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Clinical Manifestations of Superego Pathology. Part II. The Resistance of the Superego and the Liberation of the Paralyzed Ego

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The present article is concerned with the handling of resistance in patients suffering from severe character and superego pathology. In these patients the ego is paralyzed by powerful forces generated (1) by repression and (2) by the superego, both of which manifest themselves as apparently impenetrable resistance in the clinical situation. Against this the traditional technique in which the therapist confines himself to interpretation is totally powerless. I have demonstrated that the therapist can exert a far more direct influence on the balance between therapeutic alliance and resistance than is possible by simply trying to make the resistance conscious. The main intervention consists of challenge to both forms of resistance. The result is a train of events ending with the paralysis of the resistance and the liberation of the patient's ego. These phenomena are illustrated by clinical examples.

In Part I of the present article (see Davanloo, 1987c), I described a type of patient with the following characteristics: In their everyday life they manifest severe self-destructive behavior, impoverished personality, and sterile relationships; and at interview, when their unconscious is unlocked, they reveal extremely violent, murderous impulses directed against close members of the family and loaded with intense guilt, grief, and pain. Examination of the evidence led to the conclusion that these patients suffer both (a) from a loss of essential parts of the personality, due to repression, and (b) from an all-pervading need for punishment for their underlying impulses with intense guilt, which we can formulate as emanating from a severely punitive superego. The superego appears to have invaded and taken over the patient's ego, to have paralyzed its functioning, and to have replaced the normal search for satisfaction and fulfillment with an ever-present need for suffering.

The previous article was concerned with the light that these patients throw on psychopathology. The present article is concerned with the way in which this psychopathology manifests itself in the clinical situation and how the therapist can handle it.

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The Nature of Resistance

When a therapist tries to reach any patient's unconscious he meets a quite tangible opposing force which we all know as resistance. Freud recognized very early in his work that this consisted of the same force as that holding unacceptable feelings and impulses in check within the patient, i.e., it is the force of repression now manifesting itself between patient and therapist. Much later he named it the "resistance of repression" in order to distinguish it from other forms of resistance which he had come to recognize. Of these the particular one with which we are concerned is the "resistance of the superego," which arises from the fact that the patient's need for punishment causes him to try and prevent the therapist from relieving him of his suffering (see Freud, 1926a, p. 160). It is clear that this also is a force originally within the patient, but now manifesting itself between patient and therapist in the clinical situation.

Handling Resistance in Traditional Technique

In his paper, "Remembering, Repeating and Working-Through" (1914), Freud made clear that he regarded the removal of resistance as the analyst's primary task, and here he was clearly referring to the resistance of repression. He wrote optimistically: ". . . the doctor uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty" (1914, p. 147).

More than a decade later, in "The Question of Lay Analysis" (1926), he wrote of the resistance of the superego in much less optimistic terms: "The 'unconscious sense of guilt' represents the superego's resistance. It is the most powerful factor, and the one most dreaded by us." (1926a, p. 224).

More than a decade after this, in "Analysis Terminable and Interminable" (1937), he wrote even less optimistically of the resistance offered by patients under the influence of a severely punitive superego: "For the moment we must bow to the superiority of the forces against which we see our efforts come to nothing. Even to exert a psychical influence on simple masochism is a severe tax upon our powers" (1937, p. 243).

Throughout all Freud's writings on technique from 1910 onwards the instructions to the therapist are always that he should play a passive, waiting role, and that the one type of intervention in his armoury—whether for dealing with the resistance of repression or that of the superego—is interpretation. Thus just before the 1914 passage quoted above he writes:

> Finally, there was evolved the consistent technique used to-day, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the patient's mind, and he employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient.

In "An Outline of Psycho-analysis" (1940) he writes in similar terms of the resistance of the superego:

> In warding off this resistance we are obliged to restrict ourselves to making it conscious and attempting to bring about the slow demolition of the hostile super-ego. (1940, p. 180)

To summarize, Freud understood only too well both the importance and the nature of resistance, but in his attempts to deal with it he never progressed beyond pointing it out and trying to make it conscious. In view of the great length of psychoanalysis and its many failures, it is obvious that Freud's position of bowing to punitive superego, playing a passive waiting role and hoping that interpretation might bring about "slow demolition of the hostile superego" is totally, to say the least, unsatisfactory. In traditional technique no one has found a way of dealing with resistance, and least of all with the resistance of the superego.

The Mechanism Involved in Interpretation of the Resistance

We may discuss this with the help of the trial therapy of a highly motivated responsive patient. The patient was a young man of 28, married for four months, complaining of sexual difficulties; a change in his feeling for his wife, and episodes where he becomes angry easily with her and emphasized that he wants to do everything that he can to keep his marriage. No attempt will be made to give every detail of all aspects of the trial therapy of this patient. I will primarily focus on those aspects of the interview to highlight the mechanism involved in the interpretation of the resistance as applies to motivated and responsive patients.

Exploring His Marriage

He met his wife two years prior to marriage and indicated that his relationship with her was fantastic. All his difficulties began around the time of his marriage.

The Day of the Wedding

PT: I was like a cut-off, I was stunned, I was like I was doing something but my heart wasn't there . . . uh, mixed bag of emotions.
TH: Then as soon as you moved to marriage . . . you totally . . .
PT: Uh, I became so nervous the words didn't come out . . I couldn't say my vows, I really don't even know what I was saying . . . I . . . remember the morning of the wedding, I just couldn't relate to anybody . . . probably suppressed feeling that I had all along you know . . . even I felt I wanted to pull out.

PT: Right away, the best that I can describe was that my heart wasn't there, my feeling, emotionally it wasn't . . .
TH: How was sex that night?
PT: I remember being scared that I wouldn't be able to do it, the thought that I would not be able to perform sexually.

PT: Once we got married, we stopped sexually . . . in a sense I stopped . . . which disturbs me as I want to keep the marriage.

