say it, but it will definitely demand an effort on my part cause on my part it is not something I would normally do.*  
*TH: Uh hmm. So you see, to begin we have a problem in front of us which might interfere in what we want to do.*  
*PT: Yeah, but it is a recognized problem, recognized by me.*  
*TH: But this is an important issue, do you see what I mean?*  
*PT: Yes, I do, but I don't think it is a major problem because now I recognize it, and therefore can just. . .*  
*TH: Okay, hopefully then you would be able to exercise that as we go on.*  
*PT: Yeah. I expect this to be hard work, I don't expect this to be easy.*

In the foregoing passage we saw the extensive work that the therapist did on the transference. The therapist brought into focus the way in which two characterological problems, namely passivity or flight, might become an obstacle in the process of therapy. The patient's responses finally were very positive, and the therapist then proceeded to take the history of her depression.

### The History and Nature of the Patient's Depression

She has had three major episodes of depression in her teenage years, one at 13 or 14 and the other at 18. Each lasted one year. The third depression she referred to as a nervous breakdown. Since then she has had frequent episodes of depression lasting from a few days to one or two weeks. The therapist made a careful assessment of the extent to which her major ego functions are affected during depression. While depressed she manages to continue with her job.

Then she talked about an episode of depression experienced three years ago which lasted three to four weeks. The therapist focused on the circumstances that triggered this off. She was living in a house which she shared with three other people, her brother Peter and his girlfriend Gina, and Gina's brother Tony. They had been living in the house for a year, and she described her relationship with her brother as strained and conflictual. The patient is 30 and her brother is one year younger.

She referred to the year of living in this house as being "absolutely disastrous." She described her brother as easy-going and referred to his girlfriend Gina as a "self-admitted hypochondriac," suffering from massive anxiety attacks and always

complaining. Peter and Gina had been living together for some time. She described Gina's brother Tony as being highly manipulative, highly intelligent, and with a cruel streak liking to hurt people, to put them down. In view of this it is significant that she was interested in Tony sexually.

The focus is on her relationship with Tony. For some time she was chasing him, there was a lot of teasing, but there was no sex. She was pursuing him, but he was turning it into jokes. He did not want to have sex with her; he was involved with another girl. Tony finally broke off with his girlfriend, and the patient got the feeling that Tony was interested in her but wanted to take his time, so finally she stopped chasing him.

### The Triangle of Conflict in Relation to a Recent Relationship (C)

*PT: Uhh, well he finally broke off with his girlfriend, his signals were mixed. I got the feeling he was interested but wanted to take his time and not move too fast and then when he did make his move it was just to slap me in the face.*  
*TH: Slap on your face.*  
*PT: Yeah it was uh. . . I had stopped chasing him.*  
*TH: Uh hmm.*  
*PT: It was no longer fun, okay. And he commented on it, he says you're not coming up with the repartees anymore, and I said well the ball's in your court now. I'm not playing the game anymore.*  
*TH: What do you mean balls?*  
*PT: I was telling him that if you want to make the next move it's up to you, I'm not chasing you anymore. So he let a couple of days go by and then he. . .*  
*TH: But when you say the ball is in your court are you saying. . .*  
*PT: That's an expression I used.*  
*TH: I know, but are you saying prior to that it was in your court?*  
*PT: Yeah, I was doing all the chasing, okay, and uh which was very flattering to him and it was fun, it was good-natured for both of us but then I just stopped doing the chasing. I just stopped and he went oh, how come?*  
*TH: So you told him that the ball was in his court and prior to that then the ball was in your court?*  
*PT: Right.*  
*TH: Which ball are you talking about?*  
*PT: No, it is just a figure of speech. I am just saying that. . .*  
*TH: Yeah, but maybe there is something about this figure of speech.*  
*PT: I'm sorry?*  
*TH: Maybe there is something in it when you say ball in your court and ball in his.*  
*PT: It's a tennis expression, that's all. That's all it means to me.*  
*TH: What does it mean to you?*  
*PT: That it's now his turn to serve, it's his turn to make a move.*  
*TH: And then?*  
*PT: That's all. He did, he made a move, he approached me one evening when we were alone in the house, and uh we spent most of the evening building up slowly to go into bed together, and then when I turned around he was gone.*

What emerged was that she had gone to the washroom to change into her nightgown, and when she came back into the living room Tony was not there. He had gone to his room, hiding under the blankets in his bed, and he told her that he had changed his mind, and the patient says she was very much humiliated. "The guy was weird."

### **Establishing Whether the Patient Requires the Restructuring Technique**

This incident, which obviously might have been expected to arouse intense anger, gives the therapist the opportunity to establish whether (1) the patient is capable of truly experiencing her impulses; or whether (2) she can only experience the other two corners of the triangle of conflict, defense and anxiety, in which case he will have to use the restructuring technique with which this article is concerned. At the same time he undertakes the evaluation of another important issue, namely, whether or not she suffers from a tendency toward functional disorder as well as from depression. This would mean that part of her response to the above situation would be mediated through involuntary (smooth) muscle, resulting e.g. in irritable bowel syndrome, rather than voluntary (striated) muscle, expressing itself through such action as withdrawal, taking flight or tension in striated muscle. If involuntary muscle is involved, then the need for a carefully graduated technique is even greater than if she suffers from depression alone. This is the reason why in the following passage the therapist concentrates so strongly on the nature of her physical reaction.

### **The Triangle of Conflict in a Current Relationship (C) (Cont'd)**

In the above passage the therapist for a few moments focused on the issue of the ball, but did not want to get entangled. He knows that this woman has suffered from major depressions, so he focuses on the triangle of conflict in relation to Tony, employing a certain amount of pressure and challenge, to see if her ego is able to differentiate between impulse and anxiety. The following passage indicates that at the unconscious level the impulse goes directly into the defense, and that what the patient experiences is anxiety expressed through voluntary muscle.

*TH: And then how did you react to this situation?*

*PT: Iuhh...I got, uhh, very remote for a few days. I stopped talking to anybody.*

*TH: But how did you feel? "Remote" is a mechanism you use to deal with the feeling at that moment.*

*PT: Uh yeah, I was hurt, I was very...*

*TH: What was the way you experienced this hurt?*

*PT: By pulling away from the other three people.*

*TH: But that doesn't say how you felt.*

*PT: I felt hurt.*

*TH: How did you experience this physically?*

*PT: I was hurt.*

*TH: You say you are badly humiliated...Let's to see how you felt.*

*PT: I was humiliated and I was angry with him. Not, you know, blind angry, but I was angry. I mean it's...it's an anger.*

*TH: You mean you were angry with him?*

*PT: Yeah.*

*TH: How did you experience physically this anger?*

*PT: There was no physical reaction. I was just...I...*

*TH: You use a word to describe something that you say you don't know how...*

*PT: Well what other word is there besides angry?*

*TH: You see you say you are angry okay?*

*PT: Yeah.*

*TH: How did you physically experience this anger? When you are anxious, you have some tightness in your chest, you might get some butterflies in your...*

*PT: Yeah, I perspire.*

*TH: So you perspire; your voice might become shaky; your mouth might get dry; you have the physical manifestation of anxiety, but now...when you are in a rage or anger how physically you experience that?*

*PT: I was not enraged.*

*TH: So you were angry.*

*PT: Yeah.*

In the above passage we saw the therapist focusing on the feeling, the lower corner of the triangle of conflict, but what she described was a defense "very remote for a few days, stopped talking to anybody." Under pressure, she finally said that she was angry. The therapist now explores whether she can really experience her anger.

*TH: What was the physical reaction, how did you experience this anger physically?*

*PT: I was just angry, uhh. There was nothing really noticeable. I wasn't that angry. I was...I was humiliated.*

*TH: You were somewhat angry.*

*PT: Uh hmm. But not enough to have any physical reaction that I can remember...I don't remember having any kind of...I did not get the shakes, uh...*

*TH: You did not get the shakes. Let's to look to this. You were humiliated, and let us see how did you react to this humiliating situation?*

*PT: I went to bed, that is how I physically reacted.*

*TH: But that is flight.*

The evaluator has clarified the defense in the triangle of conflict. I refer to this as a clarification of the defense as the patient is not experiencing the impulse, and the process is not in the domain of the unconscious.

*PT: Yeah, I went to bed, but physically I didn't do anything.*

*TH: But how did you experience your anger? You said you were angry.*

*PT: Then I guess I didn't experience it.*

*TH: Here is a situation that Tony humiliates you and you don't have any reaction and you go to bed.*

*PT: Yeah I didn't even cry.*

*TH: But you say anger. What was it that you were experiencing which you label as anger?*

*PT: Well, I don't know what else to call it. I was angry but I did not break out in sweats. I really don't.*

### **Reducing the Pressure by Returning to Enquiry in the Area of C**

From the above passage it is clear that the patient's ego cannot differentiate between impulse, anxiety, and defense. In view of the fact that she has had major episodes of depression and has been chronically depressed, it is clear that the impulse is directly internalized, and the technique calls for restructuring the ego's defensive operation to undo the mechanism of depression.

As described above, an essential feature of this technique is that pressure and challenge should be carefully graduated, and therefore the therapist's first move is to reduce the pressure *for the moment* by returning to pure enquiry.

In reply to the question, "What happened then?" the patient said that she was "flabbergasted" and that it was "anti-climatic." For a few days she was very withdrawn. The therapist explored her state of mind during those few days and she said that she was confused and embarrassed and she spoke of "severe humiliation." Exploring the confusion, she said that she didn't know what was going on and she added "I really felt sorry for the jerk," thus clearly describing the depressive defense of turning anger into sorrow. She finally resigned herself to the idea that "it was not a big deal," now describing the defense of "sour grapes." "All I wanted from him was sex; I was not emotionally attracted to him at all." It became clear that she lets herself be abused by men, and that is her way if handling a conflictual situation is to walk out of it.

The therapist now returned to pressure and challenge at an increased level.

### **Return to Pressure and Challenge in Relation to C**

*TH: We are looking to your reaction.*

*PT: Physical reaction was virtually nil.*

*TH: You notice you put your fist like that. (One of her hands, which was hanging, changes to a fist)*

*PT: Yeah, I know.*

*TH: You smile now.*

*PT: I know. (laughs)*

*TH: You put one hand between your legs and the other hand like this and then you say physical reaction was nil.*

*PT: But it was.*

*TH: Do you notice that in a sense you are crippled to declare to yourself how you really feel? In the beginning you told me either you submit or you run away from the scene—flight.*

*PT: Yeah.*

*TH: So in a sense you are crippled either to assert yourself... .*

*PT: Hmm.*

*TH: Flight is another form of being crippled.*

*PT: Yeah.*

*TH: Is it or isn't it?*

*PT: Yeah.*

*TH: You agree because I say so or. . . ?*

*PT: No. I agree because it is true. . . 'cause one is not solving it.*

*TH: It is crippling for a woman of your age. How old are you?*

*PT: Thirty.*

*TH: Either you are not able to assert yourself, the person walks all over you, or the other way is to take flight from a situation, hmm?*

*PT: Uh hmm.*

*TH: So both of them are crippling for a young woman of your age, isn't that? Let's to see how you felt. You said you felt angry.*

*PT: No I didn't. I didn't.*

In the previous passage of pressure and challenge the therapist had merely reiterated his questions about the patient's feelings, concentrating mainly on physical manifestations, and using no challenge stronger than simply pointing out the nature of her defenses ("remote is a mechanism. . ." "but that is flight"). In the above passage he has increased the pressure and challenge, e.g. repeatedly speaking to the patient how her ego is crippled and pointing out that her nonverbal signals belie her denial of feeling. He knows also that these challenges will have mobilized some degree of unconscious impulse in the transference. Nevertheless, the patient has finally used the defense of retraction, now completely denying her former clear statement of anger with Tony ("not blind anger, but I was angry"); and this serves as a warning that any immediate attempt to confront her with her anger, whether in the area of C or T, will arouse too much anxiety, and merely result in the impulses becoming immediately repressed and turning into depression. Therefore, once more he takes off the pressure by returning to enquiry, asking "What happened subsequently"?

### **Reducing the Pressure a Second Time by Returning to Enquiry in the Area of C**

The patient now described another incident with Tony. Two weeks after the previous incident, Tony invited the patient's sister Linda to dinner and he and Linda slept together and had sex. She said that she was angry because Linda has her own apartment. "What's to stop them from going to her place?" Now the therapist is able to focus again on the triangle of conflict in relation to Tony, this time in a three-person situation. At this moment one can say that the unconscious therapeutic alliance is in operation; for, by bringing a second incident, she provides another opportunity to focus on how she experiences her feeling. Moreover this mobilization of the unconscious therapeutic alliance confirms that the therapist's move of reducing the pressure was correct, keeping the anxiety at just the right level.

*PT: Why do it under my nose two weeks after he's kicked me in the face?*

*TH: Hmm.*

*PT: I thought that was more than just a little bit mean, that. . . that was really humiliating. . . that kept me awake all night.*

*TH: In a sense, that night Tony was having sex with your sister?*

*PT: Yeah, down the hall.*

*TH: And you were hearing the way that they had intercourse?*

*PT: I'm not curious about how other people make love, how other couples, you know, behave. That doesn't interest me.*

*TH: Uh hmm.*

*PT: But that. . .*

*TH: Night.*

*PT: Episode was more. . .more humiliating. I did not sleep all night.*

*TH: That was maximum. . .*

*PT: Yeah, that is the worst I've ever. . .I've ever experienced. Then I experienced the anger. I don't know if it was anxiety, but I. . .I didn't sleep.*

All night she was awake, tossing and turning.

*PT: I was just. . .I was ruminating, thinking about, you know, what. . .what was happening.*

*TH: What was happening? He's having sex with Linda.*

*PT: Yeah.*

*TH: Uh hmm.*

*PT: But figuratively speaking right under my nose. Uhhh he uh,. . .the crudeness of it. Not having sex, but doing it under those circumstances. . .*

*TH: Uh hmm.*

*PT: How he had manipulated me two weeks before.*

*TH: What was your reaction? So far what you said, you were mute for a few days.*

*PT: Yeah.*

*TH: And Linda your sister is having sex with Tony next to you.*

*PT: Yes, in a sense, yes.*

*TH: What was your reaction?*

*PT: Uhh aside from the lack of sleep I was uhh. . .I gotta think back because I. . .I haven't blanked it out otherwise I wouldn't remember any of it, but I. . .*

### Return to Challenge in the Area of C

The therapist now returns to challenge, stepping it up considerably.

*TH: Do you notice you have tremendous difficulty to declare your negative feeling? You say you were devastated, humiliated.*

*PT: Yeah.*

*TH: But you have tremendous difficulty to declare. . .In a sense you are almost crippled here to tell me how you really felt.*

*PT: Well, I. . .I. . .*

*TH: I get the feeling, and you should not just agree, because we know that is a problem you have, what I say. . .*

*PT: Uh hmm.*

*TH: But I feel you are crippled to say how you really felt toward Tony who humiliates you in such a way.*

*PT: I find it difficult to verbalize it.*

*TH: But I am talking about how you feel.*

*PT: Yeah, but to say how I feel. You see if I say I'm angry. . .*

*TH: But you are crippled almost, here, here.*

*PT: Yeah.*

*TH: But "yeah" is not enough, and you smile as well.*

*PT: (laughs) It is because I recognize it. But uh. . .*

*TH: A woman at the age of 30 so paralyzed to talk about her emotions and feelings in such circumstances of the kind you describe.*

*PT: I don't know why, uh, I never. . .*

*TH: You are almost crippled here.*

*PT: Yes. . .*

The therapist now directs his challenge to the therapeutic alliance, i.e., the patient's ego:

*TH: Yes is not enough. Let's to see what you are going to do about it.*

*PT: But I don't know why.*

*TH: Here right now we are not looking at why you are crippled. We are looking that you are crippled, that you are paralyzed. First we have to identify that you are crippled and paralyzed.*

*PT: Okay (softly).*

The words "crippled" and "paralyzed" are directed not only at the ego but also at the superego, which supplies the force responsible for the patient's paralysis. In the following intervention the challenge is directed first to the ego and then to the id:

*TH: Then we have to see what you are going to do about it. You must have a lot of feeling about such a disastrous situation, at two levels. You must have a lot of feeling toward Tony. . .*

*PT: There is still a lot.*

*TH: Who humiliates you that way. And also Linda who is humiliating you, hmm?*

*PT: Yeah.*

*TH: But "yeah" is not enough. Let us see how you really feel.*

*PT: How I felt then or how I feel now towards them?*

*TH: Then or now, because obviously these are the ulcers of your life.*

The above passage demonstrates some aspects of the process of restructuring the ego's defense mechanism. In the second incident the therapist has increased the challenge and the pressure on the patient's resistance, and it is important to note that the system of challenge and pressure is along the line of the structural concept of the psychic apparatus, namely, Id, Ego, Superego. Throughout the process it is absolutely clear that the evaluator is only challenging the patient's maladaptive defenses and not the patient herself. And this is of crucial importance in my technique. Throughout the challenge and pressure the responses are carefully monitored, and all the indications are that not only has there been no adverse effect, but that the patient's feelings are considerably nearer to the surface. The therapist takes this as his cue to switch his attention to the transference.

**Challenge to Resistance in the Transference (T)**

TH: What I'm bringing to your attention is that even when you want to talk about it you are taking a paralyzed, crippled position with me.

PT: Because I'm not accustomed to telling people how I really feel.

TH: And you prefer to call me "people" rather than me. Do you notice that?

PT: Yes, but . . .

TH: Let's not rationalize about that.

As the patient has problems with intimacy and closeness, the evaluator brings that into focus in the transference.

TH: You prefer to call me "people" rather than me. In a sense you say 'I don't want to share with you or to let you—that is me—to get close to my intimate thoughts and my intimate feelings'. This is what you are saying.

PT: Yes it is, yes it is, is what I'm saying.

TH: But then you put it in a vague term—"I am not accustomed to talking about these things with people".

PT: It's easier to say it that way.

TH: Let's see. Then a major problem is between you and me.

PT: No it could be anyone saying that.

TH: Doesn't make a difference. Right now it is me.

PT: Yes right now it's you, fine.

TH: And now we know you have two ways of dealing with every issue; you either submit or take flight, and both of them are crippling processes. Compliancy is crippling you as much as flight, okay?

PT: Yeah.

TH: So what you say is this; you don't want to share with me your intimate thoughts and feelings. . .

PT: It's not that I don't want to but it's difficult.

TH: Doesn't make a difference. But that is a major obstacle.

PT: Yes it is.

The therapist continues to increase the pressure.

TH: I'll tell you why it is a major obstacle. And I have a feeling you have a problem—again I emphasize, don't agree with what I say because you have a problem there. I have a feeling that you have a major problem with intimacy and closeness.

PT: Well I don't know how I'm supposed to correct it.

TH: We should identify it. Is it or isn't it?

PT: Yes.

TH: You are putting a wall?

PT: Yes. But I'm not putting one, it's already there. It's there when I walked in.

TH: Okay, is there, doesn't make a difference. Putting it consciously or putting unconsciously still is there.

PT: Still there.

TH: So there is a wall between you and me okay?

PT: Uh hmm.

TH: And this wall is like this; "that I would not want to have this stranger; I am not going to let this stranger get to my intimate thoughts and feelings." And it is very important we look to this process.

PT: Yeah, but even I don't know what they are.

TH: Doesn't make a difference. But the wall is there. Now you say it is not intentional okay but still is there.

PT: Fine.

The patient is still highly resistant but she has shown no adverse reaction to the increased pressure, and the therapist therefore introduces the maximum challenge—the head-on collision with the resistance in the transference.

TH: But still is an obstacle. I'll tell you why it is an obstacle. Let's look at it. You and I are here together. The aim of this is that you and I, that we can establish what are the nature of your difficulties and problems that are paralyzing your life, okay. And then also to get to the core of your problem, to understand what is the engine to all these difficulties that you have. So this means if you put a wall, intentionally or nonintentionally, when the wall comes up between you and me we will not be able to understand the nature of your difficulties and we will not be able to get to the core of your difficulties, to the engine of all your problems.

PT: But I don't even. . .

TH: Then this process is doomed to fail. Up to the time the wall is there then the process is going to fail. Let me tell you what way it fails. Because up to the time you don't want me to get to your thoughts and feelings, again intentionally or non-intentionally then we would neither understand your problems nor get to the core of the problem. Then I would become useless to you on one hand. We depart from each other, okay, at some point today, we depart from each other. I say, okay I did my best to get to understand this woman's difficulties in life but then I failed. I can afford to fail because I cannot always be successful, but can you walk from this office and perpetuate your paralyzed life. Can you? Can you afford that?

PT: I didn't expect to walk out of here cured today. I mean I don't know. . . I don't know what to say.

TH: But do you see what I mean?

PT: Yes I. . . I. . .

TH: Right now we see there is a self-sabotaging pattern in you.

PT: Of course there's a wall there, if there wasn't. . .

TH: Yeah but first is what are we going to do about this wall?

PT: Today I don't know besides identify the fact that it's there.

TH: Yeah but you see again you want to postpone it which is another form of flight.

PT: No, I think it's called being realistic.

**Challenge to the Non-Verbal Defenses in the Transference (T)**

*TH: Now what you say is I am unrealistic. Is it that? You see again you don't want to look to my eyes and say I am unrealistic.*

*PT: I don't know what you want from this. What I want. . .*

*TH: Now you see again you use "what I want from this." We are here to get you out of this crippled life. Of course you are the one to decide is it a crippled life or isn't it?*

*PT: Yes, it is.*

*TH: And it is sad that a woman of your age is running a life which is so paralyzed. One one hand you have your potentiality and on the other hand you have paralyzing forces within you.*

*(pause)*

*And you have tears also in your eyes and you avoid my eyes. Do you notice that you avoid my eyes?*

*PT: I don't like to cry (spoken softly).*

*TH: How do you feel when you look to my eyes?*

*PT: Embarrassed.*

The above passage shows systematic work on the transference with the therapist assessing communications both to the patient's conscious and unconscious. There was a rise in the pitch of the patient's voice when she implied that the therapist was unrealistic. The therapist has no doubt that there is a rise in transference feeling, but he maintains his attention on the wall and distancing, and the patient starts to cry. It is of crucial importance at this moment to differentiate between the regressive defense of weepiness and genuine painful feelings which come from the unconscious. If it is a regressive defense it should be challenged, but if it is genuine sadness which comes from the unconscious it must have its link in the past. But there is a third phenomenon that he should take into consideration; that is, the emergence of sadness as the ego-syntonic characterological problems becomes ego-dystonic and the patient starts to realize that this maladaptive, ego-syntonic characterological problem has messed up a major part of her life. In my teaching on this subject, I always bring to the attention of the therapist that if you are not sure, don't move and challenge it as a regressive defense, and equally don't move to the idea that the breakthrough is taking place. Don't fall into the trap of the phenomenon which I have referred to as *mirage*. We take up the interview.

*TH: How do you feel when you look at my eyes? (Patient is sniffing) . . . because you are avoiding me in a sense.*

*PT: I know I am.*

*TH: And I am repeatedly saying avoidance is another part of your problem. You are terrified of closeness with me.*

*PT: Yeah.*

It is of importance to note that each time the therapist verbalizes the words intimacy or closeness, there is a rise in the patient's anxiety betrayed by frequent sighs, which confirms that in this particular patient intimacy and closeness must be a major conflictual issue. Obviously the truth is that in all character neurotics there is

some degree of conflict over intimacy and closeness, but in some this is much more intense, and this applies to this particular case. We don't want to conceptualize nor speculate about the reasons for this at this moment. We only look to the moment when we open the dynamic unconscious and have a direct view of the core neurotic structure.

*TH: And that is what I'm saying, this is a major obstacle for a woman in life. Of course I am not the one to decide, you are the one to decide. In this. . .*

*PT: Well this is one of the reasons I came, yeah.*

*TH: Hmm?*

*PT: This is one of the reasons I came here.*

*TH: So you feel uncomfortable to look at my eyes?*

*PT: Yeah.*

*TH: But let's see how you feel when you look at my eyes?*

Patient is highly charged, with frequent deep sighs.

*PT: Uhh. . .*

*TH: Again you are still avoiding my eyes.*

*PT: I know!*

*TH: But you know is not enough.*

*PT: (sighs) It's uncomfortable. (sniffing)*

*TH: But let's to see how physically you feel when you look to my eyes?*

*PT: Physically no worse than when I don't look at them.*

*TH: You see I say how you feel physically. Makes you anxious when you look to my eyes?*

*PT: No uhhh. . .*

*TH: What? I'm questioning, how do you. . .*

*PT: I'm trying to tell you. I'm having trouble breathing. I'm having trouble talking. . .*

*TH: Right now you're. . .*

*PT: Yeah whether I look at you or not I'm having that trouble.*

*TH: You feel tightness in your chest you mean?*

*PT: No, just, uh, short of breath.*

*TH: Shortness of breath. And when you are anxious you get this way?*

*PT: Yes.*

**Reducing the Pressure by Exploring the Physical Experience of Anxiety (T)**

There is a rise in the level of anxiety and there are frequent sighs. Here I want to point out an important technical issue: In patients with obsessive character structure and severe ego-syntonic character pathology, with no history of depression or functional disorder, if challenge and pressure on the transference resistance mobilizes anxiety, one should not divert the process by asking the patient to describe the physiological concomitant of the anxiety or how the patient experiences anxiety. On the contrary the technique calls for maintaining the challenge and pressure. But in

patients with depression or functional disorder one should definitely move to exploring how the patient experiences the anxiety, which brings anxiety down to a level that is manageable. Here we should note that we are still in the process of restructuring the patient's regressive defenses. We take up the interview where we left off.

*TH: When you are anxious you get tightness in your chest. What part of the chest do you get this?*

*PT: I get shortness of breath.*

*TH: I know, but do you feel a pressure in the middle of the chest or do you feel like a tightness?*

*PT: No heavy. Not pressure, heavy.*

*TH: Heavy. Do you get any palpitations?*

*PT: No.*

*TH: Only pressure.*

*PT: Yeah.*

*TH: When you are very anxious?*

*PT: Yeah.*

*TH: Are you anxious right now?*

*PT: No, actually I feel better now than before I cried.*

*TH: Uh hmm. Did you feel anxious here with me?*

*PT: Yes I did.*

*TH: How do you feel right now?*

*PT: Uhh. . .*

### Further Challenge to the Transference Resistance (T)

For a very brief moment the evaluator has focused on the patient's anxiety in the transference. Now having checked that her anxiety has been reduced, he immediately moves back to challenging the transference resistance.

*TH: Again your eyes are not with me.*

*PT: I know.*

*TH: A smile, hmm. (The patient laughs) A cover up.*

*PT: Yeah.*

*TH: You know, I feel that you are a woman of facade.*

*PT: I'm very good at that.*

In this response the patient is making clear that her facade is ego-syntonic. The therapist's next intervention is designed to make it ego-dystonic.

*TH: Yeah but when you say you are very good at that, that is the ulcer of your life. Do you see what I mean? You say you are very good at that but that is the most crippling factor—facade.*

*PT: Yeah.*

The focus is on her facade and what emerges is that in her job she constantly keeps up the smile while inside she is agonized, and she says that this is a habit "which

is hard to break." The therapist clarifies with the patient the way she defends against her inner feeling by smiling. She says that when she is very nervous she ends up giggling, which indicates another form of facade. Then the focus is on the here and now as she has frequent sighs. She says that she feels anxious and her hands are sweaty, "I fidget." Then the therapist questions the patient from where her tears came a moment ago, and she says, "You wouldn't let me fake it anymore," "The realization that I would not be able to fake it." Then the focus is on the tears and weepiness and the clarification of this as a defense to sabotage the process. And further the session moves to her giggling and smiling and the clarification of this as a set of mechanisms to deal with her underlying anxiety. She adds that they have a releasing function. Then there is a recapitulation on the smile and giggling as a mechanism for dealing with the anxiety and at the same time releasing some of the built up tension. Crying and weepiness also have a releasing function, while at another level they are used as a mechanism for avoiding and sabotaging a confronting situation. Then there is a recapitulation on the mechanisms of passivity, submissiveness, weepiness, flight and the whole set of regressive defenses that she uses. Then the session focuses on the patient's self-sabotaging pattern, and there is a return to the transference.

### Return to Challenge in the Transference—The Need to Defeat (T)

*TH: As we have seen so far there is a need in you to sabotage.*

*PT: Yes, I do.*

*TH: That you set a goal for yourself and you defeat that goal.*

*PT: Yeah.*

*TH: But the question is this. How that applies here with me? Still you are distancing yourself. So if you put the wall it means defeat, and then we depart from each other this process would be a failure like your life.*

*PT: Yes.*

*TH: Maybe you want to defeat this by your distancing and add a new addition to your past.*

*PT: I know that on a short term basis it would be a lot easier to walk away from this, but I also know that on a long term basis I must not.*

*TH: But you see what I'm saying is this; if you walk out of here defeated. . . If this process defeats then you might go and carry a crippled life to your grave. My question is this: why should you do that?*

*PT: No I. . .*

*TH: You have along way ahead of you. Why should you set the stage for. . .*

*PT: I shouldn't, that's why I'm here. That's why I'm here because I don't want that.*

*TH: So then we should keep that in mind.*

*PT: Yes.*

*TH: That defeat means perpetuating the crippling life to your grave and you are young and you have many years ahead of you. This is very important we monitor it.*

*PT: Yeah.*

*TH: Your need to defeat. I cannot be an exception to this rule.*  
*PT: No. No you're not.*

### Focusing on the Patient's Feeling in the Transference (T)

*TH: How do you feel right now?*  
*PT: A lot more scared.*  
*TH: Uh hum.*  
*PT: A lot more scared.*  
*TH: Scared.*  
*PT: Scared yeah. You know it's one thing to tell you that this is going to be a lot of hard work, and it's another to realize exactly how much.*  
*TH: And then the barrier and the wall between you and me, hmm.*  
*PT: I don't know if it's gone, uhh.*

### Return to Resistance in the Transference (T)

*TH: We can see your eyes constantly avoid me still. You prefer actually to interact with the all than with me.*  
*(Patient laughs)*  
*TH: You can laugh, but there's a truth in it.*  
*PT: Well, yeah, walls are easier to deal with, yeah.*  
*TH: So let's see what we are going to do about that because you don't want to be in interaction with me, you want to interact with the wall.*  
*PT: No what I want is to get out of this rut.*  
*TH: Okay but the major issue. . .*  
*PT: The problem is the wall.*  
*TH: Immediately the major obstacle between you and me is this need in you to erect a massive wall.*  
*TH: Yeah.*  
*TH: Then I would be on the other side of the wall and you are on this side of the wall. And I don't know what has happened in your life in the past. . .*

### Further Systematic Challenge to the Resistance in the Transference (T)

*TH: . . .that you are terrified of intimacy and closeness. But whatever has happened in your life that you decided to set up this massive wall, this massive wall between you and I is going to cripple the process that we are aiming at, as it has done outside of here. But outside is not the issue right now. The issue is what are we going to do about you and I and the massive wall you put between you and me?*  
*PT: Well I've got to get rid of it, but I don't know how.*

*TH: You move to the helpless position.*  
*PT: No I. . . I really.*  
*TH: You see when you say I don't know how, that is the helpless position.*  
*PT: Okay so it's the helpless position. I don't know how!*  
*TH: But the helpless position wouldn't help us. And you have developed a pattern of moving to the helpless crippled position and obviously weepiness is another way of. . .*  
*PT: I find it. . . I find it a great release.*  
*TH: I know, but still is a crutch.*  
*PT: Yeah, okay, fine.*  
*TH: You see you say 'okay,' fine' but that. . .*  
*PT: I find it to be a release and. . .*  
*TH: I know but still is a crutch. Still is a crutch.*

As we see, the therapist has returned to the patient's resistances. There is a systematic challenge and pressure to the patient's tactical defenses including weepiness. Her communication that she is more scared was handled as a regressive maneuver to put the therapist off. The therapist is now putting further pressure which brings about weepiness and anxiety.

*TH: So we know your anxiety and your weepiness. . .*  
*PT: Uh, fear and uh. . .*  
*TH: Anxiety and weepiness we have seen. What else besides fear?*  
*PT: Some anger.*

### Admitting to Anger in the Transference

The question for the therapist at this moment is this: Is the anger itself a regressive defense or is it a true impulse? Is it from the lower corner of the triangle of conflict or is it from the upper left corner? We take up the interview where we were left.

*TH: You felt some anger?*  
*PT: Yeah uhhh. . .*  
*TH: Do you notice when you want to say "some anger" your hand is like this?*  
*PT: Yeah, I'm very nervous.*  
*TH: You see when you want to declare to me you were angry with me you don't want to look into my eyes and directly tell me that during this process you had anger towards me. Do you notice that?*  
*PT: Yeah.*  
*TH: Again you prefer to tell to the wall that you had anger towards me rather than to tell me. Why? Why when you want to declare you were angry with me you had to look to the wall or look somewhere else and avoid my eyes? Not to look at my eyes and tell me that you were irritated or angry with me.*

As I mentioned earlier, these patients have a major difficulty in distinguishing between impulse and anxiety. Restructuring the regressive defenses of the ego

requires that the impulse must actually be experienced by the patient in the transference situation, which means that the defense mechanism of instant repression of the aggressive impulse is no longer in operation. At this moment the patient is declaring anger. Those interested in learning and practicing this technique should not only have a precise knowledge of the anatomy of the psychic apparatus, they should also have a clear knowledge of the physiology of psychic processes. Here the work of Cannon on the Fight-Flight reaction is of importance. At this very moment she declares anger in the transference, and if we monitor it carefully her level of anxiety is much less. Her body movements have changed; she moves her hands, and there is some rise in her voice. The tension in her jaw is no longer there. From all this we have an indication that there is a good possibility that the true unconscious impulses and feelings are breaking through. The therapist continues to clarify the triangle of conflict.

*TH: You said you felt angry with me.*

*PT: Yes.*

*TH: But it is very important for you to examine it. During the moment that you felt angry with me, was there also anxiety?*

*PT: Yes there was.*

*TH: Okay, so on one hand there is anger, on the other hand is the anxiety. Do you think there is a link between the anger and the anxiety? That whenever you get. . .*

### **Breakthrough of the Impulse in the Transference (T:) The T-C Link**

The therapist increases the pressure by asking how she experiences her anger, and she says, "anger is anger." The therapist points out that it is still not clear how she physically experiences her anger toward him. Further he brings to her attention the incident with Tony (T-C link) when she also said she was angry, but what she actually experienced was first anxiety and then detachment, and she ended up in her room banging her two hands against the wall until they were badly bruised, which was followed by her being depressed for some weeks. The patient raised her voice and said, "This is different."

*TH: In what way is it different?*

*PT: I am telling you that I am angry.*

(Rise in voice)

*TH: If you put it out in terms of thoughts and ideas, what would you want to do to me?*

(The patient raises both her clenched hands at the therapist. Her voice is loud.)

*PT: I would grab your lapels and shake you badly.*

*TH: What further would you want to do to me in terms of thoughts and ideas?*

*PT: I would grab you and shake you badly.*

*TH: Then what would happen to me?*

*PT: (A loud voice with frequent sighs) You would be on the floor.*

*TH: So you throw me on the floor. What else? Would you damage me?*

*PT: No. (Increased level of anxiety. She is now sitting on the chair in a more controlled position.) I don't want to damage.*

What we have seen is the breakthrough of the impulse through the repressive barrier. For this short period the defense mechanism responsible for her depression was undone, which means that her aggressive impulses were no longer instantly internalized and she actually experienced the difference between the impulse and anxiety. This is of crucial importance. Unless this takes place the therapist should not under any circumstances move on to a major unremitting challenge to the patient's resistance. This differentiation in the triangle of conflict is a prerequisite to the phase of major challenge. Extensive accumulated clinical data both with currently depressed patients and patients with life-long depression show the following: that if the therapist does not reconstruct the ego's regressive defense mechanism and proceeds to major challenge, the result is that the patient becomes more depressed, the ego becomes flooded with anxiety, and the process becomes paralyzed.

### **The Phase of Consolidation by Systematic Analysis of the Transference Understanding of the Depressive Defense and the Contrast Between T and C**

The patient has now actually experienced the impulse in the T, which the therapist now links with the incident with Tony (C). She can clearly see the difference. He drives this lesson home, making absolutely sure that she understands the difference.

*TH: In terms of experiencing anger, you actually experienced it with me?*

*PT: Yes.*

*TH: It is very important that we look and examine the process that took place here with me. You experienced some degree of anger in relation to me, which was to the level of grabbing me and shaking me and throwing me on the floor.*

*PT: Uh hmm.*

*TH: But if we go back to the incident with Tony, what differences do you see?*

*PT: It was very different. That was more anxiety and tension. With you my head is*

*very clear, but with him I was very confused. . .*

*TH: But we should look at this carefully. There, there was rage that somehow you did not experience and you set up a set of mechanisms against the rage. Then you became anxious, remote, detached and subsequently became depressed. Do you see what I mean?*

*PT: Yeah.*

*TH: But these are mechanisms you use to defend against your negative impulses as well as other feelings that so far we don't know.*

*PT: I can see it clearly.*

*TH: But another issue you might want to look at are the incidents in which you end up badly damaging your hand. Do you think the way you deal with your rage is to instantly turn it against yourself, taking it out on your hands?*

*PT: Uh hmm. I can see the difference between what I have been calling anger and what I felt here.*

*TH: Okay.*

### **Further Analysis of the Transference: Exploring the Positive Feelings (T)**

After the analysis of the triangle of conflict in the transference and its link with C, the further analysis of the transference is of crucial importance. It completes the restructuring of the patient's ego defense mechanism. In addition, we should not forget that patients with life-long depression have some degree of impoverishment of ego functions and the libidinal energy is at a low level. This process of analysis of the transference serves the purpose of fueling the ego for the final journey. Extensive clinical data show that beneath the repressed sadistic impulses—the “butchery houses”—that are found in these patients, there lie extensive grief-laden layers of painful feelings which are equally profound. Our journey to the dynamic unconscious requires the ego to have the capacity to withstand the impact of a major outpouring of these sadistic impulses and painful feelings, and we have to equip the ego before we start the second phase of the journey. The restructuring of the ego's defense mechanism, which includes the systematic analysis of the transference, is a preparation for this journey to the unconscious.

So far, with this patient, the therapist has brought into focus both the whole set of defense mechanisms against negative impulses and her problem over intimacy and closeness. He now pursues the positive feelings directly, immediately arousing further anxiety and resistance.

*TH: Okay. But then you said that you would not go further than that. Do you think that between this also maybe there is some positive feeling toward me? (Pause) In a sense you didn't want to leave me damaged?*

*PT: Hmm. Yes. . .uhh (the patient is anxious).*

*TH: When I talk about the positive. . . You see when I talk about the positive feeling you get paralyzed as well.*

*PT: I get squirmy, yeah.*

*TH: Uh hmm. How you felt when I said there might have been also positive feelings toward me?*

*PT: I wanted to deny it right away.*

*TH: Positive feelings?*

*PT: There was.*

*TH: You always talk about the past. There was a positive feeling.*

*PT: (Laughs). No.*

*TH: A smile. But obviously you have a conflict about the issue about the positive feeling as well. Because as soon as I used the words “a positive feeling” toward me, that mobilizes as well anxiety in you. Isn't it that? You see as also I talk about the positive feeling you freeze, hmm?*

*PT: Yeah.*

*(Patient sighs)*

*TH: You saw the deep sigh?*

*TH: Hmm? Hmm?*

*PT: I don't know what to say.*

*TH: But it is very important you examine it because when I say you have problems with intimacy and closeness, there is also the problem with the positive as well as the negative.*

### **Return to Negative Impulses and Further Analysis of the Mechanism of Depression**

*TH: You see, you said that the side that has to do with the negative is dead. Obviously it is not dead. It is defended against by a variety of mechanisms.*

*PT: Uh hmm.*

*TH: Do you see what I mean? That the rage and the murder—all the aggressive impulses within you, they are not dead, they are defended.*

*PT: Yeah.*

*TH: There are a set of mechanisms you use in dealing with all these negatives and rage and the murderous impulses there. One of the mechanisms you use in depression which is very crucial because when you get depressed you turn it against yourself, and then you become a crippled person. Because you know, you have experienced what it is like when you are depressed.*

*PT: Yes.*

*TH: You see. Then life is no good, life is gloomy and you know, the thoughts are gloomy, the world is no good and you have the feeling that it would be better to be dead.*

*PT: Yeah.*

*TH: You see. So you have experience first hand. You have had firsthand experience of what it is like to be depressed. So one way of dealing with this massive rage is turning it against the self and getting depressed and weepy. Another mechanism of it, that you use is becoming defiant.*

*PT: Hmm.*

*TH: You distance yourself, withdrawal, detachment okay. Locking yourself up in the room. Another mechanism is to use a regressive pattern of dealing with it. Namely banging against the wall, yelling and this and that. You see a wide range of mechanisms that you use. Another mechanism is the level of anxiety that comes in a split second. To the level that you don't even experience the anger. You see? Okay. But if you look awhile ago, when your hand went. . . like that, you experienced the negative impulse. It's different from anxiety.*

*PT: Yes.*

*TH: Is different isn't it?*

*PT: Yes.*

*TH: But anxiety also comes immediately. Okay?*

*PT: Yeah.*

**Return to Analysis of the Transference in Terms of Closeness (T)**

*TH: But what I want to say is this; the same is a serious conflict about intimacy and closeness and the positive. I don't know what has happened in your life that you have developed all these sets of mechanisms to deal with it. Okay, that is a different issue that we have to look at, but there is something. Because as soon as I say is there a positive feeling toward me?—then we see.*

*PT: Yeah.*

*TH: You become uptight and your anxiety. . .*

*PT: Yeah.*

*TH: Have you ever considered these issues?*

*PT: No not. . .uh. . .*

**Return to Driving Home the Understanding of the Triangle of Conflict**

The therapist focuses on the patient's feelings at the present moment, and she says she is somewhat more relaxed.

*PT: I do feel now that I know the difference between. . .*

*TH: Between the. . .?*

*PT: Anger and anxiety. I thought I was experiencing anger.*

*TH: Now that you know the difference it is better.*

*PT: Well, yes. . .I didn't even realize I was feeling it.*

*TH: Okay.*

*PT: So it came and went.*

*TH: It is very important.*

*PT: Yeah.*

*TH: So let's take a piece and examine that piece.*

*PT: Yeah.*

*TH: For the first time you actually experienced that anger, to whatever extent it was, you actually experienced it and now you are equipped with a different knowledge about yourself. That is different from anxiety.*

*PT: Anxiety, right.*

*TH: You see? Anger and rage are different emotions than anxiety, and anger immediately mobilizes anxiety. Depression is a mechanism of dealing with this internal rage okay. Now we persisted and worked hard together and finally you experienced it, okay? So now you are better equipped than if you had not experienced it. I'll tell you why. Because then you would have left me, gone with some feelings that you have repressed within yourself without experiencing it. But the fact that you experienced it, you have a better knowledge of yourself.*

*PT: Yes.*

*TH: It is not only a cognitive knowledge, it is an experienced knowledge.*

*PT: No. . .yes, I see.*

**Further Focus on the Positive Feelings (T)**

*TH: But I am sure you only got a glimpse of it. But if you can get in touch with the deeper parts it would make a big difference. Now let's look at the positive feelings. How do you feel toward me?*

*PT: Uhh. . .*

*TH: At this moment.*

*PT: Friendlier than I did ten minutes ago.*

*TH: But you see again you have difficulty to look to my eyes and say you have positive feelings towards me. What happens when you say that you have positive feeling?*

*PT: Physically?*

*TH: Uh hmm.*

*PT: Sort of blocks up. . .mobilizes anxiety. . .more fear of vulnerability.*

*TH: And obviously vulnerability refers to intimacy and closeness.*

*PT: Yeah.*

**Exploring Interpersonal Relations (C)**

*TH: You see because I'm sure in all your interpersonal relationships, particularly—I don't know, you can correct me because you know your life better than I do. Maybe you put a massive wall and barrier in relationship with them. Is that the case?*

*PT: Yes, definitely, uh I can't recall a single satisfying relationship with anyone, with a man either emotionally, or. . .*

*TH: So in a sense all men are on the other side of the wall?*

*PT: Yeah, it's like there's half the population doesn't really exist.*

*TH: You are relating that the man is on the other side of the wall. hmm? That there is a serious conflict about the intimacy and closeness. From where it roots we don't know yet.*

*PT: No.*

The restructuring of the depressive defense is now completed.

The therapist explores the patient's reactions to previous contacts and then brings the interview to an end.

**Closing the First Part of the Initial Interview  
Exploring the Patient's Reaction to the First Independent Evaluator**

*TH: How did you feel toward him?*

*PT: I felt much less anxious, physically more at ease.*

*TH: Uh hmm. What else?*

*PT: He didn't challenge me. . .was different*

*TH: Then you would prefer to see him. . .*

*PT: No. I'd rather be challenged because I would get somewhere with it. . .I don't want to brag, but I could put the wall up higher and stronger and leave it there with him.*

*TH: Uh hmm. What you say, with him you put a massive wall.*

*PT: Yeah.*

*TH: But this massive wall has crippled your life. More wall means maintaining the crippled life, which further means carrying your suffering to the end of your life.*

*PT: Yes.*

*TH: Which one do you prefer?*

*PT: I would rather work with you. . .well this is what I am saying because I feel that I'd have to go through much more painful feelings with you. But I'd get more done.*

*TH: How did you feel when he asked you to see me?*

*PT: I knew I was going to see two persons today. I had no idea how the tests would be done, but I knew I was going to see more than one person. I didn't know what I'd be seeing.*

### **Exploring the Patient's Experience with Her Previous Therapist**

*PT: That was a very bad experience. It was a bad choice.*

(She said she had gone because of depression, but the therapy had focused on her sexual difficulties, her being anorgasmic and experiencing extensive pain during penetration so she ends up avoiding sex, which was there and still is there.)

### **Termination of the First Part of the Initial Interview**

*TH: You know, let me describe to you. The purpose of this interview is to determine what would be the best way to work on your problems. Now we have really not finished this and the time is running out and we have not finished. I was wondering. . .we need another similar session. Probably it might take another two hours or what before we decide what would be the best treatment for you.*

*PT: Okay.*

*TH: Now is it acceptable to you to come back next Monday?*

*PT: Uhh. . .*

*TH: We could meet at 8:30 and hopefully finish by 10:30.*

*PT: Uh hmm. Yes. Yeah.*

*TH: Is it okay, then, for you to come back next week?*

*PT: Definitely it is okay with me, yes.*

### **Conclusion**

Here it is worth while to recapitulate the main issues with which this article has been concerned, and also to summarize the course of the interview that was used in illustration. In my standard technique for handling highly resistant patients, pressure and challenge to the resistance are steadily increased and are not relaxed until the patient directly experiences the complex transference feeling, and "triggering" mechanism for the unlocking of the unconscious comes into operation. This technique is appropriate for the majority of patients suffering diffuse psychoneurotic disturbances with mild to severe degree of character pathology. However, when the following conditions are present the technique requires quantitative modification. These are depressive disorders, characterological depression, patients with chronic depression with episodes of clinical depression, patients suffering from functional disorder and finally patients with psychosomatic disorders. Such patients suffer from a deep-rooted inability to distinguish between the corners of the triangle of conflict. If they are challenged too relentlessly, the only result is an intensification of their defenses, which means a serious exacerbation of the original condition. In this observation there lies a major warning of all therapists seeking to learn the practice of ISTDP.

### **The Restructuring Technique**

Extensive clinical investigation has shown me that his problem can be overcome by *graduated pressure and challenge* in the following way. The therapist starts by exerting gentle pressure toward the avoided feelings, followed by limited challenge, monitoring the patient's responses with the utmost vigilance. As soon as he senses that the threshold of tolerable anxiety is about to be exceeded, he immediately reduces the pressure, which he can do in three ways: (1) by returning to pure enquiry, (2) by shifting from one area to another, e.g., from transference (T) to current (C) or vice versa, or (3) by asking the patient to describe the experience of anxiety, particularly its physical manifestations. After a while he returns to pressure and challenge, now to some degree increasing them above their formal level. Because the defensive mechanism has begun to be loosened by the previous period of challenge, without an intolerable increase in anxiety, the patient's ego is now able to approach the pressure before the tolerable threshold of anxiety begins to be exceeded. By means of this stepwise process, the impulse can finally be brought fully into consciousness with complete safety. Now the therapist drives home *insight* into the original defense mechanism, and repeatedly points out the difference between the present experience and the defensive manifestations that the patient had formerly mistaken for anger. The final result is that the patient's ego is enabled to experience and tolerate the impulse in a way that reduces anxiety instead of increasing it.

Although during this process the therapist has usually alternated between the transference and current relationships, it is inevitably in the transference that the first true experience of impulse/feeling must take place. The next step is for the therapist to enter a phase of *consolidation*, and systematic analysis of the transference in which he uses a much more interpretative technique to resolve every aspect of transference that is still contributing to residual resistance. Now the defensive mechanism has been completely and permanently *restructured*, and the therapist can

proceed to use the standard technique of unremitting pressure and challenge that is used with neuroses and character disorders uncomplicated by the above-mentioned conditions.

### The Course of the Interview

Enquiry soon revealed that the patient had suffered from recurrent episodes of depression since her teenage years. This made it clear that she came into the category of *chronic depression*, and the inference was that almost certainly it would be necessary to use the *restructuring technique* with which this article is concerned.

The therapist then concentrated on the precipitating factor for a recent attack of depression, which consisted of an incident in which she had been severely humiliated by a man. The natural reaction to this incident would have been extreme anger; but when the patient was asked to describe her feelings, though she did use the word "anger," it became absolutely clear that she had suffered no experience of anger whatsoever—"I don't remember having any kind of physical reaction. . . I went to bed, that is how I physically reacted. . . Then I guess I didn't experience it." This description of a defensive move ("I went to bed") as her only way of describing anger is typical. It makes clear that she is quite unable to distinguish between the corners of the triangle of conflict, and thus it completely confirms the inference that the restructuring technique will be necessary.

The therapist now employed the technique of challenge alternating with a reduction in pressure, in the following stages:

**(1) Limited Pressure:** When the patient made the remarks quoted above, the therapist exerted no more pressure than simply reiterating questions about her experience of anger, and pointing out the nature of her defensive moves ("But that is flight, not anger").

**(2) Reduction of Pressure:** He then took the pressure off by returning to pure enquiry, eliciting further details of the precipitating incident.

**(3) Challenge:** He now began to use a considerable degree of challenge, pointing out her non-verbal indications of hidden anger, and using such words as "crippled" to describe her inability to experience her feelings. Yet this only resulted in a blank wall, with the patient finally retracting her former statement of anger completely (TH: "You said you felt angry." PT: "No, I didn't. I didn't.").

**(4) Reduction of Pressure:** He therefore returned once more to pure enquiry with the question, "What happened subsequently?"

**(5) Continued Resistance:** This led to her describing a second incident with the same man, which had added insult to injury, and should have resulted in even greater rage than before. This time she again mentioned anger, but then quickly turned it into "anxiety," and ended by having difficulty in recalling anything that she had felt at all.

**(6) Increased Challenge:** Again the therapist returned to challenging the resistance, and then directing his remarks toward the therapeutic alliance with the repeated rhetorical question, "What are you going to do about it?"

**(7) Transference:** He then switched to the transference resistance, challenging her unwillingness to allow him into her intimate thoughts and feelings.

**(8) Head-on Collision:** Although she remained highly resistant she showed no adverse reaction, and he therefore introduced the maximum challenge in the form of the "head-on collision," forcefully pointing out the self-destructive consequences of maintaining her resistant position.

**(9) Sadness and the Defense against It:** This produced two reactions. First, she became intensely sad as she began to realize the way in which her difficulties had ruined her life; and second, she did her best to conceal this from the therapist and not to share it with him.

**(10) Further Challenge:** He therefore repeatedly challenged her defense against allowing herself to become emotionally close to him, with particular reference to non-verbal indications of this such as avoiding eye contact.

**(11) Increased Anxiety:** As a result there was a considerable rise in anxiety and its physical manifestations, which included shortness of breath and difficulty in speaking.

**(12) Reduction of Pressure:** Taking this as his cue that anxiety was rising to a dangerous level, the therapist immediately reduced the pressure once more, this time by means of the devise of asking her to describe her physical experience of anxiety.

**(13) Return to Challenge:** Within a short while the patient said she felt better, and the therapist returned to challenging the transference resistance, emphasizing in particular the self-defeating nature of the barrier that she was putting up between them.

**(14) Breakthrough of the Impulse:** Under pressure she finally experienced the impulse (anger) in transference, and under further pressure she described with raised voice how she would like to grab the therapist by the lapels and throw him on the floor.

**(15) Insight:** This had a major freeing effect. She said that her head felt clear, and that her present feelings were quite different from those that she had experienced in the incident which had precipitated her depression. The therapist drove home the lesson in order to give her insight, and she finally put it into the clearest possible words: "Now I can see the difference between what I have been calling anger and what I felt here."

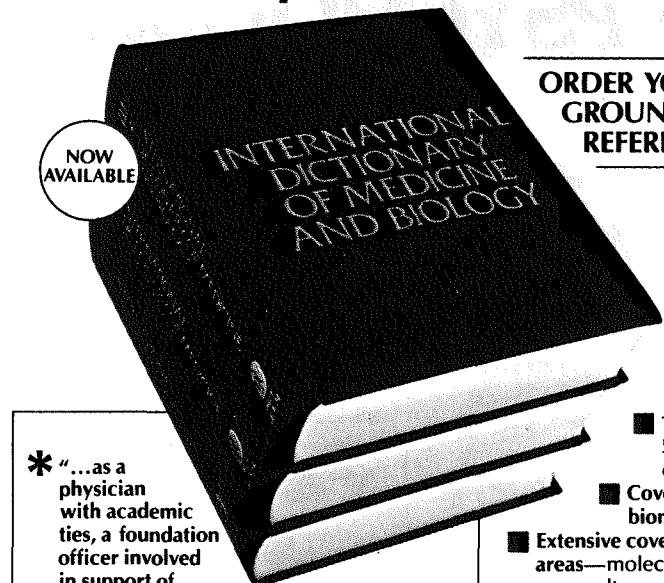
This complex phase was followed by the *phase of consolidation*, consisting of further analysis of the transference resistance, with particular reference to her wish to protect the therapist from her anger and her defense against the positive feelings that this implied. Now at last the phase of restructuring was completed and the therapist could make a further appointment, knowing that when resistance returned next time he would be able to return to his standard technique, keeping up his challenge without remission until the major unlocking of the unconscious could be achieved.

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- then work as a team to explore the unconscious and to put unconscious processes and elements into a different perspective.
- (4) Davanloo's technique of rapid breakthrough into the unconscious represents a major discovery and is an invaluable tool that allows the therapist to relieve a wide range of patients from their neurotic suffering.

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# Intensive Short-Term Dynamic Psychotherapy with Highly Resistant Depressed Patients: Part II—Royal Road to the Dynamic Unconscious

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This is the second part of a series of articles concerned with the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of certain kinds of patients suffering from depressive, functional, and psychosomatic disorder. Part I was concerned with the restructuring of a depressive patient's defenses, leading to a full experience of complex transference feeling in particular anger in the transference. The patient came back to a second interview in a state of renewed resistance, but now this could be penetrated safely with the use of unremitting pressure and challenge. In this part of trial therapy a second experience of complex transference feeling resulted in the unlocking of her unconscious and a direct view of her core neurotic structure.

This is the second part of a series of articles concerned with the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of certain kind of patients suffering from depressive, functional, psychosomatic and panic disorder. In my previous publication I described a powerful technique of Short-Term Dynamic Psychotherapy which is highly effective to the whole spectrum of neurotic disorder and gave a general account of the phases of trial therapy with highly resistant patients suffering from life-long character neurosis. The standard technique that I have developed may be summarized as follows:

Pressure toward the experience of feeling, which leads to increased resistance. Systematic challenge to and pressure on the resistance, which leads to a rapid rise in transference feelings and a further intensification of the patient's resistance. Systematic challenge to the resistance in the transference leading to direct experience of transference feelings, which leads to the first breakthrough into the dynamic unconscious.

Systematic analysis of the transference to remove residual resistances, which finally leads to the unlocking of the unconscious, with a direct view of the core neurotic structure and mobilization of the unconscious therapeutic alliance.

In Part I, I described certain variations in the technique of the trial-therapy model of the initial interview, which depend on the structure of the patient's

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psychopathology and the patient's ego-adaptive capacity. One of the variations I outlined is the application of my technique to patients suffering from certain types of depression, namely chronic depression and characterological depression. These patients in addition to depression suffer from a wide range of ego-syntonic character pathology.

One of the features of these patients is the inability to distinguish between the corners of the triangle of conflict, especially the impulse of anger or rage, on the one hand, and anxiety or defense, on the other. The unconscious defense mechanism responsible for depression instantly internalizes the rage. These patients do not experience the repressed sadistic impulses; instead they experience anxiety and depression, together with a wide range of ego-syntonic maladaptive character defense. In many of them unconscious homicidal impulses are instantly internalized and what we see clinically is a depressed suicidal patient. In turn, these suicidal impulses might be defended against by psychomotor retardation.

It is found with these patients that if the therapist uses the standard technique described above, which involves *unremitting* pressure and challenge, it arouses more anxiety than the patient's ego can bear, and the end result is that the depression becomes intensified. However, I have systematically demonstrated that this can be avoided if a two-phase technique is used, as follows:

The first phase consists of restructuring the ego's unconscious depressive defense mechanism. The therapist works on the triangle of conflict in the area of C (current or recent relationships) and T (transference). He employs gentle pressure toward the experience of feeling and gentle challenge to the defenses, monitoring the patient's reaction with the utmost vigilance. As soon as he observes that too much anxiety is being aroused he immediately reduces the pressure. He can do this in three main ways: (1) by returning to pure enquiry; (2) by switching from one area to another, e.g., T to C or C to T; or (3) by asking the patient to describe the experience of anxiety. He then returns to pressure and challenge at an increased level, again monitoring the response, and so on. In this way he systematically reworks and clarifies the triangle of conflict in relation to C and T, finally bringing the patient to the direct experience of the impulse in relation to T. The therapist drives home the lesson of the difference between the impulse and the other two corners of the triangle of conflict, defense and anxiety. He then continues with a systematic analysis of all aspects of transference, including the links between T and C, making sure that the patient both experiences these and understands them cognitively. Now the phase of restructuring the depressive defense is completed, and the therapist can proceed to the second phase, in which he can employ unremitting pressure and challenge in order to break in to the unconscious, without the fear that this will result in making the depression worse.

In Part I the restructuring phase was illustrated by means of the first interview with a patient suffering from chronic depression. This will now be summarized before the second interview is presented.

### **The Case of the Woman with a Machine Gun**

The patient was an unmarried woman aged 30. As we saw, the therapist started by focusing on her previous treatment, which she had undertaken because of depression. However, he rapidly moved to focusing on some of the patient's characterological problems which had manifested themselves in her previous treatment, such as

passivity, compliance, inability to assert herself, and flight from a conflictual situation, and their implications for the present transference. Taking her history, he learned that she had suffered from lifelong depression, including episodes of acute depression with suicidal ideation. She then described a more recent attack of depression which had occurred in response to two incidents in which she had been badly humiliated by a man. In response to one of these she had banged her hands against the wall and badly damaged them. It was clear that she was incapable of distinguishing the corners of the triangle of conflict—weepiness (defense) and self-directed aggression (defense) for her meant anger. There was systematic work on the triangle of conflict in relation to the recent past (C) and the transference (T), and finally for a short period her rage passed through the repressive barrier, and she was able to experience and describe her impulse to shake the therapist and throw him on the floor. Now she could clearly differentiate between her anger and her defenses against it. She also repeatedly told the therapist that she did not want to damage him. This enabled the therapist, in the phase of systematic analysis of the transference, to focus on her positive feelings and her conflict over intimacy and closeness. It was arranged for her to come for a second interview after one week.

She came to the second interview in a state of renewed resistance, appearing totally detached and noninvolved. However, the situation was now quite different from that at the beginning of the first interview. For now the therapist knows that the systematic work on restructuring the depressive defense has prepared the ground for unremitting pressure and challenge to the resistance, and that the patient now has the capacity to withstand the impact of her unconscious. As described in Part I, this relentless pressure and challenge represents the royal road to the dynamic unconscious and the exposure of the core neurotic structure.

We now take up the second interview. The therapist is referring to the obvious manifestations of the patient's resistance.

### **Pressure and Challenge to the Resistance in the Transference**

- TH: Still you are like that.
- PT: I could sit like this and we'd be no further ahead.
- TH: You are looking at the carpet or the wall, avoiding my eyes and maintaining a paralyzed, detached, remote position. Why do you want to do that?
- PT: I don't want to do it.
- TH: But you are doing it right now.
- PT: Yes, that's right. I am.
- TH: Now let's see, what are you going to do about it?
- PT: Ah, I'm . . .
- TH: Your weepiness, avoidance, need to distance yourself. So let us see what you are going to do about it.
- PT: I'm going to start by stopping crying, (sniffs); it's not going to do me any good.
- TH: Uh hmm. That is another way of defending against your rage.
- PT: Crying . . .
- TH: This crying is another way of ah, avoiding the rage inside you. Another mechanism you use is putting your hands in the crippled position, totally immobile and paralyzed. Now let's see what you are going to do about it.
- PT: I don't know what to do.

TH: Again that is a helpless position.  
PT: Yes, it is.  
TH: But that is not good enough. I mean, that is what has destroyed your life up to now. Now you are fidgeting, holding your hands together. Let's see how you experience this rage.  
PT: I can't let it out. I'm trying to, and it's not going anywhere.  
TH: But you see, again you are ruminating. I say, how do you experience the rage?  
PT: I'm not experiencing it, and I'm . . . I don't know how to get rid of it.  
TH: But still you are ruminating on helplessness.  
PT: Sitting here saying I know how won't make me know how.  
TH: But that is helpless. You have taken this helpless position for years of your life, flight, running away.  
PT: Which is what I want to do now.  
TH: Again, you see, look to your hand. Still is crippled. So let's see what are you going to do about it. Now, sigh . . .  
PT: Yeah.  
TH: . . . holding the chair, still we don't know how you experience the rage.  
PT: I'm not, I'm, I'm, I'm taking a deep sigh.  
TH: And now you see you move toward the position that you don't.  
PT: I'm not saying there is no anger.  
TH: There is anger in you. We know but we don't know how you experience it. And look to your hand again.  
PT: I'm pushing it down, I'm pushing it back, I'm pushing it so far back.

#### **Further Challenge to the Patient's Characterological Defenses in the Transference**

TH: So your defiance is up again.  
PT: Yes, there is.  
TH: And that is what is in operation with me. You are taking a defiant, crippled position with me.  
PT: I'm trying to do something.  
TH: Still you are taking a crippled position with me. You are taking a defiant position, and defiance is another part of this wall. The paralyzed, crippled woman, and becoming retarded. Now, you see, totally paralyzed.  
PT: There's nothing I can do or say.  
TH: You see, again that is helplessness.  
PT: I know.  
TH: You see how crippled you are in dealing with your negative feeling here with me?  
PT: Yes, I see it. I see it.  
TH: I see it is not good enough. We are looking how you experience this negative . . . your weepiness comes . . .  
PT: Yes it does.  
TH: . . . there is a weepiness, there is a defiance, taking a crippled, helpless position.

#### **Rise in the Complex Transference Feelings with Further Challenge to Resistance**

PT: Well, how else does one communicate? (In a raised tone of voice) I'm trying to get something out . . .  
TH: How do you experience this rage here with me, if you look into my eyes and tell me how you experience this.  
PT: I'm not! (In a very raised tone of voice) I don't know how. I don't know how to describe it.  
TH: How do you experience physically?  
PT: I, I get tight.  
TH: But that is anxiety, that is not rage.  
PT: Well then to me it's the same thing! I get tight . . .  
TH: Yeah, but . . .  
PT: I get very tense.  
TH: Yeah, but what else do you experience besides tightness?  
PT: Uhh . . .  
TH: If you put it out, how that would be like?  
PT: I get tense, I get . . .  
TH: You see.  
PT: . . . I stop sweating . . .  
TH: Uh hmm.  
PT: . . . and I find it difficult to speak, I get very tight in the jaw and in the throat.  
TH: But that is tension build up.  
PT: Yes.  
TH: These are mechanisms of dealing with the rage. That is a mechanism of dealing with rage.

#### **Direct Experience of Complex Transference Feeling**

What has emerged is a high rise in transference feelings. The pitch of her voice is very high and communicates anger. There is a definite change in the patient's psychomotor activity, moving her clenched hands forward. She is bouncing back in the transference, which indicates that the anger in the transference has passed the repressive barrier. It is also extremely important that, side by side with an increase in tension and anxiety, she reports a *decrease* in one of the physiological concomitants of anxiety—"I stop sweating." This confirms that she is really beginning to experience her anger.

Since she suffers from chronic depression, it is essential to focus on the impulse in the transference until she can experience her anger fully. We take up the interview.

TH: But it is not clear how you experience the rage by itself.  
PT: I, I'm describing it to you, and you're telling me that's not, that's not . . .  
TH: I mean, if you put it out, how would this rage be like?  
PT: The way it is right now.  
TH: Yeah. How would you be . . . ?  
PT: I, I, I'm, I'm yelling. I'm moving my, my arms slash around . . .  
TH: If you put it out in terms of thought and fantasy, what would it be like?

PT: *This is it!* (with a loud voice) *This is it! This is what it is!*  
 TH: *But still it is not clear . . .*  
 PT: *Well, what do you want me to do, beat the wall I don't . . .*  
 TH: *Do you feel that way?*  
 PT: *No. I don't feel like beating the wall . . .* (moving her hands in fist-like position) *I don't know what else. I am sitting here angry, telling you I am angry, and you say . . .*  
 TH: *Are you angry right now?*  
 PT: *Yes, I am.* (Very firm and loud voice)  
 TH: *What else?*  
 PT: *I stop sweating.*

TH: *Uh hmm . . . You are angry and no sweating, what else?*  
 PT: *Shouting!*  
 TH: *What else do you experience?*  
 PT: *(Referring to her head) Ah, clarity up here.*

It is very important to note that as the physiological and psychological concomitants of anger have increased, the concomitants of anxiety have correspondingly greatly decreased. Thus again she says she has stopped sweating, and she does not want to use the defense of directing her aggression against herself by banging her hands against the wall. Moreover, whereas in the early part of the interview she used the word "confused," she now says "clarity up here," referring to her head. It is therefore quite clear that what we are seeing is a breakthrough of the aggressive impulse through the repressive barrier and a definite undoing of the depressive mechanism.

