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Intensive Short-Term Dynamic Psychotherapy Major Unlocking of the Unconscious — Part II. The Course of the Trial Therapy After Partial Unlocking

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In this two-part article the author presents his technique of partial and major unlocking of the unconscious in the trial therapy. The partial unlocking was described in Part I. In this Part II, the central dynamic sequence for the major unlocking of the unconscious is described by complete account of the interview which was used as an example in Part I.

Recaptulation

In Part I of the present article I described the phases of the central dynamic sequence in the partial, major and extended major unlocking of the unconscious. Here, I will describe the dynamic sequence in major unlocking, which can be summarized as follows:

* Inquiry, exploring the patient's difficulties; initial ability to respond.
* Pressure, leading to resistance in the form of a series of defenses; challenge to the defenses leading to a rise in transference and increased resistance; rapid identification of the patient's character defenses.
* Challenge to resistance and making the patient acquainted with the defenses that have paralyzed his functioning and turning the patient against his resistance; crystallization of the character resistance in the transference; rise in the transference and mobilization of the therapeutic alliance.
* Transference resistance; mounting the challenge to the transference resistance with special emphasis on head-on collision with transference resistance to bring the patient face to face with the self-destructiveness of his resistance, and

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to intensify the rise in the transference feeling; mobilization of the therapeutic alliance against the resistance; to loosen the patient's psychic system to make the unlocking possible.

* Direct access to the unconscious; interlocking chain of head-on collision with the character defenses crystallized in the transference; systematic weakening of the major resistance of repression and all the tactical defenses entrenched in the major resistance; a high rise in the transference feelings; high mobilization of the unconscious therapeutic alliance; direct experience of the transference feelings; major unlocking with the passage of murderous rage in the transference, emergence of sadness; passage of the guilt-laden unconscious feelings and grief-laden feelings; the unconscious transfers the murdered body of the therapist to the genetic figure; and a direct view of the psychopathological dynamic forces responsible for the patient's symptoms and character disturbances.
* Systematic analysis of the transference.
* Dynamic exploration into the unconscious; consolidation; recapitulation, and psychotherapeutic planning.

I indicated that these phases tend to overlap and proceed in a spiral rather than in a straight line.

Case of the Strangler

In Part I, I analyzed the process of the early phase of the trial therapy of a man in his forties which can be summarized as follows:

(1) The interview started with the phase of inquiry, which was not possible. Then the therapist introduced pressure to the resistance of vague generalization, asking the patient for a specific example, to which the patient responded "it is difficult." There was further pressure, which mobilized some rise in the transference feelings and anxiety in the transference. Then the therapist introduced further pressure by focusing on his feelings, which led to resistance in the form of a number of tactical defenses. Then process entered into:
(2) Challenge to the resistance, which now has acquired a tranference quality. Patient was systematically acquainted with his character defenses.
(3) Psychodiagnostically, the therapist had come to the conclusion that the patient suffered from character neurosis, is highly resistant, and that rapid breakthrough into the unconscious was the procedure of choice.
(4) On the basis of this, the therapist moved to a systematic challenge to the patient's character defenses with further crystallization of the character resistance in the transference and a further rise in the transference feelings. Then the process moved to the phase of tranference resistance. Then:
(5) He applied his most powerful technique of interlocking chain of head-on collision with the aim: to mount a direct challenge to all the forces maintaining self-destructiveness; to intensify the rise in the transference; to loosen up the patient's psychic system in such a way to make the unconscious more accessible; to mobilize the therapeutic alliance against the resistance; to create an intrapsychic crisis, which is a state of high tension between resistance and therapeutic alliance in the transference.
(6) Partial unlocking of the unconscious with the passage of major waves of painful feelings and there was direct access to the center of the very early trauma, namely being abandoned by both parents at the age of one. Then the dynamic sequence moved to:
(7) The phase of analysis of the transference, and then:
(8) The therapist returned to the phase of inquiry into the patient's disturbances, to which the patient was highly responsive. The inquiry indicated that he

suffered from diffuse symptoms and character disturbances. He has suffered from life-long psychoneurotic disturbances, chronic anxiety, episodes of clinical depression, major disturbances in interpersonal relationships, somatization, pain in his neck, some functional disorders, major marital problems, characterological problems and masochistic character traits.

Further Exploration into the Marriage

In exploring his marriage, the patient indicated that he makes love with his wife only when she puts pressure on him, and spontaneously said that he has to bring the mental image of another woman. In recent years he brings the mental image of a woman named Linda.

At this point of the interview, the patient is highly responsive and highly collaborative and the unconscious therapeutic alliance is clearly in command of the process., The long passage of major waves of painful feelings has come to an end but still he is sad. The therapist knows that the resistance that so far has been the focus is not all of the story in a man who has been so badly abandoned in the very early phase of his life, and that the major resistance, which consists of the powerful defense mechanism of repression, must be in operation.

Search for the Resistance

For the time being the therapist continues the dynamic exploration and follows the lead of the unconscious therapeutic alliance, asking the patient to describe the body of Linda while monitoring the patient's unconscious responses. In exploring the body of Linda there is mounting anxiety and mobilization of resistance.

In Part II I will attempt to analyze the rest of this initial interview. We return to the interview where we had left it at the end of Part I.

Return of the Resistance

The therapist is putting pressure on the patient to describe the body of Linda, and he finally says that she has blue eyes and small breasts.

TH: How about the rest of the body?
PT: Her eyes are blue.
TH: How about the rest of the body now?
PT: The rest of the body. Broad shoulders, uhh she's strong.

As we see, resistance is being mobilized. He uses the tactical defense of cover words "broad shoulders," "she's strong."

Challenge to the Resistance

TH: Do you notice, again, now that we want to focus on the body of Linda, now you are becoming detached and withdrawn, and erecting a wall?
PT: Hm hmm.

Head-on Collision with the Resistance

The therapist progressively escalates the degree of challenge and brings about a head-on collision with the transference resistance, trying to mobilize the unconscious therapeutic alliance against the resistance. In the following passage, he introduces a composite form of head-on-collision.

* Puts pressure to the resistance: "Hm hmm is not enough;"
* Challenges the resistance against emotional closeness in the transference;
* Emphasizing the consequences of the resistance in the transference:
* Pressure, emphasizing the patient's will;
* Challenging the self-defeating, self-sabotaging, self-destructive aspect of the resistance in the transference, the masochistic component of his character;
* Challenge to the defiance;
* Keeping the responsibility with the patient;
* Further pressure to unconscious therapeutic alliance.

TH: "Hm hmm" is not enough. If you want to go that way then the barrier and the wall is here with me. In a sense you don't want me to get to your intimate thoughts and feeling; and if you what to do that then this would be a crippled, paralyzed process.

PT: No I don't want.

TH: Then let's to see what you are going to do about this first. Because from the beginning I have told you that if you want to censor yourself, if you want to erect a wall between yourself and me, this process is doomed to fail and you'll carry a crippled life to your grave. Now you have a right to do that if you want to do that. If you want to keep your paralyzed life, after all that is your life and you have the right to do that. But the question in why you want to do that?

PT: No I don't want to do that. (very low voice)

As we see, in spite of the patient's declaration "No I don't want to do that" with a very low voice, the balance between resistance and the therapeutic alliance is in the direction of increasing resistance. The therapist is well aware of this and moves to further crystallization and intensification of the resistance in the transference. He asks the patient to compare the body of Linda with that of his wife.

TH: If you compare her breasts with your wife's breasts what would be the difference?

PT: I've never seen her breasts.

TH: In terms of thought I mean, a picturing. If you compare hmm.

PT: Her breasts are small.

TH: Hmm?

PT: Her breasts are small.

TH: The breasts of Linda are small. And your wife's breasts?

PT: Are large.

TH: Large. So compared would be small breasts vis-à-vis *large breasts.*

PT: And my wife is very heavy and Linda is slim.

TH: Heavy where?

PT: Big, she's . . .

Then the patient says "my wife is fat"—but Linda is very slim and athletic. Linda has blond hair, small breasts and the pubic hair is dark. The therapist questions about the rest of the body, but he says that he cannot remember and he cannot describe the rest of her body.

TH: What else you could say about the body of Linda?
PT: Ohh . . . ohhh.

Escalating the Degree of Challenge

TH: We have again a paralyzed . . . do you notice again your memory collapses?
PT: Yes.
TH: Yes what!
PT: Yes it collapses, I don't remember it.
TH: I mean you say you are an engineer.
PT: Yes.
TH: As an engineer you have a problem with your memory?
PT: No.
TH: Then how come here your memory with me immediately collapses? Do you notice the position here?
PT: Hm hmm.
TH: What "hm hmm?"
PT: I feel . . .

In some patients, "I don't remember" can be a tactical defense, but in this patient this defense is well entrenched with the major resistance. In the following passage the therapist mounts the challenge to the resistance, which results in a rise in the transference, rise in anxiety and further crystallization of resistance in the transference. The important task is that every character defense which is mobilized rapidly be identified and challenged with the aim of further intensification of the rise in the transference. By doing so, the process rapidly moves to the major resistance in the transference, which the therapist is looking forward to. We return to the interview.

TH: Holding your hand like that. Do you notice?
PT: Yes I notice.
TH: But admitting that you are paralyzed doesn't help us. Look at it. My question was, was there any other woman besides Linda? but now you move towards the collapse of your memory.
(Pause)
TH: So you have a need to actively censor yourself. And nodding your head is not enough.
PT: I don't feel that.
TH: You see your rumination "I don't feel that." You are actively doing it and then at the same time actively denying that you do it. That is the portait of the paralyzed man.
PT: Hmm.
TH: But nodding your head is not good enough. So let's to see what you are going to do about this need in you to censor yourself and take a crippled position. Your

hand again is like that, eyes closed, half opened. (Pause) *And the paralyzed crippled position you take.*

PT: That's exactly the . . .

TH: But that is not good enough.

PT: It's very frustrating.

It is important to note that during this process the therapist must monitor and address the nonverbal signals, such as clenching of the hands, the rate of deep sighing respiration and so forth. They are the indicators for the rise in the transference and rise in unconscious anxiety in the form of tension in the striated muscles; a rise in the transference feelings and the direct experience of the transference feelings is the goal toward which the therapist is working.

The patient has declared frustration. Frustration is a tactical defense against anger and, in many patients, anger by itself, can be a tactical defense against rage, and the rage can be a tactical defense against murderous feelings. It is important to note that the patient declares "I feel frustration." Here we see another tactical defense, the fact is that the patient is bypassing the transference "well, I'm frustrated." This again is a form of tactical defense that is well entrenched with the major resistance. Technically, the therapist must maintain a systematic challenge to this tactical defense and consider it as part of the major resistance. In the following passage the therapist maintains systematic challenge and pressure to the resistance.

TH: You mean it is frustrating here with me?

PT: Yeah you're aah . . .

TH: You are frustrated here with me?

PT: I don't know what to think.

TH: No you are not answering the question, I say is this . . .

PT: I feel frustration.

TH: You feel frustrated with me. Is this what you say?

PT: I feel frustrated, that's what I'm saying.

TH: You feel frustrated at who? Again you are crippled, to say you are frustrated . . . is a cut-off sentence. "I feel frustrated" is a cut-off sentence. Frustrated at who?

PT: I'm . . .

TH: Again you're crippled, frustrated at who? Your hand again.

PT: I'm frustrated.

TH: Frustrated at who; First let's to establish at who are you frustrated. Now your head goes there, your hand goes there . . .

PT: (makes growling sound) *Orrrrrh . . .*

TH: . . . and then you move toward this crippled position. Frustrated at who? You said you are frustrated, frustrated at who?

PT: Do I have to be frustrated at someone?

TH: Again you ruminate.

PT: Well I'm frustrated!

TH: Yeah but frustrated at who?

PT: I'm just frustrated, I'm not frustrated . . .

TH: At who are you frustrated?

Now, he moves to the defense mechanism of denial and negation and says "I am not frustrated at anybody."

PT: *I'm not frustrated at anybody.*

TH: *Again you take a crippled position, cut-off position. You see a cut-off position is exactly like Linda, has a head and hair but the rest of the body is cut-off.*
(Pause)
Do you notice how crippled you are? You say you are frustrated, but at the same time you don't want to really spell out at whom you are frustrated. Look to your hand. Now you are fidgeting.

PT: *Hm hmm.*

TH: *'Hm hmm'.*

PT: (laughs)

TH: *Admitting you are crippled is not going to solve anything . . . Now you are avoiding my eyes.*

PT: *I...*

TH: *At who are you frustrated? Let's first establish that. You have a tendency to flight, you have a tendency to run away from any issues.*

PT: *Yes.*

In the following passage there is head-on collision with the defiance, deactivation of the transference, and emphasizing the consequences of maintaining the resistance in the transference.