In the above passage we see the patient's clarity of communication, the fluidity and clearly his communication is within the context of the triangle of the conflict. He communicates in term of suppressed feeling that he has from the past, in term of anxiety as well as defense. Then he spontaneously talks about his masturbatory activity since the marriage and the therapist moves exploring his masturbation and structure of his fantasies while masturbating. This gives rise to resistance in the transference.

Resistance in the Transference

TH: What was your fantasy during masturbation?
PT: I can't remember, I masturbated with my hand.

Avoiding direct question he becomes detached and passive. As anxiety-laden area is explored, we see immediate mobilization of the resistance in the form of a series of defense, "I can't remember," detachment, passivity.

Handling Resistance in the Transference

TH: How do you feel right now?
PT: As you see, tense . . . anxious. (Patient is clenching his hands on the arms of the chair)
TH: What else do you experience . . . besides anxiety?
PT: I feel frustrated. (Impulse)
TH: Still you keep your hand like that . . .?
PT: I feel very tense.
TH: How do you experience your frustration . . . still you keep your hand like that . . . still you are distancing . . . putting up a wall. (Impulse, anxiety & defense)
PT: Yeah, hmm, I feel like grabbing something. I feel like kicking something.
TH: Uh hmm.
PT: I feel like getting it out . . . it is an energy.
TH: And if you let yourself go in term of thoughts and ideas.
PT: I would just kick . . . I get this energy, this anger out.
TH: Uh hmm.
PT: I can get it out of my system.

Patient can clearly differentiate the three corners of the triangle of conflict and is very much in touch with his feelings which is one of the major features of patients who are motivated and responsive.

PT: And if there was a punching bag here I would hit the punching bag.

The process focuses on the triangle of the conflict in the transference in term of his positive feeling and his wish to protect the therapist against his anger.

T–C Link

Patient becomes sad with some tears in his eyes and gives an account of an incident. He and his wife had dinner at his parents home and his mother, as usual, was doting on him. When they returned home his wife was upset and told him that she could never match his mother in his eyes. He became very angry with his wife and had the impulse to punch her in the mouth. He became withdrawn, detached, and passive and indicated that he was afraid of his anger. The triangle of the conflict in the transference, namely impulse, feeling, anxiety and defense, was interpreted with the further T–C interpretation which involved the interpretation of impulse, feeling, anxiety and defense in relation to his wife. His resistance disappeared and he freely talked about the structure of his masturbatory fantasy which contained an older woman in her thirties, "well-shaped, large breasted, dark hair," different from his wife.

The whole process indicates the total absence of superego resistance, the presence of a healthy ego function; psychological mindedness, motivation for insight, the presence of therapeutic alliance from the very beginning of the interview. Now we take up the interview.

TH: You said that prior to marriage sex was very good with Joanne.
PT: Yeah, was fantastic.
TH: Did you have fantasies of other women?
PT: Yeah.
TH: Then you would fantasize as if you were having sex with the other woman.
PT: Yeah, during intercourse I used to fantasize.
TH: Could you decribe the woman in your . . .
PT: Again the older woman, dark hair, well-shaped.
TH: Different from your wife.
PT: Yeah.

TH: Now how about the wedding night . . . who was the woman in bed that you were attempting to have intercourse with?
PT: Joanne, plus.
TH: Who is the plus?

With no further return of the resistance the process moves to the inter-

pretation of the patient's nuclear conflict which here is an oedipal triangular one.

If we examine the therapist's use of these interventions carefully we may see that: (1) He aims to make conscious (a) the underlying feeling and impulse, (b) the system of defense mechanism against the impulse/feeling, (c) the link between the two. (2) To make conscious the whole set of defense mechanisms and the genetically structured core-neurotic conflict. (3) He hopes that the result will be that the defensive barrier will be penetrated, the impulse becomes conscious, the whole intrapsychic mechanism will be undone and the resistance will be resolved. But now we need to ask the question, why does the intrapsychic mechanism become undone simply because it is made conscious?

The answer is far from simple, but seems to be as follows: First, the underlying unconscious impulse/feeling is striving for expression all the time, and if the therapist speaks of it explicitly he brings it nearer to the surface and renders the defensive mechanism more difficult to maintain. Second, the intrapsychic situation may be highly "ego-dystonic" and once the patient had been acquainted with his defense he had a very considerable motive for giving it up. Third, the therapist is largely relying on the healthy part of the patient to come to the realization (1) that the unconscious feelings and impulses are acceptable, and (2) that defenses against them are counterproductive. The therapist does not actually make these statements himself, though it is true that he implies them very indirectly. Thus in this kind of intervention the therapist is speaking both to the patient's unconscious and to his therapeutic alliance, aiming to mobilize both against his resistance. In the above case the intervention was successful.

This case mainly involved the resistance of repression, but exactly similar considerations apply to the resistance of the superego. For instance the therapist may interpret that the patient, because of his need for punishment, does not wish to be relieved of symptoms which cause him suffering. Here the aim is to make the inner mechanism conscious, to rely on the healthy part of the patient to realize that it is self-destructive, and to mobilize the therapeutic alliance against it.

When the patient comes into the category of those (1) who are highly motivated and responsive, (2) in whom resistance is relatively light and highly ego-dystonic, and (3) in whom the anxiety is no more than moderate —all of which was true of the patient described above—this kind of simple interpretation may be sufficient. But these highly responsive patients represent only a very small proportion of the psychotherapeutic population. In the majority of patients there is severe character and superego pathology, in many of them this pathology is ego-syntonic, and in some of them the underlying anxiety is potentially overwhelming. The result is that the resistance is so strong, and the unconscious therapeutic alliance so absent, that merely attempting to give the patient insight fails to shift the balance between the two. Thus the therapist who confines himself to interpretation is totally helpless against the forces operating against him. He ends up to bow to the forces of superego resistance and interminable interpretation of the resistance with the hope that "The slow demolition of hostile superego"

would be brought about, and in this process the patient's suffering is at stake. But what else can he do? The answer to this question is the theme of the present article.