The therapist now exerts further pressure in order to get the ego to experience the aggressive impulses to the full, and follows this by returning to a systematic analysis of the transference, vigilantly monitoring the process of entry into the unconscious. We take up the interview.

TH: *You say you are enraged. If you look into my eyes, do you feel that you want to lash out?*  
 PT: *I am lashing out verbally . . . this is called verbally lashing out, what I am doing right now.*  
 TH: *Do you see how much, you have tremendous problems to experience the rage which has crippled your life and a while ago you felt banging against the wall and we know the incident with Tony . . . there you banged your hand against the wall and you were crippled for almost two weeks.*

Challenge and pressure are applied further, and what emerges is a sudden further rise in the intensity of her rage in the transference. Then the evaluator explored her thoughts and fantasies. "If you put your anger out, what would it be like?" The patient is repeatedly moving her hands up and down in front of her and once more she says she would grab the therapist by his lapels and shake him, and in her fantasy the therapist would be on the floor; and again she said, "I don't want to damage you." The therapist focused on her positive feelings and her defense against

them. Then the focus is on her hands which she had damaged badly in the second incident with Tony. We take up the interview.

TH: *You see, you describe some incidents with Tony that you were humiliated, but then you ended up banging your hands against the wall which as we know was turning the rage against yourself and it is important that we look that on two occasions when you felt to put your anger physically out, it was with your hands. Is there any other incident that involved your hands?*

### The First Mention of the Past (P)

She described an incident that took place when she was an adolescent. Her year-younger brother Peter was aggressive, and she was humiliated by him, ended up crying. "I started crying, thrashing," and she ended up beating her hands against a tree and bruised them badly.

TH: *And it is very striking that we talk about the crippled, limp hands; and in that incident also beat up your hands and bruised your poor hands.*  
 PT: *Well . . . In that situation he was gone, so there was nothing I could do about it.*  
 TH: *What happened to the rage?*  
 PT: *I thought that was the rage.*  
 TH: *Weepiness is not rage. Beating up your hands is a way of dealing with rage. Let's see how you experienced the rage.*

### P-T Link

PT: *I don't know; in retrospect I cannot tell.*  
 TH: *But it is very important you look at what happens to the rage.*  
 PT: *I can't tell what happened to it back then.*  
 TH: *You see in relationship with me what happens to the anger?*  
 PT: *I don't let it out.*

The focus of the session is further on analysis of the transference, the impulse, the anxiety, and the range of defenses she uses. The focus is on the experience of anger in the transference and its differentiation from anxiety.

TH: *Obviously, if you put your rage out in the form of physical attack, that is not constructive either.*  
 PT: *No. Right.*  
 TH: *But if you also turn it to yourself, turn against yourself and get depressed or seized with anxiety or become paralyzed or take a crippled position, that is not constructive . . .*  
 PT: *Either.*  
 TH: *. . . way as well . . . is not constructive, okay?*  
 PT: *Yeah.*

**T-C-P Links**

The therapist links transference, recent, and past and once more drives home the lesson about her former inability to distinguish the corners of the triangle of conflict. Now she gives unmistakable evidence that the lesson has been learnt.

TH: *Today when you experienced anger in relation to me your hands went like that (therapist demonstrates fists) for a moment. There was an impulse to grab me with your hands, attack me with your hands; but with Tony you ended up beating your hands against the wall. And you could not use your hands for some time. Now it is important that you look at it again, the mechanism you used to deal with your rage.*

PT: *I always thought that was the anger.*

TH: *And the same was with Peter. You ended up beating your hands against the tree.*

PT: *I realize it is the same. That is the way I always thought.*

TH: *Somehow, we don't know why, you are terrified to experience the negative impulse.*

PT: *The anger?*

TH: *And you have developed a set of mechanisms to deal with it. And I think this is of all the issues that you want to look at, this is a very fundamental issue. You see that when there is this rage in you, you don't experience it.*

PT: *Yeah, and I'm not even aware that I'm doing it.*

She says that she has been like this all her life.

PT: *Yes, I think I was like that. I mean I don't, I don't remember much of my childhood at all, okay. But I don't, umm, I don't remember a time when, umm, I didn't cry easily when I didn't express anger with tears.*

TH: *Uh hmm.*

PT: *I don't remember a time when I did it differently. I don't know if there ever was such a time.*

**Exploring Further the Extent of the Anger in the Transference**

TH: *What was the extent of your negative feelings toward me during that moment, when you became . . . ?*

PT: *Intense . . . yeah . . . it was intense. It was intense, umm, I, I felt it very strongly.*

TH: *Uh hmm. What did you feel strongly? For example, did you feel at any split-second that you wanted to really blast out?*

PT: *I was blasting out.*

TH: *More than that. Did you at any moment, for if you a split second examine it very carefully, was there any time that you felt like blasting out?*

PT: *It was, I was, I was blasting out. I was, umm, how can I, it was satisfying to blast out the way I was.*

TH: *Yeah, I know but was there more than that?*

PT: *No, there wasn't.*

**Unlocking the Unconscious**

TH: *Uh hmm. But do you think that in a sense maybe a part of you also wants to protect me against your anger? You know what I mean by protecting against the anger?*

PT: *Yes, yes.*

TH: *That in a sense if all of it comes out . . .*

PT: *God knows what I'll do. Ah . . .*

TH: *So you see, if all of it comes out you say God knows what you would do, okay?*

PT: *Yeah, I, I don't . . .*

TH: *Now, I am looking to the thoughts and fantasy.*

PT: *Yeah.*

TH: *Again it is very important to fantasize and we know you have indicated that in many other areas you have a very strong fantasy world.*

PT: *Yes.*

TH: *Yeah, what, you say God knows what I would do.*

PT: *Yeah.*

TH: *Now this means that then you would do something, huh, that you say God knows what I would do.*

PT: *Yeah.*

TH: *And I know you know very well what you would do. Let's see what in term of fantasy you would do here in this room . . .*

PT: *I, I, yeah . . .*

TH: *What would you do?*

PT: *Stand up and wave my arms . . . yes . . . very strongly . . . and walk around . . .*

TH: *But you said, God knows what you would do.*

PT: *No, I was just, that was just an expression, ah, I, I, I wouldn't do anything.*

TH: *How would you portray yourself if you became a very violent person? Remember, we talked about Dr. Jekyll and Mr. Hyde. Now the question is, what would you be like if you were to become a violent person?*

PT: *Yeah, yeah, very, very, umm, cold, ah . . .*

The patient is heavily involved in this process.

TH: *But that is not it.*

The patient's resistance is now so reduced that so far from avoiding the subject, she makes plain that she wants to pursue it.

PT: *No, no let me talk this through, umm, if I, if I'm very violent, cold and unfeeling, umm, umm, very efficient in the violence.*

TH: *But what would, could you portray yourself if . . .*

PT: *Umm . . .*

TH: *. . . the monster comes out of you what would that be like?*

PT: *What would I do?*

TH: *Uh hmm.*

PT: Ah, probably buy a gun.  
 TH: Uh hmm.  
 PT: And a big gun.  
 TH: Uh hmm. How big?  
 PT: Umm, one of these big, you know, a big gun. (She demonstrates a machine gun.)  
 TH: Uh hmm. Uh hmm.  
 PT: And learn how to use it.  
 TH: Uh hmm. And then?  
 PT: And get very good at it.  
 TH: Uh hmm. And who would be the target of that?  
 PT: Umm . . .  
 TH: In term of thoughts . . .  
 PT: Yeah, who, who would I most likely like to see . . .  
 TH: First . . .  
 PT: Ah, of my family.  
 TH: Uh hmm. Which one would be the first target?  
 PT: My mother.

She has become intensely sad. Her eyes are filled with tears and she has waves of painful feeling that one can see from her face. The evaluator continues.

TH: Uh hmm. Uh hmm. In a sense then you would have that gun and then target would be your mother.  
 PT: Yeah.  
 TH: How would you in fantasy and thoughts, how would your mother, you shoot her?  
 PT: I'd just pull the trigger.  
 TH: Trigger and then . . .  
 (Pause) (Patient is crying heavily)

As the patient describes how she would murder her mother we see a breakthrough of a major degree of painful feeling. She is choked up and trembling. What we have seen so far is the emergence of the guilt-laden murderous impulses toward her mother which are grief-laden as well. It is important to note that the major work in restructuring the ego's unconscious regressive defense mechanism was the essential first step in the journey down the path to the unconscious. Now the ego has the capacity to withstand the painful feelings, the grief-laden feelings attached to her sadistic impulses in relation to her mother. A major phenomenon of entry into the unconscious is that neither the defense mechanism of isolation of affect nor repression is in operation. Metapsychologically, the whole system of resistance and unconscious defense mechanisms are no longer in operation, and the superego structure for the time-being is cornered against the wall; and the therapist has the unique opportunity to make a careful appraisal of the structure of the dynamic unconscious, and to explore the structure of the instincts and all the guilt-laden, grief-laden feelings within the unconscious.

We take up the interview where we left off. The patient is going through an intensely painful experience. The therapist should vigilantly monitor his own reaction so as not to lose sight and become supportive.

TH: You must have a lot of painful feelings. There must be an agony in you.  
 PT: Yeah. (She is crying intensely.)  
 TH: And you see, you cover your face when your painful feeling comes; you cover your face from me. So then, where would the shooting take place? In the head or chest or where?  
 PT: Ah, no just without aiming, just, you know . . .  
 TH: But in terms of thoughts, what . . . The shooting be targeted against?  
 PT: Yeah.

Her emotional turmoil continues.

PT: Ah, nowhere in particular I would want to hit her, I'd just fire the gun, that's all.  
 TH: Uh hmm. And what happens to her after the, I am talking about thoughts.  
 PT: She'd die.  
 TH: Instantly die? And could you portray what she would be like dead?  
 PT: Just lying there that's all.  
 TH: But what way she is lying down there? In what position?  
 PT: Ah, just on her back, just ah . . .  
 TH: In the back.  
 PT: On her back.  
 TH: On her back, in a face . . .  
 PT: Face up.  
 TH: . . . up. And eyes?  
 PT: Ah, closed.  
 TH: Closed, the eyes are closed. And then what else? Mouth?  
 PT: I can't see it.

The patient continues in a painful emotional state with genuine painful feelings. The evaluator continues with this piece by piece review of the murder of her mother. She is totally absorbed in this process.

TH: Uh hmm. You cannot see the mouth.

(She is crying)

TH: Uh hmm. And then would be a painful death or would be . . .  
 PT: No, she would die right away.  
 TH: Instant death. Uh hmm. And the eyes you said closed, but mouth?  
 PT: Ah, (She sniffs frequently) Ah, the face is ah, (she pauses frequently between words)  
 TH: Uh hmm. Is not clear the, the face.  
 PT: No.  
 TH: Uh hmm. What color would be the face? There would be blood or anything?  
 PT: I don't see it on the face . . . more on the body . . . I see it coming out of the chest.  
 TH: Where in the chest?  
 PT: It is just covered, that's all.

The patient suffers waves of emotional distress and crying.

*TH:* Uh hmm. And what do you do after now the gun and then you have shot her to death, so she is murdered, what do you do?

(Patient is crying)

*PT:* I don't know.

*TH:* In term of thoughts.

*PT:* Walk away.

*TH:* Walk away. You mean you wouldn't touch anything?

*PT:* No.

*PT:* You don't touch her body, hmm?

*PT:* No.

*TH:* Uh hmm. Do you look at her and walk away or . . .

*PT:* I just look to see that she's dead and then walk away.

*TH:* Uh hmm. And what would you say to her before you walk out, to the dead?

*PT:* Nothing, not a word.

*TH:* Uh hmm. Not a word. And walk a way and then what do you do when you walk away?

*PT:* I don't see me. Just walking . . .

*TH:* What happens to you in life, then? After that?

*PT:* Uh . . . I don't get caught.

*TH:* Uh hmm. What happens to her burial?

*PT:* I'm not seeing that.

*TH:* How would her burial be?

*PT:* I don't know. I wouldn't go.

The intensity of the patient's emotional turmoil has increased. The force of resistance has so far been in a paralyzed state, and the evaluator has clearly seen the way the murder of her mother has taken place and that she has "not left any trace." When he questioned her what happens to her life after the murder, she said, "I don't get caught". But the truth of the matter is that she has imprisoned herself behind a wall of suffering, like a criminal. But during the entire process we have seen no sign of a wave of return of resistance. We take up the interview where we left off.

*TH:* Uh hmm. So then is there the indication that maybe on the very deep part of you maybe there is massive, murderous impulses toward your mother?

*PT:* Anger. Anger.

*TH:* Which is very painful to declare, but you know one of the things that I have been looking . . . that is very important for you to look at, if you face with all the painful feelings that you have buried for many years in yourself, if you look at them, if you examine them and face them, then you have a chance at freedom.

*PT:* (Continues to be in a painful state but with much less intensity.)

*TH:* Because your life is like the life of a murderer if you look at it.

*PT:* I'm in hiding.

*TH:* You are running and running and running, hmm? Hmm?

*PT:* I've been hiding for all these years.

*TH:* Uh hmm. But then underneath, there is a massive murderous impulse there, hmm? Which gives us a glimpse in one area that is why you are so terrified of anger. Do you see what I mean?

*PT:* Yes.

*TH:* And you have used a mechanism of depression as a way of dealing with these massive murderous impulses. This is very important for us to examine. You see, there are these buried repressed murderous impulses; and the way you deal with them, you turn it, you have turned it into a depression.

*PT:* I have turned it against myself.

*TH:* Yeah. Hmm? And suffered from depression, suffered from, you are crippled in that sense, hmm? Hmm?

*PT:* A great deal of rage.

*TH:* . . . of rage . . . and there are other feelings as well.

*PT:* Yeah.

*TH:* Which in a sense you are holding onto and then you are setting, you have set up a system of defense mechanisms as you say precise . . .

*PT:* Yeah.

*TH:* . . . to defend against these impulses. One of them above all is the depression which is a very crippling mechanism, you see? Hmm? Paralyzes you totally.

*PT:* Yeah.

*TH:* And of course you have experience of it, of depression when it comes, hmm?

*PT:* I'm useless, yeah. I go through the motions, that's all.

*TH:* Uh hmm. How do you feel right now?

*PT:* Very sad, choked up.

*TH:* Uh hmm.

*PT:* Physically very weak, and surprised, too. (Sighs deeply) I wasn't expecting . . . (sigh) . . . thoughts like that to come into my mind.

*TH:* Uh hmm. But obviously it is there.

*PT:* Yeah. (Sighs)

*TH:* Hmm? And has been there for years of your life hmm? A lot of mixed, buried feelings in relation, obviously, to many other people. Now, you said the first person that you would shoot would be your mother. Who would be the next?

Thus far we have seen the process of entry into the unconscious with mobilization of the unconscious therapeutic alliance which came into operation when the transference feelings reached the threshold. What emerged first was the patient's murderous impulses toward her mother. This was carefully explored, and she went through intensely painful feelings with waves of physical distress. In a sense, we saw her mourning the death of her mother, grief-laden feelings, the whole complex set of feelings. By this time the ego-adaptive capacity has reached a higher level and is ready to continue the journey to the dynamic unconscious. We take up the interview where we left off.

**Return to the Trail**

TH: Here we are travelling in this path of fantasy and thoughts.  
 PT: I'm afraid to go back into it.  
 TH: Uh hmm. But still we are climbing the mountain toward freedom.  
 PT: Uh huh. (She sniffs.)  
 TH: So we should climb rather than retreat.  
 PT: Ah, I would ah . . . my, ah, I don't know. I can't distinguish between my father and my sister.  
 TH: Uh hmm.  
 PT: And for some reason or other . . .  
 TH: Yeah, but if you shoot, which one got it first? Your father would be the next or your sister?  
 PT: Yeah, ah, no, I, I can see them both standing there.  
 TH: Both, you mean, they would both be the target . . . ?  
 PT: Yes. Yeah . . .  
 TH: Who would be next?  
 PT: Peter.

As we see, the next target is her father and sister, then comes her brother. What emerged is that the next target is Tony. She has described two incidents. In one she had prepared to have sex with Tony, but he humiliated her. In the other incident, following the first, Tony and her sister Linda had sex in the room next to hers. She was very upset, couldn't sleep. For a few weeks she was very depressed. She ended up banging her hands against the wall and bruised them badly. The effects lasted two weeks. At this point the therapist brings up the incident.

TH: Hmm? You said the next would be your father and Linda, then Tony; and I raise the question, maybe that night that you got, that you couldn't sleep and for days you were depressed, hmm, maybe there was the impulse underneath that you could have the machine-gun and machine-gunned the whole room and blasted them hmm? But what did you do?  
 PT: I . . . That didn't come. I got depressed.

Then she remembers that for months afterward she begged her sister to keep Tony away from her.

TH: Begging her to keep Tony away from you?  
 PT: Yes. Yes.  
 TH: . . . because then the ideation is that if your fear was that you might murder him.  
 PT: I might act it out, yes. It might actually happen.  
 TH: Uh hmm. And where would they get the bullet?  
 PT: (She stutters a bit) Again in the body, I don't aim for the head at all. Somewhere in the body.  
 TH: It is very important along this path. The night that Tony was having sex with Linda you couldn't sleep. Was there the impulse to machine-gun, to blast both of them?  
 PT: Physically to retaliate?

TH: Yeah.  
 PT: Retaliate.  
 TH: But this is not retaliation. We are seeing murder. It is important for us to look at this because underneath your depression . . . now we know what is underneath. There is a machine-gun; and you are going first to murder your mother, then your father and sister together, then your brother, then Tony and your sister, and finally Tony's sister Gina.

The patient continued to be highly charged with painful feelings, and the therapist continues.

TH: And who else would be next in this target of this machine-gun?  
 (Pause)  
 PT: There's no one else that I would want to hurt that badly.

By now the therapist has got a good view of the patient's unconscious and has been able to map it out. Now he returns to some work on the transference, preparing the ground for completing a dynamic phenomenological description of the patient's psychopathology and then to complete the patient's developmental history.

**Return to the Transference**

TH: Now if we go back to you and me, there was rage in you toward me. If we put it on a continuum, where do I stand on that continuum?  
 PT: As I told you, I was angry to the level of visualizing grabbing you by the lapels and shaking you; but . . .  
 TH: Are you saying with your mother the rage was to the level of murdering her with a big machine-gun, and it was the same with your father and sister?  
 PT: The degree of violence is disproportionate. With you I don't see doing more than that.  
 TH: Uh hmm. Why do you think that is?  
 PT: The anger was not beyond that level.  
 TH: I know, but why? There must be something there.  
 PT: It is because I . . . I . . . umm . . . the . . . the caring is not there. I mean there is no way I can care for you as much as I care for my family.  
 TH: Uh hmm.  
 PT: Ah . . . If they hurt me, it hurts more than if you hurt me. Let's say hypothetically because you are not my family.  
 TH: Uh hmm.  
 PT: I . . . I . . . I cannot get as angry at you.  
 TH: Uh hmm.  
 PT: . . . Because there's, there's just . . . (sighs) there's no . . . mmm . . . no real connection.  
 TH: Then what you say is that with your family there was attachment and a severe let-down, then the pain of it. This is what you say?  
 PT: It is greater, yes, because it is attachment.

### Exploring the Patient's Feelings about the Interview

PT: Yes, mmm, there is a feeling that although this is frightening it is vitally important. And that tempers the anger. It tempers it. And that is constructive. You are like a catalyst, okay? And that is good. And that's what I badly need. There is a feeling of confidence. There is a realization of being able to remember things and to talk about them that I didn't even know were there. And nobody dropped dead.

The patient again becomes choked up with emergence of painful feelings with eyes filled with tears.

TH: So it must be very painful. You see, the pain that you go through.

PT: It is also a relief.

TH: Uh hmm. I know. There is a lot of painful feeling in you.

As the patient is visibly anxious, the evaluator explores this.

TH: How do you feel right now?

PT: Relieved and shaky . . .

TH: Still you feel shaky?

PT: Yeah. It is frightening . . . the whole realization that I can turn into a madwoman.

TH: But obviously another thing about you is that you have a tendency to underestimate your potential.

PT: (She sniffs) I don't have much belief in myself, yes.

TH: This is what I am referring to—that you have tremendous underestimation of your own capacity and your own potential because you see the potential under such difficult circumstances to go through these experiences, hmm? Do you see? But you have been underestimating if you would have such a capacity and such a potentiality to go through it. Do you see? I am sure you do it in any other area of your life, that if your potential is at this level you treat it like this. I don't know. You know yourself better. You only can say, am I right or wrong.

PT: Yeah.

TH: Do you think that is the case?

PT: (She sniffs) Yes.

TH: And my question is this. Do you function at the level of your potential in life?

PT: No.

TH: Or do you function much below your potential?

PT: Considerably below.

TH: How is your anxiety right now?

PT: Right now it is much less, but I am still very sad, weak, and empty.

Now the therapist proceeds to complete the dynamic phenomenological description of the patient's psychopathology, a comprehensive psychobiosocial assessment, elementary and high school years, sexual history, and medical history. After com-

pleting these, he takes the developmental history, and finally he is able to formulate the multi-focal core neurotic structure responsible for all the patient's problems, both symptomatic and characterological.

### Conclusion

These two articles have been concerned with the application of Intensive Short-Term Dynamic Psychotherapy in the treatment of patients suffering from chronic depressive disorder. These patients suffer from a deep-seated inability to distinguish between the impulse of anger, on the one hand, and the mechanisms that they use to defend themselves against anger, on the other. If the therapist uses the "standard" technique of unremitting pressure and challenge, intolerable anxiety is aroused, and the end result is a serious exacerbation of the original condition. However, this can be avoided by the use of *graduated pressure and challenge*. The therapist monitors the patient's responses with the utmost vigilance, and immediately reduces the pressure when he senses that the anxiety is approaching an intolerable threshold. After an interlude he can then return to pressure and challenge at an increased level. By repeating this cycle several times he can eventually bring the patient safely to the experience of anger in the transference; and after a further phase of *consolidation*, in which he uses a more interpretative technique to resolve residual resistance, the patient's defensive mechanism is restructured. The therapist can now use the standard technique of unremitting pressure and challenge with safety.

I illustrated this restructuring process in detail in Part I, using the initial interview with a woman suffering from chronic depression. The therapist finally succeeded in bringing her to the point of speaking with raised voice about her wish to grab him by the lapels and throw him on the floor. Thus for a moment her anger passed the repressive barrier; and she was able to experience to the full the difference between this and her previous defensive manoeuvres, which had included emotional withdrawal and banging her hands against the wall, and which hitherto she had mistaken for true anger. Thus her defensive system had been restructured. After some further work on the transference, now concerned with her resistance against positive feelings, the therapist was able to terminate the interview and make another appointment in a week's time.

In this second interview it became clear at once that she was in almost as resistant a state as before, but by now the therapist knew that it would be safe to escalate his challenge until he achieved a breakthrough. Accordingly he began a systematic challenge to a series of defenses that she was using against her impulse and feelings in the transference: detachment, avoiding eye contact, weepiness, helplessness, defiance. Her underlying feeling steadily increased, and this time her impulse consisted of verbal lashing out without any physical attack. Nevertheless it was quite evident that she was truly experiencing her rage, since she described the disappearance of both physiological and psychological manifestations of anxiety: "I stopped sweating," "Clarity up here" (i.e., in her head).

This led back, by contrast, both to the two recent incidents which had precipitated her depression, and to a previous incident long ago in which, in a rage with her brother, she had banged her hands against a tree and had bruised them badly. Once more the therapist drove home the lesson, and she said with insight, "I always thought that was the anger." He then concentrated both on the impulse of anger in the

transference and the need to protect him from it, and suddenly her unconscious therapeutic alliance delivered a crucial message: ". . . if it all comes out," "God knows what I'll do." Taking note of this, the therapist pressed her to say what she would be like if she became very violent. It now became clear that the direct experience of her feelings in the transference, both negative and positive, had begun the process of unlocking her unconscious. She became deeply involved in her fantasy world, determined to see it through to the end, and spoke with a mixture of astonishment, calculated violence, and profound grief, of a hitherto entirely unconscious impulse of killing her mother with a machine gun. Relentlessly, and entirely in the patient's interest, the therapist took her first through every detail of her mother's murder, and then through her impulse to do the same to most of the important people in her life, her father, sister and brother, and she had the impulse to murder Tony and her sister Linda, whose final insult to her had been to have sex together in the room next door—the event that had precipitated her most recent depression.

All this had been achieved with hardly any reference to the distant past, so that the therapist had no idea of the reasons for her violent feelings against her mother and all the other members of her family. Now that the breakthrough had occurred it was time to take all this history, which was accomplished without difficulty, and with which this article need not be concerned.

The work in this second interview ran a smooth and relatively rapid course from total resistance, through systematic challenge, to breakthrough; but this was only made possible by the careful and laborious restructuring process that had been carried through in the interview a week before.

Finally it is worth noting the extraordinary precision with which theoretical knowledge and clinical experience can be used to manipulate the forces within another human being in order to achieve a therapeutic result. Thus the therapist knows from previous experience that part of the mechanism underlying the patient's depression is likely to be her defense against intolerable rage; this is confirmed when he learns that her recent attack of depression had followed two episodes of quite deliberate humiliation at the hands of a man; he also knows that a chronically depressed patient of this kind is likely to suffer from a deep-seated inability to distinguish between *impulse* and *defense*; this is confirmed in turn by her total inability to describe the experience of anger, and her description of defensive moves such as withdrawal instead; he knows also that part of the mechanism underlying certain kinds of depression consists of self-directed aggression, and this is confirmed when she describes a recurrent pattern of banging her hands against some object to the point of severely bruising them; he knows that the use of unremitting pressure and challenge is dangerous, but that the patient can be brought to the experience of anger if his interventions are carefully graded; he is able to monitor the signs of anxiety in the patient so as to adjust the degree of pressure exactly; he knows that the restructuring of the depressive defense must come from the experience of anger in the *transference*, and this is confirmed when she first describes with raised voice her fantasy of throwing the therapist on the floor, then describes a state of mental clarity in contrast to her confusion in the recent incidents, and then states explicitly that her present experience is quite different "Now I can see the difference between what I have been calling anger and what I felt here"; he knows that resistance will return, but that now it will be safe to use unremitting pressure and challenge, and this is confirmed in the second interview when there is a smooth progression from appar-

ently impenetrable defense, through relentless challenge, to the further clear experience of anger in the transference; and finally he has discovered that when this complex transference feeling reaches its threshold it would trigger off the mechanism of the unlocking of the unconscious and the direct view of the core neurotic structure, which is confirmed by her deeply felt fantasy of the murder of her mother—thus once more unmistakably illustrating one of the mechanisms underlying some kinds of depression, namely the repression of rage that is made intolerably painful by guilt and sorrow.

Yet the view is still widely held that, in psychodynamics, all theories are no more than speculation and scientific proof is inherently impossible.

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# The Technique of Unlocking of the Unconscious. Part I

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This two-part article focuses on the discovery of the technique of unlocking the unconscious and the direct view of multifoci core neurotic structure by the author. The process of the unlocking of the unconscious can be divided into a number of phases. The aim of the first seven phases is to create an intrapsychic crisis between the patient's resistance and his therapeutic alliance, which results in the breakthrough of very complex feelings mostly in the transference. This breakthrough represents the essential triggering mechanism for unlocking the unconscious. Then the process enters to the interpretative phase and the direct view of the multifoci core neurotic structure responsible for patient's symptoms as well as character disturbances. In the second part of this two-part article a verbatim account of complete interview will be used for illustration.

While in a previous article I discussed the nature of resistance and the various types of intervention that can be used to overcome it, in the present two-part article I shall describe the whole process in which these interventions are used, and the way in which they eventually make possible direct access to the patient's unconscious.

The complete process, which is used at trial therapy in the initial evaluation interview, can be divided into a series of phases, each consisting of a particular type of intervention with its corresponding response. These together make up what I call the *Central Dynamic Sequence*, which may be summarized as follows:

## Phase (1)

- (a) Inquiry, exploring the patient's difficulties; initial ability to respond.
- (b) Rapid identification and clarification of patient's defenses.

## Phase (2) Pressure, leading to Resistance in the Form of a Series of Defenses.

## Phase (3) Clarification of Defenses

- (a) Clarification, challenge to defenses, leading to rising transference and increased resistance.
- (b) Challenge directed against the defenses; recapitulation of the defenses and casting doubt on the defenses.
- (c) Challenge directed toward the therapeutic alliance.
- (d) To make the patient acquainted with his defenses so that he can see that his defenses have paralyzed his functioning.
- (e) To turn the patient against his own defenses.

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**Phase (4) Transference Resistance**

- (a) Clarification and challenge to transference resistance.
- (b) Head-on collision with the transference resistance with special reference to that maintained by the superego.
- (c) Exhaustion of resistance and communication from the unconscious therapeutic alliance.

**Phase (5) Intrapsychic Crisis**

- (a) High rise in the complex transference feeling, breakthrough of the complex transference feeling—the triggering mechanism for unlocking the unconscious.
- (b) Interpretative phase.

- (c) The first direct view of the multifoci core neurotic structure.

**Phase (6) Systematic analysis of the transference leading to resolution of the residual resistance with partial or major de-repression of current or recent past (C) and distant past conflicts (P).****Phase (7) Inquiry, completing dynamic phenomenological approach to patient's psychopathology, medical psychiatric and social history and developmental history.****Phase (8) Direct view of the multifoci core neurotic structure and its relation to patients symptom and character disturbances and psychotherapeutic plan.**

Of course not all trial therapies consist exactly of this simple sequence. The phases tend to overlap and most interviews of necessity contain a good deal of repetition and thus proceed in a spiral rather than a straight line. Nevertheless careful dissection will almost always reveal all these phases in their natural order. The central dynamic sequence can therefore be seen as a framework which the therapist can use as a guide, constantly working from one phase to another.

However, the first subject to be discussed must be the classification of patients, with reference to the types for whom the technique either is indicated or contraindicated.

**Contraindication**

The main general contraindications to Intensive Short-Term Dynamic Psychotherapy are severe fragile ego structure; major affective disorder; manic depressive disorder; psychotic breakdown; developmental neurosis such as borderline disorder, severe alcoholism, or drug abuse; serious sociopathic tendencies; an inability to function without constant support and certain potentially life-threatening psychosomatic conditions such as ulcerative colitis. These contraindications may be detected from the history, from the signal appearing in the interview such as disruption of the cognitive function of the ego, disorganization of the thought process, and the ego's very low capacity to tolerate anxiety. The clinician's clinical skill to detect the danger signal in the first few minutes of the interview is obviously important and his ability to modify the technique accordingly is essential.

**Indication****Spectrum of Structural Neurosis**

With the exception of patients with severe fragile ego structure, all neurotic patients are suitable for Intensive Short-Term Dynamic Psychotherapy. However, the ease with which the breakthrough can be achieved, and the relative emphasis on different types of intervention, depend on a number of different variables. In this connection I arrange patients in a spectrum running from the least difficult on the left, to the most difficult on the right as follows:

On the left are highly motivated and responsive patients with single psychotherapeutic focus based either on an inability to face grief, or on conflict in uncomplicated triangular family relationships. These patients suffer neither from character pathology nor from resistance arising from the superego.

As one passes toward the right, motivation decreases and the following variables increase: resistance, severity and diffuseness of character pathology, impoverished relationships, and involvement of a punitive superego leading to self-destructiveness; and finally toward the right-hand end the character pathology becomes increasingly ego-syntonic, i.e., the patient becomes identified with his defenses.

In this right-hand part of the spectrum, therefore, the following elements in the central dynamic sequence must be given more and more emphasis:

- acquainting the patient with the fact that he is using defenses, clarifying what they are, and pointing out their self-destructiveness;
- sustaining and steadily increasing the power of the challenges used;
- dealing with the inability to allow emotional closeness in the transference;
- challenging the resistance of the superego.
- in highly resistant patients with ego-syntonic character pathology the phase of clarification and elaboration of the patient's ego syntonic character defenses is an essential step before the therapist undertakes a relentless challenge and pressure to the patient's resistance;

sufficient work must be done to restructure the ego-syntonic defenses to ego-dystonic before the therapist proceeds to the unlocking of the unconscious. In patients with severe character pathology who suffer in addition from (a) chronic depression with major depressive episodes, (b) panic disorders, (c) somatization disorders, (d) functional disorders such as irritable bowel syndrome, restructuring of the ego's regressive defenses is an essential step before the unlocking of the unconscious. These patients suffer from a deep-seated inability to distinguish between the impulse of anger and the other two corners of the triangle of conflict, namely defense and anxiety. If the therapist, without restructuring, attempts to achieve a breakthrough by means of steadily increasing pressure and challenge, the only result is creation of misalliance.

The therapist should apply the restructuring technique, the essential features of which consist of (a) regulating the pressure very carefully and immediately reducing it when there are signs that too much anxiety is being aroused, and (b) repeatedly driving home cognitive insight into the connection between defense, anxiety and impulse. The main way of regulating the pressure is to proceed in a spiral deliberately, repeatedly moving the focus from the area of current relationships (C) to the transference (T) and back again. Nevertheless this part of the interview contains all the elements of the central dynamic sequence, the difference being essentially quantitative rather than qualitative. By this means the patient's defensive system can be gradually restructured, and now the therapist can go on to a steadily progressive technique and achieve a breakthrough without risk. (For a full description of this technique, with a detailed clinical example, see Davanloo, 1987, a, b, c, d).

The rest of these articles will be mainly concerned with the use of the central dynamic sequence in the right hand half of the spectrum. In the first part of the present article I shall use brief illustrative excerpts taken from interviews with patients who have already been described in detail in previous articles, namely the Man from Southampton and the German Architect and three other interviews. These patients were poorly motivated and suffered from diffuse, ego-syntonic character pathology, impoverished relationships, self-destructive life patterns, and resistance maintained by the super-ego. In the second article I shall illustrate the technique in greater detail by means of a full interview.

It should be added here that although these patients lie in the right hand half of the spectrum, they should not by any means be considered the most difficult patients on the right side of the spectrum.

#### Detailed Description of the Central Dynamic Sequence

In the following account the abbreviations C, T, and P refer to the three corners of the triangle of person, Current (which includes recent past), Transference, and Past (i.e., distant past), respectively.

#### Phase (1): Exploring the Patient's Difficulties

##### *Inquiry in the Area of C*

The therapist opens with a question about the patient's complaints, e.g., "Can you tell me what seems to be the problem"? Patients in the left-hand half of the spectrum usually respond by describing some current difficulty, and as long as answers are freely and spontaneously given, the therapist continues with further clarification and history-taking.

Most patients in the right-hand half of the spectrum show resistance from the beginning and are unable to describe their difficulties. Below are examples;

#### The Man from Southampton

*PT: I don't know, it's been a long time that I've been seeing doctors, and in all that time I don't know that I would be able to identify the problem . . .*

Exploring his difficulties:

*PT: I still feel somewhat guilty about it but . . .*

*TH: What is that you refer to as guilt when you say . . .?*

*PT: Well I have always felt that I should not be doing what I do.*

The defense of vagueness, his tactical defenses to distance himself from his feeling in referring to his sexual life is clarified with some degree of challenge.

In cases such as this pressure begins at once.

#### Phase (2): Pressure, Leading to Increased Resistance

Among the many ways of exerting pressure the five most often used—like the major phases of the central dynamic sequence—themselves form a logical sequence, as follows:

(a) directing the patient toward significant areas that give him difficulty in his current life, or asking him to elaborate on areas already mentioned;

(b) asking him to be more specific, or asking for a specific example of a recent incident that has given him difficulty.

The interview then often crystallizes around such an incident and leads to the next three forms of pressure:

(c) focusing on feelings aroused by the incident;

(d) focusing on the actual experience of feelings;

(e) if anger is involved, focusing on impulses.

Even if they start by answering freely, most patients become resistant in response to any of the above interventions, because they sense consciously or unconsciously that painful or avoided areas are being approached.

Resistance may be defined as the use of defenses in the therapeutic situation, and therefore when an interview is being described the terms "resistance" and "defense" can often be used interchangeably. Resistance usually takes the form of a series of tactical defenses, of which there are a very large number, such as vagueness, intellectualization, obsessional rumination, diversionary tactics, defiance, etc.

The therapist may persist with his pressure, often reiterating his questions, for a considerable time, waiting until the resistance has crystallized unmistakably so that he can move on to clarification and challenge. In the

case of the Man from Southampton the patient was repeatedly pressed to be more specific or to give specific examples, but he was quite unable to do so. Only when this had become obvious did the therapist move on to Phase (3). With the German Architect the resistance was so clearly in evidence from the beginning that the therapist moved to Phase (3) almost at once.

### Phase (3)

#### (a) Clarification and (b) challenge to the defenses in the area of C.

These two types of intervention overlap and need to be considered together, since almost all clarification contains an element of challenge, and most challenges contain an element of clarification. Their relation is of fundamental importance and is best introduced as follows:

Until the final breakthrough takes place there are always two opposite forces at work in the patient, with each of which a part of him is identified, though this is largely unconscious. The part that wishes to obtain relief is identified with his therapeutic alliance, while the part that wishes to avoid pain is identified with his resistance. Equally, whenever the therapist speaks, his remarks will lie at some point on a spectrum; at one end they are addressed to the part of the patient that is identified with the therapeutic alliance, at the other end they are addressed to the part identified with the resistance, and in between they may be addressed—in various proportions—to a combination of the two.

In the third phase of the interview the therapist's aims are first, to speak to the therapeutic alliance, clarifying the nature of the defenses; and then to speak to the resistance, challenging each defense as it arises, which means calling it in question, casting doubt on it.

The following are three examples lying at different points on the spectrum of clarification, addressed to the therapeutic alliance, and challenge, addressed to the resistance.

The first example simply clarifies the fact of using defenses:

*TH: It's not clear how you felt. Do you see we are having difficulty seeing how you felt? (The Case of the Corporate Lawyer)*

In the next example the therapist specifies the nature of the defenses but introduces an element of challenge as well:

*TH: (to the Man from Southampton) Now could we clarify a few things, because I wonder if you notice you generalize issues or difficulties that you have? You generalize and somehow you remain vague. You see, for example, you say "sexual difficulties," or you say you feel "guilty," okay? These are all labels, they are vague, and we don't understand what really you mean by any of these issues. Do you notice that?*

This example consists mainly of clarification, but the therapist has also used words and phrases (such as "labels," "vague," "do you notice") which

call the defenses in question or cast doubt on them—which are two of the essential features of challenge. As long as clarification is present, it is legitimate to introduce an element of challenge at the same time.

In the third example there is yet another element:

*TH: (To the German Architect) Yeah, but you see this is very vague. The question that I had was "what seems to be the difficulties?", and so far you are in a sense ruminating in a vague fashion . . .*

Here, in addition to clarification there is a strong element of casting doubt on the defenses. It is essential to emphasize the following.

The rationale behind these interventions is that once the patient has been acquainted with his defenses, he will begin, so to speak, to see the sense of the therapist's challenges and turn against the defenses himself. Then, a situation which is potentially one of external conflict between patient and therapist is transferred to within the patient and becomes an internal conflict between his therapeutic alliance and his resistance. As the therapist heightens this internal tension, this will eventually lead to an intrapsychic crisis, which forms an essential step in the process of unlocking the unconscious. However, if the patient has not first been acquainted with his defenses, he will take the challenge as referring to himself, and then the conflict will remain external—his therapeutic alliance will turn, not against his defenses, but against the therapist. The result will be a misalliance, and the whole therapeutic process will be at an impasse.

In this connection I have carried out the following clinical experiment: Where a trainee or colleague has made the mistake of introducing challenge without sufficient clarification, I have interviewed the patient, shown him the videotape of the relevant passage, and asked him to describe his feelings. Invariably he has said that he failed to understand what the therapist was doing and felt himself to be under attack. When, on the other hand, challenge has been preceded by systematic clarification, the patient has clearly understood his resistances that have paralyzed his function have been challenged. Though he may have been angry at the time, his principal feelings now consist of warmth and appreciation.

Not all challenges are directed against the defenses. There is also a second kind of challenge which is directed toward the therapeutic alliance, aiming to mobilize it against the resistance. This is particularly important when the patient is strongly identified with his resistance, i.e., it is ego-syntonic to him, as in the following piece of dialogue:

*PT: (the German Architect) Yes, I know, but I am vague. I mean I'm very vague about . . .*

*TH: So the first question for us is, what are we going to do about the vagueness? Because as long as you are vague then we won't have a clear picture of what seems to be the problem . . . Our problem here is first to establish what seems to be the difficulty that you have. But if you want to be vague, then we wouldn't even understand what is the difficulty.*

Here the words "what are we going to do?" constitute the challenge to the therapeutic alliance, while the whole of the intervention is designed to begin the process of making the defenses more ego-dystonic.

The therapist may go on to point out explicitly that the defenses are a manifestation of self-destructiveness or self-sabotage, and he may use language such as that they are "a crippling force," or "the ulcers of your life." Some of his interventions may be identical with those used in the head-on collision in Phase (4), but the emphasis and the aims are different. In Phase (4) the aim is to mount a powerful assault on the resistance maintained by the superego. Here, on the other hand, his aims are twofold: to clarify his position in relation to the two opposing parts of the patient, and to begin the process of making the defenses ego-dystonic. The patient needs to be brought to see that his defenses have paralyzed his functioning throughout his life, and thus to understand at a deep level that the therapist's challenge to them is carried out in order to free him.

Once the therapist has driven this message home he can begin to increase the strength of his challenge against each defense as it arises, without the fear that he will create a misalliance.

There is no space to describe the many forms that such challenges may take, but the following are two examples, both taken from the interview with the Man from Southampton.

*TH: Do you notice you want to leave things in a state of limbo? "You know," "I guess," "perhaps,"? Is it like that always?*

*PT: Because I don't remember distinctly . . .*

*TH: How is your memory usually?*

The first example includes clarification, but the word "limbo" and the deliberate irony in the question, "Is it like that always?", are used to challenge the defenses and cast doubt on them. In the second example the question, "How is your memory usually?", is itself challenging; and it is used to bring out that the patient has problems with his memory only over personal issues, so that his apparent loss of memory is a defense. Thus this intervention also includes clarification as well as challenge.

Finally, there are some challenges which do not include clarification, such as bringing the patient to commit himself to a decision, as in the following example also taken from the Man from Southampton. The subject at issue is the patient's sexual life:

*TH: What was it like?*

*PT: For me it was exciting and I suppose it was more or less satisfactory.*

*TH: But you say "suppose."*

*PT: Well otherwise I would not have wanted to—*

*TH: Was it satisfactory or wasn't it?*

To summarize, the aim of these challenges, directed against the defenses and toward the therapeutic alliance, is to turn the patient against his own

defenses. The ultimate aim is, by raising the tension between the two halves of him, to create an intrapsychic crisis. This process is continued in phase 4.

#### Phase (4a) Challenge to the Transference Resistance (T)

As the inner tension between the two parts of the patient is progressively raised, it inevitably begins to manifest itself between patient and therapist in the form of conflicting transference feelings. The part of the patient that is identified with his defenses reacts with anger at having them challenged; while the part that is identified with the therapeutic alliance reacts with warmth and appreciation toward the therapist for his sustained efforts to help. In the great majority of patients both the negative and the positive transference feelings give rise to further resistance, the negative because the patient has conflict over his anger which has its unconscious link with unconscious repressed sadistic impulses in relation to the past, and the positive because in the past warmth and closeness have always ended in disappointment. The result is an intensification of resistance, which has now become a transference phenomenon.

During Phase (4) the therapist must monitor the signs of this with great care. They are more often nonverbal than verbal. Signs that the patient is defending himself against anger may consist of clenched fists, gripping the arms of the chair, becoming increasingly tense and passive, involuntary smiling, or sighing respiration; while the signs that he is defending himself against positive feeling and emotional closeness may come from the over-all atmosphere of distancing and also from the avoidance of eye contact. When the therapist senses that the tension has reached a sufficient pitch, he breaks in with a direct question, and he frequently follows this up by drawing attention to the nonverbal signals:

*TH: (to the Man from Southampton) How do you feel when I repeatedly bring to your attention this keeping things in a state of limbo?*

*PT: I feel a little annoyance at it but then I realize that—*

*TH: But you say you feel annoyance with me and then at the same time you smile. You notice that, hmm?*

The patient's reply to the initial question about his feelings was clearly defensive—as it almost invariably is with all patients—and there now follows a sequence of clarification, pressure, and challenge in the area of T similar to that already described for the area of C. However, there is one important difference, namely that the therapist no longer needs to be so careful and can increase his challenges more rapidly and to a higher level.

Here he must direct his pressure and challenge to the defenses both against anger and emotional closeness:

*TH: (to the Man from Southampton) And you frequently take a deep sigh, isn't that? You smile again. Now let's look to your annoyance. What is the way you experience this being annoyed?*

*PT: I guess I swear to myself when you point out to me my behavior. I say, ‘Jesus Christ, again, and again and again.’*

*TH: Now you are avoiding the issue of annoyance. You said you felt annoyed with me. What was the way you experienced that?*

*TH: (to the German Architect) Now your eyes also avoid me.*

*PT: Well, I mean I can't look at you all the time.*

*TH: Do you notice that you avoid my eyes?*

#### Phase (4b) Head-on Collision with the Transference Resistance, Especially that Maintained by the Superego

Under this kind of pressure the resistance crystallizes more and more clearly in the transference, and in addition there may be signs that the defenses are becoming exhausted, which take the form of communications from the unconscious therapeutic alliance. Thus both parts of the patient are in evidence, and it is clear that the tension between the two is at a high level.

Now, using this situation as his cue, the therapist brings in his most powerful intervention, the head-on collision, which is designed to maximize the inner tension. The intervention has the following characteristics:

- (a) it is essentially addressed to the therapeutic alliance, with the aim of mobilizing this against the resistance,
- (b) the emphasis is almost always on the resistance in the transference,
- (c) special emphasis is usually given to the patient's refusal to allow emotional closeness, and
- (d) most important of all, it is largely intended to mobilize the therapeutic alliance against a form of resistance which so far has not been dealt with, namely that arising from the superego—the patient's need to defeat the therapeutic process in the interests of perpetuating his own suffering.

In its complete form the head-on collision usually spells the situation out starkly from first principles, and contains the following elements:

- (a) emphasizing that the patient has a problem which causes him pain, and that he has come here of his own volition to solve it with the therapist's help;
- (b) specifying the patient's defenses, particularly his emotional distancing in the transference, and pointing out that if he continues to use these defenses he will be defeating his own goal, perpetuating his own suffering, and making the therapist and the therapeutic process useless to him;
- (c) pointing out the self-destructiveness in this and calling it in question;
- (d) linking this with the patient's life and relationships outside.

In the case of the German Architect the therapist's interventions were as follows:

*TH: Obviously you have some problem that so far we don't know anything about, okay? . . . But if you stay like this, vague, nonspecific and withholding as you are, then we will depart from each other . . . without getting to the core of your problem . . . Then I would be totally useless to you. Now, you have set a goal, obviously to come here to understand your problem . . . But then if I become useless to you and we don't get to the core of your problem, then you walk out of here carrying your own problem, whatever it is, with yourself . . . Then who is defeating? So obviously what is immediately coming into focus is that you have a self-defeating pattern. My question is, why does an intelligent person like you want to do that?*

In the case of the Corporate Lawyer there was greater emphasis on the refusal to allow emotional closeness:

*TH: So then you want to keep me behind a wall. And as long as you keep me, behind a wall . . .*

*PT: You can't help me.*

*TH: Then I would be useless to you . . . Now why an intelligent person like you goes to the whole trouble to come but at the same time wants to defeat the purpose of this . . .*

*PT: There's no ration . . .*

*TH: Why do you want to sabotage this and why do you want to make me useless to yourself?*

*PT: I don't want to sabotage it.*

*TH: But obviously it is there.*

In the case of the Man from Southampton this phase of the interview developed as follows:

The patient's strongly worded remark reported above, “Jesus Christ, again and again . . .,” was one of the indications that his defenses were beginning to become exhausted. The therapist took this as his cue to begin the head-on collision.

*TH: So if you continue to be vague and keep things in a state of limbo, then we would not get to understand the core of your problem, and the end result would be that I would be useless to you like the 20 years of your past therapy, okay? Why do you want to do that? Because obviously it is very evident that you put a barrier between yourself and other people. Is that barrier between you and me?*

In many cases the head-on collision may have to be continued for a considerable time, and may need to be followed by further work on the defenses, before the first breakthrough occurs. In the case of the Man from Southampton, however, the breakthrough began almost immediately, though the therapist continued with the head-on collision in order to complete the process.

### Phase (5) Intrapyschic Crisis, the Direct Experience of Transference Feelings, and the First Breakthrough

Most frequently the principal manifestation of intrapsychic crisis is that the patient is faced with a feeling which so far has been completely hidden, namely his grief and remorse about all the wasted opportunities and destroyed relationships brought about by his self-destructive defenses. This is usually expressed in tears. Of course he wishes to conceal his grief from the therapist, as well as his anger and warmth, which leads to further resistance. The therapist must now bring all these complex feelings into the open. Highly condensed, this happened with the Man from Southampton as follows:

In response to the intervention above the patient put his head in his hands and began to cry.

*TH: How do you feel right now?*

*PT: (Recovering from his bout of crying) What you've told me made me feel angry for sure.*

*TH: What was it like when you felt angry with me?*

Suddenly the patient switched to his grief, behind which there lay a great deal of warmth, but the therapist continued the head-on collision in order to free all the feelings completely:

*PT: . . . I got very upset just now because what you were saying indicated that there is no good in your sitting there and talking to me like this unless we can get something out of it.*

*TH: But that is one of the major problems that we should focus on. Because you are putting a barrier between yourself and me, you are hiding behind a wall. And as long as there is this wall, then obviously we cannot get to the core of your problem. So the question is, what are we going to do about this wall? Because I assume this is the problem in any other relationship. Have you ever had a person in your life that you felt you wanted . . .*

*PT: A person with whom there was no barrier at all? No.*

*TH: So this is a lifelong problem, hmm? (The patient looks away). Do you notice that when you become tearful you avoid me? You avoid both the eye contact as well as not looking at me. Why? Because you are talking about closeness, hmm?*

The patient begins to sob without restraint.

### Discussion of the Process of Unlocking the Unconscious

#### The Therapist's Interventions in Phases (3) to (5)

In these three phases, it is important to note the need for a profound understanding of the forces both within the patient and between patient and

therapist. This understanding leads to specific interventions designed to manipulate each of these forces, with the aim of bringing about an intrapsychic crisis and achieving a breakthrough into the unconscious.

In the cases described above, the therapist's interventions in Phase (3) included the following:

- (a) Clarification of the defenses in the area of C ("I wonder if you notice you generalize . . . ?"). This has the aim of making sure that it is the defenses and not the patient himself that is being challenged.
- (b) Challenge directed against the defenses in the area of C—calling them in question ("These are all labels, they remain vague . . ."), and casting doubt on them. (". . . so far you are ruminating in a vague fashion"). This has the aim of undermining the patient's identification with his resistance.
- (c) Challenge directed toward the therapeutic alliance (". . . what are we going to do about this vagueness? Because as long as you are vague . . ."). This has the aim of making ego-syntonic defenses egodystonic and mobilizing the therapeutic alliance against them.

In Phases (4) and (5) the therapist's interventions included the following:

- (a) Pressure toward the experience of transference feelings ("How do you feel when I bring to your attention this keeping things in a state of limbo"? "What is the way you experience being annoyed"?).
- (b) Drawing attention to nonverbal signals indicating tension in the transference ("You frequently take a deep sigh"). This informs the patient's unconscious that it is betraying its rising conflict, heightens the tension, and brings the underlying feelings nearer to consciousness.
- (c) Challenging and thus weakening the resistance to experiencing negative transference feelings ("Now you are avoiding the issue of annoyance").
- (d) Drawing attention to nonverbal or verbal signs indicating avoidance of emotional closeness in the transference ("Do you notice that you avoid my eyes"? "You want to keep me behind a wall.") This constitutes a challenge to the resistance against experiencing positive transference feelings.
- (e) The head-on collision with the resistance of the superego in the transference ("If you stay vague and withholding, I will be totally useless to you . . . What is coming into focus is that you have a self-defeating pattern"). This weakens the superego resistance, mobilizes the therapeutic alliance against it, and activates the patient's grief about his own self-destructiveness.

The corresponding complexity of the patient's feelings will be considered under the next heading.

**Discussion of the Process of Unlocking the Unconscious (cont'd)**  
**The Patient's Emerging Feelings**

As described above, the whole aim of these interventions has been to bring about an intrapsychic crisis, which leads to the direct experience of extremely complex feelings, principally in the transference. The Man from Southampton showed very clearly almost all the different kinds of feelings that may be aroused:

The simplest feeling was anger caused by the therapist's repeated challenge to his resistance, as represented by his strongly worded remark, "I guess I swear to myself, 'Jesus Christ, again and again and again'."

However, side by side with this the patient made the following remark, which was loaded with grief: "I got very upset just now because what you were saying indicated that there is no good in your talking to me like this unless we can get something out of it."

This requires considerable analysis:

First, one root of his grief lay outside the transference: the recognition of the way in which his self-destructiveness had spoiled his life over many years.

Second, the very fact of sharing his grief with the therapist indicated something highly positive in the transference, namely the ability to abandon his withdrawn position and allow emotional closeness.

Third, there lay behind this another highly positive transference feeling, which was a warm appreciation of the therapist's determination not to give in to his resistances. In a later part of the interview he said, "There is one big difference from my previous therapist, and that's an interest in my welfare . . . Nobody has talked to me the way you do about identifying the problem."

Finally, both the anger and the grief led directly into the distant past. In Phase (5) it was easy to bring out that his anger with the therapist had roots in his unexpressed anger with his father, who used to oblige him to be specific. And in Phase (8) it became clear that the reason why he was so deeply touched by the therapist's concern for him lay in his longing for a good relation with his father, which—as he now remembered—he had once known but had later lost.

It is a mass of conflicting feelings like this that the intrapsychic crisis brings to the surface, at least potentially, in every patient suffering from character pathology and much more so in those suffering from severe character pathology.

The fact that these complex feelings, mainly in the transference, are so clearly related to the distant past makes the following—universally found—observation less surprising: the patient's experience of them constitutes the triggering mechanism which will eventually lead to unlocking the whole of his unconscious.

However, the word "eventually" is important, because although a major unlocking has taken place this is only the first stage, and there is still much resistance hidden beneath the surface. This is of two kinds. The first is unresolved transference resistance arising from aspects of past relationships not

yet touched on, which will be dealt with in Phase (6) by interpretation, with the use of the two triangles. The second is nontransference resistance arising from the reluctance to face painful feelings, which is dealt with in Phase (8), much more easily, by minimal pressure and challenge.

Thus the unlocking of the unconscious occurs in stages: First, the intrapsychic crisis as described above; then the dissolution of residual transference resistance by interpretation in Phase (6); and finally the sweeping aside of minor resistance against facing painful feelings in Phase (8). Nevertheless the most important of these is the first, because without it any attempt to reach the unconscious quickly by traditional interpretative methods is bound to fail.

**Phase (6 & 7) Systematic Analysis of Transference, Inquiry, Completing Dynamic Phenomenological Approach to Patient's Psychopathology, and Developmental History**

The immediate result of the intrapsychic crisis is a major drop in tension and a considerable shift within the patient, so that for the time being the therapeutic alliance gains the ascendancy. This has important consequences: (a) areas outside the transference can now be explored in a much more meaningful way, (b) interpretation, which so far has hardly featured in the interview at all, now becomes effective. After systematic analysis of the transference and two triangles then the therapist may begin by completing the psychiatric enquiry—an essential step in all initial interviews—and, provided nothing untoward has emerged, he will then go on to explore the patient's current life and relationships. The exploration of the past where the patient's neurosis originated needs to be carried out in the most dynamic way possible, which can only be done after the residual transference resistance has been analyzed and dissolved. In many cases, information about the past emerges spontaneously, so that the therapist can include this in his interpretations as well, thus completing the triangle of person.

The therapist makes use of the material that emerges to give interpretations based on the two triangles, the triangle of conflict (defense, anxiety, and underlying feeling or impulse) and the triangle of person (current, transference, past). He emphasizes the different ways in which the patient has defended himself against his underlying feelings and impulses; and above all he draws the parallel between the use of these defenses in other relationships, and their use in the transference in the service of resistance.

In the case of the Man from Southampton this phase of the interview unfolded as follows:

- (a) The therapist began with psychiatric enquiry. Here the patient revealed the mobilization of his therapeutic alliance by spontaneously making some deep interpretations about his own behavior, in particular that some accidents that he had had were an expression of suicidal impulses.

- (b) Since in one of these accidents the patient's wife narrowly escaped

- being killed, the therapist made an interpretation of murderous feelings toward her.
- (c) The therapist gave a superego interpretation, that the patient had a self-sabotaging, self-punishing pattern. The patient fervently agreed, confirming this with a further spontaneous interpretation of his own behavior.
  - (d) In connection with enquiry about previous psychotherapy, the above-mentioned strongly positive feelings for the therapist emerged: "There's one big difference with you and that's an interest in my welfare."
  - (e) As the patient said this he was once more overcome with grief, and he then spontaneously contrasted the therapist's concern with the fact that when he got upset his father used to ridicule him, i.e., he gave his own TP interpretation, linking two corners of the triangle of person.
  - (f) This enabled the therapist to give major interpretation of the resistance, making use of the two corners of the triangle of conflict and two of the triangle of person; that the patient's detached and withdrawn attitude in the early part of the interview was his way of dealing with anger, and that this was the same pattern as he had used with his father, i.e., linking defense with underlying feeling and past with transference.
  - (g) This led to a further experience of anger in the transference, more direct and intense than before: "Now I realize that I would like to say, 'For Christ's sake leave me alone. Don't keep asking me these questions'."

Finally the therapist linked the patient's avoidance of eye contact in the interview with the same reaction to the father (another TP interpretation).

During this phase the patient twice openly expressed strong feelings for the therapist—on the first occasion positive and on the second negative—both kinds of feeling being linked with the father. These moments gave evidence of the second stage of unlocking the unconscious, which was a direct result of the analysis of the residual transference resistance.

In this connection it is also important to emphasize the presence, side by side with anger, of the patient's warm appreciation of the therapist's approach. This was only made possible by the preliminary systematic clarification of the defenses, which enabled the patient to realize at a deep level that it was his resistance and not he himself that was under challenge.

The analysis of residual transference resistance and the phase of inquiry was now completed, and the therapist could embark on the final phase of the central dynamic sequence.

#### Phase (8) Direct View of the Multifoci Core Neurotic Structure

The therapist now undertakes a systematic exploration of the past, often starting with purely factual enquiry—"Where do you come from?", "How

old are your parents?", and learning about the family situation in the patient's upbringing. Then, once sufficient evidence has accumulated, he begins to make his enquiry much more dynamic, exploring genetically structured conflicts and patient's core pathology.

#### Major Unlocking versus Partial Unlocking of the Unconscious

If the protocol has called for the major unlocking of the unconscious during the phase of (6) and (8) there is no return of the resistance. Exploration of the multifoci core neurotic structure and the emergence of the guilt-laden eroticized feelings, guilt, and grief-laden unconscious feelings in relation to the people in the past is without any return of the resistance. But if the research protocol calls for the partial unlocking of the unconscious such as the Case of the German Architect, the Man from Southampton, and the Corporate Lawyer, then during the phase of (6) and (8) resistance is not over and will almost always return when painful areas are approached, but now it can be penetrated much more easily, e.g., by simply repeating a question, and in many cases the transference no longer needs to be mentioned at all. The therapist aims to bring the patient's most painful feelings to the surface and to enable him to experience them directly. This is possible in proportion to the degree to which there has been direct experience of complex feelings in the transference. Where transference experience has been intense there will be major breakthrough; where it has been only partial the breakthrough will not be so complete, but it will still be highly significant. In either case this represents the third stage of unlocking the unconscious, leading to a direct view of the patient's multifoci core neurotic structure.

With the man from Southampton (partial unlocking of the unconscious) the major features that emerged were as below. It is worth noting that throughout this phase the transference was not mentioned at all.

The patient somehow became the outsider in his own home. Of the five children, a sister was preferred by the father, and his brother one year younger became the favorite of the whole family. Nevertheless, the patient gave evidence that there had been a time when he felt close to his father. Resistance returned as the therapist tried to bring this into the open, but now it was quite easily swept aside, which led to a fresh memory:

*PT: I remember looking for my father when he would return from work. I could see the pathway that he would take approaching the house.*

*TH: What is your memory of that path?*

*PT: (Using the defense of evasiveness) it was just a path across the field.*

*TH: ... So you looked forward to your father.*

*PT: Yes I did, and I ran down to meet him and fell down the stairs and knocked myself out and had to be taken to hospital. I've just remembered that.*

The patient went on to describe, with tears, how his father used to punish him physically with a strap. Further enquiry then suggested strongly

that a major source of conflict lay in the relation with the brother, with whom the patient used to fight constantly. He said that his father bought them boxing gloves and told them that if they were going to fight they should fight properly. He described an occasion on which, fighting in this way, his brother knocked him backwards into a china cabinet. The dialogue then proceeded as follows, with resistance returning and once more being easily penetrated:

*TH: How did you feel when he knocked you down? Did you feel that you wanted to get at him?*

*PT: I don't know. I suppose I did . . . I don't remember how I felt.*

The therapist reminded him that during quarrels with his wife he had had the wish that he could kill her:

*TH: . . . Was there the wish that you could do that to your brother?*

*PT: I'm sure there was. Yes, because on one occasion I remember fighting with him in the field . . . and I did a terrible thing when he walked away. I took a stone from the ground and threw it at him and hit him on the back of the head.*

*TH: If you didn't have a brother what would have happened?*

*PT: Well, I would not have had a rival in the family, would I?*

Further exploration led to another fresh memory, this time involving the triangular relation between the patient and his father and mother. The father became angry with the mother and called her a pig, and the patient stood in front of his mother and raised his fist, wanting to attack his father, who said he would disown him as his son. The relation with the father eventually became so bad that the patient had to leave home.

Toward the end of the interview the therapist dealt with the patient's feelings about his father's death, taking him in detail through the last time he had seen his father alive. It became clear that behind the anger there was much buried grief. Once more there was resistance, and once more this was quite easily penetrated. The final part of this passage was as follows:

*TH: What do you remember about the funeral.*

*PT: I didn't attend the funeral. I didn't have the money to travel to England.*

*TH: Was that the only factor or was it less painful for you?*

*PT: I don't remember considering whether I should or should not go.*

*TH: But this is not you, is it? I mean you are a sensitive person, aren't you? You were wishing for the father that you didn't have, and you were very much touched when he was incapacitated . . . So do you think that a part of you wanted to go but a part didn't want to face that dead body? Where is he buried?*

At this point the patient became overwhelmed by grief.

The above account illustrates very clearly the contrast from the begin-

ning of the interview, where the patient could hardly describe his problems, let alone any feelings. Now, on the other hand, the degree to which his whole psychic system had been loosened became entirely apparent. Resistance was minimal, and in each area that was explored intense buried feelings emerged from his unconscious.

### The End of the Interview

The final phase is followed by a relatively brief period, in which the therapist enquires how the patient feels now, explores motivation for continued therapy, and sums up some of the issues that have been discovered, before bringing the interview to a close.

### Cases in Which Phases (1) to (3) are By-passed

Some patients enter the interview room betraying obvious transference feelings from the beginning, in which case the therapist by-passes phases (1) to (3) and returns to phase (1) at a later point. There is not enough space to describe this in detail. Here I will briefly outline *The Case of the Woman who Frequently Bruised her Thigh*. She suffered from characterological problems, major problems in human relationships, inability to allow herself intimacy and closeness and a life-long pattern of self-defeat and self-sabotage. She entered the interview room visibly nervous. The therapist focused first on her anxiety.

*TH: How do you feel right now?*

*PT: I feel very nervous and anxious.*

The physiological concomitant of the anxiety were explored and she indicated that she had trouble with breathing, tightness in her chest, she sighed frequently, fidgeting, these were reflected on.

*PT: Well I know it was to do with coming here this morning.*

*TH: And what were the thoughts in your mind about coming here?*  
(Patient sighs deeply)

*PT: I feel that I'm going to sort of expose myself, you know?*

Immediately the process is shifting to the triangle of the conflict in the transference bringing into focus one of her major problems which has to do with intimacy and closeness.

*TH: The idea is you are going to expose yourself which means in a sense you are going to come here and we are going to get to your intimate thoughts . . . intimate feelings, huh? That is the idea huh?*

*PT: Yes.*

*TH: So you have to let me into your intimate thoughts and intimate feelings, huh? And that mobilizes anxiety in you?*

*PT: Yes, and I'm afraid of what you will see.*

The focus of the session is on the conflict over intimacy and its transference implication and the patient has deep sighs.

*TH: You took another sigh as soon as I said intimate thoughts and feelings.*

*PT: Well, I know, this is part of my difficulty that I have trouble getting, allowing a man to get close to me.*

*TH: You say one of the problems you have is letting a man get to your intimate thoughts and feelings and close to you. Are you saying that you put up a barrier . . .*

*PT: Yes, I don't trust men.*

The above passage shows that the process has by-passed phases (1) and (2) and is on phase (3) to (4). Clarification of her defenses and her tactical defenses such as "I don't trust men" and the therapist moves to further clarification of her defenses in the area of T drawing attention to her nonverbal and verbal signs indicating avoidance of emotional closeness in the transference.

Some patients enter the interview room in a state of transference resistance. This can be illustrated by the following case. Because of the research protocol he was on the waiting list for a period of six months and entered into the interview explicitly referring to his frustration and declared that he was annoyed.

*PT: I was annoyed quite frankly.*

*TH: You mean you were annoyed, that is past or you are annoyed?*

The process is focused on the patient's tactical defenses and the triangle of conflict in the transference. He says "annoyed" which refers to the lower part of the triangle of the conflict. He uses tactical defenses, puts the annoyance in terms of the past and also does not indicate at whom he was annoyed.

#### Clarification and Challenge to the Defenses in the Transference

*TH: So what you say is this, you were annoyed but you are not annoyed anymore.*

Focusing on how he experienced his annoyance:

*PT: Well I said to myself, you know to me it doesn't make sense.*

*TH: But that is a sentence.*

#### Challenge to the patient's resistance in transference Phase (4)

*PT: Well in my mind I said you know stupid, bloody doctors.*

His defenses are clarified, challenged and his use of a sentence to describe a feeling is challenged and further it was pointed out.

*TH: But then also you made it plural—doctors (Patient has a deep sigh)*

*TH: Who is stupid and bloody? . . .*

*PT: Well I guess it was directed at you.*

*TH: You say guess. It was directed at me?*

In this case the central dynamic sequence started with phase (4) namely transference resistance. The major intervention consisted of systematic challenge to the patient's resistances against experience of the impulse in the transference.

