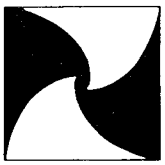

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Intensive Short-Term Dynamic Psychotherapy: Spectrum of Psychoneurotic Disorders

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In this article the author first describes the spectrum of patients that can successfully be treated with his technique of Intensive Short-Term Dynamic Psychotherapy and then he describes the application of the technique in the treatment of patients who are highly responsive with a single psychotherapeutic focus. There is an in-depth analysis of the process of a patient who was treated in a single interview.

Introduction

During the past 30 years, I have developed a method of Intensive Short-Term Dynamic Psychotherapy with extraordinary power, capable of resolving the core neurotic structure of the most resistant longstanding psychoneurotic disturbances. In the development of this technique, I have used audiovisual recording for teaching and research purposes.

The work of the early sixties primarily focused on the patients who are responsive with a single psychotherapeutic focus. The work of the latter part of the sixties and seventies primarily focused on patients suffering from severe phobic and obsessional disorders and those highly resistant suffering from life-long character neurosis. This systematic work resulted in the discovery of the technique of unlocking of the unconscious by the author, which provides a unique opportunity for both the therapist and the patient to have a direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances. I was able to demonstrate that the direct access to the unconscious is possible, in a single interview, with every resistant patient and that the degree of the unlocking of the unconscious is exactly in proportion to the degree that the patient has directly experienced the transference feelings. The clinical data clearly demonstrated the interrelation between the rise in the transference feelings, character resistance and unconscious therapeutic alliance.

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The systematic work of the early eighties was concerned with the application of my technique with patients suffering from depressive, functional, somatization and panic disorders. This work clearly demonstrated that the technique is highly effective in the treatment of the whole spectrum of psychoneurotic disturbances.

Then I concerned myself with the application of the technique to patients with fragile character structure. There I have been able to demonstrate that the technique can be applied even with patients with severe fragile character structure.

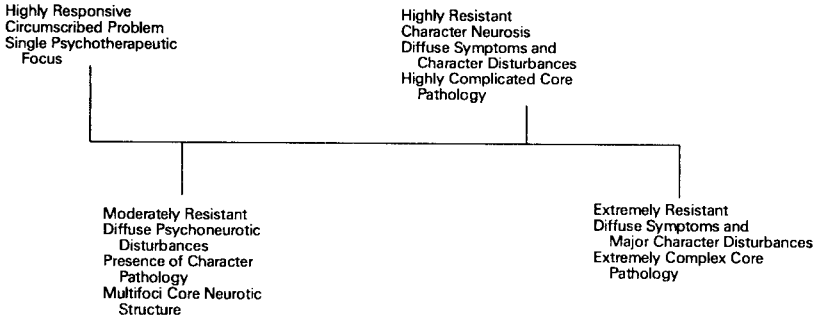
The work of the eighties and the early part of the nineties resulted in a great deal of refinement in the technical interventions in Intensive Short-Term Dynamic Psychotherapy, as well as in the development of a very highly powerful method of Psychoanalysis which has the power to bring multidimensional structural character changes in the extremely resistant patient with the most complex pathogenic unconscious (which will be the concern of a series of publications to follow). The truth of this statement has been demonstrated unequivocally, it has been presented at a large number of audiovisual symposia, courses and training programs to professional audiences in both North America and Europe.

The first few series of articles will be concerned with my technique of Intensive Short-Term Dynamic Psychotherapy and its application to two major spectrums of patients that can be treated successfully with the technique:

(a) Spectrum of psychoneurotic disturbances
(b) Spectrum of patients with fragile character structure.

Spectrum of Psychoneurotic Disorders

Based on the clinical research data, patients on this spectrum can be classified into five major groups.



(1) Extreme left on the spectrum

These patients are highly responsive to psychotherapeutic intervention. They might suffer from mild obsessional neurosis of recent onset, or mild phobic

disorder, or other forms of neurotic disorder. The main features of all patients on the extreme left of the spectrum can be summarized as follows:

* High responsiveness
* Circumscribed problems
* Single psychotherapeutic focus
* Very mild degree of resistance
* Absence of unconscious murderous rage

(2) Mid-left side on the spectrum

The second major group are patients with a moderate degree of resistance. Briefly, the main features of this group can be summarized as follows:

* Moderate degree of resistance
* Diffuse symptom disturbances
* Presence of some degree of characterological disturbance
* Presence of unconscious violent rage and guilt- and grief-laden unconscious feelings toward early figure(s), e.g., parent(s), sibling(s), etc in their life orbit
* Multifoci core neurotic structure

