

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."

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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."

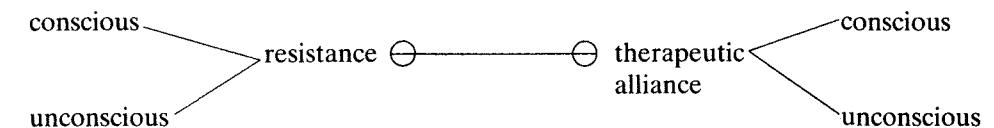
Almost all attempts to reverse this trend and develop an effective technique of short-term psychotherapy have been based on taking back some of the control and putting more of the motive power into the hands of the therapist. Instead of following wherever the patient's associations lead, he actively 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.*

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)

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.

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.

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

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

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 . . .

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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