#### Summary and Conclusion

##### The Central Dynamic Sequence-Recapitulation

In the first part of this two-part article I have outlined the process of the unlocking of the unconscious and indicated that the whole process can be divided into a series of phases each consisting of a particular type of intervention with its corresponding response and this whole process I have called the "Central Dynamic Sequence." The following is an account of the complete sequence as used in patients with moderate to high levels of resistance. The therapist opens with pure enquiry exploring the patient's difficulties: Phase (1), but very soon begins to exert pressure: Phase (2), directing the patient toward significant areas, asking for specific examples, enquiring about the experience of feelings. This inevitably leads to resistance, which takes the form of a series of tactical defenses. The therapist waits until the resistance has crystallized unmistakably and then begins first to clarify the defenses and then to challenge the defenses Phases (3a and 3b).

Clarification is an essential step before challenge, because the patient must be enabled to understand that it is his resistance and not himself that is under challenge. Challenge may be directed against the defenses, calling them in question and casting doubt on them, or toward the therapeutic alliance, urging it to make a supreme effort to overcome them. In either case the aim is to increase the intrapsychic tension between these two opposing forces, with each of which a part of the patient is identified. The inevitable result is a rapid rise in transference feelings, usually negative on the surface and positive underneath. Both kinds of feeling lead to a further increase in resistance, which has now become a transference phenomenon.

The therapist carefully monitors the signs of this, most of which are non-verbal, and when the tension has reached a sufficient level he breaks in with the question, "How do you feel right now"? [the beginning of Phase (4)].

The patient's answers to this direct question about his feelings are invariably resistant, and there now begins a phase of pressure, clarification, and challenge, to the resistance both against experiencing anger, and against allowing emotional closeness, in the transference [Phase (4a)]. The therapist

draws attention to nonverbal signs of increasing tension and emotional distancing.

There now often emerge signs that the defenses are beginning to become exhausted, which take the form of communications from the unconscious therapeutic alliance. Using these as his cue, the therapist introduces the head-on collision, which consists of a challenge directed toward the therapeutic alliance, with the aim of mobilizing it against the self-destructive resistance of the superego in the transference [Phase (4b)].

The result is an intrapsychic crisis [Phase (5)], the triggering mechanism which makes possible all the stages of the unlocking of the unconscious. In the first stage of the unlocking, which occurs now, the resistance breaks down and the patient is brought to the direct experience of feelings of great complexity, which include negative and positive transference feelings, and grief both about losses due to his own self-destructiveness, and about earlier losses which were not under his own control. All these feelings have roots in the distant past, and the result is a loosening of the patient's whole psychic system. The immediate effect is a great drop in tension, and what follows is the first unlocking of the unconscious and the direct view of the multifoci core neurotic structure. The therapist now moves to the systematic analysis of the two triangles. The process is now actively in the interpretative phase. The analysis of the transference is important in removing residual transference resistance. The therapist now embarks on enquiry completing dynamic phenomenological approach to the patient's psychopathology Phase (7). The trial therapy then enters Phase (8) which usually starts by the therapist undertaking a systematic exploration of the past. This phase provides both patient and therapist with a direct view of the patient's multifoci core neurotic structure.

In the second part of this article the whole process will be illustrated by means of a complete trial therapy.

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# The Technique of Unlocking of the Unconscious. Part II: Partial Unlocking of the Unconscious

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In this second part of the two-part article the author presents his technique of the unlocking of the unconscious. The technique of partial unlocking is illustrated with the verbatim account of a complete interview.

## Partial Unlocking of the Unconscious

In the first part of this two-part article I discussed the *Central Dynamic Sequence* which leads to the unlocking of the unconscious. They can be summarized as follows:

- (a) Clarification of the patient's defenses.
- (b) Challenge directed against the defenses, undermining the patient's identification with his defenses.
- (c) Challenge directed towards the therapeutic alliance, mobilizing the therapeutic alliance against resistance.
- (d) Pressure towards experience of the transference feeling; challenging and thus weakening the resistance to experiencing negative transference feeling; challenge to the resistance against experiencing positive transference feelings.
- (e) Head-on collision with the resistance; weakening the superego resistance.
- (f) Bringing about an intrapsychic crisis.
- (g) Direct experience of extremely complex feelings in the transference which constitute the triggering mechanism which will lead to the unlocking of the unconscious with partial or major de-repression in relation to the current and recent past, (C), and in the distant past (P).

In this technique of unlocking the unconscious the therapist aims to bring aggressive impulses and the patient's most painful feelings to the surface and to enable him to experience them directly. The degree of unlocking

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is in proportion to the degree to which there has been direct experience of the highly complex feelings in the transference. If the therapist plans to have a major unlocking of the unconscious it requires that the experience of the highly complex transference feelings be intense with a direct breakthrough of the impulse in the transference which is always followed by intense direct experience of guilt and grief-laden unconscious feelings.

In achieving the major unlocking of the unconscious the therapist's technical intervention must be systematically directed in Phases (3), (4), (5), and (6) of the central dynamic sequence. I have described this in previous articles in this Journal (See Davanloo, 1987a, b), the Case of the Machine-Gun Woman. In the first phase of the interview there was systematic work on the patient's resistance in the "T" and "C" and the activity of the therapist centered on Phases (1) to (4), and finally what followed was a systematic challenge to the resistance in the transference particularly challenge and pressure to the superego resistance. This then was followed by the breakthrough of the impulse in the transference. Then there was again return of the resistance in the transference and the therapist moved to Phase (4) with a major pressure and challenge to the resistance in the transference; challenge to the resistance against experiencing aggressive impulse with concomitant challenge to the resistance against experiencing positive transference feelings. Then the process entered Phase (5), with the intense rise in the complex transference feeling and the direct experience of highly complex feeling in the transference and what emerged was a major unlocking of the unconscious and a very high rise in the unconscious therapeutic alliance and throughout the rest of the interview Phase (6), (7), and (8) there was no trace of resistance.

This technique of the major unlocking of the unconscious is a powerful psychotherapeutic tool and is equally important in teaching and research. However the therapist should take into consideration that with this technique the patient should not be placed on a waiting list and it requires that the patient enter treatment within one to two weeks.

I have developed a third technique which is based on the same central dynamic sequence but aims at bringing about massive de-repression of the unconscious. This will be the subject of another two-part article.

#### **The Technique of Partial Unlocking of the Unconscious**

As I indicated earlier the degree of the unlocking of the unconscious is in proportion to the degree to which there has been direct experience of the complex feelings in the transference. If the therapist aims at a partial breakthrough into the unconscious then he must monitor the central dynamic sequence in such a way that the experience of the complex transference feeling, particularly the breakthrough of the impulse in the transference, is partial. Here the unlocking of the unconscious might go to a number of stages. In this technique after having achieved the first unlocking of the unconscious resistance is not over and will almost always return when painful areas are approached but now it can be penetrated much more easily.

The technique of partial breakthrough into the unconscious is a powerful

therapeutic technique. The patient can wait on the waiting list until a therapist is available and is very important in controlled clinical research in psychotherapeutic process and outcome.

In the balance of this article I will describe a technique of partial breakthrough into the unconscious which I have used in controlled psychotherapeutic research. A verbatim account of a complete interview is used for illustration.

#### **The Case of the Corporate Lawyer**

The patient was a 37-year-old married woman.

#### **Phase (1) Exploring the Patient's Difficulties, Enquiry in the Area of C, Together with the Beginning of Pressure**

In answer to the therapist's opening question the patient spoke as follows, obviously playing down her distress from the outset:

*PT: . . . I've been having a little bit of problems with my boss, and I haven't been sleeping for about six months. I've been getting up at two in the morning and just worrying, and sort of eating my heart out over all the little incidents.*

*TH: You usually wake up at two in the morning or it varies?*

*PT: Oh no, I've stopped now. As soon as I started talking about it to somebody I realized just how stupid it was.*

The therapist begins to exert pressure:

*TH: What do you mean by stupid?*

It is worth noting here the clear communication in the patient's reply about her defenses, and—as will be seen—the tip of the iceberg that it represents:

*PT: Well normally I've never let things bother me. I guess I'm just that type of person that I don't talk too much about things that bother me that much. I just rationalize it.*

She said that 18 months ago she had got a new boss, and she and he had disliked each other from the beginning. The therapist now directs her toward what seems to be a significant statement that she had made:

*TH: And then you said he dislikes you because you are a woman. What is—?*

*PT: Okay, we had a Christmas party, and everybody had to buy a surprise present to give to another person, so we all drew names out of a hat. My surprise was a penis.*

Phase (2): Pressure toward the Avoided Feelings in the Area of C,  
Leading to Resistance

The therapist elucidated what she meant by this, learning that it was in fact a replica of a penis, and that there was very considerable evidence that the anonymous donor was her boss. He now began to exert pressure toward her avoided feelings about this incident, meeting immediate and sustained resistance. In the following passage the various tactical defenses that she used are entered in brackets:

*TH: And how did you feel?*

*PT: Stupid and embarrassed (cover words).*

*TH: No, stupid is uh—*

*PT: Stupid is a bad word. Embarrassed, really embarrassed.*

*TH: What did you think?*

*PT: I was so humiliated I didn't think at all. (The word "humiliated" is nearer to a feeling but is still a cover word, as can be seen from the fact that it calls for a further question, "What did you feel about being humiliated"?).*

*TH: Now what came to your mind? I'm trying to see what went to your mind immediately.*

*PT: Okay, I was humiliated, I went flame red. I blush very easily. When I blush my ears get red, red, red. (Physical manifestation rather than feelings.)*

*TH: And then what else did you experience?*

*PT: Embarrassment (stone-walling).*

*TH: Yes, but in terms of inner feeling, what type of feeling?*

*PT: Let's see, embarrassment, shame (going round in circles).*

Phase (3a): Clarification of Defenses and Continued Pressure in the Area of C

In the following passage the therapist begins the process of clarifying the defenses, bringing in a certain element of challenge as well, and continues sustained pressure toward the avoided feelings:

*TH: Embarrassment, shame is a "sentence," words, it doesn't tell us how you felt.*

*PT: Terrible (a nonspecific, "blanket" word).*

*TH: "Terrible" is again a word.*

*PT: Embarrassed, humiliated.*

*TH: Yeah, but that doesn't tell us how—*

*PT: I didn't feel sick to my stomach, I didn't feel angry, I just felt very embarrassed (saying what she didn't feel, followed by "negation"—saying something obviously true only to dismiss it).*

*TH: But, you see, it is not absolutely clear how you felt. You say you did not feel angry, you did not feel sick to your stomach.*

*PT: I was curious as to who had done it, because at that point I was*

*very shocked (intellectualization followed by another "blanket" word).*

*TH: It's not clear how you felt. Do you see we are having difficulty to see how you felt?*

*PT: I felt, "My God"! (This exclamation still doesn't say how she felt, though it may seem to).*

*TH: Being humiliated in front of 60 people, you must have a certain feeling at that moment.*

*PT: Isn't humiliation a feeling?*

*TH: You are humiliated but it is not clear how you experienced your feelings at that moment (pressure toward the actual experience of feeling).*

*PT: Oh I got very embarrassed. I put it away and threw it in the garbage. (She smiles.)*

Here the patient has used yet another defense, describing actions rather than feelings, while at the same time her smile both serves as a defense and betrays that something inside her has been touched. The therapist draws attention to the incongruity of the smile, and hence its defensive nature, by the word "but":

*TH: But still you smile.*

*PT: Now I'm smiling, but believe you me, then I was not smiling.*

*TH: What was it then that you experienced? This is what I'm looking at. How did you feel being put in such a position in front of 60 people?*

*PT: I tried to mask it, I tried to sort of say "oh ho ho" and laugh about it in front of everybody (describing not what she felt, but how she covered up her feelings).*

*TH: But still you are not saying how you felt. You are humiliated in front of 60 people you work with, but then you have difficulty to tell me how you felt. How do you experience this? How do you feel inside?*

*PT: You mean, how do I react?*

*TH: Reaction, internal reaction.*

*PT: That's a very good question. I never thought about it before (she smiles).*

*TH: You smile and say—*

*PT: Oh I definitely wasn't smiling then. I smile now but—*

*TH: Why are you smiling now?*

The patient's response illustrates how her defenses have gradually begun to become somewhat exhausted, because she now introduces a word which admits to one of the most important feelings that she has been trying to avoid:

*PT: Probably because it's still an open wound a little bit, like I still—*

The above passage demonstrates the phase of systematic clarification and challenge toward the patient's defenses and there is some degree of rise in the patient's transference feelings manifesting itself with the first signals, sighs, which indicates anxiety in the form of tension in the intercostal muscles.

*TH: You see, this is very interesting and we should look at it. Here is a situation in which you feel humiliated and your face is red, and then you talk about an open wound. That means you felt wounded then.*

*PT: Of course I did.*

*TH: But then what I'm saying is this: how did you feel being wounded?*

*PT: How did I feel being wounded? I didn't feel sick, I guess maybe it was—*

The therapist both clarifies and challenges this defense:

*TH: But you are talking about what you didn't feel. I'm talking about what you felt.*

*PT: You mean psychic?*

*TH: Inside, yeah.*

*PT: Well, my stomach was probably in an uproar (the word "probably" waters down even the defensive somatization). I'm sure with humiliation like that my stomach went flip-flop and uh—*

*TH: What was the way you experienced this flip-flop in your stomach? You smile again.*

*PT: It's—it's because I can't answer your question. I think that's the reason.*

*TH: Could we look into this? That you say you were wounded, humiliated, your stomach went flip-flop; and I said, how did you experience this inside?*

*PT: Oh I'm sure I felt terrible (indirect speech, repeat of a blanket word used before).*

#### Phase (3b): Challenge to the Resistance in the Area of C

The therapist now begins to introduce steadily increasing challenge:

*TH: But "I felt terrible" is a sentence, words. It doesn't tell us how you—*

*PT: Okay, I left very soon afterwards (describing actions instead of feelings).*

*TH: You see, you are moving away from how you felt at that moment (clarification and implied challenge).*

*PT: I probably was angry—*

*TH: Now you say "probably" you were angry (merely pointing out the defense calls it in question).*

*PT: Well I'm sure I must have been angry. I mean, you know, like—*

*TH: Now you are moving to the position that you "must have been" angry, as if you're not sure.*

*PT: Well I was not happy, let's put it that way.*

*TH: But again—*

*PT: I was very unhappy at that point, like I—*

*TH: But, you see, first you say you "must have been" angry, which is not committing yourself (clarification). Were you angry or weren't you angry? (challenge to her indecisiveness)*

*PT: I probably was.*

The therapist now continues the systematic challenge to the patient's resistances as well as reflecting and challenging the nonverbal defenses.

*TH: "Probably" again is hanging in the middle of nowhere. You smile now.*

*PT: You can tell I'm a lawyer. I very seldom will commit myself.*

*TH: Oh no, just a moment. You say you are a lawyer and you don't commit yourself. You must be precise as a lawyer.*

The patient's defenses such as obsessional rumination are challenged. The therapist kept up his pressure and challenge and the patient began to get increasingly anxious, trying to cover it by smiling, which the therapist pointed out, emphasizing the here-and-now and thus leading toward the transference:

*PT: . . . I smile a lot, for no reason (generalization followed by denial).*

*TH: You smile a lot, I'm talking about here, let's not go outside here.*

There is a gradual build up of inner anxiety and as is seen she contradicts herself.

*PT: Okay. For no reason at all I'm smiling, for the simple reason that—*

The therapist challenges this and at the same time again leading toward the transference:

*TH: You mean you are smiling here with me for no reason?*

Suddenly there is a message from the unconscious therapeutic alliance which indicates that the defenses are beginning to become more exhausted:

*PT: Uh yes, there is a reason. For the simple reason that I have identified that maybe there is something behind my actions and that I am going to uncover what has been bothering me.*

*TH: Now let's see how you felt at that moment.*

As the therapist kept up his pressure and challenge, amongst all the re-

sistance there were further glimmerings of communication from the unconscious therapeutic alliance:

*PT: When blood surges there must have been some sort of emotional—there must have been a trem—there was an emotional reaction for sure.*

*TH: Yeah, but “emotional reaction” doesn’t tell us what your reaction was.*

*PT: Hate if you want to call it but not directed at anyone specifically. Anger, but not specific.*

*TH: Are you talking in a hypothetical way or are you saying that you were angry?*

The patient is still in a state of resistance and the therapist continues clarification and increasing the degree of challenge pointing out to her that she is “totally incapable”; a challenge to the resistance in a woman who so prides herself on her independence and efficiency. The interview continues.

*TH: Do you notice that you are totally incapable of telling me that you are put in a situation in front of 60 people that is degrading to you but then you don’t have any reaction?*

Suddenly there emerges a crucial communication from the therapeutic alliance, giving evidence of further exhaustion of defenses, and making clear both the presence of resistance in the transference and the form that it takes:

*PT: Can I open up? I’ve never opened up.*

#### Phase (4a): Clarification and Challenge to the Transference Resistance

These words of the patient’s also make clear that she is strongly identified with her defense of distancing, i.e., that it is ego-syntonic. The therapist notes this for future reference, but turns his attention first to clarifying and challenging the nonverbal signs that this defense is operating here and now in the transference.

*TH: And do you notice also you look somewhere else, you avoid my eyes?*

*PT: It’s not intentional.*

*TH: Doesn’t make a difference. Still you do. How do you account for that? A smile again.*

The therapist continues his clarification and systematic challenge directed against the resistance as well as challenge to the resistance against closeness in the form of distancing.

*PT: Not smiling, maybe it’s because you can see something, or you understand why I don’t express any feeling, and uh—*

*TH: And still you avoid my eyes.*

This brings her ego-syntonic defense completely into the open, with a defiant statement of her resistant position;

*PT: I have never in my entire life expressed any feeling to anyone.*

*TH: Uh hmm.*

*PT: To myself, to my parents, to my husband.*

*TH: But you see again you are avoiding my eyes.*

Challenge to the resistance against experiencing positive transference feelings.

The therapist returns to the incident at the party.

*TH: We have to see how you felt.*

*PT: Angry prob—*

*TH: You see again even when you want to use the word angry you have to say “probably,” as if even when you want to use the word “anger” you don’t dare.*

The patient returns to her ego-syntonic defense.

*PT: Probably because I’ve never expressed my true feeling to anyone about anything and uh—*

*TH: But still you are maintaining an incapable position.*

*PT: I’m not doing it intentionally.*

*TH: That doesn’t solve our problem.*

*PT: No, it doesn’t solve my problem.*

#### Phase (4b): Head-on Collision with the Transference Resistance, Including that Maintained by the Superego

The therapist now speaks directly to the patient’s therapeutic alliance, mounting an assault on her identification with her own resistance, and pointing out the self-defeating consequences that stem from it.

*TH: And our problem here, hmm? Because let’s face it, there are problems that you have, hmm?*

*PT: Obviously.*

*TH: Obviously, okay? And then you are searching to get help for them, hmm?*

*PT: That’s right.*

*TH: You are not coming on the will of your husband?*

*PT: It's my will.*

*TH: Now if you remain here with me helpless and incapable of seeing how you felt, then we wouldn't understand the problem and wouldn't get to the core of your problem, hmm?*

*PT: Mmm.*

*TH: So then I would be useless to you, wouldn't I?*

*PT: In that effect, yes.*

*TH: You leave me tonight, we say good-bye to each other and then I am no use to you.*

*PT: I don't know how to answer you.*

*TH: But again you move to the position, "I don't know how to answer you." That is a helpless position.*

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Return to Phase (4a): Clarification and Challenge to the Resistance against Allowing Emotional Closeness in the Transference

*PT: I have masked my feelings for so long.*

Having challenged the patient's identification with her transference resistance, the therapist proceeds to clarify and challenge the specific nature of the resistance, namely her unwillingness to allow him to get emotionally close to her.

*TH: Yeah, but that is what I am saying. Right now I have a feeling that in your relationship with me you not only mask your feelings, you are erecting a massive wall between yourself and me.*

*PT: Not intentionally.*

*TH: Doesn't make difference. Do you see there is a massive wall here?*

*PT: No.*

*TH: That I'm trying to understand you and you are erecting this wall.*

*PT: You are trying to understand me but I don't understand me completely.*

*TH: Do you notice that you are trying to put a barrier between yourself and me?*

*PT: It's not conscious.*

*TH: First we have to identify, is there a barrier or not? Now you move to the conscious or unconscious . . .*

Return to Phase (2): Pressure toward Avoided Feelings in the Area of C

Here the therapist returned to the incident at the office party, again making a sustained attempt at reaching her true feelings. Her resistance was now weakened to the point that she was able to admit more explicitly that she had been angry:

*TH: . . . I am trying to understand how you felt being degraded in*

*that fashion, but then you are incapable of telling me how you felt.*

*PT: Degraded, embarrassed, angry. Angry is a feeling.*

*TH: So you felt angry?*

*PT: Definitely angry.*

There has been a progressive rise in the patient's transference feeling and she has finally admitted to the anger in the area of C but still the resistances are in operation.

*TH: What was the way you experienced your anger at that moment?*

*PT: I'm going to get back at them."*

*TH: But what was the way you were experiencing it internally? Was it like a rage inside you?*

*PT: I don't think I've ever been in a rage in my life . . . I've never felt anger to a point where I could kill, okay? . . . I suppose there's anger at an inconvenience.*

*TH: But we are talking about that situation. You felt angry, what was the way you experienced it?*

*PT: On a scale of one to ten I was probably an eight angry . . .*

*TH: What was the eight degree of anger like?*

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*TH: So what was the way you experienced the anger?*

*PT: I kept quiet, I didn't say a word and I walked away . . . My face went like a mask . . .*

There has been a steady increase in the patient's transference feeling and she has become increasingly anxious in the interview with frequent sighs and now the therapist moves to the issue of emotional closeness in the transference.

Return to Phase (4a): Challenge to the Resistance against Emotional Closeness in the Transference

*TH: What else do you experience here with me besides nervousness? Again your eyes are on the—*

*PT: I'm thinking. I find it hard to think when I look at you—*

*TH: Do you see you have difficulty to look at my eyes and talk to me about it? Why?*

*PT: No reason that I can give you.*

*TH: But still you are ruminating.*

Her defenses were sufficiently weakened for the unconscious therapeutic alliance to offer an important communication about the reason for avoiding eye contact with the therapist: "The eyes are the mirror of the soul." The therapist capitalized on this to bring out, in the teeth of great resistance, that the issue of emotional closeness stood between them: "So then you want to

keep me behind a wall." Here he returned to the head-on collision, this time laying greater emphasis on self-sabotage, i.e., on the resistance of the superego.

Return to Phase (4b): Head-on Collision with the Superego Resistance in the Transference

*TH: . . . And as long as you keep me behind a wall—*

*PT: You can't help me.*

*TH: Then I would be useless to you.*

*PT: Mmm.*

*TH: Now why an intelligent person like you goes to the whole trouble to come but at the same time wants to defeat the purpose of this—*

*PT: There's no ration—*

*TH: Why do you want to sabotage this and why do you want to make me useless to yourself?*

*PT: I don't want to sabotage it.*

*TH: But obviously it is there. You said that looking to the eyes implies that I would get to know you, hmm? So then you don't want me to get to know you.*

*PT: I think you would probably be the first person that ever got to know me.*

The process in this phase, as I have indicated before is to maintain challenge directed against the resistance and challenge directed toward the therapeutic alliance. The intervention of a head-on collision with transference resistance has a number of characteristics; essentially is addressed to the therapeutic alliance with the aim of mobilizing the therapeutic alliance against the resistance; is largely intended to mobilize the unconscious therapeutic alliance against superego resistance, and there is a special emphasis on the patient's defense against emotional closeness. The aim in this phase is the creation of an intrapsychic crisis and raising the tension between the resistance and the therapeutic alliance.

Phase (5): Direct Experience of Complex Transference Feelings—

The First Partial Unlocking of the Unconscious

By carefully monitoring the patient's reactions, the therapist detects that she is trying to control the breakthrough of her grief. He has to employ a great deal of further pressure and challenge to bring this feeling properly into the open; she has become sad with tears.

*TH: And maybe you have a lot of feeling about that—that I would be the first person in your life that gets to know you, hmm?*

*PT: Yes.*

*TH: And then do you see your tears are always there?*

*PT: Yes.*

*TH: And you are choking with a lot of feeling.*

*PT: Yes, I probably—*

*TH: And then you are again avoiding my eyes and trying to push away these feelings. (tearful and sad)*

*PT: Yes (barely audible)*

*TH: Why? Why don't you want to see your feelings?*

*PT: I've never shown my feelings.*

*TH: But right now you are—*

*PT: Yes, I said, the tears, the uh . . . oh dear.*

The patient is emotionally charged, with tears.

*TH: So you have a lot of feeling right now.*

*PT: Yes.*

*TH: Could we look at your feeling, because you said that I am the first person in your life—*

*PT: Yes, I guess.*

*TH: Because I have a feeling that I want to get to understand you, and you are bouncing back. Any way I want to move, you push me away.*

*PT: Okay (barely audible).*

*TH: That is what I refer to as this wall, and I think it is very important to look at this.*

*PT: Mmm, wall—*

The therapist now makes the link with life outside, aiming to make the origin of her grief explicit.

*TH: Now you said that in a sense you have never had any close relationship.*

The patient provides important information about the limitations in the relationship with her husband and indicates that with her husband she is very independent and has never depended on him financially or otherwise. She further indicates that he is not demonstrative.

*PT: I never show my feelings and I think that if I ever did I might be afraid of some of the things that I actually feel which I've never shown. I might tell people what I actually think of them, which I never do.*

Further Challenge to the Resistance, Towards Closeness in the Transference:

*TH: . . . There is a constant need in you to put a barrier between you and me, which has to do with closeness.*

*PT: I'm afraid of closeness.*

*TH: . . . in a sense you have decided not to let anybody close to you.*

*PT: Okay. In the past, and I'm talking about now, yes that has been very, very true.*

*TH: That some time in your life you have decided you would not let anybody get close to you.*

*PT: Probably.*

*TH: Why do you say "probably"?*

*PT: Well, it's not probably, it's definitely, yes.*

*TH: And still the tears come and you are holding onto it. I think underneath there is much more feeling, and you might want to push it aside with your smile.*

*PT: If all the feeling—*

*TH: You must have tremendous feeling underneath.*

*PT: Well . . . (she sighs) . . . there comes I guess a point when—*

*TH: Let's not go to the talk about it, rather than to see what is your inner experience, because I have a feeling that it is much more than what we see on the surface.*

*PT: Oh, for sure, for sure, but I never show anything on the surface.*

*TH: Yeah, but we are here to look, to examine your feelings and to understand them.*

*PT: Well, I am obviously noncommittal. When that incident happened something was—*

Frequent sighing, to which the therapist draws her attention, her non-verbal signals indicating tension in the transference. She makes an important communication of the incident at the office party, which indicates the degree to which the therapeutic alliance has been mobilized.

*TH: You see, I am talking about right now, you and me.*

*PT: Okay, just listen. When that incident happened, it started me, I guess, thinking about how I felt and how I never showed my feelings. You know, how I didn't even know. How I didn't even know.*

#### Phase (6): Analysis of the Transference Resistance

What happens now is an example of the overlapping of the two phases, as Phase (5), the first partial breakthrough continues. The transition to Phase (6) occurs spontaneously; for when the therapist again emphasizes the here-and-now the patient's therapeutic alliance itself links the incident at the office party with the resistance in the transference (the C-T link). Analysis of the transference resistance has many aims, but most important of all aims at handling the unresolved transference resistance which has its origin in the past relationship and not yet touched upon. It also deals with the nontransference resistance arising from the reluctance to face painful feelings. It is particularly essential when the therapist is applying the technique of partial breakthrough into the unconscious. It is essential to emphasize that this whole passage illustrates the importance of analyzing every vestige of transference resistance. In the present case it would be very easy to take the de-repression which indeed is occurring as the final unlocking of the uncon-

scious, which it is not. If the analysis of the residual resistance is not undertaken, the final unlocking will never be achieved.

The patient is emotionally charged. We pick up the interview.

*TH: Okay, but I'm looking right at this moment. You are charged with all these feelings and you are trying to divert the situation to that incident to avoid your feelings here and now.*

*PT: Probably because I'm afraid of, I guess, exposing my feeling because for the first time in my life I would be vulnerable.*

The therapist concentrates her attention on this communication.

*TH: Could we look into this, vulnerability for the first time in your life?*

*PT: Okay (she looks away).*

*TH: You see how often you look to your—*

*PT: No, it's just a nervous reaction, it's . . . (she frequently sighs). I guess, since I was very, very small I've always been independent, strong, never showed anything, and never been vulnerable.*

#### Phase (5a) The First Unlocking

##### P-T Link

This leads directly into the past, spoken with deep feelings and leading toward another link with resistance in the transference.

*PT: Oh, ever since I was, you know . . . friends and family etc. have always been at the distance I want. And it's always been like that (she is speaking very softly). My parents . . . (pause) . . . there was always my sister to protect . . . I have a sister, 14, 15 months younger than me. Uh, my parents were alcoholics. Uh, I suppose the only thing they've ever cared about was money, material things.*

*TH: And do you see, when you are talking right now there is a massive amount of feeling moving up? (highly charged emotionally)*

*PT: Oh yes (she is choked up). That is a subject which I never discuss with anyone, my parents. Never. I feel I guess guilty because I don't love them, and I try to call every week or two, but ultimately I don't think I really care, and I feel very guilty about that, and sometimes I think I feel very guilty because I love my husband very much but I never show it. You know, like, I show it in physical things, I buy him presents.*

Throughout this process the patient is highly charged, a tremendous outpouring of deep, painful feelings.

*TH: Material things.*

*PT: But to me that's all there is. I never felt close to him, and sometimes I feel very guilty that I just never get close to anyone and whenever—*

*TH: So you keep them at a distance.*

*PT: Oh very much so. I'm very, very reserved. I smile, but it's all on the surface and, uh, I just long to . . . My God, years ago, without even consciously looking at it, I made a decision that I would never show it, and I guess this is it, and whenever anyone breaks down the barrier I feel very vulnerable, and I guess I don't know how to cope with it, and I guess that's it in a nutshell (she is very choked up). I analyzed how I felt the day of the Christmas party, and for a second that day the barrier was down . . .*

She indicates she felt angry and vulnerable "When I am vulnerable then the other people can get to me." Once more the therapist links this with the resistance in the transference, a C-T link. The patient becomes resistant, which is systematically challenged and weakened.

Due to lack of space, the process is abbreviated, but otherwise verbatim.

*PT: I would feel vulnerable with anyone that could understand me.*

*TH: Do you notice that you prefer not to refer specifically to me and you?*

Return to the Transference

*PT: . . . Okay, when I open up—okay when I open up to you, it would be the first time in my life that I've ever sort of allowed myself.*

*TH: So then you must have a feeling that I am the first person.*

*PT: Okay, you are the person that will, I guess enable me to understand what's been—*

*TH: You see, you are talking about if this barrier breaks down—*

*PT: Not "if," it is breaking down.*

*TH: You must have a feeling about that, that I am the first person.*

*TH: But how do you feel toward me being the first person?*

*PT: I trust you.*

*TH: But still that doesn't say how you feel toward me.*

*PT: Okay, I don't say I like you or dislike you. Right now I'm ambivalent.*

*TH: You mean I'm hanging in the middle of nowhere, hmm?*

*PT: I trust you. I don't dislike you. I feel more comfortable now than when I walked in.*

#### *T-P Link*

*TH: But what you said is this, there is something in the past of your life—*

*PT: Oh, yes.*

*TH: That in a sense you had set up the stage, that you would never in your life let anybody get close to you, hmm? Something has happened at some point in your life that you have put the wall around yourself and told yourself that nobody can pass through that wall. Do you see what I mean?*

*PT: Yes. I guess my parents never really loved either my sister or I. I guess that's probably the first person I've ever said that to. It's, I guess, in the past year that I've actually realized that the only people they do love are themselves, and the realization, well, I guess, hurts. That if I died tomorrow—nothing. The only thing they care about is money, the material things, and uh yeah, I guess, the realization that that is actually how they felt, and I've always realized it, I guess just came home.*

The obvious spontaneity and the whole atmosphere of the interview, the breakthrough of affect-laden, grief, and guilt-laden unconscious feelings indicates that her resistance has been weakened considerably. Taking into consideration that research protocol calls for partial unlocking the therapist moves to the next phase.

#### Phase 7: Inquiry into the Area of C, Alternating with Phase 6

##### *Analyzing the Residual Transference Resistance: C-T Link*

In accordance with the principle of exploring the patient's current life first and postponing the exploration of the past the therapist started by inquiring about the relationship with her boss and followed this with the relationship with her husband. In both cases the therapist used the information that emerged to make interpretation of C-T link relevant to the residual transference resistance and once more focused on the triangle of conflict in the relationship to her boss. In the technique of a partial breakthrough the attempt is to bring once more the repressed impulse closer to the surface. The patient spontaneously compared her boss with her father.

*PT: He is very, very much like my father in personality. He is critical authoritarian, degrading—and not only to me but to everyone—and I think more so to himself.*

As I have outlined before, the degree of the unlocking of the unconscious is always in proportion to the degree to which the patient has experienced directly the whole complex transference feelings. A major break-

through always requires direct experience of the aggressive impulse in the transference with the experience of a major degree of guilt and grief-laden unconscious feelings. But in a partial breakthrough the proportion of the direct complex transference feelings is much less intense. In this patient the protocol was partial breakthrough, but if the plan was to bring a major unlocking of the unconscious after the first breakthrough and the T-P link then the therapist should return to the triangle of conflict in relation to her boss (C) and systematically challenge the patient's defenses, which means return to Phases (3) and (4). This brings a major crystallization of the transference resistance. Then, like The Case of the Machine-Gun Woman, he should apply pressure and challenge to the patient's resistance with heavy challenge toward the superego resistance which finally brings about a major intrapsychic crisis and typically would follow direct experience of the aggressive impulse in the transference with again direct experience of the guilt and grief-laden unconscious feelings. But in a partial breakthrough, which is the aim of this article, after the first unlocking the process moves to Phase (7), inquiry, and often alternates with Phase (6), which is an analysis of the residual transference resistance.

After the link between her boss and her father, the therapist turned to her relationship with her husband. She has been married for 12 years. There are no children. She admitted that she was sometimes angry with him.

#### The Relationship with her Husband and the C-T Link over the Issue of Control

*PT: . . . He's not a dominant personality, he's very, very easygoing.*

*TH: But my question was, who controls who?*

*PT: In a way I guess I control him.*

*TH: Do you usually feel much more comfortable in a situation where you are in control?*

*PT: Yes.*

*TH: And if you are not in control, what happens to you?*

*PT: I feel very uncomfortable.*

*TH: Now one question we have is how this issue of who is in charge applies in your relationship with me?*

*PT: I don't think either of us is in charge. I don't think you're controlling me or I'm controlling you.*

*TH: But in a sense you are controlling me by putting up the wall.*

*PT: And you're controlling me by breaking down the wall . . .*

*TH: So then, do you see what I mean that in a sense you are controlling me by putting a wall between yourself and me?*

*PT: No. I did in the past, but not now.*

#### The Relationship with her Husband; the C-T Link over Issue of Dependency

What emerged is that she is the one who makes decisions. His indecisive-

ness angers her. They have never opened up to each other. He is not physically demonstrative except during sex. What emerged was that there was hardly any eye contact between them.

*TH: . . . You feel more comfortable when you are in control of a situation, hmm?*

*PT: Okay, it's ambiguous. I want to be in control and I want to make the decisions.*

*TH: So your husband is dependent on you?*

*PT: Well, not dependent, dependency requires—*

*TH: Because I am also getting a feeling that you are almost phobic about the issue of dependency.*

*PT: I don't like to be dependent on anyone.*

*TH: That is what I said. You see what I mean by being phobic about dependency, hmm?*

*PT: I've never been dependent on anyone if I could help it.*

*TH: So dependency is something you have a conflict about, hmm?*

*PT: Yes. Not an open conflict. I think you'd be the only one to know besides me, and most people would classify me as independent.*

*TH: On the outside, on the surface, you put a facade?*

*PT: Yes, a facade of being very independent.*

#### C-T Link

*TH: And now the question for us is how your fear of dependency would apply here with me?*

*PT: I don't see me being dependent on you or you dependent on me. I would see it being—*

*TH: What do you mean? If you put a wall between you and me, then if we are going to get to the core of the problem, then we are dependent on breaking the wall, hmm?*

*PT: That's on the supposition that there is a wall. If two people can speak honestly about feelings, then there is—*

*TH: Then that wall is not there anymore now?*

*PT: Not as much as there was.*

#### Phase 7: General Summing up in the Area of C Undertaking Phenomenological Approach and Psychiatric History

The therapist sums up her problems in interpersonal relationships, her problems with her boss, the conflicts in her marriage, her wide range of characterological problems. She suffers from mild episodes of depression, major conflicts with intimacy and closeness, suffers from anxiety—her life orbit is lonely and there is no figure in her life with no barrier, always an element of distancing. "Lives behind a facade."

*TH: Have you ever had thoughts that these are problems that you want to do something about?*

*PT: No. This is the first time I've thought about it and decided that maybe my way isn't completely right. Maybe it's time to look at it another way.*

#### Phase 8: Direct Access to the Unconscious

The therapist now embarked on a long exploration of the past. The family, in addition to the patient and her parents, consisted of a sister 15 months younger and the paternal grandmother who was four feet ten inches tall, and weighed 350 pounds. She described her parents as having been alcoholics throughout the whole of her life, constantly quarrelling. Her earliest memory was of them drunk, screaming at each other. These quarrels were verbal—her father never hit any of the family. She has no pleasant memory of her early years. She said the situation was no different now—five minutes after she enters the house her father is screaming and shouting.

Her parents travelled a great deal, and the patient was in boarding school from the age of ten. They later moved away and she now has not seen them for three or four years.

She described her father as very good-looking but without personality. He is unable to cope with people and just calls them swear words. He has always been critical and degrading—he accuses her mother of being a whore. She has everything she wants materially, but no friends are allowed in the house and she is not allowed to drive a car. If anyone phones her mother, he is on the other extension listening to the conversation.

#### The Issue of the Resemblance Between the Parents' Marriage and the Patient's Marriage (with Sexes Reversed)

Here the therapist began to prepare the ground for making an interpretation—a long way ahead—of the resemblance between (a) her father's control of her mother, and (b) the patient's control of her husband ("I make the decisions"). The patient unconsciously sensed this and immediately became resistant, trying to avoid looking at the situation between her parents. This was the first example of the return of resistance in Phase (8) because the breakthrough in Phases (5) and (6) had been only partial. The therapist had to employ clarification and challenge and work through the resistance and return to the exploration of the past.

*PT: Well he obviously never called me a whore, but in five minutes after I'm in the same room with him there's a tremendous fight. It can be that I didn't eat my dinner. He doesn't like the color of my finger nails. He doesn't like the color of my blouse.*

*TH: So he puts you down and degrades you, hmm?*

*PT: Uh hmm, yes. There's nothing good about me or my sister or anybody.*

Further questioning revealed that neither her father nor her mother was ever physically demonstrative either to the children or to each other. Her mother was 40 when the patient was born and was quite unable to cope with children. The patient and her sister were brought up by their grandmother in a separate part of the house. She described her father as abusive and when drunk was miserable. When she was 16 he had bought her a car and after six months became explosive and took the car from her. She described her mother as helpless, passive, and ineffective and her father as controlling and demanding. Then the session focuses on which parent she is more similar to.

*TH: Are you more similar to your father or your mother? Of course it is disturbing to you to look—*

*PT: I'm very similar to my father in, uh, I guess, intellect and some of my personality traits.*

*TH: It is very important to look at it in spite that it must be disturbing.*

*PT: Not... okay, not...*

*TH: Because, you see, you give me a picture that everything has to be your way, hmm?*

Her resistance now breaks down and she admits both that she has thought of this herself and that it is disturbing to her. In this case, simple persistence on the therapist's part converts a defensive understatement into one that is much more heartfelt and direct:

*PT: I think that's part of the thing that "scares me a little bit," because I know what he was like and I see myself showing the same traits, although I'm not physically abusive, I'm not verbally abusive, and I don't drink.*

*TH: I know, but there are a lot of things that are similar to your father, hmm?*

*PT: Yes, and I think that really scares me. It really scares the hell out of me.*

*TH: But then, if you look at your husband, you describe him mostly like your mother, in a sense. Not exactly, you know, but in many—*

*PT: There's a lot of similarities, that's why—*

*TH: Have you ever had thoughts that there is some similarity?*

*PT: Yes, it's very disturbing, yes.*

*TH: That you are like your father and he is like your mother? Marrying a man that has many features of your mother—not exactly, but in a certain context?*

*PT: Well... yes... I don't think I ever realized it consciously.*

*TH: You see, one of the things you have to look at is this: either you are going to look at the painful issues and see them as they are, or you are going to push them aside and pretend they are not there.*

*PT: Exactly, And my reaction with my boss is very similar to my mother's reaction, and I hate her for it, and I wasn't happy with*

*myself for behaving like that. I mean I was an asshole. If I had been intelligent I would have told him where to get off.*

#### The Grandmother: The Issue of Unresolved Mourning

The therapist was satisfied with the above admission and turned to the situation in her upbringing. Her parents spent much time travelling and were seldom at home. The therapist now opens up what emerges much later as a central issue which further expands the unlocking of the unconscious as the central issue.

*TH: So your grandmother then stands more strongly in your life?*

*PT: Oh yeah, my grandmother was, I think, the only person that I loved.*

*TH: Uh hmm. Could you tell me about your grandmother?*

The first focus was the question of the degree of emotional closeness between the patient and her grandmother. Here the over-all conclusion was that there was a very close relation indeed, but that there was no direct expression of this, either verbal or nonverbal. She said that her grandmother, who was a native of a European country, was illiterate, had little command of English, was never physically affectionate, and never expressed affection directly in words. Nevertheless, the following extracts show the depth of the patient's feelings for her.

When asked for an early memory the patient told of an occasion when she was five and her grandmother started a severe hemorrhage from varicose veins. In describing this memory the patient becomes emotionally charged. The whole atmosphere of the interview has changed. She is very animated and talks with a great deal of feeling, with waves of breakthrough of painful feelings and indicates considerable freeing of feelings, even about long past events. There is emergence of fresh memories *re* the events of the distant past accompanied by a depth of feeling.

#### *De-repression in P*

*TH: So there is this Granny that does everything for you.*

*PT: And she needed help.*

*TH: And there is blood all over the place, and then—*

*PT: I did what I had to.*

*TH: I know, but you have a lot of feeling even right now when you talk about it.*

*PT: Oh yeah. I was scared out of my mind, I'd never been so scared.*

*TH: I know, but I'm talking about your feelings now, you see.*

*PT: I loved her very, very much. I think she's probably the only person I really—*

*TH: You see your eyes are teary, but then you are again back—*

*PT: I guess she was probably the one person—*

*TH: Because she must have meant a lot to you.*

*PT: Oh heavens, yes. When she died, oh, it was terrible. I didn't cry for a year, and the only reason I started crying was that I developed an ulcer. Because it was just too deep, and I really didn't start crying, but I started talking to a priest . . .*

*TH: . . . Do you notice that when these waves of painful feelings come, you have a tendency to push them aside?*

*PT: Well it's still very painful. I still miss her.*

This passage gave a pointer to the patient's unresolved mourning for her grandmother, which the therapist noted for future reference. Our research data in cases of pathological mourning show that in order to achieve therapeutic effects, the feelings lying beneath unresolved mourning of this kind are usually the first that need to be brought to the surface and experienced.

The patient said that the relation with her grandmother was the one thing in her childhood that was warm, comforting, and secure. The grandmother lived for the two girls, but it was the patient who was her favorite. Early memories included the three of them going for picnics, going fishing, and much laughter. The parents were away most of the time, and when they did return they were constantly drinking and fighting, and the two children would go to their rooms, where the grandmother would protect them. The patient used to pick at the wall of her bedroom with her fingers up to the age of nine, and succeeded in making a hole in it.

#### The Issue of Death Wishes toward Her Parents

In the technique of a partial breakthrough in exploring the past the therapist would like to get some picture of libidinal cathexis vis-à-vis aggressive cathexis in relation to the early configuration. In this patient she has given all evidence that the negative heavily outbalances the positive. In this particular patient she has given evidence that her parents were like a pain in the neck. The therapist focuses on her unconscious death wishes.

*TH: And if they had dropped dead, what would have happened to your life?*

*PT: I probably would have been happy, I probably would have been.*

*TH: But, you see, you smile.*

The smile is an indication that the therapist was indeed pressing toward a significant area. Then she talked about her early life and said "sometimes I wished that I was dead."

Here the therapist focused on the third corner of the triangle of conflict, the anxiety, bringing in a link with the transference:

*TH: One thing that you told me is if you show your anger—*

*PT: I might say something that I would be really sorry for.*

*TH: So that makes it clear why you couldn't declare your anger with your father, because he would have become more verbally abusive.*

*PT: Yes.*

TH: Okay? So then this is very important to look at. If you show your anger then you might regret it. What does it mean? That I might react with anger? Hmm?

PT: Yes.

TH: So then wasn't this in relationship with your father?

PT: Yes.

TH: So then that explains why you had the wish that you were dead.

PT: Yes, because it was too complicated to handle.

TH: Then the wish obviously is clear that it was directed at who?

PT: Me.

TH: I know, but who was it really directed towards?

PT: Him.

#### Relation with the Grandmother

She lived until the patient was 16. The patient was sent to boarding school at the age of ten. She spoke as follows about this, giving evidence about one of the sources of her defensive independence:

PT: Oh, I missed my Granny terribly, but then afterwards I didn't miss her. It sort of became less and less, and I guess I became more dependent on me.

TH: Did you see her during that four years?

PT: Oh yeah, we went home on weekends sometimes and then Granny was there. She did all the washing, took care of us, made supper.

TH: She was looking forward to seeing you?

PT: Oh yes, I mean, that was the biggest thing for her.

The patient went on to say that she used to go and buy dresses for her Granny with money given to her by her mother—money was never a problem. She also used to do her Granny's hair for her.

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PT: Talked to me about how she felt when she was growing up, how she didn't like what was happening in the house. She taught me how to sew, she used to sit while I painted her picture.

TH: So there was a tremendous closeness there.

PT: Oh yes, very, very much so.

TH: You know, when you said that there was nobody in your life that you felt very close to . . . you see, in the beginning of the session you told me that nobody ever passed the wall.

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TH: I know, but obviously there was a tremendous feeling between you and your Granny.

PT: Yes, but it was an unspoken feeling, like I would never tell her how I felt.

#### Unresolved Mourning for Grandmother

The following passage illustrates the technique of working through unresolved mourning which consists of a detailed reconstruction of the events surrounding the loved person's death. Changing the pathological mourning to acute grief as if it happened the day before signals the final unlocking of the unconscious in this technique of partial breakthrough. The passage is reproduced with some abbreviation.

#### *The Last Visit to Granny*

TH: What happened to her finally?

PT: She died. She decided she wanted to die.

TH: When was that? What do you remember about the last part of her life?

PT: I don't recall that because I was away at school.

TH: You mean you were not there when she died?

PT: No. My parents had put her in a home.

TH: This was how long before she died?

PT: I guess about six months. She starved herself to death. She decided that she didn't want to live anymore and I—

TH: Do you remember the last visit with her before she died?

PT: She didn't know who I was.

TH: I know, but do you remember the last visit with her?

PT: Yes . . . she . . .

TH: Where?

PT: Uh, heavens, I don't remember the nursing home.

TH: I mean, whereabouts?

PT: Uh, all I recall—she didn't know who I was, she didn't know at all.

TH: What did she look like?

PT: A 90 pound skeleton.

TH: From 300 pounds she had gone to a 90 pound skeleton?

PT: Yes.

TH: Could you describe her then? She was in bed?

PT: Oh yes, with tubes.

TH: Tubes where?

PT: In her arms. Cheeks very hollow, white hair. She always had beautiful white hair. It was all over the place.

TH: All over the place. And then her face?

PT: Drawn.

TH: In what way was her face drawn?

PT: Her cheeks, you know, sunken, and wrinkles. She always used to have a beautiful plump face.

TH: Okay, it was wrinkled, and what else? What was the color?

PT: Yellowy.

TH: How about the eyes?

PT: They were closed.

TH: Closed, and then?

PT: When she opened them she looked, but she didn't see. She had beautiful blue eyes, beautiful blue eyes. She couldn't speak English anymore.

TH: What was the way she was in bed? Her position.

PT: Oh, just lying flat, but she didn't know that we were in the room.

TH: You were not alone?

PT: Oh no, we went with my parents, and my father was crying and everything. But then what happened was that he and my mother left, and I had to go back to school. When my grandmother died, they called me at school.

#### *The Last Good-Bye to Granny*

TH: When was your last good-bye to her before?

PT: About a month.

TH: Do you remember your last good-bye to her when you left?

PT: Uh, really no (barely audible).

TH: (Ignoring her denial) Did you touch her that day?

PT: Oh yes, I must have. I think I held her hand. She didn't know who I was.

TH: Did you talk to her?

PT: No, my parents and my sister were there.

TH: But did you feel that you wanted to be alone with her? Because at one time you always wanted to be alone with her, but now—

PT: No, at that point, no, because she didn't know who I was.

TH: Doesn't make a difference, it's a matter of your feelings.

PT: No, I don't think I wanted to be alone with her.

TH: Why?

PT: I think she scared me.

TH: You mean, that woman who was so important—?

PT: She scared me. I still loved her.

TH: I know, but there is something there. You see, this is a woman that all through these years and tragic situations, she stood so strongly, hmm?

PT: What I do—

TH: Let's look at it, don't move away. Because she stood so strongly and there was a wonderful relationship with her, hmm? Now she is 90 pounds, skin and bone. You said you held her hand?

PT: Hand, yes.

---

TH: Did you feel you wanted to move toward her?

PT: Well, with my parents in the room I would not do anything, and I felt tremendous anger at them for what they did to her because really what should have happened was that she should have died at home with—

TH: So you had a lot of feeling.

PT: Oh yes, very negative towards my parents.

TH: That they dumped her into that place?

PT: Exactly, they dumped her and they didn't tell me.

#### *Emergence of Wave of Painful Feeling*

There is emergence of waves of physical distress; tearful.

TH: Do you see again your waves of painful feeling that are coming right now, and you are fighting it?

PT: Oh . . . Look, this is, I guess, the most traumatic thing, I mean . . . and I wasn't even 16.

TH: But a smile doesn't—

PT: The smile doesn't indicate happiness, it's just—I mean this was the most traumatic event of my life.

TH: Why are you right now trying to fight these feelings?

PT: Oh—

TH: Why? Why don't you want to be honest with yourself?

PT: I am being honest with myself. It was very painful. It was probably the most traumatic thing that's ever happened to me in my life, but I had to protect my sister. She couldn't cope.

TH: Let's look at you and her.

PT: Okay. With—oh boy—with my grandmother, I was very angry at my parents for putting her in the home. I thought what my father did was inexcusable.

TH: But maybe you wished you had done something for her. Did you wish that?

PT: Yeah.

TH: What was the wish?

PT: That I had done something, that maybe—

TH: I know, but in terms of thoughts and ideas, what was the wish?

PT: I couldn't do anything. I knew I couldn't do anything. Here I was 15, sent to boarding school. I had no way of doing anything.

TH: I know, but in terms of the wish. I mean, reality is one thing but a wish is another.

PT: That I could have made them realize that she should have been at home. That she shouldn't have died that way. They shouldn't have fought, and, I guess, driven her to want to die. Nobody should be put in that position.

TH: So she really died lonely in this world, hmm?

PT: Yes. Well, she is getting on in years too, she was in her eighties.

TH: I know, but what I'm looking at is this. If you look to the Granny—

PT: She had no friends.

TH: She didn't have anybody, but what she really had in life primarily was you.

PT: Yes. And when they sent us away there was—

TH: But she was so important in your life and she really was living for you.

PT: Yes.

TH: What do you think went on in her mind about you?

PT: She was senile.

TH: Doesn't make a difference. What do you think went on in her mind, in terms of thoughts, about you before she died?

PT: Well, I'm sure she loved us.

TH: No, I'm talking in terms of your thoughts. What do you think, if you think about it?

PT: She would have wanted us there.

TH: So she went with nobody there, hmm?

PT: Yes.

TH: So it must be very painful.

#### *Granny was Buried*

PT: Yes. She was even buried with nobody there except me. Because my father was—(she is highly choked up)

TH: You mean that nobody was there when she was—?

PT: Nobody buried her because my father was travelling (She is tearful and emotionally charged.)

TH: What month was it that she died?

PT: (Whispering) When was it? Oh dear, September, October. My mother and father were travelling. I didn't know where they were. The people at the nursing home called me at school. I went home and tried to find them, and the company found them and told them that she had died, and they wouldn't come back for the funeral. I did it all by myself. Do you have a kleenex? (She is crying.) . . . Oh boy . . . You're the only person I've ever told that to . . . There was nobody there but me. Oh . . .

TH: What do you remember then?

#### *At the Grave*

PT: Oh, sadness. I had to get a priest, and our parish priest wouldn't bury her because he said that she had never been to church, and I had to get a priest from another town, and I think I paid him 100 dollars to come and bury her, and my father's brother came, and the only thing he wanted was a party at the house. When she was in the home he never sent her a card, never called her up, never visited.

TH: So you got another priest, and then what happened?

PT: I don't remember his name or anything. I paid him 100 dollars to come and say prayers at the grave.

#### *Further Wave of Painful Feeling*

TH: This is a family grave that you have?

PT: No, we didn't have a family grave. I had to make all the arrangements, get the plot, and get a stone.

TH: So do you remember the burial?

PT: Yes.

TH: You were alone?

PT: Yes, my sister couldn't cope with it. She came to the funeral but she was 14 and she just—

#### *Two Sisters Burying Their Grandmother*

TH: So you and your sister, hmm?

PT: And my father's secretary told me that he cried when he heard she'd died, but he didn't come home (she is sniffing and choked up).

TH: Uh hmm.

PT: He couldn't face it. So he left me to face it.

TH: Do you remember the last moment of the burial?

PT: Yes, when they threw the earth on it and then I walked away.

TH: How did you feel then?

#### *She is Crying with Intense Painful Feeling*

PT: As if maybe I would die because of a broken heart and—yes, I guess that's it. That every day—I guess probably difficult to cope and to know that she was gone. But I managed. I went back to school and I didn't cry (she is very choked up). Didn't say anything to anybody. In fact you're the only person that knows how much—I guess I was so angry at my parents for, I guess, the ultimate insult to me, to her, and to themselves, that they didn't—my father didn't have the guts to bury his own mother. Terrible thing. I . . . (she sighs) have very little, I guess, feeling or affection, I have no respect, nothing. I feel guilty that maybe I should. There's nothing.

TH: But that is a conflict that you have? That you have constantly to tell yourself that you should love but at the same time the other person in you says otherwise?

TH: You say she is buried in cemetery. What does it say on the stone?

PT: "Anna, born"—I didn't know when she was born. I knew when she had died. I didn't even know her maiden name. I knew her last married name. Oh, what a terrible thing (another wave of emotional distress, crying).

TH: Do you think of her?

PT: Yes.

TH: What way does she come to your mind?

PT: I remember her with affection. I guess she was always the one who told me I could do anything or be anything I wanted to be, and I think in all my endeavors like my studying for my degree, and my marriage, anything, whenever I've had a problem I always think of what she gave me and how she lived . . .

### Discussion

Now looking back over the interview with hindsight, we can see the patient's pathology and the therapist's technique clearly in relation to one another.

The patient suffered from moderately severe character pathology, which briefly consisted of the following.

- (a) Compulsive independence and efficiency, which was accompanied by a refusal to acknowledge within herself intense feelings of any kind. This served as a defense against severe psychic pain arising from unresolved mourning for her grandmother; and, certainly behind this, massive grief-laden unconscious feeling for the good parents that she never had.
- (b) Very great difficulty over acknowledging or expressing anger in any situation, with its origin in her feelings about her highly controlling and verbally violent explosive father and her passive and ineffective mother, both of whom seem in addition to have been neglectful and totally uncaring, and with whom she had no memory of any good relation at any time.
- (c) Unconscious repressed murderous impulses in relation to his father and pathological identification with some aspect of character pathology of her father.

#### Phase (1) Inquiry in the Area of C, with the Beginning of Pressure

At the beginning of the interview, therefore, the therapist immediately comes up against the defenses of watering down and dismissing the emotional significance of anything that has happened—"a little bit of problems with my boss," "sort of eating my heart out all the little incidents," "I realized just how stupid it was." Very soon, also, her unconscious therapeutic alliance together with her resistance, acting in combination, give a very clear communication about the nature of another of her main defenses: "Things don't normally bother me that much. I just rationalize them."

The therapist knows "little bit of problems with my boss" will almost certainly lead into highly significant events in the area of C, the patient's current life, and it is toward this that he will direct her attention: "Now you said you had problems with your boss," "You said he dislikes you because you are a woman." This is the beginning of pressure.

The patient without resistance describes the incident at the Christmas party. This is exactly one of the favorable situations that the therapist is seeking, namely the description of a recent incident laden with unconscious significance, around which the early part of the interview can crystallize.

Here it is worth considering in some depth the significance of this incident for the patient, and the way in which her own pathology probably interacted with that of the boss. As mentioned above, it seems that the patient's compulsive efficiency in part took the form of masculine identification (on two occasions, not included in the excerpts given above, she nearly

used a fascinating neologism, "manfaction" when she meant "manifestation," just managing to stop herself in time). Her efficiency had resulted in her having excellent qualifications as a lawyer, which presumably played on her less well qualified boss's sense of inferiority, and caused him to dislike her from the beginning and to wish to take revenge on her. This he did by causing her to open the present of a "penis" in front of 60 people at the Christmas party, playing in turn on an area about which she felt extremely sensitive.

The therapist cannot know in detail the underlying feelings aroused in the patient by this incident, and there is no need for him to do so. What is quite certain is that it is of extreme emotional significance. As in any interview where the patient describes such an incident, he therefore opens Phase (2) with the question, "And how did you feel?", i.e., exerting pressure toward the avoided feeling.

The fact that the incident is highly significant is immediately revealed by the patient's resistance. She starts with cover words: "stupid," "embarrassed," then "humiliated" (still a cover word); then somatization, "I went flame red"; and then starts going round in circles, "embarrassment," "shame."

#### Phase (3a) Clarification Combined with Sustained Pressure

Here the therapist senses the amount of pain lying behind her resistance, and he therefore continues with systematic clarification [Phase (3a)] of her defensive position, speaking directly of her therapeutic alliance.

The patient's statement "I didn't feel angry" is followed by clarification and some degree of challenge; "But you see, it is not absolutely clear how you felt. You say you did not feel angry . . . , and he reiterates pressure and clarification again and again: "But still you are not saying how you felt. You are humiliated . . . How do you experience this?"

During this phase the therapist must watch for signs that the patient is responding to this sustained pressure. Here, the patient gives two such indications. In the first, she gives an involuntary smile, which the therapist points out, informing her unconscious that it is betraying itself, and thus heightening the tension. In the second, her unconscious therapeutic alliance suddenly produces the words, "an open wound," which points forward to the true significance of the incident which will be revealed much later. The therapist seizes on this and exerts further pressure: "That means you felt wounded then . . . How did you feel being wounded?"

#### Phase (3b) Challenge to the Resistance in the Area of C

The result is further resistance, "Oh I'm sure I felt terrible." The therapist now sees that the resistance has crystallized unmistakably and begins his challenge, gradually increasing it from "But 'I felt terrible' is a sentence, words" to "'Probably' is hanging it in the middle of nowhere."

Again, the therapist must watch for signs both that his interventions are beginning to take effect, and that transference feelings are rising to the surface and leading to further resistance.

In this case the patient becomes increasingly anxious, using a series of tactical defenses, interspersed with messages from her unconscious therapeutic alliance indicating some degree of exhaustion of defenses ("... maybe there is something behind my actions and I am going to uncover what has been bothering me").

The therapist now increases his challenge further: "Do you notice that you are totally incapable of telling me how you felt"? Suddenly the unconscious therapeutic alliance responds with a clear communication about the resistance in the transference: "Can I open up?" (obviously implying the words "to you"). "I've never opened up" (implying "to anyone").

#### Phase (4a): Clarification and Challenge to the Transference Resistance

This communication indicates resistance against allowing emotional closeness. The therapist therefore draws attention to the nonverbal signs of this ("Do you notice that you avoid my eyes"?).

The second inference is that the patient is identified with her resistance against closeness, i.e., that it is ego-syntonic.

#### Phase (4b): Head-on Collision with the Ego-Syntonic Transference Resistance

The therapist therefore mounts an assault on this, pointing out its self-defeating nature to the patient's therapeutic alliance: "Now if you remain here with me helpless and incapable of seeing how you felt, then we wouldn't get to the core of the problem. So then I would be useless to you."

He continued with further challenge to the resistance against emotional closeness, referring to the "massive wall" that she was erecting against him.

#### Return to Phase (4a): Challenge to the Resistance against Emotional Closeness in the Transference

He then returned to challenging the verbal and nonverbal signs of distancing in the transference, eventually eliciting the important communication that the reason why she had difficulty in looking at him was that "the eyes are the mirror of the soul."

#### Return to Phase (4b): Head-on Collision with the Superego Resistance in the Transference

He now used the head-on collision to mount an assault on the self-destructiveness inherent in her resistant position, i.e., on the resistance maintained by the superego: "Why do you want to sabotage this and make me useless to yourself"?

#### Phase (5): Breakthrough of Complex Feelings, the First Unlocking of the Unconscious

When the therapist employs the head-on collision with the patient's self-destructiveness, the first effect is very often the breakthrough of grief, and the therapist must watch carefully for the signs of this. He then both draws attention to the grief and challenges the resistance against experiencing it and sharing it. This challenge must be much more gentle than the challenge against experiencing anger.

The head-on collision produced an important communication, "You would be the first person that ever got to know me." As she said this, she was obviously experiencing intense inner turmoil. The therapist responded, "You are choked with a lot of feeling, and you are avoiding my eyes and trying to push these feelings away."

After further pressure and challenge to the transference resistance she came out spontaneously with the central issue both in the transference, in the past, and at the office party—the link between the areas of T, P, and C: namely that she was afraid of exposing her feelings to the therapist because it would make her vulnerable for the first time in her life, that her parents were alcoholics and she felt intensely guilty because she didn't love them, that therefore years ago she had made a decision never to show her feelings, and that this was the significance of the incident at the office party, that it had broken down her barriers and made her vulnerable.

#### Phase (6): Analysis of Residual Transference Resistance, with the Use of the Two Triangles

Although this breakthrough of intense, painful feeling, followed by a major mobilization of the therapeutic alliance, does represent the first partial unlocking of the unconscious, it still leaves much potential resistance beneath the surface. The difference, however, is that now this resistance will respond to interpretation, which in the earlier stages of the interview it would not. The therapist therefore embarks on inquiry, starting with the patient's current life, and aiming to leave the past till phase (7) when it can be explored in the most dynamic way possible. Each time he sees a parallel between an outside relation and the resistance in the transference, he makes an interpretation of this link, thus gradually eroding the last vestiges of resistance. Because some information about the past has often emerged spontaneously, the therapist may be able to include this in his interpretations, thus completing the triangle of person.

In the interview under consideration here, Phase (6) had already begun when the patient herself made the TCP interpretation of her determination never to become vulnerable. The therapist continued the process as follows:

- (a) With her husband she is the one in control, and she admitted that in any relation she felt very uncomfortable if she was not in control.

- The therapist made the CT link with the barrier that she put up against allowing emotional closeness in the transference.
- (b) The therapist brought out that she was very afraid of dependency in relation to her husband, and he made a further CT link with the transference resistance over the issue.
  - (c) Finally he brought out that every relationship had to be on her terms, and—without actually mentioning the transference—he focused in making this defensive pattern ego-dystonic.

#### Phases (7 & 8) Inquiry and Direct Access to the Unconscious

Now knowing that major resistance has been dissolved with the partial unlocking of the unconscious, the therapist undertakes a systematic inquiry into the past; and each time he meets a significant area he tries to bring unconscious feelings to the surface. Here he will meet minor resistance, but this can usually be swept aside with relative ease, e.g., by simply repeating a question. The patient is then enabled to experience directly the painful feelings responsible for the neurosis.

In the present case the patient was able to describe very clearly the family situation, in which her parents were constantly quarrelling and seemed to care about no one but themselves. It became clear that the one good person in the children's upbringing was the grandmother, who did her best to protect them from the worst of the parents' excesses, and provided them with care and companionship. He then turned his attention to the direct relation with the grandmother, bringing her to reconstruct the events surrounding the grandmother's death, and he thus put her in touch both with her intense and overwhelming grief, and some of the anger with her parents, which had lain dormant for over 20 years. This was the third stage of partial unlocking of the unconscious.

As described above, the degree to which this unlocking is possible depends almost entirely on the degree to which there has been direct experience of complex transference feelings in the earlier stages of the central dynamic sequence. In the Case of the Woman with the Machine Gun, for instance, the patient had experienced the impulse to take the therapist by the lapels and throw him to the floor, together with the conflicting impulse to protect him. The result was a major unlocking of the unconscious, fantasy of extreme violence came to the surface, accompanied by intense guilt and grief, in which she murdered every member of her family with a machine gun (see Davanloo, 1987a, b).

In the present case as the research protocol calls for the partial unlocking of the unconscious the therapist had to monitor the earlier stages of the central dynamic sequences in such a way that the experience of the complex transference feeling in phase (5) was only partial. If the protocol required a major unlocking of the unconscious, similar to the case of the Woman with the Machine Gun, the therapist would have to exert sufficient challenge and pressure to the resistance against the experience of Impulse in phase (3) and (4) which would have resulted in the breakthrough of the impulse in the

transference in Phase (5) and major derepression of her repressed murderous impulses in relation to her parents.

#### Conclusion

##### The Patient's Position on the Spectrum of Structural Neurosis

We can now see more clearly where this patient lies on the spectrum of structural neurosis described at the beginning of the first article. It may be remembered that patients become more difficult to treat the more the following conditions apply:

- (a) there is character pathology,
- (b) the character pathology is diffuse,
- (c) there is superego involvement with self-sabotage and self-destructiveness, and
- (d) the character pathology is ego-syntonic.