(3) Mid-spectrum

The third major group, which we may call mid-spectrum cases, are patients who suffer from character neurosis. They demonstrate:

* Moderate to high degree of resistance
* Suffer from diffuse symptom and character disturbances
* Presence of unconscious murderous rage, guilt- and grief-laden unconscious feelings in relation to early figure(s), e.g. parent(s), sibling(s), etc in their life orbit
* Fusion of sexuality and murderous rage
* Presence of masochistic character traits
* Complicated core pathology

(4) Mid-right side on the spectrum

Patients in this group are more complex and more resistant. They suffer from long-standing psychoneurotic disturbances. They demonstrate:

* High resistance
* Life-long character neurosis
* Diffuse symptom and character disturbances
* Highly complicated core pathology
* Presence of an unconscious primitive murderous rage, guilt- and grief-laden feelings toward both parents and others in their early life orbit—"The Perpetrator of the Unconscious" (Davanloo)
* Unresolved oedipal and sexualized feelings, when present, are deeply fused with the primitive murderous rage

(5) Extreme right side on the spectrum

These are patients with the most complex character neurosis, highly syntonic character resistance. They demonstrate:

* Extreme resistance
* Diffuse symptom and character disturbances
* Presence of a punitive superego pathology, high degree of masochistic character traits
* Highly complicated core pathology
* Highly primitive unconscious torturous murderous rage and intense guilt and grief, multidimensional in relation to early figure(s), e.g., parent(s), sibling(s), etc
* Unresolved oedipal and sexualized feelings, when present, are deeply fused with the primitive murderous rage of the unconscious.

The profile of patients on the right side of the spectrum, based on the research data, demonstrates with no exception:

(a) The presence of trauma, abandonment and/or series of traumatic experiences in the very early phase of life.
(b) The presence of a highly painful feeling in relation to the trauma and abandonment.
(c) The presence of an unconscious murderous rage or primitive murderous rage or even primitive torturous murderous rage in relation to parents, siblings and other figures in their early life orbit.
(d) The presence of intense guilt- and grief-laden unconscious feelings.
(e) They demonstrate a high to an extremely high degree of resistance.
(f) The presence of resistance against emotional closeness.
(g) The presence of a masochistic component in their character.

Based on this data, I introduced a concept which I called "The Perpetrator of the Unconscious."

Spectrum of Patients with Fragile Character Structure

The second spectrum, as I have already indicated, are those suffering from fragile character structure. If we place these patients within a spectrum we might consider three major groups: patients with mild and moderate degree of fragility, and those with severely fragile character structure. Patients with severe fragility cannot withstand the impact of their unconscious during the first interview, that is, during the trial therapy. These patients do not have the capacity to experience and tolerate anxiety and painful feelings, and they have life-long access to a spectrum of primitive defenses such as temper tantrums, explosive discharge of affect, poor impulse control, projection, projective identification and double projective identification. These patients easily become flooded with a high degree of anxiety and a major disruption of their cognitive and perceptual functions with hallucinatory experiences. They easily become light-headed, experience the phenomena of "drifting," drowsiness and dissociation.

I have demonstrated that the whole spectrum of patients with fragile character structure can be treated successfully with my technique, and the course of therapy

has a number of phases. Briefly, in the first phase the task of the therapist is to bring about sufficient unconscious structural changes to enable the patient to withstand the impact of his/her unconscious. As a result of such structural changes, the discharge pattern of the anxiety shifts from cognitive and perceptual functions to anxiety in the form of tension in the striated muscles. When the therapist has accomplished this task and has brought about sufficient cognitive and psychic integration, then he can proceed with the technique of repeated, first partial then major unlocking of the unconscious. The technique of bringing about structural changes with fragile patients will be the focus of a series of articles in the future. It has already been presented in many symposia and courses, both in North America and Europe; but, briefly the research data demonstrates the presence of an extremely high degree of primitive murderous rage within the unconscious.

Intensive Short-Term Dynamic Psychotherapy with Highly Responsive Patient

The rest of this article will focus on the application of the technique in patients who are highly responsive and so-called "motivated." The course of the initial interview of a patient who was treated in a single session will be analyzed in depth.

The Case of the Salesman and His Sister-in-law

At the time of the initial interview he was a 26-year-old married man. As will be seen, he is exceedingly responsive and in the early stages is willing to talk freely and meaningfully about difficult and painful subjects. He goes into a very mild degree of resistance comparatively late in the interview, and as a result the therapist is able to complete a large part of the inquiry before any sustained dynamic interaction begins. When this does happen, some of the interventions making up the Central Dynamic Sequence are used, though continuing to alternate with the phase of inquiry throughout the interview.