TH: *You have done it 46 years of your life, and if you want to do it you can do it and go to your grave.*

Often, tactical defenses are strategic satellite defenses and are different from so-called major defenses. But our research data indicates that tactical defenses can be well entrenched with the major resistance and should be considered as such. As we see, the process is still a systematic challenge to this defense "Do I have to be frustrated at someone," which is totally avoiding the transference. The challenge in the above passage has further intensified the rise in the transference, and the therapist monitors it via unconscious anxiety in the form of tension in the striated muscles. He has deep, sighing respiration, the rate of which has increased and which clearly indicates to the therapist that the rise in the transference feelings is in the upward position. It should be emphasized that it would be a major mistake for the therapist to explore the patient's feelings. That is what the resistant part of the patient would like. The therapist well knows that the nature and the degree of the resistance and the complexity of the psychopathology are extremely different from those of the Case of the Salesman, or of any other patient who is placed on the extreme left of the spectrum of psychoneurotic disorders. We return to the interview where we had left it.

PT: *No I don't want to do it.*

TH: *So let's to see at whom you are frustrated.*
(Pause)
Again you are terrified at looking at my eyes and declaring.

PT: (deep sigh)

TH: *Again your sigh. Do you notice your hand? You are totally crippled to look at my eyes and tell me at who you are frustrated. Because frustration refers to something negative huh?*
PT: *Yes.*
TH: *But you are paralyzed to look to my eyes . . . Let's establish at who are you frustrated?*
PT: (mumbles)
TH: *And we know your father died in your life in the very early years and your mother died in your life in the very early years, and you want to relate to me as if I am dead as well.*
(Pause)
Now let's to see at who you are frustrated. Now your hand is like this.
PT: (laughs) *Is there no place to put my hand? I'm frustrated, frustrated.*
TH: *Hm hmm. But you are paralyzed to declare at who you are frustrated.*
PT: *Yes that's right.*

Finally, in the following passage he declares "I am frustrated at you."

TH: *That is right is not enough. Admitting you are crippled doesn't help. And that is another part of you; you resort to the crippled, paralyzed position. Because you are totally crippled to declare where the direction of the frustration is. In a sense you don't want to declare that I am a part of this system. That is why I say you want to dismiss me.*
PT: *Hmm.*
TH: *'Hm hmm' and repeatedly another part of you is admitting to a crippled position. Do you notice that in a sense you don't want to involve me in this process. "I am frustrated."*
PT: *I'm frustrated at you.*

The question that we might raise, why such a defense "Do I have to be frustrated at someone" should require this degree of challenge and pressure? As I have already indicated, such a tactical defense is well entrenched with the major resistance, which is the resistance against the experience of the unconscious murderous rage and guilt. It is equally important to note that when such a resistance is timely identified, challenged, pressured and head-on collided with, it functions in the service of mobilization of transference feelings as well as mobilization of the therapeutic alliance, which is the goal toward which the therapist is working.

Head-on Collision with Resistance

In the following passage, the therapist applies his technique of head-on collision:

* Pointing out the nature of the resistance;
* Emphasizing the therapeutic task "to get to the engine or the core of your problem;"
* Emphasizing the partnership "for you and I to see what are we going to do," "then the whole process of both of us working together;"
* Addressing the resistance against emotional closeness;

* Pointing out the self-destructive component of the resistance in the transference;
* Pointing out the consequences of the resistance in the transference "the process is doomed to fail."

TH: How do you experience this frustration with me? So far what you say is that you are frustrated with me, but your hand is clenching like that, your body is immobile and you are taking a detached, paralyzed position. So let's see what are we going to do about this crippled man? It is very important for you and me to see what are we going to do about this crippled man. Because this detachment . . . and that is very important for you to look at it, unless you want to dismiss this as well.

PT: (deep sighing respiration)

TH: If this paralyzed position continues, if you maintain this detached and extremely passive position, this process is doomed to fail and these mechanisms are the ingredients of the wall; and if this continues the whole process of both of us working together, trying to understand your difficulties, which we have understood, but equally important to get to the engine or the core of the problem is doomed to fail. So the important issue for both of us is what are we going to do with this massive wall? And it is very important to identify this, you see, because a part of you wants to give up your crippled life, okay.

PT: Yes.

TH: Okay? A part of you wants to give up the crippled life but another part of you wants to perpetuate the crippled life. The other part that wants to perpetuate the crippled life uses all kinds of systems and all kinds of mechanisms. But this part that wants to perpetuate is using all these mechanisms. Now the question for you and I is what are we going to do with that part of you who wants you to remain crippled?

PT: Yeah.

TH: It is very important to see what are we going to do for that part of you that wants to remain in a crippled paralyzed position? Do you follow me?

PT: Yes, I understand.

The main aim of head-on collision at this point of the interview is:

(a) To bring the patient face-to-face with his self-destructiveness.
(b) To make him well acquainted with the nature of the resistance.
(c) Further rise in the transference feeling
(d) To maintain the resistance crystallized in the transference.
(e) To mobilize the therapeutic alliance against the resistance.
(f) To create a state of high tension between resistance and therapeutic alliance in the transference; the two major forces "a part of you wants to give up the crippled life" (therapeutic alliance), but "another part of you wants to perpetuate the crippled life" (punitive superego).

Anger in the Transference

TH: You said you are angry with me?

PT: Yes.

TH: How do you experience your anger towards me? You are pressing your hand. We don't know how you physically experience your anger towards me. We know how you experience anxiety hmm.

PT: Hm hmm.

TH: What is the way you physically experience your anger in relation to me? Your head goes down.

Almost all patients with character neurosis cannot differentiate between the physical experience of anger and that of anxiety, which is in the service of resistance. At this point, the task of the therapist is to maintain his challenge and pressure, and if necessary head-on collision to the resistance against physical experience of the anger in the transference. The therapist puts pressure on the physical experience of the anger and concomitantly challenges the resistance. Especially important, the therapist must see that the patient is well acquainted with the resistance that is being challenged, and that his communication is very specific. If we look to the following passage, the patients says "I have a hard time with anger," and the therapist's response is "immediately that part, that paralyzed part comes up," addressing the part of the patient that has heavily identifed with the resistance. It is also important that the therapist himself does not use tactical defenses. For example, in the following passage "You see I questioned you how do you experience your anger in relationship with me" rather than to say to the patient "how do you experience your anger." Now we return to the interview.

PT: Well I've . . . I have a hard time with anger.

TH: You see again immediately that part, that paralyzed part comes up. You see? You have a side of you that uses all kinds of mechanisms to maintain the paralyzed . . .

PT: I'm afraid of losing my temper.

TH: Yeah but we are looking to how you experience your anger here with me.

PT: Physically?

TH: Yeah. We know how you experience the anxiety, and it is important to see how you experience your anger in relationship with me. How do you experience your anger in relationship with me? So far we see a paralyzed . . .

PT: I feel tense, I tense.

TH: Yeah okay. You see I questioned you how do you experience your anger in relationship with me; you say you feel tense, but that is anxiety.

PT: Yeah.

TH: But anxiety is not the anger. Do you follow that?

PT: I'm not sure I see the difference.

TH: You see I question you how do you experience your anger in relationship with me? You say you feel tense. Tension is a part of one's anxiety. When you are anxious there is a tightness in your chest, that is tension. But that is not anger. What you describe is anxiety. Do you notice your hand? What you describe is anxiety. Do you notice your hand?

PT: Yeah.

TH: What? What do you notice?

PT: I'm I'm . . .

TH: Clenching.

PT: Clenching and . . . but that's anxiety too. I don't . . .

TH: Tension.
PT: Tension.
TH: But maybe there is another feeling underneath of this tension because you say you're angry hmm.
PT: So they're both gonna be there.
TH: But obviously there must be some link between the anger and the anxiety.
PT: Yes.
TH: But we know how you experience the anxiety but we don't know how you experience the anger. (Pause) *You see when we focus on your anger towards me how paralyzed you become?*
PT: Yes I block it.

The process demonstrates systematic weakening of the repressive mechanism which is the major resistance against the murderous rage and guilt. It is important to note that one of the defense mechanisms that can easily complicate the process, which is often syntonic, is the mechanism of defiance. For that reason it is important that the therapist moves to the deactivation of this defense. This can be done by pointing out to the patient "unless you don't want to do anything about it," "maybe your decision is to carry your misery the rest of your life." This form of intervention at the same time contains deactivation of the transference and keeping the responsibility with the patient. Now, we return to the interview.

Challenge, Pressure Combined with Repeated Partial Head-on Collision

TH: But that is the part, the side, the part that I said that a part of you wants to perpetuate this miserable life., So then we have to do something about it, unless you don't want to do something about it.
PT: No I want to, uh a . . . I want to do something about it.

It is important to note that the therapist repeatedly puts pressure on the patient's will, to the patient's therapeutic alliance to make a supreme effort.

TH: So do you see there is a part of you that wants to sabotage the whole process. (superego resistance)
PT: Yes, yeah I can see that.
TH: But a part of you wants to say goodbye to the crippled life. (therapeutic alliance)
PT: Yes.
TH: So then we have a major problem ahead of us. (employing the partnership)
PT: Yes.
TH: That part of you that wants to sabotage the whole process. (destructive aspect of resistance in transference) *And the issue is this, what are you going to do about it?* (question to the unconscious therapeutic alliance)

Further Challenge

PT: *I find it so hard to say how I experience . . .*
TH: *You see again the paralyzed part comes immediately to the front, you see?*
PT: (deep sighing)
TH: *Do you notice?*
PT: *Yes.*
TH: *Immediately crippled "I don't know."*
PT: *Yes.*
TH: *46 years you have been on that boat.*
PT: *I don't know how to . . .*

Challenge, Pressure and Head-on Collision

TH: *And I assume you want to say goodbye to it.*
PT: *I do, but I don't know how.*
TH: *Let's to see how you experience your anger in relation to me.* (pause) *Let's to see how you experience your anger. Your hand is like that, your leg you are keeping it tight. Do you notice the position of your hand?*
PT: *It's . . . I'm protecting myself.*
TH: *Hm hmm. So let's to see how you're experiencing your anger. So far you're a cut-off man.* (pause) *Let's to see how you experience your anger. Moving to the crippled position is not going to help us. 46 years you have done it anyway. Let's to see how you experience this anger. Again you want to move toward this . . .* (PT deeply sighing) *. . . paralyzing poofffff and so forth. Let's to see how you experience your anger.*
PT: *But that's how I experience it.*
TH: *And your head is down. Using all kinds of the mechanisms to avoid to see how you experience your anger. There is a part of you that wants to perpetuate this crippled position, and we have to see what we can do about that part. Unless you don't want to do something about it.*
PT: *I want to do something about it.*
TH: *The first issue is how do you experience your anger. Now, you are becoming more slow, looking puzzled; again further paralysis.*
PT: *Hm hmm.*
TH: *"Hm hmm" is not enough. You have lived this crippled life for 46 years; do you want to say goodbye to it or do you want to keep it?*
PT: *I want to say goodbye to it.*
TH: *Then let's to see how you experience your anger in relation to me. Now you move like this.* (pause) *Do you notice your body? Do you see your body?*
PT: *Hm hmm.*
TH: *You want to move toward that side, the paralyzed side. And we are here together to deal with that paralyzed side; unless you don't want to.* (Pause) *So then obviously you want to carry this to your grave. That is becoming clear.*
PT: *I don't! But I don't know what to do with it.*

TH: To do with what? How do you experience your anger towards me, physically . . . we know when you are anxious, physically you have a certain way of experiencing anxiety, but how do you experience the anger that you have inside you towards me? Do you see how terrified you are?

PT: I am afraid . . . I am afraid of being violent.

In the above passage, the therapist maintains the challenge, pressure and a repeated composite form of head-on collision while carefully monitoring the signaling system; the nonverbal cues such as frequent deep sighs, clenching of both hands, etc. The process clearly indicates a steady rise in transference feelings. The systematic work on weakening the major resistance of repression is progressing and the patient now declares "I am afraid of being violent," "it is something totally irrational," "a loss of control." It is important to note that the process has moved from "frustration" to "violence" and we have a clear indication of the mobilization of the unconscious therapeutic alliance against the resistance. We return to the interview.

TH: Violent. You mean there is a volcano inside you?, a fireball inside you that you are afraid might come out? This is what you are saying? You mean there is a fireball inside you that . . . you are afraid that it might erupt.

PT: (deep sighing) *It is something totally irrational, a loss of control.*

TH: Losing control? but how do you physically experience this? How internally do you experience this wave that goes within you? We are talking about this violent rage. (pause) *Again, you see, clenching. You are protecting me against your anger, isn't that?*

PT: Yes.

TH: Hmm?

PT: Yes.

TH: Yes what?