The Forces Operating Within the Patient

The forces operating against the therapeutic process all come under the heading of resistance, which can consist of the resistance of repression or the resistance of the superego, and can be concerned with feelings about relationships outside or with the transference. Resistance can be defined as the use of defenses in the therapeutic situation. The therapist encounters a series of defenses, many of which are the same as the patient uses in his everyday life, and in the clinical situation the terms "resistance" and "defense" can mostly be used interchangeably. Thus resistance belongs to the upper left hand corner of the triangle of conflict. The motive power for the defenses, or the resistance, comes from impulse, anxiety, guilt, or pain.

For our present purposes it is equally important to state that there is a part of almost all patients which is identified with their defenses and hence with their resistance, i.e., the resistance is ego-syntonic. At the extreme, patients will say that they like themselves, and will imply that they see no reason whatsoever why they should change.

Operating for the therapeutic process is the therapeutic alliance, which is complex and consists of conscious and unconscious components. The conscious component consists of the patient's willingness to cooperate with the therapist, to face the truth however painful, and to try actively to give up his defenses. The unconscious component consists basically of the repressed feelings and impulses—the lower corner of the triangle of conflict—which are pressing for expression and are therefore on the therapist's side. But until the final breakthrough the therapist will encounter the therapeutic alliance in a form modified by the resistance, manifesting itself as more or less disguised communications about any of the three corners of the triangle of conflict, especially the lower corner. These communications point the therapist in the right direction and help him in the process of bringing the underlying feelings to the surface.

The Forces Available to the Therapist

Central to my technique of the unlocking of the unconscious is the observation that the therapist can do far more than simply attempt to make the resistance conscious and then rely on the forces within the patient to come to his aid. On the contrary, he can supply forces of his own which directly weaken the resistance and strengthen the therapeutic alliance. Here his essential intervention consists of challenge, which may be directed against the resistance or toward the therapeutic alliance. In the first, he speaks to the part of the patient that is identified with the resistance, calling in question each defense as it arises, casting doubt on it, and undermining it. In the second he speaks directly to the therapeutic alliance, challenging it to give the resistance up.

Audiovisually recorded data with a large series of patients from our research center demonstrates that these interventions do actually begin to shift the balance between resistance and therapeutic alliance. At a deep level, the patient "hears" the message and takes it in, and begins to turn against his own defenses. The tension within him rises.

However, this is only the beginning of the process, for now the same increase in tension appears between patient and therapist in the form of transference. This is complex and consists of both "negative" and "positive" components. The patient might become increasingly angry at having his defenses challenged; while on the other hand he deeply appreciates what the therapist is trying to do, namely to relieve him of his defenses which has paralyzed his autonomy and function.

In the type of patient with which we are concerned here, both forms of transference give rise to a further increase in resistance: the negative because the patient is afraid of his anger; and the positive because he is afraid of allowing emotional closeness, since in the past this has always resulted in disappointment.

The therapist now employs challenge against both these forms of transference resistance, calling the defenses in question and challenging the therapeutic alliance to give them up. However, it is crucial for him to understand that in this type of patient there is also a third form of transference resistance, namely the resistance of the superego, which expresses itself as the need to defeat the therapeutic process in the interests of self-punishment. The therapist challenges this by speaking of its self-destructiveness in forceful terms to the therapeutic alliance, using an intervention which I refer to as the "head-on collision."

When these interventions are timed correctly there are usually three main consequences. The patient's anger against the therapist reaches the surface and can be experienced directly; there is often intense sadness about self-destructiveness in the past; and the experience of anger frees positive feelings, which may take the form of a warm appreciation of the therapist's sustained determination to help, and a willingness to share the sadness openly with him. These feelings are complex and I have referred to them as "complex transference feelings." The unlocking of complex feeling in the transference has profound effect on the unlocking of patient's whole psychic system. This may be revealed first in the form of major communications from the unconscious therapeutic alliance, which throw light on important aspects of the patient's psychopathology. Now, with the help of some further analysis of resistance, it becomes possible to achieve direct access to the unconscious, so that the patient can experience the buried feelings from the past that have led to his neurosis.

Signs in the Patient

Obviously the therapist must be able to recognize which of these interventions to use at any given moment. This will depend on signs in the patient, which can be verbal or nonverbal:

First of all, the therapist must be familiar with all the different tactical defenses which patients use in the service of resistance. These take a very large variety of forms and at the same time are endlessly repeated from one patient to another. Examples are: vagueness, evasiveness, weepiness, intellectualization, obsessional rumination, defiance.

He must be able to monitor the patient's anxiety, the discharge pattern of anxiety, verbal cues such as facial expression, bodily posture, and respiration, so that he can prevent it from reaching an intolerable level.

He must be able to recognize when transference feelings are becoming a major issue. This might manifest itself from nonverbal cues, such as clenched fists or avoidance of eye contact.

He must be able to recognize signs that the unconscious therapeutic alliance is being mobilized. This comes mainly from verbal communications.

He must be able to recognize and accept genuine feelings as soon as it emerges.

Armed with these abilities, the therapist should be able to respond in each situation with the appropriate intervention. In this way he can operate like a skilled surgeon directing the forces within the patient, entirely in the patient's interest, and above all he can gradually drive the resistance into a corner so as to enable the patient to be freed.

The whole process will now be illustrated by a clinical example. Here I shall choose a patient who has already been presented in detail, the Woman with the Machine Gun (see Davanloo, 1987b). This will inevitably involve some repetition, but the presentation will be from an entirely different point of view.