Initial Exploration, Psychiatric Inquiry

In the following passage the therapist opens with the standard question about the nature of the patient's presenting complaint. He learns that this is an obsessional symptom, and he sets about inquiring into its severity, the extent to which the patient's life is affected and whether there are any other difficulties. This is part of the psychiatric inquiry and the psychodiagnostic function of the trial therapy, the aim of which is to assign the patient at once to his correct position on the spectrum of severity of psychoneurotic disturbances, which obviously has importance in determining the roadmap to the unconscious. At one end of the spectrum he may be a basically healthy young man suffering from a mild obsessional symptom with a very mild degree of resistance; in the middle he may be a severely obsessional character with a very high degree of resistance; while at

the other end his whole life may be affected or even crippled by rituals and other obsessive–compulsive phenomena with a major degree of resistance.

In fact, it rapidly becomes clear that he suffers from only a single type of symptom, that this is relatively mild, and that although it pervades his life it does not seriously affect his functioning.

Initial Contact

TH: Could you tell me what seems to be the problem that you are facing?

PT: Well, the main thing is this repeating of, like checking my work and everything — almost like an obsession with it. I will take figures and transfer them from one sheet to the sheet that I am working on, and I go back and recheck them; and even then I am still checking and rechecking, and I get almost like a phobia — that I have done it wrong. Yet I know that I have done it right. I have been doing this work for many years now, and even checking it I can see that I have done it right. But it just seems to nag, like at the back of my head, that I have done it wrong. Sometimes after I have done something and I think back afterwards and think — did I do that right? Sometimes it bothers me so much I go back and check it again. Other times I can say, "No, I have done it right," and try to forget about it.

TH: You get these intruding, nagging thoughts if you have done it right . . .

PT: Yes, and I go back and check it over and over.

TH: Could you give me a specific example?

This seemingly innocent question is one of the standard moves toward exerting pressure. In response to it some patients immediately become alarmed and go into resistance, already sensing that they are going to be asked to be specific about more difficult areas as well; but, as will be seen, it takes much more than such a mild degree of pressure to alarm this particular patient. The indicator from the beginning is that the unconscious is in a fluid state. The therapist therefore continues with a straightforward question to clarify the psychiatric picture.

PT: For example, we have a statement in our office we send out every month, and there is like a correction routine that we have. I do it, but I have these nagging thoughts that it is not right, and I have to repeat it over and over. I know the code number and the information laid out on the sheet, and I know it is correct; but I have to check and recheck with no end. The thing is, now while I am doing my work I look at figures and I transfer figures from one place to another, and I worry whether I have done them correct or not. As I told you, I go back and check them, and check, and still I check back; and I end up checking . . . and rechecking, you know — still I have these doubts, and I get like a funny feeling in my legs and like in my head a kind of fuzzy feeling — like almost like my nerves, every one of my nerves are just sort of on edge.

TH: Is this only in your job — this need to check and recheck?

PT: No, like I will go into the carport at home and take out a bag of chips, read all the stuff on it — almost like I have to remember exactly what it says on that bag of chips, you know, how many ounces, which company, made by such and such, checking . . . well, I always check. Then read it over again, memorizing what it

says on the bag of chips. And this is not only with potato chips — labels at home on other packages, everything — street signs — keeping my mind occupied.

TH: So there is this nagging doubt if what you have done is right, and there is a constant need to keep your mind occupied.

PT: Even when I leave my job a couple of hours later I just sit there and start worrying about what I have done at work, even though I know I have done it right, which becomes very painful.

TH: These intruding thoughts and your need to check and recheck, is it interfering with your job?

PT: I have got that almost — lack of self-confidence, sort of; and I just sit there. I keep thinking about it, and people will talk to me and it will seem that they are not there — I am so busy concentrating on these other things.

TH: Hm. Hmm. Does it interfere with your personal life?

PT: Oh yeah. My mind still is there, and my wife is talking to me and I have to concentrate, you know, as if my mind is still on my job, on those figures.

TH: Are there any other areas that you have difficulties?

PT: Putting the lights off in my car at night. Like I will get home and automatically put it in "park," turn the lights off, turn the key off, get out, lock the door and close it. And now I have to check and recheck, trying to convince myself that they are off. I go in, and I have the thought that the lights are on. "Look, it is automatic, you do it, so." I know I turned the lights off, but then I have to go and check them. But again the thoughts and the doubts. And I say to myself — "Aw, I checked it," you know, I say I checked them, and I say to myself, convince myself that the lights are off. And sometimes I am successful.

