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Intensive Short-Term Dynamic Psychotherapy—Central Dynamic Sequence: Head-On Collision with Resistance

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In this article the author presents his technique of head-on collision with resistance and outlines the major aims and the main technical interventions in head-on collision. In the second part of this article there will be an in-depth presentation of the spectrum of head-on collision; a technical and metapsychological conceptualization.

Introduction

I have already outlined the Central Dynamic Sequence: the phase of inquiry; dynamic inquiry; pressure; challenge; transference resistance; direct and rapid access to the unconscious, and have emphasized that the resistance needs to be crystallized to the point at which it can be challenged meaningfully and systematically. I have already indicated that the course of any interview depends to a great extent on the rapidity of the development of the twin factors of resistance and transference. Where these two factors are not immediately detectable, and are slow to develop, the phase of pressure begins with the search for the resistance. In previous publications, I have presented the phase of challenge and emphasized that it is the key intervention in both the technique of Intensive Short-Term Dynamic Psychotherapy as well as in the new form of Short-Term Psychoanalysis; and I indicated that challenge lies on a spectrum from relatively mild at one end to exceedingly powerful at the other, culminating in the head-on collision. This article briefly presents aspects of the technique of head-on collision with resistance.

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Technique of Head-On Collision with Resistance

Head-on collision is used within the setting of resistance in the transference or when the patient's character defenses, as the result of the phase of pressure or pressure and challenge, have been crystallized in the transference. It may take various forms: there is a spectrum of head-on collision; from single format to composite forms, and at the other end of the spectrum interlocking chain of head-on collision, which is the most complex of all the therapist's interventions.

The Major Aims of Head-On Collision

These could be summarized as follows:

(1) Total blockade against all defenses maintaining the forces of the 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) Mobilization of the therapeutic alliance against the resistance; to tilt the balance between the two forces in favour of the therapeutic alliance. It is essentially addressed to the therapeutic alliance and directed against the self-destructiveness inherent in the patient's conscious or unconscious refusal to abandon his resistance
(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 it creates an extremely complex state within the patient, one in which he both wishes to cling to his resistance ever more strongly and at the same time begins to turn against it, and becomes both angry and 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 resistance and therapeutic alliance in the transference, it calls for further head-on collision with the aim of mobilizing unconscious therapeutic alliance against resistance
(6) The patient is brought face to face with his self-destructiveness with such communication as 'good-bye', 'doomed', and 'misery' to both shock him out of the syntonic part of his resistance and challenge his unconscious therapeutic alliance to make a supreme effort
(7) In many cases, the head-on collision results in major communication from unconscious therapeutic alliance
(8) The aim is to loosen the patient's psychic system in such a way as to make the unconscious more accessible; mobilization of the unconscious
(9) In the interlocking chain of head-on collision the aim is to loosen or to mobilize the patient's psychic system and to make a partial or major unlocking of the unconscious possible.

The Main Technical Interventions in Head-On Collision

Here I summarize the main technical interventions in head-on collision. But the therapist must keep in mind that in any given case some of them are used

more frequently and some of them are not needed. The following is a summary of the main technical interventions:

(1) To point out and emphasize the problem and its effect on the patient's life
(2) Keeping the responsibility with the patient: undoing the omnipotence
(3) Emphasizing the patient's will: that the patient is the prime mover in seeking help
(4) Emphasizing the therapeutic task and the patient's goal
(5) Emphasizing the partnership between the patient and the therapist
(6) To point out and emphasize the nature of the resistance
(7) To point out the consequences of the resistance
(8) Challenging and emphasizing the self-destructive aspect of the resistance; challenging the self-destructiveness in the resistance
(9) Emphasizing and challenging the self-destructiveness in the transference resistance and emphasizing the consequences of the resistance in the transference
(10) Establishing and emphasizing a parallel between self-defeating and self-sabotaging patterns in the transference and other relationships
(11) Emphasizing self-sabotaging and self-destructive aspects of the resistance; the masochistic component of the patient's character resistance; need for self-defeat and self-sabotage; challenge directed at the perpetrator of the unconscious
(12) Deactivation of the transference; refusing the transference role the patient wants to assign to the therapist
(13) Deactivation of defiance
(14) Challenging the dependent transference pattern: the need to use the therapist as a crutch
(15) Challenge and pressure to the resistance against the emotional closeness
(16) Pressure to the unconscious therapeutic alliance

Now we can discuss the main technical interventions in head-on collision. In any given interview, the therapist chooses those that he considers appropriate to a specific patient. As I have indicated, head-on collisions are within a spectrum, some fall within the short-range form of head-on collision, others fall in the category of a composite form and at the end of the spectrum is interlocking chain of head-on collision, all with specific indications.