PT: I'm protecting myself.

TH: But obviously protecting me as well. Because your hand is like this.

PT: But I think of it more as protecting myself.

TH: But still we don't know how you experience this rage inside. How you're experiencing it inside? We are not talking about putting it out, we are talking about how you're experiencing it inside.

PT: Just stays up in the head.

TH: But still we don't know how you physically experience this rage.

PT: I feel tight, I feel it.

TH: But that is anxiety, that is not rage. And what you experience is anxiety but underneath of it is rage. You experience the anxiety but we don't know how you experience the rage. Do you notice there is a link between anxiety and rage?

PT: Hmm, but they're not the same.

He indicates that he has "an awful temper" and that he is afraid of losing control, "might become destructive." The therapist brings his attention to the experience of rage. The deep sighing respiration has increased, which signals a further rise in the transference feelings. Referring to his inner rage he says "I don't feel a connection."

PT: I can't relate it to ah, to an experience.

TH: How do you physically experience it?
PT: It all sounds like anxiety, I mean I felt a tightness in the chest and ah . . .
TH: But you see tightness in the chest means anxiety in this muscle.
PT: Yeah.
TH: But anxiety and rage are two different things. Underneath the anxiety obviously is the rage, and as soon as the rage is mobilized you become anxious. So anxiety is a mechanism of dealing with rage, detachment is a mechanism of dealing with rage, holding the fist like that is a mechanism of dealing with rage, making yourself tight like that is a way of dealing with the rage. But how do you experience the rage itself?

For a moment, it is very important to summarize the process and discuss some of the technical and metapsychological issues *re* the way the unconscious functions:

(1) There has been systematic challenge, pressure and repeated head-on collision with the patient's transference resistance, which gave:
(2) A steady rise and a direct experience of the complex transference feeling, which was signalled by;
(3) Rise in anxiety in the form of tension in the striated muscles and its nonverbal cues;
(4) There is mobilization of the unconscious therapeutic alliance;
(5) The process indicates that the repressive mechanism is in the process of being weakened, which has been mobilizing a high degree of anxiety, again in the form of tension. His body is immobile and other nonverbal cues already mentioned;
(6) The unconscious murderous rage is close to breakthrough, which is a major source of mobilization of anxiety;
(7) Therapists working with this technique must have a good knowledge about the somatic or the psychophysiological pathway of unconscious anxiety in the form of tension in the striated muscles (will be discussed briefly at the end of this article);
(8) Therapists must have knowledge about the somatic pathway of the passage of the unconscious murderous or unconscious primitive murderous rage. I have clearly demonstrated in a large series of unlockings, that the passage of the murderous or primitive murderous rage has a definite somatic pathway, which has been presented in many symposia and courses; and I will briefly address it at the end of the article;
(9) As soon as the unconscious murderous rage is experienced in the transference the whole anxiety and tension drop, signaled by the nonverbal cues.

Here it is important to very briefly summarize some of the fundamental principles of the way the unconscious functions:

(a) Actual experience and passage of the unconscious murderous rage in the transference is instantly associated with a drop of anxiety and tension, and emergence of sadness is an indicator that the breakthrough of the guilt and grief-laden unconscious feelings is eminent.
(b) Experience and the passage of the unconscious murderous rage in the transference, as I have indicated before, is instantly associated with sadness. The patient's attention is on the murdered body of the therapist and then his unconscious transfers the murdered body of the therapist to the genetic figure, namely father, mother or sibling.
(c) As soon as this transfer takes place there is a breakthrough of intense major waves of guilt-laden unconscious feeling, which is then followed by a major passage of grief-laden unconscious feelings.

Principles (b) and (c) can be demonstrated with every extended major unlocking of the unconscious with every highly resistant patient with complex psychopathology. One of the main reasons has to do with the fact that the rise of and the direct experience of transference feelings is at its optimum level and there is optimum mobilization of the unconscious therapeutic alliance and the resistance has lost its power. This is what I have called mobilization of the "unconscious therapeutic alliance; *dreaming while awake,*" (Davanloo) which has already been presented in many symposia and courses and will appear in future series of articles.

If we go back for a moment to major unlocking, there is some degree of variation and this depends on the extent of the rise and direct experience of the transference feelings. I have aleady indicated that the degree and the extent of the breakthrough into the unconscious is exactly in proportion to the degree that the patient has directly experienced his transference feelings. On that basis we can say that there is a spectrum of major unlocking of the unconscious. Now we return to the interview with this patient. The therapist maintains challenge to the resistance against the experience of his rage in the transference, asking how the patient experiences the rage. The specificity of this question is extremely important. The patient finally indicates that there is "something rising" and the therapist follows.

TH: *That fireball?*

PT: *Yeah, it's, rising up inside.* (referring to the somatic pathway) (hands are not clenched, his totally bent position becomes upright and he says, "rising up inside" referring to his abdomen and chest)

TH: *What is the way you are experiencing it?*

PT: *Well, it's to, it's to . . . it's to explode, you know it's to shout.* (the hand is in the upward position, his voice is loud, no tension in the vocal chords, indicating that the breakthrough is taking place)

TH: *Explode?*

PT: *It's to shout and . . .*

TH: *There is a rage in you like that?*

PT: *Yes.*

TH: *That you wanted to blast on me? That there is a rage in you toward me?*

PT: *No, rage is too big a word for it.*

TH: *And I think that it is very important that we examine this, unless you want to keep your misery the rest of your life.*

PT: *No.* (*deep exhalation*)

There is definite evidence that the breakthrough has taken place. Anxiety and tension have dropped. The therapist bypasses the tactical defense "No, rage is too big a word for it." Now the therapist explores how it would have been like if he had put his rage out (it is important to note that if this was an extended major unlocking, with an optimum rise in the transference feeling and optimum mobilization of the unconscious therapeutic alliance, direct experience and passage would have been spontaneous). We return to the interview.

Passage of the Murderous Rage in the Transference

TH: *If you lash out, how that would be like? In terms of thought and fantasy. You know the story of Dr. Jekyll and Mr. Hyde?*

PT: *Yes.*
(the atmosphere of the interview is different, there is no tension and no anxiety)
TH: *Now, if . . . you know, that monster comes out of you, what you would be like? and that is very important for you to look at because that has made your life miserable, that has paralyzed your life and why would you go to your grave in that way? If that monster comes out of you, what that would be like? In terms of thought and fantasy.*
PT: *I would attack you directly, with my fists . . .*
TH: *Then there would be attack on me?* (he is sitting in the upward position. At this moment, his two hands are in the upward position, outstretched opposite to each other, and is demonstrating to the therapist how he would strangle the therapist)
TH: *Could you portray how you would attack me?*
PT: *Throttle you around the neck . . . like that.*
TH: *You mean your hands?*
PT: *Right, right in. . .*
TH: *Over where? Could you portray it?*
PT: *Yeah.*
TH: *Around here?* (referring to the neck)
PT: *Yes.*
TH: *So you would hold . . . put your hands around my neck, your thumb would be on my. . .*
PT: *And choke.*
TH: *Uh huh, and then choke me?*
PT: *Yeah.*
TH: *And then, how would you go further? If you let this . . . go further.*
PT: *I would choke you and shake you until, until you stop moving.*
TH: *Yeah, but then how it would be like? in terms of your thoughts.*
PT: *My fingers would be just pressing* (referring to the therapist's neck)
TH: *And push?*
PT: *Push and push and shake.*
TH: *And then?*
PT: *And then, release.*
TH: *But what happens? I mean finally I am. . .*
PT: *You would fall to the ground.*
TH: *You mean that I would be gasping for air.*
PT: *No, you would be dead.*
TH: *I would be dead hmm. In the chair there or where?*
PT: *It wouldn't matter whether you're in the chair or fell to the ground.*
TH: *Yeah but in terms of thought. I mean your hand is on that and then you are pushing and pressing and pressing and then I die. Could you portray the dead body of mine on the . . . Where?*
PT: *You would be . . . you just slump back on the chair.*
TH: *On the chair and the head back you mean?*
PT: *Yeah like that.*
TH: *And how about my eyes?*
PT: *Wide open and staring.*

TH: Staring at where?
PT: Just staring up.
TH: The ceiling?
PT: The ceiling.

The patient is becoming increasingly sad. There is no anxiety and tension and the patient is in an altered inner state. We continue the interview.

TH: and then my hand?
PT: Just . . . like that.
TH: Like that. And then what do you do after that? After I am murdered?
PT: If I'm still angry? If I'm . . . if I'm full of remorse?
TH: No I mean what happens? Now you have put your hands on my neck and then I. . .
PT: I've killed you; remorse, guilt. I would. . the rage would be gone.
TH: Rage is gone but what other feeling would you have? I mean I'm back there and I am dead.
PT: I, I . . .
TH: What would you do?
PT: I'm just totally stricken, I would just ah . . . (sighs)
TH: But then what would you do after that? How would you feel at that moment?
PT: Dreadful, I'd feel. . .
TH: Why?
PT: For having killed you.
TH: Why? Why would you have remorse?
PT: For having killed a human being.
TH: And what do you do with my dead body?
PT: Nothing. (sniffling)
TH: I mean what do you do with it? You mean you walk out or you . . .
PT: I can't . . . I would . . . I can picture a collapse, I picture not doing anything.
TH: I mean what do you do? I mean you leave me and walk out the door?

The sadness is becoming intensified, tears are in his eyes.

PT: No I would go and find someone.
TH: Who? What comes to your mind? (heavy sobbing)
PT: I picture going out that door and finding the first person and saying I've killed this man.
TH: Hm hmm. And how would you feel toward my dead body?

Passage of Guilt-Laden Unconscious Feeling

There is a breakthrough of a major wave of guilt-laden unconscious feelings, with heavy sobbing. The guilt-laden unconscious feelings come in waves and involve the whole upper respiratory area. The interview continues.

TH: How would you feel towards my dead body?
PT: (crying) *I would be sorry.*
TH: Hmm.

PT: *I want to help bring you back to life.* (further breakthrough of guilt and painful feeling)
TH: *You mean there are positive feelings as well?*
PT: (further breakthrough of guilt)
TH: *Hmm?*
PT: (further breakthrough of guilt)
TH: *Positive feelings there also?*
PT: *Yes.*
TH: *And then my burial what. . .*
PT: *Ohhhhh.*
TH: *How that would be like?*
PT: *Ohhhhhh.*
TH: *Hmm? You would be at my burial?* (Breakthrough of waves of guilt-laden unconscious feeling).

It is important to note that the unconscious has not, as of yet, transferred the murdered body of the therapist to the dead body of the genetic figure, which shortly as we will see is the mother. Throughout that passage, there will be major waves of painful feelings. Now, we return to the interview.

PT: *I think I'd want to hide from it, but I'd be there. I'd be afraid.*
TH: *Afraid? Of who?*
PT: *Of those that loved you.* (cries)
TH: *Those?*
PT: *Who love you and seeing the person who'd murdered you.*
TH: *Because there is an element of death, murder and death hmm. But who comes to your mind, because the one who loved me who would be mostly affected by this, by my death? In terms of thoughts.*
PT: *Children.*
TH: *There would be children?*
PT: *All those who'd be close to you, friends, most, mostly family.*
TH: *Who would be most hurt about this death?*
PT: *Well a child.*
TH: *Child. In a sense the one that they would be mostly affected would be . . . children*

At this moment, there is another major wave of guilt-laden painful feelings; and the unconscious therapeutic alliance clearly identifies the identity of the murdered therapist, which is the dead mother. His voice is choked-up and what emerges is the murderous rage to strangle the mother. The focus is on the murderous rage towards "my mother," murderous rage to throttle her neck to death.

PT: *It is my mother.*
TH: *You say that, or that comes . . .*
PT: *I can see it, it is my mother.*

What we have seen so far indicates major weakening of the resistance and mobilization of the unconscious therapeutic alliance, which is now in command of the process.

Analysis of the Transference

Now the therapist returns immediately to the phase of analysis of the transference before he undertakes the dynamic exploration. For the sake of brevity, some aspect of this part of the interview is omitted, otherwise it remains verbatim.