With this patient the picture was very mixed. She certainly suffered from character pathology, but in a sense this was fairly circumscribed and consisted of a "false self" of efficiency designed to hide her vulnerability, together with great difficulty over expressing anger. Her false self was to a considerable degree ego-syntonic, but it had indeed been very useful to her and had enabled her to become highly successful in her career and to make a reasonably good marriage. Correspondingly, there was no evidence for any serious pattern of self-sabotage throughout her life. On the other hand, her false self had resulted in lack of closeness in all her personal relationships, including that with her husband. All these mixed factors place her somewhere to the right of center on the spectrum, but still very far from the most difficult at the right-hand end.

#### Summary of Technique of Unlocking of the Unconscious

I outlined three techniques of the unlocking of the unconscious:

- (a) partial unlocking,
- (b) major unlocking,
- (c) massive derepression of the unconscious.

The principles of the technique are exactly the same. The differences are purely quantitative.

In term of the partial unlocking of the unconscious, which was the focus of this article, we may sum up the essence of the technique in terms of what the therapist must do and what he must watch for in each phase of the interview. The principles are exactly the same for even more complicated and difficult patients—the differences again are purely quantitative, in the sense that more time, effort, and power must be devoted to clarification and chal-

lence to the resistance, and particularly to that part of the resistance that is maintained by the superego:

After early inquiry [Phase (1)], the therapist begins to exert pressure toward avoided feelings, watching for signs of resistance [Phase (2)].

When the resistance has clearly crystallized, he first clarifies it [Phase (3a)], and then increasingly challenges it [Phase (3b)], all the time watching for signs that the resistance is involving the transference.

When these signs are clear, he employs pressure, clarification, and challenge to the transference resistance, paying attention where appropriate to resistance both against expressing anger and against allowing emotional closeness [Phase (4a)]. Here he must watch for signs that the resistance is breaking down as the defenses begin to become exhausted. Where superego resistance appears to be a significant factor, he now brings in the head-on collision, pointing out in forceful terms the self-defeating consequences of maintaining the resistance position [Phase (4b)].

When this is timed correctly it usually results in the direct experience of very complex feelings, which include both negative and positive transference feelings, together with guilt and grief-laden unconscious feelings. This is the first stage of unlocking the unconscious [Phase (5)].

The therapist now enters a phase of inquiry, concentrating on the patient's current life, and alternating this with interpretation of residual transference resistance, with the use of the two triangles, particularly the links between the areas of C and T [Phase (6)]. This results in the dissolution of much of the residual resistance and thus represents the second stage of unlocking the unconscious.

When every possible link has been made, the therapist begins an exploration of the past. He watches carefully for significant areas, sweeps aside minor resistance, and brings the underlying painful feelings to the surface; finally both patient and the therapist have a direct view of the multifocal core neurotic structure responsible for the patient's disturbances.

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# Clinical Manifestations of Superego Pathology

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The discovery of the technique of unlocking the unconscious and direct view of core neurotic structure by the author offers an unrivalled opportunity for checking aspects of psychoanalytic theory against empirical evidence. In the present article clinical material from five cases is presented, each of which illustrates the following four phenomena: (1) self-destructive behavior, (2) violent and murderous underlying impulses, (3) intense guilt and grief, (4) impoverished personality; the higher the intensity of repressed murderous impulses; the intensity of guilt and grief, the higher the level of resistance. Detailed examination of the evidence points overwhelmingly to the operation of a self-punitive mechanism identical with Freud's concept of the superego; and this emphasizes the crucial part played by the superego in creating and maintaining the human core neurosis. Although this material confirms Freud's over-all formulation, it is also clear that the superego can arise from non-Oedipal conflicts at least as early as the beginning of the second year of life, so that Freud's view that the superego is exclusively "heir to the Oedipus complex" is not confirmed.

### Part I: Introduction

#### The Threefold Division of the Psyche

If anyone thinks clearly about the forces operating in human beings, it seems almost inevitable that he will end up classifying them into three broad categories. (1) First, there are the basic drives or instinctual reactions, and their accompanying feelings or emotions, which supply the energy leading toward action; (2) second, there must be some function which mediates between the drive and reality, and decides whether the action is possible, or wise, and if so, how it is to be carried out; and finally (3) there must be a third function, which is concerned with "approval" or "disapproval" by the self or others, and modifies action accordingly, or reinforces it, or holds it in check. Because we tend to think in terms of concrete analogies, we begin to speak of these functions as belonging to three different parts of a structure. For the overall structure we can use the term "psyche," and for the three parts we can use terms such as (1) "instinct," (2) "ego," and (3) "conscience." Thus this threefold division of the psyche is a natural consequence of using purely armchair or introspective reasoning on aspects of mental functioning that are entirely conscious.

#### The Triangle of Conflict

However, if, like Freud, we study human beings with the help of the psychoanalytic method, we discover much greater complexity than this. Of

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all psychoanalytic observations the most fundamental consists of another triad, the triangle of conflict, which turns out to be closely related to the one above, namely, (a) that feelings and impulses associated with certain drives may be *kept out of consciousness*; (b) that the way in which this is achieved is by the use of various *defense mechanisms* which themselves may be unconscious; and (c) that the *reason* why this occurs is that the feelings or impulses are loaded with *pain, anxiety, or guilt*, which also may be unconscious.

#### The Relation between the Two Triads

The relations between the three elements of the triangle of conflict and the three divisions of the psyche can be expressed as follows:

(a) The *feelings and impulses* that are kept out of consciousness, at any rate mostly, belong to the "instinctual" part of the psyche, i.e., (a) is related to (1).

(b) According to the threefold division of the psyche, it is the "ego" that mediates between the drive and reality, and thus we may reasonably say, as Freud did, that it is this part of the psyche that mediates between the drive and *consciousness*, i.e., that the ego is responsible for the defenses, so that (b) is related to (2).

(c) It is difficult to decide which part of the psyche is responsible for *pain* and *anxiety*, though we know that Freud attributed them to the ego. However, it is obvious that *guilt* comes from that part of the psyche which we have called "conscience," and therefore where guilt is involved (c) is related to (3).

Since, as stated above, feelings and impulses, defense mechanisms, and guilt may all be unconscious, we have arrived at the position that all three divisions of the psyche can have unconscious components.

A quotation from Freud's *The ego and the id*, published in 1923 describes the empirical evidence on which one aspect of this theoretical position is based, namely the existence of an unconscious component in the "ego":

Now we find during analysis that, when we put certain tasks before the patient, he gets into difficulties; his associations fail when they should be coming near the repressed. We then tell him that he is dominated by a resistance; but he is quite unaware of the fact, and even if he guesses from his unpleasant feelings that a resistance is now at work in him, he does not know what it is or how to describe it. Since, however, there can be no question but that this resistance emanates from his ego and belongs to it, we find ourselves in an unforeseen situation. We have come upon something in the ego itself which is also unconscious . . . (Freud, 1923; p. 17)

#### Complexities in the Concept of "Conscience"

In the present article we are mainly concerned with the third division of the psyche, namely the "conscience." It is here that we meet the greatest

complexity of all, part—though only part—of which may be formulated as follows:

(1) The operation of conscience cannot only involve the *avoidance* of pain—in the sense of preventing a person from doing something that he will later regret—but it can also involve a *sense of guilt* leading to the *need* for pain, in the form of a need for punishment.

(2) Observation makes clear that if the punishment does not come from the outside, then this need may express itself as *self-punishment*.

(3) This need for punishment or self-punishment can itself be either conscious or unconscious.

(4) Since punishing someone is an aggressive act, self-punishment by definition consists of turning aggression against the self.

(5) And finally, the ultimate in complexity, self-punishment may therefore become not only a way of *dealing with* guilt-laden aggression, but also a devious way of *expressing* it, and thus a fusion of aggression and guilt.

#### Freud's Concept of the Superego

It was complexities such as these that made Freud feel the need to coin new terms for the basic drives, on the one hand, and conscience on the other, dividing the psyche into "id," "ego," and "superego," in German, *das Es, das Ich, und das Über-ich*. Condensed quotations relevant to the concept of "superego," with which this article is concerned, and the observations on which this concept is based, are given below. Freud introduced the term in 1923 in *The ego and the id*, but the first quotation shows that his thinking was leading in that direction many years before:

We may say that a sufferer from compulsions and prohibitions behaves as if he were dominated by a sense of guilt, of which, however, he knows nothing—so that we must call it an unconscious sense of guilt, in spite of the apparent contradiction in terms. (Freud, 1907, p. 123)

In our analyses we discover that there are people in whom the faculties of self-criticism and conscience are unconscious, and unconsciously produce effects of the greatest importance. This new discovery compels us to speak of an 'unconscious sense of guilt,' especially when we gradually come to see that in a great number of neuroses this unconscious sense of guilt plays a decisive economic part and puts the most powerful obstacles in the way of recovery. (Freud, 1923, pp. 26-27)

Patients do not easily believe us when we tell them about the unconscious sense of guilt. We may, I think, to some extent meet their objection if we give up the term, and speak instead of a 'need for punishment,' which covers the observed state of affairs just as aptly. (Freud, 1924, p. 166)

There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment, they show signs of discontent and their condition invariably becomes worse. They exhibit what is known as a 'negative therapeutic reaction.' This reveals itself as the most powerful of all obstacles to recovery. In the end we come to see that we are dealing with what may be called a 'moral' factor, a sense of guilt, which is finding its satisfaction

in the illness and refuses to give up the punishment of suffering. (Freud, 1923, p. 49)

If we turn to melancholia, we find that the excessively strong super-ego which has obtained a hold upon consciousness rages against the ego with merciless violence, as if it had taken possession of the whole of the sadism available in the person concerned. Following our view of sadism, we should say that the destructive component had entrenched itself in the super-ego and turned against the ego. (Freud, 1923, p. 53) (Here, to lessen confusion, it may be right to say that Freud seems to be using the term "ego" in a different sense, namely as synonymous with "self.")

From the point of view of instinctual control, of morality, it may be said of the id that it is totally non-moral, of the ego that it strives to be moral, and of the super-ego that it can be super-moral and then becomes as cruel as only the id can be. It is remarkable that the more a man checks his aggressiveness towards the exterior the more severe—that is aggressive—he becomes in his ego ideal. It is like a displacement, a turning round upon his own ego. (Freud, 1923, p. 54) (Here Freud is again using the term 'ego' to mean 'self,' and he also seems to be using the term 'ego-ideal' as almost interchangeable with 'super-ego'.)

A large part of (an individual's) conscience may have vanished into his masochism. In order to provoke punishment the masochist must do what is inexpedient, must act against his own interests, must ruin the prospects which open out to him in the real world, and must, perhaps, destroy his own real existence. The sadism of the super-ego and the masochism of the ego supplement each other and unite to produce the same effects. (Freud, 1924, pp. 169-170)

All these quotations are concerned with the theme of the present article, namely the aggressive, punitive, self-destructive aspects of the superego; but it is important to note that there are many other complexities, controversial issues, and unanswered questions, of which the following are examples:

(1) To what extent is the superego something intrinsic in human beings, which comes into existence quite independently of the environment, and to what extent does it arise from *identification* with prohibitions arising from parents, parent substitutes, or society in general?

(2) To what extent does the operation of the superego express *love* of parents (or others), and the *wish to protect them and not to hurt them*, in addition to guilt, fear of punishment, or fear of disapproval?

(3) Does the superego arise only from the *Oedipus complex*, as Freud believed, i.e., from guilt about erotic feelings toward the parent of the opposite sex and jealous or hostile feelings toward the parent of the same sex, within a three-person situation, or are there other sources of guilt as well?

As it is well known, inferences about the early development of human beings made from studies of both adults and children, especially those of Melanie Klein (e.g., 1932, 1933) and Winnicott (1933), suggest clear answers to all these questions, which may be presented very briefly as follows:

It is thought that aggressive impulses of a very primitive kind can arise very early in life and be directed against the mother. Here I shall entirely leave aside the extremely obscure and controversial question of the degree to which these are intrinsic, or constitute a response to inadequate mothering. In the first few months of life it seems that the child expects impulses of an equally primitive and ruthless kind to be directed back at him either from the outside world or from inside himself, which gives rise to what Melanie Klein calls "persecutory anxiety." These impulses thus form a kind of primitive superego. At about the age of six months, however, there is a major change, which accompanies the dawning awareness of the mother as *another person*. Then *persecutory anxiety* gives way to "depressive anxiety," *fear* is replaced by *guilt* and *concern*. Thus Winnicott suggested the term "stage of concern" for this point in development, which he regarded as more satisfactory than Melanie Klein's term "depressive position." The superego now becomes less primitive, and in normal development will mature into what we mean by "conscience." Winnicott wrote: "The healthy child has a personal source of sense of guilt, and need not be taught to feel guilty or concerned."

Thus the tentative answers to the above questions are as follows:

- (1) Part of the superego is intrinsic and independent of the environment.
- (2) Part of the force of the superego arises from love and not just from fear.
- (3) Part of the guilt arises very early, before the child could possibly be aware of the three-person, Oedipal situation.

#### Problems in the Concepts of Id, Ego, and Superego

One of the problems inherent in the concept of "structure" in the psyche is that it is in fact only an analogy, and it is very easy to get led away into regarding it as an actual physical entity and then to meet all sorts of theoretical difficulties and contradictions. If we return to the first quotation given above from *The Ego and the Id*, and continue it, we can see Freud struggling with one of these difficulties, which arises from the question of whether something can be *unconscious* without being *repressed*—since the ego is regarded as being responsible for repression, it seems difficult to regard the unconscious part of the ego as repressed:

We have come upon something (i.e. resistance) in the ego itself which is also unconscious, which behaves exactly like the repressed—that is, which produces powerful effects without itself being conscious and which requires special work before it can be made conscious . . . We recognize that the *Ucs.* (i.e. Unconscious) does not coincide with the repressed; it is still true that all that is repressed is *Ucs.*, but not all that is *Ucs.* is repressed. When we find ourselves thus confronted by the necessity of postulating (an) *Ucs.* which is not repressed, we must admit that the characteristic of being unconscious begins to lose significance for us. (Freud, 1924, pp. 17-18)

Here it is worth saying that this seems to express Freud's despair at making his threefold division of the psyche into a self-consistent system, since if anything is central to psychoanalytic theory it is surely the characteristic of being unconscious.

There is another important difficulty which Freud also struggled with in *The Ego and the Id*. As touched on above, Freud clearly ascribed both grief and psychic pain to the ego, and yet he recognized that pain "behaves like a repressed impulse" (Freud, 1923, p. 22). Certainly in Intensive Short-Term Dynamic Psychotherapy it is necessary for the therapist to handle grief and pain in exactly the same way as he handles anger, i.e., to challenge the defenses against them in order to bring them to the surface, so that they can be experienced and their power can be neutralized. This will play a major part in the clinical examples that follow.

All these considerations suggest that Freud's threefold division of the psyche is *not* really a self-consistent system, and therefore that the use of Freud's terms in the present article is only a convenient piece of shorthand, and does not necessarily imply a slavish adherence to psychoanalytic theory. Perhaps surprisingly, on the other hand, the *superego*, in spite of being the most complex of the three concepts, is probably also the most self-consistent.

#### The Status of Evidence in Psychoanalytic Theory

The final point in this long introduction is as follows: Freud presented many of his concepts and theoretical ideas as overall impressions or conclusions, without a detailed examination of evidence from clinical material, and without the usual scientific discipline of a careful consideration of alternative hypotheses. One of our most urgent tasks is to try and sort out the wheat from the chaff, to answer the questions: which of his ideas are inescapable scientific facts, which are half-truths with a mistaken emphasis, and which need to be discarded altogether and assigned to a historical museum? But how are we to find the evidence on which any answers are to be based?

The almost insuperable difficulty of trying to base answers on psychoanalysis or long-term psychotherapy lies in the fact that the process is so gradual, and the material becomes so voluminous, that direct evidence is almost impossible to obtain. For instance, if therapeutic effects occur, how can one know what factors were responsible for them? Another consequence is that so few analyses can be conducted by any single therapist during a lifetime that he is in no position to present cumulative or statistical evidence based on a number of similar cases. As a result, single cases tend to be used as a basis for generalizations of highly questionable validity.

If only it were possible to unlock the unconscious and achieve a direct view of its contents in a single session! Then, we would be in a position to provide real evidence which would enable us to answer the questions posed above, and to put psychoanalysis—or rather psychodynamics—on a proper scientific basis.

And this is exactly what I have discovered, namely the triggering mecha-

nism for the unlocking of the unconscious with the direct view of the core neurotic structure in a single interview which is now the basis of the trial therapy for Intensive Short-Term Dynamic Psychotherapy. The present article is a preliminary communication in which an important psychoanalytic concept, that of the punitive superego, is examined in the light of evidence obtained in this way.

#### The Mechanism of the Unlocking of the Unconscious

Perhaps it never dawned on Freud and later generations of analysts that it is possible to achieve a major unlocking of the unconscious, making possible a direct view of the dynamic unconscious and the core neurotic structure responsible for the patients neurotic suffering. I have systematically demonstrated that this is not an event that happens with a few dozen patients, but it can be achieved with the whole spectrum of patients suffering from structural neurosis with the sole exception of those with very severe, fragile ego structure. In summary, my standard technique for handling resistance and unlocking the unconscious is as follows:

- Rapid identification and clarification of the patients defenses in the transference.
- Pressure toward the experience of impulse/feelings, which leads to the intensification of resistance.
- Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of resistance.
- Systematic pressure and challenge to the transference-resistance leading to a further intensification of resistance.
- Head-on collision with the transference-resistance. Creation of intrapsychic crisis with turning of the ego against its own defenses.
- Direct experience of the complex transference feelings—the "triggering" mechanism.
- Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious.
- Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.
- Major de-repression of current or recent past (C) and distant past (P) conflicts, leading to a direct view of the dynamic unconscious and multifocal core neurotic structure.

As we can see the transference is activated and intensified by immediate and repeated challenge to each of the defenses which make up the resistance and eventually these become exhausted and the transference feelings break through and can be both experienced and acknowledged. This has the effect of loosening the patients whole psychic system.

With this technique the therapist has an unrivalled opportunity not to make inferences about the unconscious, but to observe what lies there directly, and thus to test the validity of many concepts that form part of

psychoanalytic theory. The operation of this powerful research tool will be illustrated by presenting the following clinical material.

## Part II: Clinical Material

### The Case of the German Architect

I shall start with a case (already described in this journal; see Davanloo, 1986) which shows the operation of the superego particularly clearly.

The patient was an unmarried man in his early thirties. The therapist opened with the standard question, "Could you tell me what seems to be the problem"? In response, the patient manifested immediate resistance, using the defenses of vagueness and intellectualization: "I only have some hazy idea . . . I'm not sure whether these difficulties are the normal part of being a human being," and so on. The therapist responded with repeated challenge, and the patient's resistance rapidly crystallized in the transference—he became evasive, stubborn, sarcastic, provocative, and at times openly insolent, maintaining emotional distance by avoiding the therapist's eyes. Thus what he was doing was to *express aggressiveness* toward the therapist without himself becoming *emotionally involved* in it.

In an everyday human relation this provocativeness would inevitably bring some form of retaliation and set up a vicious circle, and that the similar behavior occurred outside the therapeutic situation. This was therefore the first indication of one of the patient's self-destructive patterns.

Here the therapist employed the *head-on collision with the resistance*, forcefully pointing out the self-destructiveness inherent in the position that the patient was maintaining:

*TH: If you stay like this, vague, nonspecific and withholding, then we will depart from each other without getting to the core of the problem. Then I would be totally useless to you. So obviously what immediately is coming to focus is that you have a self-defeating pattern. My question is why an intelligent person like you wants to do that?*

In this intervention the therapist is speaking directly to the patient's therapeutic alliance in order to shift the balance between it and the resistance. (To anticipate terminology to be used later, the therapist is speaking to the ego in order to shift the balance between it and the superego.) The result was some immediate evidence that this shift was beginning to occur, and after further repeated challenge the patient's defense of noninvolvement in his own aggressiveness was finally penetrated. He became overtly angry, raising his voice to the therapist for the first time:

*TH: Again you leave it in the state of limbo. 'I think so.'*

*PT: Well I do think so! Goddamn it, I'm not a psychiatrist.*

*TH: How do you feel right now?*

*PT: I feel fine. I'm getting belligerent.*

Although there was nothing dramatic in the breakthrough of the patient's anger, in fact it represented a major change in his psychic system, and it illustrates the profound unlocking effort which this kind of direct experience of transference feelings invariably has. Now, in response to the therapist's request that could he describe a situation in which he had become angry, a crucial communication emerged. This took the form of a "cover memory": an incident which summed up a large part of his core neurosis.

The incident occurred in a bistro. The patient witnessed a drunken man repeatedly insulting and needling a woman. He got into a rage and attacked the man, but only hit him on the shoulders, with the result that the man was unhurt and was merely provoked into beating him up. The patient ended up with a bleeding nose and a black eye.

He became very deeply involved and, perhaps surprisingly, very sad and tearful as he described this incident. He was quite unaware of its significance or the reason for his sadness.

Under pressure he admitted that he wanted to do much more than hit the man on the shoulders, and that he could have done so: "I could easily have hurt him"; and when he was asked if he had really wanted to "beat him up to the level that he would not move," he responded with words that clearly expressed his impulses, "You mean, 'I want to kill, I want to kill'."

Shortly after this he spontaneously mentioned his parents, which reactivated his transference-resistance. He put his feet up on the table, thus expressing insolence, while at the same time he tilted back his chair, putting himself in danger of falling over backwards. He spontaneously linked his defiance of the therapist with the relation with his father, and the therapist linked the mixture of aggression, on the one hand, and putting himself in danger, on the other, with the incident in the bistro:

*TH: . . . you took the defeated, beaten position as a mechanism to deal with the impulse which had a **murderous quality**—that you could have knocked him down with the first strike, but defensively you managed to be the beaten man with the bleeding nose, and to be humiliated in front of the woman.*

To this interpretation there was a major response:

*PT: Okay, the closest I have come to **murder** is when my father went for a lung operation . . . and I expressed the wish out loud that he would die.*

Not only this, but shortly afterwards he brought up a fresh memory of having used a table knife to try and slash the wrists of one of his brothers, Gustave, who was the favorite of their father. "I am very relieved that it wasn't sharp" (later he said, "Thank God I didn't cut his artery"). Mention of his brother introduced an entirely new theme, because his jealousy implied the grief-laden wish that he had had a warm and close relation with his father.

By now the patient was in a far more responsive state, with his unconscious therapeutic alliance strongly in operation, and it was possible to explore the family situation that had led to his neurosis:

With sadness, frequent sighs, much anxiety, and sometimes tears, the patient described how his father, a Calvinist minister, had been authoritarian, brutal, and sadistic. He frequently beat the patient on his bare behind with a brass-studded ruler; at table he would hit him over the knuckles with the blunt edge of a table knife; and after punishing him he would often lock him in a dark cellar. This continued till the patient was about 11. The mother was always busy, physically undemonstrative, and utterly subservient to the father. The patient was the eldest of four surviving children, and neither his brothers nor his sister were punished in the same way as he was. He became the black sheep of the system.

During the course of this account the patient began to show signs of both wanting, and trying to avoid, a closer relation with the therapist, and when this was brought into the open he spontaneously revealed the disappointed love lying behind his anger. He spoke of his paternal grandfather, who had become a father-substitute for him, and with whom he had developed the close and warm relation that he had never had with his father. It also emerged that he had found mother-substitutes in his two grandmothers and an aunt. He said that each time the family moved, "I would always find some kind of substitute for parents, a mother and father, whom I could call aunt and uncle."

When his adult life was explored, it became clear that he suffered from major problems in relation to people of both sexes. With men, particularly those in authority, he adopted the same kind of detached or belligerent attitude as he had to the therapist, provoking retaliation and spoiling the relationship. With women he had a serious problem over commitment, and though his feelings might start positive, sooner or later they changed and he broke the relationship off. His last relationship had been totally disastrous, since the woman had moved in with him, had had a psychotic breakdown, and he had had to look after her for three years because she had nowhere else to go. As far as his professional life was concerned, he made clear that he was quite unable to fulfill his potential. The final result of all this was that his life was empty.

As the patient spoke of his mother, he began to express resentment against her for never standing up for him or protecting him from his father. The therapist gave a summing up interpretation—the helpless mother and brutal father (like the couple in the bistro)—and the patient's search for refuge and parent substitutes.

At this point the patient became extremely sad and tearful, though still trying to avoid both the impact of his feelings on himself and the emotional closeness that would result from sharing them with the therapist. After these two forms of resistance had been challenged, he de-repressed what was an important central issue in his pathology, very sad, tearful, with waves of painful feelings and with the intensely felt words, "I don't want to punish them any more," which was followed later by: "I don't want to tell them that they have been terrible parents, which they have been."

Here the therapist pointed out that he was punishing himself as much as punishing them.

Finally, it is worth mentioning that during his subsequent session the patient recalled the following incident: that he went alone into the woods to cut down a tree, and positioned himself in such a way that the tree fell on him. This happened not once but twice. On the first occasion he was not discovered for many hours.

#### The Case of the German Architect, Discussion

The clinical material on this patient can be summarized under four main headings.

##### (1) Self-Destructiveness

The evidence for this is as follows:

(a) The first manifestation in the interview of self-destructiveness occurred in the patient's initial state of resistance, in which he used the defenses of detachment and provocativeness. Obviously, if this resistance could not be penetrated, the whole therapeutic process would be defeated.

(b) In an everyday situation this kind of provocative behavior would inevitably bring retaliation, which would set up a vicious circle and would probably result in the destruction of the relationship. Enquiry revealed that this was what actually happened in the patient's life outside, and that it was a recurring pattern, particularly with men in authority.

(c) With women he also showed a recurrent pattern, namely losing his feelings and terminating the relationship.

(d) In the incident in the bistro he behaved in such a way as to get himself beaten up.

(e) It soon became clear in the interview that in his defiance of the therapist the patient was repeating a pattern which he had expressed with his father over a period of many years, and which had clearly led to a vicious circle of provocativeness and punishment and a disastrous relationship between father and son.

(f) Finally there was the patient's serious accident caused by felling a tree, which happened not once but twice.

##### (2) Sadistic and Murderous Impulses

(a) The patient more or less admitted that his rage against the man in the bistro was murderous in quality.

(b) The parallel between the situation in the bistro and that in the patient's family, an aggressive man attacking a helpless woman was very striking. Moreover, the man in the bistro was described as very energetic in his movements, which represented another parallel with the patient's father. In other words the potentially murderous attack on the man in the bistro was a symbolic attack on the patient's father.

(c) At the age of 11 the patient had openly expressed the wish that his father would die.

(d) In his childhood the patient had made an attack on his brother Gustave, which was at least a *symbolic* if not an *actual* attempt at murder. He demonstrates a high level of resistance which correlates significantly with the intensity of murderous impulses as well as repressed guilt and grief.

### *(3) Intense Guilt, Remorse, and Grief*

Once the breakthrough had been made, these feelings permeated the whole interview, often expressed all at the same time. One example occurred in the words, "Thank God I didn't cut his artery"; and the climax came with the words, spoken with deep and intense feeling, "I don't want to punish them any more. I don't want to tell them they have been terrible parents, which they have been. I just want to let sleeping dogs lie as far as they are concerned."

Here we may ask the highly relevant question, in what way was he punishing his parents? Since they were in Europe and he was in Canada, he had little means of punishing them *directly*. Therefore the answer can only be that he was punishing them *through his own suffering and the messing up of his own life*. In this way he could become a living reproach to them, and could fuse anger and guilt in a single pattern of self-destructive behavior. Thus the evidence becomes strong for a mechanism of *turning the punishment on himself*.

### *(4) Impoverishment of the Personality, Sterile Relationships*

(a) It was clear that the patient's distancing and inability to allow emotional closeness with the therapist also occurred in his relationships outside.

(b) As mentioned above, he had never had a satisfactory relation with a woman.

(c) His neurosis considerably stunted his ability to fulfill his potential in work.

(d) His major ego functions are impoverished in varying degrees.

The four elements of (1) self-destructive or self-punitive behavior, (2) violent underlying impulses, (3) guilt and grief, and (4) impoverished personality are observed in all the cases about to be presented.

### **The Case of the Man from Southampton**

The two initial interviews with this divorced man by the present author were described in a two-part article by Malan in this journal, entitled "Beyond Interpretation" (Malan, 1986a, b). The following is a summary of the relevant features in the order in which they emerged. Many of them show a striking parallel with the Case of the German Architect.

### *Initial Massive Resistance*

At the time of the initial interview he was 47-years-old and divorced and had had 20 years of previous psychotherapy which had done little more than reinforce his defenses. His resistance, which was present from the beginning, took the form of vagueness and distancing. He was unable either to describe the nature of his difficulties or to give specific examples of situations in which his difficulties arose. He mentioned "anxiety" and "guilt," but when pressed for his inner experience of these feelings he would only say that these were the labels applied to them by his previous therapists.

### *Impoverishment of Personality, Sterile Relationships*

There was already evidence of this in his state of vagueness and distancing, since these transference phenomena were almost certainly typical patterns in his relationships outside. He confirmed this by saying that in his personal relations he had never really felt close to anyone, in particular neither to his wife nor his children. He also said that he was unable to fulfil his potential in work.

### *Challenging the Self-Destructiveness in the Transference-Resistance*

An essential part of technique with these patients suffering from severe character disorders is the intervention of head-on collision that I have described in detail in other publications in which the self-destructiveness in the transference-resistance is pointed out and strongly challenged. Here the therapist's aim is to mobilize the therapeutic alliance against the resistance, or—to anticipate terminology that will be used later—to mobilize the ego against that part of the resistance which is maintained by the superego. The following is part of the relevant passage:

*TH: Now let me ask you this. If you remain vague and if you remain evasive and continue to generalize and not be specific, then what would be the end result of this session with you? You said you have had 20 years of treatment, and it hasn't got you anywhere obviously. So then the end result of this session would be of no use to you, wouldn't it?*

*PT: Not very much use.*

*TH: So if you continue to be vague and evasive and generalize and keep things in a state of limbo then we would not get to understand the core of your problem, and the end result would be that I would be useless to you like the 20 years of your past therapy, okay? Now my question is this. Why do you want to do that? . . .*

When correctly timed, this assault on the superego begins the process of breakthrough, as in this patient, whose feelings were mobilized in the form of intense sadness about his wasted opportunities.

### *Evidence for Self-Destructive and Self-Punitive Behavior*

(a) The patient said, "I always sell myself cheap and let myself be exploited."

(b) After his therapeutic alliance had been partially mobilized as described above, followed by some degree of experience of transference feelings, he spontaneously began to give deep interpretations of his own behavior. He described himself as accident-prone, saying that this was a suicidal equivalent. (We may compare this with the German Architect's tree-felling accidents.) On one occasion he had overturned his car under conditions which, though icy, were not dangerous to a careful driver. On another, when in a state of rage with his wife, he had driven through a stop sign, and the car had been hit by a truck on the passenger's side where his wife was sitting.

(c) The following piece of dialogue, in which he spontaneously gave another deep interpretation, illustrates the degree to which he was aware of his need to perpetuate his own suffering:

*TH: So there is a sort of self-sabotaging and self-punishing pattern in you.*

*PT: Yes there is, constantly.*

*TH: That in a sense you carry this suffering with yourself in life.*

*PT: Yes. I think that's what led to my wife and I staying together for so many years, when we should have realized many years ago that things were not right, and we should do something about it.*

### *Guilt-Laden Violent Impulses in the Patient's Recent Life*

The patient suffered from violent outbursts which broke through his attempts at control. On one occasion he had been angered by a shop assistant and had smashed his umbrella down on the counter. His wife used to have outbursts of violence such as trying to hit him over the head with a chair or smashing the television down on the floor, and at times he had said to himself that he would kill her.

### *Activation of Transference and Breakthrough of Transference Feelings*

Under repeated challenge his transference resistance was eventually fully penetrated, and he became able to acknowledge and experience both his anger against the therapist and, with tears and sadness, his warm appreciation of the therapist's concern for his welfare. He clearly revealed that the origin of the grief lay in disappointed love when he contrasted the therapist with his father, who used to ridicule him if he spoke of his feelings and became upset. This experience of both positive and negative transference feelings led to a breakthrough into his unconscious and the possibility of exploring the roots of his neurosis in the past.

### *Family Relationships*

There were a number of striking parallels between this patient's situation and that of the German Architect:

(a) The father was dominant in the home and—though not so obviously sadistic as the father of the German Architect—would frequently administer physical punishment with a belt. The patient did remember an early close relationship with him, which represents a contrast from the German Architect.

(b) When the patient was in his early teens, there was an incident involving himself and his parents directly—in contrast to the *symbolic* incident with the German Architect in the bistro. The father had become angry with the mother and called her a pig, and the patient had raised his fist in defense of his mother, wanting to attack his father, who said he would disown him. The relation between father and son steadily deteriorated, and the situation eventually became so bad that a cousin took the patient into her home.

(c) As with the German Architect, the other siblings were much more favored than the patient, who became the black sheep of the system. In particular there was a brother, younger by one year, of whom the patient was extremely jealous. There were many fights between them, and the father bought them boxing gloves and told them to fight it out properly. In spite of the fact that the patient was a year older, he eventually got knocked backwards into a china cabinet, after which the mother forbade further fights. There was also evidence of other ways in which he allowed his brother to gain the upper hand, thus "taking the role of loser."

(d) The following piece of dialogue reveals yet another striking parallel with the German Architect who, it may be remembered, had tried to slash his brother's wrists with a table knife:

*TH: How did you feel when your brother knocked you down? Did you feel that you wanted to get at him?*

*PT: I don't know how I felt.*

*TH: We know that when you get into a fight and your wife humiliates you, there is the feeling that you wish that you could kill her. So the question is this: Was there any time the wish that you could do that to your brother?*

*PT: I'm sure there was. Yes, because on one occasion I remember fighting with him in the field . . . and I did a terrible thing when he walked away. I took a stone from the ground and threw it at him and hit him on the back of the head.*

*TH: If you didn't have a brother what would have happened?*

*PT: Well, I would not have had a rival in the family, would I?*

*TH: And the rival is the one that knocked you down and beat you and humiliated you.*

*PT: Yes.*

*TH: Now the question is, what does that mean? If you didn't have a brother?*

*PT: I don't know. Only that there would have been no one between my father and myself, I imagine.*

As with the German Architect, this passage reveals both guilt-laden murderous feelings toward the more favored brother, and a longing for a closer relation with the father.

In summary, we see the following:

- (1) Self-destructive and self-punitive behavior. Taking the role of loser.
- (2) Violent and murderous impulses toward people close to him.
- (3) Guilt about the above murderous feelings. Grief about the warm relationships that he did not have.
- (4) Impoverishment of his personality and his inability to form a meaningful relationship; high level of resistance and a harsh punitive superego.

#### The Case of the Woman with the Machine Gun

The first part of the initial interview with this 30-year old single woman was described in an article in this journal (Davanloo, 1987), the purpose of which was to illustrate the special restructuring technique that needs to be used with patients suffering from chronic depression. Many of these patients, when asked to describe their experience of anger, are quite unable to do so and describe *defense* or *anxiety* instead. It is necessary to use a technique of *graduated* rather than *unremitting* pressure and challenge in order to bring them eventually to the experience of anger in the transference, and then to drive home insight into the distinction between the true impulse of anger and the defense or anxiety which they have been mistaking for anger hitherto. Once this has been done it is safe to use unremitting pressure and challenge in order to achieve the final breakthrough into the unconscious.

The following are the features in this patient relevant to the theme of the present article.

#### Masochistic Relation with a Man

The early part of the first interview quickly crystallized around two incidents in which the patient had been severely humiliated by a man called Tony. It is highly significant that she described Tony as a man with a cruel streak, who liked to put people down, and although she knew this she had "set her cap" at him with the aim of eventually enticing him into bed with her. In the first incident he had led her on and then deliberately rejected her, and two weeks later he had had sex with her sister in the bedroom next to hers.

These two incidents would be expected to arouse extreme anger, and indeed the patient said she had been angry, but when pressed all she could describe consisted of anxiety or defenses:

*PT: The second episode was even more humiliating. I did not sleep all night. That is the worse I've ever experienced. Then I experienced*

*the anger. I don't know if it was anxiety, but I didn't sleep. I was ruminating, thinking about what was happening.*

*TH: What was your reaction?*

*PT: Aside from the lack of sleep I was . . . I gotta think back because I . . . I haven't blanked it out because otherwise I wouldn't remember any of it, but I . . .*

and so on.

#### *Self-Directed Aggression*

It emerged that after the second incident the patient had ended up by banging her two hands against the wall, which had resulted in their being so badly bruised that she was unable to use them for some days. She then became depressed. Moreover, when much later the therapist asked her if there had been any other incident involving her hands, she described how in her adolescence she had been humiliated by her brother and had severely bruised her hands by banging them against a tree.

#### *Three Major Depressions*

She had one in her early adolescence and the second one in her late adolescence which was of many months duration.

#### *Anger in the Transference*

The therapist finally succeeded in bringing her to the point of really experiencing her anger with him, which she expressed in a fantasy of taking him by the lapels (with her hands) and throwing him on the floor. After a second experience of anger in the transference she was able to say that now she understood the difference between this and what she had previously mistaken for anger. Moreover these experiences resulted in the disappearance in the interview itself of both the physical and psychic manifestations of anxiety, namely sweating and mental confusion, respectively.

#### *Defense against Emotional Closeness in the Transference, Showing the Parallel with Lack of Fulfillment in Other Relationships*

As with almost all patients suffering from chronic character disorders, the defense against anger is not the only problem leading to resistance in the transference. Their disappointment in previous relationships also leads them to defend themselves against emotional closeness with any other human being, which of course includes the therapist. This patient became uneasy whenever the subject of positive transference feelings was mentioned, and the therapist therefore asked her if she put the same kind of "wall" or barrier between herself and other people. In response she spoke as follows:

*PT: Yes, definitely, I can't recall a single satisfying relationship with anyone, with a man either emotionally, or . . .*

*TH: So in a sense all men are on the other side of the wall?*

*PT: Yeah, it's as if half the population doesn't really exist.*

#### *Lack of Fulfillment in Her Life in General*

The patient was well aware of the degree to which her life was marked by lack of fulfillment, as is shown by the following passages of dialogue:

*TH: . . . We are here to get you out of this crippled life. Of course you are the one to decide is it a crippled life or isn't it?*

*PT: Yes, it is.*

*TH: And it is sad that a woman of your age is running a life which is so paralyzed. On one hand you have your potentiality and on the other hand you have paralyzing forces within you . . . And you have tears in your eyes, and you avoid my eyes . . .*

*PT: I don't like to cry.*

*TH: Do you function at the level of your potential in life?*

*PT: No.*

*TH: Or do you function much below your potential?*

*PT: Considerably below.*

#### *Major Unlocking of the Unconscious: Violent and Murderous Impulses Directed against Everyone Close to Her*

The second occasion on which she reached the direct experience of the impulse in the transference resulted in a dramatic breakthrough into her unconscious. She became intensely involved in her fantasy world, and de-repressed hitherto entirely unconscious fantasies of murdering first her mother, then her father and sister, and then almost everyone to whom she had ever been close, with a machine gun.

#### *Evidence for the Love Lying Behind the Hatred*

It is very important to note that her murderous fantasies were accompanied by the most intense grief and waves of intense painful feelings. For much of the time she was in tears, and the therapist described her as "choked up and trembling." She also expressed positive feelings behind the negative in relation to the therapist, saying that although she wanted to attack him she didn't want to damage him. In the later part of the interview she compared her feelings toward the members of her family with those toward the therapist, saying that she didn't want to do more than throw him to the floor. The dialogue continued as follows:

*TH: Why do you think that is?*

*PT: It is because the caring is not there. I mean there is no way I can care for you as much as I care for my family. If they hurt me it hurts more than if you hurt me.*

This gives a very important indication of some of the forces at work in the patient leading to her self-punitive behavior.

#### *Response to Interpretation about Lifelong Guilt*

After her fantasy of murdering her mother the therapist asked her what happened next, to which she said, "I don't get caught." The therapist reiterated that she had "massive, murderous impulses" toward her mother, and she said, "Anger, anger." The therapist then said that if she could face all these painful feelings she had a chance of freedom. He then gave an interpretation of her lifelong guilt, which the patient made clear that she understood at a deep level:

*TH: . . . because your life is like the life of a murderer if you look at it.*

*PT: I'm in hiding.*

*TH: You are running and running and running, hmm?*

*PT: I've been hiding for all these years.*

#### *Summary*

The relevant features found in this patient can now be summarized as follows:

(1) Self-destructiveness and self-punitive behavior: A sexual attraction for a man whom she knew to be cruel, resulting in severe humiliation. Anger expressed in the form of injuring her own hands, a self-directed aggression.

(2) Extremely violent and overtly murderous impulses directed against her mother and almost everyone close to her.

(3) These impulses accompanied by the most intense grief and pain. We see a high level of resistance: Intense repressed murderous impulses as well as intense guilt and grief with harsh punitive superego.

(4) A self-defeating and self-sabotaging pattern which has permeated all aspects of her life, a marked vulnerability to clinical depression and she has already had three major depressions.

Finally, it is important to emphasize that in her fantasy she attacked the therapist with her *hands*, and murdered everyone close to her with a machine gun and it was her hands that she damaged by her self-punitive behavior. Hands are not the only part of the body used in such fantasized attacks. This issue will be discussed more fully later, after the presentation of other case material.

#### *The Case of the Woman Who Bruised Her Thigh*

This was a patient who was interviewed by the author and was the subject of an article by Said in this journal, the purpose of which was to illustrate the application of Intensive Short-Term Dynamic Psychotherapy in treatment of patients suffering from characterological depression (Said, 1986).

At the time of the initial interview she was in her forties and suffered from the following disturbances.

- (a) Lifelong depression, with episodes of major clinical depression marked by motor retardation and ideas of committing suicide by drowning.
- (b) Chronic anxiety.
- (c) Characterological problems—compliance and passivity alternating with stubbornness and defiance.
- (d) Major problems in human relationships, which included an inability to allow herself intimacy and closeness, and a pattern of seeking relations with people by whom she was used and abused.
- (e) A lifelong pattern of self-defeat and self-sabotage.

Thus she showed features clearly indicating the operation of a self-destructive tendency in her life. However, there was an additional striking feature, namely the close correspondence between one detail of her self-punitive behavior and the violent impulses that were revealed when her unconscious was unlocked.

As in the case of the Woman with the Machine Gun, the interview crystallized around a recent incident in which the patient had been unable to experience her anger. She had got into conflict with a woman supervisor called Catherine and had walked out of Catherine's office. The therapist pressed her to describe how she experienced her anger, which produced marked resistance:

*TH: We are focusing on how you experienced your rage towards Catherine and you want to talk about how incompetent she was.*

*PT: Well it is clear that I am not able . . .*

*TH: Simply declaring that you are incapable, you are helpless and crippled to tell me how you experience your rage, is not going to help us.*

*PT: (Sigh) I walk out . . .*

*TH: Walking out is a mechanism, it is not experiencing it. You have said that you get depressed, but that is a mechanism of dealing with rage. It is not the experience of rage.*

*PT: Well I was banging into things, bruising myself . . . I mean like my balance was off . . . I remember I got a big bruise on my leg because I walked into something with a sharp corner.*

*TH: You mean when you left Catherine's office?*

*PT: No, during that period of conflict with Catherine before I left my job.*

The patient went on to say that in situations like this she moved "very fast and very jerkily," and that on this occasion she had got "an enormous bruise" on her thigh. It later emerged that it was her *right* thigh that she injured, and that this had happened on a number of previous occasions when she was faced with a situation that should have made her angry.

We now move on to a passage that occurred some time later, when the

therapist was able to challenge the resistance against declaring her feeling in the transference.

*TH: . . . first we want to know here how you feel towards me.*

*PT: I feel angry with you.*

*TH: Angry towards me. How do you experience this anger physically?*

*PT: I feel like kicking.*

*TH: . . . how would the kicking be like?*

*PT: Kicking your shins so that you would get out of my way.*

*TH: Left leg or right leg?*

*PT: With my right leg to knock you down, to get your feet out from under you so that you would fall.*

*TH: How then would I fall?*

*PT: You would fall to your right side, would be lying down straight and I would step on you and walk out.*

In the following passage it is important to note the "positive" feelings of love and concern, which are accompanied by intense sadness:

*TH: Then what happens to me? And what do you do further?*

(The patient is highly emotionally charged, with a rise in her voice.)

*PT: Pick you up, help you up.*

*TH: So on the one side of the massive rage there is also positive feelings?*

*PT: Yes.*

*TH: In what way am I damaged?*

*PT: You are not too damaged.*

*TH: Why don't you want to damage me? You see you want to protect me against your anger.*

*PT: I could really hurt you but I don't want to kill you . . . I am capable of killing.*

*TH: From where does it come that you are capable to kill?*

*PT: Rage. I could have sat on you . . . when I had you on the ground I could have stamped all over you but I didn't want to do that.*

*TH: You mean you could have murdered me?*

*PT: Yeah. I could have really hurt you.*

*TH: Now if you go further in terms of thoughts and fantasies?*

*PT: That is what I'm doing.*

*TH: Okay, with the thoughts. If you had gone to the level that you wanted to murder me how would you murder me in terms of thoughts? We can see your fist.*

*PT: I would step all over you with my shoes on.*

*TH: But not your fists, which are like that?*

(The patient sighs deeply, there is a high rise in complex transference feelings)

*PT: Okay, yeah.*

*TH: What would happen? Where would be the target of your rage?*

*PT: Your stomach.*

*TH: Am I bleeding to death or am I what way? I mean is there blood or what?*

*PT: It is not to . . . you're not . . . I am not going to kill you but I could really hurt you.*

*TH: Damage me?*

*PT: Yeah . . . your stomach.*

*TH: Mm hmm. And then after you have done it what would be the extent of the damage to my stomach?*

*PT: The thought that came into my mind was, whatever is in your stomach would . . . come out.*

*TH: Oh, open up, you mean that way, you mean . . .*

*PT: No, not open up, I think . . . I mean . . . I mean . . . that is, it is a baby.*

*TH: Baby?*

*PT: In there. It is not you, it's my mother.*

*TH: Mm hmm. Again you move to your mother.*

*PT: Well that is who I was really imagining, not you.*

*TH: So a sort of baby would come?*

*PT: Or whatever it is, I don't know what is in there.*

*TH: And what do you do with my damaged body?*

*PT: Help you up.*

*TH: Are you saying, in a sense, again in this massive rage toward me there is also positive feeling for me? Or which you are equally terrified.*

*PT: I need you.*

(The patient has become very sad, tearful, and highly charged emotionally.)

*TH: How do you feel, because I feel that in a sense your eyes . . .*

*PT: I feel sad.*

*TH: I feel there are some tears in your eyes.*

*PT: Yes, I feel sad. I am thinking of my mother.*

*TH: Right now?*

*PT: Yeah.*

We now meet the source of the anger which, as so often, lies in disappointed love:

*TH: What are your thoughts about your mother?*

*PT: Very sad (crying).*

*TH: Any thoughts that come to your mind? You must have a lot of mixed feelings there.*

*PT: Well, she did have a baby.*

*TH: She did have a baby?*

*PT: In her tummy, yes.*

*TH: Mm hmm. What happened?*

*PT: She had another baby when I was a year old.*

*TH: Mm hmm.*

*PT: And the baby was sick and she had to take her to the hospital and she left me.*

*TH: How old were you?*

*PT: One year old, 13 months. She left me with my Grandfather and my great aunt.*

Thus the Woman with the Machine Gun had the impulse to attack the therapist with her hands, and it was her hands she damaged in her self-punitive behavior; while the present patient had the impulse to attack the therapist with her right leg, and it was this leg that she damaged as a result of her inability to control her balance.

In summary, we see in this patient the same four features:

(1) Various forms of self-punitive and self-destructive behavior.

(2) Violent impulses toward her mother and murderous impulses toward the unborn baby.

(3) Intense guilt and grief.

(4) An impoverished personality. The ego has lost its autonomy in relation to punitive superego.

#### Brief Summary of other Relevant Cases

##### *Other Patients with Bruising of the Right Leg*

The patient just described was one of a series of 24 highly resistant and poorly motivated patients suffering from major characterological problems and episodes of severe depression. In this series there were two others who suffered from frequent attacks of staggering with bruising of the right leg. It so happens that both were female, and in both the traumatic experience was the mother's pregnancy when the patient was very small—one-year-old in one case and two-years-old in the other. In these two cases also the unlocking of the unconscious revealed an impulse to attack the mother with the right leg, in one case on the abdomen and in the other on the head.

##### *The Case of the Unwilling Moose Hunter*

This patient was one of a series which included patients suffering from obsessional and phobic disorders who had a hostile relationship with either their father or their mother. The striking feature of his recent history was that when seen he was in his third marriage, and that all three had been to women who were highly explosive and violent. Every day he was in a state of inner rage with his current wife, with a whole set of characterological defenses against his own violent impulses.

The history of his background revealed a sadistic father who frequently used to beat his son, laying him down on an ironing board. In the parents' marriage the mother was completely subservient and the patient formed an alliance with her against his father. When the patient was in his

twenties the father mellowed and showed a great interest in his son before he died.

After the unlocking of the unconscious the patient became highly emotionally charged and recounted the following incident: When he was a boy his father had forced him to come on a moose-hunting expedition. He had been unwilling to go but had complied. Some time during that day his father asked him to climb a tree and search the area with binoculars. He had refused and his father had become very angry and in a temper had climbed the tree himself, leaving his rifle on the ground. The boy had had the impulse to pick up the rifle and shoot his father, but as a defense he had developed weakness in his limbs. He told of this incident in a state of intense guilt and grief, at times unable to speak because of a tremor in his face.

Once more we see certain features common to all these cases: a repeated pattern of self-punishment, here taking the form of marrying violent women; and, lying behind this, violent murderous impulses in the patient's childhood, which were laden with intense grief and guilt. Another striking feature not yet mentioned is the resemblance between the marriage partner and the family member against whom the murderous feelings were directed. This has an important bearing on the origin of the phenomenon named by Freud the "compulsion to repeat," which will be discussed below.

### Part III: Discussion

#### The Relation between Suffering and Self-Punishment

Of course a life of suffering is intrinsic to chronic neurosis, but we need to ask whether there is evidence that these patients show behavior in which they actively seek suffering. Such behavior can be: (1) direct, in the sense of inflicting suffering on themselves, or (2) indirect, in the sense of causing others to do it for them.

As examples of (1) we may cite: (a) the self-inflicted damage to her hands in the case of the Woman with the Machine Gun, which occurred at least twice and was a quite conscious act; and (b) in other patients, a number of unconsciously based and apparently accidental occurrences, all of them also repeated, such as the bruising of the right leg in three women patients, the German Architect's two tree-felling accidents, and at least two avoidable and serious motor accidents in the case of the Man from Southampton.

Examples of (2), in which the patient causes other people to inflict the suffering, are found in: (a) the German Architect, whose pattern in relation to his father in his upbringing, and to all authority-figures since then, was to provoke them into retaliation; (b) two male patients, the Man from Southampton and the Moose Hunter, who married violent women, one three times; and (c) the Woman with the Machine Gun, who tried to seduce a man whom she knew to be cruel, with the result that she was exposed to severe humiliation.

Now it is possible to find alternative explanations for every one of these phenomena, if each is considered in isolation. For instance, the accidents could be described as the result of "carelessness" or chance; provocative be-

havior could be interpreted simply as a way of expressing aggression, which of course it is, with the induced retaliation no more than an inevitable by-product; the seeking of relations with violent or cruel partners could be dismissed as the result of poor judgment; and so on. But anyone who puts forward such alternatives is ignoring the true power of the argument in favor of the active seeking of suffering, which comes from the following sources:

(1) Patients like the Woman with the Machine Gun, who express anger in a way that injures themselves.

(2) Cumulative evidence from individual patients. Thus it becomes difficult to dismiss *two* tree-felling accidents as due to simple carelessness; or *three* marriages to violent women as simply due to poor judgment, or—to use an example not mentioned above—*repeated* self-injury to the same part of the body, as simply due to lack of coordination when under the influence of suppressed anger; and so on.

(3) Cumulative evidence from the sample as a whole, in which there is an *overall pattern* of behavior that can only be described as self-injuring or self-destructive, the details of which vary from one case to another.

(4) Finally, there is the correlation between the part of the body that certain patients injured, and the part of the body used for fantasized attacks. Again, each individual case can be ascribed to coincidence—after all, the parts of the body that can be used in physical attack, or are likely to get repeatedly injured, are fairly limited—but *three* patients who both injured their right leg, and used the same leg in fantasized attacks on their pregnant mother, carry the argument in terms of coincidence toward the edge of credibility. Moreover, this evidence suggests something more specific than simply the seeking of *suffering*, namely the seeking of *punishment*.

#### The Underlying Reasons for Self-Punishment

In all these patients we find the same set of phenomena, namely *violent and murderous impulses toward close members of the family*, which are laden with intense guilt, remorse, and grief. The inference that it is these impulses that lead toward the need for self-punishment then becomes almost inescapable.

#### Impoverished Personality, Sterile, Destroyed Relationships

The evidence for (a) impoverished personality, and (b) sterile or destroyed relationships in all these patients is overwhelming. Obviously, they condemn the patient to a life of suffering, and impoverishment of the major ego functions. There can be little doubt that part of the explanation lies in the operation of *defenses*: (a) the repression of sadistic impulses, intense guilt, and grief, which means the loss of immense and essential areas of the personality; and (b) the avoidance of emotional closeness for fear of a repetition of earlier disappointments, which makes fulfilling relationships impossible. On the other hand the evidence for feelings of guilt and self-punishing

tendencies in these patients is so great that it seems difficult to believe that these defenses are not reinforced by the need for suffering. This will be discussed in length in a later article, "Ego and Superego and the Problem of Resistance."

#### The Ego and Superego

If we assume that one of the main functions of a "normal ego" is to enable an individual to achieve satisfaction and fulfillment and to avoid pain, then these patients behave as if their ego has lost much of its autonomy and functions and has been taken over by some alien, all-pervading, self-destructive force. We can add that beneath this, in all these patients, we have found violent and murderous impulses against close members of the family, and profound guilt, remorse, grief, and pain.

Thus we reach evidence not only for Freud's concept of the punitive superego, but also for the mechanism underlying its formation. This latter consists of *self-punishment for murderous impulses*, which are laden with intense guilt and grief.

#### Grief and Love

It is important to emphasize that guilt is not the only emotion accompanying these impulses. In all our cases there is also a mass of related, much more "positive" feelings, consisting of grief, remorse, love, and (Winnicott's term) concern, and there is also strong evidence for *disappointed love*. Some of these feelings are epitomized by the German Architect's deeply felt statement, "I don't want to punish them any more"; or the statement made by the Woman with the Machine Gun, "There is no way I can care for you as much as I care for my family. If they hurt me it hurts more than if you hurt me"; or that made by the Woman who Bruised her Thigh, "I need you"; and many other examples.

It is clear that these positive feelings, which themselves are unconscious, supply much additional power to the repressing forces. This also raises the possibility that part of the function of the self-punishment is to express love—"I would rather hurt myself than hurt you"—and, by directing the aggression inwards instead of outwards, to protect the people against whom it was directed originally.

#### The Superego and the "Compulsion to Repeat"

The discussion of this subject may be approached through the Case of the Moose Hunter. This patient had married a succession of violent women, against whom he was in a constant state of suppressed rage; and in his background it emerged that his father was violent and sadistic, and that the patient had entertained highly guilt-laden murderous impulses toward him. Thus in his recent life the patient was exposed daily to the same kind of conflict as he had experienced in his upbringing. Could it be that there was some force at work driving him to choose partners who resembled his father?

This is not an isolated observation. In the case of the Man from Southampton we saw that the father was punitive and frightening, and the patient married a woman who smashed the television and attacked him with a chair. This observation is a universal phenomena in all our patients suffering from character neurosis.

Moreover, there is a corresponding observation in both sexes in relation to the mother. In a series of severely neurotic, highly resistant, and poorly motivated patients, we have found the following:

That when the mother was demanding, critical, and punitive, there was a resemblance between the *wife* and the mother in the case of men, and between the *husband* and the mother in the case of women.

These patterns are still more striking when there has been actual physical abuse, in which case there is an even greater need for masochistic suffering. In spite of their best intelligence these patients tend to choose partners who use and abuse them, and each time they escape they quickly find someone else to do the same, thus going "from the frying pan into the fire."

These are all examples of what Freud, in *Beyond the Pleasure Principle* (Freud, 1920), named the "repetition-compulsion" (the literal translation of the German compound word *Wiederholungzwang*) which was later retranslated by James Strachey into the less unwieldy term "compulsion to repeat." His view of this extremely obscure phenomenon was that it represented the ego's attempt to master the traumatic situation, and although this explanation does not seem to be entirely satisfactory, so far no one has since come up with a better one. The evidence from our extensive clinical data indicates that at least part of the compulsion to repeat involves the superego, and represents the need to suffer as a punishment for the violent and murderous impulses found so frequently in patients suffering from severe character neuroses. This whole subject will be discussed at length in a later article, "Clinical Manifestation of Superego Pathology, Repetition-Compulsion."

#### The Question of Self-Directed Aggression

As was mentioned in the introduction, punishment is an aggressive act, and therefore self-punishment must by definition involve self-directed aggression. The clinical material presented here certainly confirms Freud's view that the superego is as sadistic as the patient's id. On the other hand, in these cases at any rate, there was little or no detailed evidence that it was the *same* underlying impulses that were expressed by the patient both against the outside world and against himself. We can illustrate this with the Woman who Bruised her Thigh: This patient's fantasized attack was on the mother's abdomen with her leg and if she was going to direct these impulses against herself we would expect that she would find some way of bruising her own abdomen. In fact, of course, it was her leg that she bruised, which obviously represents *self-punishment* but does not seem to represent the *turning of her own impulses against herself*. Equally, the German Architect did not slash his own wrists, and the Moose Hunter did not have the impulse of shooting himself. This means that, in these patients, whereas the description of *self-punishment* for *aggressive impulses* is obviously correct, the description

of turning the aggressive impulses against the self does not quite seem to fit the evidence.

#### The Time of Origin of Neurotic Conflict

All our clinical material confirms one of my most fundamental general findings, namely that the vast majority of neurosis stems from the patient's conflicting feelings within family relationships, and is laid down at the time when the child is already aware of the existence of members of the family in addition to his mother, including, of course, a sibling not yet born.

#### The Role of the Oedipus Complex in the Formation of the Superego

It seems that Freud believed the superego to develop relatively late, and to be invariably bound up in both sexes with the Oedipus complex. In his last major work, *An Outline of Psycho-Analysis* (Freud, 1940) he wrote: "The super-ego is in fact the heir to the Oedipus complex and is only established after that complex has been disposed of" (Freud, 1940, p. 205). The implication of this statement is that the only source of guilt in human beings consists of incestuous feelings for the parent of the opposite sex and hostile rivalry for the parent of the same sex. Our systematic research data using the technique of the unlocking of the unconscious surely demonstrates that this view is quite erroneous. Of course Oedipal conflicts are a major source of guilt, and in the clinical material presented here there is no doubt that murderous impulses toward the father in male patients, and toward the mother in female patients, play a prominent part. But where the father has been punitive and the mother passive and distant, as in the case of the German Architect, the murderous impulses would seem to be more obviously explained as a retaliation for the father's sadism rather than an expression of rivalry for the mother. Moreover, in cases such as the Woman who Bruised her Thigh, the murderous impulses indeed had their origin in a situation of jealousy and rivalry, but one that had nothing whatever to do with the Oedipus situation, namely the threat of being displaced in the mother's affection by the birth of a sibling; and, since this event actually occurred when the patient was 13 months old, it long pre-dated what Freud, though not Melanie Klein, would regard as the Oedipal period. Freud's narrow view of the origin of the superego is surely one of those that should be assigned to the historical museum.

#### Conclusion: The Role of the Superego in Neurosis

Our extensive clinical data emphasizes the immense importance of the punitive superego in the causation and maintenance of neurosis. The technique of unlocking of the unconscious and the direct view of the core neurotic structure indicates that all patients suffering from character neurosis who are highly resistant and poorly motivated have a punitive superego which have eroded their ego function and have impoverished their character structure. In cases of severe character neurosis, patients with highest

level of resistance, what we see is the invasion of ego functions by a harsh punitive superego with much more impoverishment of patient's personality. Our work in Intensive Short-Term Dynamic Psychotherapy highlights the importance of directing attention to the weakening of the punitive superego, and particularly its major contribution to resistance, as an essential part of a therapy. This is something that has been lost sight of by psychoanalysts and dynamic psychotherapists.

On the other hand, careful reading suggests that Freud did not underestimate the importance of the superego in his later writings, as is shown by two further condensed quotations from *An Outline of Psychoanalysis* (Freud, 1940, pp. 172-173):

The severest demand on the ego is probably the keeping down of the instinctual claims of the id. But the demands made by the super-ego too may become so powerful and so relentless that the ego may be paralysed, as it were, in the fact of its other tasks. We may suspect that the id and the super-ego often make common cause against the hard-pressed ego which tries to cling to reality in order to retain its normal state. If the other two become too strong, they succeed in loosening and altering the ego's organization, so that its proper relation to reality is disturbed or even brought to an end.

Our plan of cure is based on these views. The analytical physician and the weakened ego of the patient, basing themselves upon the real external world, are to combine against the enemies, the instinctual demands of the id and the moral demands of the super-ego. (Strachey's 1949 translation)

These ideas of Freud's have been entirely confirmed by my work. Indeed the whole concept of the superego, as expressing a need for punishment for aggression and yet itself being partly derived from aggression, appears to be one of the most essential both in the theory of neurosis and the practice of Intensive Short-Term Dynamic Psychotherapy.

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# Clinical Manifestations of Superego Pathology.

## Part II. The Resistance of the Superego and the Liberation of the Paralyzed Ego

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The present article is concerned with the handling of resistance in patients suffering from severe character and superego pathology. In these patients the ego is paralyzed by powerful forces generated (1) by repression and (2) by the superego, both of which manifest themselves as apparently impenetrable resistance in the clinical situation. Against this the traditional technique in which the therapist confines himself to interpretation is totally powerless. I have demonstrated that the therapist can exert a far more direct influence on the balance between therapeutic alliance and resistance than is possible by simply trying to make the resistance conscious. The main intervention consists of challenge to both forms of resistance. The result is a train of events ending with the paralysis of the resistance and the liberation of the patient's ego. These phenomena are illustrated by clinical examples.

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In Part I of the present article (see Davanloo, 1987c), I described a type of patient with the following characteristics: In their everyday life they manifest severe self-destructive behavior, impoverished personality, and sterile relationships; and at interview, when their unconscious is unlocked, they reveal extremely violent, murderous impulses directed against close members of the family and loaded with intense guilt, grief, and pain. Examination of the evidence led to the conclusion that these patients suffer both (a) from a loss of essential parts of the personality, due to repression, and (b) from an all-pervading need for punishment for their underlying impulses with intense guilt, which we can formulate as emanating from a severely punitive superego. The superego appears to have invaded and taken over the patient's ego, to have paralyzed its functioning, and to have replaced the normal search for satisfaction and fulfillment with an ever-present need for suffering.

The previous article was concerned with the light that these patients throw on psychopathology. The present article is concerned with the way in which this psychopathology manifests itself in the clinical situation and how the therapist can handle it.

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### The Nature of Resistance

When a therapist tries to reach any patient's unconscious he meets a quite tangible opposing force which we all know as resistance. Freud recognized very early in his work that this consisted of the same force as that holding unacceptable feelings and impulses in check within the patient, i.e., it is the force of repression now manifesting itself between patient and therapist. Much later he named it the "resistance of repression" in order to distinguish it from other forms of resistance which he had come to recognize. Of these the particular one with which we are concerned is the "resistance of the superego," which arises from the fact that the patient's need for punishment causes him to try and prevent the therapist from relieving him of his suffering (see Freud, 1926a, p. 160). It is clear that this also is a force originally within the patient, but now manifesting itself between patient and therapist in the clinical situation.

### Handling Resistance in Traditional Technique

In his paper, "Remembering, Repeating and Working-Through" (1914), Freud made clear that he regarded the removal of resistance as the analyst's primary task, and here he was clearly referring to the resistance of repression. He wrote optimistically: ". . . the doctor uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty" (1914, p. 147).

More than a decade later, in "The Question of Lay Analysis" (1926), he wrote of the resistance of the superego in much less optimistic terms: "The 'unconscious sense of guilt' represents the superego's resistance. It is the most powerful factor, and the one most dreaded by us." (1926a, p. 224).

More than a decade after this, in "Analysis Terminable and Interminable" (1937), he wrote even less optimistically of the resistance offered by patients under the influence of a severely punitive superego: "For the moment we must bow to the superiority of the forces against which we see our efforts come to nothing. Even to exert a psychical influence on simple masochism is a severe tax upon our powers" (1937, p. 243).

Throughout all Freud's writings on technique from 1910 onwards the instructions to the therapist are always that he should play a passive, waiting role, and that the one type of intervention in his armoury—whether for dealing with the resistance of repression or that of the superego—is interpretation. Thus just before the 1914 passage quoted above he writes:

Finally, there was evolved the consistent technique used to-day, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the patient's mind, and he employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient.

In "An Outline of Psycho-analysis" (1940) he writes in similar terms of the resistance of the superego:

In warding off this resistance we are obliged to restrict ourselves to making it conscious and attempting to bring about the slow demolition of the hostile super-ego. (1940, p. 180)

To summarize, Freud understood only too well both the importance and the nature of resistance, but in his attempts to deal with it he never progressed beyond pointing it out and trying to make it conscious. In view of the great length of psychoanalysis and its many failures, it is obvious that Freud's position of bowing to punitive superego, playing a passive waiting role and hoping that interpretation might bring about "slow demolition of the hostile superego" is totally, to say the least, unsatisfactory. In traditional technique no one has found a way of dealing with resistance, and least of all with the resistance of the superego.

### The Mechanism Involved in Interpretation of the Resistance

We may discuss this with the help of the trial therapy of a highly motivated responsive patient. The patient was a young man of 28, married for four months, complaining of sexual difficulties; a change in his feeling for his wife, and episodes where he becomes angry easily with her and emphasized that he wants to do everything that he can to keep his marriage. No attempt will be made to give every detail of all aspects of the trial therapy of this patient. I will primarily focus on those aspects of the interview to highlight the mechanism involved in the interpretation of the resistance as applies to motivated and responsive patients.

### Exploring His Marriage

He met his wife two years prior to marriage and indicated that his relationship with her was fantastic. All his difficulties began around the time of his marriage.

