

Gerda Gottwik, Ingrid Orbes

TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY HEAD-ON COLLISION WITH THE RESISTANCE

(Part III)

No Part of this Article may be Reproduced by any means or
Translated without the Written Permission of Dr. H. Davanloo

ABSTRACT

This is the third of four articles on basic technical interventions in Dr. Davanloo's system of Intensive-Short-Term Dynamic Psychotherapy (pressure, challenge, the entry of transference and head-on collision), bases on the proceedings of a five-day immersion course presented by Dr. Davanloo. Part 3 focuses on Dr. Davanloo's new concept of the transference, by analysing a series of clinical interviews (strict avoidance of the transference neurosis, unconscious therapeutic alliance, twin factors of the transference and resistance). Several clinical vignettes were presented to elaborate on the way how transference enters the process.

Introduction

The authors in this article summarize the proceedings of a five-day course on the technical and metapsychological roots of Dr. Davanloo's technique, presented to the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany.

Davanloo, in over thirty years of audiovisually-recorded clinical research with more than 1,000 patients, developed his powerful system of IS-TDP to access and work through the unconscious dynamic forces responsible for neurotic disorders. Key is the rapid access to the neurotic core in a single interview. Davanloo has divided the process of the trial therapy into various phases, the

Central Dynamic Sequence, which contains a set of technical interventions: pressure, pressure and challenge, culminating in head-on collision.

The other three articles of this series summarized Dr. Davanloo's presentation on pressure (Gottwik, Ostertag, Weiss), pressure and challenge (Gottwik, Sporer, Tressel), entry of transference (Gottwik, Kettner-Werkmeister, Wagner).

The focal point of this paper lies on head-on collision. To illustrate, the paper contains transcripts of video vignettes of three of the patients presented by Dr. Davanloo.

Head-on collision with the resistance

In this section of the course, Dr. Davanloo focused on the technique of head-on collision, and presented twelve different forms of head-on collision to highlight the application of the technique. Some head-on collisions are used when there is major resistance in the transference, with the aim of direct access to the unconscious, while others may aim at loosening the psychic system, mobilizing the patient's unconscious, and making the patient acquainted with their syntonic character defenses, and, at the same time, creating further mobilization of the transference feelings.

Head-on collision essentially addresses the therapeutic alliance and is directed against the self-destructiveness inherent in the patient's conscious or unconscious refusal to abandon his resistance. It aims both to mount a direct assault on all the forces maintaining the self-destructiveness, and, at the same time, to mobilize the patient's unconscious therapeutic alliance against the destructive forces of the resistance.

Head-on collision contains a number of technical interventions, and it can be the most complex of all of the therapist's interventions.

Here, we summarize the major aims of head-on collision, as was presented to the Program.

Aims of Head-On Collision with Resistance

Head-on collision is always used within the setting of resistance in the transference, or when the patient's character resistance, as the result of pressure or pressure and challenge, has been crystallized in the transference. It may take various forms. One is the interlocking chain of head-on collisions, which is the most complex of all the therapist's interventions.

Head-On Collision aims:

1. At total blockade against all defenses maintaining the forces of resistance,
2. To mount a direct assault on all the forces maintaining self-destructiveness, self-defeat, and self-sabotage,
3. To intensify the rise in transference feelings,
4. At mobilization of the therapeutic alliance against the resistance; to tilt the balance between the two forces in favor of the therapeutic alliance,

5. To create a state of high tension between resistance and therapeutic alliance in the transference; the act of challenging the resistance, combined with the conveyed lack of respect for them, creates an extremely complex state within the patient - one in which he both wishes to cling to his resistance even more strongly, and, at the same time, begins to turn against them, deeply appreciative of the therapist's relentless determination to help him. This is what is meant by the tension between resistance and therapeutic alliance. When the process has created tension between the resistance and therapeutic alliance in the transference, it calls for some form of head-on collision with the aim to mobilizes therapeutic alliance against resistance.
6. To bring the patient face to face with his self-destructiveness with such a communication as "good-bye," "doomed," and "misery" to both shock him out of the syntonic part of his resistance and challenge his therapeutic alliance to make a supreme effort,
7. In many cases, the head-on collision results in major communication about the nature of the resistance,
8. The aim is to loosen the patient's psychic system in such a way as to make the unconscious more accessible.
9. In the interlocking chain of head-on collision the aim is to loosen or mobilize the patient's psychic system and make a partial unlocking of the unconscious possible.