TH: It is very important we examine it.
PT: Well I think . . . so afraid to show it.
TH: I know, but you see that is what we see.
PT: I would die myself if I showed it.
TH: You see, you have developed a set of mechanisms for 46 years to deal with these buried feelings, with this buried murderous rage, the painful guilt feelings and obviously other feelings.
PT: Yes. (he is sobbing)
TH: Not only the murderous rage and the guilt but also other feelings, the feeling of sadness and the grief about the way life has gone for you.
PT: (continues crying) (whispering)
TH: There must be a tremendous painful feeling in you, the pain of being left by your parents . . . and that there are a lot of feelings that a big chunk of your life has gone in waste and misery, hmm.
PT: Yes. (whispering)
TH: Something has to explain why you are so terrified of anger, hmm. Obviously, as we see, there has been a major seething rage that you could murder her and the guilt feelings about it, but also the major pain of being dumped by her and the way you have dealt with this, the pain of being abandoned, the seething rage and the guilt that made you a paralyzed man and that this was a defense mechanism against all of these feelings, hmm?
PT: (whispering) *I can see that.* (continues crying)
TH: Do you follow me? don't agree with what I say. Here we are for you to examine them.
PT: I can see . . . (whispering) (he is very sad, with a low voice)
TH: That this need in you to suffer, this need in you to perpetuate suffering and misery, the need in you to destroy your potentiality, all are mechanisms of dealing with this pain, murderous rage and guilt which is within you, that you would put your hands over her neck and choke and choke until she would be dead. Do you follow me?
PT: Yes.
TH: And that the way you dealt with it is to become a paralyzed man, to lose your autonomy and freedom as well as a mechanism of dealing with that. But obviously, we haven't so far touched your feelings towards your father, your brother, and obviously there are other figures in your life such as your aunt and your grandmother as well.

In the above passage, the therapist drives home insight into the aspects of the psychopathological dynamic forces that are responsible for the patient's disturbances, his masochistic character pathology, the "perpetrator of the unconscious" (Davanloo), which may be summarized as follows:

(a) Attachment and the bond:

(b) Abandonment and the severe trauma;
(c) The pain of the trauma;
(d) Murderous rage toward the mother by strangling her;
(e) Intense guilt-laden unconscious feelings and;
(f) Intense grief-laden unconscious feelings;
(g) the whole set of character defenses "you have developed a set of mechanisms for 46 years to deal with these buried feelings, with this buried murderous rage."

It is important to note that the therapist is clearly working with what the process so far has covered and what the unconscious therapeutic alliance so far has introduced. At no point he made a communication that the patient may have rage toward his father, brother and so forth; and this is an important aspect of the technique.

Major Communication from the Unconscious Therapeutic Alliance

Murderous Rage towards the Brother

Now the powerful dynamic force of the unconscious therapeutic alliance spontaneously introduces the patient's murderous rage toward his brother. He spontaneously talks about an incident in which he was near to murder (his brother).

PT: *Shame and guilt and . . . all because . . . is I tried to hurt my brother very much when I was very young; throwing scissors at him in a fit of rage.*
TH: *Fit of rage?*
PT: *Yeah.*
TH: *With your brother.*
PT: *I lost my temper and . . .*
TH: *I mean there was an incident?*
PT: *I have strong memory of this, of getting enraged with him. The last time I lost my temper and felt the rage I had scissors in my hand and I picked them up and I threw them at him.*
TH: *How big were the scissors?*
PT: *Big scissors.*
TH: *Oh one of those okay. How did you throw it at him? What was the incident?*
PT: *The incident uh I . . . he he got me angry, my brother and I could always get each other angry, very, very angry.*
TH: *Hm hmm.*
(the incident as he describes it is as follows. The brother had bent down to put his overshoes on, and the patient threw the scissors which could have got on the brother's neck, as patient shows it with his body movement, but the scissors went into the overshoes)
PT: *And I could get him very angry, he could get me very angry. I don't know what it was that he got me angry with, I was . . . all I know he was holding a pair of those overshoes that we would put on and I can remember just screaming in rage and throwing them and having them, having them stick with the knife into the shoe.*
TH: *Stick with the knife?*

PT: *Not stick with the knife, the scissors.*
TH: *Scissors.*
PT: *Into the, into the boot that he was holding.*
TH: *How? You mean the scissors . . .*
PT: *The scissors I threw them and sss . . . they went right into the boot that he was holding.*
TH: *That bad? You mean that heavy?*
PT: *Yes.*
TH: *You mean then you were really enraged.*
PT: *I was . . . yes I was totally out, enraged . . . totally out of control.*
TH: *And then the scissors went . . .*
PT: *Went right into the . . . these these rubber boots you know, went right into the boot.*
TH: *And then?*
PT: *I don't know what happened immediately after but I remember that being the last time; I said no more, that I'm going to . . .*
TH: *I know but . . .*
PT: *I don't know what happened right after. I don't have a recollection.*
TH: *Now if it had got on his neck what would have happened?*
PT: *Ohhh . . .* (deep sigh)
(The comment of the therapist "if it had got on his neck what would have happened"—at this moment he has shivering with some tremor. He is very sad and tearful).
TH: *If that scissors had got like that on the neck what do you think would have happened?*
PT: *Ohh would have been awful.*
TH: *Picturing I mean.*
PT: *Picture him bleeding and I picture me just . . .*
TH: *What part of the neck would catch?*
PT: *Ah into the neck right there.*
TH: *Like this?*
PT: *Yeah.*
TH: *So in a sense would go over the neck like that and then?*
PT: *Then I see myself . . . I would . . . then we just dissolve, just, just be . . . the rage would be gone in in . . .*
TH: *I know but what would happen to him?*
PT: *He would die or he would bleed vey badly and I would try to stop it. I . . . I . . . I'd be . . .*
TH: *So then he would be murdered.*
PT: *He would be murdered.*
TH: *Hmm?*
PT: *Yes.* (deep sighing with major wave of painful feeling)
TH: *So then there is also this murderous rage and guilt toward your brother.*

His brother is 4 years older than the patient. In a painful state he says "He was the first baby and was privileged to have a mother and a father until the age of four." It is important to note that as he describes the incident he is fully in touch with the murderous rage the way he held the scissors, the way he threw the

scissors, and the way they would have gone into his brother's neck. A shivering moment indicated his reaction and his intense experience of the guilt and the whole psychophysiological concomitant characteristic of the passage of the guilt. In the summary of this article, I will briefly discuss my research data on the importance of the actual experience of the passage of the murderous rage, the intense guilt-laden unconscious feelings and their psychophysiological components in the here and now, and their relation to structural character changes.

Death and the Funeral of the Mother

After the passage of the guilt-laden unconscious feelings, the patient came with a memory of a picture with his brother smiling and "is happy with his mother." It is important to note that he refers to "his mother," referring to the mother of the brother. Then he comes with a vivid memory of his brother crying over "her death." Then he spontaneously talked about the death of his mother. She died at the age of 67, as a result of a massive blood clot. The therapist makes a dynamic exploration into the circumstances surrounding her death. On the way to to attend her funeral, he shed tears. Then the focus of the process is on the funeral.

TH: *How did she look like at the funeral . . . when you looked at the dead body?* (Patient is sad and tearful)
PT: *Not my mother.*
TH: *What did she look like I mean?*
PT: *The body, the body was hard, the face was hard and bitter. The face was sharp and and, and uh . . . cold.*
TH: *Hm hmm.*
PT: *And I thought that's not my mother. But I didn't feel, I didn't feel, I didn't cry. I didn't feel that feeling of emotion until at the funeral the moment they closed the casket for the last time.*
TH: *What was your goodbye to her? What did you tell her at the last goodbye?*
PT: (heavy sobbing) *I just said goodbye.*
(Breakthrough of a major wave of painful feeling.)
PT: *I ju.. I just said goodbye.* (very choked-up voice)
TH: *But what did you say to her?*
PT: *It was something very simple like goodbye . . .*
TH: *You touched her and said goodbye?*
PT: *I did touch.* (grasping her hand)
TH: *So you touched the hand and said goodbye.*

Two Hours with his Mother

Now, the *unconscious therapeutic alliance* introduces an incident which intensifies the patient's painful feeling. In a very highly charged, emotional state, he sobs. This is so intense that it interferes with his speech and he says that he only spent 2 hours in his life with his mother, and it was some months prior to her death. We return to the interview.

PT: *I said goodbye.* (Pause) *I think it's import . . . the year just before, I had not . . . I didn't see my mother, I hadn't known her as a person at all, and literally that happened in the winter, I guess it was the fall, that was in January. And in October she was in town, and for the first time she came to visit and we went out together for dinner . . . just for lunch, and spent 2 hours just talking. That's the first and the last time that's ever happened.* (voice breaks) *And I was very grateful.* (sobs)

TH: *You mean that October was the first and the last time that you had together.*

PT: *I get pretty . . .* (major wave of painful feelings)

TH: *So you must have a lot of mixed feelings about life with your mother.*

PT: *Yeah. We never lived as a family, even when we . . . after the war. We always lived with my grandmother and . . . aunts.*

TH: *But where was that?*

PT: *We are a rest . . . a little restaurant, went to a little restaurant.*

TH: *You and your mother.*

PT: *Just my mother.*

TH: *And you say this is the first time that you . . .*

PT: *First time I ever sat down and we talked about anything, anything that was personal . . . or . . . and even then it was a start, it was just a little . . .* (loud sobs) (choked voice) *I'd loved to have known her as a person.*

TH: *What?*

PT: *I'd have loved to have known her as a person and not as a mother, not as that . . . she was never part . . . my parents, neither of them had ever been people to me. Even my father, even now I can't reach him, not . . . I try and it's impossible.*

TH: *Hm hmm. So then there is a lot of mixed buried feeling within you.*

Further Dynamic Exploration

He further talked about his mother, he and her alone together in the little restaurant which he refers to "a lucky chance," "we spent a good 2 hours together," and that his talk with his mother was "at a much deeper level than I had ever experienced before." "She was in good health." He didn't see her again after that; she died suddenly. He again talks about their two hours together. "It was special, I hugged her." (breakthrough of another major wave of painful feeling) He indicated that it was something so different that had never happened before. Then a few months later, his father telephoned and told him that she had died suddenly. The patient felt numb. He thought of excuses, all of the reasons he could not go to the funeral. But finally he went and saw her on view the day of the funeral. It was during the winter, with heavy snow and they couldn't bury her. But then in the spring his father buried her and the patient couldn't go. In a sad state he talked about his early years and the memory of his aunt taking him to the city where his mother lived, while he always had the memory that his mother came to visit him. The realization of this, that she never came to visit him mobilizes further waves of painful feelings. In his memory his mother never showed any emotion. The focus is on his grief-laden unconscious feelings, and he indicated that he realizes that his feelings are deeply buried, "had been buried and controlled."

Further Analysis of the Transference

After the passage of these waves of painful feelings, once more the therapist moves to the analysis of the transference. First his rage, followed by murderous rage, and finally the murder of the therapist by strangulation. Here, the therapist once again recapitulates on the whole set of unconscious character defenses that he had used in the transference and its link with the unconscious anxiety, and its further link to the unconscious murderous rage. The therapist clearly and explicitly points out the whole set of character defenses in the transference. "These are all a set of mechanisms you used in dealing with your murderous rage towards me," and further points out that the murderous rage in the transference was the murderous rage towards the mother.

The therapist maintains the focus on the mother and further indicates the trauma of abandonment, the major pain of the trauma, the murderous rage, guilt- and grief-laden feelings and the whole set of character defenses that he has developed to defend against all these buried feelings. Then the therapist focuses on his mixed feelings in relation to his brother; the murderous rage, guilt and grief and the whole set of mechanisms he used to defend against these buried feelings. The therapist, so far, only emphasizes the mother and the brother and points out to the patient, "Of course we haven't touched your father yet." Patient's response indicates that he is well in touch with the process.

PT: Yes, I.. I.. I... it makes sense.
TH: Hmm?
PT: It makes sense to me.
TH: Now my question is this, do you get depressed?

Exploring the Episodes of Depression

After the first breakthrough into the unconscious murderous rage and guilt, for the first time the major defense mechanism responsible for the depression, namely the instant repression of the murderous rage, has been weakened to a major extent; and it is important that the therapist explores the episodes of depression and drives home further insight into that mechanism. He indicates that he suffered from episodes of depression. They always follow episodes of periods of major conflict with his wife, or when the marriage is threatened to break up which might result in the breakdown of the relationship with his two children. When depressed, he says he is like "half a person," "close to a state of paralysis." He stays in bed, suffers from poor concentration, and his thoughts become fatalistic and gloomy. In his younger years, before he got married, he had two major episodes of depression, each lasting a few weeks and both of them followed a breakdown of a relationship with a woman. Suicide was explored, and he has never been suicidal. Then the therapist further explores his relation with his wife.

Exploring his Relation with his Wife

He indicates that he has no joy in seeing her, fuming inside but silent, withdrawn and detached outwardly. Then he talked about a recent incident. He

had picked up his wife at the airport, had forced himself to show her that he had been looking forward to her return. "I didn't have the joy of seeing her back." He further emphasizes that throughout his marriage he had learned to put up a facade, to prevent her from getting angry, explosive, and critical. After they returned home from the airport that night she wanted him to make love to her, but he couldn't respond so she got angry with a biting temper, criticizing him and putting him down. "She knows my weaknesses." This went on until he got angry and the way he handled it was becoming totally detached, withdrawn and silent.