The Case of the Woman with the Machine Gun

As described in the previous articles, this was a single woman of 30. She suffered from severe disturbances indicating the operation of a highly punitive superego, which included the following: lifelong recurrent depression; inability to fulfill her potential; inability to allow herself close to anyone, especially men; a pattern of allowing herself to be used and abused; inability even to know the meaning of anger; serious self-directed aggression. In other words, her healthy ego functions were largely paralyzed.

The theme of the previous articles was that patients manifesting this kind of depression suffer from a deep-seated inability to distinguish between anger on the one hand, and defenses against it or anxiety aroused by it, on the other. Consequently the therapist must modify his technique in two ways. First, he must use graduated rather than unremitting pressure and challenge to the patient's resistance, taking the pressure off as soon as he detects that he is arousing anxiety beyond a certain level, and only returning to pressure and challenge after the patient has been given time to recover. Failure to observe this rule arouses more anxiety than the patient can bear and results in exacerbating the patient's condition. Second, whenever there is a partial breakthrough of anger, he must drive home cognitive insight over and over again into the link between the impulse and the many defenses that the

patient has been using against it. If he does not do this no permanent effect will be achieved, and the defenses will merely reassert themselves the next time a situation of anger is encountered.

In the present article, however, these aspects will not be emphasized. The themes will be: (1) the paralysis of the patient's ego in everyday life, (2) the way in which this paralysis manifests itself in the form of resistance in the clinical situation, (3) the various forms of intervention used by the therapist against the resistance, and (4) the transformation that occurs when the resistance is finally broken through.

Resistance and Challenge in a Current Relationship (C)

The interview quickly crystallized around a recent incident in which the patient had been severely humiliated by a man named Tony living in the same house. It was evidence for her need for self-punishment that, knowing that Tony had a cruel streak and liked to put people down, she had nevertheless made a sustained effort to seduce him. The result was that he had first led her on and then had ended up by taking refuge in his own room and hiding under the bedclothes. It was obvious that somewhere inside her she must have been very angry about this, and the therapist now embarked on the first phase of what I call the Central Dynamic Sequence, namely pressure toward the avoided feelings. This consisted first of asking the patient to describe what she had felt, and then, when she mentioned a feeling, to describe her actual experience. It quickly became clear (1) that in the actual situation she had completely avoided any experience of anger and had used the defense of withdrawal, and (2) that in the interview this same avoidance appeared in the form of resistance against describing anything other than defenses against her anger.

The interview now proceeded as follows:

TH: And then how did you react to this situation?
PT: I got very remote for a few days. I stopped talking to anybody.

Here the therapist used the only clarification that appeared in the interview for sometime, pointing out the defense:

TH: But how did you feel? "Remote" is a mechanism you use to deal with the feeling at that moment.
PT: Uh yeah, I was hurt, I was very . . .

The patient has now described a feeling, so the therapist asks her to describe her actual experience:

TH: What was the way you experience this hurt?

In response the patient again describes a defense:

PT: By pulling away from the other three people in the house.

The therapist kept up the pressure. The patient described being "humiliated" and "angry," so the therapist asked her to describe her physical experience of anger—since the physical manifestations are likely to be less anxiety-laden than the feelings or impulses themselves. Some of the patient's responses are given below:

PT: There was no physical reaction . . . I was just angry. There was nothing really noticeable. I wasn't that angry, I was humiliated . . . I don't remember having any kind of . . . I did not get the shakes . . . I went to bed, that is how I physically reacted.

The therapist now employs the first challenge:

TH: But that is flight.

The Nature of Challenge

This extremely brief intervention on the part of the therapist contains many of the essential ingredients of challenge and can be used to introduce a discussion of the whole subject:

First of all, we may consider what the therapist might have said at this point if he had decided to give an interpretation. The following is a possibility:

TH: Surely you went to bed to avoid the situation (defense) *because you were afraid* (anxiety) *of your anger* (impulse).

This interpretation completes the triangle of conflict in the area of C. Of course it is absolutely correct, but in my view it would be purely an intellectualization and in the service of resistance. The anger is much too deeply buried, no internal shift would occur, and the patient would hear nothing more than a theoretical statement. The actual intervention differs in the following ways:

(1) It concentrates entirely on the defense;
(2) The word "but" calls the defense in question; and
(3) The word "flight" conveys an attitude toward the defense containing a subtle but unmistakable lack of respect for it.

This leads to an extremely important point: almost all defenses are at least in part "ego-syntonic," i.e., there is a part of the patient that accepts them and identifies with them. At the extreme (which did not apply to this particular patient) they are completely ego-syntonic, and if such patients are asked they will say they regard their defensive system as part of their personality and are entirely satisfied with it. The therapist's attitude of scant respect for defenses is aimed, not at the patient, but at the part of the patient that is identified with her defenses. It aims to challenge her acceptance of her defenses and to mobilize the therapeutic alliance against them—to turn

the patient against her resistance. Finally, we may note that this particular challenge is directed against the resistance of repression rather than that of the superego.

Return to Enquiry

By now it had become clear that the patient was not merely resisting the description of anger, but was incapable of experiencing it. This meant that the modified technique described above must be used, and therefore the therapist took the pressure off for the time being, asking her to describe what happened next.

Again all she could describe was a series of defenses: She said she was "flabbergasted," "embarrassed," and "confused," that she felt "sorry for the jerk," and finally that she resigned herself to accepting that "it was not a big deal." The therapist now returned to pressure and challenge, employing two new types of intervention.

Drawing Attention to Nonverbal Signals

As already mentioned, the therapist is employing a modified technique, in which his interventions are used with caution. Nevertheless, when used, they all have the same aim, namely to shift the balance between resistance and therapeutic alliance, which inevitably means raising the tension within the patient. The therapist draws attention to nonverbal signals by which this increase in tension is being betrayed. Since the patient is trying to keep the tension to a minimum, this clear message that she is failing to do so raises the tension further:

TH: We are looking to your reaction.
PT: Physical reaction was virtually nil. (One of her hands, which was hanging, has changed to a fist.)
TH: You notice you put your fist like that?
PT: Yeah, I know. (She smiles.)
TH: You smile now.