In the following passage, we present three of the clinical vignettes, presented at the course which illustrate three different forms of head-on collision. The vignettes come from Dr. Davanloo's research library. All of the metapsychological concepts and technical interventions presented are those of Dr. Davanloo. All research data mentioned in this proceeding refers to Davanloo's audiovisually-recorded clinical research.

Patient 1

The first case is a man who described himself as having been "naive" in not noticing the signs that his wife was having an affair. This involved the defense of denial, since the truth was that he had unconsciously turned a blind eye to the signs because they caused him too much anxiety.

TH: Let's not get into this ... because if you put it in terms of being "naive" then we are going to dismiss some of the very essential issues.

The first intervention "Let's not get into this"; is challenge by blocking the defense of denial. By addition "If you put ... issues", this intervention turns into head-on collision. This addresses the therapeutic alliance. It emphasizes the consequences of maintaining the defense, and is aimed at mobilizing the therapeutic alliance against the resistance. In addition, the therapist's intervention is designed to make the resistance unacceptable. Thus, the therapist's intervention is a simple form of head-on collision. Although the therapist does not directly say that the result would be self-destructive, definitely this is implied. The therapist is communicating that if the patient uses

this particular form of the defense, then the therapeutic process would be at an impasse. Usually in head-on collision, the communication with the therapeutic alliance about the self-destructiveness is very explicit.

The Major Technical Interventions of Head-on Collision

The following are some of the main technical interventions used in the head-on collision. For the sake of brevity, we have summarized it, but the therapist must take into consideration that there is a wide range of head-on collisions; from short form, composite form; composite extensive form, and interlocking form of head-on collision. These forms have specific indications.

1. To specify and point out the nature of the resistance. The therapist must emphasize the nature of the defenses that the patient is using. For example: "If you maintain a defiant, passive position;" "As long as you are going to rationalize, intellectualize, ruminate, and being vague ..."
2. To point out and emphasize the problem and its effect on the patient's life. When the patient is deeply involved in his resistance, he tends to fight to maintain his resistance and lose sight of the fact that he has a problem which causes him pain. So the therapist begins by reminding him of this fact, but in forceful terms, like: "major problem" "misery and suffering", "agony." The aim is to maximize the impact of this technical intervention.
3. To challenge the self-destructive aspect of the resistance. This can be explicitly introduced with a rhetorical question: "Is there an element of self-defeat and self-sabotage? Why do you put a goal for yourself to come here of your own volition, so that together we can get to the core of your problem, but, at the same time, you want to make it a failure, which obviously means perpetuating your own suffering."
4. To point out and emphasize the self-sabotage and self-defeating component of the resistance and its masochistic component: "And there will be self-defeat in it, isn't that so? Now my question is this, why should you of your own will come here to see if we can get to the bottom of your problem, and, yet, at the same time, another part of you wants to defeat the goal you have set for yourself and wants to perpetuate your own misery?"
5. To establish a parallel between self-defeating and self-sabotaging pattern in the transference and in other relationships: "And throughout your life, people have been useless to you, a self-defeating, self-sabotaging pattern which right now is in operation with me".
6. To point out and emphasize the patient's will, that the patient is the prime mover in seeking help: "You have come here on your own will seeking help for your suffering."
7. To emphasize the partnership between the patient and the therapist: „You and I are here together to find the core of your misery."
8. To point out the therapeutic task and emphasize the therapeutic task: „Then we will not get to the core of your problems. Our task is to understand your problems and get to the engine."
9. To deactivate the development of transference pattern: "As long as you take a passive, defiant position, then this process is doomed to fail, but who is the failure? It's your decision, you said

you want to get free, then we must look at this. When you will do this, good, when you won't, good, too. You have the right to be defiant, but you also go to misery." (He must see clearly, that he is his own architect of his life.)