Now, the therapist makes a link between the transference and his wife. We return to the interview.

PT: I was very angry with my wife, but again I became withdrawn, silent and remote.
TH: So you withdraw then.
PT: I withdraw into silence, I . . . I . . . I don't say anything.
TH: So silence is another mechanism. Do you notice also silence was with me?, was another way of dealing with your anger. When you were enraged with me you took a silent position.
PT: Yes, I . . . I think.
TH: You say that because I . . .
PT: No, no, no you're right, you're right. You would say something and . . . then I got silent, detached . . . withdrawn.
TH: And then she is angry with you huh?
PT: Yes.
TH: And then what happens to you?
PT: And then, then it gets worse, then I withdraw even further or I . . .
TH: So that means there is more anger in you?

This might result to further escalation and she might threaten to terminate the marriage. The therapist knows that underneath the anger is murderous rage. It is important to note that the therapist can simply interpret this, but by doing so he is making a major mistake. As I emphasized earlier, the patient must actually experience, in the here and now, if he has murderous rage towards his wife, and most importantly interpretation should come from the unconscious therapeutic alliance. Again we see a major and fundamental difference between the traditional psychoanalytic system and my technique.

The therapist reemphasizes the set of mechanisms that he uses against his negative feelings in relation to his wife. "But this is important that you examine some of these sequences," emphasizing that the more angry he gets the more silent and withdrawn he becomes, which sets the stage for more anger in his wife with criticism; she becomes more demanding and puts him further down, then he becomes more detached, remote and more silent. Then he points out that his wife becomes physically violent, attacking him with her fists on his head, with him protecting himself, holding his hands over his face; and then she threatens to terminate the marriage. Then he indicates that he moves into a state of paralysis and then depression takes over. He emphasizes the two aspects of his wife, one being critical, demanding, explosive, etc.; but the pendulum can shift to the other side where she becomes distant, remote and wants to be left on her own, and

"none of us could feel her presence." Then he spontaneously said that there has been many incidents when he felt "so frustrated, where I wanted to strike out."

PT: Again it . . . it . . . it would be.. as I say it's happened several times. It would be that point of her saying you know "You leave me in silence and you gotta stop doing that. Do something! You can do something. You can do something, you can do something, you can do something."

TH: And then she would be after you to do something.

PT: To do something. "You gotta do something!" . . . and demanding in a preaching voice.

Direct Experience of the Murderous Rage in Relation to his Wife

Throughout this passage, he is clearly experiencing an intense violent rage towards his wife. He is sitting straight up, highly charged, his hands are in the upward position, outstretched, opposite to each other, exactly the same way he was when he wanted to throttle the therapist. He is experiencing his murderous rage. Now we return to the interview.

TH: If you had let yourself go . . .

PT: What would I do?

TH: How the attack on her would have been? With your brother it was scissors on the neck, with me it was the hand on the neck to throttle and with your mother it was the hands on the neck and again to throttle.

PT: Well I certainly can see the hands on the neck too; choke and stop the, stop the talking and . . .

(With his two hands he is showing how he would murder his wife by strangling her.)

TH: Have you experienced it like this with your wife?

PT: Not at the time. It was just when you asked me what would I do and and . . .

TH: What comes to your mind if you . . .

PT: It's the throttling that would stop the, stop the talking.

TH: How would you go on her neck?

PT: Again it would be in the bed and I'd be on . . .

TH: In bed.

PT: She would be in the bed.

TH: And then you are?

PT: I'm, I'm over her and throttling her saying "shut-up, shut-up, shut-up I don't wanna here anymore."

TH: How would you do that?

PT: And I would uh and hit it up and down and up and down on the bed; shut-up, shut-up.:

(Intense sadness; breakthrough of a major wave of painful feeling)

TH: Yeah but how your voice would be like if . . .

PT: I would be screaming. (weeping)

The strangling of his wife takes place in bed. The therapist emphasizes the similarity of the passage of the murderous rage in the transference to that with his

mother and now to that with his wife. Then the patient says "Yeah, a very strong hand motion." Now the therapist moves to some analysis of the process, reemphasizes the similarity of the way he experienced the murderous rage towards the therapist, his brother, his mother and now to that with his wife, and he follows it clearly.

It is important to note that the forces of resistance to a major extent have been weakened and the unconscious therapeutic alliance has been mobilized to a degree that it is in command of the process. The therapist continues his dynamic exploration into the patient's marriage. He explores the patient's sexual life and questions him how his detachment, withdrawal and silence affects his sexual life and his erection.

TH: So then in a sense, your relationship with your wife is quite stormy and as you, yourself, put it, you are paralyzed, you have to comply, you have to perform and you have to do your best by putting on a facade. But at the same time there is a major volcano within you.
PT: Yes, it's quite right, it is.
TH: Then she is like a pain on your neck.
PT: Like a pain in the neck. Get rid of the pain in the neck.
TH: You smile when I say she is a pain in the neck.
PT: No, I . . . well it was the relationship to throttling her by the neck and the pain in the neck.

It is important to note that this man suffers from frequent episodes of pain in his neck and also the murder of his wife, his brother and his mother is at the neck level, which demonstrates the mechanism of projective identification and symptom formation. But at this moment the therapist concerns himself with the incident at the airport, which the unconscious therapeutic alliance has introduced. The therapist raises the question how he would have felt if her plane had crashed? This technical intervention, as we will see, is important.

TH: Now, if the pain in the neck, say from __ to __ had . . . there was a crash and your wife had died. What would have happened to you and your life?
PT: I'd feel free, first of all I would feel free, and no . . . I've often thought of it.
TH: You've had often thoughts that if she drops dead then you would be . . .
PT: It would be a relief.
TH: A free man you mean.
PT: That's the first thought, that, that is the initial . . . that's, that's . . .I think beyond that but yes there is a sense of relief.
TH: Relief.
PT: If it would end.
TH: Could we look to your thoughts. Again we are examining these thoughts.
PT: Yeah.
TH: What way she would die?
PT: It doesn't seem to be specific, it doesn't seem to matter, cause I also think if she were to walk out the door tomorrow and say I'm leaving I would feel relieved. So its the going away.
TH: So in a sense she is such a pain in the neck that you look forward to her death in a sense.

PT: (sighing) *I don't knowwww.*
TH: *But its very important you examine your feelings.*
PT: *Yes, that's right, that's right.*
TH: *You have to face with the truth.*
PT: *Yes.*
TH: *You see, even if that truth is an ugly truth. I mean "trooth", you have to face with it.*
PT: *Yes, it is quite right.*

In the above passage, with a great feeling of relief he talked about the death of his wife; and the process clearly demonstrates that the resistance is not present and that the unconscious therapeutic alliance is in command, and the therapist emphasizes the ugly truth that he has to face. Patient has already admitted to active death wishes for his wife and the therapist moves to the incident that he wanted to strangle his wife. The therapist attempts to explore his feelings in relation to the murder and the death of his wife.

TH: *. . . and if she dies, and ahead you have described how you throttle her to death. What she would be like when you strangle her in the bed? You have strangled.*
PT: *I strangle her and I see her then at peace.*

In the following passage, the therapist focuses on the dead body of the wife, and it is important to note that he spontaneously links it with the portrait that he had already made of the throttling and murdering of the therapist. Suddenly there is a major passage of guilt-laden unconscious feeling.

His Feeling for his Wife

TH: *She's at peace.*
PT: *And I'm at peace because she's at peace because she . . .*
TH: *But how does she look in bed?*
PT: *Her eyes are closed and her hair is framing her head like an Ophelia or someone like that who is lying dead and is now peaceful.*
TH: *And how do you portray her body in bed?*
PT: *Just lying and ah with her head on a pillow and she's got long dark hair and just framing her face and she's . . . and and she's not saying anything anymore, eyes are closed and her face is in repose. If I also see in my mind's eye her face all distorted as I pictured yours as eyeballs staring out and tongue protruding and the violence of having killed her that would be awful.*
TH: *And how would you feel towards her?*
PT: *Aaah if . . . again . . . Having killed her, if it's violent and and the eyeballs are staring and so on and then the rage is gone then, then again the remorse because I care for her too.*
TH: *You mean there are also positive feelings for her?*
PT: *Yes I've got a lot of positive feeling.*
(low voice) (Intense sadness and the passage of waves of painful feelings)
TH: *One of the other issues is this, do you notice that as much as you have problems with the the negative you have problems also with the positive?*
PT: *Aw yes.*

It is important to note that while portraying the face of the murdered body of his wife, he spontaneously brought the portrait of the murdered body of the therapist "eyeballs staring out and tongue protruding" (and after the passage of the murderous rage towards the therapist, the murdered body of the therapist was transferred to the murdered body of the mother.) This form of interpretation usually is made by the patient after high mobilization of the unconscious therapeutic alliance.

The process now enters to the phase of consolidation, and the therapist analyses the mechanism of projective identification and symptom formation. He further reemphasizes the murderous rage in the transference, which was the murderous rage toward his mother and the guilt-laden unconscious feelings and murderous rage toward his brother and the intense guilt-laden feelings; and brings into the focus the murderous rage toward his wife with intense guilt, as well as his positive feelings.

The therapist is well aware that the major resistance was mobilized when he focused on the body of Linda, whom he brings into the bed when he has intercourse with his wife. The identity of Linda so far has been a mystery, but now the unconscious therapeutic alliance makes it absolutely clear.

Major Communication from the Unconscious Therapeutic Alliance

After he talked about his positive feelings for his wife he spontaneously talks about his two children, a daughter aged 18 and a son aged 16 and emphasizes that his life centers around his two children. "All the passion that I don't feel in the marriage I feel it with my children." Then he talked about his daughter Isabel, saying that "she is brilliant."

PT: She is slim, blond, with blue eyes.
TH: Is blond?
PT: She is fair haired, it's honey blond, it is fair.
TH: Okay, she is blond.
PT: Blond and slim and both passionate and worried and frustrated about life and we talk a lot, uh, about all kinds of things she shares with me, how she feels about things, and her troubles. So we share a lot of things. Uh blue-eyed, and she worries a lot.
TH: How is the physical expression of affection like between you and your daughter?
PT: I hug her a lot and she hugs me a lot.
TH: Really you feel open?
PT: Ohhhh yeah, oh yeah.
TH: Oh I see.
PT: And yet I don't think she . . . she's physically emotional.
TH: When you hug her and hold her do you get flashes of the past?
PT: (deep sigh) *Uhhhh I think out . . . like it's certainly. . .*
TH: You see one thing significant in your past is the absence.
PT: That's right, I mean I think it's because of the absence of that connection that I feel so, so strongly. There came a time last year when we almost separated, my wife and I. And when it came to it, if the children hadn't been there I was gone, I wouldn't have stayed. But when it came to the actual night to go and I told the children I just . . . just . . . (cries) *. . . just couldn't leave.*

TH: *So with Isabel you capture the past in a sense.*
PT: *And with my son, we're very close.*
TH: *I know, but we can go to that as well.*
PT: *Yeah, yeah. Very close. Uh yeah but it's a . . . but I can see a very close link there. I couldn't leave them for one minute* (choked-up voice) (breakthrough of waves of painful feelings)
TH: *When you hold her or hug her you get the flashes of . . .*
PT: *I . . . is that what it is? Like am I consciously . . .*
TH: *Is buried and repressed in you but unconsciously you must be feeling . . .*
PT: *Yes.*
TH: *. . . the experiences that you wish you could have had in the past. You see what I mean? Because there is a major gap in you about your life in these early years you see. The craving for a tender affectionate relationship hmm with. . .*
PT: *Yeah, and I think I crave that from my wife, and I don't get it because she's not my mother and she refuses to be a mother. And I think also that relates to in this other woman Linda I was mentioning, is that my. . I sense that my passion for her or my sense of wanting to be with her is because I sense the mothering and caring. She's a close friend.*
TH: *Yeah I'm talking about the affectionate.*
TH: *But if we keep with Isabel.*
PT: *Yeah.*
TH: *You say your daughter reciprocrates and you are able to both exchange a tender affectionate feeling for each other?*
PT: *Yes, yes.*

In the above passage the unconscious therapeutic alliance clearly identifies the woman that he brings into bed during intercourse is his daughter, who is slim, blond, with small breasts and blue eyes. The unconscious has introduced two portraits: one is the portrait of Linda, the other is the portrait of his daughter, which are exactly identical. The therapist follows the communication and raises the question to the patient if he had had a wife like his daughter.