### The Day of the Wedding

*PT: I was like a cut-off, I was stunned, I was like I was doing something but my heart wasn't there . . . uh, mixed bag of emotions.*

*TH: Then as soon as you moved to marriage . . . you totally . . .*

*PT: Uh, I became so nervous the words didn't come out . . . I couldn't say my vows, I really don't even know what I was saying . . . I . . . remember the morning of the wedding, I just couldn't relate to anybody . . . probably suppressed feeling that I had all along you know . . . even I felt I wanted to pull out.*

*PT: Right away, the best that I can describe was that my heart wasn't there, my feeling, emotionally it wasn't . . .*

*TH: How was sex that night?*

*PT: I remember being scared that I wouldn't be able to do it, the thought that I would not be able to perform sexually.*

*PT: Once we got married, we stopped sexually . . . in a sense I stopped . . . which disturbs me as I want to keep the marriage.*

In the above passage we see the patient's clarity of communication, the fluidity and clearly his communication is within the context of the triangle of the conflict. He communicates in term of suppressed feeling that he has from the past, in term of anxiety as well as defense. Then he spontaneously talks about his masturbatory activity since the marriage and the therapist moves exploring his masturbation and structure of his fantasies while masturbating. This gives rise to resistance in the transference.

#### Resistance in the Transference

*TH: What was your fantasy during masturbation?*

*PT: I can't remember, I masturbated with my hand.*

Avoiding direct question he becomes detached and passive. As anxiety-laden area is explored, we see immediate mobilization of the resistance in the form of a series of defense, "I can't remember," detachment, passivity.

#### Handling Resistance in the Transference

*TH: How do you feel right now?*

*PT: As you see, tense . . . anxious. (Patient is clenching his hands on the arms of the chair)*

*TH: What else do you experience . . . besides anxiety?*

*PT: I feel frustrated. (Impulse)*

*TH: Still you keep your hand like that . . . ?*

*PT: I feel very tense.*

*TH: How do you experience your frustration . . . still you keep your hand like that . . . still you are distancing . . . putting up a wall. (Impulse, anxiety & defense)*

*PT: Yeah, hmm, I feel like grabbing something. I feel like kicking something.*

*TH: Uh hmm.*

*PT: I feel like getting it out . . . it is an energy.*

*TH: And if you let yourself go in term of thoughts and ideas.*

*PT: I would just kick . . . I get this energy, this anger out.*

*TH: Uh hmm.*

*PT: I can get it out of my system.*

Patient can clearly differentiate the three corners of the triangle of con-

flict and is very much in touch with his feelings which is one of the major features of patients who are motivated and responsive.

*PT: And if there was a punching bag here I would hit the punching bag.*

The process focuses on the triangle of the conflict in the transference in term of his positive feeling and his wish to protect the therapist against his anger.

#### T-C Link

Patient becomes sad with some tears in his eyes and gives an account of an incident. He and his wife had dinner at his parents home and his mother, as usual, was doting on him. When they returned home his wife was upset and told him that she could never match his mother in his eyes. He became very angry with his wife and had the impulse to punch her in the mouth. He became withdrawn, detached, and passive and indicated that he was afraid of his anger. The triangle of the conflict in the transference, namely impulse, feeling, anxiety and defense, was interpreted with the further T-C interpretation which involved the interpretation of impulse, feeling, anxiety and defense in relation to his wife. His resistance disappeared and he freely talked about the structure of his masturbatory fantasy which contained an older woman in her thirties, "well-shaped, large breasted, dark hair," different from his wife.

The whole process indicates the total absence of superego resistance, the presence of a healthy ego function; psychological mindedness, motivation for insight, the presence of therapeutic alliance from the very beginning of the interview. Now we take up the interview.

*TH: You said that prior to marriage sex was very good with Joanne.*

*PT: Yeah, was fantastic.*

*TH: Did you have fantasies of other women?*

*PT: Yeah.*

*TH: Then you would fantasize as if you were having sex with the other woman.*

*PT: Yeah, during intercourse I used to fantasize.*

*TH: Could you describe the woman in your . . .*

*PT: Again the older woman, dark hair, well-shaped.*

*TH: Different from your wife.*

*PT: Yeah.*

*TH: Now how about the wedding night . . . who was the woman in bed that you were attempting to have intercourse with?*

*PT: Joanne, plus.*

*TH: Who is the plus?*

With no further return of the resistance the process moves to the inter-

pretation of the patient's nuclear conflict which here is an oedipal triangular one.

If we examine the therapist's use of these interventions carefully we may see that: (1) He aims to make conscious (a) the underlying feeling and impulse, (b) the system of defense mechanism against the impulse/feeling, (c) the link between the two. (2) To make conscious the whole set of defense mechanisms and the genetically structured core-neurotic conflict. (3) He hopes that the result will be that the defensive barrier will be penetrated, the impulse becomes conscious, the whole intrapsychic mechanism will be undone and the resistance will be resolved. But now we need to ask the question, why does the intrapsychic mechanism become undone simply because it is made conscious?

The answer is far from simple, but seems to be as follows: First, the underlying unconscious impulse/feeling is striving for expression all the time, and if the therapist speaks of it explicitly he brings it nearer to the surface and renders the defensive mechanism more difficult to maintain. Second, the intrapsychic situation may be highly "ego-dystonic" and once the patient had been acquainted with his defense he had a very considerable motive for giving it up. Third, the therapist is largely relying on the healthy part of the patient to come to the realization (1) that the unconscious feelings and impulses are acceptable, and (2) that defenses against them are counterproductive. The therapist does not actually make these statements himself, though it is true that he implies them very indirectly. Thus in this kind of intervention the therapist is speaking both to the patient's unconscious and to his therapeutic alliance, aiming to mobilize both against his resistance. In the above case the intervention was successful.

This case mainly involved the resistance of repression, but exactly similar considerations apply to the resistance of the superego. For instance the therapist may interpret that the patient, because of his need for punishment, does not wish to be relieved of symptoms which cause him suffering. Here the aim is to make the inner mechanism conscious, to rely on the healthy part of the patient to realize that it is self-destructive, and to mobilize the therapeutic alliance against it.

When the patient comes into the category of those (1) who are highly motivated and responsive, (2) in whom resistance is relatively light and highly ego-dystonic, and (3) in whom the anxiety is no more than moderate—all of which was true of the patient described above—this kind of simple interpretation may be sufficient. But these highly responsive patients represent only a very small proportion of the psychotherapeutic population. In the majority of patients there is severe character and superego pathology, in many of them this pathology is ego-syntonic, and in some of them the underlying anxiety is potentially overwhelming. The result is that the resistance is so strong, and the unconscious therapeutic alliance so absent, that merely attempting to give the patient insight fails to shift the balance between the two. Thus the therapist who confines himself to interpretation is totally helpless against the forces operating against him. He ends up to bow to the forces of superego resistance and interminable interpretation of the resistance with the hope that "The slow demolition of hostile superego"

would be brought about, and in this process the patient's suffering is at stake. But what else can he do? The answer to this question is the theme of the present article.

### **The Forces Operating Within the Patient**

The forces operating against the therapeutic process all come under the heading of resistance, which can consist of the resistance of repression or the resistance of the superego, and can be concerned with feelings about relationships outside or with the transference. Resistance can be defined as the use of defenses in the therapeutic situation. The therapist encounters a series of defenses, many of which are the same as the patient uses in his everyday life, and in the clinical situation the terms "resistance" and "defense" can mostly be used interchangeably. Thus resistance belongs to the upper left hand corner of the triangle of conflict. The motive power for the defenses, or the resistance, comes from impulse, anxiety, guilt, or pain.

For our present purposes it is equally important to state that there is a part of almost all patients which is identified with their defenses and hence with their resistance, i.e., the resistance is ego-syntonic. At the extreme, patients will say that they like themselves, and will imply that they see no reason whatsoever why they should change.

Operating for the therapeutic process is the therapeutic alliance, which is complex and consists of conscious and unconscious components. The conscious component consists of the patient's willingness to cooperate with the therapist, to face the truth however painful, and to try actively to give up his defenses. The unconscious component consists basically of the repressed feelings and impulses—the lower corner of the triangle of conflict—which are pressing for expression and are therefore on the therapist's side. But until the final breakthrough the therapist will encounter the therapeutic alliance in a form modified by the resistance, manifesting itself as more or less disguised communications about any of the three corners of the triangle of conflict, especially the lower corner. These communications point the therapist in the right direction and help him in the process of bringing the underlying feelings to the surface.

### **The Forces Available to the Therapist**

Central to my technique of the unlocking of the unconscious is the observation that the therapist can do far more than simply attempt to make the resistance conscious and then rely on the forces within the patient to come to his aid. On the contrary, he can supply forces of his own which directly weaken the resistance and strengthen the therapeutic alliance. Here his essential intervention consists of challenge, which may be directed against the resistance or toward the therapeutic alliance. In the first, he speaks to the part of the patient that is identified with the resistance, calling in question each defense as it arises, casting doubt on it, and undermining it. In the second he speaks directly to the therapeutic alliance, challenging it to give the resistance up.

Audiovisually recorded data with a large series of patients from our research center demonstrates that these interventions do actually begin to shift the balance between resistance and therapeutic alliance. At a deep level, the patient "hears" the message and takes it in, and begins to turn against his own defenses. The tension within him rises.

However, this is only the beginning of the process, for now the same increase in tension appears between patient and therapist in the form of transference. This is complex and consists of both "negative" and "positive" components. The patient might become increasingly angry at having his defenses challenged; while on the other hand he deeply appreciates what the therapist is trying to do, namely to relieve him of his defenses which has paralyzed his autonomy and function.

In the type of patient with which we are concerned here, both forms of transference give rise to a further increase in resistance: the negative because the patient is afraid of his anger; and the positive because he is afraid of allowing emotional closeness, since in the past this has always resulted in disappointment.

The therapist now employs challenge against both these forms of transference resistance, calling the defenses in question and challenging the therapeutic alliance to give them up. However, it is crucial for him to understand that in this type of patient there is also a third form of transference resistance, namely the resistance of the superego, which expresses itself as the need to defeat the therapeutic process in the interests of self-punishment. The therapist challenges this by speaking of its self-destructiveness in forceful terms to the therapeutic alliance, using an intervention which I refer to as the "head-on collision."

When these interventions are timed correctly there are usually three main consequences. The patient's anger against the therapist reaches the surface and can be experienced directly; there is often intense sadness about self-destructiveness in the past; and the experience of anger frees positive feelings, which may take the form of a warm appreciation of the therapist's sustained determination to help, and a willingness to share the sadness openly with him. These feelings are complex and I have referred to them as "complex transference feelings." The unlocking of complex feeling in the transference has profound effect on the unlocking of patient's whole psychic system. This may be revealed first in the form of major communications from the unconscious therapeutic alliance, which throw light on important aspects of the patient's psychopathology. Now, with the help of some further analysis of resistance, it becomes possible to achieve direct access to the unconscious, so that the patient can experience the buried feelings from the past that have led to his neurosis.

#### **Signs in the Patient**

Obviously the therapist must be able to recognize which of these interventions to use at any given moment. This will depend on signs in the patient, which can be verbal or nonverbal:

First of all, the therapist must be familiar with all the different tactical defenses which patients use in the service of resistance. These take a very large variety of forms and at the same time are endlessly repeated from one patient to another. Examples are: vagueness, evasiveness, weepiness, intellectualization, obsessional rumination, defiance.

He must be able to monitor the patient's anxiety, the discharge pattern of anxiety, verbal cues such as facial expression, bodily posture, and respiration, so that he can prevent it from reaching an intolerable level.

He must be able to recognize when transference feelings are becoming a major issue. This might manifest itself from nonverbal cues, such as clenched fists or avoidance of eye contact.

He must be able to recognize signs that the unconscious therapeutic alliance is being mobilized. This comes mainly from verbal communications.

He must be able to recognize and accept genuine feelings as soon as it emerges.

Armed with these abilities, the therapist should be able to respond in each situation with the appropriate intervention. In this way he can operate like a skilled surgeon directing the forces within the patient, entirely in the patient's interest, and above all he can gradually drive the resistance into a corner so as to enable the patient to be freed.

The whole process will now be illustrated by a clinical example. Here I shall choose a patient who has already been presented in detail, the Woman with the Machine Gun (see Davanloo, 1987b). This will inevitably involve some repetition, but the presentation will be from an entirely different point of view.

#### **The Case of the Woman with the Machine Gun**

As described in the previous articles, this was a single woman of 30. She suffered from severe disturbances indicating the operation of a highly punitive superego, which included the following: lifelong recurrent depression; inability to fulfill her potential; inability to allow herself close to anyone, especially men; a pattern of allowing herself to be used and abused; inability even to know the meaning of anger; serious self-directed aggression. In other words, her healthy ego functions were largely paralyzed.

The theme of the previous articles was that patients manifesting this kind of depression suffer from a deep-seated inability to distinguish between anger on the one hand, and defenses against it or anxiety aroused by it, on the other. Consequently the therapist must modify his technique in two ways. First, he must use graduated rather than unremitting pressure and challenge to the patient's resistance, taking the pressure off as soon as he detects that he is arousing anxiety beyond a certain level, and only returning to pressure and challenge after the patient has been given time to recover. Failure to observe this rule arouses more anxiety than the patient can bear and results in exacerbating the patient's condition. Second, whenever there is a partial breakthrough of anger, he must drive home cognitive insight over and over again into the link between the impulse and the many defenses that the

patient has been using against it. If he does not do this no permanent effect will be achieved, and the defenses will merely reassert themselves the next time a situation of anger is encountered.

In the present article, however, these aspects will not be emphasized. The themes will be: (1) the paralysis of the patient's ego in everyday life, (2) the way in which this paralysis manifests itself in the form of resistance in the clinical situation, (3) the various forms of intervention used by the therapist against the resistance, and (4) the transformation that occurs when the resistance is finally broken through.

### **Resistance and Challenge in a Current Relationship (C)**

The interview quickly crystallized around a recent incident in which the patient had been severely humiliated by a man named Tony living in the same house. It was evidence for her need for self-punishment that, knowing that Tony had a cruel streak and liked to put people down, she had nevertheless made a sustained effort to seduce him. The result was that he had first led her on and then had ended up by taking refuge in his own room and hiding under the bedclothes. It was obvious that somewhere inside her she must have been very angry about this, and the therapist now embarked on the first phase of what I call the Central Dynamic Sequence, namely pressure toward the avoided feelings. This consisted first of asking the patient to describe what she had felt, and then, when she mentioned a feeling, to describe her actual experience. It quickly became clear (1) that in the actual situation she had completely avoided any experience of anger and had used the defense of withdrawal, and (2) that in the interview this same avoidance appeared in the form of resistance against describing anything other than defenses against her anger.

The interview now proceeded as follows:

*TH: And then how did you react to this situation?*

*PT: I got very remote for a few days. I stopped talking to anybody.*

Here the therapist used the only clarification that appeared in the interview for sometime, pointing out the defense:

*TH: But how did you feel? "Remote" is a mechanism you use to deal with the feeling at that moment.*

*PT: Uh yeah, I was hurt, I was very . . .*

The patient has now described a feeling, so the therapist asks her to describe her actual experience:

*TH: What was the way you experience this hurt?*

In response the patient again describes a defense:

*PT: By pulling away from the other three people in the house.*

The therapist kept up the pressure. The patient described being "humiliated" and "angry," so the therapist asked her to describe her physical experience of anger—since the physical manifestations are likely to be less anxiety-laden than the feelings or impulses themselves. Some of the patient's responses are given below:

*PT: There was no physical reaction . . . I was just angry. There was nothing really noticeable. I wasn't that angry, I was humiliated . . . I don't remember having any kind of . . . I did not get the shakes . . . I went to bed, that is how I physically reacted.*

The therapist now employs the first challenge:

*TH: But that is flight.*

### **The Nature of Challenge**

This extremely brief intervention on the part of the therapist contains many of the essential ingredients of challenge and can be used to introduce a discussion of the whole subject:

First of all, we may consider what the therapist might have said at this point if he had decided to give an interpretation. The following is a possibility:

*TH: Surely you went to bed to avoid the situation (defense) because you were afraid (anxiety) of your anger (impulse).*

This interpretation completes the triangle of conflict in the area of C. Of course it is absolutely correct, but in my view it would be purely an intellectualization and in the service of resistance. The anger is much too deeply buried, no internal shift would occur, and the patient would hear nothing more than a theoretical statement. The actual intervention differs in the following ways:

- (1) It concentrates entirely on the defense;
- (2) The word "but" calls the defense in question; and
- (3) The word "flight" conveys an attitude toward the defense containing a subtle but unmistakable lack of respect for it.

This leads to an extremely important point: almost all defenses are at least in part "ego-syntonic," i.e., there is a part of the patient that accepts them and identifies with them. At the extreme (which did not apply to this particular patient) they are completely ego-syntonic, and if such patients are asked they will say they regard their defensive system as part of their personality and are entirely satisfied with it. The therapist's attitude of scant respect for defenses is aimed, not at the patient, but at the part of the patient that is identified with her defenses. It aims to challenge her acceptance of her defenses and to mobilize the therapeutic alliance against them—to turn

the patient against her resistance. Finally, we may note that this particular challenge is directed against the resistance of repression rather than that of the superego.

#### **Return to Enquiry**

By now it had become clear that the patient was not merely resisting the description of anger, but was incapable of experiencing it. This meant that the modified technique described above must be used, and therefore the therapist took the pressure off for the time being, asking her to describe what happened next.

Again all she could describe was a series of defenses: She said she was "flabbergasted," "embarrassed," and "confused," that she felt "sorry for the jerk," and finally that she resigned herself to accepting that "it was not a big deal." The therapist now returned to pressure and challenge, employing two new types of intervention.

#### **Drawing Attention to Nonverbal Signals**

As already mentioned, the therapist is employing a modified technique, in which his interventions are used with caution. Nevertheless, when used, they all have the same aim, namely to shift the balance between resistance and therapeutic alliance, which inevitably means raising the tension within the patient. The therapist draws attention to nonverbal signals by which this increase in tension is being betrayed. Since the patient is trying to keep the tension to a minimum, this clear message that she is failing to do so raises the tension further:

*TH: We are looking to your reaction.*

*PT: Physical reaction was virtually nil. (One of her hands, which was hanging, has changed to a fist.)*

*TH: You notice you put your fist like that?*

*PT: Yeah, I know. (She smiles.)*

*TH: You smile now.*

#### **Challenge to the Resistance of the Superego**

The therapist has perceived that this patient has a pattern of letting herself be used and abused. In such patients it is essential to challenge the contribution to the resistance made by the superego as well as that made by repression. The therapist does this by repeated use of the word "crippled"—a word which both (1) accurately describes the operation of the superego, and at the same time (2) brings home to the patient the self-destructive effect that her defenses have upon her, and thus (3) aims to turn her against them. Here the therapist is directing his challenge toward the therapeutic alliance and against the resistance of the superego.

*TH: Do you notice that you are crippled to declare to yourself how you*

*really feel? . . . Flight is another form of being crippled . . . Either you are not able to assert yourself, and the other person walks all over you, or the other way is to take flight from a situation. So both of them are crippling for a young woman of your age.*

However, it became clear that this approach was in danger of arousing too much anxiety, since the patient now withdrew entirely from her former position and completely denied her original statement that she had been angry.

*TH: Let's see how you felt. You said you felt angry.*

*PT: No, I didn't, I didn't.*

The therapist therefore reduced the pressure once more, giving her time to recover from the underlying anxiety.

#### **Reducing the Pressure by a Return to Enquiry**

The therapist asked what happened subsequently, and the patient gave evidence that her therapeutic alliance was able to respond since she described a second incident with the same characteristics as the first. She had been further humiliated by Tony, who had had sex with her sister Linda in the room next to her room. The therapist returned to pressure on her feelings. Once more she used the word "anger" but when pressed could only describe defenses:

*PT: That episode was more humiliating . . . That is the worse I've ever experienced. Then I experienced the anger . . . I don't know if it was anxiety, but I didn't sleep . . . I was ruminating, thinking about what was happening . . .*

*TH: What was your reaction?*

*PT: Uhh, aside from the lack of sleep I was, uhh . . . I gotta think back because I . . . I haven't blanked it out, otherwise I wouldn't remember any of it, but I . . .*

#### **Return to Challenge to the Defenses in the Area of C**

The therapist senses that the patient can now withstand further challenge, and he therefore mounts a sustained challenge on both the resistance of repression and that of the superego:

*TH: Do you notice you have tremendous difficulty to declare your negative feeling? You say you were devastated, humiliated.*

The words "Do you notice?" are very carefully chosen both to speak to the therapeutic alliance and to convey, in a striking way, a lack of respect for the resistance of repression and the part of the patient that is identified with it.

The therapist continues with challenge on superego resistance.

*TH: In a sense you are almost crippled here to tell me how you really felt.*

The therapist knows that his repeated challenge will have activated powerful transference feelings, which in turn will have intensified the resistance. The words "here" and "tell me" draw attention to the here-and-now and prepare the way for challenging this new aspect of resistance. For emphasis the therapist repeats the word "here" in the following passage:

*PT: Yeah, but to say how I feel. You see if I say I'm angry . . .*

*TH: But you are crippled almost, here, here . . . A woman at the age of 30 so paralyzed to talk about her emotions and feelings . . . You are almost crippled here.*

*PT: Yes.*

#### Challenge and Pressure Directed at the Resistance as well as Toward the Therapeutic Alliance

The therapist now begins to try and activate the therapeutic alliance by challenging it directly:

*TH: Yes is not enough. Let's see what you are going to do about it.*

*PT: But I don't know why.*

The therapist immediately blocks any tendency toward intellectualization:

*TH: Here right now we are not looking at why you are crippled. We are looking that you are crippled, that you are paralyzed. First we have to identify that you are crippled and paralyzed.*

*PT: Okay (softly).*

*TH: Then we have to see what you are going to do about it.*

The therapist now turns his attention to activating the underlying feeling:

*TH: You must have a lot of feeling about such a disastrous situation . . . toward Tony, who humiliates you in that way. And also Linda who is humiliating you, hmm?*

*PT: Yeah.*

*TH: But "yeah" is not enough. Let us see how you really feel.*

The patient prevaricates:

*PT: How I felt then or how I feel now towards them?*

*TH: Then or now, because obviously these are the ulcers of your life.*

These striking words are chosen to challenge the ego-syntonic aspects of the patient's defenses and to begin to make them ego-dystonic.

#### Challenge to the Resistance in the Transference

Throughout all this the therapist has been carefully watching the patient's nonverbal responses, monitoring both the level of anxiety and the activation of underlying feeling. All the indications are both that anxiety is at a tolerable level and that feelings are much nearer to the surface. Therefore the therapist turns his attention to the resistance in the transference.

He opens with a challenge to the resistance of the superego in the transference:

*TH: What I'm bringing to your attention is that even when you want to talk about it you are taking a paralyzed, crippled position with me.*

*PT: Because I'm not accustomed to telling people how I really feel.*

This response betrays another crucially important component of transference resistance, namely refusal to allow emotional closeness. The fact that the patient actively communicates this aspect of her resistance, thus giving the therapist the opportunity to challenge it, indicates that her unconscious therapeutic alliance is beginning to be mobilized:

*TH: And you prefer to call me "people" rather than me. Do you notice that? . . . In a sense you say, "I don't want to share with you or let you—that is me—to get close to my intimate thoughts and my intimate feelings."*

*PT: Yes it is, yes it is, it is what I'm saying.*

Thus the patient has said almost explicitly that she is identified with this defense, which is essential to challenge:

*TH: . . . Then a major problem is between you and me.*

The therapist now continues to challenge and pressure the patient's unwillingness to allow emotional closeness. In response the patient becomes argumentative and slightly defiant, thus once more revealing that she is identified with this defense, and—even more important—that her feeling of anger in the transference is coming nearer to the surface:

*TH: I'll tell you why it is a major obstacle . . . And I have a feeling that you have a major problem with intimacy and closeness.*

*PT: Well I don't know how I am supposed to correct it.*

*TH: We should identify it. Is it or isn't it?*

*PT: Yes.*

*TH: You are putting a wall?*

*PT: Yes, But I'm not putting one, it's already there. It's there when I walked in.*

*TH: Okay, is there, doesn't make a difference. Putting it consciously or putting unconsciously, still is there.*

The patient continued argumentative and the therapist now took this as his cue to introduce the most powerful of all his interventions.

### The Head-On Collision with the Resistance

In this intervention the therapist mounts a concerted challenge and pressure on two aspects of resistance, essentially in the transference: (1) the patient's identification with it, and (2) the part that is maintained by the superego. The aim is to call in question, in the strongest possible terms, the patient's self-destructiveness—a feature of her pathology which permeates her life and is now manifesting itself in the therapeutic situation. In the following passage the therapist's remarks have been highly condensed:

*TH: Let's look at it. You and I are here together. The aim is that you and I can establish the nature of your difficulties and problems that are paralyzing your life. So when the wall comes up between you and me we will not be able to understand the nature of your difficulties, the engine of all your problems.*

*PT: But I don't even . . .*

*TH: Then this process is doomed to fail. Then I would become useless to you. At some point today we depart from each other. I say, okay, I did my best to get to understand this woman's difficulties . . . in life but then I failed. I can afford to fail because I cannot always be successful, but can you walk from this office and perpetuate your paralyzed life? Can you?*

*PT: I didn't expect to walk out of here cured today. I don't know what to say.*

*TH: But do you see what I mean?*

*PT: Yes, I . . . I . . .*

*TH: Right now we see there is a self-sabotaging pattern in you.*

*PT: Of course there's a wall there. If there wasn't . . .*

The therapist makes a challenge directed toward the therapeutic alliance:

*TH: Yeah, but first is what are we going to do about this wall?*

*PT: Today I don't know, besides identify the fact that it is there.*

*TH: Yeah, but you see again you want to postpone it, which is another form of flight.*

*PT: No, I think it's called being realistic.*

Her voice rose as she said this, so that again there was clear evidence of an increase in transference. The therapist takes up the underlying implication, which of course she had not stated explicitly:

*TH: Now what you say is that I am unrealistic. Is it that?*

The patient gives nonverbal clues to her avoidance of negative transference feelings, which the therapist immediately challenges:

*TH: You see again you don't want to look to my eyes and say I am unrealistic.*

*PT: I don't know what you want from this. What I want . . .*

The therapist again directs a challenge toward the therapeutic alliance and against the resistance of the superego:

*TH: Now you see again you use "what I want from this." We are here to get you out of this crippled life.*

Now the patient says explicitly that it is a crippled life, thus forcing her to confront the incongruity of her situation and undermining her identification with it:

*TH: Of course you are the one to decide, is it a crippled life or isn't it?*  
*PT: Yes, it is.*

He now seeks to activate the feelings that all patients must experience if they realize the true extent of their self-destructiveness, namely grief and remorse:

*TH: And it is sad that a woman of your age is running a life which is so paralyzed.*

Suddenly nonverbal clues make clear that her resistance is not impenetrable, that this intervention has struck home, and at the same time that she is trying to avoid revealing this. The therapist draws attention to both aspects:

*TH: And you also have tears in your eyes and you avoid my eyes. Do you notice that you avoid my eyes?*

The patient is very close to her feelings:

*PT: I don't like to cry (spoken softly).*

*TH: How do you feel when you look at my eyes? (The patient is sniffing.) . . . because you are avoiding me in a sense.*

*PT: I know I am.*

The therapist challenges the ego-syntonic aspect of this part of her resistance and at the same time makes the anxiety explicit:

*TH: And I am repeatedly saying that avoidance is part of your problem  
You are terrified of closeness with me.*

*PT: Yes.*

The therapist now concentrated on challenging the patient's avoidance of eye contact.

*TH: Again your eyes are not with me.*

*PT: I know. (She smiles.)*

*TH: A smile, hmm. (She laughs.) A cover-up. You know, I feel you are a woman of facade.*

*PT: I'm very good at that.*

The clearly expressed ego-syntonic aspect of this is immediately challenged;

*TH: Yeah, but when you say you are very good at that, that is the ulcer of your life.*

This intervention heralded a period of systematic challenge and pressure to the transference resistance, with special reference to the head-on collision with the resistance of the superego. This will only be summarized because it consisted largely of a repetition of themes that have already been described:

*TH: . . . there is a need in you to sabotage . . . you set a goal for yourself and you defeat that goal . . . then we depart from each other and this process would be a failure, like your life . . . If this process is defeated then you might go and carry a crippled life to your grave . . . why should you do that?*

This systematic challenge continued for sometime. There was now a difference from before, namely that anxiety did not rise to intolerable levels and the therapist was able to sustain his challenge without interruption. Eventually she was able to acknowledge that she was angry with him. He reminded her of the incident with Tony in which she had said that she was angry, but in fact all that she had experienced had been first anxiety and then detachment, and she had ended up by self-directed aggression, banging her hands against the wall and severely bruising them.

#### Breakthrough of the Impulse in the Transference

Suddenly the first breakthrough occurred. The patient raised her voice and said, "This is different."

*TH: In what way is it different?*

*PT: (With raised voice) I am telling you that I am angry.*

*TH: If you put it out in terms of thoughts and ideas, what would you want to do to me?*

(The patient raises both her clenched hands at the therapist. Her voice is loud.)

*PT: I would grab your lapels and shake you badly.*

In this passage it was quite clear that she was truly in touch with her anger, and this was entirely confirmed when she revealed a major difference from the previous incident with Tony: "With you my head is very clear, but with him I was very confused."

In the rest of this first part of the trial therapy the most important type of intervention by the therapist was to drive home insight into the variety of defense mechanisms that she used against anger, and the distinction between anger and anxiety. As described above, this is essential in order to prevent the defenses from reasserting themselves automatically the next time anger is aroused in her.

All the evidence now suggested that her defensive system has been "restructured," and that when she returned for a second part of the trial therapy unremitting pressure and challenge could be safely used.

#### Second Part of the Trial Therapy: Unremitting Pressure and Challenge to the Resistance

The patient returned in a state of renewed and apparently impenetrable resistance. The therapist mounted challenge and pressure on this. The following are examples of the challenges used:

*TH: You are looking at the carpet or the wall, avoiding my eyes and maintaining a paralyzed, detached, remote position. Why do you want to do that?*

(Challenging the patient's transference defenses, speaking to the therapeutic alliance).

*TH: Let's see how you experience the rage. (Pressure toward the avoided feeling.)*

*PT: . . . I'm not experiencing it. I don't know how to get rid of it.*

*TH: But still you are ruminating on helplessness. (More lack of respect for the defenses.)*

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*PT: I'm not saying there is no anger. (Some shift, but the indirect speech and double negative completely eliminate any true feeling.)*

*TH: There is anger in you. We know that but we don't know how you experience it. And look to your hand again.*

*PT: I'm pushing it down. I'm pushing it back, I'm pushing it so far back.*

*TH: . . . You are taking a defiant, crippled position with me. (The juxtaposition of "defiant" and "crippled" is aimed to make her defiance ego-dystonic.) . . . You are taking a defiant position, . . . and defiance is another part of this wall. The paralyzed, crippled, woman, and becoming retarded. Now, you see, totally paralyzed.*

Gradually the transference feelings come nearer to the surface, as the patient raises her voice:

*TH: How do you experience this rage here with me, if you look into my eyes?*

*PT: I'm not! I don't know how! I don't know how to describe it!*

As the feelings came nearer to the surface the patient described manifestations of tension in her voluntary muscles. "I get tight in the jaw and the throat . . . I stop sweating."

Finally the feelings broke through:

*TH: If you put it out, how would this rage be like?*

*PT: I, I, I'm yelling. I'm moving my, my arms, slashing around . . . (With a loud voice) This is it! This is it! This is what it is!*

*TH: Are you angry right now?*

*PT: Yes I am. (Very firm and loud voice.)*

*TH: What else?*

*PT: I stop sweating . . . Shouting . . . Ah, clarity up here. (Referring to her head.)*

There was then a further period of consolidation in which the therapist drove home insight into her former defense mechanisms. During this it emerged that there had been a previous occasion in her teens when she had expressed anger—against her brother—by bruising her hands. The therapist made links between her mechanisms for dealing with anger in the three situations, transference, current, and past (a TCP interpretation). The patient said, "I always thought that was the anger."

The therapist now brought out that, side by side with her anger with him, there was a wish to protect him. Then, suddenly, the unconscious therapeutic alliance produced a crucial communication: "If it all comes out, God knows what I'll do."

The therapist seized upon this, pressing her to say what she would be like if she became violent.

*PT: Yeah, yeah, very, very, umm, cold, ah . . .*

Suddenly there emerged the most important moment in the interview so far, pointing the exceedingly striking contrast from what had gone before—for now, instead of finding some new way of avoiding the issue of her feelings, she insisted on seeing her fantasy through:

#### **The Unlocking of the Unconscious**

*PT: No, no, let me talk this through, umm, if I, if I'm very violent, cold and unfeeling, umm, umm, very efficient in the violence . . .*

Deeply involved, she now proceeded to unfold a fantasy of buying a

machine gun, learning how to use it, and murdering her mother. As she spoke of it she became intensely sad, crying, with waves of very painful feeling, her inner turmoil revealed by the expression on her face. When she had been taken through every detail of the murder of her mother, the therapist made the link with her lifelong paralysis, the punishment constantly inflicted on her by her punitive superego. The patient's response revealed her deep understanding of this:

*TH: Because your life is like the life of a murderer if you look at it.*

*PT: I'm in hiding . . . I've been hiding for all these years.*

The therapist now knew that she had the strength to face the whole of her unconscious, and he went on, relentlessly, to take her through the murder of almost all the important people in her life—her father, her sister, her brother, and finally the man Tony whose humiliating behavior had precipitated her recent depression.

Afterwards, very sad she spoke of some of her feelings about what had happened:

*PT: I'm physically very weak, and surprised too. I wasn't expecting thoughts like that to come into my mind . . . There is the feeling that although this is frightening it is vitally important. And that tempers the anger with you. That is constructive. You are like a catalyst. And that is good. That's what I badly need. There is a feeling of confidence. There is a realization of being able to remember things and talk about them that I didn't even know were there. And nobody dropped dead.*

*TH: How do you feel right now?*

*PT: Relieved and shaky.*

It was now possible to take her through the history of her past, which so far had hardly been mentioned, and to discover the situations and relationships which had led to her neurosis. It emerged that in the very early years of her life she had a close relationship with her parents. Then her brother was born and became the favorite of their father and shortly after that a sister was born who again became the favorite of both parents. She had totally lost her place. She developed a very close relationship with her paternal grandmother who became like her substitute mother. The family moved to another country for sometime when she was in her teens which separated her from her grandmother and resulted in her first major depression. When she was in her adolescence the family again moved for awhile to another country which again separated her. This brought about her second major depression. It is interesting to note that for a few weeks after trial therapy she went through hallucination of the smell of dishes that her grandmother used to cook for her and she even searched for the recipes so that she could recapture some of the good experiences of her childhood.

## Discussion

The second interview illustrates the technique of unlocking of the unconscious and the systematic erosion of resistance in a highly self-destructive patient. It is worth while reviewing the whole process once again.

From the moment when the therapist began to press her for her feelings about the incident with Tony, until the first breakthrough of her anger in the transference many pages of transcript later, the patient showed virtually nothing but resistance, much of which was ego-syntonic. The therapist, entirely in the patient's interests, activated the forces within her by means of the following sequence of interventions:

(1) Challenging the resistance of repression in the area of C: e.g. "But that is flight," which calls the defense in question and casts doubt on it by treating it with studied disrespect.

(2) Drawing attention to nonverbal clues which betray her denial of feelings in the area of C: PT: "Physical reaction was virtually nil." TH: "You notice you put your fist like that?" This clearly threatens to activate the patient's anger and thus increase the tension.

(3) Speaking to the therapeutic alliance with the words "do you notice . . .?", attempting to mobilize it against the resistance of the superego, ". . . that you are crippled to declare how you really feel"? "You are almost crippled here to tell me how you really feel."

(4) Further calling in question the resistance of the superego: "A woman at the age of 30 so paralyzed to talk about her emotions and feelings."

(5) Directing challenge and pressure toward the therapeutic alliance and against the resistance of the superego: "Let's see what you are going to do about it."

(6) Using striking language to mount challenge on the patient's identification with her own defenses: "Obviously these are the ulcers of your life."

(7) Challenging the resistance against allowing emotional closeness in the transference: "You don't want to let me get close to your intimate thoughts and feelings."

(8) Challenging the patient's identification with her resistance against emotional closeness: "Then this is a major problem between you and me."

(9) The head-on collision with the resistance of the superego in the transference, speaking directly to the therapeutic alliance: "When the wall comes up between you and me . . . this process is doomed to fail. There is a self-sabotaging pattern in you."

(10) Challenging the nonverbal signs of resistance against negative transference feelings: "You don't want to look into my eyes and say I am unrealistic."

(11) Activating the underlying grief about her own self-destructiveness: "It is sad that a woman of your age is running a life which is so paralyzed."

(12) As signs begin to appear that this grief is in fact coming to the surface, the therapist challenges the nonverbal signs of resistance against

sharing it with him: "Do you notice that you have tears in your eyes and you avoid my eyes"?

(13) Return to the head-on collision with the resistance of the superego: "There is a need in you to sabotage. If this process is defeated then you might carry your crippled life to your grave."

(14) As the patient admits that she is angry with him, the therapist emphasizes her former mechanisms for avoiding anger: first she experienced anxiety, then detachment, and then she ended up by self-directed aggression.

(15) This leads to the first breakthrough of anger in the transference: "I would grab your lapels and shake you badly."

(16) The therapist ends the first part of the trial therapy by once more driving home insight into her mechanisms for avoiding anger.

(17) In the second part of trial therapy she returns in a state of resistance. The therapist mounts challenge and pressure on her defenses against negative feelings in the transference, first drawing attention to nonverbal signals of resistance and treating the defenses with studied disrespect: "You are avoiding my eyes and maintaining a paralyzed, detached, remote position."

(18) Challenge directed toward the therapeutic alliance: "Why do you want to do that"?

(19) Activating the underlying negative transference: "Let's see how you experience the rage."

(20) Further challenge to the defenses: "You are ruminating on helplessness."

(21) Drawing attention to nonverbal signs of anger: "There is anger in you. And look to your hand again."

(22) Challenging the patient's identification with her resistance, making it ego-dystonic: PT: "I'm pushing it so far down." TH: "You are taking a defiant, crippled position with me."

(23) At last the breakthrough into direct experience of anger in the transference, with the accompanying signs of reduction in anxiety: "I'm yelling. This is it! I stop sweating. I'm shouting. Ah, clarity up here."

(24) Further consolidation of insight into her defense mechanisms, followed by the description of an incident of self-directed aggression in her teens, and a TCP interpretation of defense and impulse.

(25) Bringing out positive transference feelings—the wish to protect him from the worst of her anger.

(26) There is now a major mobilization of the unconscious therapeutic alliance, with a clear message about the violence of her feelings: "If it all comes out, God knows what I'll do."

(27) The unlocking of the unconscious. The final breakthrough into her unconscious murderous feelings, first against her mother and then against almost everyone who had been close to her.

(28) The direct view of the multifoci core neurotic structure.

In her life outside this patient had been largely paralyzed. She suffered

from the following: lifelong recurrent major depression, inability to fulfill her potential, inability to allow anyone close to her, inability to form any kind of relation with a man (and when she did try she picked a cruel man who deliberately humiliated her), inability even to know the meaning of anger, serious self-directed aggression. In the interview there was a similar paralysis: As soon as the therapist started exerting pressure toward her feelings almost all that could be observed was resistance, much of which was ego-syntonic. And yet, after the systematic work described above on the forces within her, there was a major mobilization of the therapeutic alliance and a major breakthrough into the repressed unconscious. Here the crucial observation was that—as with all patients when a major breakthrough is achieved—there was no trace of a return of the resistance from then on.

With these highly self-destructive patients, it is as if the ego is driven against the wall, cornered, and paralyzed. If the therapist does not know how to deal with this and takes a passive waiting role for “slow demolition of superego resistance,” he will be cornered and paralyzed by the superego resistance, along with the patient. But there are weapons at hand, and if he knows how to use them he can systematically gain the upper hand and end by driving the resistance into a corner and paralyzing it in its turn. Then, in an instant, the whole psychic system becomes available, the ego recovers its normal powers, and the patient herself can enter the world of freedom.

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# Overview: Trial Therapy in Intensive Short-Term Dynamic Psychotherapy

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This article briefly summarizes Davanloo's technique of trial therapy model of initial interview and its application to the whole spectrum of structural neurosis. The major function of trial therapy is elaborated in terms of psychodiagnostic, psychotherapeutic function as well as teaching, supervision, and clinical research.

## Introduction

With the discovery of the technique of the “unlocking of the unconscious” by Davanloo, direct view of the unconscious and multifoci core neurotic structure has been made available to both therapist and patient. This is considered a revolutionary development in dynamic psychiatry and has been able to confirm many aspects of psychoanalytic theories and has revised other aspects of psychoanalytic concepts.

The major goal of this article is to present a general overview of Davanloo's system of Intensive Short-Term Dynamic Psychotherapy. What is presented here is from his seminars at the Center for Teaching and Research of Short-Term Dynamic Psychotherapy of the Montreal General Hospital as well as his presentation at the Immersion courses of the International Institute for Teaching and Research for Short-Term Dynamic Psychotherapy..

## Trial Therapy Model of Initial Interview

Since learning the technique of the trial therapy and the technique of the “unlocking of the unconscious” is central to Dr. Davanloo's system of Intensive Short-Term Dynamic Psychotherapy, I would like to review some of the major aspects of his presentations.

## Major Function of the Trial Therapy

The major functions of Davanloo's system of trial therapy can be summarized as follows:

\*The author would like to acknowledge with grateful thanks the permission of H. Davanloo, M.D. to summarize some of his lectures and extensive audiovisual presentations.

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# The Central Dynamic Sequence in the Unlocking of the Unconscious and Comprehensive Trial Therapy. Part I. Major Unlocking

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This two-part article describes the discovery of the technique of the major unlocking of the unconscious by the author. The central dynamic sequence which brings about direct access to the unconscious is illustrated by process analysis of the trial therapy of a patient suffering from a masochistic character pathology.

The discovery of the technique of unlocking the unconscious by the author provides a unique opportunity for both the therapist and the patient to have a direct view of the patient's multifoci core neurotic structure.

As I outlined in previous publications, this technique of a rapid uncovering of the unconscious offers the clinical researcher in the field of psychoanalytic psychotherapy an unrivaled opportunity to check aspects of psychoanalytic theory of neurosis against empirical evidence.

## Handling the Resistance

I have already discussed the nature of resistance, resistance of repression, and superego resistance. I outlined that patients who are at the extreme left of the neurotic spectrum, who are highly motivated and responsive, show major fluidity in their character structure, and suffer from neither character pathology nor resistance arising from the superego. But as we move to the right-hand side of the spectrum of structural neurosis we see cases suffering from severe character and superego pathology. Here we can generalize based on our extensive clinical data and state that in all patients on the right side of the spectrum the ego and its major functions are paralyzed by powerful forces generated by: (1) repression, and (2) the superego, both of which manifest themselves as impenetrable resistance in the clinical situation. While in previous publications I described various types of intervention that can be used in handling resistance and making direct access to the patient's uncon-

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scious possible, in this two-part article I primarily will focus on the central dynamic sequence essential in the process of the unlocking of the unconscious. The process will be illustrated by an analysis of the trial therapy of a patient.

### The Central Dynamic Sequence

The whole process which is used in trial therapy is divided into a series of phases, each consisting of a specific type of intervention with its corresponding response. But the phases tend to overlap, and most interviews contain a good deal of repetition and the process proceeds in a spiral rather than a straight line. The central dynamic sequence can be summarized as follows:

**Phase (1) Inquiry.** Exploring the patient's difficulties, initial ability to respond; is the phase of descriptive, dynamic phenomenological approach to patient's psychopathology.

**Phase (2) Pressure.** Leading to resistance in the form of a series of defenses.

**Phase (3) Clarification and Challenge to Defenses.** This phase can be summarized as:

- (a) Rapid identification and clarification of the defenses.
- (b) Challenge to the defenses, leading to rising transference and intensification of the resistance.
- (c) Further clarification of the defenses; casting doubt on the defenses.
- (d) Systematic attempt to make the patient acquainted with the defenses that have paralyzed his functioning.
- (e) To turn the patient against his resistance; the patient must clearly see that his resistance that has paralyzed his functioning is being challenged.
- (f) Challenge that is directed against the resistance; challenge to the resistance against experience of impulse/feeling outside of the transference; challenge to the resistance against experience of the impulse/feeling in the transference; challenge to the resistance against emotional closeness in transference.
- (g) Head-on collision with character resistance with special reference to the resistance against emotional closeness in the transference and resistance maintained by the superego.

### Phase (4) Transference Resistance.

- (a) Clarification and challenge to the transference resistance. The emphasis is on the resistance in the transference.
- (b) Head-on collision with the transference resistance with special reference to that maintained by the superego.

- (c) Exhaustion of the resistance and communication from the unconscious therapeutic alliance.
- (d) To maximize the inner tension between unconscious therapeutic alliance and resistance.

### Phase (5) Intrapsychic Crisis.

- (a) High rise in the complex transference feeling; direct experience of the C.T.F.; the triggering mechanism for the unlocking of the unconscious.
- (b) Mobilization of the unconscious therapeutic alliance; creation of internal conflict and tension between therapeutic alliance and resistance; finally to turn the therapeutic alliance against the resistance.
- (c) The first unlocking of the unconscious.

**Phase (6) Systematic Analysis of the Transference.** Leading to the resolution of the residual resistance with partial or major de-repression of the current or recent past (C) and distant past (P) conflicts.

### Phase (7) Further Inquiry Exploring the Developmental History.

**Phase (8) The Phase of Direct Access to the Unconscious.** Direct view of the multifoci core neurotic structure and its relation to the patient's symptoms and character disturbance; and psychotherapeutic planning.

As I have already stated, not all therapies proceed in exactly this simple sequence. The phases tend to overlap and proceed in a spiral rather than a straight line. However, for those interested in learning the technique of Intensive Short-Term Dynamic Psychotherapy, the central dynamic sequence can be seen as a framework which the therapist can use as a guide, constantly working from one phase to another. With the exception of patients who suffer from severe fragile ego structure, the whole spectrum of structural neurosis are good candidates for Intensive Short-Term Dynamic Psychotherapy. But the evaluator should take into consideration that the ease with which the breakthrough can be achieved and the relative emphasis on different types of intervention depends on a number of variables. For example, the phase of inquiry which is a dynamic phenomenological approach to the patient's psychopathology outlining the patient's symptom disturbances and character disturbances varies from the left-hand side of the spectrum to the right-hand side of the spectrum. Patients on the extreme left are highly responsive with major fluidity in their unconscious and with great lucidity they describe their problems. But patients on the right-hand side of the spectrum, particularly those with ego-syntonic character pathology, are not able to respond. They have heavily identified with their resistance and they enter the interview with major character resistance, and the process immediately moves to the phase of identification and clarification of the patient's defenses.

## 4 DAVANLOO

**Partial and Major Unlocking of the Unconscious**

The degree of unlocking of the unconscious is exactly in proportion to the degree that the patient has experienced the complex transference feeling. In major unlocking of the unconscious under systematic challenge and pressure to the patient's resistance there is a breakthrough of the impulse in the transference which is accompanied by the breakthrough of the guilt and grief-laden unconscious feelings (the case of the machine gun woman, the case of the woman who frequently bruised her leg). But if the therapist aims at the partial unlocking of the unconscious the therapist must monitor the central dynamic sequence in such a way that the breakthrough of the impulse in the transference is partial. In this procedure the breakthrough of the aggressive impulse in the transference is partial but the breakthrough of the guilt and grief-laden unconscious feelings is at a much higher degree. The partial breakthrough into the unconscious is extremely important in controlled clinical research where a waiting list is essential.

I have repeatedly emphasized the care and vigilance with which this technique must be used and the therapist must undergo extensive training in utilizing such a powerful technique. In this two-part article I give an example and analyze the case in depth and again emphasize the technical skill and vigilance in the process of the unlocking of the unconscious.

**The Case of the Fragile Woman**

The patient is a 32-year old divorced woman. She had been interviewed one week previously by a relatively experienced trainee who had suspected the presence of a severely fragile ego structure. The present author, the second independent evaluator, undertook to interview her not knowing anything about the patient except a question mark of the possibility of a severely fragile ego structure. The interview needs to be considered in advance in terms of the phases listed above. As described, the therapist usually opens with a question about the patient's presenting complaints and continues with a certain amount of psychiatric inquiry. However, many patients—including the present one—arrive at the interview betraying obvious feelings which usually have an important transference component. The therapist then opens with a question, "How do you feel right now?", and begins to clarify and then challenge the patient's resistance against acknowledging transference feeling, at first cautiously and then with increasing power. When this happens not only does the central dynamic sequence begin at once, but the phases of pressure (2) and challenge to the resistance outside the transference (3) are bypassed. The therapist proceeds immediately to phase (4), namely, *Challenge to the resistance in the transference*, while as always vigilantly monitoring the patient's responses for danger signals. However, because the present patient had already been described as potentially fragile and entered the interview with a great deal of anxiety, the therapist had to modify his technique and proceed with much greater caution. In the opening phase, therefore, he employed the following devices:

- (1) exerting gentle pressure toward transference feelings;
- (2) concentrating on physical manifestations rather than actual feelings;
- (3) frequently taking pressure off the transference by inquiring about situations outside the interview;
- (4) avoiding challenge;
- (5) allowing the patient escape routes by which she would describe something less anxiety provoking than feelings; and
- (6) proceeding less fast.

As will be seen, these interventions to a great extent decrease the level of anxiety and the patient is able to describe the disturbing transference feelings stirred up in her by her previous interview, and doing so in such a way as to make it absolutely clear that she was not suffering from a fragile ego structure at all and was a good candidate for Intensive Short-Term Dynamic Psychotherapy. (See Davanloo, Trial Therapy as a Psychodiagnostic Tool.)

Therefore, the therapist quickly passed over into systematic use of the central dynamic sequence, putting pressure on the patient to experience her transference feelings, steadily escalating his challenge, and finally bringing about a head-on collision with the transference resistance (Phases 3 and 4 of the Central Dynamic Sequence). This resulted in a major breakthrough (Phase 5). There followed a phase of inquiry alternating with both challenge and interpretation directed against the defenses in general and the residual resistance, culminating in a second head-on collision. From then on it was possible to move to the phase of direct access to the unconscious, which consisted of exploring first the patient's sexual fantasies, and then past events and relationships. The therapist was now able to bring to the surface some of the patient's deepest pain.

It is worth mentioning also that this interview, similar to those I have already published, demonstrates signs indicating the operation of an unconscious therapeutic alliance, which in the author's opinion is the most reliable criterion for Short-Term Dynamic Psychotherapy.

**The "Fragile" Woman: Interview**

For the sake of brevity the dialogue has been shortened and paraphrased in places, but nothing important has been omitted.

**The Phase of Gentle Pressure toward the Transference  
Alternating with Inquiry**

The patient enters the interview visibly anxious, and the focus is immediately on her anxiety here and now, exploring the physiological concomitants of the anxiety and reducing the level of her anxiety.

*TH: How do you feel right now?*  
*PT: A little bit nervous.*

The patient has mentioned a feeling, and the natural step is to direct her

toward her actual experience. Here, however, the therapist carefully allows the escape route of describing only the physical manifestations of her nervousness:

*TH: What is it like right now physically?*

*PT: My hands are cold. I feel my heart is racing a bit. It feels somewhat uncomfortable.*

The therapist knows that this nervousness is likely to be concerned with the patient's feelings about the present interview. He seeks confirmation of this, and having received it, he directs the patient's attention toward these feelings. Thus he is already approaching the transference.

*TH: How long have you been like that?*

*PT: Since about five minutes after arriving here.*

*TH: So you didn't have it before, you mean?*

*PT: Uh hmm.*

*TH: So it has to do with here?*

*PT: Yeah, I'm fearful, I'm not really sure what's going to happen.*

*TH: What do you have in mind about what's going to happen?*

*PT: I don't know.*

Thus the patient has avoided the question, but the therapist makes no attempt to challenge this. Instead, he continues with a question which is purely factual and leads away from the transference—thus serving to reduce the pressure—but at the same time is designed to throw light on the transference indirectly:

*TH: Usually you are like that? You get nervous in situations like this?*

*PT: Not all situations, but there is a certain reaction that I have in going for interviews or meeting people for the first time professionally. Not so much in personal interactions like meeting friends.*

The therapist asks a question which gives the patient the choice of speaking about feelings or continuing with physical manifestations. She chooses the latter:

*TH: What else do you experience besides pounding of the heart?*

*PT: And cold hands.*

The therapist receives the message that she would rather not talk about feelings. He does not challenge this for the moment.

*TH: Your hands get cold. Any other experiences physically?*

*PT: Uh, I have to urinate more often.*

The therapist has noted that her present anxiety is a general phenomenon, and he now asks a question which is part of the psychiatric inquiry (Phase 1), but can also be used to lead naturally into the psychodynamics.

*TH: How long would you say you have been like this, that when you meet a new situation or person professionally you develop this?*

*PT: Probably . . . the first time I was aware of this was when I was about ten. I was aware of being nervous and having to urinate. I wasn't so aware of my heart racing or cold hands but I remember cold.*

*TH: You are talking about elementary school, am I right?*

*PT: Yes, when I had to put on a performance I was very nervous.*

*TH: Were there incidents when you were called to the front of the class and you would become anxious and nervous?*

*PT: I went first to a parochial school which was very strict, and we weren't allowed to speak out of turn—so that was a very nerve-racking situation, and I really was never asked to . . . Oh no, wait a minute, when I was in first grade, first year, the teacher humiliated me in front of the class.*

The therapist's exploration of the physiological concomitants of anxiety and his cautious approach are paying dividends. She is feeling more at ease with an indication that the conscious therapeutic alliance is being cemented. Moreover, as will emerge much later, this memory is actually a "cover memory" for one of the most significant situations in her early life. The therapist continues his line of inquiry.

*TH: What age would you say?*

*PT: Six, seven, eight.*

*TH: What was the humiliating situation?*

*PT: I was given a series of photographs, and I had to draw lines to indicate the way they related to each other, and I went up to the front of the class and gave it to her, and she smacked me across the face because I had done it incorrectly.*

In the following question the therapist uses the word "reaction," which allows the patient the escape route of saying what she did without describing how she felt:

*TH: And what was your immediate reaction?*

*PT: I cried and I know . . .*

*TH: So it is a situation that in front of the class she humiliated you, but then your reaction was weepiness, hmm?*

The use of the word "weepiness" needs to be discussed. At first sight it may seem rather unfair on the therapist's part—after all a child of eight is humiliated by a person in authority has little option but to cry and (as we see later) to appeal to her parents for help. At the same time, however, the therapist knows that crying can be used as a way of avoiding massive underlying anger; and moreover that this defense can become ingrained and be used in later life at times when the expression of anger would be much more appropriate. Also, the patient has made the link between this incident and her current anxiety in interview situations, and she has arrived at the present interview

in a state of considerable anxiety which is giving rise to somatic symptoms. The therapist knows that anger is likely to be one of the underlying feelings that the patient is avoiding. Thus the use of the word "weepiness" constitutes a subtle indirect message to the patient's unconscious that he knows all about defenses against anger, including anger in the here and now, and this can be considered as his first and only challenge in this early phase. He repeats the word, for emphasis:

*TH: Any other reaction besides weepiness?*

*PT: Well, I don't remember reactions in the classroom. I remember crying to my father. I refused to go to school.*

*TH: Oh I see, you did actually refuse?*

So, another of the patient's character defenses may be avoidance.

*PT: Yes, so I was changed into another class and had a new teacher. It seems my parents took great offense to me being slapped, my father more so.*

*TH: You say the teacher humiliated you in front of the class, and it was so bad that you didn't want to go back to the class anymore. And you got your parents to help, and finally you went to another class. But if you go to that situation, you are weepy and crying, but what other physical reaction did you have?*

*PT: It's a blank in my mind. All I remember is being smacked and the feeling of shame and humiliation, and crying.*

*TH: So the only manifest things are weepiness and crying. You don't know what was your physical reaction, hmm?*

*PT: I don't remember.*

The therapist begins to exert a little more pressure: (Phase 2)

*TH: Any other incidents of a similar kind that mobilized anxiety in you? This is very important to look at, because you say it goes back to the very early part of your life.*

*PT: Before that, no, I don't remember anything. Uh, after that . . .*

The therapist draws attention to the here and now. He notices nonverbal clues which presumably betray the patient's reaction to the pressure. He decides to bring this into the open at once, but mentions only "tension" without making any attempt to ask about the cause of the tension:

*TH: How do you feel right now? Still you are tense?*

*PT: A little tense.*

*TH: And usually you clench your . . . ?*

*PT: Yeah, my hands are very cold right now, I want to put them under my arms.*

*TH: The nervousness is still as bad as a few minutes ago, or a little better or what?*

*PT: It feels a little bit less.*

*TH: Uh hmm. Okay.*

The content should be avoided in this phase, should only be acknowledged. This intervention of bringing into the open the patient's immediate reaction in the here and now even though it is only her anxiety has helped a great deal. Anxiety has been reduced and we have a manifestation of her conscious therapeutic alliance. Then she mentions recurrent dreams which might have a bearing on her psychopathology; but the therapist should keep in mind that resistance is in operation and moving to content while the patient is in a state of resistance would be totally counter-productive. In addition he has to clear up the transference. Moving into content would lead to pure intellectualization, but at the same time the therapist should not convey an atmosphere of rejection. He therefore carefully acknowledges her communication and then goes back to trying to understand the reason for her anxiety. In the early stages of this exploration his whole approach is still very cautious and he confines himself to asking about outside situations, but his ultimate aim—provided there are no contraindications—is that this will eventually lead him to the transference.

*PT: What comes to my mind is that there are many things I'd like to understand about myself. Since I was a child I have been plagued by a certain type of dream which I feel is "somewhat representative of some of my behavioral patterns."*

*TH: You mean you have recurrent dreams?*

*PT: Uh hmm, and I think it's indicative of a certain split sometimes in the way I feel.*

*TH: And what you say is that those dreams reflect on some of your problems in life?*

*PT: Yes.*

This apparently rich content is in the service of resistance, would only lead to intellectualization of the dream, an attempt to move away from the transference. The therapist gently moves to the anxiety.

*TH: Okay, let's stay with this anxiety for a moment. Do you have any other incidents in recent years? When you are in front of a crowd, for example, do you experience it?*

*PT: Uh, in general no, I've always felt fairly comfortable speaking in front of crowds. It's when I feel that I'm being tested in some way that I feel this.*

*TH: Like an examination, or going to an interview to see if they're accepting you for a job?*

This is a message to the patient's unconscious about the parallel situation of being accepted for therapy. The phase of inquiry continues.

*PT: Yes.*

TH: Could we look to the examination, because that is a situation in which you have to perform? Let me ask you, what is your occupation?

PT: Right now I'm a graduate student in economics.

TH: What is it like in examinations?

PT: Uh . . . I feel anxious. My hands are cold, my heart is racing when I go into the classroom and sit down.

TH: How about before? Do you have anticipation anxiety?

PT: Some anticipation. I'm not too bad where I know it's something I have to write down. The anxiety is more when I'm being tested verbally.

TH: In written you have less? What is the extent of the anxiety then? Is it to the level that your hands shake?

PT: No, I just notice that what I have to do is urinate, or I sweat.

TH: Does it interfere with your sleep the night before?

PT: Yeah, yeah, sometimes it does. Usually after an exam I feel worse than before. I usually dream more profoundly.

TH: After the exam you are worse in the form of a dream. Now in oral you say it is much worse? So you have gone through many oral exams?

PT: No, I haven't.

TH: You said you are a graduate, maybe I . . .

The patient makes a disguised reference to her previous interview, which takes the form of a mis-statement about what happens in the class. This is a clear indication that she is ready to deal with transference issues. The therapist notes this and decides to keep it at bay. He continues to check further on the degree to which she experiences somatization of her anxiety.

PT: No . . . I'm just saying that when I'm being asked a question in class — "Elena, what do you think?" or "Elena, what's the answer, how do you feel?" . . . not "How do you feel?" . . . they don't ask how do you feel, they ask you what do you think—I feel intimidated.

TH: What are the physical symptoms that you get?

PT: Tightness, choking uh . . .

TH: And then what else? Heart pounding?

PT: Yes, not very heavily, but I feel all of a sudden a sensation of stopping.

TH: Do you get severe tremors, shaking?

PT: No.

TH: Any other physical experiences such as faintness?

PT: No.

TH: Finally what happens? Do you overcome this?

The therapist continues in the line of psychiatric inquiry, phase (1), to determine the extent the cognitive function of the ego becomes disrupted under the impact of anxiety.

PT: I'm able to sometimes muster up some words, but I feel that my mind goes blank and I can't think of an answer, so I feel frightened.

The therapist is immediately on the alert, since this is one of the important signals.

TH: You mean you lose track of your thoughts?

PT: Yeah.

TH: How do you master that situation, because if you lose track of your thoughts then it obviously must be very difficult for you?

PT: I don't think I do it very successfully. I might sometimes keep very quiet, or just say any answer, or talk about the question, or try to divert the question in some way.

TH: So this is quite a disturbing symptom for someone in academic life?

PT: Yes.

TH: How was it in high school, was it better or worse than now?

PT: I don't remember all that well. I did well and I was generally well liked by my teachers. I don't remember being nervous. I think my anxiety in front of people started when I came to Canada because all of a sudden I was in a new uh . . . a new . . .

TH: When did you come to Canada?

PT: Eleven years ago.

TH: From where?

PT: Philadelphia.

TH: Okay. Now you said that when you have to perform, like a test or an examination, then this anxiety mobilizes?

PT: Uh hmm.

### Transference

At last the therapist is ready to open up the issue of transference directly. However, it is not the present transference that the patient wants to talk about, but her transference in the previous interview. This is a crucial issue and the therapist concentrates upon it. By this time the level of anxiety is greatly reduced. Here it is worth summarizing the sequence of events in advance. The patient described the disturbing effects of the previous interview and mentions that very soon after the end of the interview she felt great anger. She is able at the cognitive level without anxiety to declare anger in relation to the first evaluator. So far for the therapist there is no sign of fragility and he concentrates her attention on the actual experience of anger and the impulses it involved. The patient becomes resistant. Now the process enters the phase of clarification and challenge to the patient's resistance. She finally is able to acknowledge the way she would have wanted to verbally lash out at the first evaluator with no sign of anxiety. This is further reassurance about her supposed fragility. The therapist then undertakes a very important step which will be discussed more fully later, namely to acquaint her with the inner mechanism responsible for one of her major symptoms. He

points out to her repeatedly and with great emphasis the fact that she doesn't feel anger but feels anxiety in its place, so that at least part of the mechanism responsible for her anxiety has to do with her inability to face her anger. It must be mentioned, too, that she began to suffer from anxiety soon after she entered the hospital for the present interview, so that opening up this will lead to dealing with the present transference as well. From now on the therapist can proceed relentlessly with the whole of the central dynamic sequence though by concentrating at first on the physical manifestation of her anger.

*TH: And then how does that apply here with me, because here also you say you are very anxious? What is the nature of the performance here?*

As mentioned above, it is not the present but the previous interview that the patient wants to speak about:

*TH: What was it about that shook you?*

*PT: Well uh . . . (she laughs).*

*TH: You smile when I say . . .*

The focus of the session is further on transference, countertransference evaluation, and her feeling toward the first independent evaluator; she indicates that she felt under attack.

Parenthetically it is important to emphasize, based on the clinical data that emerges, that the first evaluator had not done work on phase (3) of the central dynamic sequence, and also the patient left the interview with unresolved transference feelings which have to be worked through in this interview. Now we return to the interview. The therapist is still troubled by the patient's previous mention of thought block:

*TH: When you say you didn't know what was going on, did you lose track of your thoughts?*

*PT: I don't know exactly what you mean.*

*TH: I mean that you are talking about a subject but then suddenly you don't know what you were talking about.*

*PT: That happened, yeah. Because he kept on asking me, how do you feel, or what do you think, what do you feel, what do you feel? And when I said I didn't remember, "what do you mean you don't remember?" I said I can't remember.*

*TH: So actually during the interview you lost the train of your thoughts?*

The patient's answer is very reassuring—she does not run away from disturbing feelings:

*PT: Well immediately after I walked out I felt, uh, anger, immense anger toward him.*

*TH: You mean you felt anger toward him after you left, but not while you were there?*

*PT: I . . . I . . . for some reason I couldn't feel anger while I was here. I was so frightened that I couldn't feel my anger.*

The therapist now prepares to make the link between the underlying feeling and the anxiety:

*TH: So then let's look at it. While you were with him you had a lot of anxiety. Am I right?*

*PT: Yeah.*

*TH: There was no anger.*

*PT: I didn't feel anger.*

*TH: I know, that is what I mean. You did not experience the anger while you were with him. What you experienced was anxiety, hmm?*

*PT: Uh hmm.*

*TH: But how long after you left did you start to experience the anger?*

*PT: About five minutes.*

*TH: So you were still in the hospital when you had this anger toward him?*

*PT: Yeah.*

Throughout the following passage he takes her through her impulses in detail, challenging her resistance as necessary, but at the same time supporting her by constantly reassuring her that what she is describing consists only of thoughts and ideas:

*TH: How then did you experience that anger? You know, physically? When you are anxious we know how you experience anxiety—you have palpitations, tension, tightness. How do you physically experience the anger?*

*PT: (She sighs.) The same way almost.*

*TH: You mean anxiety?*

*PT: Except that there's a switch, that I want to lash out verbally or physically in some way.*

*TH: Both physically as well as verbally.*

*PT: Or I feel that my physical movements become, uh, more pronounced.*

*TH: Uh hmm. These were the thoughts and ideas in your head, that you wished you could have verbally and physically lashed out at him?*

*PT: Yes.*

She has frequent sighs in talking about her anger toward the first evaluator which indicates that the impulse of anger gives rise to the anxiety which discharges itself in the form of tension in the intercostal muscles as well as the subdiaphragmatic muscles. The therapist moves to challenge.

*TH: Now this is only thoughts and ideas, hmm?*

*PT: Uh hmm.*

*TH: Now in terms of thoughts and ideas, if you had lashed out—I mean you didn't—but if you had, what would that have been like? What are you like when you lash out verbally?*

*PT: Uh . . . my voice is raised, I yell.*

*TH: You yell, your voice goes up, uh hmm.*

*PT: I . . . I have not too much control on exactly what I'm saying.*

*TH: What would you have told him? . . . You smile.*

*PT: (Laughing) What would I have told him?*

*TH: I know it is difficult to tell me what you wanted to tell him. We are talking about thoughts and ideas.*

*PT: I . . . I don't remember what I would have told him.*

The therapist begins his systematic challenge to the resistance against experience of the impulse in relation to the (C), the first evaluator.