10. To challenge the dependent transference pattern, the need to use the therapist as a crutch. "Now you again move to the crippled position. What will you do against this. At the moment you are using me as a crutch."
11. To challenge the self-destructiveness in the transference resistance: "Let's look to your relationship with me", "Then, I will be useless to you, why should you want to make me useless to you?"
12. To challenge the resistance against emotional closeness. "There is a wall between us. When you don't want me to get to your intimate thoughts, then why you are here?"

As mentioned above, there are many types of head-on collision each of them with a specific indication and composed of a smaller or larger number of these interventions. The sequence, emphasis and repetition of the given interventions depends on the response of the patient's unconscious (signals of anxiety and/or appearance of new resistances). Because head-on collision is, by its nature, addressing the unconscious, the therapist, while colliding head-on does not allow any dialogue with the patient.

Patient 2

The Man with the Baseball Bat

The pseudonym of this man in his early thirties is based on some of his fantasies which were of great violence. The patient entered into the interview with anxiety, giving evidence of an immediate transference. The phase of inquiry rapidly moved to the phase of pressure and challenge, and under challenge he became openly defiant "I refuse to answer you when you ask that question." After further pressure, there was a fleeting moment in which there was sudden upsurge from his unconscious therapeutic alliance: "I am looking to punish and I don't know how to do it." Shortly after which the therapist introduced head-on collision.

TH: Now, let's look at it, obviously you, have a major problem and this problem is a source of misery a suffering for you. I don't know, you have to decide is it or isn't it?

In the above passage, we see two components of head-on collision: emphasizing the problem and its effect on the patient's life; then addressing the patient's autonomy to decide whether it is a problem for him or not, so that the responsibility remains with him.

PT: Yes.

TH: And I assume you have come here of your own will, and you have a goal, otherwise you wouldn't be here?

In the above passage, the therapist points out that the patient is the prime mover in seeking help (addressing the patient's autonomy and free will in the decision to seek help), and emphasizes the patient's goal (pressure to conscious therapeutic alliance, as well as message to unconscious therapeutic alliance).

PT: That is right, many goals.

TH: One of the major tasks that we have ahead of us, hopefully, is that you and I with the help of each other will explore and understand where you stand in life, what your problems are and where the core of your problem lies.

In the above passage, the therapist emphasizes the partnership and the therapeutic task. Spelling out the therapeutic task "to explore and understand what your problems are and where the core of your problems lies" is another powerful technical intervention in Davanloo's IS-TDP. Although it sounds simple, it has a very complex effect on the therapeutic alliance.

PT: Exact.

TH: Okay, and the fact is that the problem is yours. If there is suffering it is yours and if there is happiness it is yours, if there is success and the failure, again it is going to be yours, okay? But if you maintain a defiant, passive, cutoff position what will happen here?

Again the therapist is repeating that the responsibility is with the patient, adding the nature of resistance and the destructiveness of maintaining the resistance, and at the same time undoing the omnipotence.

PT: Nothing.

TH: In a while when this session finishes and we say good-bye to each other and you go away and carry on the miserable life that you have ... because as long as you take a passive, cut-off or defiant position you will not be able to reach the goal you have set for yourself. We will not be able to understand the core of your problem and the process is doomed to fail.

In the above passage, the therapist is pointing out again the nature of resistance, the destructive component of the resistance, emphasizing the therapeutic task and the consequences of maintaining the resistance.

TH: There will be self-defeat in it, isn't that so? Now my question is this, why should you of your own will come here to see if we can get to the bottom of your problem, and yet at the same time another part of you wants to defeat the aim you have set for yourself, and wants to perpetuate your own misery.

The self-destructive component of the resistance is now introduced explicitly with the rhetorical question, and again the therapist is addressing the patient's will and the therapeutic task and then he is challenging this destructive mechanism. Also this passage contains the technique of making the two sides within the patient explicit: the resistance and the unconscious therapeutic alliance. This is starting to put the battle where it belongs: within the patient (eventually leading

to the intrapsychic crisis of phase 5 of the central dynamic sequence). This is a very strong measure of undoing defiance in the form of "battle of will" between therapist and patient.