In some cases, all the technical interventions, the making of the head-on collision, follow a logical progression, as in the Case of the Man with the Baseball Bat (Davanloo, 1984a, 1987a), but this is not necessarily the case with every patient. Further, I would like to emphasize that although the wording of all these interventions is very carefully thought out and is the result of the development and refinement over many years of audiovisually recorded research, it is obvious that every therapist must find for himself the particular language with which he feels comfortable. On the other hand, he should have a thorough knowledge about the technical and metapsychological roots of the technique.

Now I will discuss briefly some of the main technical interventions.

To Point Out and Emphasize the Problem and its Effect on the Patient's Life

The therapist must underline the patient's problem which causes him suffering and often must begin by reminding him of this fact in forceful terms. This is particularly important in patients who have a tendency to minimize their

problems and their suffering. Here the therapist might use the words 'Major'; 'Misery'; 'Suffering'; and when appropriate the word 'Agony'. The therapist should make an attempt to maximize the impact of this intervention: 'You see, you know yourself better, but you have a tendency to minimize your difficulties and your suffering'.

Undoing the Omnipotence: Keeping the Responsibility with the Patient

Undoing the omnipotence is closely linked with the deactivation of the transference. Many patients have a strong tendency to transfer to the therapist the role of someone from the past. The aim is to emphasize and bring the patient back into the reality of the task and to avoid getting involved in the patient's transference.

As the therapist's major task is to mobilize the unconscious therapeutic alliance against the resistance, he must at all costs avoid getting into the position of implying that the purpose of the interview is for him to change the patient, rather than for the patient to change himself. The therapist's task is to avoid getting into the position of being omnipotent and a figure of the past.

Throughout the head-on collision, the therapist repeatedly emphasizes the patient's responsibility, 'refusing the transference role' that the patient is trying to impose on him. To give an example: 'I don't know, you have to decide'. Or the head-on collision might contain the question: 'Is it or isn't it?' As a result of this form of head-on collision, the patient accepts responsibility explicitly. The following is from a head-on collision and the therapist is returning to this theme with the words: 'The problem ... suffering ... success or failure ... are yours'. In another head-on collision: 'If we fail, the misery and suffering is yours, but if this becomes a major success, then the happiness and the freedom is yours'.

Emphasizing the Patient's Will: That the Patient is the Prime Mover in Seeking Help

During both the initial interview and the course of the therapy, the therapist attempts to mobilize the patient's will and this can be in the form of head-on collision: 'You have come here on your own will?' Obviously, the therapist must check that the patient really is the prime mover, rather than that he has been 'sent' by another physician or another agent, or that he is only coming out of compliance with someone else. In that case, he should apply a technical intervention to create a shift and make it the patient's will. Always, one of the elements of head-on collision contains emphasis on the patient's will. For example:

TH: (The Case of the Praying Mantis) And you have decided on your own volition, I assume, to do something about it. Am I right in saying that it is your own decision? Or is it that you came because your counsellor referred you?

Emphasizing the Therapeutic Task and the Patient's Goal

This component of head-on collision is closely linked with the element of keeping the responsibility firmly where it lies. Reviewing a large number of head-on collisions, I notice that it is one of the most frequently used elements.

Emphasizing the Partnership between the Patient and the Therapist

Most of the head-on collision emphasizes the partnership, that the patient is a major partner. When the therapist is directly challenging a defense, he assumes the role of adversary against the part of the patient that is identified with his resistance. When he is speaking to the therapeutic alliance, he emphasizes his role as ally; the following is an example: 'One of the major tasks that you and I have is that you and I, with the help of each other, will explore and understand where the core of your problem lies'.

In many interventions forming part of the head-on collision, the therapist may use the word 'We'. Both 'You and I' and 'We' reemphasize the partnership.

To Point Out and Emphasize the Nature of the Resistance

The therapist must point out and specify the nature of the defenses that the patient is using: 'If you maintain a defiant, passive, cut-off position . . .'; 'If you are going to avoid'; 'If you remain helpless and incapable of seeing how you felt'; 'As long as you are going to rationalize, intellectualize, ruminate and be vague'; 'You see you keep ruminating and now you want to procrastinate and take a stubborn, defiant position'.