*TH: We are not talking about remembering. Let's portrait a situation like that. It's not too far, it's a week ago, hmm? You smile again, hmm?*

*PT: (Laughing) I'm feeling embarrassed.*

*TH: Why? Because you want to tell me you wanted to tell him off verbally?*

*PT: Yes.*

*TH: So let's see in terms of thoughts and ideas how you would have told him off?*

Finally she indicates that she would have verbally lashed out at him. Then the therapist turns his attention to the physical impulse, which is likely to be even more disturbing than purely verbal.

*TH: If you physically had lashed out what would that have been like? You didn't do it but if you had done it? In terms of thoughts again?*

*PT: I . . . uh . . . I wanted to smack him across the face with the back of my arm.*

*TH: How?*

*PT: I'd like to go . . . wham! Across his face.*

*TH: And then? Only once?*

*PT: Yeah, that would have been sufficient.*

The therapist sees a parallel with the distant past which seems to still live on her.

*TH: But you had the impulse to verbally tell him off, and there was also the impulse, like the teacher in school did to you . . . (The patient laughs.) You smile when I say that. Then you had the impulse to smack him in the face, hmm?*

*PT: Uh hmm.*

The next passage needs discussion. One of the principle manifestations that has been brought to light is that in the previous interview instead of anger the patient experienced anxiety. This must mean that she has a powerful unconscious anxiety of the expression of anger, which needs to be brought into the open.

#### Analysis of Two Triangles—An Important Principle of Technique

During the course of this work I have become quite certain that it is extremely important for the patient not merely to respond to interpretation about some of her inner mechanisms, but to achieve lasting insight into them—particularly the way in which some fleeting feeling or impulse is immediately replaced by something else. If the patient is not given this insight there will be a failure of prophylaxis, and it will be only too easy for the same mechanism to re-establish itself as an automatic reaction on future occasions. Since there is a considerable amount of unconscious resistance against this insight, it is often necessary to repeat the interpretation over and over again in order to consolidate it.

It is very important to give a full impression of this process, so that I shall include almost all the therapist's interventions; but for brevity, I shall omit many of the patient's responses, almost all of which consisted simply of showing that she was following what the therapist said.

#### Link between the Impulse of Anger and Anxiety, Phase (3)

*TH: But do you think the anxiety is a mechanism of dealing with the anger? Do you see what I mean? . . . The anger is not experienced in the moment, what is experienced is more the anxiety . . . There was a situation that mobilized anger in you but you did not immediately experience the anger . . . And what you experienced immediately was anxiety. You see? . . . It is very important that we see this: that the immediate reaction is anger but the mechanism that comes to the fore is anxiety . . . And anger is pushed underneath but later on it comes out . . . And what did you do with the anger? You wanted to lash out, but what happened to that anger? Where did it go?*

Making the patient well acquainted with the impulse, anxiety, and defense [Phase (3)].

*PT: I don't know where it went.*

*TH: It's very important we look at it, because you cannot say the anger evaporates.*

*PT: In other situations the anger does not evaporate, it stays with me for a long time; but with him for some reason there was a part of me that was very accepting of the whole process.*

*TH: That is intellectually true; but still, where does the anger go?*

*PT: Well, immediately after I felt angry, which didn't last very long, I felt very shaken.*

*TH: Oh I see. First anger, and then again the anxiety.*

*PT: No, this was more trembling, total body trembling. I felt as if, uh, I had just been through a cyclone, or that something very traumatic just happened and the after-effects finally hit me.*

It becomes more and more clear that she has a very powerful unconscious anxiety in relation to the expression of the anger, and the therapist continues to make her well acquainted with the three parts of the triangle of the conflict: the impulse-feelings, anxiety, and defense.

*TH: The reason I say it is very important is because first there is the anger, but it immediately mobilizes a great deal of anxiety in you. In the session, obviously the anger was there but then you had anxiety. Then away from here the anger comes out, but then the massive anxiety takes over again, hmm? . . . As if the anger is something that disturbs you a great deal.*

*PT: Well, I was taught not to express anger.*

The therapist dismisses this attempt to avoid the central issue:

*TH: We can get to that, but first is to see that you are really terrified of a situation that mobilizes anger.*

We saw the repeated emphasis on the link between anxiety and anger. Then she talked about the way she felt after the first interview.

*PT: That is exactly what I realized after I left. After I got angry and then I felt trembling, all of a sudden I had a feeling of calmness; and, I don't know if it was a sadness, but I felt as if something had been exposed inside of me and chiseled out, or a hole poked in; and the release of emotions associated with that, psychologically, physically, made me feel very centered and very solid within myself, almost withdrawn but very much myself; and my actions the rest of that day were very quiet and more observant of people, but I felt better about myself for some reason, because I realized that I have to deal with my anger. I have to learn how to express it, I have to say it when it comes out.*

The therapist does not want her to form the impression that she has to go around expressing her anger on all occasions:

*TH: But obviously expressing it is not necessarily going to be constructive. I mean if you slap another person . . . The most important thing for us to see is what it is that happens when something mobil-*

*izes anger in you and this tremendous anxiety takes over. Do you see what I mean?*

*PT: Yes.*

The therapist searches for confirmation that talking about her anger has led to relief in the here and now.

*TH: How do you feel right now?*

*PT: Better.*

*TH: Because I have a feeling that you have a tremendous difficulty to even talk about anger. Am I right to say you prefer I don't talk about anger?*

*PT: I think I prefer you talk about anger. I need to talk about my anger.*

*TH: But talking about anger disturbs you? Is painful?*

*PT: Yes.*

The therapist now approaches the issue of her transference in the present interview:

*TH: Then do you think that something like that would happen here with me? Namely it might mobilize the impulse in you to lash out at me? You see, if I focus on something painful you don't want to focus on, then . . .*

*PT: I won't feel that I'll want to lash out with you right here. If anything I'll start feeling my hands getting cold.*

*TH: I know, the anxiety takes over.*

*PT: I'll just keep on being anxious, I feel that.*

At this point the therapist delivers a message to both the patient's conscious and her unconscious therapeutic alliance, speaking of the devastating effect that this mechanism of replacing anger with anxiety has on her life. His aim is to prepare the way for much later work about her self-destructive tendencies which arise out of the repressed impulses, with guilt and grief-laden unconscious feelings.

#### Challenge to the Patient's Defenses, Leading to Rising Transference Phase (3)

*TH: Okay, so one thing so far we can understand is that it is very crippling, this anxiety—I don't know, you can say it is or it isn't—and it is very diffuse in many areas of your life. And then when a situation mobilizes anger, you don't experience anger but anxiety; and later anger comes, and then you become anxious again . . . But my question was, where does the anger go?*

*PT: It goes (smiling) somewhere here inside. That's where it goes.*

The therapist takes the smile as an indication of transference feelings:

*TH: Do you feel like smiling or is this a cover-up of something else?*

*PT: I feel embarrassed.*

*TH: Is it embarrassed or something else?*

*PT: (Smiling again) I don't know.*

*TH: I don't know, you know yourself better. I only met you for a short period I have a feeling that you have a tendency to cover up, to put up a facade.*

*PT: That's right.*

*TH: And do you think there is something of a facade with me?*

*PT: No, I feel that you see through the facade, and it makes me embarrassed. I feel a little bit naked. It's almost as if I'm sitting here with no clothes on and you're just looking at me.*

#### The Issue of Emotional Closeness

Extensive clinical data indicates the importance of realizing that many patients defend themselves as strongly against the positive feelings as against their negative, and therefore they put up a barrier against any form of emotional closeness. In some patients resistance against emotional closeness is much more extensive than others. Here the therapist senses that the word "naked" refers to such a problem in the transference, and immediately sets about trying to bring this into the open.

(It is worth noting that at this moment many therapists might feel inclined to take up the sexual implications of the patient's remark. I am quite convinced that this would completely miss the point and would divert the whole interview and put the process of unlocking into impasse. There are indeed sexual implications present, but their relevance is quite secondary—in this context sexuality is merely an aspect of closeness, and closeness is the issue that needs to be dealt with, so that sexuality does not need to be mentioned at all.)

*TH: "Naked" has to do with closeness, if you carefully look at it, hmm?*

*PT: Closeness?*

*TH: Yeah, that I am getting close to your intimate thoughts and feelings. Do you have a problem with closeness, intimacy?*

*PT: Uhh...*

*TH: I have a feeling that here with me you are trying to cover up your feelings.*

*PT: Yes.*

The therapist's conclusion by this time is that there is resistance against emotional closeness in the transference which at the appropriate time needs to be systematically challenged. Then he decided to undertake the psychiatric inquiry.

#### Psychiatric Inquiry (Phase 1)

The patient has given conclusive evidence of her capacity to respond well to a rapid uncovering approach, but the therapist now needs to make doubly

sure. He carefully inquires about depression, quality and severity, assessment of suicide.

This part of the interview will be summarized because it consisted entirely of question and answer. On the other hand, the fact that it is summarized must not be taken as an indication of its lack of importance, since psychiatric inquiry, a comprehensive dynamic phenomenological approach, forms an essential part of every trial therapy.

Her answers made it clear that while she suffers from a fairly severe depressive illness, she has so far always possessed the strength to survive without breakdown.

The answers that indicated the fine balance between severity on the one hand, and absence of danger signals on the other, were as follows.

In her depressive states she feels indifferent and that life is a failure, but she does not suffer from more serious or delusional depressive ideation, examples of which might be the feeling that she is an "empty shell," or that she has "destroyed the world." She says she does get into a state of withdrawal and may cancel her activities for a day at a time; but on inquiry it emerges that she usually counteracts this state by going to school or by energetic physical activity. There was no evidence that such activities were hypomanic. Her longest attack of depression lasted two months, but this was clearly reactive—to a major life event, the separation from her husband.

She can trace some kind of depressive state back to her teens, her description of this is not of true clinical depression, and there is no evidence for an "endogenous" depressive cycle, i.e., attacks without obvious external cause. Finally, although she does entertain thoughts of suicide she has never attempted it nor made serious plans to do so.

When she was asked about other psychiatric disturbances she mentioned a "dream state," which could be manifestation of schizophrenia, and "confusion," which could indicate an organic condition; but on inquiry both of these seemed to be no more than states of indecision.

This part of the inquiry ended with the following statement by the patient:

*PT: . . . I think all my anxiety comes from the fact that my personal—my intimate relationships have not been stable.*

This immediately led the therapist back to investigating the psychodynamics.

#### Pressure, Challenge to the Resistance outside the Transference (Phases 2 and 3)

Since the only other disturbances that the patient has mentioned are concerned with personal relations, the therapist is satisfied that he has covered the psychiatric inquiry. He therefore asks about the nature of these disturbances, preparing to make the transition to more dynamic inquiry. In fact a brief passage of challenge to the resistance leads back into the transference in a way that could not have been foreseen.

The therapist asked first whether her problems in personal relationships

were more pronounced with men than with women. The answer was that they are more pronounced with men, but that she does have problems with certain women in her professional life. This led to the relation with a fellow student named Priscilla, by whom the patient felt rebuffed, which had caused the patient to feel anxious. In answer to the question of what else she had felt, she said that she felt angry, but that she had only become aware of the anger later. The therapist immediately made the link with the previous evaluation interview:

*TH: It's always later on, like last week here, hmm?*

*PT: Yeah.*

Pressure and challenge to the resistance against experience of anger in relation to (C) (Phases 2 and 3).

*TH: How did you experience the anger in relation to her?*

This question produces some kind of inner turmoil, to which the therapist immediately draws attention:

*PT: Uh . . . wheww . . .*

*TH: As soon as I asked how do you experience anger, you said "whewww."*

The patient laughs in such a way as to indicate that some further reaction has been touched off in her. Once more the therapist immediately draws attention to this:

*TH: Again the smile comes.*

*PT: Because I hide it so well I don't even feel it.*

The therapist returns to challenging the defense:

*TH: I know, you have a mastery of covering it up.*

*PT: That's right.*

The therapist now introduces the word "crippling," repeating it for emphasis—an intervention that he could not have known would eventually lead into the depths of her pathology:

*TH: You are the master of covering up, to put the facade. This is a "crippling" force in your life.*

*PT: That's right, yes.*

#### Making the Patient Acquainted with the Defenses That Have Paralyzed Her Functioning (Phase 3)

*TH: And as this is a crippling force in your life, it is very important*

*for you and I to examine it—unless you prefer not to examine it?*

*PT: No, I want to examine it.*

*TH: Because obviously this is a very crippling force for a young woman of your age, hmm?*

*PT: Yes.*

*TH: So then it is very important for us to examine it, for if we can see what it is like, then later on hopefully we can get to the core of it.*

#### Rising Transference, Resistance, Challenge to Transference Resistance (Phases 3 and 4)

The following passage is extremely important because it illustrates almost all the aspects of transference that were described in my other publications. The therapist concentrates exclusively on the transference, employing challenge. He deals with all three corners of the triangle of conflict in connection first with negative and then with positive transference feelings, and ends up with a head-on collision with the transference resistance. The result is a major breakthrough. When this patient is compared with the left side of the spectrum the far greater complexity of the transference in a severe character neurosis, as opposed to a symptom neurosis, will be evident.

An overall view of this passage is as follows.

(1) The patient herself suddenly re-introduces the transference, saying that she is angry about the therapist's use of the word "crippling."

(2) The therapist focuses on the actual experience of anger. The patient responds with a mixture of defenses such as somatization and laughter on the one hand, and nonverbal cues betraying her inner feelings on the other, to both of which the therapist draws attention (two corners of the triangle of conflict in the transference).

(3) The patient's anger is now very close beneath the surface, and with the help of repeated challenge the therapist succeeds in bringing out the actual impulses involved.

(4) He then sees that in order to free her further it is important to deal with the third corner of the triangle of conflict, and he therefore focuses on the anxieties that make it difficult to express her anger.

(5) He makes a move toward positive transference feelings by mentioning her need to protect him from her anger, where by implication the anxiety is of causing him harm, but in fact this does not seem to be the important issue.

(6) She eventually names her anxiety as fear of his retaliating by rejecting her, either if she expresses her anger or, indeed, if she fails to do so.

(7) As she speaks of this she begins to betray an underlying sadness which she tries to control, and he draws her attention to this.

(8) He now focuses on her fear of emotional closeness in the transference and her defenses against it (two corners of the triangle of conflict involving positive feelings).

(9) He senses that this needs a major effort on his part, and therefore it is here that he introduces the head-on collision with the transference resistance.

(10) This brings out intense feelings about her disappointment and disillusion with close relationships, and her fear that she can never love anyone again. Her ability to share these feelings with the therapist represents the emergence of the underlying positive feelings, the third corner of the triangle of conflict in the transference.

(11) Now that this major breakthrough has been achieved, he suggests taking a five-minute break.

We may now take up the interview where we left off.

#### Negative Transference

*PT: Well, I'll tell you, I'm experiencing anger right now because you keep on saying crippling force, crippling force. It sounds like . . . well what the hell are you trying to say?*

*TH: So you say right now you are angry with me?*

*PT: Yes! Yes.*

*TH: Then how do you experience this anger with me?*

*PT: Well I feel I want to tell you to stop saying crippling force, crippling . . .*

#### The Link between Negative Transference and Various Defenses against It

*TH: But how do you experience this physically? You didn't like me to use the word crippling?*

*PT: No, I didn't.*

*TH: And then this mobilizes anger in you? Let's see how you experience this anger physically?*

#### Challenge and pressure to the resistance against experience of anger in the transference.

*PT: I don't remember . . . I didn't feel anything. I felt maybe a little tension in my stomach.*

*TH: But that is anxiety, you see. What is the way you experience anger? It is very important you look at it because last time you walked out from here with your anger. Now are you going to repeat that this time as well?*

*PT: No.*

*TH: Or do you want to experience it?*

*PT: I want to experience it.*

The therapist emphasizes that this is a golden opportunity to acquaint her with her mechanisms for avoiding anger while they are actually happening:

*TH: So let's see, because it's a very split-second process that needs to be examined. I use the word crippling, and for whatever reason—it doesn't make a difference—you didn't like it.*

*PT: No.*

*TH: That mobilized certain irritation and anger in you.*

*PT: Yeah.*

#### Nonverbal Cues

He now draws attention to a number of nonverbal cues betraying her inner feelings:

*TH: And I don't know if you noticed, but immediately your fist also became clenched, like that. You see?*

*PT: Yeah.*

*TH: And is still like that. (The patient starts giggling)  
And I'm sure you don't like it when I tell you your fist goes like that.*

*PT: No, it's okay.*

*TH: The smile comes to the forefront.*

*PT: I laugh, yeah.*

*TH: Which is a cover-up for your underlying feeling.*

*PT: That's right.*

*TH: Then let's see what is the underlying feeling. Is the anger, hmm?*

*PT: Yeah, that's right.*

*TH: Were you aware that when you got angry your fist went like that?*

*PT: No.*

*TH: But it is very important. And when you get angry, physically you take a very defensive, on-guard position, hmm?*

*PT: Yes, I'm feeling very anxious right now. Because you're probing me. I feel a tension here in my stomach.*

*TH: And you take a deep . . . (Patient has frequent deep sighs.)*

*PT: Yeah, I'm having trouble breathing.*

*TH: And then also you are holding onto the anger.*

*PT: Yes.*

*TH: So let's see how you experience the anger. You experience anxiety.*

*PT: That's right, yes.*

*TH: But let's see how physically you experience the anger. You see, a smile comes again. Let's face it, you can laugh . . .*

*PT: I know, I know, I know. But this defense mechanism is so good.*

*TH: But this defense mechanism is your worst enemy. Of course I am not the one to decide that. You have to decide, because that is your life.*

*PT: Well I don't know if laughing is my worse enemy.*

*TH: No, I'm not talking about laughing. It is the cover-up.*

The patient is now using the defense of somatization against her anger. The therapist explores the extent of her somatic symptoms:

*PT: I feel such pain right now. I think I have indigestion.*

*TH: Usually when you become very anxious you get indigestion?*

*PT: Yes.*

TH: By indigestion you mean what? Vomiting or . . . ?

PT: No, just a tightness, inability to eat.

TH: What else do you get when you say indigestion?

PT: Diarrhea, gas.

TH: Do you feel that way right now?

PT: Not that profound, but yeah, I feel a little bit of it. And I'm having trouble breathing.

TH: Now let's see how you experience this anger, because there is always a delayed reaction. With Priscilla you were angry, hmm? But then the anger came later on, hmm?

PT: That's right.

TH: And now you are angry with me because you don't like the word crippling.

#### Negative Transference, Impulse

There is a drop in the level of anxiety, and the process indicates that the physiological concomitant of impulse is surfacing, the therapist maintains the focus on the actual experience of impulse.

TH: Or, you don't like me to focus on your facade, hmm? Okay, let's see how you experience the anger. We know there is a link between anxiety and anger, but that doesn't tell us how you experience the anger. Did you feel you wanted to verbally lash out at me? Or physically? You mean I am the exception?

The patient avoids the impulse by rationalizing, which the therapist challenges:

PT: Why should I be that angry at you because you said crippling? I mean there are degrees of anger.

TH: Yeah, but you are rationalizing it . . .

The patient admits the impulse but then starts to weaken it by further rationalization, which the therapist interrupts, bringing her back to the impulse:

PT: I experience the anger by wanting to raise my voice, and I don't understand . . .

TH: You feel you want to raise your voice?

Absence of anxiety and tension in vocal cords.

PT: Yes.

TH: So if you raise your voice what will you be like here?

PT: Uhh . . .

#### Negative Transference, Anxiety

Having exposed part of the impulse, the therapist senses that further freeing can only take place if he exposes the anxiety:

TH: Because obviously you are protecting me against your anger.

PT: Yes.

TH: Why? Why do you want to protect me against your anger? Let's look to your thoughts and ideas of what my reaction would be.

The patient is evasive:

PT: I don't know what your reaction is going to be.

TH: No, I'm saying in terms of thoughts and ideas.

PT: Well, my reactions of your reactions?

TH: You said yourself that I would have a reaction to it. That it might hurt me or it might . . . hmm?

PT: I don't know. I imagine you will be hurt.

TH: What else besides me getting hurt?

PT: That you would get angry at me.

TH: Okay, could we look to this? Because it is very important. I am sure it is a pattern outside of here. I cannot be an exception, hmm?

The therapist now embarks upon an extremely important procedure with any patient who has such difficulty over anger, namely driving home cognitive insight about the inner mechanisms involved and the reasons for them.

TH: Let's look to the pattern step by step. First is me focusing on crippling.

PT: That's right.

TH: This immediately mobilizes anxiety, but under the anxiety you experience anger.

PT: That's right.

TH: Then verbally you want to tell me off, but the idea is that I would get angry at you, and then what would happen? In terms of thoughts again.

PT: I'm afraid that you might put me in my place or say something hurtful to me, which either means I'd have to cover up or be more angry.

TH: So then could we look to that? The idea is that I would become revengeful toward you.

The therapist introduces this word, because he knows that almost certainly it would be an appropriate description of someone in the past.

PT: That's right.

TH: That I would retaliate with you? Could we look to this?

The therapist now emphasizes the irrational nature of the anxiety thus informing her unconscious that he knows it comes from the past:

*TH: Now could we look to see what evidence there has been that I would retaliate, or react with anger if you get angry with me?*

*PT: I have no evidence.*

*TH: So where does that come from? It is very important you look at it. So you say it comes from your head.*

*PT: That's right.*

*TH: Was there the thought also that I might terminate, or tell you, look, if you don't want it . . . did that thought pass through your head?*

*PT: It didn't pass through my head but it's maybe . . . I don't know.*

*TH: It is very important you examine that.*

*PT: Well yeah, maybe to some degree. It's something that passed through my head.*

One of the fundamental principles of the technique is that the patient's whole psychic system is loosened by the direct experience of feelings about the therapist, of which a negative impulse is often the first component. These feelings are complex and they have their genetic roots in all the unresolved feelings and impulses in relation to the past. The patient's major unconscious anxiety has its links with repressed sadistic impulses as well as guilt-laden, grief-laden unconscious feelings in relation to the people in her past life orbit.

It is important to highlight that the challenging language such as crippling, in which many of the therapist's interventions are phrased, has come from patients themselves during the course of a large series of interviews over a span of 30 years.

Here it is worth anticipating; later in the interview it emerges that self-punishment in the form of crippling herself is a central part of her pathology. Not only this, but there is a link with the most important person in the patient's life, toward whom she felt the deepest guilt and remorse, who in the end had herself become crippled. This is why she reacts with anger every time the word is mentioned. We may now resume the interview.

#### Direct Experience of Anger in the Transference (Phase 5)

*TH: What evidence is there that I intentionally want you to get angry? Because you are saying that I am dishonest, in a sense. If I do something intentionally to create a reaction in you then that becomes more dishonesty. So then you perceive me as a dishonest person, hmm?*

*PT: That's right.*

*TH: But what evidence have I given that I am intentionally doing something like that? Let's face it, you describe your life as paralyzed in many ways, I feel that your life is in some way crippled, okay? But now the issue is this: you are the master of your life.*

*PT: Right.*

*TH: Maybe you want to live in a crippled, paralyzed fashion. (Addressing superego resistance.)*

*PT: No.*

*TH: If you want to do it, so that is your life. But what I am saying is this: why does a young women of your age—and obviously you have potentiality, you have got yourself to college and so forth—want to carry on the life like this? (Putting further pressure toward unconscious therapeutic alliance.)*

*PT: Yeah.*

*TH: So where does the idea come from that I want intentionally to get you angry with me?*

*PT: That was the experience that I had last time I was here.*

*TH: You see, that is your perception of the situation, not that the situation is like that.*

*PT: That's right.*

*TH: Because you give me a single evidence.*

*PT: Wait, wait, wait, you're talking so much, though.*

*TH: How do you feel when I talk too much?*

*PT: (Laughing) You're getting on my nerves.*

*TH: My talking too much also gets on your nerves?*

*PT: Yeah.*

*TH: What else do you experience besides . . . ?*

*PT: I want to shrug you away. I want to say, stop it. Stop pushing me. Stop talking so much.*

*TH: How do you feel right now?*

*PT: Movemented.*

There is a major change in her posture, her voice is loud, absence of tension in her vocal cords.

*TH: So your position is no longer like that. Now it is like this, hmm? Which is more positive.*

*PT: That's right.*

*TH: Because this is a crippled position. The other one . . .*

*PT: That's right (laughing).*

*TH: You smile when I said that this is crippled.*

*PT: Right, it is.*

*TH: But you see it is very important that you look at it . . . One perception of me is that I would retaliate, okay? The other is that I would be dishonest in a sense. Of course later on we can look at it to see where this distorted perception of me comes from. Because I am sure if you examine it—you can laugh again—this is in operation in other relationships, because I cannot be an exception.*

*PT: Yeah.*

*TH: And if it is, then it is a fundamental job for us to examine it—unless you don't want to.*

*PT: Ohhh God, why do you . . . ? Yes! I want it. Yes, see I'm open. Okay that's what you want. Yes I want it. I want to examine my anger, my inability to express and feel it.*

Sadness

Suddenly there is a major change in atmosphere:

*TH: But I am sure it is not only anger, there are other things as well.*

*PT: I am sure there are too.*

*TH: How do you feel right now? Because one of the other things I feel—I might be wrong, I don't know—is that there are moments when there are waves of sadness coming. I see it in your eyes, but then you go dry. If you examine yourself, was there a moment that you had waves of sadness?*

*PT: I felt it more in my face, like a tightening here.*

*TH: How about your eyes?*

*PT: Throughout this, since I've arrived, yes.*

*TH: You try to control it, why?*

*PT: Because I feel that's another way of escaping.*

#### Challenge to Resistance against Emotional Closeness in the Transference (Phase 3)

*TH: Maybe it has to do with the issue of closeness with me. I have a feeling that you are terrified of closeness with me and you are putting a wall between you and me.*

*PT: Terrified?*

*TH: That I want to get to know you, I want to get to your intimate thoughts and feelings, but a part of you is very strongly fighting that.*

*PT: Yeah, because my feeling is, what gives you the right to be close to me?*

*TH: And that is very important that we look at it. What you say is what right has this stranger to pass the barrier and get to your intimate thoughts and feelings?*

*PT: That's right.*

*TH: So then we have a major obstacle between us, hmm?*

*PT: That's right.*

#### Head-on Collision (Phase 4)

The therapist now embarks on a head-on collision with the resistance, speaking directly to the therapeutic alliance about the self-destructive consequences of maintaining her defense of distancing.

*TH: But then as long as this barrier is there, this process is doomed to fail.*

*PT: Yes.*

*TH: Let's look at it.*

One of the ways of dealing with major resistance is to look ahead in

imagination to the end of the interview, and to face the patient with the disappointment that she will feel if she goes away having made the whole undertaking useless:

*TH: It's very important you look at it, because as long as that wall, that barrier, is there and you don't want me to get to your intimate thoughts and feelings, then in a while when this session finishes, at the end of it, then when we say good-bye to each other, we will not have been able to understand the central core of your problem. You say good-bye to me and I say good-bye to you, you go on your own and I go. But you go on and carry on your crippled life—you carry your problems with you and carry on the miserable life that you have. I don't know, you have to decide, is it or isn't it? And then I will be useless to you.*

*PT: You're talking too much.*

This is a defense of diversification, the therapist challenges it.

*TH: Again that is another way of distancing.*

*PT: Is it really?*

*TH: Because I will be useless to you.*

The resistance is swept aside in favor of the therapeutic alliance. The patient opens up an important issue contributing to her resistance in the transference.

#### The Issue of Control

*PT: How can I feel that you want to get to know me if you're trying to overpower me? This is what I feel. You're trying to overpower me. You're trying to take control.*

*TH: So passing the wall becomes the issue of control, hmm?*

*PT: That's right.*

*TH: If I pass the wall and get to your intimate thoughts and feelings . . .*

*PT: Maybe I'll feel that you have more control and I don't like having less control.*

*TH: So that is another problem.*

*PT: That's right.*

*TH: So then let's see what you are going to do about it. Because, let's face it, if the distance remains there, if you don't want me to get to your intimate thoughts and feelings, I will be useless to you. It's as simple as that. But why does a young intelligent woman of your age want to do that?*

*PT: I don't want you to be useless to me.*

*TH: But it will happen if the wall is there, if you don't want me to get to your intimate thoughts and feelings, then I will be useless. Look, right now you have a lot of feeling. Tears are there but you are very strongly fighting them. Why?*

PT: I'm not (she smiles).

TH: You are, with a smile. If you be honest with your feeling right now, if you really let your feelings come out what would you feel right now?

PT: Sad.

TH: And you don't want to share it with me.

PT: It's very painful. I don't understand you.

TH: I'm not sure it's that. You see, right now you are very sad and you don't want to let it go.

PT: I'm trying to let go.

TH: You want to control.

PT: But I'm afraid you're going to talk so much that you're not going to let me let it go.

In the following passage the therapist carefully avoids getting involved in what the patient is saying, and repeatedly confronts her with the central issue.

TH: Right now I am saying you are fighting the feeling. Let's look to your feelings.

PT: I feel very tight in my throat and I feel my eyes . . .

TH: You see, right now you talk, not to let the feeling come out. And I don't know why.

PT: Because I don't want you to come too close to me. I'm afraid of you in some way. I don't trust you.

Patient's tactical defense is swept aside.

TH: I'm not sure it is trust. It is tremendous conflict and fear, I don't know from where it comes. There is a tremendous fear of intimacy and closeness. Obviously it is sad.

PT: Somehow I'm afraid you'll make fun of me or something.

The patient's tactical defense is again swept aside.

TH: You see, these are all mechanisms you use to avoid your painful feelings. You know it well.

PT: (Pause) Maybe I don't believe that you can . . .

TH: Yeah, but right now you know that these are all mechanisms for fighting your very painful feelings.

PT: I can't go around crying in front of people every time they hurt me.

Direct Experience of Sadness, Breakthrough of Grief-Laden Unconscious Feelings (Phase 5)

TH: The issue really is this: I don't know what has happened in your life that you are so terrified of closeness. You want to keep all these painful feelings to yourself. You don't want me to get there.

There is a long pause. The patient is charged with feeling.

TH: You see, a while ago I was saying that you have a tremendous problem with the issue of intimacy and closeness.

PT: (Whispering, hardly audible) I keep people very far away.

TH: Far away, uh hmm. (Pause) Is it much more with men or women?

PT: (She sighs deeply.) I don't know. (Hardly audible) I don't know. I really don't know. Men have hurt me more, but I don't know if it's . . .

TH: So it has been more with men?

PT: Only because I've had a series of relationships with men that didn't work out.

TH: You mean a series of relationships with men that ended up in disappointment?

PT: Uh hmm. (She is very sad, crying.) The disappointment is so deep. (She is very emotionally charged.) Disillusionment is so deep that I wonder if I can ever love anyone.

TH: I don't know what has happened, but maybe a part of you has decided that you will never let any person get close to you again.

PT: (Whispering) I think so.

TH: What in a sense you have decided that you are going to live the rest of your life in a cave, so to say.

PT: Yeah. Do you have any kleenex?

TH: Conflict over control, conflict over closeness and intimacy. And hopefully you and I today will get to the core of your problem and get that into the open, so that you can see what it is. And we both can see where it originates and then a new avenue opens for you in life, hmm? And then there is a hope that, for the balance of your life—because you are very young now, you have a long way ahead—you can live the way you want to live rather than be affected by all these problems that you have. Then if we achieve that today, we can say good-bye to each other in a positive atmosphere. How do you feel toward me now?

PT: I feel better, but I can tell you honestly I think I'd feel differently if you were a woman . . .

This also is being used as a defense and must be challenged:

TH: But that doesn't solve the problem.

PT: No, but I have difficulty being close to you.

TH: I know, but we are here to solve the problem. You have been trying to avoid the problem. "If I was a woman"—still, avoidance. But avoidance doesn't solve the problem. You don't need me to expound on that. Running away, closing your eyes, facade, avoiding, doesn't solve it. We have to examine it. I am sure it is painful, but that is the only way we have, hmm?

PT: That's right.

At this point the therapist suggests having a five-minute break.

Now that the first breakthrough has been achieved the therapist embarks on fact-gathering. As always the aim is first to explore the patient's adult life and relationships. This will give him a picture of the disturbances that need to be explained, which will help to direct him in his later exploration of the past.

### Summary

In the first part of this two-part article I have outlined the central dynamic sequence in the process of direct access to the unconscious and pointed out that the whole process can be divided into a series of phases, each consisting of a particular intervention with its corresponding response, and emphasized that these phases tend to overlap and proceed in a spiral rather than a straight line. The central dynamic sequence can be seen as a framework which the therapist can use as guide. The two major protocol, partial and major unlocking of the unconscious, were presented; and the trial therapy of a case, the "Fragile" Woman, was presented to demonstrate the technique of the major unlocking of the unconscious.

She entered the interview with a great deal of anxiety and in a state of transference resistance. The therapist for a moment bypassed the transference resistance and employed a set of interventions and came to the conclusion that there was no sign of a severely fragile ego and there is a major anxiety in relation to aggressive impulses. Then he quickly moved to pressure and challenge to the transference resistance and there was a head-on collision with the transference resistance. This finally led to a breakthrough of the aggressive impulse in the transference and the emergence of a deep sadness with a major communication from the unconscious therapeutic alliance. Here we break off the interview, which will be continued in the next article.

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# The Central Dynamic Sequence in the Major Unlocking of the Unconscious and Comprehensive Trial Therapy. Part II. The Course of Trial Therapy after the Initial Breakthrough

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In this Part II of a two-part article the author presents his technique of comprehensive trial therapy. The central dynamic sequence for the major unlocking of the unconscious is described by a complete account of the interview which was used as an example in Part I.

## Recapitulation

In Part I of the present article I described the phases of the central dynamic sequence in the major unlocking of the unconscious, which may be summarized as follows:

- Inquiry: exploring the patient's difficulties and the patient's initial ability to respond
- Pressure: leading to resistance
- Clarification and Challenge to Resistance: with particular emphasis to make patient acquainted with the defenses that have paralyzed his functioning and turning the patient against his resistance and emphasized challenge to the resistance against experience of impulse-feelings in the transference and challenge to resistance against emotional closeness in the transference.
- Transference Resistance: with special emphasis on head-on collision with transference resistance; mobilization of the unconscious therapeutic alliance and to maximize the inner tension between the unconscious therapeutic alliance and the resistance.
- Intrapyschic Crisis: breakthrough of the complex transference feelings; the triggering mechanism for unlocking the unconscious.

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- Systematic Analysis of the Transference
- Further Inquiry and Developmental History
- Phase of Direct Access to the Unconscious and Direct View of the Multifoci Core Neurotic Structure

I emphasized that these phases tend to overlap and proceed in a spiral rather than a straight line.

### The Case of the "Fragile" Woman

In Part I, I gave an example and analyzed the process of a trial therapy of a 30-year old divorced woman who suffered from a masochistic character pathology, depression, diffuse anxiety which had permeated most aspects of her life, and major disturbances in inter-personal relationships. She entered the interview with a great deal of anxiety. The therapist modified his technique and bypassed the transference resistance for a moment, to determine if she suffered from a fragile ego structure as was diagnosed by the first evaluator. After the therapist had determined that she did not suffer from a fragile ego structure, he moved to putting pressure on the patient to experience her transference feelings, progressively escalating the degree of challenge, and finally bringing about a head-on collision with her transference resistance (Phases 3 and 4). This led to systematic challenge to and pressure on her resistance to experience the impulse in the transference, the link between the impulse of anger and anxiety, challenge to her resistance against emotional closeness in the transference, which finally led to the breakthrough of the aggressive impulse in the transference (Phase 5) and emergence of a deep sadness and the breakthrough of grief-laden unconscious feelings, and in a state of sadness and crying saying that "the disappointment is so deep that I wonder if I can ever love anyone." At this point we resume a detailed account of the rest of the interview.

After the first breakthrough was achieved the therapist embarked on fact gathering.

### Inquiry, Alternating with Challenge and Interpretation Directed toward Various Defenses

As I indicated before, the aim is to explore the patient's adult life and her present life orbit. This will give a clear picture of the disturbances that need to be explained, and most importantly will help the therapist in his later exploration of the past.

This phase proceeds in a spiral: it starts with purely factual inquiry, but very quickly the therapist has to deal with the return of resistance in the transference. In fact this is the last occasion on which transference needs to be mentioned until the very end of the interview. The therapist then begins to explore current relationships and finds an opportunity to show her the various mechanisms that she uses in order to avoid anger. He resumes factual inquiry and meets her most important—and most pathological—recent rela-

tionship, and from now on the inquiry becomes completely psychodynamic. This leads into an area which she finds the utmost difficulty in discussing, and he has to carry out a great deal of work on her defense, which involves a second head-on collision. The result is a deep exploration of her fantasy life.

The question-and-answer parts of this phase will be summarized.

*TH: Now you said that you got a separation, am I right?*

She met her husband while travelling in Mexico and married him at the age of 21. The marriage lasted seven years. She described him as very active physically and mentally, very athletic, intellectual, and musical. Throughout their marriage he was a student, doing his undergraduate degree followed by a master's degree.

*TH: What type of person was he besides athletic and intelligent?*

*PT: He was a demanding type of person.*

*TH: In what way demanding?*

*PT: Uhh . . .*

As will emerge later, the patient's relation with difficult men is a very sensitive area, and the therapist detects nonverbal signs of mounting resistance which need to be challenged.

### Phase (5) Resistance in the Transference

*TH: May I ask you, how do you feel when you look at my eyes, because I have a feeling that you don't feel comfortable?*

*PT: No I don't, I don't know why.*

Challenge to the resistance against emotional closeness in the transference.

*TH: How do you feel when you look at my eyes?*

*PT: Uhh, that you're looking through me.*

*TH: But that doesn't say how you feel, that is a description of me.*

*PT: Uh, I feel it's too personal. I want to hide from you.*

*TH: Do you usually have difficulty with eye contact or is it specifically with me?*

*PT: I don't know.*

*TH: I am not sure that you don't know. This is a way of avoiding again. You see, we know about the facade and the way you hide, and "I don't know" is another way. "I don't trust you" is another way. These are all mechanisms you use to avoid. If you move to avoidance we are not going to get there, and I hope your decision is that we get there.*

*PT: Okay.*

## Return to Inquiry

In answer to the therapist's questions the patient said that her husband demanded both that she should be as physically active as he was and that she should have the same intellectual interests. He wanted her exclusively to himself, to be with him all the time.

The therapist detects the issue of control, which had emerged as a problem in the transference, and he underlines this:

*TH: So he was a very controlling person?*

*PT: Yes.*

*TH: Something that is always very disturbing to you.*

*PT: Yes.*

The therapist searched for the possibility that she already knew her husband to be controlling before she married him, to which she said that he was the leader and she was something of a follower. The quality that had attracted her was his "versatility," which she admired. It seemed that their relation began to deteriorate a few months after they were married. Her husband had been very inexperienced sexually, but their sexual relation had become more fifty-fifty as he became more confident. In the first two or three years, sex was not too satisfactory and she had experienced orgasm, but she said that he had not been sensual or caressing enough.

The therapist then asked a question which led back into a crucial dynamic issue.

## Analysis of Triangle of Conflict in Relation to Her Ex-Husband (C)

*TH: Did you look forward to sex or were you forcing yourself to go through it?*

*PT: Sometimes I looked forward to it and sometimes when there was animosity between us I resented it.*

*TH: When you say animosity, what was that?*

*PT: Anger.*

*TH: What was the anger like?*

*PT: (She hesitates) . . . I got very excited, I would yell and scream, I would talk very fast.*

*TH: So your way of expressing anger is screaming, hmm?*

*PT: That's right.*

Just as it is crucial to be able to distinguish between true grief and the defense of "weepiness," it is crucial to distinguish between anger as an Impulse and Anger as a defense, screaming, temper tantrum, etc.

*TH: I see. It is like a form of temper tantrum?*

*PT: Uh, yeah.*

*TH: So then one of the ways you deal with anger is getting anxiety, hmm? Another way is in the form of a temper tantrum?*

*PT: Uh hmm, that's right.*

## Analysis of the Mechanism Responsible for Her Depression

The therapist now seeks to acquaint the patient with the link between anger and depression:

*TH: Now the other thing that is very important to look at: have you noticed that when you get angry and then get anxious, you get depressed as well?*

*PT: Yeah, withdrawn, which I guess is synonymous with depression.*

*TH: Because one of the mechanisms you use to deal with anger is becoming detached or withdrawn, hmm?*

*PT: That's right.*

*TH: Another one is that massive anxiety takes over. Another is that you get depressed, hmm?*

*PT: Yes.*

*TH: Because a while ago I was asking, where does the anger go? You know it doesn't evaporate. So one way of dealing with anger is detachment, another way is to become withdrawn, and another is to have a temper tantrum, which is a helpless position. Another way is to get depressed, hmm? Have you had thoughts about that? One of the ways of dealing with anger is getting depressed and weepy?*

*PT: Weepy?*

*TH: You know, crying and then depressed.*

*PT: Oh yes, I do that. I feel helpless when I have anger and I can't express it, so I get very depressed and I cry.*

## Return to Inquiry: Previous Therapy

The therapist asked how the marriage ended, and the patient mentioned that she was pushing her husband to go with her to a (woman) counselor. Her aim had been to find some way of making him understand what was wrong in their relationship. However, he had refused, and she had gone by herself intermittently for about two years, continuing after the separation, which was about four years ago. They are now divorced. There are no children.

*TH: Then any other men in your life?*

*PT: While we were approaching a separation I felt close to another man. His name was Kirk.*

*TH: Could you tell me about him? What type of person was Kirk?*

At this point the severe pathology in her relation to men begins to emerge and the inquiry becomes entirely psychodynamic.

### Psychodynamic Exploration of Adult Life

*PT: Uh, he was a very athletic person. Very explosive.*

*TH: So you gravitate toward athletics mostly, hmm?*

*PT: Uh hmm, mind you, I hate people in sports. I think they're stupid most of the time.*

*TH: Paradoxical, hmm?*

*PT: I don't have such respect for big football players and people who spend their whole lives watching—I don't even watch sports. I abhor them and people have to drag me.*

*TH: But you marry them, hmm?*

*PT: There's a difference between being athletic and physically active and being a sports-person.*

*TH: Okay. What else would you say about Kirk?*

*PT: Uh, he was the most difficult person I've ever met in my entire life.*

*TH: In what way?*

*PT: I felt he deceived me. He extended his friendship and understanding to me, and really he was a very insecure human being. He was three or four years older than me, and when I became more open and told him about the things that had happened between myself and my husband, it all boomeranged back to me. He became abusive verbally and physically.*

*TH: In what way? Could you give me an incident?*

*PT: I remember once we were talking about something, and I disagreed with him. He slapped me across the head really hard and my head went banging into a wall. I had a lump on my head afterwards.*

*TH: You were living together?*

*PT: Yeah. We lived together for about five months.*

*TH: How many times did this happen, that he slapped you or physically hit you?*

*PT: Uh, three distinct times.*

*TH: So it is the kind of situation that you end up to be abused by him?*

*PT: Yes, very badly.*

*TH: Do you remember the incident when he became so violent and your head was bruised?*

The patient explained that she identified herself with her husband's politics, with which Kirk violently disagreed.

*PT: And he yelled and screamed at me and threw me across the room.*

*TH: Are you saying that he threw you across the room?*

*PT: Yeah, and he humiliated me verbally.*

*TH: He verbally attacked you and physically, and you were on the floor?*

*PT: Yeah, I was petrified.*

The relation with Kirk indicates that a punitive superego is in operation; her need to be used and abused. The therapist now employs a general principle of dialogue with the unconscious, which was contained in his handling of the issue of "trying to get the patient angry"—that is, he goes straight for the simple emotional truth, ignoring the fact that the whole truth is more complicated than this. The patient is describing a state of fear, which is a natural response to an external danger. There is no doubt that this is part of what she felt; but the therapist knows that she is also using this description as a defense against describing her fear of her own violent reaction, which would be experienced not as fear but as anxiety. The objective truth is that she probably experienced a mixture of the two, and it would be easy to get drawn into a sterile intellectual discussion of the exact proportion of each that were present in her state of mind. Instead of this he ignores objective reality and implies that all she felt was anxiety, which is too black and white to be literally true, but which tears aside the defense and confronts her unconscious—which deals largely in black and white—with the psychodynamics of the inner situation. This leads at once into her fear of her own impulses, and very shortly into a central aspect of her psychopathology:

*TH: Petrified. You mean a great deal of anxiety? And what else did you feel, because it is a situation where Kirk in a very brutal way is abusing you. But then you are on the floor and have a massive amount of anxiety, but what else did you feel toward him?*

*PT: Immense hatred.*

The word "hatred" does not imply any impulse.

### Challenge and Pressure to the Resistance against Experience of Impulse Outside of the Transference

*TH: But what else?*

*PT: Immense anger.*

*TH: How did you experience that immense anger?*

*PT: Oh, I felt paralyzed.*

*TH: So, you see, you have a lot of anger and rage toward him but what comes to the surface is being paralyzed, hmm?*

*PT: Well, I was defenseless. If I raged against him my life would be in danger.*

*TH: That intellectually is one thing, but again there is massive rage, and a great deal of anxiety to the level that you are helplessly paralyzed.*

The therapist recognizes an all too familiar pattern which seemingly is more often encountered in women than in men: the patient is terrified of her own violent impulses and full of guilt about them, and therefore needs both to defend herself against them and to punish herself for them. She can combine the two by turning them against herself and becoming the "professional victim," seeking out men who will use and abuse her. (Clinical manifestation of superego pathology by the author (Davanloo, 1987c, d). The therapist prepares the way for bringing this mechanism into the open:

*TH: You are the victim, hmm? (She is the victim to her punitive superego.)*

*PT: I did react once when I was outdoors and he started getting abusive and I screamed at the top of my lungs.*

A less experienced therapist might be forgiven for thinking that this was the full expression of her rage, but here the therapist recognizes the crucial fact that it was a regressive defense, a helpless ego in relation to a highly punitive superego.

*TH: What happened to your rage with Kirk? What happened to that rage?*

*PT: Oh, it was sublimated.*

*TH: Yeah, but sublimation means what? It is very important this, you see.*

The true extent of her rage now emerges:

*PT: Well it . . . it . . . what happened . . . it manifested itself in very mean devious thoughts of hurting men.*

*TH: You mean in fantasy you wanted to get at him? What was the fantasy?*

*PT: I wanted to see him dead. I wanted to see him killed.*

*TH: In what way did you want him dead? Was it in the form of murder?*

*PT: Beaten.*

*TH: By who?*

*PT: By somebody that I hired to kill him.*

*TH: In what way would that somebody kill him?*

*PT: To verbally and physically brutalize him.*

*TH: But in what way? With a knife? What equipment would be used?*

*PT: Bashing his head. I don't know . . . to tell you the truth, I don't remember.*

*TH: I'm not sure you don't remember. These are the things you wipe out. Because the idea is that you hire a person to brutally murder him, and then obviously who is that someone who is going to brutally murder him?*

---

*PT: I don't know.*

*TH: It is you! (The patient laughs.) The impulse is within you. But you prefer somebody else to commit the murder rather than yourself.*

*PT: That's right.*

The therapist now interprets the mechanism of turning her aggression against herself:

*TH: So the rage with Kirk has the quality of murdering him, but then who gets murdered really? Who is crippled?*

*PT: Me.*

*TH: You are crippled.*

*PT: Uh hmm.*

#### Distributional Pathway

There is further analysis of triangle of conflict; the therapist summarizes mechanisms for avoiding anger and continues the process of driving home insight into her manifold defenses against the impulse.

*TH: So then what is the pathway of this massive rage? It is multiple now. One pathway is massive anxiety, or you take it out on your G.I. tract. You develop gas and diarrhea. And another way is turning these massive murderous impulses against yourself in the form of depression. And I think it is very important that you keep your eye on the way you deal with these impulses. One way is to be detached and withdrawn, another way is to be crippled with anxiety, another way your poor G.I. tract has to suffer. Another way is that you become depressed, and sometimes you have the idea that you wish you were dead. Then it is very clear that the rage doesn't evaporate, hmm?*

*PT: No.*

*TH: This is how you deal with the rage.*

#### Further Exploration Leads To a Crucial Issue

*TH: Now you left him or he left you?*

*PT: I left him.*

*TH: How was the sexual aspect of your relationship?*

*PT: It was very intense.*

*TH: You mean it was better than with your husband?*

*PT: Yeah, in some ways it was better. He was very seductive.*

*TH: But, you know, there is something there. You might want to look at it. Kirk is brutal and aggressive and sexually you respond better, while your husband is not outwardly sadistic or aggressive.*

*PT: Oh, he was to some degree.*

*TH: You mean physically also? Like Kirk, you mean . . . ?*

*PT: When he got really angry, he wasn't—I never met anybody like Kirk—but he would lash out at me sometimes physically, push me—but I wasn't afraid of his anger. Well in the moment I was but not as a rule.*

*TH: Have you ever had thoughts that in situations where there is brutal and aggressive behavior toward you, like with Kirk, that you would have more pleasure sexually?*

#### Major Increase in the Unconscious Therapeutic Alliance

At this point the work on the defenses is shown to be paying dividends, for the patient comes out with a revelation that lies at the heart of her pathology:

*PT: Yeah, there is problem sexually, because I notice that my sexual fantasies were always of me being brutalized, and that's how I was excited.*

This information would not have been reached by direct questioning, without all the work on her defenses. The information emerged spontaneously in a highly dynamic fashion, in the context of the description of her relations with men and interpretations about self-directed aggression. This marked a major increase in the unconscious therapeutic alliance, but it cannot yet be described as the beginning of the phase of major direct access to the unconscious, because—as will be seen—superego resistance is very far from being at an end.

*TH: In sexual fantasies you are always being brutalized? You mean sex and aggression are mixed together?*

*PT: Yes.*

*TH: Could we look to one of the fantasies?*

*PT: Uh, being raped, in a way.*

*TH: Could you describe the situation?*

*PT: Uh, being held down, being . . .*

*TH: Could you give a specific fantasy?*

*PT: That's too hard.*

#### Phase (5) Head-On Collision with Transference Resistance

It is absolutely essential to handle this resistance, and the therapist brings in a second head-on collision:

*TH: Again I'm passing the barrier, hmm? (The patient sighs.) Because again we are getting to the intimate thoughts, hmm? And now as soon as we want to get to your intimate thoughts, then you want to put again the barrier, and I have told you that as long as this barrier is put up this process is going to be crippled.*

*PT: Uh hmm.*

*TH: Now do you want it crippled or do you want that we . . . ? It is your choice.*

*PT: I'll try.*

This is not enough, and the therapist redoubles his challenge on her defenses. "The resistance must be not merely knocked out but counted out."

*TH: Let's face it, if we don't pass the barrier and get to your intimate thoughts and fantasies—we have to come a long way and understand many things much better, okay?—but if we don't pass this barrier and get to the very important issues which are the sources of your suffering, then this process will fail, okay?*

*PT: Uh hmm.*

*TH: You fail, the process fails, and you go on perpetuating your suffer-*

*ing. Now let's face it. I can walk out when we say good-bye to each other, and accept that I failed. I can afford to be a failure—what can I do? I can do my best and say, okay I failed, what can I do further? But can you afford to be a failure? You are young and intelligent and have potentiality, which are all crippled. So as long as you put up this barrier the process is doomed to fail, but you are going on to suffer. Now let's see what is your specific sexual fantasy.*

#### The Patient's Sexual Fantasies

The following passage needs considerable discussion. In it the therapist relentlessly extracts from the patient every intimate detail of a number of highly embarrassing sexual fantasies. The therapist's reasons for doing this are twofold: First, only if such details are known will it be possible to understand her psychopathology in depth; and second, this process provides an exercise in self-revelation which will have a "desensitizing" effect and will facilitate the later exploration of other difficult and painful areas.

However, the therapist must exert the utmost care. The common theme running through the patient's sexual fantasies is getting sexual pleasure from being humiliated—does not the very act of making her tell her fantasies collude with this need in the actual therapeutic situation? At first sight it would seem that this is inevitable, but in fact it is not so, provided two essential conditions are fulfilled: The first is that, as mentioned before, the therapist must be comfortable with his own unconscious impulses and must make clear by his attitude and manner and his unconscious communication that his relentlessness contains no trace of sadism and is entirely in the interests of helping the patient. The second is that the transference—especially the anger—must have already been thoroughly brought into the open and experienced, and thus resolved. Since the patient's masochism is a way of dealing with her anger, there is now no need for a masochistic relation with the therapist; and in fact the therapeutic alliance is powerful enough to respond to the reality of the therapist's efforts to help, and to override completely the transference fantasy that might otherwise develop.

Now we return to the interview.

*TH: Okay, the one that you used to have, what was that?*

*PT: Being captured by a gang of people, men and women, and abducted.*

*TH: Where are you captured by these people?*

*PT: I'm in a city. I'm abducted by a group of people, brought blindfolded. I'm brought to a basement or a dark place, and both men and women have sex with me and force me to have sex with them.*

*TH: You mean your eyes are closed but . . . ?*

*PT: Well maybe when I'm there my eyes are not closed.*

*TH: How do they look? They are recognizable people?*

*PT: Uh hmm.*

*TH: What type of men and women are they?*

PT: Young, my age.  
 TH: What color?  
 PT: White.  
 TH: How many are they?  
 PT: Six, seven.  
 TH: And then all of them are having sex with you?  
 PT: Not all, maybe two or three, and the others are watching.  
 TH: But they are forcing you against your will?  
 PT: Uh hmm.  
 TH: How do they do that?  
 PT: I guess they threaten my life.  
 TH: The ones that have sex with you, are they men or women?  
 PT: Both.  
 TH: And the ones who are watching?  
 PT: Both.  
 TH: In what way are the men making love to you?  
 PT: Uh, forcing me to perform fellatio, having intercourse, having anal sex.  
 TH: So first they demand you suck their penis, and then they have intercourse, and then they force you to anal intercourse. How about the women? How do they make love to you?  
 PT: I have to perform cunnilingus.  
 TH: Oh, there you have to suck their genitals and oral sex. And the other ones watch. They don't touch you, you mean?  
 PT: No.  
 TH: And then what happens?  
 PT: It ends. Uh . . . uh . . . I'm left feeling brutalized. I never imagine the ending, or maybe I don't remember. I don't know.  
 TH: After anal intercourse it stops, or there is something else?  
 PT: I relive the fantasy many times until I feel, I guess, either somewhat disgusted with myself, or physically satisfied in some way.  
 TH: You lie down in bed when you have this fantasy?  
 PT: Yeah.  
 TH: And what do you do while you have this fantasy?  
 PT: Uh, I don't remember.  
 TH: I mean, you're masturbating, or . . . ?  
 PT: I think I'm touching myself.  
 TH: You see, again you are censoring yourself: "I think I'm touching myself."

Her vagueness having been challenged, she tries generalization:

PT: Well, because each type of fantasy is different.  
 TH: We are talking about one of them.  
 PT: Well . . .  
 TH: Do you masturbate when you have this fantasy?  
 PT: Masturbate? Yes, I touch myself. Whether I'm actually masturbating to bring myself to a certain sexual peak, no, I have not. With that fantasy, no.

TH: Not with that fantasy?  
 PT: No.  
 TH: What part of your body do you touch?  
 PT: I touch my genitals but I just touch them. It's like I'm holding onto myself.  
 TH: And this brings pleasure to you?  
 PT: Uh, yes.  
 TH: Does it lead to orgasm?  
 PT: It leads to intense sexual excitement but not to orgasm.  
 TH: The sequence is oral sex, then vaginal, and then rectal?  
 PT: Uh, yeah.  
 TH: I see. Now you said you have another fantasy. This fantasy you don't have any more. Up to what age did you have it?  
 PT: Up until two or three years ago maybe.  
 TH: But then you have another fantasy that comes with masturbation? What is that like?  
 PT: That I'm uh, performing on a stage for a group of people.  
 TH: In what way are you performing?  
 PT: I have to bring myself to orgasm and that's my only goal.  
 TH: I know, but could you describe the stage?  
 PT: Uh, I'm in some kind of sex bar or place where people perform sexual acts, and it's a performance.  
 TH: And you're nude, you mean?  
 PT: I'm nude or at least my genitals are showing in some way.  
 TH: And then what else?  
 PT: Uh, there are people watching. They are in an audience, it's like a bar and they're drinking and watching.  
 TH: And what are you doing on stage?  
 PT: To . . . masturbate myself. To touch my clitoris until I orgasm.  
 TH: You have this fantasy at the present time?  
 PT: Sometimes, yes.  
 TH: But there is no violence toward you in this fantasy, am I right?  
 PT: Yes.  
 TH: In the first one . . .  
 PT: There is violence.  
 TH: How far back in time does the first fantasy go?  
 PT: It started at about 13. I feel like, I told you . . . but there are others. I feel embarrassed a little bit, I guess.  
 TH: Uh hmm. But obviously these are very important things, because in some of them you are being tremendously abused. Hmm? And if you look to your relationship with men, there is a tremendous amount of you being used and abused.  
 PT: Uh hmm.  
 TH: But you said there is another type of fantasy, and I have a feeling that there is some censorship with me. You don't want to tell me some of the other ones.  
 PT: Uh hmm.  
 TH: What is the nature of the other ones?  
 PT: Hmm, involving animals.

*TH: What animals?*

*PT: Ah, dogs.*

*TH: What is that fantasy?*

*PT: Having sex with the dog. Being forced to.*

*TH: Who are the people who are forcing you?*

*PT: Same people.*

*TH: What type of dog is it?*

*PT: Ah, a German Shepherd, I don't know, black dog, big dog.*

*TH: Uh hmm. And then in what way is the dog having sex with you? Because we know they would have oral, then vaginal, then anal, but how about the dog?*

*PT: Vaginal.*

*TH: Uh hmm. So, this dog is having sex with his penis, hmm? And this would bring you excitement?*

*PT: Yes, but not orgasm.*

The therapist now needs to find out whether these fantasies are so powerful as to override her sexual response to an actual man:

*TH: Did you have this kind of fantasy during the sexual relationship with Kirk, for example, or with your husband?*

*PT: No.*

*TH: Where was your mind when you had sex with your husband?*

*PT: Ah, wait a minute now, sometimes with my husband I felt it was more the performance type of fantasy, somewhat forced performance though. Because we were very sexually active, we danced for each other and umm, we created fantasies of seducing each other, imagining that we didn't know each other. And my husband, umm, ah, liked to force me sometimes to do certain things.*

*TH: Sort of pretending he is forcing you to have sex with him?*

*PT: No, actually the fantasies that we had together were not so brutal. They were more pleasurable and fun, and childlike in a way.*

*TH: I know, but a mild type of forcing you to have sex, as if you didn't want it but you did want it?*

*PT: Yeah.*

*TH: How about with Kirk? Was there the force element in it?*

*PT: Yes, yes, yes there was force.*

*TH: What we can see is this, that when you are forced into it, it is more intense.*

*PT: More exciting. Ah, with him there was a force element. He . . . he was physically very aggressive.*

Here enquiry revealed that the main preference on both their parts was for straightforward sexual intercourse.

#### Relations with Other Men

In answer to further enquiry, it emerged that she had had two men friends since she broke up with Kirk. She described the first, John, as "a

very nice man, very gentle," but the relation only lasted for six months because they came from different religious backgrounds—a fact which she knew when she first started dating him. Soon after this she met a man called Charles, who came to live with her. This relation lasted for two years, up to four months ago. She described Charles as "very gentle and accepting," and she said she really loved him. He would listen to her and comfort her when she was upset, but he kept her at a distance emotionally and never let her into his world. She said that after about a year she had become very unhappy because their sex life was "very dispassionate."

The therapist summed up:

*TH: So you see—it is very important that you look at this process—that all your relationships with men have turned out to be a severe disappointment, one way or another. In some of them you have been the target of being used and abused. In others you get emotionally attached, but then for whatever reason he cannot move toward you. So all your relationships with men end up in failure or disaster.*

*PT: Uh hmm. It's caused me a lot of pain.*

#### Further Inquiry

#### Previous Therapy (In Addition to Marriage Counselling)

She went to a woman therapist for about seven months last year. She said they never touched on her problems in relation to men. "Overall it was rather boring. She wasn't good enough to get through the facades. I guess I never let her through."

#### Direct View of the Multifoci Core Neurotic Structure

The therapist has completed his survey of the patient's recent life and has exposed a very severe sado-masochistic character disorder. The time has now come to try and find out how this originated.

He opens with purely factual questions, but as soon as he begins to ask about relations within the family the enquiry inevitably develops more and more of a dynamic quality. As eventually becomes clear, all the previous work—the challenge to the resistance, the open emergence of anger in the transference, the head-on collision with the resistance against allowing emotional closeness, the emergence of deep sadness, the analysis of the transference, and the "desensitization" provided by refusing to allow her to gloss over her sexual fantasies—has led directly to Phase (7) of the central dynamic sequence, namely the phase of direct access to the unconscious. Now resistance is only minor and is easily penetrated, and there is no need to mention the transference again until the closing passages of the interview.

#### Family Background

The family on both sides is of Greek extraction, but both parents were

born and brought up in Philadelphia. The patient is 32 and has two younger sisters, one 28 and the other 24.

#### The Patient's Father

She said that her father was a very loving, emotionally expressive man, and that she got on well with him "until adolescence." The therapist noted this but did not ask for details.

#### The Mother

As soon as the therapist opened up the subject of the patient's mother, the enquiry rapidly became much more than purely factual:

*TH: And then how do you remember your mother as a child?*

*PT: Very nervous.*

*TH: In what way was she the nervous type?*

*PT: Always yelling and screaming. Very loving and affectionate, but very abusive.*

*TH: Uh hmm. In what way was she abusive?*

*PT: Verbally and physically?*

*TH: Abusive of whom.*

*PT: Of me.*

It emerged that she was probably most abusive with the middle sister, and least abusive with the youngest, whom she spoiled more. As far as being affectionate was concerned, the patient spoke of her mother as follows:

*PT: She would always feel guilty after she was abusive and tell us that she loved us; and she would always try to blackmail us—not blackmail, but bribe our love back by buying us gifts or taking us to a store and buying us something that we liked.*

Further enquiry established that in addition to being abusive she had also been physically affectionate, but that this was true only when the children were small. It changed after they reached the ages of eight to ten.

Thus it seems that the patient lost the love of both her parents, which must be linked with her statement, "the disappointment is so deep." Moreover, it seems probable that her pattern of taking up with men who abuse her must be linked in some way with her relation with her mother.

At this point the therapist proceeds to explore genetically structured conflict.

*TH: What is your earliest memory of life? As far back as you can go, anything that stands out in your memory.*

*PT: Ah, the first time my mother hit me, I remember.*

*TH: Uh hmm.*

*PT: I also remember . . .*

The therapist blocks this attempted diversion:

*TH: What is that memory that your mother hit you?*

*PT: I was living in the house that I came home to after I was born. So I must have been less than three years old. When I was three we moved, and my mother was already having another child. She was washing or dressing me and she smacked me on my rear end for fooling around.*

The therapist remembers both the teacher and the sexual fantasies:

*TH: You mean there was an element of humiliation?*

*PT: I was shocked. I remember being shocked.*

*TH: Was this pleasant or unpleasant?*

(Was there an element of masochism already present?)

*PT: Very unpleasant.*

*TH: So your first memory relates to your mother smacking you on your rear end, hmm? Was she like that later?*

*PT: As the others came along she became more abusive, but not too much to me.*

It is worth noting how easily this denial is penetrated. We are now entering the phase of direct access to the unconscious.

*TH: Could you describe incidents that your mother was abusive? Because "abusive" doesn't tell us much.*

*PT: Ah, she would curse and say things like, she should have had her head examined when we were born, ah, she would take her shoe and whack me from behind ah . . .*

*TH: Was it mostly on your rear end . . . ?*

*PT: On my arms, with shoes.*

*TH: What else did she use to punish you? She was physically violent?*

*PT: Very physical. She'd chase after me with a belt. I, I, remember this in my later years. But I was always bigger than her, she's only five foot four and I grew tall very fast.*

*TH: It doesn't make a difference, there was physical punishment.*

*PT: Yeah, but I could escape though, because I could run faster.*

*TH: But you mean you managed to stay and get beaten by her?*

(The therapist is still searching for early masochistic tendencies.)

*PT: It was a surprise attack, I wouldn't stay there and allow myself to be hit by her. I would run, or sometimes I'd block her with my arm.*

*TH: You mean you would fight back?*

*PT: No, I didn't fight back, I would block her when I saw her arm or hand coming.*

*TH: What else did she use besides her shoe?*

*PT: A, a belt, a strap, she would grab my father's belt and chase me.*  
*TH: Where would she hit you most?*

*PT: Anywhere, she just aimed, aimlessly. I remember one incident when she actually hit me with the buckle on my head and I started bleeding.*

*TH: Uh hmm. That bad!*

The therapist is noting a link between the way she was attacked by her mother on her head and the way she was pushed by her boyfriend Kirk against the wall and she had a bump on the top of her head.

*PT: But she started crying . . .*

*TH: And this violent behavior carried on until what age?*

*PT: Oh, 14 or so. She became less physically violent as I got older and more verbally abusive.*

*TH: Uh hmm. What was her verbal abuse like?*

*PT: She called me a whore, a tramp, a bitch, anything that was derogatory toward women.*

*TH: She would call you a whore.*

(The therapist is noting a further link with her sexual fantasies.)

*PT: Uh hmm. She would spit at me sometimes when she was really mad, spit in my face.*

*TH: So then you had a very disastrous relationship with your mother, didn't you?*

*PT: Uh hmm.*

#### Another Very Important Relationship

Many patients who have had a disastrous relationship with their own parents have managed to turn for warmth to someone else, either a neighboring family, or some other relative—who may also be a member of the household. These substitute parents and families are of central importance, mitigating the traumatic nature of the early experiences—but in many cases something has gone wrong even with them, which intensifies the tragedy and solidifies and perpetuates the pathological patterns of relationships throughout the patient's subsequent life.

*TH: Was there any other person in your life besides your mother and your father?*

*PT: My grandmother, my father's mother, lived with us.*

*TH: Uh hmm. How old was she when you were a little girl?*

*PT: She must have been in her late fifties, early sixties.*

*TH: Uh hmm. What type of woman was she?*

*PT: Ah, a little, sort of very loving, ah, little old peasant woman, very superstitious.*

*TH: She was born in Philadelphia or in Greece?*

*PT: Greece. She was quite sick.*

*TH: How do you remember her? Because, you see, you have a disastrous relationship with your mother, belted, the shoes . . .*

Having previously reached the anger and the deep sadness, we now reach the pain: Patient is very sad, is choked up with waves of painful feeling, sobbing.