PT: I know.

TH: Then I will be useless to you.

The therapist is pointing out the self-destructiveness in the transference resistance.

PT: Yes. (Now the patient is becoming increasingly sad)

TH: Why should you want to make me useless to you.

The therapist is challenging the self-destructiveness in the transference resistance. As an indicator of rise in the unconscious therapeutic alliance, the patient makes the following communication:

PT: I don't want you to be useless to me.

TH: And throughout your life, many people have been useless to you. (Pause)

TH: But you see, what is immediately coming into focus is that you have a self-defeating and self-sabotaging pattern which right now is in operation with me.

In the above passage, the therapist is challenging the self-sabotaging and self-defeating pattern in the transference relationship, and establishing a parallel with outside relationships.

PT: Yes, I have.

TH: Let's look at this self-defeating pattern, if this process continues like this we will fail to understand where the core of your problem lies, and let's face it. I can afford to fail - obviously I cannot always be successful - but the fundamental question for you is can you afford to fail?

Again, he is pointing out and emphasizing the consequences of maintaining the resistance and deactivating the transference and undoing the omnipotence.

PT: That is right.

TH: Then what are we going to do about it?

PT: Overcome it.

TH: So let's see how we are going to overcome it ... and I have a feeling that you are putting a massive wall between yourself and me.

Patient 3

Here we focus on another patient who was presented in the program. It shows how the dynamic inquiry crystallizes the resistance in the transference by exerting pressure, and how the application of the phase of pressure and challenge prepares the ground for head-on collision which totally blocks the resistance. This allows a rapid breakthrough into the unconscious.

The Scottish Strangler

When he came into treatment, he was in his forties and worked as a salesman. The evaluator does not know anything about the patient.

Phase of Inquiry

TH: Do you want to tell me what is the nature of the difficulty you want to get help for it?

PT: Yeah ... My inability to form a long-term relationship with a woman.

TH: Only with women?

PT: I have problem with men too, but more pronounced with women.

Further dynamic inquiry indicates that he has problems in interpersonal relationships with both men and women, but becomes more pronounced with women.

PT: Well, all my life, you know, I have never been with, one partner for very long and the... ahh ... with my second wife, there was a major problem.

What emerges is that he has had many extramarital affairs with a number of women, and both of his marriages have ended up in divorce.

TH: You mean both?

PT: Two marriages, yeah.

TH: And now you are divorced?

PT: I am divorced, yeah.

Further Inquiry

TH: Divorced, how long ago?

PT: Eight years.

TH: So you have been eight years divorced.

PT: Yes.

TH: I see. So one problem is with, women and your tendency of having frequent relationships ?

PT: Yes.

TH: Any other problem besides an inability to develop any long-lasting relationship?

Further inquiry indicates that he suffers from episodes of depression. He also suffers from a chronic state of anxiety, particularly in his job. Exploration into the physiological concomitant of his anxiety indicates that the discharge pattern is heavily at the striated muscles, particularly the muscles of the hands, of the forearms and the intercostal.

Anxiety in the Transference: Phase of Pressure

He is becoming increasingly anxious during the interview, which definitely has a transference implication, and the therapist focuses on the anxiety and exerts pressure.

TH: Are you anxious? I notice you took a deep sigh. Do you feel anxious right now?

PT: Yeah. (He takes another sigh,)

TH: You took another sigh here.

PT: Yes.

TH: Are you aware here, you had a few times a deep sigh?

PT: No (sighs).

TH: As if you have to catch your breath. Are you aware?

PT: Yeah, when you when you point it out, yeah, but ah ...

TH: You are not conscious of this?

PT: No. It's, it's sort of... normal, you, know, for me to do that. I guess, you know, so I don't notice it (sighs).

TH: Yeah, but the issue is not is it normal or abnormal. You have a deep sigh but you say you are not aware of it.