Pointing Out the Consequences of the Resistance

This component is extremely important and sometimes it might be repeated a number of times. It addresses the destructive organization of the resistance. In the Case of the Praying Mantis:

> *TH: As long as you have a need to censor yourself, we will not be able to get to the core of your problem. What I really want to tell you is this: that you set up a goal for yourself to come here to understand your problem, but by censoring yourself you are defeating the goal. Now my question is this: if your need is to defeat your goal, then why should we meet and have this interview?*

Emphasizing the Self-Destructive Aspect of the Resistance; Challenging the Self-Destructiveness in the Resistance

The therapist must introduce explicitly the self-destructive aspect of the resistance and then he can challenge it with a rhetorical question: 'And there will be a 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 perpetuate your own misery?' The following is another example of challenging self-destructiveness in the resistance (The Case of the Chess Player):

> *TH: Isn't 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?

Emphasizing and Challenging the Self-Destructiveness in the Transference Resistance and Emphasizing the Consequences of the Resistance in the Transference

Some form of the head-on collision is used after the resistance has been crystallized in the transference and has become a transference phenomenon. The therapist could open the head-on collision with the words 'Let's look at your relation here with me'. In the Case of the Praying Mantis, which will be discussed later, the patient was in a state of resistance in the transference and became defiant. The therapist introduces head-on collision: 'Let's look at your relationship here with me', and later on: 'Then I will be useless to you'. This was followed by the question: 'Why should you want to make me useless to you?' These communications carry deep messages.

The word 'useless' can have two distinct meanings. One is concerned with the negation of a person's 'active' role, where the meaning is powerless or ineffective; while the other is concerned with the negation of a more 'passive' role, where the meaning is no longer available for use. In using this word, the therapist is conveying both meanings, saying, on the one hand, that the patient is destructively trying to render him powerless, and that, on the other, this will make him unavailable, which is self-destructive. Based on our empirical clinical research data of the kind of psychopathology that the therapist is working with by means of this intervention, many patients, because of the buried rage, violent rage, primitive murderous rage and intense guilt, suffer from recurring pattern of forming relationships and then destroying them. This repeated pattern presents for a variety of reasons: overt trauma, covert trauma, attachment and bond, the traumatization of the bond, and the pain of the trauma as well as murderous rage and intense guilt. Such patients under the impact of this dynamic system, namely the perpetrator of their unconscious, may constantly try to frustrate and irritate another person to take away his power, or make the other person suffer as they have suffered.

But in the early stage of the interview, which we are considering here, the therapist knows little or nothing about the origins of such problems in the past life of any patient. But this does not matter. Based on our current knowledge about the metapsychology and structure of human neurosis, the therapist can use this form of intervention. In using these words, he has two aims: (1) to deliver a message to the patient's unconscious that he has sensed this kind of destructiveness in the transference, and (2) he is speaking to the unconscious therapeutic alliance directly about the self-destructiveness inherent in such a relationship. It is important to note that this source of resistance has its origin in unconscious rage, or murderous rage, and guilt- and grief-laden feelings. In addition, once the therapist has spoken in this way, he has covered resistance derived from all substructures of the psychic apparatus: destructive murderous rage, intense guilt and self-punishment, and unconscious defensive organization, and so on.

The therapist in using the word 'useless' carries all these highly significant messages and the therapist usually underlines it and repeats it. This underlining

and repeating is extremely important. I demonstrate this in the following passage from the Case of the Masochistic Woman with the Brutal Mother, which I have presented in other publications:

TH: *If you don't want me to get to your intimate thoughts and feelings, I will be useless to you. It is as simple as that. But what I say is this; why does a young intelligent woman of your age want to do that?*
PT: *Do what?*
TH: *To make me useless to you.*
PT: *No, I don't want you to be useless to me.*
TH: *But it will happen if the 'wall' is there between you and me. If you don't want me to get to your intimate thoughts and feelings, then I will be useless.*

In the above passage, the word 'useless' was used four times, and it is also important to note that the therapist is focusing on the resistance against emotional closeness, which I will discuss briefly later in this article.

Establishing and Emphasizing a Parallel between Self-Defeating and Self-Sabotaging Patterns in the Transference and other Relationships

This is another component of the head-on collision, and usually the therapist has some information at this point about the patient's life in other relationships. Then, on that basis, he can include in the head-on collision the parallel in the transference with the relationships outside the transference. In the Case of the Praying Mantis; as a result of her refusal to allow sexual penetration, men would leave her with anger. She was stubborn and refused to undergo medical procedures, such as a gynecological examination, and in the beginning of the interview had indicated that she was obstinate with her pediatrician as a child. The therapist had focused on the patient's sexual fantasy during masturbation, the point where she goes to a major resistance in the transference:

TH: *How do you feel right now when I confronted you with your need to make me useless to you, because if we follow your censorship I will be useless to you obviously? And let's face it, all men have been useless to you—your relationships with all men have been a failure.*

In the Case of the Teeth-grinding Woman:

TH: *... We would not be able to understand your problem, and we would not be able to get to the core of your problem and then the end result would be that I would become useless to you, in the same way that many years of your treatment with other psychiatrists have been useless. But my question is this, why do you want to do that?*

and then the therapist moves to head-on collision with the resistance against emotional closeness in the transference.