PT: *Look, if you carefully examine your mind hmm, if you had a wife like your daughter, how would you portrait that? Again we are talking about something that is heavy but is again very important. Has it ever passed through your mind that if you had a woman like Isabel?*
PT: *No I think not.*
TH: *I know because you suppress it. You have a tendency to suppress. You know what I mean by suppress?*
PT: *Push it aside.*
TH: *But the most important for you is not to go to that.*
PT: *Yes.*
TH: *Very carefully examine even if it is painful because she's your daughter.*
PT: *Yes.*
TH: *But a part of you might at times have flashes that if you had a wife, or a woman . . .*
PT: *Yes.*
TH: *Now has such a thing, like a flash, a split-second, at times has passed through your mind?*
PT: *Well not that thought.*

TH: What thought?

Now the *unconscious therapeutic alliance* brings into the open his incestuous feelings for his daughter.

PT: I know that . . . what what . . . as she was becoming a woman I was certainly aware of how easy it must be sometimes for incest to occur. I was certainly aware of a physical response to my daughter.
TH: In a sense you have some incestuous thought about her.
PT: Yeah, yeah.
TH: What exactly your incestuous thoughts are?
PT: Well I mean I can feel a stirring of my body, my my . . . I get an erection.
TH: You would feel an erection?
PT: Oh yeah I would, I would, I would feel it and and be aware of it and . . .
TH: While she was . . .
PT: While, while I was . . . yeah while I was sitting and talking with her on her bed or it could be some intimate, intimate situation.
TH: Again these things are painful.
PT: Yeah, uh . . .
TH: But our job is to examine them carefully.
PT: The flash is as if what it would be like to make love to her.
TH: And you have also erection with it?
PT: Yeah.
TH: Hm hmm, that she would be nude?
PT: Nude yes, or partly so.
TH: You have seen her nude?
PT: I see her, I mean even now.
TH: How she looks, . . . her body?
PT: She's beautiful.
TH: I know but how would you describe?
PT: I describe her as uh . . .
TH: She's blond in the hair.
PT: Blond in the hair and black in the pubic hair.
TH: Her genital is black.
PT: Yes black. Uh and she's very slim.
TH: Slim.
PT: Yeah she's. . .
TH: And small.
PT: . . . she's not big at all.
TH: Hm hmm.
PT: Uh and you know her breasts are just small.
TH: Small.
PT: Small breasts
TH: So then in actuality your daughter is slim, with small breasts, blond hair.
PT: Yes.
TH: Dark genitals.
PT: Hmm.
TH: And you have had passing thoughts about a sexual relationship with . . .
PT: Yes.

TH: *And that obviously is something that passes through your mind and you even have erection.*
PT: *Yeah, it has.*

It is important to note that the unconscious therapeutic alliance has made two major communications: that he has incestuous feelings, even erection, in relation to his daughter and that the woman he brings into the bed during intercourse with his wife is his daughter, which clearly explains why when the therapist was exploring the body of Linda the resistance was mobilized. Now we return to the interview.

TH: *And very important again you examine this, when you are making love to your wife . . .*
PT: *Yes.*
TH: *. . . and you bring another woman . . .*
PT: *Yeah.*
TH: *. . . okay? Who is that woman that you bring into the bed?*
PT: *Well . . .*
TH: *It's very important because the woman you described . . .*
PT: *. . . is like my daughter. But it's not . . .*
TH: *But you see, look, you are here to examine rather than to repress these issues.*
PT: *Yeah.*
TH: *Okay, because the essence of all these things is to face with the truth . . . the ugly trooth, which is T-R-O-O-T-H.*
PT: *Yeah.*
TH: *Because the question is this, the one that you described was blond, slim, small breasts and genital dark.*
PT: (mumbles)
TH: *And then we know you get this kind of thought about the sex and sexual feelings for your daughter. Now the question is this, who is the woman when you are making intercourse with your wife?*
PT: (sighs)
TH: *I know as a father it's very painful to declare this, but at the same time you are here to face with the truth of your . . .*
PT: *Well it's. . .*
TH: *Because you are now 46 years, you have been running away from facing with your buried feelings.*
PT: *Yes.*
TH: *But it is time you examined them, face with them, and face with the truth. Then you would be a free man. Then your relationship with your daughter would also follow a different perspective rather than. . .*
PT: *You see, I haven't had the . . . I've never thought of that before.* (sighing)
TH: *I know, but that is exactly the woman that you describe when you are making love. It is exactly your daughter.*
PT: *But it's also a woman I know so I . . . see I've never . . . I can say I've never. . I'm not even aware of trying to think a thought of my daughter when I've been in bed with my wife.*
TH: *I know, but the woman you describe is exactly your daughter.*
PT: *Yes, yes.*

TH: How do you feel when we see a bridge . . . you see the middle of the bridge is wiped out.
PT: Yeah.
TH: The bridge between the bedroom; you are making love with your wife and then there is this slim blond . . .
PT: Yes.
TH: . . . petite and then genital dark and then the hair blond.
PT: Yeah.
TH: Which is your daughter. How do you feel when we bring this to . . .
PT: Consciousness? I can see.
TH: Because obviously there must be something like that there. You yourself said you get this when you sit with her and so forth; you have had such a feeling.
PT: You see, I feel very close to her, but I don't want to affect her that way, and I have been very disturbed about this erection and the incest feeling, and I feel positive that we are able to examine some of this . . .

Then he talked about his concern that these feelings might affect his daughter negatively. He has a close relationship with his son, who is taller than he, and enjoys hugging and holding him. (It is important to note that a few weeks after the trial therapy, the patient entered into treatment and pointed out that his incestuous feelings for his daughter have been totally resolved, which was a great relief to him.)

Exploring his Relationship with his Father

His relationship with his father was explored. He says that he was not around to hug until the patient was seven, and after that he refused to hug him and remembers being told that "fathers did not hug sons." The therapist points out "you never had the taste of a tender, affectionate father–son relationship," "life has passed and the affectionate father–son relationship never was realized." He becomes more sad and says that must be the reason "I feel so good to hug my son, it feels to good to hug him," and his son reciprocates.

Exploring his Current Family

The therapist explores his current life orbit, which centers around his two children. Then he talked about his fear if something happens to them. The therapist explores his reaction and he said "I would become paralyzed . . . it would be a tremendous blow." Patient is sad and with a low voice said "Would I rage or . . . cry," "Yeah I think I would find it overwhelming, that loss." Then he added, "I would sob," "I would wonder whether I would have a rage against god," "I would go into shock."

Inquiry into the current family dynamics shows that there is a power struggle between mother and the children and indicates that the children handle it much better than he does, in particular his daughter. As the therapist must bring the initial interview to the end he must explore areas that so far have not been covered.

Inquiry into his Previous Treatment

The patient indicates that the conjoint therapy was totally unsatisfactory. It mainly focused on their system of interaction and how to bring about a better way of interacting on a day-to-day basis. What emerges is that he had negative feelings toward the therapist, and the way he dealt with it was taking a passive-compliant position with her. "At the time I just accepted it meekly, saying 'Well that seems reasonable', and so on." And finally she, the therapist, decided that his problem dates back to the "preverbal stage of my development," and she indicated to him that he needs long-term treatment. His wife decided that she wanted to continue in individual treatment with the same therapist. The therapist for a moment brings the tranference to the focus.

TH: You see, in relationship with your wife, as well as Dr. X., you mould yourself and as you say it "I just accepted it meekly," and you complied and it is important . . . I want to make sure that . . . that has not been between you and me.

PT: I see what you mean. No, it is not.

TH: That you are doing it because you feel that this is important for you?

PT: Yeah. It's important . . . It is very important and I want to do everything that I can to overcome my difficulties.

Return to the Phase of Inquiry

Exploration into the developmental, medical and social history

The therapist begins by questioning, "Where were you born?" He was born in Eastern Canada, then the family moved towards the Midwest. As already indicated both of his parents left him when he was one. His father was an engineer before the war. After he returned from the war he worked as a manager in an apartment building. His earliest memory of life is of being left alone. In the early part of his life he lived with seven other children, his Aunt Elizabeth, two other aunts, his uncle, and grandmother Blanche. He comes with a memory that every morning he was put out into the street along with other children by his grandmother, as the uncle wanted to sleep. He comes with another memory as a little boy with a stick of wood and wanting to make a gun out of it. As a child he was shy, detached, passive, never a fighter, and didn't like other children. Then he talked about his grandmother Blanche, describes her as being highly controlling, demanding, critical and punitive both physically and psychologically, often with a vicious biting tongue that mobilized fear. Then he talked about Aunt Elizabeth, who was kind, affectionate. He came with vivid memories of her dressing him up, taking him by bus to the city where his mother was living. He has memories of her rocking him, as he used to cry a lot. During the interview he says "even right now here I can hear her voice telling me 'don't be afraid, don't be afraid' " and indicates that is what actually he does when he faces with a difficult situation at home, when things are falling apart, he whispers to himself and repeats to himslef "don't be afraid, don't be afraid." In talking about Elizabeth he becomes sad, with tears in his eyes.

Then, in a sad state he talks about his brother, indicating that in the early years of his life he had looked up to him as a protector. Currently he has a detached relationship with him and refers to him as a man with a strong homophobia. In

talking about his closeness with his brother, there is a wave of sadness with tears in his eyes.

Further Dynamic Exploration

It is important to note that the unconscious therapeutic alliance is in operation. He is spontaneous, and very lucidly talks about aspects of his early life. In the following passage, he talks with a great deal of feeling about his brother as a protector and its link to his son.

PT: I think that comes again from that feeling that my older brother was, was a protector.

TH: You know, when you talk about how you wish that you could have a physical closeness with your brother you become sad with tears in your eyes.

PT: Yeah.

TH: And when you talked about the physical closeness, hugging and holding with your son then also there were tears and sadness. Have you noticed that?

PT: Yes, definitely, I can see that.

TH: And immediately sadness and tears come. This raises the question if there isn't some connection between the two, that when your son hugs you and holds you, and he is quite taller than you, you might have some feeling about your brother that you looked up to as a protector, as you said.

PT: Yes, that's right.

TH: That a part of you has murderous feelings for him as we saw, but another part of you has positive. . .

In the following passage the process again moves to his father and the major gap within him about the father–son relationship, and the patient responded "the male connection too, yes."

TH: In a sense there is a major big vacuum within you for the father–son relationship that died by virtue of the war or whatever, doesn't make a difference you see, and as you yourself said, you looked up to your brother as a protector, and when you talk about him in the early years you become sad and tearful. But there also, that relationship ended up in an exchange of rage as we saw the scissors incident that you were near to murder him. And now in your current life you are recapturing these elements in the relationship with your son. But still you have major mixed feelings.

PT: Hm hmm.

TH: Because when you talk about your brother, true a part of you has had murderous feelings, but at the same time what we can see is a part of you has a lot of positive huh?

PT: Very positive.

Further Exploration into his Early Life

It is important to note, and this is always the case in trial therapy with patients with complex psychopathology with moderate to high degree of resistance as well as those who are extremely resistant, that the phase of inquiry and exploration into the developmental history becomes possible after direct access to the

unconscious has been achieved and there is a major weakening in the forces of the resistance with a strong mobilization of the unconscious therapeutic alliance. So far, the unconscious therapeutic alliance has made clear the two aspects of his feelings toward his brother, the murderous rage and guilt and his positive feeling as a protector. At the same time he has emphasized that his son is taller than he, and when they hug each other patient said, "it feels so good": and what we see is the link between his brother and his son, which later on becomes linked to his father, to which the patient refers "male connection".

Our knowledge about the father is not clear. But it is important to note that it is not the function of the trial therapy to cover all areas, particularly in a patient with as complex a psychopathology as this. This will be covered in the body of the treatment after a series of repeated breakthroughs into the unconscious take place. Now the therapist explores what he remembers about his father. "What happened when your father came back from the war?" He remembers getting dressed up and going to meet the train, but "I don't remember meeting him, all I remember is meeting the train and all the soldiers looking out of the window." He does not remember which train station it was. He remembers his Aunt Elizabeth being with him, along with his brother. Then he added "of course, I wouldn't recognize him"; and he further added "but I don't remember." "Do you remember the contact with him?" Patient answered "No I don't. I don't remember it at all," and added "I have no . . . totally blanked out."

After the return of the father, his mother returned and they moved into the same house. The family configuration consisted of the patient, mother, father, brother, two aunts and grandmother Blanche. The situation became very difficult. Then he talked about the conflictual years with grandmother Blanche, who was controlling, domineering and demanding, with a vicious temper, manipulating one against the other; and the patient refers to himself as the gofer. "There was a battleground." With bitterness he talked about Blanche, who put him down, was critical of him. "Don't do this, don't do that." No matter how he did it "still she would put me down," "She had a vicious biting tongue." He continues: "Uh, you left the toaster on."