PT: No, when ... only when you point it out, ah

Dynamic Inquiry; Pressure

The therapist now explores directly the family dynamics, and the patient indicates that his anxiety increases with his children, particularly with his younger daughter, Joan. With her, he has episodes of violent rage, with explosive discharge of the affect and blow-ups. The therapist exerts pressure by asking for a recent incident. A few weeks prior to the interview, he lost control, which resulted in a physical attack on her. It seems that this incident has been a major factor for him to search for help, as there was the possibility that he could have damaged her physically.

Then the therapist focused on his current girlfriend. There are many episodes where he gets into rage towards his girlfriend and handles it by walking out. Further dynamic inquiry indicates that he suffers from explosive discharge of the affect which is specific with women and which has been a problem for all of his life. Focusing on his first marriage, this was at the age of twenty, he states that the relationship deteriorated immediately after the marriage. His wife would have episodes of explosive discharge. She was highly volatile, stormy and on occasions would throw the plate of food on him. There were many episodes where he got physically violent with her. This dynamic inquiry with exerting pressure intensifies the patient's resistance in the transference. He becomes detached, totally non-communicative and silent. The therapist focuses on the patient's feeling in the transference.

Resistance in the Transference

Focusing on the patient's feelings in the transference is leading to increasing resistance in the transference (silence), followed by pressure to resistance in the transference.

TH: How do you feel talking about these issues with me? I feel as if you are not with me.

PT: Oh, I'm trying to, you know ...

TH: You are not here with me.

PT: Oh no, no I'm ...

TH: Are we together here, or are you somewhere else?

PT: No ahh, we're together here, I'm ...

TH: You see, you are detached from me and suddenly you have become non-communicative?.

PT: Well, uh-hh.

TH: You know, what passes through my mind is if I don't tell him anything, or question him anything, what would happen here between us? Do you know what I mean?

PT: Yeah.

TH: If I don't question him, that is ...

PT: Meaning me?

TH: Yeah.

PT: Okay, yeah, yeah.

TH: Then what would happen here?

PT: Nothing, probably.

TH: You mean you wouldn't say anything, huh?

PT: No.

TH: Then we would have silence between each other, huh?

PT: Yeah, yeah.

In the above passage, the therapist is exerting pressure by pointing out the nature of the resistance which is in the transference. The patient goes along and confirms that nothing would happen and that silence would prevail. The pressure against the resistance in transference mobilizes more anxiety, as we can see, when the patient continues to have more sighs. The process indicates the presence of the resistance against emotional closeness which has been mobilized during the phase of dynamic inquiry and pressure in relation to his daughter, first wife and current girlfriend.

The computerized data from the early part of this interview point out the following:

- a man suffering from life long character neurosis;
- moderate to high degree of the resistance; presence of resistance against the emotional closeness and moderate degree of syntonicity in his character;
- major regressive defenses, such as explosive discharge of the affect, which is a major defense against homicidal feeling as well as suicide which alternates with a high level of anxiety and flight from the situation.

The therapist's decision is to accomplish the task in two phases in a single interview: partial breakthrough into the unconscious to be followed immediately by a major breakthrough into the unconscious.

Head-On Collision with the Resistance Against Emotional Closeness: First Partial Direct Access to the Unconscious

The therapist cannot make a patient acquainted with this resistance unless it manifests itself in the transference. In the early part of the interview, the patient had indicated that he has problems in relationships with both men and women, but more pronounced with women. Later on, the therapist moved to a dynamic inquiry into his intimate life with his first wife as well as into his current relation with his girlfriend, which led to the mobilization of the resistance in the transference. Now, the therapist moves to the head-on collision with this resistance.

Pointing Out the Nature of the Resistance

TH: Do you have problem with closeness, because I feel you keep a detached position with me.

This is the way I feel, you can tell me how you feel. You are detached from me and you are not involved with me and that there is a barrier between you and me. You know what I mean by barrier?

PT: There is a barrier, there is a barrier, yes.

It is important to note that the therapist must be very specific: "closeness," "wall" "not involved," "barrier", and "detached." As we saw, he immediately used another component of the head-on collision, namely, deactivation of the transference, when he said to the patient: "This is the way I feel, you can tell me how you feel." If the transference is coloured by any genetic figure, the patient ends up getting into battle with the therapist, the same person he wants help from.