Challenge to the Resistance of the Superego

The therapist has perceived that this patient has a pattern of letting herself be used and abused. In such patients it is essential to challenge the contribution to the resistance made by the superego as well as that made by repression. The therapist does this by repeated use of the word "crippled" —a word which both (1) accurately describes the operation of the superego, and at the same time (2) brings home to the patient the self-destructive effect that her defenses have upon her, and thus (3) aims to turn her against them. Here the therapist is directing his challenge toward the therapeutic alliance and against the resistance of the superego.

TH: Do you notice that you are crippled to declare to yourself how you really feel? . . . Flight is another form of being crippled . . . Either you are not able to assert yourself, and the other person walks all over you, or the other way is to take flight from a situation. So both of them are crippling for a young woman of your age.

However, it became clear that this approach was in danger of arousing too much anxiety, since the patient now withdrew entirely from her former position and completely denied her original statement that she had been angry.

TH: Let's see how you felt. You said you felt angry.
PT: No, I didn't, I didn't.

The therapist therefore reduced the pressure once more, giving her time to recover from the underlying anxiety.

Reducing the Pressure by a Return to Enquiry

The therapist asked what happened subsequently, and the patient gave evidence that her therapeutic alliance was able to respond since she described a second incident with the same characteristics as the first. She had been further humiliated by Tony, who had had sex with her sister Linda in the room next to her room. The therapist returned to pressure on her feelings. Once more she used the word "anger" but when pressed could only describe defenses:

PT: That episode was more humiliating . . . That is the worse I've ever experienced. Then I experienced the anger . . . I don't know if it was anxiety, but I didn't sleep . . . I was ruminating, thinking about what was happening . . .
TH: What was your reaction?
PT: Uhh, aside from the lack of sleep I was, uhh . . . I gotta think back because I . . . I haven't blanked it out, otherwise I wouldn't remember any of it, but I . . .

Return to Challenge to the Defenses in the Area of C

The therapist senses that the patient can now withstand further challenge, and he therefore mounts a sustained challenge on both the resistance of repression and that of the superego:

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

The words "Do you notice"? are very carefully chosen both to speak to the therapeutic alliance and to convey, in a striking way, a lack of respect for the resistance of repression and the part of the patient that is identified with it.

The therapist continues with challenge on superego resistance.

TH: In a sense you are almost crippled here to tell me how you really felt.

The therapist knows that his repeated challenge will have activated powerful transference feelings, which in turn will have intensified the resistance. The words "here" and "tell me" draw attention to the here-and-now and prepare the way for challenging this new aspect of resistance. For emphasis the therapist repeats the word "here" in the following passage:

PT: Yeah, but to say how I feel. You see if I say I'm angry . . .
TH: But you are crippled almost, here, here . . . A woman at the age of 30 so paralyzed to talk about her emotions and feelings . . . You are almost crippled here.
PT: Yes.

Challenge and Pressure Directed at the Resistance as well as Toward the Therapeutic Alliance

The therapist now begins to try and activate the therapeutic alliance by challenging it directly:

TH: Yes is not enough. Let's see what you are going to do about it.
PT: But I don't know why.

The therapist immediately blocks any tendency toward intellectualization:

TH: Here right now we are not looking at why you are crippled. We are looking that you are crippled, that you are paralyzed. First we have to identify that you are crippled and paralyzed.
PT: Okay (softly).
TH: Then we have to see what you are going to do about it.

The therapist now turns his attention to activating the underlying feeling:

TH: You must have a lot of feeling about such a disastrous situation . . . toward Tony, who humiliates you in that way. And also Linda who is humiliating you, hmm?
PT: Yeah.
TH: But "yeah" is not enough. Let us see how you really feel.

The patient prevaricates:

PT: How I felt then or how I feel now towards them?
TH: Then or now, because obviously these are the ulcers of your life.

These striking words are chosen to challenge the ego-syntonic aspects of the patient's defenses and to begin to make them ego-dystonic.

Challenge to the Resistance in the Transference

Throughout all this the therapist has been carefully watching the patient's nonverbal responses, monitoring both the level of anxiety and the activation of underlying feeling. All the indications are both that anxiety is at a tolerable level and that feelings are much nearer to the surface. Therefore the therapist turns his attention to the resistance in the transference.

He opens with a challenge to the resistance of the superego in the transference:

TH: What I'm bringing to your attention is that even when you want to talk about it you are taking a paralyzed, crippled position with me.
PT: Because I'm not accustomed to telling people how I really feel.

This response betrays another crucially important component of transference resistance, namely refusal to allow emotional closeness. The fact that the patient actively communicates this aspect of her resistance, thus giving the therapist the opportunity to challenge it, indicates that her unconscious therapeutic alliance is beginning to be mobilized:

TH: And you prefer to call me "people" rather than me. Do you notice that? . . . In a sense you say, "I don't want to share with you or let you—that is me—to get close to my intimate thoughts and my intimate feelings."
PT: Yes it is, yes it is, it is what I'm saying.

Thus the patient has said almost explicitly that she is identified with this defense, which is essential to challenge:

TH: . . . Then a major problem is between you and me.

The therapist now continues to challenge and pressure the patient's unwillingness to allow emotional closeness. In response the patient becomes argumentative and slightly defiant, thus once more revealing that she is identified with this defense, and—even more important—that her feeling of anger in the transference is coming nearer to the surface:

TH: I'll tell you why it is a major obstacle . . . And I have a feeling that you have a major problem with intimacy and closeness.
PT: Well I don't know how I am supposed to correct it.
TH: We should identify it. Is it or isn't it?
PT: Yes.
TH: You are putting a wall?
PT: Yes, But I'm not putting one, it's already there. It's there when I walked in.