*PT: Uh hmm. I remember her as my friend. (The patient is choked up, emotionally charged.)*

*TH: You had a close relationship with her?*

*PT: As close as a child can have, I think.*

*TH: Was she a loving woman?*

*PT: Yeah. (She is crying.) She always protected us. She'd scream at my mother.*

*TH: Was it effective, her protection of you?*

*PT: Sometimes, yeah.*

*TH: Uh hmm. So then you must have developed a much closer relationship with your grandmother, am I right?*

*PT: Yeah. But she didn't speak English that well, so it was very limited.*

*TH: But still, demonstration of affection doesn't have to be verbal, but there was a feeling of closeness, that she was interested in you. She was a loving woman?*

She is crying, with the wave of emotional distress.

*TH: Must be very painful, isn't it? . . . What happened to her?*

*PT: Oh, terrible things. terrible things. My father finally saved up enough money to take my mother and I, and my grandmother, to Greece to see her family, whom she had never seen since she left.*

*TH: And what happened?*

*PT: She, she broke her hip.*

*TH: Uh hmm. How old were you then?*

*PT: Oh, 16 I guess. She slipped on a step in the family room. She broke her hip and she had to walk around on a walker, and we couldn't go on the trip and she became so incapacitated and ah . . .*

*TH: Uh hmm. So then, what happened finally?*

*PT: Well, she became very difficult to live with because, ah, she needed constant care; she needed someone to give her a bath, put her in and take her out . . .*

The therapist prepares to make a link:

*TH: So she became really a "crippled" woman.*

*PT: Yeah, yeah.*

*TH: Uh hmm. So your grandmother was so loving and affectionate towards you, in this disastrous situation, then she breaks her hip and becomes crippled, so that somebody has to take care of her, hmm?*

The patient is choked, cries, has waves of somatic distress, sighing respiration, indications of an active mourning process.

TH: Uh hmm. And what happened to her finally?

PT: She wound up in a nursing home in Philadelphia because no one could take care of her.

#### Unresolved Mourning for Grandmother

In trial therapy, after unlocking the unconscious and direct access to the unconscious the pathological mourning becomes transformed into acute grief reaction no matter that the loss may have occurred many, many years before. Here the task of the therapist is to set this process in motion in the initial interview. The following passage illustrates the technique of working through unresolved mourning. The process consists of detailed reconstruction of the events surrounding the grandmother's death.

TH: Do you remember her in the nursing home?

PT: Oh yeah.

TH: What do you remember?

PT: Ah, she was very sad. She was getting senile, she couldn't remember things that well. She was very unhappy. She was very confused.

TH: And what happened to her relationship with you? Because at one time she was . . .

PT: It, it, it deteriorated when she was in the nursing home because I didn't visit her that much. I was leaving home, ah, I had my own problems, I was too distracted to really pay attention to her.

TH: Yeah, but it is very important to look at it. We know already that you have a strong tendency to avoid painful issues, you see. Now, if you look to this early part of your life, you have a disastrous relationship with your mother, and then this woman with the difficulty with the language, really it is an intense relationship you have with her, hmm?

PT: Yeah. (She is crying.)

TH: As if she was your mother, hmm? But then she becomes crippled, and now she is alone, hmm? And maybe a part of you wished that you could visit her, but the part of you that didn't want to face the pain avoided it.

PT: Yeah.

TH: Do you remember, when did she die?

PT: Ah, when I was 18.

TH: She died in the nursing home?

PT: In the hospital. I think she got a bleeding ulcer and it could have been cancer.

TH: Uh hmm. Do you remember what hospital she was in?

PT: Yeah. I was, I was there when she was dying.

TH: You were at her bedside?

PT: Yeah.

TH: How did she look then?

PT: She was moaning, ah, constantly, ah with pain, moaning these repetitive moans, like a crescendo of pain, and I held her hand and told her it would be okay, and I, I gave the . . .

TH: You held her.

PT: . . . I was holding her hand and I gave her water because she couldn't sit up. She was in agony.

TH: Uh hmm.

PT: And I just, I couldn't do anything.

TH: Uh hmm. How did you feel toward her? Because at one time she was your major support. Now she's crippled.

PT: I felt, ah, ah, I felt, I couldn't feel anything. I just knew that I loved her but I couldn't really feel anything.

TH: You put up the wall.

PT: I, I, I could see her dying and I was holding her and I knew she was dying, but I couldn't feel anything. I stopped myself.

TH: So she died in a very lonely way, hmm?

PT: Yeah.

TH: Do you remember the funeral?

PT: Yeah.

TH: What do you remember?

PT: Ah, my cousins and I, with my sisters, we all sat around and we talked about all our memories of her. We called her Yia-yia, from a Greek word for grandmother.

TH: But in a sense she was your . . . like your . . . mother.

PT: Yeah. And we talked about her, we cried. I cried a lot, but I think I was crying . . .

TH: Where is she buried?

PT: Near Philadelphia somewhere.

TH: Uh hmm. You mean you don't know where she is buried?

PT: I never went, I never go back to her grave.

TH: Uh hmm. Do you remember the burial?

PT: Vaguely, vaguely.

TH: You were 18 years old!

PT: Yeah.

TH: And this woman meant a lot to you obviously, hmm? So how come you don't remember?

PT: I guess I don't want to remember.

TH: I know.

The technique of a piecemeal review with the patient about the last part of her life with the deceased was originally described by Eric Lindemann. She is highly charged, crying; and as we see the process of mourning is both a cognitive and an affective process.

TH: You must have a lot of feeling about this woman who died both crippled and lonely.

PT: Yes. Yes. I can somehow see myself standing in a cemetery, but it's so vague, it's so blurry.

TH: Uh hmm.

PT: Ah, there's a lot of pain. I left soon afterwards.

TH: Did you at any time wish that you could visit her grave?

PT: Yeah.

TH: And did you? Avoidance?

PT: I didn't live in Philadelphia anymore.

TH: I know, but we know a part of you—look to the waves of pain, hmm?

PT: Yeah.

TH: So you have a lot of mixed feelings about this woman who dies crippled and lonely, hmm? And then obviously a lot of it was so painful that you avoided it, isn't that so?

PT: That's right.

#### Direct Interpretation of the Core Pathology

##### (1) Identification with the Crippled Grandmother

The patient's unconscious therapeutic alliance now responds to the therapist's repeated use of the word "crippled," enabling him to make a link which marks the beginning of interpreting the core pathology.

PT: I notice that you're using the word crippled again.

TH: I use the word crippled because she was crippled. She had a fracture, she was crippled, wasn't she.

PT: Well, she could walk with a walker, but she was handicapped. Yes, she was crippled.

TH: But don't you think that she died crippled and lonely and you are leading your life . . .

PT: Yeah.

TH: . . . as a crippled, lonely life also? Hmm?

PT: Yeah.

##### (2) Death Wishes toward the Mother

The therapist now opens up a much deeper source of intense guilt, self-punishment, use and abuse of herself, which are some of the manifestations of a punitive superego pathology.

TH: Now what do you think would have happened if your mother in the early years—this disastrous relationship that she is abusing you, chasing you with a belt and so forth—had died, dropped dead, what do you think would have happened to your life?

PT: I think I would probably have been raised by my grandmother.

TH: What would your life have been like if she had died?

PT: It would have been calmer, a lot calmer. Peaceful.

TH: Do you think maybe a part of you at some point wanted her dead?

PT: Oh yeah. Yes.

TH: If she had died you would have had a different situation? You say so because I said that or . . . ?

PT: No, because it's true. My father was more calm, even though he had problems. He was very strict. But her abusive yelling and screaming were unbearable.

Throughout this passage the patient is emotionally charged and crying.

##### (3) Mixed Feelings toward the Father

TH: Your father in the face of this brutal relationship of your mother and you, what was his reaction?

PT: He asked me to understand my mother.

TH: So in a sense he would prescribe tolerance of abuse, hmm?

PT: Yeah, and he would talk to her sometimes, and she would calm down for a little while.

TH: So you must have a lot of feeling because, from what you describe, you have a lot of positive feeling for your father. You are caught in the situation that your mother is brutal and aggressive, then obviously you move towards a tremendously close relationship with your father.

PT: Yeah, yeah.

TH: But then at the same time you must have other kinds of feeling, because he is prescribing tolerance of abuse. So do you think that you also have some other mixed feelings towards your father for not standing up, hmm?

PT: Yes, anger at him for not putting my mother in her place.

TH: So at one level you had an intense close relationship with your father, but at another level it was negative because he is prescribing that you have to be tolerant of abuse, hmm?

PT: Yeah. So I distanced myself from him, I lost respect for him.

TH: Uh hmm. You mean that you started to punish him, hmm?

PT: Yes.

##### (4) Oedipal Feelings

TH: But it is very important to look at that also. You start to punish your father when you are becoming a woman, hmm? Have you had thoughts about that? You see, at age 13 or 14 your body is growing and you are becoming a woman, and then you start to punish your father, hmm? Distance yourself, hmm?

PT: Yeah, I . . .

TH: Maybe that was another way of defending against certain other feelings for your father, that now that you are becoming a woman, you start to distance, and in a sense you are punishing him, but at the same time you have a tremendous close relationship with him, hmm?

PT: Uh hmm.

TH: So the question is this. Why do you start to punish him when you are becoming a woman?

PT: I didn't trust him to understand.

TH: What was the relationship between your father and mother like?

PT: Well, they were very affectionate with each other.

TH: She wasn't brutal with your father?

PT: Sometimes. But she behaved herself in front of my father.

TH: Uh hmm. What was the sexual life of your mother like?

### Exploring Her Parents' Relationship

PT: Ah, my father seemed to display physical affection to my mother in front of us, touching her rear, ah, grabbing her, holding her; not often, but enough to make me realize that they had some kind of physical contact behind closed doors.

TH: Uh hmm. You mean your father was sexually active?

PT: Sexually active . . . phew . . .

TH: Where does the idea come from that he was sexually active?

PT: Ah, there were condoms in his drawer.

TH: Uh hmm. So that was the indication that your father had an active sex life, hmm?

PT: Uh hmm.

TH: And how did you know that the condom was in the drawer?

PT: I looked.

TH: You mean you were curious about the . . .

PT: That's right. I was very curious about sex.

TH: You say you were curious about sex, but obviously you were curious about his sexual life, hmm?

PT: Yeah.

### Link between the Past and the Current

It is now essential to try to clarify the way in which her current disturbances originated in the past.

#### (5) Brutal Mother Patient's Need to be Brutalized by Kirk

TH: Now—we haven't had a chance to go over your relationship with your sisters—and as we are running out of time, we want to look to what we have observed. You see, if you look at it, and it is very important that we examine these things, you had this very disturbed relationship with your mother, you see?

PT: Uh hmm.

TH: And now you end up to be treated in the brutal way by men, at least with two of them, hmm?

PT: Uh hmm.

TH: If you look at it, with Kirk, it is as if you repeated your relationship with your mother, and the question is whether you have a tendency to gravitate toward men like your mother in some sense?

PT: Yeah.

TH: That they are either brutal, or nonaffectionate and cold, hmm?

PT: (She takes a deep breath) But I think Charles is more like my father.

TH: I am not saying that all is black and white, but if you look at it your relationship with men has a certain pattern. Either they are brutal like your mother, or they have difficulty with emotional closeness and affection, like Charles for example. Now, if you look to your sexual fantasies; in all of them, in a devious way, you are pushed into being brutally treated, being forced to have oral sex, anal sex—there is the element of aggression toward you, the element of use and abuse of your body.

PT: Uh hmm.

TH: And strikingly there is a mixture of men and women who are using your body and abusing it, okay?

PT: Uh hmm.

TH: And then another thing is that your mother repeatedly calls you a whore, hmm? And in your fantasy isn't there that as well?

PT: Uh hmm.

TH: So the question is this, if you hated your mother so much, why is there a need to gravitate towards a situation in which either you are used and abused, or there is element of prostitution in it? Do you see, your fantasy is an active production by your own self? Something that comes from your mother, hmm?

PT: Uh hmm.

#### (6) Major Conflict over Intimacy and Closeness

TH: But then if you recall, I told you that you are terrified of closeness and intimacy, and I was raising the question of what has happened to you in life that you have decided not to let anybody close to you?

PT: Uh hmm.

TH: Because if you look to your relationship with your mother, your father, even your grandmother, all of them are full of pain and disaster. The one that you had a very close relationship with ends up to have a fracture, becomes crippled and then dies in a very lonely way, hmm? So there is something about all these relationships—and we haven't touched your sisters—all these are playing in a very devious way into the core of your problem, hmm?

PT: Yeah.

(7) Murderous, Sadistic Impulses and Self-Punishment; Further Link between Mother and Current Relationships with Men

*TH: Now, as far as relations with men are concerned, you end up wishing you could murder Kirk. In terms of the fantasy that you hire somebody to blast him to the level that his brain is out. Now, who do you really want to murder?*

*PT: My mother.*

*TH: So Kirk was the representation, hmm?*

*PT: Yeah.*

(8) Brutality and Better Sexual Response

*TH: But then another thing is that when there is brutality in the system then you respond better sexually because there is an element of punishment, hmm?*

*PT: Yeah.*

(9) Need to Prolong and Perpetuate Suffering:

Masochism and Superego Pathology

*TH: But then, on the other side of the picture, these things have been going on until the age of 32 and somehow you have never wanted to do something about it. Maybe a part of you wants to carry on the crippled life and die like your grandmother. Hmm?*

*PT: Yeah, maybe.*

*TH: Because why is it that an intelligent person like you postpones and postpones and postpones up to this time, hmm? Obviously we have been only touching the surface of these problems, and the core problem is not as simple as that, it is much more complicated. But we touched on some aspect of it, hmm?*

*PT: Yeah.*

*TH: Have you ever had thoughts that when you have the impulse to blow up the head of Kirk, it was your mother?*

*PT: (She sighs) Yeah.*

*TH: That had entered your mind?*

*PT: Yeah.*

*TH: Have you had thoughts that there is some feature of men that is like your mother and some feature that is like your father?*

*PT: Oh yes. I see those patterns sometimes. I see those characteristics manifest themselves in people.*

#### Bringing the Interview to a Close

Exploring the patient's unconscious therapeutic alliance, setting up psychotherapeutic contact:

*TH: But the question at this moment is, do you want to do something*

*about it? Or do you want to carry the . . . ? I know you don't like the word crippled, but let's face it, it is a crippled life.*

*PT: Ah, I wouldn't be here if I didn't want to do something about it.*

*TH: Because, you see, you said in the beginning that you don't want us to focus on painful issues. but obviously the major work requires a lot of painful issues.*

*PT: I know.*

*TH: Now the question I want to raise is this: Today we have sort of rapidly gone to the tip of the iceberg, the surface of all these issues. Do you think that if you do this in a more systematic way with a therapist, it would be of help to you? Is this something you want to do?*

*PT: Yes, I do.*

*TH: And obviously it requires a lot of hard work and a lot of pain.*

*PT: I'm very willing to put the energy, I want to do it, I'm desperate to do it, to learn . . .*

*TH: Because really, if you look at it, you are not a free woman. All your potentiality is crippled. Under very difficult circumstances I can see you have made a major achievement in other areas, but then a major part of you is crippled.*

*PT: Yeah.*

*TH: But obviously avoidance wouldn't do it.*

*PT: Yeah.*

#### Handling Residual Transference Feelings

In conducting a trial therapy as such, which is a single interview and took just over three hours, it is extremely important before closing the interview to bring into the open any residual transference feelings. This applies to both negative and positive transference feelings.

*TH: How do you feel now?*

*PT: Very choked up with emotions. My head hurts.*

*TH: How do you feel toward me now? Because we have to say good-bye.*

*PT: (She takes a deep sigh) Ah . . .*

*TH: You took a deep sigh when I say, how do you feel?*

*PT: Somewhat angry for, for, for ah, umm, for focusing on my pain. Even though I want to be focused on my pain.*

*TH: Uh hmm. So then let's see what we are going to do about that.*

The therapist moves to the major power of the unconscious therapeutic alliance in resolving the patient's negative feelings in the transference.

*TH: Because a while ago I told you that if you want to do this you have to go through a lot of painful issues. But then at the same time you say you are angry about these painful issues.*

*PT: (She sighs) But I'm, I feel less anger . . . I mean I don't feel angry now, but I, maybe angry's the wrong word, I don't know.*

TH: Uh hmm. But still you don't say how you feel toward me.

PT: I don't know how I feel. I, I can't identify it right now. When I leave the room I'll realize it.

TH: Always the delayed reaction, hmm?

PT: I want to like you but there's a part of me that says, hold reservation.

#### Defense against Positive Feelings in the Transference

PT: I mean hold, ah, hold yourself, don't like him too quickly.

TH: But maybe that is a part of your conflict about positive feelings.

PT: Yeah.

#### Link with Mother

TH: You see, because we shouldn't really say that the major conflict is about anger. I think also there is a major conflict about closeness, because I am sure that in the depths of your mind there is a craving and a wish that your life with your mother had gone differently. You see, I am sure there is a very painful area there, the wish that your relationship with your mother had gone in a very positive and tender way, hmm? And then maybe there must be some thoughts that, if you become a mother, what would happen between you and your child? Have you had thoughts about that?

PT: Yeah. It worries me.

TH: The nagging fear that the same pattern might repeat itself with them?

PT: I might be cold with my children.

#### Interpretation of Unresolved Attachment to Father

TH: But, you know, obviously another side is a tremendous tender feeling for your father, which was there in the very early years, hmm?

PT: Yeah.

TH: But also you are very angry with him for letting you down, hmm?

PT: Yeah.

TH: And then, in a roundabout way, if your relationships with men go in a disastrous way, then at the very deep level of your mind, whom do you remain faithful to? The wonderful, tender relationship that you had in the very early years. That in a sense you remain faithful to him, hmm?

This deep interpretation is also confirmed.

PT: I've often thought, if I could find a man like my father . . .

TH: Uh hmm. So no man is going to replace him. And that is another thing that you have to put in the right perspective, you see. Because in the very early phase, obviously you move toward your father because things with your mother were going in a very negative way.

PT: Yeah.

TH: Okay? But then what happens later on is a severe letdown, as we have discussed, hmm?

The patient's next remark shows that her repeated agreement is not just compliance, but that she is following what the therapist says and actively working on it.

PT: And I move towards my grandmother. That's what happens.

TH: So then obviously at the very deep level there is a tremendous attachment to your father, but at another level there is a tremendous rage toward your father for letting you down. Okay?

PT: Uh hmm.

TH: Now when your relationship with all men turns out in this disastrous way, then in the back of your mind you remain faithful to who? Your father.

PT: Uh hmm.

TH: But then if you look to your fantasies, also there are men and women and everything is mixed. Because, as I said, also another part of you craves tremendously for a different relationship with your mother, hmm? Have you had thoughts about this?

PT: No, I, my, my thoughts have always been more towards finding a man who is, ah, as adoring as my father.

TH: So no man is going to replace him, the way it goes. So then really the issue is this: that the essence of the work that you want to do is to explore all these areas and to put all of your feelings in relation to your father, your mother, your grandmother, in the right perspective, to see them exactly as they are rather than to run away from them. You see the positive, negative, all these mixed bags are there.

#### Comparison of the Interview with Previous Therapy

TH: Now, you said that you had experience of a previous therapist. If you compare this interview with that, what differences do you see?

PT: Ah, well, ah, she ah, she couldn't trap me.

This highly ambivalent remark needs to be dealt with immediately.

#### Further Work on the Transference, the Transference-Current Link

TH: You see, you refer to what we did as a trap, hmm?

PT: You have to trap me in order to make me be honest. (She laughs.)

This leads to another deep transference interpretation – here it must be remembered that some of her sexual fantasies are of being abducted and having sexual activities forced on her.

*TH: You see, because you said that with your husband there is always the pretence that you are forced to have sex, hmm? But now if we look to the work that we have done, you want to say that it is forced on you rather than that you want it, hmm? Do you see some parallel?*

*PT: Uh hmm. Yeah, it's like my fantasies.*

*TH: But then obviously if that is the case it is of no use to you, hmm? Because what you say is that you are not an active participant.*

*PT: But I want to be an active participant. That's why I'm here.*

*TH: The active participant means fifty-fifty, hmm?*

*PT: Yeah. Maybe sometimes I felt that my therapist was so quiet that it drove me mad. I didn't know what she wanted me to do, she was too quiet.*

*TH: Uh hmm. You mean she portrayed you.*

*PT: Yes, yes.*

*TH: Because you started to be passive, noninvolved, hmm? Now what would you say at this moment? You're passive, noninvolved, or are you the active participant.*

*PT: I feel more emotionally active. I feel I'm experiencing many different emotions. I'm feeling a lot of physical pain right now.*

*TH: Physical pain means what?*

*PT: In my chest, in my body, my head.*

*TH: So how about we stop here. Are you going back to College? Uh hmm. So, how about you have a seat in the waiting room.*

### Summary and Conclusion

Here it is important while recapitulating the main technical interventions with which this article has been concerned also to summarize the course of the trial therapy that was used in illustration.

(1) The two-part article described phases of the central dynamic sequence in the major unlocking of the unconscious: (a) the phase of inquiry, exploring the patient's areas of disturbance; (b) pressure leading to resistance; (c) clarification and challenge to the resistance, turning the patient against his own defense; (d) transference resistance, head-on collision with the transference resistance, mobilization of the unconscious therapeutic alliance against resistance; (e) breakthrough of complex transference feelings, the triggering mechanism for the unlocking; (f) systematic analysis of the transference; (g) exploration of the past; and (h) direct view of the multifoci core neurotic structure responsible for the patient's symptom and character disturbances and setting up psychotherapeutic planning.

(2) The trial therapy of a 30-year old woman who suffered from: (a) diffuse anxiety, (b) G.I. tract symptomatology, (c) somatization, (d) major disturbances in interpersonal relationships and (e) masochistic character pathology was presented.

(3) She entered the interview in a state of transference resistance with a great deal of anxiety, and the therapist for the time being bypassed the transference resistance and rapidly moved to a set of interventions to determine if

she suffered from a severely fragile ego structure. He rapidly ruled out a severely fragile ego structure and concluded that she had a major unconscious anxiety in relation to aggressive impulses.

(4) Then the therapist focused on the transference resistance and put pressure on the patient to experience her transference feelings, bringing about a head-on collision with her transference resistance (Phase 4).

(5) Then the process led to further challenge and pressure on her resistance against experience of aggressive impulses in the transference and resistance against emotional closeness in the transference (Phase 3).

(6) Finally, the process led to the breakthrough of the aggressive impulses in the transference with direct experience of grief-laden unconscious feelings with a major communication from the unconscious therapeutic alliance. "The disappointment is so deep that I wonder if I can ever love anyone."

(7) Then the therapist moved to explore the patient's adult life. What emerged was major problems in her previous marriage. Her ex-husband was controlling. Their sexual relationship was unsatisfactory, she could get pleasure only if there was an element of force, he forcing her to have sex in the form of play.

(8) After she left her husband she became depressed. Then the process focused on her episodes of depression, and a systematic analysis of the mechanisms responsible for her depressions.

(9) Then the session focused on other men in her life, and all of the relationships had been terminated with severe disappointment. Then she talked about a man with whom she had lived, Kirk, which threw further light on her severe pathology in relation to men. Kirk was highly explosive and abusive, verbally and physically. She described an incident when he became very violent, banging her head against the wall. As a result she had a lump on her head, which indicated that her punitive superego was strongly in operation. The process led to challenge and pressure on her resistance against the experience of impulse outside the transference. What emerged was a sadistic impulse to have Kirk brutally murdered.

(10) This led to the exploration of her sexual fantasies in which she is always brutalized. Focusing on the structure of her sexual fantasies brought about transference resistance, followed by a second head-on collision (Phase 5).

(11) Details of her sexual fantasies threw further light on the depth of her psychopathology. When there is an element of humiliation and brutalization forcing her to have sex, that produces intense sexual excitement. With men who are nice and gentle, sex becomes very dispassionate.

(12) The therapist, having completed his survey of the patient's recent life, then moves to developmental history and a direct view of her core pathology. There what emerged was a highly explosive, abusive mother. She came with the memory of an incident when her mother attacked her physically with a buckle on her head, and she was bleeding. She used to call her a "whore" and a "tramp." This was from the early years to early adolescence. Her relationship with her father was highly affectionate, but he was highly ineffective in dealing with the violent behavior of the patient's mother.

(13) Then the process focused on her paternal grandmother, who was substitute mother for her. We saw the transformation of a pathological mourning to acute grief, and the focus then was on her unresolved mourning in relation to her grandmother.

(14) Now that the direct view of the multifoci core neurotic structure by both therapist and patient had become possible, the process moved into a direct interpretation of the patient's core pathology, and finally handling residual transference feelings bringing the interview to a close and setting up psychotherapeutic planning.

In conclusion, as I have indicated before our extensive clinical research data emphasize the immense importance of the punitive superego in the causation and maintenance of neurosis. In all these cases the punitive superego has eroded the patient's ego functioning with major impoverishment of the ego structure. Another point, which again we see in this patient, is the issue of the superego and the compulsion to repeat. What emerges from our clinical data is that repetition compulsion is one of the clinical manifestations of superego pathology. In closing, clinicians who are working with this technique should take into consideration that the major unlocking of the unconscious requires that the patient enter treatment without a waiting list. In the technique of major or massive de-repression of the unconscious, the patient should enter treatment immediately. This applies to the present patient. The clinical picture of massive de-repression of the unconscious will be the subject of another article in this journal.

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# Intensive Short-Term Dynamic Psychotherapy in the Treatment of Chemical Dependency. Part I

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Alcohol and drug dependency are major problems throughout the world. In general, there is agreement that intensive psychotherapy, designed to expose and interpret unconscious material with chemically dependent patients, is usually more deleterious than helpful. Davanloo's system of IS-TDP may be an exception to this guideline for chemically dependent neurotic patients without ego fragility. Edited transcript material from a trial therapy evaluation is presented to demonstrate treatment techniques of IS-TDP and its potential use for a specific subset of patients with this illness.

## I. Introduction

Chemical dependency, in light of its morbidity as contrasted to mortality, is probably the number one health problem in the United States (Gill, 1987; Selzer, 1980). Treatment of these patients is difficult and expensive. Poor motivation creates a high initial dropout rate. Unfortunately, there is also a high rate of recidivism for patients who are able to achieve abstinence (Smart, 1978).

Since chemical dependence is a term encompassing a heterogenous set of conditions and treatment population, no single treatment protocol or theoretical perspective has yet been designed that integrates the numerous facets and interactions involved. The importance of behavioral, learning, pharmacologic, psychodynamic, biologic, and environmental influences has been substantiated, although debate over primacy fruitlessly continues.

Given the multiple factors that play a role in the causes of chemical dependency, it is not surprising that no treatment modality yields successful treatment results. Clinical trials showed that a combination of two or more treatment modalities substantially increased the number of patients with a favorable outcome (Selzer, 1980). Hence, we have seen the development of multimodal treatment approaches, which include a combination of individual and group psychotherapy, medication, and self-help groups. Psychoanalytically-oriented psychotherapy has either been ineffective or detrimental in the treatment of this illness (Woody et al., 1986).

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# The Technique of Unlocking the Unconscious in Patients Suffering from Functional Disorders. Part I. Restructuring Ego's Defenses

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In many types of patients, especially those who are highly resistant and suffer from character neurosis and diffuse symptom disturbances, pressure and challenge can be used unremittingly. In patients with functional disorder, particularly when it is with chronic depression and episodes of major clinical depression, the unremitting technique can arouse too much anxiety and make the process both ineffective and, most importantly, can exacerbate the patient's functional disturbances. In such patients the therapist must use a carefully graded technique in which he temporarily takes the pressure off as soon as anxiety reaches a certain level, proceeding in a "spiral," and gradually restructuring the patient's defensive system. Once this has been achieved he can revert to a much more unremitting technique. In the present article this process is illustrated by means of the first part of the trial therapy with a patient suffering from both migraine and chronic depression with episodes of major clinical depression and severe masochistic character pathology.

## Introduction

In my previous publications (Davanloo, 1987a, b, c; 1988), I discussed the nature of resistance, the resistance of repression, and superego resistance and outlined the clinical manifestations of superego resistance and the technical interventions necessary in handling such resistance. I further elaborated on the central dynamic sequence for unlocking the unconscious. The whole process is used in trial therapy, which is a comprehensive psychodiagnostic evaluation.

The central dynamic sequence can be summarized as follows:

- (1) The phase of inquiry.
- (2) The phase of pressure.
- (3) The phase of clarification and challenge to patient's resistance with systematic attempt to acquaint the patient with his defenses that have paralyzed his functioning and turning the patient against his own defenses.
- (4) The phase of transference resistance with head-on collision.

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(5) Creation of intrapsychic crisis with a high rise in the complex transference feeling with breakthrough of the complex transference feelings—the triggering mechanism for unlocking the unconscious and the direct view of the multifoci core neurotic structure.

(6) The phase of systematic analysis of transference and partial or major de-repression of the current or recent past (C) and distant past (P) conflicts.

(7) Return to further inquiry, to be followed by developmental history.

(8) The phase of direct access to the dynamic unconscious with the direct view of the multifoci core neurotic structure and its relation to the patient's symptoms and character disturbances.

This standard technique can be applied to the whole spectrum of structural neurosis no matter how resistant a patient might be; the therapist must employ unremitting pressure toward the underlying feelings or impulses, persistently increase challenge to the resistance, and not take the pressure off until the unlocking of the unconscious has taken place. However, there are a number of conditions (see Davanloo, 1987a, b) where this technique must be modified such as:

- (a) Patients suffering from characterological depression with episodes of major clinical depression (Davanloo, 1987b).
- (b) Highly resistant patients suffering from functional disorder such as common migraine headache with depression, irritable bowel syndrome, etc.
- (c) Patients with panic disorder with or without fainting attacks.
- (d) Certain psychosomatic disorders.
- (e) Patients with fragile ego structure.

A general account of the technique that needs to be used with these types of patients is described in a previous two-part article (Davanloo, 1987a, b). The present two-part article illustrates in detail the technique of unlocking the unconscious in patients suffering from migraine and chronic depression and major character pathology.

In these patients the link between the underlying impulse of anger on the one hand, and the defenses of depression or somatization on the other, is very deeply unconscious. They are quite unable to experience the impulse of anger and describe instead one of the two other corners of the triangle of the conflict, namely defense or anxiety, while remaining quite unaware that this is what they are doing. This has the following important consequences:

- (1) The use of unremitting pressure and challenge may cause, instead of a breakthrough, an increase in anxiety leading to an intensification of defenses and an exacerbation of the depressive and/or functional symptoms.
- (2) Therefore the therapist (a) uses a carefully graded degree of pressure and challenge, (b) monitors the patient's anxiety level with vigilance, and (c) immediately takes the pressure off when he detects that the anxiety is exceeding a tolerable threshold.
- (3) One of the most important ways of reducing pressure is to switch

attention to another area, e.g., from transference relationships (T) to the current relationship (C).

(4) After an interval in which the therapist brings the level of anxiety to a manageable degree, he returns to pressure and challenge, now increasing it to a higher level. In this way he can proceed in a spiral, increasing the patient's ego adaptive capacity to tolerate a higher degree of anxiety and painful affect, gradually weakening the defensive system and bringing the impulse nearer to the surface so that it eventually reaches the point of partial breakthrough.

(5) Each time a partial breakthrough occurs, whether in the area of C or T, it is essential to make repeated analysis of the triangle of conflict, driving home the insight into the link between impulse, anxiety, and the defense. If this analysis of the triangle of conflict, particularly in the transference, is not done the defense inevitably re-establishes itself, and when the patient returns for a second interview the symptoms will be found to have recurred.

(6) This sequence may have to be repeated many times, but eventually the patient's defensive system is restructured; and now it is possible to use unremitting pressure and challenge in order to achieve a final breakthrough, and to proceed to the phase of direct access to the unconscious.

The special features of this graded technique are therefore as follows:

- (1) Greater alternation between the areas of C and T.
- (2) Successive moments of partial breakthrough either in C or T.
- (3) After each partial breakthrough, the introduction of a phase of consolidation of insight by analysis of the triangle of conflict in C and particularly in the transference, the link between the underlying impulses, anxiety and the defenses against them.

These features mean that the interview proceeds more obviously in a spiral rather than a smooth progression; but all of them represent differences of degree rather than kind, from the "unremitting" technique, since exactly the same forms of intervention are used in both types of interview. The differences of degree are in two opposite directions: Challenge and pressure are used and increased gradually while analysis of the triangle of conflict, the link between impulse, anxiety, and defense, is used more frequently and more emphatically.

The clinician applying the technique of unlocking the unconscious should take into consideration:

- (a) These patients have easy access to major regressive defenses such as depression and somatization.
- (b) Clinical research data show that in all such patients the sadistic impulses, guilt and grief-laden unconscious feelings, are of such high intensity as to produce disturbance when the breakthrough takes place. For that reason the technique of restructuring which I have described, a carefully graded technique is essential.

The following trial therapy illustrates the technique of unlocking the unconscious in patients suffering from migraine, chronic depression with episodes of major clinical depression, and major masochistic character pathology.

### The Case of the Woman Used as a Go-Between

#### Enquiry (Phase 1)

The patient, a 48-year-old divorced woman, said she had applied for this particular form of therapy because she understood that there was "no transference and no dependency."

*PT: I applied on my own because I have been looking for a kind of therapy which is short-term and what intrigued me about your approach is that there's no transference and no dependency.*

*TH: Uh hmm.*

*PT: Simply because I think that way, I'm suffering from migraine headaches since I was a child, and it . . .*

*TH: When you say since a child, how old?*

*PT: Umm, six.*

She went on to say that she was Austrian, that her father was a Nazi sympathizer, and that she had suffered from migraine headaches—as often as 25 days in a month—since she was sent away from her parents for a period at the age of six. She then led the enquiry in the direction of psychodynamics by saying that her headaches, together with depression, seemed to occur after the break-up of a relationship with a man.

#### Further Enquiry

*TH: You mean when there is a breakdown of a relationship following that you develop a severe migraine headache, and depression, both?*

*PT: Both, ah, I would relate the migraine headaches, I would say, maybe it's a depression, I don't know.*

*TH: But what you say is this. You get the headache plus depression after breakdown of a relationship.*

*PT: I have to admit I'm not sure what depression really entails.*

*TH: But you said that you get depressed, didn't you say that?*

*PT: Yes, you heard me say that I assume that I must be depressed first of all it's a loss, secondly it's a letdown.*

*TH: Yeah, but you say it is depression because it's a loss or do you experience something that you call depression?*

*PT: (She sighs.) I should have read up on depression before. (She laughs.)*

*TH: Could you tell me the state of mind that you are in when there is a breakdown?*

#### Pressure Leading to Resistance (Phase 2)

The therapist began to exert pressure by asking for a specific example, in answer to which the patient mentioned the break-up of a relation with a man called Dick three years ago. However, she soon started to go into unnecessary detail about irrelevant matters, and the therapist began the preliminary clarification and challenge to her defenses.

#### Clarification and Challenge to the Resistance in the Area of C—Phase (3) of Central Dynamic Sequence

*TH: Is it usually like this, that when you want to describe something you go round about the way? Are you usually like that or only here with me?*

*PT: Ah, in my private life I might be like this. On my job, I'm very much on the dot. (She laughs.)*

*TH: So here is more like your private life?*

*PT: Ja, because I'm dealing with my private self here.*

*TH: Uh hmm. So let's see first how you feel about your private self. You are smiling.*

The patient now gives an answer which indicates that some of her neurosis is ego-syntonic. The therapist immediately begins the process of making her resistance ego-dystonic, with the aim of establishing a common aim with her therapeutic alliance.

*PT: (She sighs.) I like my private self.*

*TH: Uh hmm. So let's see what are we going to do about that first. Because you say you come of your own will here.*

*PT: Uh hmm.*

*TH: And then you want to understand your problem, obviously we are here for that, isn't that?*

*PT: Ja, ja.*

#### Clarification and Challenge to the Resistance in the Area of T

The therapist now both draws attention to the transference resistance and challenges it, continuing the process of trying to establish a common aim.

*TH: But at the same time you don't want me to get to know you then.*

*PT: Oh yes I do.*

*TH: But you said that you like your private self.*

*PT: You're getting to know me right now as we . . .*

*TH: But you have a certain feeling about telling me about yourself?*

*PT: Why I'm here, I have a feeling . . .*

*TH: No, let's see, is it that you have difficulty to talk about yourself here with me?*

*PT: No. Yet I don't know what is really the real self. I have the feeling . . .*

*TH: No, let's not get to this because another tendency of you is labeling things. Hmm? Do you notice also you have a tendency to label yourself?*

*PT: No.*

*TH: Hmm?*

*PT: No, I'm learning that right now.*

*TH: Uh hmm. Do you notice that you label, you know that . . .*

*PT: No, I didn't notice.*

*TH: So, we were talking about this. That you are, you have difficulty to be specific, another difficulty also, you have a certain feeling about this interview and me knowing you. Now, you are holding back like that now.*

*PT: Maybe I don't understand you right.*

*TH: Now, you move to the position that you don't understand me right.*

*PT: I don't . . .*

Here the therapist notices the patient's withdrawn posture and draws attention to this nonverbal manifestation of her resistance.

*TH: Now you are holding back like that.*

*PT: Maybe I don't understand you right.*

*TH: Now you move to the position that you don't understand me right. Do you notice your posture right now?*

*PT: . . . I don't know whether this is the posture I assume when I am withdrawing into myself to search. I sometimes think I know myself and . . .*

*TH: But you see, again you are ruminating on the issue that you sometimes think you know yourself. That doesn't tell us anything.*

*PT: Could you give me an example of how I should express myself so that we get to the point quicker?*

*TH: Again that is vague, "to get to the point." Which point? You want to tell me a specific example of a situation that you become attached to a man and then that relationship ended.*

*PT: Uh hmm, uh hmm, uh hmm. Yes.*

*TH: But then what we see is this. You have to go all round about the way, and then you didn't tell me still, because what we wanted to know was what was Dick like? So could you tell me about Dick?*

Return to Exploration, Pressure, and Challenge in C

The patient continues resistant.

*PT: So, I met Dick.*

*TH: What type of person is he?*

*PT: (Silence) Ah . . . (She sighs a little.)*

*TH: You see again your hesitation.*

*PT: What type of person . . .*

*TH: How would you describe him as a person?*

*PT: He's rather dynamic.*

*TH: But that doesn't say anything, he's dynamic, dynamic what?*

Under further pressure and challenge the patient said that Dick had been extremely generous and attentive and had pursued her in a way that she had never been pursued before. Their sexual relation had started within four weeks and had been very intense. She also said that he was a very ugly man, that all her previous relationships had been with very good-looking men, and that she had said to herself, "Why not try an ugly one"?

Return to Challenge to the Resistance in T, with Special Reference to Nonverbal Indications

Pressure on the details of their sexual relationship produced a flirtatious attempt at diversionary tactics, which the therapist aborted in such a way that she did not try again.

*TH: What was specific sexually? . . . Do you notice that when you want to talk about this you are looking over there?*

*PT: Because I'm searching for the right word.*

*TH: But maybe at the same time there is a way of avoiding me.*

*PT: You look a little bit like Dick. (She laughs.)*

*TH: Uh hmm. You smile and say I look like Dick. And you also said Dick is ugly, hmm? And you are smiling now. (She laughs.)*

*PT: You look better than him.*

*TH: Now you take a sarcastic position, do you notice?*

*PT: I look to the side but I also lean forward.*

*TH: Yeah, but let's see. On one hand you are taking a sarcastic position with me.*

*PT: Sarcastic?*

*TH: Uh hmm. And also you are bending over like that. Embryonic position. And your hands. Do you notice that also?*

*PT: What's with my hands?*

*TH: Clenched like this . . .*

*PT: It's loose . . . Ah . . .*

*TH: Now you are becoming slow as well. So, you said Dick was like me, but you didn't finish that.*

*PT: It's the eyes. (She laughs lightly.)*

*TH: What about the eyes?*

*PT: Similar eyes. Well, we had a very . . . there was closeness.*

*TH: Yeah, but you moved away from the sexual relationship.*

Return to Enquiry, Pressure, and Challenge in C

The patient gives a crucial piece of information.

*PT: That is what we experienced in our sexual togetherness, a real intense closeness. And I did not know that Dick at that time had had another relationship for seven years.*

She had discovered this by chance two months after she had started sexual relations with Dick. The other woman, Maria, worked in Dick's office. Dick had opted for the patient after she had given him an ultimatum, "either Maria or me."

When she is asked to describe her feelings about Maria within this triangular situation she immediately goes into resistance, stronger than before, indicating that a very sensitive area is being touched.

#### Pressure and Challenge in Relation to C

*TH: How did you feel toward Maria? (The patient takes a deep sigh.) You took a sigh now.*

*PT: Sometimes I was angry, not I . . .*

*TH: You mean you felt angry with Maria?*

*PT: Sometimes in the beginning I was angry when ah he made a decision . . . he made a decision for me and he said he . . .*

*TH: And how did you feel that he dropped Maria for you, because she was around seven years with him, and you were two months, hmm?*

*PT: I didn't feel too good about it.*

*TH: Yeah, but you see that is just a sentence, "I didn't feel too good about it." That doesn't say how you feel.*

*PT: I did not feel guilty.*

*TH: But that still doesn't say how you felt. "I did not feel guilty" is a sentence again. Do you notice, I question you how you felt but then you use sentences to describe your feeling?*

*PT: I don't remember how I really felt.*

*TH: No. How is your memory usually?*

*PT: Very good.*

*TH: So, your memory is very good, so how come when it comes to your feeling for Maria who is dropped by Dick, suddenly your memory collapses? Now you look puzzled.*

*PT: Ja, because I try to put myself into that time.*

*TH: Do you notice how helpless you become when I question how you felt towards Maria being dropped by Dick after your demand?*

*PT: (Silence).*

The patient starts to cry, and with tears the patient said that it was the first time in her life that she had started fighting for herself. She continued highly resistant, at first using generalities to describe her feelings—"confused," "hurt"—and then falling back on an inability to describe anything. The therapist now concentrates on clarification and challenge to the resistance in the transference.

#### Clarification and Challenge to the Resistance in T

*TH: You see how much difficulty you have to be in touch with your feelings?*

*PT: Ja.*

*TH: Because you yourself say you have a lot of feeling about it.*

*PT: Ja.*

*TH: But at the same time you don't want me to know about this feeling.*

*PT: I would love you to know because I want to know too.*

*TH: I know, but there is some obstacle here between you and me. Do you notice that? Do you see that there is some kind of distancing between you and me, hmm?*

*PT: Ja.*

#### Clarification and Challenge to Resistances against Emotional Closeness in Transference

*TH: I have a feeling that in a sense you are distancing yourself from me and you don't want me to get close to you in a sense. You see, a sort of a wall, a kind of wall that you put between yourself and me. Do you notice that?*

*PT: You don't put it there consciously.*

*TH: Doesn't make difference, consciously or unconsciously. But, still we have to look to . . . Is there a wall between you and me? Is there a need in you to distance yourself from me?*

*PT: I think the wall is not between you and me; the wall is between me and me, that's why I'm here. There's a wall.*

*TH: Yeah, but that doesn't help us you are here. We have to see what we are going to do about the wall first.*

*PT: Ja.*

*TH: Hmm? Because you are holding back from me . . .*

*PT: (She sighs.) Yes, I'm looking at you now. (She laughs.)*

#### Return to Challenge to Resistance in C, Partial Breakthrough

After systematic challenge to patient's resistance she described how Maria had created "incredible scenes" at the office, which Dick seems to have deliberately provoked.

*PT: And Dick always came back and told me how he provoked her by telling her about me.*

Finally the crucial detail emerged, which the patient had concealed hitherto, revealing Dick's pathological manipulation of triangular situations.

*PT: And then he said, "Oh, I'm going on a three-week vacation," and I said, "That's good. That will do you a lot of good." And he told me*

*he wouldn't go alone. And I said, "What"? And he said, "We have planned this, Maria and I, and we are going to do it. We have a lot of talking to do."*

TH: So, now he is dropping you and going back with Maria. And how did you feel about that?

PT: I felt really shitty.

TH: But that doesn't say anything . . .

PT: (She sighs.)

TH: You are dumped and disposed like that, how you felt?

PT: Dumped.

TH: Yeah, but that doesn't say how you felt. What type of the feeling that generated in you?

PT: I froze.

TH: Uh hmm. You mean, actually, you felt numb.

PT: Ja.

TH: Where did you feel numb?

PT: My whole body.

TH: Your whole body? You mean become like paralyzed.

PT: Not paralyzed, numb.

#### Further Pressure and Challenge in Relation to C

The therapist puts pressure on the feeling, the lower corner of the triangle of conflict. What emerges is one tactical defense after another. "I froze," "I felt numb," "I felt rejected," "I felt empty," (she becomes weepy), "I just became very active," "Can I report another incident?," and so on. The therapist responded with sustained pressure and challenge, and the nonverbal indications of tension steadily increased.

#### Challenge to Tactical Defenses

PT: (She sighs.) (Silence) (She cries.) *I don't know what I really feel.*

TH: Now you are becoming weepy now, right now. I question you how you felt for being disposed like that, then is not clear how you felt.

PT: It isn't clear how I feel, otherwise I would say it. (Continues crying)

TH: Now you become weepy instead of looking to see what else you felt for being disposed like that. What was your reaction?

PT: (She sighs.) (She sniffs.) *At the same time, there were so many other things happening in my life . . .* (She remains weepy.)

TH: No, let's not get to the other things happening to your life, let's focus on this.

#### Partial Breakthrough

Sustained pressure and challenge to the patient's resistance bring about a partial breakthrough.

PT: I really felt, I, I, I wanted to have it out with him.

TH: Yeah, but that's a sentence. "I felt . . ."

PT: I felt like hitting him.

TH: So, you felt anger inside you?

PT: Ja, ja, ja.

TH: Uh hmm. Could you describe the way you experienced this anger inside? Do you notice your posture here? (She sighs.) There is a clenching . . .

PT: Uh hmm, uh hmm.

TH: You said that you wanted to hit him.

PT: I, ja.

TH: That means anger, hmm. So, let's see how you experienced your anger.

PT: Well, I cried a lot. I screamed a lot.

PT: I don't know how to express it in words.

TH: No, we don't want words, we want to see physically how you experience the anger. Was it that you wanted to lash out?

PT: It was like this (She makes an angry gesture.) . . . Ja.

TH: Now, if you had let yourself go and be honest with yourself in terms of thoughts and ideas, how would you lash out?

PT: I would have knocked his front teeth out (She laughs.)

PT: To go up to him and take him by his tie.

TH: With what hand?

PT: This hand, and just slap him.

TH: Uh hmm, uh hmm. And then . . . (She laughs.) You are smiling again.

PT: Ja because (She sniffs.) . . .

TH: Do you see how much difficulty you have to talk about anger?

PT: Slapping him.

TH: And then, until . . .

PT: Taking a bucket of shit and pouring it right on top of him . . . and letting it drain all down . . . and sending him out into the street.

#### Insight into the Link between Impulse and Defense

The therapist now begins the process of acquainting the patient with this link by repeated questioning, which itself requires challenge, but eventually an important and unexpected answer emerges.

TH: What did you do with this impulse within yourself?

PT: I remained civilized.

TH: You mean by "civilized" you become limp?

PT: No.

TH: Paralyzed?

PT: No.

*TH: What was the way you dealt with it?*

*PT: I think, I really . . .*

*TH: You think?*

*PT: I think I didn't deal with it.*

*TH: What was the way you handled this rage, internal anger?*

*PT: I handled it by rationalizing it. I handled it by hitting the bed with a tennis racket.*

*TH: Uh hmm. And who really you wanted to hit with a tennis racket?*

*PT: (She sighs.) All the male figures in my life (She becomes sad and very choked up.)*

*TH: All the male figures, hmm? Includes who?*

*PT: (She is crying.) My father, my brother, my . . .*

We saw a partial breakthrough, the negative impulse partially has been experienced as well as a major breakthrough into her grief laden unconscious feeling. Now the therapist returns to resistance in the transference.

#### Return to Challenge to Resistance in T

*TH: And where do I stand there?*

*PT: (She sniffs and sighs.) Sorry, you're not included.*

*TH: Why am I an exception.*

*PT: (She sighs.) I feel no dependency on you.*

*TH: Now, just a moment. Why am I excluded, you say all male? So that means that still I am on the other side of the wall, hmm? Are you saying that?*

*PT: Ja.*

#### Challenge to Resistance against Emotional Closeness in Transference

*TH: . . . that here in your relationship with me you are on the other side of the wall and I am on this side of the wall, hmm?*

*PT: (She takes a deep sigh and sniffs.)*

*TH: Isn't that? Hmm? . . . Could we look into that?*

*PT: I think that difference between difference is between people.*

*TH: That is rationalization, I mean, that is intellectual issue. But my question is this, am I on the other side of the wall?*

*PT: Ja.*

*TH: Is there a wall between you and me or not?*

*PT: In this sense there is a wall.*

*TH: Now what are you going to do about this wall?*

*PT: I wouldn't know how to take you into the circle of people in my past.*

*TH: Uh hmm. Are you saying you don't have any feeling here with me?*

*PT: (She sighs.) I feel comfortable with you. Uh, I'm not scared. (She laughs.)*

In the above passage the therapist again exerted some degree of challenge and pressure to the patient's resistances against emotional closeness which immediately mobilized anxiety in the form of tension in her striated muscle, particularly in the intercostal muscle with frequent deep sighs. All evidence indicates that the patient has a major conflict in relation to emotional closeness.

#### Return to Triangle of Conflict in C—Consolidation of Insight

*TH: Uh hmm. Now let's go back to this. This is very important you look at it . . . With Dick obviously there was anger in you . . . We see it in terms of the necktie and the slapping . . . And then there was the racket-banging on the bed . . . These are all related to your rage, hmm? But the way you dealt with it, it is important to look at it . . . Is it to say that the numbness, helplessness, passivity, paralyzed position that you take is a defensive way of dealing with the rage? Do you see what I mean?*

*PT: I think this is . . . (She sighs.)*

*TH: No, this is important to look at it. You see, if you look to this situation, it is a triangle in which you and Dick develop an intense relationship, okay? . . . But then your ultimatum was that either you or Maria . . . and then he plays about with it . . . and then suddenly you realize that he and Maria are going to go on vacation, okay? . . . Now this mobilizes an anger in you. This mobilizes a rage in you and then at that moment you feel physically numb, okay? . . . You become weepy, you become sad, hmm? . . . And then you don't want to eat. Now the question is this. Is this sadness, the weepiness, the numbness, a defense against the rage?*

*PT: Ja.*

*TH: You say ja because I say so or . . .*

*PT: No, it is. I started to get angry only about two years ago. I really physically felt that I turned all green . . .*

The therapist brushes aside this tactical use of the defense of "fancifulness," and concentrates on the experience of anger and the instantaneous operation of the depressive mechanism. Our extensive clinical research data, has shown that repeated analysis of transference as well as analysis of triangle of conflict in C is of extreme importance, to bring insight over and over again. If this is not done there is no lasting effect and the depressive mechanism reasserts itself on the next occasion. The following passage illustrates the importance of this technical intervention. As will be seen, the end product is an important breakthrough.

*TH: I know, but do you think that in a split second you experience the anger . . .*

*PT: Uh hmm.*

*TH: . . . in a split second . . .*

*PT: Uh hmm.*

TH: ... what you experience is not the anger. In a split second . . .  
 PT: It's not the anger . . .  
 TH: . . . you experience, look at this. This is very important you look at this.  
 PT: Uh hmm.  
 TH: That in a split second you don't experience the anger, what you experience is depression.  
 PT: Ja.  
 TH: . . . is weepiness . . .  
 PT: Uh hmm.  
 TH: . . . is numbness, as a defense against anger?  
 PT: Ja.  
 TH: Do you see that there is or no?  
 PT: Yes, yes, I see that.  
 TH: Uh hmm.  
 PT: It is numbness. It is a freezing numbness.  
 TH: Uh hmm.  
 PT: And then there . . . it takes quite some time and then comes weepiness.  
 TH: Weepiness. First is . . .  
 PT: Numbness.  
 TH: Then is weepiness. And then when does the migraine come?  
 PT: Ah, after that.  
 TH: The migraine comes after that?  
 PT: Ja.  
 TH: And the depression.  
 PT: (She sniffs.) I assume it goes all along . . .  
 TH: But you think that there is that depression, and these symptoms that you develop are a defensive way of dealing with this . . .  
 PT: With anger.  
 TH: Anger?  
 PT: Ja.  
 TH: Have you previously thought about it or . . . ?  
 PT: Yes, I've, I started to think about that . . .

#### Breakthrough in C

Now suddenly in response to the therapist's pressure she reveals that she experienced anger to a considerable degree and is terrified of it:

PT: And I'm, I, I'm afraid of, of, my anger as it came out lately.  
 TH: Hm, hmm, uh hmm. You mean, afraid that you might lose control over . . .  
 PT: That I, I might lose control.  
 TH: And is very important to look at it. If you lose control over your anger, let it go, what would you be like?  
 PT: I've . . . it would feel like losing my senses.  
 TH: But, could you portray yourself if you go berserk?

PT: I would be very physical.  
 TH: What would you be like?  
 PT: I would hit, I would . . .  
 TH: Could you describe?  
 PT: Yes. I had an anger outbreak during the Christmas holidays . . .

There is a major change in her posture from a very bent position to a more upright position; with frequent sighs and very animatedly she described the following: Every year she and many other neighbors from similar backgrounds celebrate a traditional Christmas Eve at the patient's house. It is understood that afterwards her two teenage sons will help with the cleaning up. Her son Paul, age 14, with whom she has been having trouble for some time returned home late in the afternoon and this mobilized a major rage in her in relation to Paul. The focus of the session is on the triangle of conflict in relation to Paul. Now we take up the interview.

PT: When Paul came, I mean I started throwing things already. The whole house . . .  
 TH: What was the way you experienced this rage?  
 PT: (She sighs.) It's so, it's physically, it really takes over.  
 TH: Uh hmm.  
 PT: And he came in and I grabbed him and I threw him across the, the (she sniffs), the living room. His glasses were flying and I'm losing my . . .

During the interview she shows with her hands how she grabbed Paul and how she threw him across the room. There is a sudden breakthrough of the guilt-laden feeling. She becomes very sad, crying. We take up the interview.

TH: So, you must be really in a rage then? You took him like what? From the shoulder, you mean?  
 PT: Ja. Like this and I threw him across the living room.  
 TH: With the head, you mean?  
 PT: No, sideways.  
 TH: Uh hmm.  
 PT: And, and, then I had also chairs in the kitchen on the table and I blew them off the table.  
 TH: Uh hmm.  
 PT: (She sniffs.) And then I realized where I was and I grabbed my coat and I said, 'I'm leaving.'  
 TH: So, you must be really in a rage then. You took him like what? From the shoulder, you mean?  
 PT: Ja. Like this, and I threw him across the living room. And, and, then I had also chairs in the kitchen on the table and I threw them off the table.  
 TH: Uh hmm.  
 PT: (She sniffs.) And then I realized where I was and I grabbed my coat

*and I said, "I'm leaving." All the chairs went off the table and all of a sudden it just clicked. I said, "Brother, I'm getting out of control here," and I grabbed my coat and I left.*

*TH: I see. So you were in such a rage and then the rage was directed at Paul.*

*PT: Ja.*

It is essential for the patient to experience the aggressive impulse to the maximum degree in this process.

*TH: Was there in your mind the thought at that moment on a split second that you might do something disastrous to Paul?*

*PT: Ja.*

#### Further Analysis of the Triangle of the Conflict in C

It is again important to further analyze the triangle of the conflict, the impulse, the anxiety, and the defense against the impulse, and further to determine if the negative impulse has murderous quality.

*TH: Is very important you look at it.*

*PT: Ja.*

*TH: Not because I say so.*

*PT: Ja, I . . .*

*TH: Did the thought, did you have a passing thought . . . ?*

*PT: I sometimes think I could kill them.*

*TH: Uh hmm. So, the passing thought came to your mind that you might kill him.*

*PT: Sure.*

*TH: And then you defended yourself against this impulse by walking out, hmm?*

*PT: Hmm.*

*TH: If you said to yourself this passing thought to kill him, how would you, in your thoughts?*

*PT: (She has frequent deep sighs.)*

The patient again becomes very sad and cries and what emerges is the impulse to strangle Paul which is then linked with Dick.

*TH: Obviously it must be very disturbing to you that . . . (She starts crying.) . . . You see, how would you, I mean the instrument you might kill Paul, with a knife or with what?*

*PT: No, no, no strangling, but it's not . . .*

*TH: The method is strangling. And Dick is on similar format in the different ways, hmm?*

*PT: Ja.*

The focus of the session is on the impulse to strangle her son, the massive rage within herself and the defense mechanism of walking out to protect

Paul against her massive rage. What happened is that she almost ran two miles through the city and ended up in a shopping plaza and went to a movie. A crucial piece of information emerged, namely that she did not get depressed nor did she have a migraine headache. Then she went on to say that she had two other disturbing episodes with Paul, one of which occurred as follows: She and Paul had arranged to go to an exhibition after he returned from school. But that afternoon she received a phone call from the principal saying that Paul had not been in school for five days. Questioning now revealed that during the telephone call she had been completely calm, but that a migraine headache with vomiting had set in immediately afterwards.

*PT: Ja.*

*TH: And then you had a migraine immediately?*

*PT: The migraine right away started, I threw up, and I was just incapable of functioning.*

*TH: You mean vomiting?*

*PT: Ja.*

*TH: What else when you got the call? Is very important to see what in a split second took place first before the migraine.*

*PT: I, I was totally calm during the call. At the moment the action is complete, the migraine starts.*

*TH: Now, you were, you say on the phone you were calm . . .*

*PT: Ja.*

*TH: . . . but then the migraine started. Is very important to see was that in a split second on the phone . . .*

*PT: No.*

*TH: . . . any other feeling within you?*

*PT: While I'm on the phone, it's o.k., and then it is like . . . then the, the vomit, vomiting . . .*

#### Analysis of the Triangle of Conflict in the Area of C

After the breakthrough of the waves of painful feelings she once more became relaxed, and now the therapist proceeds again to drive home insight into the link between impulse and the defense in relation to Paul. The following passage illustrates this important process, including the necessary repetitiousness very clearly.

*TH: Now let's look at this. You are calm, then you have the migraine headache.*

*PT: Uh hmm.*

*TH: In the other one, the Christmas incident, your rage is out, you are pushing Paul against the wall, you are pushing all the chairs, you are in a massive rage, you walk through the city, but you don't have the migraine headache. It is very important that you look at this too . . . in that incident of Christmas there is very explosive rage, but then you don't get the headache.*

*PT: Uh hmm.*

*TH: But the second one you are calm, but you have severe migraine headache with vomiting. Do you think that there might be a link between massive rage and the migraine headache?*

*PT: Oh, certainly.*

*TH: Because in that incident your massive rage is out, you don't have the headache. The second one you are calm—that means the massive rage is not experienced consciously, but what you develop is a severe migraine headache with vomiting. Do you notice that?*

*PT: Ja, then I had the rage at night when Paul came home, and I hit him.*

*TH: What way did you hit him?*

*PT: I slapped him, just like this . . .*

*TH: Did you have a headache that night?*

*PT: The headache then disappeared.*

#### Return to Pressure toward Impulses in the Area of C

The therapist now sets about exploring the possibility of death wishes toward Paul.

*TH: So, in a sense, Paul is like a pain in the neck in some form?*

*PT: Oh, he is (she is choked up). He, he is both. He is very . . . (She sighs.) In some way, yes, and on the other way he is a very lovely boy.*

*TH: And what happens if this pain in the neck disappears in your life? What would happen to you?*

*PT: I would be very happy.*

*TH: I mean, you would be happy if he disappears in your life?*

*PT: (She sighs.) It's hard to say about one's kid.*

*TH: How would you feel if you heard that he had dropped dead?*

*PT: (She cries.) That would make me very sad.*

*TH: Why? Why should you feel sad if he is a pain in the neck?*

*PT: I love him too. (She is crying.)*

*TH: Have you had thoughts that something might happen to him?*

*PT: (She sighs.) . . . I am afraid that something might happen to him.*

#### Further Pressure

Further pressure brought out that she had had quite specific ideas of Paul being "run over by a car," with blood all around him. She had not thought further, but in answer to the question of where the blood was coming from, she said "I'm developing that right now," and went on to say that it was coming not from his head but from his chest. The therapist asked if there was something special about the chest, to which she said, "He has a very big heart."

*PT: Be run over by a car.*

*TH: You get thoughts that he might be run over by a car?*

*PT: Ja.*

*TH: And what do you picture him when he is run over by a car?*

*PT: (She has frequent deep sighs, is very choked up.) That, that he would be dead.*

*TH: But, how do you picture him dead? In terms of thoughts.*

#### Breakthrough of Painful Feelings, and She Begins to Cry

*PT: There would be a lot of blood . . . all around him. (She has another deep sigh.) I never thought that far. (Another deep sigh) It wouldn't come out of his head . . . his chest, maybe.*

*TH: Uh hmm. His chest, hmm? Why chest?*

*PT: (Sobbing) He is a kid with a very big heart.*

*TH: Uh hmm. So then you have a lot of mixed feelings about Paul . . . hmm?*

#### Psychiatric History

Having made this important progress on impulses in the area of C the therapist turned his attention to the psychiatric enquiry. The important features that emerged were that the patient suffered from attacks of reactive depression, the worst of which lasted two years, and in two of which she had made a suicidal attempt with tranquilizers. One of these attempts was many years ago and followed an abortion in which she almost died, together with the break-up of the relation with the man involved. After taking the tablets she had been unconscious for 48 hours and was only discovered by chance by a friend who had a key to her flat. The second occasion was eight years ago and was precipitated by her husband telling her he wanted a divorce. She had taken valium and a whole bottle of liquor. She said that on both occasions she had really wanted to die. She has also had thoughts of opening a vein in the bath. During her attacks of depression she sleeps more rather than less.

Throughout this enquiry the patient showed evidence of being considerably more relaxed and willing to communicate. For instance, on one occasion she addressed the therapist by name, and on another she spontaneously opened up the problem of making wrong choices in relationships, saying that people were deceived by her facade. She emphasized the strain of her current situation, trying to hold down a job and keep two children without support. In addition, she has just learned that her landlord wants to sell the house in which she has lived for 12 years. She is very attached to this house.

She has had three periods of psychotherapy, one from a marriage counselor at the time of her divorce, and two from a psychologist to help her with Paul's behavior problems.

#### Analysis of the Transference, Return to Pressure on the Impulses Together with Driving Home Insight, Further Insight in the Area of "T"

The therapist asked how she felt about the interview so far, to which she said she felt good, adding spontaneously that she would have a hard time

getting angry with him. However, pressure now brought out that there had been a number of occasions on which she had felt angry with him.

*TH: Was there any time that you had anger toward me?*

*PT: At times when I felt I expressed myself to the best I could, and you said, "you are not saying it right," my feeling was "then bloody well help me."*

*TH: In a split moment you felt anger toward me?*

*PT: Ja. Physically I could have taken you by your neck.*

#### T-C Link

The therapist explored the similarity to her impulses against Paul.

*TH: Again, around the neck?*

*PT: No, like someone shaking someone . . .*

*PT: It is anger.*

*TH: But, do you see in a sense we see in all these situations there is this anger that mobilizes . . .*

*PT: Sure.*

*TH: . . . and we know that the defenses you use against the anger, hmm?*

*PT: Ja. It's . . .*

*TH: I mean today what we learn is the way you, there is this rage inside you . . . But then also the defenses you use against this anger . . . And we learn also the link between that and depression and migraines and so forth.*

*PT: Ja.*

*TH: Now, uh, then obviously what you said is that for those moments also, you had that flashes, or that moment, you know, came in relation with me, hmm?*

*PT: Ja.*

*TH: But, now, if I had not brought that into the focus at this moment, would you have declared that you were angry with me?*

*PT: I wouldn't even have thought about it.*

*TH: So, you would have walked out.*

*PT: Ja.*

*TH: Uh hmm.*

*PT: I would not have thought about it that there was . . .*

*TH: Uh hmm.*

*PT: . . . the anger here between you and me.*

Here, again, the therapist reemphasized the various mechanisms she employed to avoid her negative impulses, linking it again with two of her major disturbances, namely depression and migraines. As we saw, she admitted that if he had not drawn attention to her anger she would not even have thought of it. The therapist prepared to bring the first part of the trial therapy to a

close. The patient said she was feeling relieved and that she did not want to stop.

*PT: I don't want to stop.*

*TH: Uh hmm . . . uh hmm . . .*

*PT: It's like you look for the beginning in a ball of thread . . .*

*TH: Uh hmm, uh hmm.*

*PT: . . . and I don't want to let it go.*

*TH: How about we meet again in a few days?*

#### Recapitulation and Discussion

A crucial and universal phenomenon, whatever the kind of patient being interviewed, is that each time pressure and challenge are applied there is a rise in complex transference feelings. With patients for whom an unremitting, steadily progressive technique is appropriate, the complex transference feeling can be raised rapidly until it is at such a level that the transference feelings are ready to break through. With patients of the kind described here, however, this procedure would result in a level of anxiety high enough to produce a breakdown of communication. What is needed, on the contrary, is that after each period of pressure and challenge the transference feelings must be brought into the open. The effect produced is relief, and the level of anxiety never becomes intolerable.

The other important aspect of technique that is illustrated by this interview is the necessity—with patients in whom the impulses are so deeply repressed—for driving home again and again insight into the defensive mechanism by which the sadistic impulse is converted into depression or functional disturbances. The process of acquainting the patient with this mechanism is begun as soon as the underlying impulse has come near enough to the surface to enter consciousness, and the resulting insight represents an essential factor in preventing the same defense from reasserting itself in the future.

The sequence of events in this interview may be summarized as follows.

##### (1) Enquiry and Pressure in the Area of C

After an initial phase of enquiry, the therapist employed one of the mildest forms of pressure in the area of C, namely asking for a specific example of a situation that had led to depression and migraine headaches. The patient showed immediate resistance, going into unnecessary detail about irrelevant matters.

##### (2) Drawing Attention to the Transference (T)

The therapist challenged this, which led to a remark by the patient indicating that some of her neurosis was ego-syntonic, which the therapist challenged in its turn. The therapist now drew attention to the transference,

saying "You have a certain feeling about this interview and me knowing you," and followed this by drawing attention to her hands, an indication of rising anger in the area of T.

#### (3) Challenge to Resistance in the Area of T

He now returned to pressure in the area of C, meeting further resistance. This produced some overt transference resistance, which took the form of a flirtatious comparison between the therapist's appearance and that of her man friend, Dick. The therapist first challenged this, and then drew attention to her hands, an indication of rising anger in the area of T.