Continuation of the Head-On Collision

TH: And there is a wall between you and me, you know what I mean?

PT: Yeah, yeah.

TH: The wall and barrier?

PT: Hm, hmm.

TH: And you don't want me to get to know you, and you don't want me to get to your intimate thoughts, to your intimate feelings.

PT: I...

TH: This is the way I feel.

PT: Yeah, I, I can understand your feeling that way too uhh I feel that uh I have got things to hide.

TH: Hm hmm. But that is very important for us to examine it.

PT: Yeah, I know.

Each time the therapist repeats it: "You don't want me to get to your intimate thoughts, you don't want me to get to your intimate feelings," this mobilizes the center of the nuclear structure, which mobilizes anxiety in the transference. The repetition of pointing out the nature of resistance is extremely important when one works with the head-on collision against the emotional closeness,

because it is deeply rooted in the center of the pathogenic zone of the unconscious, namely the bond, the attachment, the trauma, the murderous rage, the guilt and the grief.

Now we return to the interview.

TH: *Because you, for whatever reason - I don't know what it is that makes you to be like this, but that is not important at this moment - for some reason you have a need to erect a wall between yourself and me and not to let me to get into your intimate thoughts and not to let me into your intimate feelings.*

This repetition of the nature of the resistance against emotional closeness is of paramount importance in the mobilization of the centre of the nuclear structure. The therapist further points out that the transference should be clearly spelled out: "You and me."

TH: *And now, this is very important for you and me to examine, because if this wall continues and this barrier between you and me continues, then at the end of this session I would be useless to you, because our aim here, our aim is to understand your difficulties at one level, at another level also is to get to the engine that creates all your difficulties, Okay?*

PT: *Hm hmm.*

TH: *So now up to the time there is a wall, and up to the time there is a barrier, up to the time you don't want me to get into your intimate thoughts and feelings, then by the end of this session I, would become useless to you, it would be a failure.*

PT: *Hmm.*

TH: *Then, when we depart from each other, I would say, okay I did my best, I failed, but you have to go to perpetuate your suffering. Still you are young and you have many years ahead of you, why you have to let it go to waste? Now if you go on, if you go from here at the end of this session and I be useless to you, then you have to perpetuate your suffering and this suffering you carry to your grave the balance of your life. Why you want to do that?*

PT: *I don't want to do it. I mean that is why I am here.*

TH: *I know, but being here is not enough. The fundamental issue is the wall, the barrier, and if this wall continues, means perpetuation of your suffering.*

The following will highlight step by step the components of head-on collision in the above passage:

- Elaborating and pointing out the nature of the resistance
- Emphasizing the problems
- Therapeutic task and emphasizing the patient's goal
- Pointing out the self-destructive element of the resistance
- Bringing into focus the consequences if he maintains the resistance
- The destructive aspect of the resistance, therapeutic failure and the self-defeating and self-sabotaging components of the failure
- Undoing the omnipotence

- Pointing out the perpetrator of the unconscious
- Pressure to the unconscious therapeutic alliance

First Breakthrough

As we saw, the therapist has applied a composite form of head-on collision - which results in a specific response – namely, the first breakthrough. When the first breakthrough takes place, there is the first dominance of the resistance by the unconscious therapeutic alliance. The patient becomes increasingly sad and tearful which indicates breakthrough is imminent.

We return to the interview.

PT: I have been doing it all my life.

TH: Right now, your eyes are wet, something is ...

PT: Hm hmm.

TH: Which indicates that there are certain feelings in you, but in a sense maybe you don't want to share that with me as well. Maybe part of you says who is this stranger that you let ... you know what I mean by the stranger?

PT: Well I feel close to tears now.

TH: And you are fighting it. You don't want to experience the full impact of it. Why you want to perpetuate the suffering?

The therapist puts pressure to the unconscious therapeutic alliance against the perpetrator of the unconscious.

PT: I do not, that is why I am here. (He has become further sad and tearful)

TH: Because, from the little bit I get, your life is frying pan to fire.

PT: Yeah, from one disaster to another. The only thing that has changed, there is no children this time at least uh ...