Challenging and Emphasizing Self-Sabotaging and Self-Destructive Aspect of the Resistance; Masochistic Component of the Patient's Character Resistance; Need for Self-Defeat and Self-Sabotage; Challenge Directed at the Perpetrator of the Unconscious

This is extremely important, and there are many elements involved: a wish to avoid pain; far more important is the need for punishment; the presence of intense guilt which is a powerful force in maintaining the resistance; the central issue is the perpetrator of the unconscious which consists of the attachment and bond, the original trauma, the pain of that trauma, primitive murderous rage, intense guilt and grief, and subsequent traumas.

Deactivation of the Transference; Refusing the Transference Role the Patient Wants to Assign to the Therapist

The therapist must vigilantly monitor that the patient's conscious and unconscious perception of the therapist does not become coloured by the patient's perception of the people in his past. The aim of deactivation is to bring the patient into reality.

Challenging the Dependent Transference Pattern; the Need to Use the Therapist as a Crutch

This component of head-on collision is particularly important in patients who have been very badly traumatized in the early part of their lives, patients with fragile character structure who have had very traumatic experiences in the early years. Other examples would be the cases who had been hospitalized due to illness in the early part of their lives. An example would be the Chewing Gum Man, who was hospitalized a number of times in the first few years of his life; other cases would be those hospitalized in the very early phase of life such as premature births, which require incubators; and a pathogenic family life—a highly controlling, demanding mother with no capacity for affectionate bond with the child, and, equally, an absent, ineffective father.

The therapist must challenge any manifestation of the symbiotic transference neurosis in the form of head on collision: '... And now you want to use me as a crutch'.

Rhetorical Question to the Therapeutic Alliance To Mobilize the Therapeutic Alliance Against the Resistance

The focus here is usually on a specific resistance. It is often used when a particular defense has clearly crystallized and especially if the patient agrees; it can be used at any point during the head-on collision and also at other points of the interview as well. It might take the form of: 'What are we going to do?' 'What are you going to do?', or 'Let's see what we are going to do'. These phrases are going to address a specific resistance. As I indicated, it is often used in head-on collision but is also used out of head-on collision. For example, in the Case of the Man with the Baseball Bat, it followed the patient's agreement that, on the one

hand, he continued to be resistant, while on the other hand he could not afford to fail. Another example is the following patient who cannot remember the incident:

PT: *Well, may be it is difficult for me to remember the incident.*
TH: *So let's see what are we going to do about this because obviously if it goes on like this, that you have difficulty remembering, then how are we going to understand your problem?*

In the Case of the German Architect, which I have described previously, one of the defenses that crystallized very early was vagueness, which the therapist pointed out. Eventually, the dialogue continued as below, with the rhetorical question again forming the first element in the head-on collision:

PT: *Yes, I know, but I am vague.*
TH: *So the first question is, what are we going to do about the vagueness?*

This type of intervention, like most of the others in head-on collision, is used to mobilize the therapeutic alliance against the resistance.

In the following passage the therapist uses head-on collision in a composite form. First, he points out and emphasizes the nature of the resistance and then points out the consequences of the resistance. This is then followed by challenging the self-destructiveness in the resistance and then by emphasizing the parallel between self-defeating and self-sabotaging pattern in the transference and other relationships:

TH: *You see, if you continue to be vague and if you continue to be evasive and generalize and continue with vague rumination and keep things in the state of limbo, then we would not get to understand the core of your problem and the end result would be that I would be useless to you like the 20 years of your past therapy, okay? Now my question is this, why you want to do that?*

This composite form of head-on collision is followed by a rhetorical question to the therapeutic alliance. This passage is followed by the first breakthrough as the patient becomes very sad and holds his head in his hands with the passage of the painful feeling, and crying.

Composite Form of Head-On Collision

Now we can summarize the logical progression of a composite form of head-on collision with the resistance. What the therapist is communicating to the patient is as follows. You have a serious problem which is a major problem and which causes you pain and suffering. It is your problem; you have come here of your own volition seeking help for your problem and suffering. My goal is to understand your problem and my function is to help you achieve your goal. You are now using these resistances but if you continue to use these defenses the process will be a failure and you will be defeating your own goal. This is self-destructive, it can only result in perpetuating your own suffering and misery. Why do you want to do that? In addition there is destructiveness directed against me which is equally self-destructive. Moreover, this is an example of a pattern

which applies to other relationships as well. I don't accept the role of target for your destructiveness which you are trying to thrust upon me, I have no intention of allowing you to make your problem my problem.