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

The patient continued argumentative and the therapist now took this as his cue to introduce the most powerful of all his interventions.

The Head-On Collision with the Resistance

In this intervention the therapist mounts a concerted challenge and pressure on two aspects of resistance, essentially in the transference: (1) the patient's identification with it, and (2) the part that is maintained by the superego. The aim is to call in question, in the strongest possible terms, the patient's self-destructiveness—a feature of her pathology which permeates her life and is now manifesting itself in the therapeutic situation. In the following passage the therapist's remarks have been highly condensed:

TH: Let's look at it. You and I are here together. The aim is that you and I can establish the nature of your difficulties and problems that are paralyzing your life. So when the wall comes up between you and me we will not be able to understand the nature of your difficulties, the engine of all your problems.
PT: But I don't even . . .
TH: Then this process is doomed to fail. Then I would become useless to you. At some point today we depart from each other. I say, okay, I did my best to get to understand this woman's difficulties . . . in life but then I failed. I can afford to fail because I cannot always be successful, but can you walk from this office and perpetuate your paralyzed life? Can you?
PT: I didn't expect to walk out of here cured today. I don't know what to say.
TH: But do you see what I mean?
PT: Yes, I . . . I . . .
TH: Right now we see there is a self-sabotaging pattern in you.
PT: Of course there's a wall there. If there wasn't . . .

The therapist makes a challenge directed toward the therapeutic alliance:

TH: Yeah, but first is what are we going to do about this wall?
PT: Today I don't know, besides identify the fact that it is there.
TH: Yeah, but you see again you want to postpone it, which is another form of flight.
PT: No, I think it's called being realistic.

Her voice rose as she said this, so that again there was clear evidence of an increase in transference. The therapist takes up the underlying implication, which of course she had not stated explicitly:

TH: Now what you say is that I am unrealistic. Is it that?

The patient gives nonverbal clues to her avoidance of negative transference feelings, which the therapist immediately challenges:

TH: You see again you don't want to look to my eyes and say I am unrealistic.
PT: I don't know what you want from this. What I want . . .

The therapist again directs a challenge toward the therapeutic alliance and against the resistance of the superego:

TH: Now you see again you use "what I want from this." We are here to get you out of this crippled life.

Now the patient says explicitly that it is a crippled life, thus forcing her to confront the incongruity of her situation and undermining her identification with it:

TH: Of course you are the one to decide, is it a crippled life or isn't it?
PT: Yes, it is.

He now seeks to activate the feelings that all patients must experience if they realize the true extent of their self-destructiveness, namely grief and remorse:

TH: And it is sad that a woman of your age is running a life which is so paralyzed.

Suddenly nonverbal clues make clear that her resistance is not impenetrable, that this intervention has struck home, and at the same time that she is trying to avoid revealing this. The therapist draws attention to both aspects:

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

The patient is very close to her feelings:

PT: I don't like to cry (spoken softly).
TH: How do you feel when you look at my eyes? (The patient is sniffing.) . . . *because you are avoiding me in a sense.*
PT: I know I am.

The therapist challenges the ego-syntonic aspect of this part of her resistance and at the same time makes the anxiety explicit:

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

PT: Yes.

The therapist now concentrated on challenging the patient's avoidance of eye contact.

TH: Again your eyes are not with me.
PT: I know. (She smiles.)
TH: A smile, hmm. (She laughs.) *A cover-up. You know, I feel you are a woman of facade.*
PT: I'm very good at that.

The clearly expressed ego-syntonic aspect of this is immediately challenged;

TH: Yeah, but when you say you are very good at that, that is the ulcer of your life.

This intervention heralded a period of systematic challenge and pressure to the transference resistance, with special reference to the head-on collision with the resistance of the superego. This will only be summarized because it consisted largely of a repetition of themes that have already been described:

TH: . . . there is a need in you to sabotage . . . you set a goal for yourself and you defeat that goal . . . then we depart from each other and this process would be a failure, like your life . . . If this process is defeated then you might go and carry a crippled life to your grave . . . why should you do that?

This systematic challenge continued for sometime. There was now a difference from before, namely that anxiety did not rise to intolerable levels and the therapist was able to sustain his challenge without interruption. Eventually she was able to acknowledge that she was angry with him. He reminded her of the incident with Tony in which she had said that she was angry, but in fact all that she had experienced had been first anxiety and then detachment, and she had ended up by self-directed aggression, banging her hands against the wall and severely bruising them.

Breakthrough of the Impulse in the Transference

Suddenly the first breakthrough occurred. The patient raised her voice and said, "This is different."

TH: In what way is it different?
PT: (With raised voice) *I am telling you that I am angry.*
TH: If you put it out in terms of thoughts and ideas, what would you want to do to me?

(The patient raises both her clenched hands at the therapist. Her voice is loud.)
PT: I would grab your lapels and shake you badly.

In this passage it was quite clear that she was truly in touch with her anger, and this was entirely confirmed when she revealed a major difference from the previous incident with Tony: "With you my head is very clear, but with him I was very confused."

In the rest of this first part of the trial therapy the most important type of intervention by the therapist was to drive home insight into the variety of defense mechanisms that she used against anger, and the distinction between anger and anxiety. As described above, this is essential in order to prevent the defenses from reasserting themselves automatically the next time anger is aroused in her.

All the evidence now suggested that her defensive system has been "restructured," and that when she returned for a second part of the trial therapy unremitting pressure and challenge could be safely used.

Second Part of the Trial Therapy: Unremitting Pressure and Challenge to the Resistance

The patient returned in a state of renewed and apparently impenetrable resistance. The therapist mounted challenge and pressure on this. The following are examples of the challenges used:

TH: You are looking at the carpet or the wall, avoiding my eyes and maintaining a paralyzed, detached, remote position. Why do you want to do that?
(Challenging the patient's transference defenses, speaking to the therapeutic alliance).
TH: Let's see how you experience the rage. (Pressure toward the avoided feeling.)
PT: . . . I'm not experiencing it. I don't know how to get rid of it.
TH: But still you are ruminating on helplessness. (More lack of respect for the defenses.)