TH: Yeah, but still I'm talking about you and you in life. You are right now agonized with a lot of painful feelings and you don't want to experience it, you hold yourself. You don't want to let it go, and you avoid my eyes as well.

PT: Hm.

TH: The tears are there, your sadness is there, and you are determined not to fully experience it. (He is becoming more tearful and also avoids the therapist's eyes)

You see, when you become more tearful, you avoid my eyes. When tears come, you avoid my eyes.

PT: I feel frightened. End of the vignette.

In a sad and tearful state, he talks about the way life has gone for him from one disaster to another, like a pressure cooker. In a sad way, he talked about his daughter, Joan, and his other children, repeating the life of the past. Then in a sad, tearful state, he talks about his mother,

memories of her being attentive but, at the same time, highly controlling, demanding, and everything had to be her way. She often had explosive tempers and would become volatile, was both physically and psychologically abusive. Father was passive, ineffective who stayed away and later on resorted to heavy drinking.

The therapist, after the first and partial direct access to the unconscious, then moves to the phase of dynamic inquiry until he meets the major resistance. Then he moves to the phase of pressure and challenge to the major resistance; major mobilization of the transference resistance, and, again head-on collision with a major direct breakthrough into the unconscious, and major mobilization of unconscious therapeutic alliance against the resistance.

Summary

- (1) This is the fourth of a series of four articles on technical interventions of IS-TDP. These papers are based on proceedings of a five day course on the technical and metapsychological roots of Dr. Davanloo's technique presented to the Training Program of the German Society of Davanloo's IS-TDP, June 17-21, 1998, in Nürnberg, Germany. Dr. Davanloo elaborated on his "new metapsychology" and technique by presenting vignettes of the audiovisually recorded therapies of many different patients. Each article focuses on one technical element of IS-TDP, but also contains elements of the whole concept of Dr. Davanloo's new metapsychology of the unconscious.
- (2) The first article focuses on the phase of pressure with its specific functions of mobilization and intensification of transference feelings, mobilization of the resistance and crystallization of the resistance in the transference, presenting five clinical cases.
- (3) The second paper highlights the phase of pressure and challenge, presenting one clinical case. This phase aims at further crystallization of the patient's characterological defenses in the transference, making the patient well acquainted with ego-syntonic defenses, further mobilization of the transference feelings, and intensification of the transference component of the resistance.
- (4) The subject of the third article is the "entry of the transference", to elaborate the central importance of the transference in Davanloo's IS-TDP; and seven of the cases presented at the course were discussed.
- (5) This fourth article summarizes some of the essentials, the indications, various forms, the aims and the ingredients of head-on collision, illustrated with transcripts of video vignettes of three patients presented in the course.

- (6) Head-on collision is the most powerful form of challenge, mobilizing the patient's unconscious therapeutic alliance against the destructive forces of the resistance. It is always used within the setting of resistance in transference.
- (7) There are different indications for head-on collision. In moderately resistant patients when the phase of pressure, pressure and challenge, have resulted in the crystallization of major resistance in transference the major head-on collision is applied to get a direct access to the unconscious. In highly resistant patients, particularly in those with syntonic character defenses, head-on collision aims at loosening their psychic system.
- (8) Depending on the indications and the type of unlocking the therapist is aiming for, there are various forms of head-on collision: specific, complex, composite or interlocking chain of head-on collision.
- (9) Each head-on collision is essentially aiming at the whole system of the patient's unconscious forces:
- blockade of defenses
 - assault of all forces maintaining self-destructiveness
 - intensification of the rise in transference feelings
 - mobilization of conscious and unconscious therapeutic alliance
 - creating the state of intrapsychic crisis
 - facing the patient with the syntonic part of his resistance
 - loosening the psychic system
- (10) Transcripts of three patients illustrate specific and composite types of head-on collision.

Acknowledgements

The authors in this article summarize a segment of the proceeding of a five-day course on the technical and metapsychological roots of Dr. Davanloo's technique, presented to the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany.

Authors' Note

Please address reprint request to: The German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy e.V., c/o Dr. med. Gerda Gottwik, Wackenroderstr. 11, 90491 Nürnberg, Germany