TH: Let's look at it, obviously you have a major problem and this problem has been a source of misery and suffering and agony for you. Obviously you are the one to decide: is it a major source of suffering or isn't it?
PT: Yes.

Emphasizing the problem and its effect on the patient's life (1); keeping the responsibility with the patient (2); deactivation of the transference (12).

TH: And I assume you come here on your own volition and you must have a goal, otherwise you wouldn't come here.

Emphasizing the patient's will; the patient is the prime mover (3); emphasizing the therapeutic task (4).

PT: That's right.
TH: The major task that you and I have ahead of us is, with the help of each other, to understand your problem and where the core of your problem lies.

Emphasizing the partnership between patient and therapist (5).

PT: That's right.
TH: The fact is that the problem is yours, suffering is yours, happiness is yours, success is yours and the failure is yours. But if you maintain a defiant, stubborn position, then what will happen here with me?
PT: Nothing.

Keeping the responsibility with the patient (2); emphasizing the nature of the resistance (6); deactivation of the transference (12).

TH: So in a while the session comes to an end, we say goodbye, you go your way and carry on the miserable life you have, and I go my way and say I did my best but I failed. You see, as long as you take a defiant, stubborn position we would not reach the goal and we would not be able to understand the core of your difficulties and the whole process will be doomed to fail.
PT: Yes.

Emphasizing the nature of the resistance (6); and consequences of the resistance (7); in it there is deactivation of the transference (12).

TH: You see there will be self-defeat and self-sabotage in it. Isn't that so? Now, the question I have in my mind is, why should you of your own will come here with the aim to understand your problem and to get to the core of your problem but at the same time another part of you wants to defeat the goal that you set for yourself and wants the perpetuation of your misery and suffering?
PT: I know.

TH: Then I will end up to be useless.
PT: Yes.

Challenging the self-destructiveness in the resistance (8); challenging the self-destructiveness in the transference resistance (9).

(The first breakthrough is taking place. The patient is sad with tears in his eyes.)
TH: Why you want to make me useless to you?
PT: I don't want that.
TH: And obviously throughout your life I assume many people have been useless to you. What I can say is that you have a major self-defeating and self-sabotaging element in you ... and this is right now in operation with me.

Emphasizing self-destructiveness in the transference (9); and emphasizing a parallel between self-sabotaging pattern in transference and other relations (10).

PT: Yes, I have ...
TH: It is important that we look at this self-defeating, and self-destructive pattern. If this process with me continues like this, we are bound to fail to understand your difficulties and to get to the core of your problem. Then you have to carry your problem the rest of your life ... So this would lead to failure.
PT: That's right.
TH: Then the question for both of us is what are we going to do about it?
PT: To overcome it.

Pointing out the consequence of the resistance (7); challenging self-sabotaging and self-destructive aspect of the resistance; addressing the masochistic component in the resistance (11); pressure to unconscious therapeutic alliance (16).

The patient has been increasingly sad and tearful. Now the therapist moves to head-on collision with the resistance against emotional closeness and the breakthrough into the unconscious.

Further Example of Head-On Collision

The Case of the Chewing Gum Man

In other publications, I have described the phase of pressure and challenge with this patient, who was 29 years old when he entered into treatment and suffered from major symptom disturbances such as anxiety, panic, functional and somatization disorders, dizziness, loss of balance, staggering, blurring of vision, etc., as well as phobic symptoms and characterological disturbances.

The therapist exerted pressure which consisted of making comments about the patient's secondary gain. This mobilized resistance in the transference and the process then moved to further challenge and pressure to the resistance. Shortly after that, the therapist further exerted pressure, making the comment: as a child the patient was being rocked around the clock by his mother, aunts and grandmother. This mobilized a major resistance in the transference and the therapist moved to head-on collision with the resistance in the transference. The following

passage demonstrates the form of head-on collision which resulted in the breakthrough into the unconscious.

For the sake of brevity, the dialogue has been shortened and paraphrased in places, but nothing important has been omitted.

TH: Then you run to your mother.

. . . . . .

TH: How long that sickness went which your mother, your aunt and your grandmother were shifting and then rocking you?
(The patient becomes detached and distant, and has become vague with avoidance. 'I don't know', 'Well I don't')
PT: (sigh)

. . . . . .

At this point, the patient takes a bubble gum from his pocket and starts chewing the gum, which clearly has transference implications.

TH: How do you feel here when you talk about these things?
PT: I don't know, feel . . .
TH: Because a while ago I felt that in a sense suddenly you had to go and have a gum.