The therapist is well aware that there are many aspects, or character traits, of his wife that are similar to those of his grandmother Blanche, and during the interview the patient becomes well aware of the similarities. At the same time, the therapist knows that access to his unconscious repressed buried feelings in relation to his grandmother requires another unlocking and systematic work on another major layer of resistance against the experience of murderous rage. As this is a trial therapy in the standard technique and the therapist has to accomplish the task of completing the initial interview, he should avoid further unlocking—which would turn the trial therapy into the process of treatment. At this point the therapist simply makes some further exploration about his grandmother.

Further Exploration of Grandmother Blanche

The Pathogenic Situation

TH: But you see one of the major problems that you have which you want to really start to look at; intellectualizing is a process that doesn't help one's feelings.

PT: I do a lot of it yeah.

TH: You see? You can intellectualize okay your father had to go to the war but still you have the feeling about it. Now your grandmother is critical, is demanding, everything has to be her way and so forth. At one level you can intellectualize, but the other side is to look to the feelings.

PT: Hmm.

TH: That she is critical, she's demanding, and she is running . . .

PT: Yeah . . . she's the headmaster . . . hmm, a malignant headmaster.

TH: On the one hand your mother . . . who, the way you describe, is like a dead person, your father is in the war and when he comes back he's not there neither.

PT: Yeah.

TH: Then you are left into a situation . . . your grandmother also is critical, "Don't do this, don't do that, don't move this way. " You must have a lot of feelings towards her.

PT: They were anger, angry.

TH: Hmm. How did it express itself?

PT: I don't think it did, I think again I didn't express it.

TH: Hm hmm.

PT: I remember my brother expressing it.

It is important to note that the therapist, here, asks the patient how he expressed his anger; while during the major unlocking he repeatedly pressed for the physical experience of anger. The major reason is obvious. He has decided to terminate the initial interview and the process of bringing him in touch with his unconscious murderous rage is the task for the first few psychotherapy sessions, which is the phase of repeated unlocking. Return to the interview.

TH: So your brother was more assertive, bouncing back, and then you were the compliant . . .

PT: Yeah. The pattern, yes that's right.

TH: So then you took a beaten position with your grandmother as well.

PT: Yeah.

TH: The beaten position with her as well. As if in a sense the law that you set for yourself was set up from the very early years huh. Once beaten always the beaten hmm. Once crippled the crippled.

PT: Hm.

His grandmother died when he was 24. He avoided the funeral in spite of the encouragement of Aunt Elizabeth. Then spontaneously he talked about the similarity between Blanche and his wife. "The one thing that stands out, as I am talking about my grandmother, is the way my wife demands where things must be done in a certain way, and uh, like my grandmother, she comes down and says this plate is not put away." Patient with a high pitched voice and anger talks about his wife "It is not put away," "why isn't . . . why aren't people putting plates away?" "Why is the toaster in the middle of the counter?" Then patient says "When I look at it, that is my grandmother, no question about it."

PT: You mean there are patterns of behavior of your wife that is similar to the pattern . . .

PT: Very, very close.

TH: . . . of your grandmother and so forth?
PT: Yeah, very close.
TH: What you say is this, with your grandmother this had to be this way, that way, you had the rage and the anger and wiped it out and tried to be a goody-goody boy.
PT: That is right, with anger; but that is what exactly I do with my wife.
TH: Detached, compliant, silent and so forth.
PT: This is exactly.
TH: You see, I don't know if you remember when we met today and I asked you about your difficulties you said "I act like a child" . . .
PT: Yeah, that's right, that is the way I deal with my wife. This is the time to make love, this is the time to do this, this is the time to do that. Then I freeze. Then I fume and I push it aside and go paralyzed.
TH: But we saw under the paralysis is the murderous rage to throttle her to death.

In the above passage:

(a) he clearly sees the similarity of the pattern of behavior of his wife to that of his grandmother;
(b) once more the therapist drives home insight into the nature of the defenses that he has used in relation to his grandmother, and he responded that that is exactly what he does with his wife;
(c) the significance of "I act like a child" becomes clear;
(d) patient very clearly and explicitly indicates that "I fume" and the defense mechanisms that he uses "freeze", "go paralyzed";
(e) and the therapist points out that underneath the paralysis is murderous rage to throttle his wife to death.

The therapist here is implying that his rage towards his grandmother must have that murderous quality; but as we see, technically, he leaves this for the first phase of the treament, which consists of repeated major unlocking of the unconscious.

Consolidation; Bringing the Interview to a Close

At this point of the interview, as the therapist has decided to bring the interview to an end, he usually recapitulates some of the key points of the process; briefly summarizes what has been brought to the focus; explores the patient's feelings, particularly transference feelings; outlines a general frame of the course of treatment, and finally asks the patient if he is determined to do so. Return to the interview.

TH: So, you see, you have a major diffuse problem with life. Isn't that?
PT: Yes, indeed.
TH: You have a problem in relationship with people, you have suffered from many disturbances, such as anxiety, depression of which you are well aware.
PT: Yes . . .
TH: There are many problems; is not a new problem, it is a problem that is a life-long problem.
PT: Yes, I see that. It is misery.

TH: There is a need in you to go from one disastrous situation to another, which goes to the very early phase of life . . . throughout your life, hm?
PT: Hm hmm.
TH: But at the same time, obviously on one side you have made something out of this disastrous situation of the past, you have become an engineer.
PT: Yes.
TH: Yes . . . but the other side is a disaster.

The therapist once more recapitulates on the self-destructive aspect of his resistance and the masochistic component in his character.

PT: If we look to this pattern, what we see . . . there is a major problem which roots itself in the earliest phase of your life, and you have a lot of mixed and buried feelings in relation to many of these figures.
PT: Hmm.
TH: There are a lot of mixed and buried feelings that go back to the first year of your life which have carried on up to now, huh, okay?
PT: Hm. I can see that.
TH: As we have seen, there are many other problems; passivity, detachment, going to silence or going to defiance, becoming detached, remote, depression, and pain in the neck, huh?
PT: Yes.
TH: So there is this pattern that you have been carrying all your life, but you have not done anything about it. That is another issue . . .
PT: I . . . I've not . . . yeah.
TH: Because you are intelligent, you are an engineer, and you know that these major difficulties might even permeate and negatively affect your work . . . I don't know, they may not . . . anyway you have not done anything about it. You, yourself, have said that you are like "half-a-person"; but if you look at what we have seen so far, you are going from the frying pan into the fire, from one disaster to another.
PT: Yeah, but I want to change. I don't want to go to my grave a crippled man.

The therapist once more drives home insight into aspects of the dynamic forces that are responsible for the patient's disturbances, his masochistic character pathology, the perpetrator of his unconscious.

TH: That there is a need in you to suffer, this need in you to perpetuate suffering and misery, and all the mechanisms of dealing with the pain, murderous rage and guilt, which as we saw was toward your mother, and your brother, and also we saw toward your wife. We haven't explored your father or your grandmother yet. Do you follow me?
PT: Yes.
TH: And the way you dealt with this dilemma and the pathogenic situation has been to lose your autonomy, to give up your freedom.

Here the therapist is reemphasizing:

The breakdown of the nuclear family,
Abandonment and severe trauma,

The pain of trauma,
Unconscious murderous rage and guilt in relation to his mother,
Murderous rage and guilt in relation to his brother and wife (diagram).

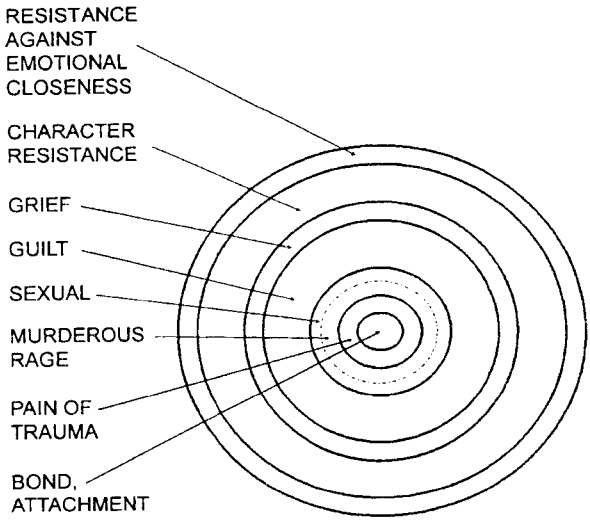

Figure 1. (Davanloo) Psychopathological dynamic forces.

The focus is on the guilt and punishment, and the therapist once more drives home further insight between the pathogenic situation of the past and his need to let himself be used and abused, self-defeat and self-sabotage. The response to these interventions are highly positive, and he further says that he wants to do everything to change, "I want to change and want to do everything that I can to free myself." Now we return to the very last part of the interview.

TH: But do you think what we did today, which was touching the top of the iceberg, to say, if you do it more systematically, this would be of help to you, to resolve all of these mixed buried feelings from the past? Not only the top of it, the whole, and to become a free man with your own . . .

PT: I want to be a free man. I don't want to continue . . .

TH: You see, what I am looking at is this; we have touched the top of that iceberg but my question is this, do you want to do it more systematically . . .

PT: I want it all cleaned up. It frightens me as well, but you know, I, I don't wanna stop now. Cause you are right. I can see the pattern going on and on forever and that's just . . . I . . . am appalled that I have gone so long. I want to change. This session has been helpful in making that much more real, what has been building up and what I have started to see, and I can see that there is a part of me that doesn't want to solve it. And you have made it clear how . . . how deep and pervasive, I guess all those mechanisms that I use.

The patient's response to the trial therapy is highly positive and indicates determination to work and liberate himself. Then the therapist brings in the

transference before he terminates. In the following passage he asks the patient how he feels towards him.

TH: How do you feel toward me?
PT: (laughs) *How do I feel?*
TH: Part of you wanted to do away with me.
PT: Yes.
TH: What happened to that part?
PT: Well . . . I don't wanna do away with you. (smiles) *What happened to that part? It is gotten out, I . . .*
TH: It is not there anymore you mean?
PT: Yes, that was quite an experience
TH: So then what is the feeling?
PT: Feeling. Well I feel close, uh, but not very close. If feel very . . .
TH: Do you notice also you have difficulty about the issue of positive as well?
PT: Yes. That has become very real today.
TH: As if you are terrified to verbalize positive feeling.
PT: Yeah, I can see that, and today it has become very real to me.
TH: Now that we say goodbye to each other, is the net—if you put the positive negative, is the net positive or negative?
PT: It's positive.
TH: Hmm.
PT: It's positive.
TH: This is compliance or . . .
PT: No. No. It is positive. This is really what I feel. It is hard but it is positive.
TH: Hmm.
PT: It has been painful, but at the same time it has been positive.
TH: But before we say our goodbye another thing about you is you underestimate your potentiality, because let's to face with it, under extreme difficult circumstances of life you have made a profession for yourself, you have a family.
PT: Yes.
TH: And under very difficult circumstances of this meeting with each other we got to some of the very fundamental issues, which is the beginning of the road to the future.
PT: Hm hmm.
TH: But you have a tremendous tendency to underestimate your potentiality. Do you follow me?
PT: Yes, I can see that.

Recapitulation

Here it is important to recapitulate the main technical interventions and the process of the initial interview—the trial therapy, which was presented in this two-part article. The process of the whole interview can be summarized as follows:

(1) The interview started with the phase of inquiry, which was not productive.

(2) The therapist introduced pressure on the resistance of vague generalization, asking for a specific example. This led to a rise in the transference and anxiety. The therapist introduced further pressure by focusing on his feelings. This led to further resistance in the form of a series of defenses. The resistance was tangibly crystallized in the transference. There was a gradual transition from pressure to challenge. The result was crystallization of the patient's character defenses in the transference, and the therapist systematically challenged the patient's character defenses and concomitantly made the patient acquainted with them.

(3) From the psychodiagnostic point of view the therapist's conclusion was a man in his forties suffering from character neurosis and decided that a rapid unlocking of the unconscious is the procedure of choice and decided on his technique of a two-stage unlocking: partial, followed by a major unlocking in a single interview.

(4) As already indicated, the process started with the phase of pressure on the patient's resistance. As soon as there was evidence that the resistance to some degree had become crystallized in the transference, the therapist introduced challenge to the resistance with further crystallization of the patient's character defenses in the transference and at the same time systematically made the patient acquainted with his character defenses.

(5) Then the therapist's technical intervention consisted of his most powerful technique of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference.

(6) This resulted in a partial breakthrough into the unconscious and major waves of painful feelings with the mobilization of the unconscious therapeutic alliance and a direct view of the psychopathological dynamic forces; being abandoned by both parents at the age of one year.

(7) This was followed by a phase of analysis of the transference and consolidation.

(8) Then the process returned to the phase of inquiry, which indicated that he suffered from diffuse symptoms and character disturbances. Now the patient was exceedingly responsive.