PT: I'm not saying there is no anger. (Some shift, but the indirect speech and double negative completely eliminate any true feeling.)
TH: There is anger in you. We know that but we don't know how you experience it. And look to your hand again.
PT: I'm pushing it down. I'm pushing it back, I'm pushing it so far back.
TH: . . . You are taking a defiant, crippled position with me. (The juxtaposition of "defiant" and "crippled" is aimed to make her defiance ego-dystonic.) *. . . You are taking a defiant position, . . . and defiancy is another part of this wall. The paralyzed, crippled, woman, and becoming retarded. Now, you see, totally paralyzed.*

Gradually the transference feelings come nearer to the surface, as the patient raises her voice:

TH: How do you experience this rage here with me, if you look into my eyes?
PT: I'm not! I don't know how! I don't know how to describe it!

As the feelings came nearer to the surface the patient described manifestations of tension in her voluntary muscles. "I get tight in the jaw and the throat . . . I stop sweating."

Finally the feelings broke through:

TH: If you put it out, how would this rage be like?
PT: I, I, I'm yelling. I'm moving my, my arms, slashing around . . . (With a loud voice) *This is it! This is it! This is what it is!*
TH: Are you angry right now?
PT: Yes I am. (Very firm and loud voice.)
TH: What else?
PT: I stop sweating . . . Shouting . . . Ah, clarity up here. (Referring to her head.)

There was then a further period of consolidation in which the therapist drove home insight into her former defense mechanisms. During this it emerged that there had been a previous occasion in her teens when she had expressed anger—against her brother—by bruising her hands. The therapist made links between her mechanisms for dealing with anger in the three situations, transference, current, and past (a TCP interpretation). The patient said, "I always thought that was the anger."

The therapist now brought out that, side by side with her anger with him, there was a wish to protect him. Then, suddenly, the unconscious therapeutic alliance produced a crucial communication: "If it all comes out, God knows what I'll do."

The therapist seized upon this, pressing her to say what she would be like if she became violent.

PT: Yeah, yeah, very, very, umm, cold, ah . . .

Suddenly there emerged the most important moment in the interview so far, pointing the exceedingly striking contrast from what had gone before—for now, instead of finding some new way of avoiding the issue of her feelings, she insisted on seeing her fantasy through:

The Unlocking of the Unconscious

PT: No, no, let me talk this through, umm, if I, if I'm very violent, cold and unfeeling, umm, umm, very efficient in the violence . . .

Deeply involved, she now proceeded to unfold a fantasy of buying a machine gun, learning how to use it, and murdering her mother. As she spoke of it she became intensely sad, crying, with waves of very painful feeling, her inner turmoil revealed by the expression on her face. When she had been taken through every detail of the murder of her mother, the therapist made the link with her lifelong paralysis, the punishment constantly inflicted on her by her punitive superego. The patient's response revealed her deep understanding of this:

TH: Because your life is like the life of a murderer if you look at it.
PT: I'm in hiding . . . I've been hiding for all these years.

The therapist now knew that she had the strength to face the whole of her unconscious, and he went on, relentlessly, to take her through the murder of almost all the important people in her life—her father, her sister, her brother, and finally the man Tony whose humiliating behavior had precipitated her recent depression.

Afterwards, very sad she spoke of some of her feelings about what had happened:

PT: I'm physically very weak, and surprised too. I wasn't expecting thoughts like that to come into my mind . . . There is the feeling that although this is frightening it is vitally important. And that tempers the anger with you. That is constructive. You are like a catalyst. And that is good. That's what I badly need. There is a feeling of confidence. There is a realization of being able to remember things and talk about them that I didn't even know were there. And nobody dropped dead.

TH: How do you feel right now?
PT: Relieved and shaky.

It was now possible to take her through the history of her past, which so far had hardly been mentioned, and to discover the situations and relationships which had led to her neurosis. It emerged that in the very early years of her life she had a close relationship with her parents. Then her brother was born and became the favorite of their father and shortly after that a sister was born who again became the favorite of both parents. She had totally lost her place. She developed a very close relationship with her paternal grandmother who became like her substitute mother. The family moved to another country for sometime when she was in her teens which separated her from her grandmother and resulted in her first major depression. When she was in her adolescence the family again moved for awhile to another country which again separated her. This brought about her second major depression. It is interesting to note that for a few weeks after trial therapy she went through hallucination of the smell of dishes that her grandmother used to cook for her and she even searched for the recipes so that she could recapture some of the good experiences of her childhood.

Discussion

The second interview illustrates the technique of unlocking of the unconscious and the systematic erosion of resistance in a highly self-destructive patient. It is worth while reviewing the whole process once again.

From the moment when the therapist began to press her for her feelings about the incident with Tony, until the first breakthrough of her anger in the transference many pages of transcript later, the patient showed virtually nothing but resistance, much of which was ego-syntonic. The therapist, entirely in the patient's interests, activated the forces within her by means of the following sequence of interventions:

(1) Challenging the resistance of repression in the area of C: e.g. "But that is flight," which calls the defense in question and casts doubt on it by treating it with studied disrespect.

(2) Drawing attention to nonverbal clues which betray her denial of feelings in the area of C: PT: "Physical reaction was virtually nil." TH: "You notice you put your fist like that"? This clearly threatens to activate the patient's anger and thus increase the tension.

(3) Speaking to the therapeutic alliance with the words "do you notice . . ."?, attempting to mobilize it against the resistance of the superego, ". . . that you are crippled to declare how you really feel"? "You are almost crippled here to tell me how you really feel."

(4) Further calling in question the resistance of the superego: "A woman at the age of 30 so paralyzed to talk about her emotions and feelings."