. . . . . .

The focus is on chewing gum to overcome the patient's nervousness, the same way that he is dependent on tranquillizers to overcome his anxiety.

PT: Well I never, never looked at the fact that I chew gum as a, as a, you know, an escape or something.
TH: But you are doing it, you started to do it and still you are continuing chewing gum and you say . . .
PT: (Laughs)
TH: You are smiling now. How did you feel when I said that you are still continuing with the chewing gum?

. . . . . .

PT: Yeah, it, it's a crutch.

. . . . . .

PT: Sure.
TH: So whenever you are anxious, Okay . . .
PT: Yeah.
TH: Then you are looking for a crutch.

There is a clear intensification of the transference resistance. All the evidence indicates that he is angry, holding on his feeling and has become very detached, distant and non-involved.

PT: I am mad.
TH: Mad. What is the way you experience the madness?

There was a head-on collision with the intensified resistance in the transference and he finally took the chewing gum out of his mouth and became more angry and non-involved. This finally resulted in the breakthrough into the unconscious with the major passage of the painful feeling about his life with his father who had died from a major stroke, and most of father's symptomatology such as loss of balance, staggering, dizziness, visual experiences, etc., are the symptoms that the patient currently has.

The Case of the Praying Mantis

This form of head-on collision is very important because it illustrates a way of handling a frequently encountered situation that is likely to cause many therapists extreme difficulty. In our research we have a number of patients with a similar pattern and we have classified all of them under the heading of Praying Mantis. The situation is as follows. An attractive, seductive, viciously man-hating, sadomasochistic young woman does her best to involve the therapist in her transference, which consists of leading him into a battle of wills that she has every intention either of winning sadistically or of losing masochistically. The problem is how the therapist can prevent, at all costs, falling into her trap, and make the process a therapeutic triumph without creating a battle of wills and become angry or behaving sadistically himself.

The two key factors for the therapist are: (1) relentlessly throwing back the responsibility where it lies, and (2) equally relentlessly refusing the transference role into which she is trying to thrust him. Both of these themes are central to the head-on collision; in this particular case, as will be seen, they pervade all the therapist's interventions.

It may help any therapist who finds himself with a patient of this kind to remember that behind the vicious attack on men there almost certainly lies deep layers of great pain, the trauma, the covert or overt traumatic experiences of failed relations, the pain of trauma, murderous rage and guilt as well as grief-laden feelings. If the therapist can cling to his knowledge, both technical and metapsychological throughout all the stresses of the transference relationship, he can win through to a situation in which he and the patient are on the same side.

When the patient entered into treatment, she was 25 years old. The immediate cause of her seeking help was that she was suffering from an infection of her genital tract, but, because of her phobic symptoms regarding medical procedures, they could not insert the speculum and the gynecologist had been unable to perform the necessary vaginal examination. She had phobic symptoms, chronic anxiety and episodes of panic attack which dated back to her childhood. Her pediatrician refused to treat her directly as she was stubborn 'turning his office upside down'. Her mother had had to describe her symptoms to the pediatrician over the phone and then carry out her treatment under long-distance instructions. The patient has a major problem with intimacy and closeness, is living alone quite distant from her parents. Her current patterning with men consisted of nightly pick-up relations in which she led the man on and both of them became very sexually excited, but, because of vaginismus and severe pain, she pushed him away as soon as he tried to penetrate her.

The early part of the interview, namely the phase of inquiry and dynamic inquiry, proceeded smoothly until the therapist asked about her sexual fantasies during masturbation:

TH: *What type of fantasies do you have?*
PT: *(Patient is smiling)*
TH: *You are smiling.*
PT: *I just really don't want to go into it, they embarrass me very much. Can we skip that one?*
TH: *You said that you have always been a stubborn person, hmm, and that you always get your way. And this has been a pattern in both your current life and in the past with your pediatrician as a child and currently with your gynecologist.*
PT: *I don't know if I get my way always. Not anymore certainly. When I was a child I got my way always.*
TH: *Yeah. But you said that when you see a doctor you manage to get your own way.*
PT: *No . . . I mean . . . I have to submit to them eventually. I will go through a bit of trying to talk them out of it in order to stall.*
TH: *Finally you give in?*
PT: *Finally I give in.*

The therapist underlines the important—and hopeful—transference message.

TH: *And do you think that might be here with me?*
PT: *Well . . . I am not going to go into those fantasies.*
TH: *You're smiling.*
PT: *Maybe if I talk to you a second or a third time I might be willing to, but on the first meeting, No, I won't. Now maybe that is stubbornness but . . .*

The above passage shows a major resistance in the transference which calls upon head-on collision, which now unfolds as follows:

TH: *What I am struck by is the fact that you have a problem which is a major problem for you. I don't know, you have to decide whether it is or not. But it seems to be a major difficulty for a young woman of your age to face.*

In the above passage the therapist is using the following technical interventions: pointing out the nature of the problem (1); keeping the responsibility with the patient (2); and deactivating the transference (12).