(9) The therapist in search of a return of resistance undertook a dynamic exploration into the patient's marriage. There emerged that the only way he could have intercourse with his wife was to bring the mental image of a woman named Linda. Under pressure the unconscious therapeutic alliance described her as blond, blue eyed, slim, with small breasts and dark genital. This was the last communication of the unconscious therapeutic alliance as a major resistance was mobilized in the transference in describing Linda's body.

(10) The therapist introduced challenge and pressure to the transference resistance, resistance against emotional closeness which further intensified the resistance.

(11) The therapist mounted the challenge, which was followed by his technique of repeated short-range interlocking chain of head-on collision to the transference resistance. This led to frustration in the transference, and the patient declared, "Well I'm frustrated." This tactical defense was considered well entrenched in the major resistance, and there was considerable challenge and pressure. Then finally the patient declared, "I'm frustrated at you."

(12) This led to anger in the transference, pressure to the physical experience of anger, with challenge and pressure, with repeated partial head-on collision aiming at a systematic weakening of the major resistance of repression which led to:

(13) Major unlocking. The direct experience of a murderous rage in the transference. The impulse to murder the therapist by strangulation, the emergence of guilt-laden unconscious feelings and mobilization of the unconscious therapeutic alliance.

(14) The unconscious transferred the murdered body of the therapist into the murdered body of his mother with the emergence of intense waves of guilt-laden unconscious feelings. Then the process entered:

(15) The phase of a systematic analysis of the transference, followed by:
(16) Major communication from the unconscious therapeutic alliance. The incident when he nearly murdered his brother: direct experience of murderous rage toward his brother with the breakthrough of intense waves of guilt. The process spontaneously moved to:
(17) Death and funeral of his mother with the passage of intense waves of painful feelings. He came with the incident of the only 2 hours he had with his mother. Then the process entered:
(18) Once more into the phase of systematic analysis of the transference and consolidation. Then the therapist made a dynamic exploration into this marriage, which led to:
(19) Major communication from the unconscious therapeutic alliance. His murderous rage toward his wife, which led to:
(20) Direct experience of murderous rage toward his wife; the passage of waves of guilt-laden feelings and the emergence of positive feelings for his wife. Then came:
(21) Another major communication of the unconscious therapeutic alliance which clearly identified that the woman he brings to bed during intercourse with his wife is his daughter. This led to:
(22) Another communication from the unconscious therapeutic alliance, his erection and incestuous feelings for his daughter.
(23) As the initial interview is coming to an end, the therapist explores the patient's relationship with his father. There emerged an absence of a father–son relationship. In his early years he turned to his brother as a protector. Then the therapist made further dynamic exploration into his early life, which clearly indicates that after the breakdown of the nuclear family the patient lived with seven other children with his grandmother, a clearly pathogenic situation; and the therapist explored further. There emerged that she was both physically and psychologically abusive. He refers to her as a "malignant headmaster."
(24) By now both the patient and the therapist have a much better view of the perpetrator of the patient's unconscious, namely the original trauma, being abandoned by both parents, and the subsequent disastrous traumatic situation with his grandmother. Here the patient introduced the link between his wife and his grandmother, saying that much of his wife's behavior is similar to that of his grandmother.
(25) Then emerged a very important relationship, his Aunt Elizabeth. The data clearly indicates that she was a kind, affectionate woman who was like a substitute mother to him. Then the interview entered:
(26) The phase of recapitulation, consolidation and finally exploring the patient's transference feelings, which clearly indicated his will and determination to change the course of his life. Around the end of the interview he clearly declares "But I want to change. I don't want to go to my grave a crippled man." Emphatically, he said, "I have got to change."

It is important to note that after the major unlocking of the unconscious the patient became exceedingly responsive and communicative. The process clearly indicates that the powerful unconscious therapeutic alliance has had total command of the process.

Summary and Conclusion

Here it is important to recapitulate the main technical interventions and highlight some of the important technical and metapsychological roots of my technique.

(1) I emphasized that the technique can be applied to the whole spectrum of psychoneurotic disturbances, no matter the degree of resistance. I summarized the features of patients on the extreme left of the spectrum — highly motivated, highly responsive, with a single psychotherapeutic focus. I emphasized a total absence of an unconscious murderous rage in this group of patients and further indicated that the nature of the resistance is very different than that of patients on the right of the spectrum. The course of treatment of one patient, the Case of the Salesman, was presented to demonstrate the extreme ease with which one can achieve therapeutic results.
(2) Then I emphasized some of the main characteristics of patients on the right side of the spectrum of psychoneurotic disorders and indicated that they suffer from life-long character neurosis, highly complex core pathology, are highly resistant; and in all of these patients there is the presence of an unconscious murderous rage or primitive murderous rage or a primitive, murderous, torturous rage and intense guilt- and grief-laden unconscious feelings.
(3) Then I briefly discussed the application of my technique to patients with severely fragile character structure, and pointed out: (a) they do not have the capacity to experience and tolerate anxiety. The discharge pattern of anxiety is heavily in the form of a major disruption of the cognitive and perceptual functions; (b) They have easy access to a spectrum of primitive defenses, explosive discharge of affect, poor impulse control, projection, projective identification and double protective identification, the phenomena of drifting and dissocation; (c) The unconscious murderous rage is extremely primitive; and (d) There is no discharge pattern of unconscious anxiety in the form of tension in the striated muscles.

Briefly, unlocking the unconscious within 30–45 minutes is contraindicated. My current data clearly demonstrates that this technique can be applied to the whole spectrum of patients with fragile character structure, and the course of therapy has a number of phases. The first phase aims at bringing about sufficient unconscious structural changes to enable the patient to withstand the impact of the unconscious. In this research I have clearly demonstrated that as a result of such structural changes, the discharge pattern of the unconscious anxiety shifts from cognitive and perceptual functions to anxiety in the form of tension in the striated muscles. Then the process enters the second phase consisting of repeated unlocking of the unconscious and the direct experience of the unconscious primitive murderous rage and guilt- and grief-laden feelings. By the second and third phases, the unconscious therapeutic alliance is at a very high level. I have called this the "optimum unconscious therapeutic alliance, dreaming while awake." In this phase there is repeated breakthrough of a primitive murderous rage with guilt- and grief-laden unconscious feelings in relation to parents, sibling(s), and other early figures. Then the process enters the phase of multidimensional structural character changes. It is important to note that this treatment is highly effective in the treatment of this group of patients provided the therapist has extensive knowledge of the structure and function of the unconscious and is in tune with all the intricacies of the unconscious universe.
(4) Then four major techniques of unlocking the unconscious were presented: partial, major, extended major and extended multiple major unlocking.
(5) Then the dynamic sequences in the process of unlocking the unconscious were discussed, and it was indicated that these phases tend to overlap and proceed in a

spiral rather than a straight line, that these dynamic sequences can be seen as a framework which the therapist can used as a guide, constantly working from one phase to another.

(6) It is important to note that the phase of pressure may contain passing moments of challenge, but systematic challenge should not begin until the resistance has been tangibly crystallized in the transference. Then not only must the resistance be challenged but the patient's attention must be drawn to it and its nature clarified for him. Making the patient acquainted with his resistance is an essential part of the early process.

(7) Challenge consists of calling upon, countering, or blocking the resistance in such a way to convey an attitude of no respect for it. Challenge is a central intervention in my technique and is foreign to the therapist trained in psychoanalysis and traditional dynamic psychotherapy.

(8) It was emphasized that the course of an interview depends to a great extent on the rapidity of the development of resistance and transference feelings. Where these two factors are not detectable and are slow to develop, the therapist must move to the phase of pressure in a search for resistance.

(9) I emphasize that the transference holds a very important key position, and the therapist must watch with utmost vigilance for indications that the transference is becoming a major factor in the interview and should take note of it and act upon it. It is important to keep in mind that pressure from the therapist leads to resistance in the patient, resistance leads to challenge from the therapist. Challenge leads to a rise in transference feelings and increased resistance. This leads to further challenge by the therapist. Now the resistance becomes crystallized in the transference in the form of transference resistance. Then the therapist's intervention is head-on collision with the transference resistance, and this eventually leads to the patient's direct experience of transference feelings, mobilization of an unconscious therapeutic alliance, and direct access to the unconscious.

(10) In the process of direct access to the unconscious I emphasized the phase of intrapsychic crisis: a state of tension between two major forces, namely resistance and therapeutic alliance. The act of challenging the defenses with the conveyed lack of respect for them creates an extremely complex state within the patient, one in which the patient wishes to both hold onto his defenses even more strongly and also begins to turn against them. He becomes both angry and deeply appreciative of the therapist's relentless determination to help him. This creates a tension between the resistance and the therapeutic alliance.

(11) Then I presented the technique of head-on collision, with heavy emphasis on the technique of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference. I consider it one of the most powerful technical interventions. It has been an integral part of my technique and has been the by-product of a series of systematic research with the aim:

(a) To block all the defenses maintaining the force of resistance.
(b) To mount a direct challenge to all the forces maintaining self destructiveness.
(c) To intensify the rise in transference feelings.
(d) To mobilize the therapeutic alliance against the resistance.
(e) To create a state of tension between the resistance and the therapeutic alliance.

(f) To loosen the patient's psychic system; to change the situation from the dominance of the resistance to the dominance of the unconscious therapeutic alliance, which is the first breakthrough, and finally a partial or major unlocking in which there is major mobilization of the unconscious therapeutic alliance.

(12) Throughout this two-part article I emphasize the triple factors: resistance, transference, and unconscious therapeutic alliance. The concept of the unconscious therapeutic alliance takes a very central position throughout the history of the development of my technique, and the way I have described it is fundamentally different from psychoanalysis or any other form of dynamic psychotherapy. In all resistant patients, and in particular those on the right side of the spectrum who are highly resistant with complex psychopathology, this dynamic force is not in operation; and the powerful force of resistance has paralyzed all the patient's major functions. It is the power of this technique via pressure, challenge, rise in the transference, intensification of resistance, further challenge to the resistance, a further rise in transference feelings, crystallization of resistance in the transference, head-on collision with transference resistance, which have been described in these two articles, which mobilize the unconscious therapeutic alliance against the forces of resistance. This powerful dynamic force first emerges in the form of tension with the resistance. Then we see a dominance of the therapeutic alliance against the resistance, which shows itself in the form of the first breakthrough, which demonstrates that the whole psychic system has been loosened and the balance between these two forces then moves in the direction of an increased therapeutic alliance. The degree of unlocking of the unconscious is exactly in proportion to the degree that the patient has experienced transference feelings and the mobilization of an unconscious therapeutic alliance. In a partial unlocking the unconscious therapeutic alliance is mobilized and has clear dominance over the force of resistance. In extended major unlocking the mobilization of the unconscious therapeutic alliance is at its optimum level. The task of the therapist in the first few psychotherapy sessions is to bring the unconscious therapeutic alliance to the optimum level.

(13) One extremely important aspect to emerge from my research is the interrelation between the rise in the transference, mobilization of the unconscious therapeutic alliance, and resistance, which I summarize very briefly:

(a) In cases of partial mobilization of the unconscious therapeutic alliance, the patient has frequent dreams with latent and manifest content.

(b) In cases of major unlocking and high degree of mobilization of the unconscious therapeutic alliance, there is passage of murderous rage in the transference with the passage of guilt- and grief-laden feelings; and finally the murdered body of the therapist is transferred to the early figure. These patients dream often. The latent and manifest contents of the dreams become closer, and the dreams are much more vivid.

(c) In the extended-major and multiple-major unlockings, which is the basis of my method of psychoanalysis, there is direct experience of the primitive murderous rage in the transference; but instantly during the passage the unconscious transfers the therapist to the genetic figure, which is then followed by passage of highly intensive guilt feelings, then grief. These patients do not dream. The unconscious therapeutic alliance is at optimum level, and they dream while awake. (This whole subject will appear in future publications.)

(14) Another important aspect of the technique is that the therapist must have extensive knowledge of the pathway of unconscious anxiety in the form of tension in the striated muscles which starts from the muscles in the hands and spreads to the forearm, arm, shoulder, intercostal, back and legs.
(15) Equally important is the somatic pathway of the direct experience of the murderous or primitive murderous rage in the transference. I have established that this pathway starts with the pelvis, then lower and upper abdomen, then chest, then moves to the head, shoulder, arm, forearm, and hand, which patients often refer to as a "fireball" or "volcano," "a buildup of heat moving upward."

Finally, in this brief exposé I want to say that I have unequivocally demonstrated that in all resistant patients with highly complex psychopathology a multidimensional structural character change is easily possible, but it clearly depends on the patient's direct experience of all the layers of unconscious primitive murderous rage and intense guilt feelings and eventually the experience of the pain of the very early trauma. Therapies that focus primarily on the experience of grief-laden unconscious feelings without direct and actual experience of the murderous rage and the guilt do not bring about structural character change.

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