(5) Directing challenge and pressure toward the therapeutic alliance and against the resistance of the superego: "Let's see what you are going to do about it."

(6) Using striking language to mount challenge on the patient's identification with her own defenses: "Obviously these are the ulcers of your life."

(7) Challenging the resistance against allowing emotional closeness in the transference: "You don't want to let me get close to your intimate thoughts and feelings."

(8) Challenging the patient's identification with her resistance against emotional closeness: "Then this is a major problem between you and me."

(9) The head-on collision with the resistance of the superego in the transference, speaking directly to the therapeutic alliance: "When the wall comes up between you and me . . . this process is doomed to fail. There is a self-sabotaging pattern in you."

(10) Challenging the nonverbal signs of resistance against negative transference feelings: "You don't want to look into my eyes and say I am unrealistic."

(11) Activating the underlying grief about her own self-destructiveness: "It is sad that a woman of your age is running a life which is so paralyzed."

(12) As signs begin to appear that this grief is in fact coming to the surface, the therapist challenges the nonverbal signs of resistance against sharing it with him: "Do you notice that you have tears in your eyes and you avoid my eyes"?

(13) Return to the head-on collision with the resistance of the superego: "There is a need in you to sabotage. If this process is defeated then you might carry your crippled life to your grave."

(14) As the patient admits that she is angry with him, the therapist emphasizes her former mechanisms for avoiding anger: first she experienced anxiety, then detachment, and then she ended up by self-directed aggression.

(15) This leads to the first breakthrough of anger in the transference: "I would grab your lapels and shake you badly."

(16) The therapist ends the first part of the trial therapy by once more driving home insight into her mechanisms for avoiding anger.

(17) In the second part of trial therapy she returns in a state of resistance. The therapist mounts challenge and pressure on her defenses against negative feelings in the transference, first drawing attention to nonverbal signals of resistance and treating the defenses with studied disrespect: "You are avoiding my eyes and maintaining a paralyzed, detached, remote position."

(18) Challenge directed toward the therapeutic alliance: "Why do you want to do that"?

(19) Activating the underlying negative transference: "Let's see how you experience the rage."

(20) Further challenge to the defenses: "You are ruminating on helplessness."

(21) Drawing attention to nonverbal signs of anger: "There is anger in you. And look to your hand again."

(22) Challenging the patient's identification with her resistance, making it ego-dystonic: PT: "I'm pushing it so far down." TH: "You are taking a defiant, crippled position with me."

(23) At last the breakthrough into direct experience of anger in the transference, with the accompanying signs of reduction in anxiety: "I'm yelling. This is it! I stop sweating. I'm shouting. Ah, clarity up here."

(24) Further consolidation of insight into her defense mechanisms, followed by the description of an incident of self-directed aggression in her teens, and a TCP interpretation of defense and impulse.

(25) Bringing out positive transference feelings—the wish to protect him from the worst of her anger.

(26) There is now a major mobilization of the unconscious therapeutic alliance, with a clear message about the violence of her feelings: "If it all comes out, God knows what I'll do."

(27) The unlocking of the unconscious. The final breakthrough into her unconscious murderous feelings, first against her mother and then against almost everyone who had been close to her.

(28) The direct view of the multifoci core neurotic structure.

In her life outside this patient had been largely paralyzed. She suffered

from the following: lifelong recurrent major depression, inability to fulfill her potential, inability to allow anyone close to her, inability to form any kind of relation with a man (and when she did try she picked a cruel man who deliberately humiliated her), inability even to know the meaning of anger, serious self-directed aggression. In the interview there was a similar paralysis: As soon as the therapist started exerting pressure toward her feelings almost all that could be observed was resistance, much of which was ego-syntonic. And yet, after the systematic work described above on the forces within her, there was a major mobilization of the therapeutic alliance and a major breakthrough into the repressed unconscious. Here the crucial observation was that—as with all patients when a major breakthrough is achieved—there was no trace of a return of the resistance from then on.

With these highly self-destructive patients, it is as if the ego is driven against the wall, cornered, and paralyzed. If the therapist does not know how to deal with this and takes a passive waiting role for "slow demolition of superego resistance," he will be cornered and paralyzed by the superego resistance, along with the patient. But there are weapons at hand, and if he knows how to use them he can systematically gain the upper hand and end by driving the resistance into a corner and paralyzing it in its turn. Then, in an instant, the whole psychic system becomes available, the ego recovers its normal powers, and the patient herself can enter the world of freedom.

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Overview: Trial Therapy in Intensive Short-Term Dynamic Psychotherapy

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This article briefly summarizes Davanloo's technique of trial therapy model of initial interview and its application to the whole spectrum of structural neurosis. The major function of trial therapy is elaborated in terms of psychodiagnostic, psychotherapeutic function as well as teaching, supervision, and clinical research.

Introduction

With the discovery of the technique of the "unlocking of the unconscious" by Davanloo, direct view of the unconscious and multifoci core neurotic structure has been made available to both therapist and patient. This is considered a revolutionary development in dynamic psychiatry and has been able to confirm many aspects of psychoanalytic theories and has revised other aspects of psychoanalytic concepts.

The major goal of this article is to present a general overview of Davanloo's system of Intensive Short-Term Dynamic Psychotherapy. What is presented here is from his seminars at the Center for Teaching and Research of Short-Term Dynamic Psychotherapy of the Montreal General Hospital as well as his presentation at the Immersion courses of the International Institute for Teaching and Research for Short-Term Dynamic Psychotherapy.

Trial Therapy Model of Initial Interview

Since learning the technique of the trial therapy and the technique of the "unlocking of the unconscious" is central to Dr. Davanloo's system of Intensive Short-Term Dynamic Psychotherapy, I would like to review some of the major aspects of his presentations.

Major Function of the Trial Therapy

The major functions of Davanloo's system of trial therapy can be summarized as follows:

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