#### (4) Challenge to Resistance in the Area of C

This produced an increase in communication, as the patient revealed one of the features of her psychopathology. Acting on this indication that the unconscious therapeutic alliance was being mobilized, the therapist stepped up his pressure in the area of C, for the first time asking the patient to describe her feelings. There was then stronger resistance, met by stronger challenge (PT: "I didn't feel too good about it." TH: "But that is just a sentence." PT: "I don't remember how I felt." TH: "How is your memory usually?" and so on). The patient now began to employ the defense of weepiness, followed by withdrawal into a state of inability to describe anything.

#### (5) Challenge to Resistance in the Area of T

The therapist clarified and challenged the transference aspects of this ("Do you notice that there is some kind of distancing between you and me?"), and continued with further challenge to resistance in the area of T.

#### (6) Challenge to Resistance in the Area of C; Partial Breakthrough

He then returned to the area of C, and the patient told of the crucial incident in which Dick announced that he was going on vacation with Maria. Again the therapist pressed for the patient's feelings, which resulted in major resistance, which took the form of a series of defenses. Now the ground had been sufficiently prepared by the previous work, responded with sustained pressure and challenge, accompanied by drawing attention to the nonverbal communication of the rise of the impulse, moving the hands upward, a decline in the level of tension in the striated muscle of the hand and forearm. This eventually led to a partial breakthrough of rage in the area of C—the fantasy of "taking a bucket of shit and pouring it on top of him . . ."

#### (7) Driving Home Insight

Having reached partially this impulse, the therapist for the first time drove home insight into the link between impulse and defense. This led to a

major communication from the unconscious therapeutic alliance: TH: "And who did you really want to hit with the tennis racket?" PT: "All the male figures of my life."

#### (8) Challenge to Resistance in the Area of T

The therapist immediately returned to the area of T: "And where do I stand there"? The ensuing renewed resistance was clarified and challenged: "Is there a wall between you and me? . . . What are you going to do about this wall"? This resulted in an important communication about the reduction in anxiety: "I feel comfortable with you. I'm not scared."

#### (9) Driving Home Insight

The therapist now embarked on a passage of consolidation of insight into the link between her impulse of rage and all the defenses so far manifested—"In a split second you don't experience the anger, what you experience is depression . . . weepiness . . . numbness . . . migraine."

#### (10) Breakthrough in the Area of C

Whereas the previous breakthrough in the area of C had been only partial, the breakthrough that now occurred was total. The patient described an uncontrollable attack of rage against her son Paul. There was a clear non-verbal communication indicating that the breakthrough of the impulse had taken place. There was a rise in her voice, she changed her position from bent to sitting straight forward, thrashed her hands around, and demonstrated the way she pushed Paul. This followed by an emergence of sadness with the breakthrough of the guilt-laden unconscious feeling and there was a major wave of painful feeling when she said, "he would be dead."

#### (11) Driving Home Insight

It emerged that this outburst was not followed by migraine and the therapist therefore drove home insight into migraine as a way of dealing with her rage.

#### (12) Exploring Murderous Impulses in the Area of C

Then the therapist explored the possibility that the patient had death wishes toward Paul, which was confirmed.

#### (13) Exploring Impulses in the Area of T

The therapist first took the psychiatric and medical history (medical and neurological investigation had been done—all negative—and she was diagnosed as suffering from common migraine headaches), and then in the final passage of the first part of the trial therapy the therapist explored anger in

the area of T. She was able to admit that she had had the impulse to take him by the neck and shake him.

#### (14) Driving Home Insight

Now once more the therapist consolidated insight into her mechanisms for avoiding anger. When he prepared to bring the first part of the trial therapy to a close she said that she didn't want to stop—"It's like looking for the beginning in a ball of thread and I don't want to let it go."

Thus a very carefully graded technique, proceeding in a spiral alternating between the areas of C and T, and repeatedly driving home insight into the link between impulse and defense, resulted in a major but controlled breakthrough, and there was both relief and a marked increase in unconscious therapeutic alliance. Now the patient is ready for the second part of the trial therapy and the completion of this comprehensive psychodiagnostic evaluation.

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# The Technique of Unlocking the Unconscious in Patients Suffering from Functional Disorders. Part II. Direct View of the Dynamic Unconscious

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Part I described the first part of the trial therapy with a patient suffering from both migraine and chronic depression. In such patients, unremitting pressure and challenge are absolutely contraindicated, and the therapist must take the pressure off as soon as anxiety reaches a certain level, only re-applying it when the level of anxiety has reached a tolerable level. In this way he proceeds in a spiral, gradually restructuring the patient's defensive system. Once this has been achieved the therapist can revert to a more unremitting technique. The present article describes this latter phase. The second part of the trial therapy of the same patient is presented to demonstrate the technique of unlocking the unconscious. The article concludes with a discussion of two further important aspects of the technique, namely: (1) the therapist's use of nonverbal communication, and (2) the handling of pathology of the superego.

#### Recapitulation

In Part I of the present article I made clear that in patients suffering from chronic or characterological depression and or functional disorders, the underlying impulses—usually sadistic—are very intense and deeply unconscious, and any attempt to bring them to the surface too quickly arouses intolerable anxiety and results in an immediate breakdown of communication and a later exacerbation of symptoms. For this reason, a technique of sustained, unremitting pressure and challenge is contraindicated. The technique that must be used has the following characteristics:

Beginning with carefully graded pressure and challenge, usually in the area of the patient's current life (C).

Acute awareness that all pressure and challenge produce a rise in transference feelings (T), which are inevitably loaded with anxiety.

Therefore, vigilant monitoring of nonverbal signs both of transference and of anxiety.

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Attempting to bring some of these transference feelings into the open as soon as they arise.

Immediately taking the pressure off as soon as anxiety reaches a certain level, which is done mainly by switching to enquiry or to another area, from T to C or vice versa.

After an interval in which the patient's anxiety has been reduced to a tolerable level, returning to pressure and challenge at a higher level, gradually bringing the underlying impulses to the surface.

Each time the impulses are experienced, whether in the area of C or T, driving home and consolidating insight into the instantaneous defensive mechanisms by which these impulses are converted into depression or functional disturbances.

In this way proceeding in a spiral until the defensive system is restructured and the final breakthrough and the unlocking of the unconscious takes place.

This spiral process was illustrated very clearly by the interview presented in Part I, and in fact the spiral contained four turns in all, at first consisting of C followed by T, and then of the sequence: C,T, consolidation of insight. The patient, a divorced woman of 48, suffered from both migraine and chronic depression. The graded, spiral technique eventually led, first, to a partial breakthrough of anger against a current man friend, Dick, and then to a violent attack of rage against her son Paul, so severe that for a moment she was in an almost psychotic state—both moments of breakthrough thus occurring in the area of C. The final result was not increased anxiety, but relief, and mobilization of the unconscious therapeutic alliance. At this point the therapist brought the first part of the trial therapy to a close.

The present article consists of an account of the second part of the trial therapy followed by an over-all discussion.

#### **The Case of the Woman Used as a Go-Between—Second Part of the Trial Therapy; A T-C Link Followed by Return to Enquiry in the Area of C**

The patient now showed evidence of her heightened therapeutic alliance, which was obviously a consequence of the work done on the triangle of conflict in the areas of T and C.

*PT: If you don't get through the wall it doesn't make sense . . . Before I had this feeling of anger to you, I felt "I hope he doesn't give up on me" . . . It was like a holding onto you and almost a begging. There was an element of fear that you would not pull through with me.*

The therapist makes use of this communication to link the transference with current relationships and open up enquiry in this area.

*TH: But do you have this feeling always in any relationship that the other person might give up on you?*

*PT: I don't "have this feeling." It happens.*

*TH: Because one of the things we learned from that part of the interview is that you have problems in relationship with people. What we understood was, with me.*

The patient said that she didn't have the same problems with women, and the therapist therefore reminded her of the relation with Dick. The patient again showed her heightened therapeutic alliance, to which the therapist responded by pointing out a major pathological feature of her relationships.

*PT: Yeah. Dick seemed to be an accumulation of everything that I had experienced before, and it is really not the relationship itself. It is as if everything that happened before came out, not really during the relationship, but in the aftermath. That I really started to get afraid of him. He used to ridicule me.*

*TH: Yeah, but in your relationship with Dick one feature of it is you being used and abused. It is then a feature in your relationships with men?*

*PT: Yes.*

The therapist asked for another example, which led to the relation with her husband, whose name is Hans. Here the following emerged, amply illustrating the seriously pathological nature of her relationships, characterized by her adoption of the role of professional victim.

She met Hans at the age of 24, at the time when she was working at a responsible job in Vienna. He moved in with her, and while he was unemployed and making no attempt to look for work, she supported him and helped him in his aim of draft-dodging. They decided they would get married, she gave up her job, and in continuance of his aim of draft-dodging he moved to Canada, where she was due to join him later. She paid his fare. She was disturbed that he had referred to her as "perverted"; she wrote to him asking if he wanted to call the marriage off, but he responded with a cable asking her to come over so that they could talk about it. The outcome was a situation bearing an extraordinary resemblance to the one—described previously though it occurred later—which Dick created between the patient and Maria.

*PT: . . . Two hours after I arrived here his girlfriend appeared. He had not told me he had a girlfriend. I had given up a marvelous position, I had left the city I loved and all the friends . . . Here arrives this woman, and an hour later she says, "Hans, shall I undress now, how long is she going to stay?"—as if I wasn't even there.*

Return to Resistance

Pressure in the area of C.

*TH: And what was your reaction to that?*

*PT: Fight. Fighting, fists.*

*TH: How did you experience your feeling? (The patient sighs deeply.) You see right now you took a deep sigh.*

*PT: Yes, because I don't remember the feeling, I remember the actions. I . . . I was just desperate.*

*TH: Now again we are back to a situation like Dick, that there is another woman in the picture. But what is your reaction to that? (The patient sighs again.)*

*TH: You remain puzzled again.*

*PT: Because I don't really remember. I must have turned cold, I think, and then my thought was a matter of survival.*

The therapist keeps up the pressure, and the nonverbal signs of anxiety become more marked; tension as a component of anxiety in the striated muscles has increased, tension in the intercostal muscles is creating continuing sighs. There is avoidance of eye contact. The therapist began to introduce challenge.

Return to Challenge to Resistance in the Area of C

*PT: I can tell you what I did but I cannot tell you what I felt.*

*TH: So again you are paralyzed regarding how you felt?*

*PT: Ja.*

The therapist pointed out the parallel with the situation involving Dick, in which she suddenly finds out that the man is not faithful. "But then what is your reaction? Totally you become helpless." The patient said that her feeling is deadened, she kills it. He pointed out that this had not been so in the situation with Dick, when she had expressed her rage by hitting the bed with a tennis racket. The patient now resorted to silence.

*TH: Do you see that as soon as we approach your feeling you become retarded and slow?*

As indicated before, discharge pattern of anxiety can be in the form of tension in the striated muscles and in some patients it might involve the whole voluntary muscles and as a result create psychomotor retardation. Such a retardation can function as a major defense against breakthrough of the impulse, and in the process of challenge to the resistance can prevent the rise in the complex transference feeling. The defense of retardation needs special attention. It can be a defense against aggressive impulse; it can be the result of too much anxiety in the form of tension in the entire system of striated muscles, it can be a mixture of the two. The process returns to challenge in the transference, which is then followed by pressure and chal-

lenge in relation to her husband; and finally a de-repression consisting of a memory in the past in relation to her first nanny, as well as anger toward her brothers.

Return to Pressure and Challenge in the Area of T, with Partial Breakthrough

*PT: I'm not retarded (she laughs).*

*TH: You smile when I say you are retarded and slow.*

*PT: I'm the last person who is retarded (she laughs again).*

*TH: But obviously you are.*

*PT: (Angrily) I wouldn't be here if I was retarded.*

*TH: It doesn't make a difference you're being here, still you are retarded, and you smile when I say you are retarded because you become immediately slow and incapable to tell me how you felt in that situation.*

*PT: I feel like shaking you.*

Because of the work done in the previous interview, the challenge could now be much stronger and more sustained.

*TH: That is again a sentence. What is the way you feel inside? (She sighs.) Again deep breathing, that is all we see. You say you feel you want to shake me.*

*PT: I want to shake you . . . I . . .*

*TH: How would you shake me?*

*PT: I would take you like this and say . . .*

*TH: Where would you take me exactly?*

*PT: Shoulders, arms. And I would shake you, and I feel like saying, "Don't tell me I'm retarded"—except that there is a wall.*

*TH: But that is a sentence, "Don't tell me I'm retarded." I'm saying, how do you feel? You say you take my shoul . . .*

*PT: I wonder whether its a matter of not wanting to give up control.*

*TH: But what is the way inside you feel? In terms of thoughts—if you let yourself go what would you be like here with me?*

*TH: Now you see again you become totally passive, and almost paralyzed like that.*

*TH: With Paul you wanted to strangle him to death.*

*PT: Yes.*

*TH: Then with me is an exception to the rule.*

*PT: You are not an exception.*

*TH: But then let's to see how you feel. So far you have a hold on my shoulder but the rest of it we don't know and you see your hand like that now.*

*PT: I don't have a strongly, a feeling, a build-up with you as a person as . . .*

*TH: In a sense I am an exception. Now let's see why I am an exception.*

*PT: You don't abuse me.*

The therapist pointed out that in her other relationships her feelings had been murderous and asked why he was an exception, she spoke as follows:

*PT: Because with Paul and Dick and Hans it is a build-up, a history of not having acted, of having been passive, and then it's like a champagne bottle; you turn it . . .*

#### Return to Pressure and Challenge in the Area of C-Triangle of Conflict in Relation to Hans

The therapist pointed out that there her reaction had been much more than passive—with her husband she had left her job and come to Montreal and found him with another woman. The focus is on her feeling.

*PT: No, there is another thing that . . .*

*TH: Let's not move to another thing, let's see how you felt there.*

*PT: I've been taught all my life to be nice and sophisticated (her voice is rising).*

*TH: . . . That is not sophistication, that is taking abuse . . . Let's see how you felt there.*

*PT: Degraded.*

*TH: That is a sentence. Now let's see how you felt there? How you felt giving up a job and coming and then suddenly the scene?*

*PT: Degraded.*

*TH: That is a sentence. (Patient sighs.) Degraded.*

*PT: God, I thought I had learned something last time. What do you want to hear?*

*TH: What do you mean, what do I want to hear? Let's not get to what I want to hear. Do you see you are incapable and handicapped to tell me how you reacted to a situation like that?*

*PT: Yes, I see that.*

*TH: We know with Paul you were boiling inside, you were near to strangling him and this and that. You walked through the city to shape up. How did you feel there between you and your future husband and this woman?*

*PT: There was a mixture of fear and anger. Fear because I was stranded.*

*TH: Let's see what was the anger. (The patient sighs.) What was the way you experienced the anger with Hans?*

#### Anger in the Past—Breakthrough of Painful Feelings

She talked about her earliest memory which was of herself at age two or three being angry as she saw the red, angry face of her nanny leaning over her cot. At this point she became very emotionally charged, sobbing as

she spoke and described her first actual outburst of anger which was at age eight.

*PT: Because I don't remember having . . . I tried to remember from last time to now when have I expressed real anger in my life.*

*TH: When?*

*PT: The very first time I remember the first memory of my life is having a very bright red angry face upon me when I was . . . (The patient is sobbing.)*

*TH: Bright red angry face.*

*PT: Furious, that's my . . . ja . . . that is my very first memory in life. (Patient continues to cry.) A face full of rage.*

*TH: Uh hmm.*

*PT: What I relate to the face of our nanny because she had red hair . . . I didn't like her. She was very stern, very strict.*

Then she went on to describe her first actual outburst of anger, which was at age eight. She explained that she was the youngest, with three older brothers, and that her father came to visit when they were away from home. They were playing a board game and she became enraged because she was losing: "I just threw the whole board down and so I was sent to bed."

Then she talked about an incident two years ago in which she had behaved in the same way. She had a relationship with a much younger man and they were playing chess and she suddenly got angry and knocked down all the pieces. She was in a state of anger.

*PT: He accused me and then he said 'by the way I'm leaving tonight anyway, I'm going to my parents' and I said why didn't you tell me before and then I could have arranged my weekend differently.*

*TH: Uh hmm.*

*PT: 'Why should I tell you?' Then shooosh, it just came shooosh.*

*TH: What was the rage like when you said shooosh, that doesn't tell us.*

*PT: It feels like champagne bottle which goes open and just losing shooosh. Everything turns red and my reaction was I threw everything down, the chess board.*

*TH: Did you feel you wanted to attack him? Is very important.*

*PT: No I didn't want to attack him. I led it out on the chess board.*

The therapist emphasized the mechanism of displacement and drew the parallel with the situation at age eight, where the impulses were so clearly displaced from her brothers.

#### The Link with the Transference—Driving Home Insight into Anger, Anxiety, and the Defense

*TH: I am questioning if with me there was mobilization of anger but then you had to protect me against the anger?*

*PT: Ja, that's right. But the anger I experienced toward you is not as strong as that I feel . . .*

*TH: It doesn't have that intensity, but did you experience the anger?*

*PT: Yes, yes I did, and I experienced it last time.*

The therapist pointed out that she protected him against her anger by becoming passive. Suddenly her therapeutic alliance spontaneously added an unexpected detail.

*PT: That's right. And I felt . . .*

*TH: The question for us . . .*

*PT: Wait, wait, wait. And I felt like stroking your face.*

*TH: That is different from the way you went to the chessboard.*

*PT: But this is how I also deal with anger.*

*TH: . . . and then the way you dealt with anger in relationship with me is going to the opposite and stroke my face, hmm? . . . And the way you deal with anger is to try to be pleasant and nice and goody-goody toward the other person?*

*PT: Ja, that's right.*

#### T-C Interpretation

The therapist now made the T-C link, bringing out that this was how she behaved in other relationships, particularly with her husband, with whom she tried to be perfect. Again her unconscious therapeutic alliance collaborated, for she now spontaneously mentioned the anxiety, thus completing the triangle of conflict.

*TH: What was the way you experienced the fear?*

*PT: That he would leave me . . .*

#### Systematic Analysis of Defenses against Anger—The C-T Link— The First Mention of Her Masochistic Pattern (Superego Pathology)

The therapist now drove home insight into the various mechanisms that she used in order to protect the other person from her anger: With her husband, she became passive and submissive and let herself be used and abused; in the transference she became passive, retarded, immobile, or went to the opposite of anger and became nice; with Paul on one occasion she had to walk out in order to cool down, and on another occasion she remained calm but developed a migraine and depression. The patient then made the C-T link, saying that her anxiety in the transference was that the therapist would reject her and refuse to continue with her. The therapist emphasized that the more appropriate word would be "retaliate" rather than "reject," and went on to say that in all her relationships there was a need to be used and abused. The patient said, "It seems there is this kind of need in me, and I don't want it," thus confirming that her masochism was becoming more

ego-dystonic and there is further increase in the unconscious therapeutic alliance against forces of resistance.

#### Return to Enquiry in the Area of C

The therapist asked her to continue the story after her arrival in Canada. In fact the other woman who had become pregnant had walked out and had then phoned the patient to say, "I'm sorry for you that you've ended up with such a schmuck." In spite of this message about Hans' character, of which in any case she had direct experience, she had continued her self-destructive pattern by becoming pregnant, and then had married him.

The story thereafter was complicated. Her husband had become ill, lost his job, and they had returned to Vienna. There she had got her previous job back, and again she had supported her husband while he became a student and thus still managed to avoid the draft. Later he had returned to Canada once more, himself returning to his previous job, while she stayed behind in Vienna. After a year he then began phoning her—"look, we are married and marriage is forever and we have a son and I've changed, let's try again"—so she came back and joined him. Within a short time she was pregnant again.

Here she gave further details about the disastrous situation with her husband, now concerning the sexual relation. Before they came to Canada this had been satisfactory to her, but she had only been able to reach orgasm by manual stimulation of her clitoris, and she did not know that her husband regarded this as a "perversion." Moreover, as soon as they got married, "it turned into just screwing," "if I wouldn't have sex with him—which means that missionary position forever, just go at it and turn over. If I refused this then he was very angry the next day and said, 'I can't concentrate if you don't let me have sex, and then I'm in a bad mood all day'." She dealt with it by complying, and once more the therapist emphasized her pattern of bending over backwards to please and her need to be used and abused.

This led to further information, now about her husband's apparently compulsive infidelity. He had tried to go to bed with all her girlfriends, and had had an affair with another woman whom they had met while on vacation.

#### Return to Pressure and Challenge in the Area of C, Leading to Breakthrough

At last the gradual, spiral approach began to pay off, for now under pressure and challenge the patient reached the true experience of anger in relation to her husband.

*TH: And how did you feel?*

*PT: Again . . . (pause)*

*TH: You are going to go again . . .*

*PT: Yes, retarded. And then I started to . . .*

*TH: How do you feel when you talk about it?*

*PT: Yuk!*

*TH:* Yeah, but "yuk" doesn't say how you feel.

*PT:* Disgusted. I feel disgusted.

*TH:* What is the way you feel right now. Being "disgusted" is a sentence, it doesn't say how you feel. Does it mobilize rage in you?

*PT:* (Loudly) NO, NO.

*TH:* No, right now how do you feel when you see your anger?

*PT:* Ahhh . . . I feel like taking my fist and just hitting the table and there's pressure in here (pointing to her stomach).

*TH:* What is the pressure like in there?

*PT:* It's like giving birth to an ulcer. You know, everything is coming out through my belly button. Like squirting pus. Oh God, it almost sounds like the White Hotel, yuk.

*TH:* Uh hmm.

*PT:* I don't want to be dirty anymore.

*TH:* So there is right now rage in you?

*PT:* Ja.

#### Breakthrough of the Impulse

There is nonverbal communication of a definite breakthrough of the impulse at this moment. There is a rise in her voice, with absence of tension in the vocal cords. Her hands are held up in a fist position, pointing to the table. There is a marked decrease in tension in the striated muscles. She then stamps her feet.

*TH:* And if Hans was here right now what would you do?

*PT:* (Using the defense of rationalization) I'm so angry at him now for other reasons, for not taking his responsibility and the . . .

*TH:* (Sensing that pressure, rather than challenge, will be enough) And if he was here how would you deal with your anger? If you could be honest with your thoughts and ideas.

*PT:* I think I would castrate him, to be very honest.

*TH:* Yeah, but that is a sentence.

*PT:* That's a sentence, yes. You know, I feel like krrrrsh.

*TH:* What?

*PT:* Just like beetle, a beetle.

*TH:* Could you exactly describe what you would do if he was here?

*PT:* I would just like a beetle put my heel on him. Turn my back on him. Squash him.

*TH:* Could we picture how you would squash him?

*PT:* I would picture him like a beetle and I would just squash him and I would turn my back on him and I would never look back.

*TH:* But after you squash him what would he be like?

*PT:* Well, if you squash a beetle it's dead. There's only a shell.

#### Analysis of the Triangle of Conflict—Interpretation of the Masochistic Mechanism

The therapist senses his opportunity to give her a major piece of insight: masochistic pattern as a defense against repressed sadistic impulses.

*TH:* So there is an impulse to torture him and to . . .

*PT:* Destroy him.

*TH:* Murder him. But who in reality are you torturing and murdering?

*PT:* Well I assume it's me.

*TH:* Assume.

*PT:* Okay, it's me. Certain parts of me which . . .

*TH:* But, you see, it is very important you look into this. That you need to be tortured, you have a need to suffer, to go to a life of agony. You have a need to live the life of a criminal, don't you?

*PT:* That's strong.

*TH:* You look at what way your life is better than the life of a criminal. (pause) So you are the one who is suffering, being tortured, living a life of agony, being squashed like a beetle.

*PT:* Uh hmm.

We have ample evidence that the resistance has been sufficiently weakened. The therapist now asks the crucial question which leads the enquiry into the past. It soon becomes evident that the phase of direct access to the unconscious has begun.

#### Direct Access to the Unconscious—The Link between Present and Past and the Origin of Her Punitive Superego Structure

*TH:* Now the question is this. What have you done that you have to mess up your life like this? Have you ever questioned yourself what you have done that you have to torture yourself? There is self-sabotage, there is self-defeat, hmm?

The unconscious therapeutic alliance has been mobilized.

*PT:* That's what I've started to ask myself during the last two years . . . If this wouldn't be there I wouldn't attract people who make use of it. I'm providing for it, but what is it? Where does it start?

*TH:* Obviously you have a need to gravitate toward people who are going to use you.

*PT:* Yes, yes that's right. It's my choice . . . just the thought of it makes my hair stand up.

Here the therapist suggested a five-minute break, and then began a systematic enquiry into the past. Very quickly the following important episodes in her childhood emerged: Her mother she described as useless, nonaffectionate, detached, totally preoccupied with herself, highly promiscuous, had no relationship with the patient. She showed more interest in her brothers, but that was mostly in the form of buying gifts and giving them material things. Her father she described as subservient to her mother, with episodes of becoming volatile, his only way to cope with his controlling, demanding wife. She remembers episodes of him becoming explosive. In the very early phase there was a nanny, whom she described as a stern, cold, and angry

woman. There was a chauffeur, who was kind. After the first nanny left, a second nanny came, who was kind. She was five when World War II started. She and her three brothers were placed with an aunt somewhere in the mountains. Her earliest memory is of prewar times, her father waking her. Her first migraine headache started when she was placed with her aunt, and she has memories of her mother coming to visit, bringing gifts to her brothers. In the early part of her life she had disturbed behavior. The most dramatic incident was when she kidnapped a baby boy and hid him in the cellar for a day before he was discovered. During wartime her mother sent food parcels to her brothers, but not to the patient. She remembers that her parents visited and took them out for a walk. She would sulk and develop a headache and be unable to walk. The therapist pointed out that this was her way of expressing her anger both with her mother and her brothers. Her therapeutic alliance responded to this by describing further disturbed suicidal behavior, in which, day after day, she climbed high into a tree and sat there, just rocking, and making her aunt afraid that she would injure or kill herself.

The therapist points out that similar mechanisms are still operating today.

*TH: The way you deal with your rage today is sulking, becoming retarded, becoming helpless, developing migraine headaches, going into depression, or wanting to kill yourself. So this system was set up in the very early years.*

#### The Relation with her Mother—The Patient's Role as "Go-Between" or Procress": Repetition-Compulsion—Marrying a Man Similar to Her Father

She spontaneously offered another crucial piece of information: that when she was about 17 her mother made use of her to entice men into the home. The patient would then go to bed, leaving the man and her mother together. This happened even though her father was at home. The focus is on bringing men to have sex with her mother. The therapist now made an important link with the "compulsion to repeat," her pattern of becoming involved in triangular relations in her current life.

*TH: Your memory totally collapses. Because, you see, what you say is very striking. Do you notice that here is a triangle of you, your mother, and another man, hmm? You bring the man home but he ends up with your mother and you go to your own bed, hmm? Now what happened with Dick and Maria? Isn't that something in a different context but similar? Dick and Maria end up to go on vacation and then you are out?*

*PT: Uh hmm. right.*

Her unconscious therapeutic alliance now adds another example.

*PT: Hans and I go on vacation and he is taking off with the group and I'm out.*

Hans ends up having sex with the wife of the couple they had met; the highly sexually promiscuous husband and its similarities to her mother. The therapist added another example and reemphasized the link between present and past.

*TH: You leave Vienna to come here to marry Hans and then you find another woman is sleeping with him. So constantly we see triangle after triangle, hmm? So we understand a little bit about these triangles of you and another woman. That in a sense you bring the man to the house and then you have him in bed with your mother.*

#### Her "First Love" and the Link with Her Father

Then the focus of the session is on bringing men home who would end up in bed with her mother, and she herself would go to her own bed. The therapist asked who, in fantasy, the patient had in bed. She responded by talking about a student named Franz who had come to live in the house with them when she was 16—though this did eventually lead to her father by a circuitous route.

She had felt herself to be in love with Franz for six years. She used to wake him up in the mornings and give him a kiss, and he would respond by making her a cup of tea. Here the therapist drew the parallel with her father, since it had emerged earlier that her father used to wake her in the morning and bring her breakfast in bed. The patient responded by saying, "But that's all he did for me, and everything else was his expectation of me—that I should do all the big things he dreamt about without any support, and that I should support the family at the same time." So it now appeared that she was in the position of being used and abused by both her parents.

However, the therapist wanted to hear the rest of the story about Franz. Franz had moved away but had still been very attentive and had kept writing to her. Then when she was 22, he had married "a very rich woman." The therapist immediately asked how she felt about being left for another woman. She said first that she felt "terrible," and then that she felt "real shitty." The therapist pointed out that this was yet another example of her dealing with anger by turning it on herself.

He then concentrated on the situation of her bringing home a man to go to bed with her mother, asking repeatedly, "What do you become in that system"? He then asked what happened between Franz and her in bed. Her reply gave a hint of the eroticized relation between she and her father—on both sides.

*PT: I had one weekend with Franz in bed where there was no intercourse, because my father had said to him, "I want her back as she went"—because he thought I was a virgin.*

The therapist now pressed her about her relation with her father. This had been reestablished when she was 11, when he used to make breakfast for her, take her for walks, and speak of dreams about her future, one of which was that she would eventually come and work for him in his business. Then she began to speak of negative feelings.

*PT: I was afraid of him . . . He had incredible anger outbursts, and if I didn't do what was expected of me he used to scream like a lion. I remember one incident in which I just dove under a bed.*

She did not remember what this incident was about, but it then emerged that her father never screamed at her three brothers but only at her and her mother. The therapist pointed out that it always seemed that her brothers were favored over her. He then searched for positive feelings for her father, to which she said that her father was physically affectionate in a very Victorian way, holding her hand or giving her "a little pecky kiss."

*TH: But you looked forward to being with your father?*

*PT: No. I found it boring and very restricting.*

#### The Final Relation with Her Father—Transformation of Pathological Mourning to Acute Grief Reaction

*TH: What happened to your father? Is he alive?*

This led to an extremely traumatic incident, which happened on the last occasion when she saw her father alive. She visited her parents in Austria the Christmas before he died. He had had a stroke and was partially paralyzed on one side, and the patient described how this man, who had formerly appeared so terrifying, now looked small and helpless. The nurse had not come to wash him and therefore the patient, knowing how strongly he felt about cleanliness, undertook this task.

*TH: You washed his body?*

*PT: And I think he must have felt very embarrassed that I did this.*

*TH: And how did you feel?*

*PT: I felt very good about it. I could do something for him. I felt really good, and later . . .*

There is a major wave of physical distress associated with affect-laden painful feeling. (Patient continues to cry.)

*TH: So you must have a lot of feeling about this.*

It seems that her father had been disturbed by the physical closeness involved in being washed by her, and found himself compelled to drive her away as cruelly as he knew how:

*PT: Because he had a terrible reaction. The next day we got into a fight and he said to me that I didn't turn out all right because I thought . . .*

Another wave of physical distress, associated with waves of painful feeling.

*TH: You mean his dream for you?*

*PT: He said to me you . . . did . . . it's even stronger. You have turned out like shit.*

*TH: So you see you have a lot of mixed feelings about your father.*

Patient continues crying.

*PT: Because I saw him being so helpless. Once he gave my mother a book . . .*

*TH: No, let's look to this last visit with your father, because it must be very painful for you. It was true that there was a lot of anger in him, but also he was dreaming for your life, hmm?*

*PT: Yes, he . . . he was, he was dreaming for all of us.*

*TH: I know, but let's look at it.*

*PT: Ja.*

*TH: It was very explicit, the relation with you, hmm? The walk was with you in the park and holding your hand and this and that, and you said he was a lonely man and he died a lonely man. Didn't he die lonely?*

*PT: Yes.*

*TH: So you must have a lot of feeling about it.*

*PT: Yes I do.*

*TH: So could we look to your feeling? Because obviously it is there.*

The wave of physical distress and affect-laden unconscious feeling continues.

*TH: So in that last moment he was angry with you again?*

*PT: Ja.*

*TH: What happened?*

*PT: I took my suitcase and I left and I said to myself I would never come back.*

*TH: Oh, you left him with anger.*

*PT: I left him with anger, ja.*

*TH: And you never saw him again?*

*PT: No.*

*TH: So that must make it very painful that your last good-bye to your father . . .*

*PT: It was very painful for awhile.*

*TH: No, let's look at it. The last good-bye to your father is in the atmos-*

*phere that he is helpless and he is on his way to his grave and you left him helplessly with anger.*

PT: Yes.

TH: And you never saw him again?

PT: No.

She never visited him and he died about a year later.

TH: Did you feel that you wanted to visit him, if you be honest with yourself?

PT: The situation at home was so terrible.

TH: We are talking about you and your father and you want to move away.

PT: I would have liked to live with my father.

The patient explained that the situation at home was intolerable, with her mother and father in constant conflict.

#### The Triangle Involving the Patient, Her Mother, and Her Father

Murderous impulses toward her mother—one of the sources of punitive superego structure.

TH: So if you had a choice you'd live with your father?

PT: I would have lived with my father, that's right.

TH: But your mother was in the way between you and your father, hmm?

PT: My . . .

TH: Let's look at this. Is that right?

PT: That's right.

Mindful of the patient's punitive superego as manifested in her masochistic pattern, her involvement with men who create triangles, and his own question, "What have you done that you have to torture yourself?", the therapist opens up the question of death wishes toward her mother. This raises resistance which needs persistent pressure and challenge.

TH: And if your mother had disappeared in the picture what would have happened between you and your father? In terms of thoughts?

PT: I would have taken care of my father but he . . .

TH: Did you have thoughts during the early years, particularly during the war?

PT: During the war I wanted my mother.

TH: Why should you want your mother? From your description she is useless, she doesn't give any affection, she sends a parcel to your brother. Again we are facing your paradoxes.

PT: This is what . . .

TH: Now if you don't want to look at these paradoxes, then you are

going to go on to your own grave and torture yourself. Let's look at it.

PT: Yes, uh . . .

TH: On the one hand you give a picture of a woman who at first you don't have any memory of. The woman who stands in your life is your nanny, okay? You said your mother is spoiled, she has affairs with other men, and when it comes to the parcel . . .

PT: I didn't know it at that time.

TH: Obviously even right now you don't want to look at anything.

PT: I only want to get it straight.

TH: Now let's look at it. You said yourself you were jealous of your brothers because they were getting parcels and you were ignored. You said that you kidnapped another child because that child had a mother. So this means that you must have had a lot of negative feeling for your mother, who preferred your brothers to you, sends parcels to them, uses you to bring men to her bed, but then at the same time you want to brush it away.

PT: Because . . .

TH: Let's not get to "because." Is there negative feeling or isn't there?

This stronger challenge now produces results.

PT: There . . . there was a lot of negative feelings, terrible negative feelings.

TH: And if your mother had dropped dead what would have happened?

PT: Oh, I would have been very happy, because she was a totally useless person.

TH: So you would have been very happy if she had dropped dead?

PT: (Laughing)

TH: You smile now.

PT: Because now I'm not sure anymore.

TH: Again you ruminate on this. You yourself said you would have been very happy if she had dropped dead, hmm? And now you move to the position that you are not sure about it. You see, you ruminate and vacillate from one . . .

PT: Because I was . . . I'm . . .

The therapist now directs a challenge toward the unconscious therapeutic alliance and against the superego.

TH: You are full of paradoxes, and what I am saying is this: if you want to look at these things and put your feelings in the right perspective and see things the way they are, then you can see the light to freedom. But if you don't want to look at them and close your eyes, you can do that—but you would never see the light, and you have to live the life of a criminal. Now let's see what was your feeling for your mother?

PT: It's love and hate, it's both.

*TH: Of course there is love and hate, but you said that if she had died then you would have been . . .*

*PT: Ja.*

*TH: And then what would have happened between you and your father? How would you picture the life then?*

*PT: We could have pursued our lives without destruction.*

*TH: So isn't a part of you still with that man in spite of the fact that another part of you has a negative feeling for him? Isn't it that in a sense you punished your father in the last part of his life? You avoided seeing that man who was so helpless and lonely, the same man that would walk in the park with you and make your breakfast, would talk about his dream for your life. You left him helpless in bed and for one year you avoided seeing him. Was that a way of getting at him? It is very important you look at it. Do you see what I mean? Because you left him with anger and never saw him again, hmm? Was that year a way of punishing your father, getting at him, taking revenge on him?*

*PT: No.*

#### Two Spiritual Experiences: The Inner Reconciliation with Her Father

The therapist persisted with his pressure, but the patient maintained her position and eventually recounted the following incident.

*PT: I don't have a lot of feeling about it now anymore because of a very strange incident. A friend took me to a seance in a church and I sat in the last row, and there was a medium—I mean, you may think I'm crazy and sometimes I think it myself—I was in the back of the church, I have never been there before. There were about 300 people. She starts to identify me, and said, "There is a woman sitting in the last row and I have a message for her." She described exactly how my father was, how I had seen him last, and this man is sending you a message. I said, My God, that's my father, and she gave me a message, and from then on I was in peace.*

The message was that he was all right, that everything was going well, and she should not worry anymore. This was five years after his death. When the therapist asked her what she thought about this experience she said that she had had many spiritual experiences. She went on to describe one which had occurred just before she had her violent outburst at Christmas. Since this one involved only herself, it is more easily explainable in purely psychodynamic terms.

*PT: I took a walk with a friend and we split and I went to an area which I really like. And the light was very beautiful. It was snowing, and I felt so peaceful, and all of a sudden there was a wind and a rustle in the leaves, and suddenly I felt I was all illuminated, and every-*

*thing was very light, and I was . . . aaaahhh . . . so elated, and I fell on my knees in the middle of the road, and I said "My God, God is alive and he's right inside me," and then I felt a little bit embarrassed and I got up and went home and I said, "Okay God is alive, the good is in me and everything is going to be all right."*

*TH: What do you think about this?*

Patient is very sad, crying.

*PT: That there's good in me too.*

#### Mixed Feelings for Both Parents, Many Links between Past and Present—Further Sources of Superego Pathology

The therapist uses this incident to bring into the open another source of guilt which must contribute to her punitive superego.

*TH: What you say is this: that there was both negative feeling for your father as much as there was positive feeling, hmm? But it is very important you look at that experience, because in a sense there is a war in you about deserting him and letting him go alone and lonely. And because of that pain—you see you are trying via these experiences to come into peace with your father, aren't you? Which indicates that you must have a lot of mixed feeling for your father. And when you talk about that gentleman, Franz, maybe he also represented the positive aspect of your father. Do you see what I mean?*

*PT: Ja.*

*TH: And when your father had a high expectation of you, it really means something. It means that he also had a high opinion of you, for you cannot have a high expectation unless there is something there. But if you look, there was something positive with your father, but then this positive was counterbalanced by events that you have described. And your memory of your father is mixed with these positive and negative, you see. And maybe a part of you is nagging on you because your mother had all these affairs, and this means your father was in a sense helplessly struggling with this woman, hmm?*

*PT: Uh hmm.*

*TH: But at the end, here he was, a man of prestige at some time in his life, but then in the latter part of his life he goes alone, hmm? . . . And then you must have a lot of feeling about deserting him during that last part of his life, you see. So that is where the negative-positive comes, hmm?*

#### Return to the Relation with Her Mother

Then she spontaneously talks about her mother.

*PT: I have a lot of feeling also about deserting my mother.*

*TH: Because you see a part of you is in rage with your mother, a part of you, as you put it, said "if she had died you would have had your freedom." So that means a lot of conflict, doesn't it? Is she alive now?*

*PT: Ja.*

*TH: When was the last time you saw her?*

*PT: Last year.*

*TH: And if she dies, how would you react?*

*PT: (Sighs)*

*TH: Have you had thoughts?*

*PT: Ja, I have thoughts about it because she is now 80 and she might die. One part of me feels I should go and take care of her, and the other side says I have to take care of my kids and I have to take care of myself.*

*TH: But that is very important to look at, because you see a while ago we established that the way you deal with your rage is to go to the opposite, hmm? Maybe a part of you feels that to deal with the massive rage against your mother you have to go to the opposite . . . part of you says to punish, not to give in, to do what you did with your father, but maybe another part says that you should sacrifice the rest of your life for the years that she's alive . . .*

This is confirmed.

*PT: You know, from my mother there was always this expectation that I as a daughter ought to sacrifice my life for her, and it was expressed many times . . .*

#### The Link between the Relation with Her Mother and Other Relations

The therapist now prepares to bring into the open the "compulsion to repeat"—here to repeat the relation with her mother in later relations—a kind of pattern that is largely perpetuated by the superego.

*TH: And obviously we see the way you were abused by your mother as well. You see, when you describe bringing men to her bed.*

*PT: It was not that. I was also providing for her, coming home and having to cook dinner. She has never washed or ironed a piece for me.*

This explains the intensity of her rage when her sons left her with the cleaning up to do after the Christmas Eve party.

#### Repetition-Compulsion and Punitive Superego Structure

*TH: Have you ever thought that . . . the men that you describe . . . if you look to your husband, is he more like your father or your mother?*

*PT: No, Franz was the only one who was like my father.*

*TH: You see, if you look at the picture you describe of you and your husband, you are taking care of him, hmm? . . . You see, your father was the one who used to cook and do things, but your mother never touched anything. So the question is this: was it really that you married your mother in a sense? You see, your mother used to have affairs with other men. Have you ever had thoughts that in a sense . . .*

*PT: I never thought of that.*

*TH: That they have some similarity to your mother?*

*PT: I only . . . when I try to analyze it, they always look more like my father. They start out as my father, being lonely.*

*TH: But look. They use you, they abuse you. If you look to your father, at least your father did something for you.*

*PT: I never thought of that . . . that the men have more the characteristics of my mother.*

*TH: That is something you have to look at. Isn't it a fact that you gravitate toward the men who use and abuse you the way your mother used and abused you . . . And when you described the relationship with Dick you said it became one-sided. Giving and giving but never receiving. So isn't that the relationship with your mother?*

*PT: Uh hmm, and it still is.*

*TH: So the question is this: isn't there a lot of mixed feelings about your life with your father, your life with your mother, and more mixed feelings about the early phase of your life. That in a sense it is totally wiped out.*

*PT: Uh hmm.*

*TH: That they are the engine to all the problems that you have. Because, look to your relationship with men, all has ended up to disaster, hmm? And if it continues like this . . .*

*PT: It won't! (She said this in a very determined way.)*

*TH: I know, but then you would join your father and be faithful to him, wouldn't you? Maybe a part of you still has a lot of feeling for that man in spite of the other part which is angry at him. Angry that he put up with your mother, hmm? Angry that he took all this messy situation?*

*PT: Why would I have the need to choose someone who resembles the person who, as I knew, was destructive to me and used and abused me. Why?*

*TH: You see, it is a very important question you are raising. It is important we look at it. Is this a way of paying for your murderous feelings for your mother? . . . You said that you wished her dead. Is it for that wish that in a sense you are punishing yourself and saying okay the destiny of your life is to be used and abused. Of course it is more complicated than that. It is not as simple as that. There are other factors as well in it.*

#### P-C Interpretation

The process now moves to further linking between her mother and the incident when she had murderous impulses toward her son Paul.

*TH: You have already indicated that in your relationship with your mother you were used and abused . . . always giving and never receiving, cooking and cleaning up after her. You see, the incident when you had intense rage toward your son, which had murderous qualities, and you ended up running out of the house, there your son had left you to clean up after the party.*

*PT: Ja, ja . . . (She has a deep sigh.) I was really physical.*

This is further linked with her husband—at one level her murderous impulses and her need to let herself be used and abused.

Further communication from her unconscious therapeutic alliance: She becomes sad and tearful and says she feels guilty; that her rage toward her sons, particularly Paul, comes when she comes home and cooks for them, and when she washes the dishes she is always fuming. They she talked about her adolescent years, complaining to her father that she is the maid in the house, that her mother never did anything in the kitchen.

Bringing the interview to a close and setting up a psychotherapeutic contract.

*TH: You see, what I'm saying is this. There are a lot of complicated issues in your current life . . . in relation to your son, in relation to men, as well as in other aspects. Going from the frying pan into the fire. In a very complicated, round-about way which is related to many buried feelings. Complicated issues of the past . . . your early life, your feelings about your mother, the mother you wished you had had. The wish that she could not have been in the picture. Your feeling for your brothers who were preferred by your mother. All the mixed feelings there and all the mixed feelings you have toward your father and the last part of the life of your father. And of course there are other features in the early part of your life like the chauffeur who was more kind, or the second nanny, who was also kind—but she left.*

*PT: Uh hmm.*

*TH: There are a lot of mixed feelings about your father, the early part of your life, the way he was used and abused, who helplessly*

*struggled and in a very lonely way died. You see . . . there are a lot of mixed feelings.*

*PT: Uh hmm.*

*TH: And also there are a lot of mixed feelings about your brothers and many figures in your past that we have not fully explored.*

*PT: Uh hmm.*

*TH: So you see you have all kinds of these mixed systems of feeling.*

*PT: Uh hmm.*

*TH: So the question is this; if you be able to examine all these feelings and carefully look at them for the way they are. Of course when I say the way they are means to look at them, to examine them in more detail and to see them as they are, hmm?*

*PT: Ja.*

*TH: Obviously a lot of them are burried in you, okay? Do you think if you put them together and see them as they are and experience them as they are, do you think this might in a sense give you your freedom in a sense?*

*PT: Ja.*

*TH: Because you are in a sense if you look at it repeating the life of the past. Is a war time life for you. Do you see what I mean?*

*PT: Ja, that's . . . I even said that the other day. It seems that my life is always war.*

*TH: Yeah, is a war time life . . . and in a sense is worse, is a frying pan into the fire pattern.*

*PT: Always.*

*TH: In a disastrous way you are, hmm? What I am looking at is this; up to the time you don't put all your mixed buried feelings in the right perspective, I am sure you are going to perpetuate the past, live a crippled life, and die in a crippled way.*

*PT: And that's what I don't want and this is why I am here. (In a very affirmative and determined tone of voice)*

*TH: We have only touched the tip of a huge iceberg. It is much deeper than that.*

*PT: Uh hmm.*

*TH: Now do you think this might be of help to you?*

*PT: Ja.*

*TH: Hmm?*

*PT: Ja. Because when . . . when . . . the things we talked about today, some things are somewhat there. I know that there are many paradoxes within which I cannot explain. I never thought about that my choices are . . . my choices in partners are really my mother.*

*TH: But you might want to think about it.*

*PT: And while I always considered them as being like my father when I thought about it.*

*TH: But obviously the story tells us different.*

*PT: And I never thought that my relationship with my children might have something to do with my mother.*

*TH: That is also something you might want to carefully examine. As*

*we saw, there are a lot of positive feelings toward them as well. Remember, you said, "I love him, too."*

The therapist brings the session to a close.

### Discussion

Summary of the course of the second part of the trial therapy: Although in the first part of the trial therapy there had been a major breakthrough of the impulse of rage (against her son Paul), and although at the beginning of the second part of the trial therapy she showed mobilization of her unconscious therapeutic alliance, it was still necessary to do some further work on her resistance before her unconscious could be unlocked; the kind of work that is necessary involves (1) applying further pressure in the areas of C and T, (2) challenging the ensuing resistance, now more strongly than in the earlier restructuring phases, and (3) systematically analyzing the residual transference.

This process unfolded as follows.

#### Pressure toward Impulses in the Area of C, Renewed Resistance Increased Challenge

The therapist began exploring the patient's relation with men, which enabled him to point out one of her most important pathological patterns, namely her need to be used and abused, which led in turn into the relation with her husband. At first, enquiry in this area proceeded smoothly, but as soon as an attempt was made to explore her feelings and impulses in the triangular situation involving her husband and the other woman, Maria, there was a return to resistance. Because of the controlled breakthrough of impulses which had occurred in the first interview, together with the partial restructuring of the defensive system which had been achieved there, the therapist now knew that it was safe to step up the level of his challenge: "So again you are paralyzed regarding how you felt . . . Do you see that as soon as we approach your feelings you become retarded and slow"?

#### Challenge and Pressure on the Resistance in the Transference

This led to further rise of the complex transference feelings and further resistance with a discharge pattern of anxiety in the form of tension in the striated muscles in the form of being retarded, which was further challenged. Nonverbal communication indicates that there is a build-up of the impulse and heightened resistance.

#### Return to Pressure in the Area of C

The therapist then returned to the area of C with pressure toward her feelings in the above triangular situation. Nonverbal cues indicate further build-up.

#### Partial Breakthrough in the Area of P, Followed by Partial Breakthrough in C

She now spontaneously took the subject into the past (P), where she described an outburst of anger displaced from her brothers onto the board game that they were playing, and followed this by describing a similar incident which had occurred two years ago (i.e., she made a P-C link). In this latter incident she was able to experience the intensity of her impulses, as indicated by her graphic description: "and then shoosh. It feels like a champagne bottle. Everything turns red." The therapist pointed out the mechanism of displacement in both incidents, which she was able to see.

#### Partial Breakthrough in T, Systematic Analysis of Transference Resistance

The therapist began with a systematic analysis of residual transference, with the use of the two therapeutic triangles—a step which tends to be forgotten by insufficiently experienced trainees but which is essential to enable the final unlocking of the unconscious to take place. He started by making the link between impulse and defense (two corners of the triangle of conflict) in the transference: the way in which she defended herself against anger with him by becoming passive and helpless, and by covering it up with a smile. In response, she was now able to answer his question with feeling: ". . . did you experience the anger"? "Yes, yes I did, and I experienced it last time." She then showed the mobilization of her unconscious therapeutic alliance by spontaneously mentioning another defense, namely turning her violence into gentleness, wanting to stroke his face. Here the therapist launched into a major linking interpretation, pointing out all the ways in which she defended herself against her anger, both in the transference, with recent men, and with her son Paul. Finally, he was able to bring out the anxiety, namely her fear of being rejected and abandoned. This systematic analysis thus covered all three corners of the triangle of conflict, i.e., defense, impulse, and anxiety, and two corners of the triangle of person, transference (T) and current (C).

#### Direct Experience of Aggressive Impulse in the Area of C, The Final Unlocking

Then we saw a breakthrough of the impulse in the area of C, with the intensely felt description of her impulse to crush her husband like a beetle, stamping her foot on the floor, high rise in her voice, no tension in the vocal cords, absence of tension in the striated muscles, all the nonverbal communication of the breakthrough of the impulse.

#### Enquiry into the Past, Direct Access to the Unconscious

Knowing that the unlocking had taken place, the therapist now began a systematic enquiry into the past. This gradually penetrated deeper and

deeper into her unconscious, culminating in her account of the traumatic last encounter with her father, which was followed by her inner reconciliation with him through two intense spiritual experiences. During this phase it was possible to undertake a comprehensive survey and a meaningful analysis of her neurosis, which covered many aspects of her relationship with each of her parents. The therapist devoted special attention to the analysis of her superego: bringing out intensely guilt-laden feelings which had caused her to live a life of constant self-punishment.

He finally closed the session by recapitulating on aspects of the multi-foci core neurotic structure responsible for the patient's symptom disturbances and character pathology.

#### Nonverbal Cues

The technique of Intensive Short-Term Dynamic Psychotherapy which I have developed involves the use of various kinds of intervention designed to influence the conflicting forces within the patient. In particular, the therapist is concerned with the balance between resistance and anxiety, on the one hand, and access to the unconscious on the other. The attempt to influence any complex system depends for its effectiveness on feedback, and this is especially true of the type of system involved here.

Central to my system of intervention is the technique of unlocking the unconscious and the major emotional upheaval associated with the breakthrough into the unconscious, and this requires a comprehensive knowledge of the psychophysiology of the psychic apparatus and all the nonverbal communication by the patient. Above all, the therapist must monitor the nonverbal signals or "cues" provided by the patient—referred to in future by the abbreviation NVC—which reveal the patient's inner state with great accuracy. These NVC are the accompaniment of an inner state of feeling and can be mediated by the smooth muscles or the striated muscles (voluntary). Examples of the former are sweating, pallor, irritable bowel, spastic colon, etc. Examples of the latter are observed more constantly throughout the interview and are of greater importance. For example, tension as a component of anxiety might produce tics in the preorbital area, in the muscles of the face, or even the abdominal wall. Tension in the vocal cords can be detected by the patient's voice; tension in the muscle of the forearm and the hand would demonstrate itself in the position of the hand; and tension of the intercostal muscles produces frequent sighs.

With a high proportion of patients, including the patient presented here, nonverbal communication reveals a number of distinct stages, which we summarize as follows.

(1) At first the defenses are uppermost, which is revealed as the patient maintains a passive and withdrawn posture, stays slumped in the chair, with hands held below waist level in an apparently relaxed state, and consistent avoidance of eye contact. In highly resistant patients with ego-syntonic character pathology, the patient might sit totally immobile, the head fixed and directed at the wall with virtually no eye contact.

(2) When pressure and challenge are applied and produce a rise in transference feelings, the build-up of impulse in the transference, this mobilizes unconscious anxiety, and if the discharge pattern of anxiety is in the form of tension in the striated muscles we see a stiff posture with hands clenched together or clenched by gripping the arms of the chair, sighing respiration indicating tension in the intercostal and subdiaphragmatic muscles, tension in the facial and jaw muscles, tension in the vocal cords producing a choked quality. We see an intensification of the patient's character defenses, further avoidance of eye contact, and even a retardation of the patient's movements which indicates tension in the voluntary muscles has been increased.

(3) Then, as challenge is maintained and the defenses are weakened, the unconscious feelings—particularly anger in the transference—begin to be experienced and expressed directly. Now the signs of anxiety and tension disappear, and the patient's whole demeanor changes from preparation for "flight" to preparation for "fight." There will be a marked reduction in sighing respiration; there is a major change in the patient's voice with absence of tension in the vocal chords; tension in the face and jaws disappears; the hands are lifted in an expressive gesture; the patient changes position and may sit up straight which indicates readiness to face the challenge; and there will be a marked reduction in the absence of eye contact. The use made by the therapist of this nonverbal communication is a crucial part of the technique which I have described in other publications and here summarize as follows: When the passive defenses are uppermost, the aim is to raise the transference feelings by pressure and challenge, and the therapist monitors the nonverbal communication to gauge the degree to which this is being achieved. One of the important ways of exerting pressure is to draw attention to the NVC directly.

This heightens the tension by indicating that the unconscious is betraying itself, because this is exactly what the defenses are designed to avoid. With patients such as the woman described here, however, the therapist uses these same signs to make sure that anxiety is not raised to too high a level, and he takes the pressure off as soon as he detects that the level of anxiety is reaching an intolerable level. Finally, as the patient begins to declare feelings—particularly anger—verbally, he can gauge whether or not these are being truly experienced by the use of the signs described. In particular, if these signs are absent, he knows that the patient is using words to cover feelings, and he steps up his challenge with the aim of sweeping this defense aside. In contrast, when the signs are fully present, he can allow the feelings to be expressed; he can then proceed to enquiry into the past, confident that this will reveal sooner or later that the phase of direct access to the unconscious has been reached.

The following account, which covers the trial therapy with the patient will give an indication of the use made by the therapist of NVC.

(1) The therapist began to exert pressure early in the interview, and signs of anxiety in the form of sighing respiration appeared at once, e.g.,

when he said, "Let's see what you feel about your private self," and she answered with a sigh, "I like my private self."

(2) Soon after this he drew attention to her withdrawn posture: "Now you are holding back like that."

(3) Her resistance increased further when he began to press her on the subject of her sexual relation with Dick, and there were clear indications that there was a rise in transference feelings. He now drew attention to her lack of eye contact and signs of inner tension: "Do you notice that when you want to talk about this you are looking over there? . . . And your hands, clenched like this."

(4) When she described the triangular relation with the other woman, Maria, she began to show further signs of anxiety, and he drew attention to these in turn: "You took a sigh now . . . Do you notice your posture? There is a clenching . . ."

(5) Sustained pressure now began to bring her underlying intense anger to the surface. In response to the question, "Did you want to lash out?", her hands became expressive and she said, "It was like this," making an angry gesture.

(6) Her whole demeanor changed from "flight" to "fight" when she finally described her fantasy of "emptying a bucket of shit" onto Dick, and later the actual act of hitting the bed with a tennis racket.

(7) Then her voice became choked with suppressed emotion as she responded to the question, "Who did you really want to hit?" by making the unexpected and highly significant statement, "All the male figures of my life." This breakthrough of her unconscious impulses completely confirmed that her anger against Dick had been truly experienced.

(8) The therapist then brought up the issue of the transference aspects of this: "And where do I stand there"? Here her response was mixed. Her conscious statement was: "I feel comfortable with you. I'm not scared," but her repeated sighs indicated the unconscious anxiety that his question aroused.

(9) The therapist now drove home insight into the various defenses that she used against her anger, which eventually led to her recounting the incident in which she had thrown her son Paul across the room. Here non-verbal communication clearly indicated the breakthrough of the aggressive impulse. Here her passivity accompanied by the signs of tension in her striated muscles for the time being disappeared and she reinforced her account with graphic and violent gestures of the way she attacked her son.

(10) Now the therapist brought into focus her murderous impulses toward Paul. This brought a major breakthrough into the guilt-laden unconscious feelings. There were waves of painful feelings. She became choked up, sobbingly said, "I love him, too." There was again a rise in the level of anxiety, sighing respiration, tearful, which continued right through her description of detailed and specific fantasies of Paul being run over by a car, with blood coming from his chest.

(11) Early in this interview the therapist began pressing her to describe her feelings when she arrived in Canada to find her husband with another woman. Here her anxiety was marked, and again there were repeated sighs

and heavy breathing, to which the therapist drew attention. Then she became increasingly slow, detached, and retarded, which indicated a build-up of anger in the transference and a rise in anxiety in the form of tension in the striated muscles.

(12) The therapist challenged her resistance in the transference to increase the build-up of transference feelings. Her nonverbal defenses, her slowness and detachment were heavily challenged. Her voice and words showed her anger. "I feel like shaking you." Her nonverbal defenses were further challenged. Her nonverbal communication indicated that her complex transference feelings are on the rise.

(13) Then the session returned to challenge in the area of C, namely her feelings about her husband. This further increased the level of the build-up of the impulse of anger with the concomitant nonverbal communication of anxiety.

(14) She now suddenly turned to memories of anger in relation to her first nanny who was stern and punitive, and then her anger in the distant past in relation to the incident which involved her father and her brothers, and finally to her anger in a more recent incident in which she was playing chess with a much younger man and had suddenly knocked down all the pieces. Here she was really in touch with her anger as she reinforced her graphic description with her hands and arms.

(15) This ability to express anger in the area of C now brought her anger in the area of T to the surface: TH: "Your anger with me doesn't have that intensity, but did you experience it"? PT: "Yes, yes I did, and I experienced it last time." Here the absence of tension in her jaw muscles and the rise in her voice made clear that she was experiencing her feelings. This was confirmed when her therapeutic alliance was able (a) to add important details about one of her defenses, namely her wish—instead of expressing anger—to stroke his face, and (b) to complete the triangle of conflict in the areas of both C and T by speaking of the anxiety that the other person would reject her.

(16) Knowing that this work had begun the unlocking of her unconscious, the therapist returned to enquiry in the area of C, learning many more details about the disastrous relation with her husband. Now, when he exerted pressure towards her anger, the NVC of anxiety and tension entirely disappeared and she was able to express her rage freely: "It's like giving birth to an ulcer. Everything is coming out through my belly button. Like squirting pus . . . krrrrsh . . . I would picture him like a beetle and I would just squash him and I would turn my back on him and I would never look back." Here the NVC of the breakthrough of the impulse was heavily present. Absence of tension in striated muscles, movement of her hands, quality of voice, stamping her feet. This was the final breakthrough which led to the phase of direct access to the unconscious.

(17) When she was describing the traumatic last encounter with her father, there was a breakthrough of guilt and grief-laden unconscious feelings. The NVC of the waves of painful feelings, the intense sadness with frequent sighing respiration. Her posture changed. And then during the description of the two spiritual experiences which had relieved her guilt

about her intense mixed feelings for him: ". . . and everything was very light, and I was . . . aaaaahhhhhh . . . so elated, and I fell on my knees in the middle of the road, and I said, My God, God is alive and he's right inside me . . ."

#### The Superego Resistance

As I described in previous publications (Davanloo, 1987c, 1988), Freud very well recognized superego resistance and he well recognized the devastating effects that it had on the lives of many patients. But on the therapeutic side his position was very pessimistic. In "Analysis terminable and interminable" (1937), he pessimistically wrote "For the Moment we must bow to the superiority of the forces against which we see our efforts come to nothing" (Freud, 1937, Vol. XXIII) And in "An Outline of Psychoanalysis" (1940), he wrote "In warding off this resistance we are obliged to restrict ourselves to making it conscious and attempting to bring about the slow demolition of the hostile superego" (Freud, 1940, Vol. XXIII, p. 144).

Most fortunately my work does not confirm Freud's therapeutic pessimism. Once the unconscious has been unlocked, it is possible to acquaint the patient with the unquestionably sadistic, self-punishing mechanisms that have permeated his or her life, and to bring to the surface the impulses—the sadistic, murderous impulses—the major grief and guilt-laden unconscious feelings for which the self-punishment is designed. With further working through during therapy and systematic de-repression of repressed sadistic impulses and guilt and grief-laden unconscious feelings in relation to the past, the therapist can bring about a major restructuring of the superego, finally causing it to cease its destructive activity altogether.

The process is begun in the trial therapy. In the present patient it unfolded as follows: When, early in the second part of the trial therapy, the therapist explored the relation with Dick, he pointed out her masochism and quickly confirmed that this was a general pattern; TH: "In your relationship with Dick one feature is that you are used and abused. Is this a feature of your relationships with men?" PT: "Yes."

Next, the moment of true unlocking of the unconscious occurred when the patient was finally able to express her rage against her husband in the fantasy of crushing him like a beetle. The therapist immediately began the process of acquainting her with the mechanism of self-directed aggression in the interests of self-punishment: TH: "So there is the impulse to torture him and murder him. But who in reality are you torturing and murdering?" PT: "Well I assume it's me . . ." TH: "So you are the one who is suffering, being tortured, living a life of agony, being squashed like a beetle."

He then leads toward clarifying the mechanism further by asking the crucial question about this reason for the self-punishment: TH: "What have you done that you have to mess up your life like this? Have you ever questioned yourself what you have done that you have to torture yourself? There is a self-sabotage, there is self-defeat . . ."

Here the patient shows her unconscious therapeutic alliance and her insight by saying that she has begun to ask herself the same question in the last two years. "If this wouldn't be there I wouldn't attract people who make use if it."

In the final part of the interview he brings out intense feelings of guilt in relation to both her parents: to her father because of her expression of rage with him by neglecting him in the year before his death; but more especially guilt about death wishes toward her mother, who did nothing for her, and used and abused her throughout her early life. Then came intense guilt in relation to her son. At the very end he makes the link between her pattern of taking up with men who are exactly like her mother with perpetuation of her being used and abused and its link with her repressed, sadistic impulses in relation to her mother and buried guilt and grief-laden feelings; and he finally focuses on her buried mixed feelings in relation to her father and her brothers.

The technique of unlocking the unconscious indicates that the "compulsion to repeat" is caused by the superego's search for self-punishment and does not confirm Freud's view that the superego is exclusively "heir to the Oedipus Complex."

#### Conclusion

Since the discovery of the technique of unlocking the unconscious by the author, our research project has been heavily interested in the application of the technique to patients suffering from panic disorders, functional disorders, certain depressive disorders, and somatization disorders.

Cases of this kind, the one I presented in this two-part article, are of extreme importance for the purpose of illustrating many issues, of which we mention three. They demonstrate unequivocally the psychopathology of the repressed sadism and guilt and grief-laden unconscious feelings that lie behind the functional disorder of migraine—or at least certain kinds of migraine. This particular patient had no further attacks of migraines after the work described here. They demonstrate, also, the operation of superego pathology in leading to a life of perpetual suffering, the role of the superego in repetition compulsion of neurotic suffering and how this can be overcome, and finally, they demonstrate how the same basic elements of the technique (which may safely be used in an unremitting form in cases of highly resistant character neurosis and cases with obsessional psychopathology) may also be used with some quantitative modification in patients suffering from functional disorders and chronic depression, with whom the unremitting technique can easily exacerbate and intensify the patient's disturbances.

Finally, we can see the extraordinary precision with which theoretical and technical knowledge and psychotherapeutic skill can be used to bring about systematic erosion of resistance in highly masochistic patients and achieve therapeutic results.

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# The Treatment of Character Neuroses in Intensive Short-Term Dynamic Psychotherapy

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This article begins by identifying the broad range of patients suitable for "Intensive Short-Term Dynamic Psychotherapy,"† as developed by Davanloo, and then focuses on a subgroup of character neuroses in this spectrum. A high percentage of patients seeking psychotherapeutic services suffer from character neuroses with diffuse symptom disturbances. The traditional psychoanalytic technique of treating character neuroses, emphasizing an interpretive approach to resistance is presented highlighting its limitations with these patients. The Intensive Short-Term Dynamic Psychotherapy pre-interpretive technique of "challenge and pressure" (Davanloo, H. In *Comprehensive Textbook of Psychiatry*, 4th ed. Baltimore: Williams & Wilkins, 1984) to the resistance as a prerequisite to meaningful interpretation with the character neuroses is then detailed. Case material of a patient presented at the Training Seminar of the International Institute for Short-Term Dynamic Psychotherapy will be discussed. Concluding metapsychological considerations are presented regarding the role of the "punitive superego structure" (Davanloo, H. *International Journal of Short-Term Psychotherapy*, Vol. 1(2), pp. 107-133) in character neuroses and the corresponding technical interventions Davanloo has developed that effectively diminish its morbid hold on the personality.

## I. Introduction

The technique of Intensive Short-Term Dynamic Psychotherapy (ISTDP) developed by Davanloo (1984, 1986) has had a powerful impact on expanding the breadth of patients suitable for brief psychoanalytically oriented treatment. A spectrum of structural neuroses has been outlined by Davanloo that defines the wide range of patients for which his system of ISTDP is treatment of choice. On the extreme left of this spectrum are low resistant patients with circumscribed difficulties. These patients are highly motivated and readily collaborate with the therapist in an animated and more spontaneous fashion. Their communication is clear and these patients are able to be specific regarding their areas of disturbance. The link via interpretation between current difficulties and genetic conflicts, i.e., single psychotherapeutic focus on loss or oedipal in nature, is relatively easily accomplished. On the extreme right of the spectrum are patients who are massively resistant with ego syntonic character pathology. These patients are grossly out of touch with their internal processes and have developed a defensive system that is concretized encapsulating the most painful of feelings in the complicated "multifoci core neurotic structure."

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† Intensive Short-Term Dynamic Psychotherapy refers to Davanloo's system of Short-Term Psychotherapy and from here on will be referred to as ISTDP.