PT: *All right.*
TH: *And you have decided on your own volition, again I assume, to do something about it. Am I right in saying that it is your own decision? Or is it that you come because your counsellor refers you?*

Technical intervention; emphasizing the patient's will (3).

PT: *No, my coming is based totally on my own decision and I have severed my contact with him.*
TH: *Let's look at it, you are in the state of suffering, you have a problem which is quite a difficult one. Of your own volition you have come here, now by*

censoring yourself we would not be able to get to the core of your problem. Of course it is your problem; but my question to you is this 'Why do you set up a goal to come to understand your problem but at the same time . . .?

The above passage shows a number of technical interventions of head-on collision: Pointing out the problem and its affect (1); keeping the responsibility with the patient (2); emphasizing the patient's will (3); emphasizing the nature of the resistance (6); pointing out the consequences of maintaining the resistance (7); and challenging the self-destructiveness in the resistance (8).

PT: I don't see what my sexual fantasies have to do with it.

It is important to point out that at this point it would be very easy for the therapist to say something like: 'Obviously your sexual fantasies are a central issue'. This would be a major mistake as it would allow the process to move into a battle of wills, into an argument which the therapist should avoid at all cost. Moreover, her unconscious knows the importance of her sexual fantasies perfectly well and there is not a slightest need to spell it out. Therefore, he completely ignores her remarks and continues systematically with the next step in the head-on collision:

TH: As long as you have a need to censor yourself, we will not be able to get to the core of the problem. What I really want to tell you is this: that you set up a goal for yourself to come here to understand your problem, but by censoring yourself you are defeating the goal. Now my question is this: if your need is to defeat your goal, then why should we meet and have this interview? . . .

In the above passage the therapist continues with head-on collision; emphasizing the nature of the resistance (6); challenging the self-destructiveness in the resistance (8); and challenging the self-destructiveness in the transference resistance (9). The intervention further aims at shocking the patient out of her identification with her own resistance and also deactivates the defiance (13). We return to the interview.

PT: Well . . . I find that a very difficult and embarrassing area to talk about.
TH: I understand that, but at the same time if we are going to get to the core of your problem we have to understand them; and you know that very well, unless you want to see this to be a failure and useless to you?

In the above passage, the therapist again reemphasizes the consequences of maintaining the resistance (7) and the self-destructive aspect of the resistance in the transference (9) and keeping the responsibility with the patient (2). Now we go back to the interview.

PT: No, I would not like that.
TH: That is your choice (keeping the responsibility with the patient)
PT: I still . . . if you . . . I am willing to tell you certain things that are common to my fantasies, but I won't go into specifics. If I tell you the things that happen in every fantasy, time and time again, which I would say is perhaps significant.

Head-On Collision Continues

Here the patient is trying to reveal a little to gain a victory. This is not acceptable, and once more the therapist must not convert the interview into a battle of wills. What he does, therefore, is to change the subject abruptly by asking about the transference feelings, at the same time proceeding to the next two steps in the head-on collision:

TH: How do you feel right now when I confronted you with your need to make me useless to you? Because if we follow your censorship I will be useless to you obviously. And let's face it, all men have been useless to you, your relationship with all men has been a failure.

The therapist challenges the patient's self-destructiveness in the transference resistance (9), emphasizing the parallel with the self-sabotaging pattern outside of the transference (10).

PT: Well, that is quite true.
TH: And I think you see it here with me ... that you want to ice skate around, you want to beat around the bush. My question is this: that is fine if you want to beat around the bush, but what would be accomplished here?

In the above passage the therapist moves to another component of the head-on collision, namely, pointing out the consequences of the resistance (7).

PT: Well ... it seems to me that you are perhaps not being fair. I mean I don't ...
TH: Now let us look into my not being fair.
PT: Because my counsellor and I, we have had an argument like this, and I have finally been ...

Because, although the patient has been trying to argue, the therapist has refused to allow himself to be put in this position, he knows the truth that he has not been arguing, and avoids becoming involved in the patient's transference. The purpose behind this is that of another important technical intervention in the head-on collision, namely, to refuse the transference role that the patient is trying to thrust upon him (12).

TH: Where have I given any evidence that I am arguing with you? Only what I am telling you is that if you want to get to the core of your problem ... (deactivating the transference and refusing the transference role)
PT: No, I am not talking about an argument. It is that we are having an argument/discussion. We have opposing viewpoints.
TH: But where is the argument?
PT: The argument is that you are trying to convince me ...
TH: I am not trying to convince you in any form. Give me a single piece of evidence of any way in which I have tried to convince you. (Further deactivation of the transference)
PT: You are telling me—and it is very reasonable, I must admit—that you cannot help me if I don't tell you things.

In the above passage, the therapist returns to reiterate the head-on collision.

TH: It is really your life and that is ...

Here the therapist emphasizes the problem, 'It is really your life'.

PT: *I am resisting, and you are correctly ...*
TH: *I think that is a problem you have. What you are really saying is this, that we have to leave things in a state of limbo and go on for a number of additional sessions.*
PT: *Now, I have been, look ... I have just offered ...*

This word represents yet another attempt to involve the therapist in bargaining, and once more, the therapist continues as if he had not heard it:

TH: *You are master of your life.*
PT: *Okay.*
TH: *Misery is part of your life and the same with happiness. If I could be of help to you.*
PT: *Certainly.*
TH: *There is nothing that I am convincing you. I am only pointing out your need to defeat. But who is the defeated person? It is you, because the problem is yours.*

The components of head-collision consist of: keeping the responsibility with the patient (2); and challenging the self-destructiveness in the transference resistance (9).

PT: *Well ... I have just ... Okay ... I am telling you that it is a very sensitive thing with me. However, I have said that you have a good point, and ... Okay ... can I tell you things that happen in every fantasy, but I don't want to go into a specific fantasy right now. But is it helpful to you if I tell you things that will come out in every fantasy that I have?*

One of the basic principles, which is a dynamic principle of political bargaining, is that when you have won, you allow the other side a face-saving formula, which the therapist now does:

TH: *Let's look at them.*
PT: *Well, at this stage, I will not tell you a specific fantasy. I am sorry. I just can't do that right now.*
TH: *What is the nature of your fantasies?*

Now, there begins a process of relentless questioning about her fantasies, in which the therapist brings out far more than she imagined she was going to reveal. The fantasies usually involve knifing the man in the heart or, particularly, in the back, at the neck level of the vertebral column, during and after intercourse. What further emerged is that knifing at the vertebral column is always present in sexual fantasies with men. She came to realize spontaneously that in her homosexual fantasies there is the absence of murder.

Fusion of Sexuality and Primitive Murderous Rage

What emerges is a fusion of sexuality and the primitive murderous rage in her unconscious, and that her father had a phobia of knives and had a constant preoccupation that she might cut herself. Father was extremely possessive,

compulsively controlling and had preoccupations that she might be raped as well. Her unconscious primitive murderous rage fused with sexuality towards the father becomes the focus of the early phase of the therapy.

Summary and Conclusion

In this article, I have briefly outlined the technique of head-on collision with resistance, which can be summarized as follows:

(1) I emphasized that the aim of the phase of pressure is to mobilize the resistance until it is tangibly crystallized between the therapist and the patient; then the resistance can be challenged effectively. It was pointed out that challenge is the key intervention and that it lies on a spectrum, from relatively mild at one end to exceedingly powerful at the other, culminating in head-on collision.
(2) Head-on collision is often used within the setting of resistance in the transference; the therapist might introduce the head-on collision at the point of high tension between therapeutic alliance and resistance, his aim being to bring all forces to bear to tilt the balance in favour of the unconscious therapeutic alliance. If he has timed his intervention well, the therapeutic alliance begins to break through.
(3) The major aim of head-on collision was discussed; in its composite and interlocking forms, it aims at the total blockade against all forces maintaining the resistance. It is a direct assault on all forces maintaining self-destructiveness, self-defeat and self-sabotage. I further indicated that it aims to loosen the patient's psychic system, mobilization of the unconscious in such a way as to make it more accessible.
(4) The main technical interventions in head-on collision were presented and discussed by analyzing a few vignettes of specific forms of head-on collision with a number of the patients.
(5) There are specific forms of head-on collision which are primarily designed for loosening the patient's psychic system; mobilization of the unconscious. They have major indications in patients who are extremely resistant with syntonic character pathology. These forms of head-on collision are of great importance psychotherapeutically and scientifically, as well as in clinical research.

In conclusion, there is a spectrum of head-on collisions, and each of them is with a specific indication, such as: head-on collision aiming at the mobilization of the unconscious and loosening of the psychic system; interlocking chain of head-on collisions; and various forms of head-on collision aiming at breakthrough into the unconscious when the resistance is heavily crystallized in the transference. These are presented in many audiovisual symposia, courses and training programs, and will be discussed in great detail in future publications.

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