The therapist now asks about the duration of this symptom. This question serves to place the patient on another spectrum, namely that of chronicity. It will then lead to the question of whether the onset can be traced to a particular moment, or at least a particular period in the patient's life. When this is possible, the evaluator must always think in terms of searching for a precipitating factor, of which the patient may or may not be aware. Such factors are usually of great dynamic significance, so that the therapist's question about duration is preparing the way for moving beyond the purely psychiatric inquiry into the exploration of the psychodynamics.

At this stage of the interview, the patient is showing no resistance. In answering the question about the duration he reveals not only the time of onset but also the precipitating factor, of which he is well aware. (It is worth mentioning here that the ambiguous term "sister-in-law" — a person who figures so prominently as the clinical material unfolds — clearly refers to his wife's sister rather than to his brother's wife.)

TH: How long is it that you find yourself in this state?

PT: About a year or so — but very bad for the last few months.

TH: Is it getting worse?

PT: Right. It started out — I was married for about a year (the patient has been married 3 years) *and got involved in a sort of an affair with my sister-in-law that lasted for a month and a half . . . a couple of months. And I started to have guilt feelings about it. So I broke it off and told my wife about it. She was upset but she forgave me and said, "Well, it happened" — sort of thing. "Forget*

about it. Look, it is done. It is over. Forget about it. You have done it. You can't undo it"—sort of thing. "You can't go back and say I didn't do it." Well, really I did not forget about it. The memory of it sort of kept coming back into my mind, and you know, without trying to think about it I would be doing my work and they would sort of come back. I would start thinking about my sister-in-law and I would feel worse. I would feel guilty again, almost as if I was recommitting the act, sort of thing. So what I started doing, really, was reading street signs, forcing myself . . . like . . . when I was doing my work to really concentrate on it—to keep these other, these thoughts of my sister-in-law out of my head. The thing is, over the . . . this went on for 6, 8 months, and I sort of succeeded in forgetting about it. Then it started . . . I thought everything was all well, and then it started coming back again so I started forcing even more so. I just seem to have transferred it from one problem to another.

The above passage shows one of the main features of patients who are responsive, with a single psychotherapeutic focus; namely here how clearly and lucidly he talks about his symptom, the onset of his symptom, the mechanism of displacement; and later on he talks about transferring it from one problem to another. The above information also poses an important question. Since his wife forgave him, it would seem that the episode should have been forgotten. Instead, he has not only continued to feel very guilty but has developed a neurotic symptom. The therapist knows that the reason is likely to be that the episode has reactivated guilt-laden feelings belonging to the past, the figures in his early life; but in no way does he impose this idea upon the patient; but he uses it to guide his exploration which starts with a simple question,

TH: Could we look into this incidence?

PT: I had my affair—I call it my affair—with my sister-in-law and after a month and a half I felt guilty, I cut it off and I told my wife, all at about the same time.

TH: How did the relationship develop?

PT: She and her husband and their three children were living on the East Coast and were moving to the West and they had a stop-over here. She and the three kids stayed with my mother-in-law while her husband went to the West Coast to get a house, or make arrangements for a house . . . and my wife and I went over there. Well, you know how it is with relatives . . . you haven't seen a relative for a while . . . you give a kiss . . . sort of hello, how are you sort of thing. When I gave her a kiss, I don't know, I felt as though there was more to the kiss than just "hello."

TH: On whose part?

PT: Uh, on my part, on her part, like the way she kissed me, I felt that there was more than "hello."

TH: How old is she?

PT: 2 years older than my wife.

TH: So what happened?

PT: Well, we started doing . . . it started working up to the fact that she used to come over to our place after they had eaten their supper, and my wife and I had eaten our supper, and she sort of come over to my wife and sometimes my wife would go out into the garden and I would kiss my sister-in-law and feel her, and she would do the same.

TH: Hmm.

PT: Well, I never had intercourse with her, just more or less playing around . . .

The therapist now begins searching for further precipitating factors. The patient does not demonstrate any resistance, and it is important to note that he is ahead of the therapist and spontaneously answers the question about sex, which had been implied but not directly asked. The absence of any obvious factors is clearly significant but deepens the mystery.

TH: This started a year after your marriage. How was your relationship with your wife during that year?
PT: Always happy. Our sexual relationship fine.
TH: Any problems?
PT: There were no problems.
TH: Could you tell me more about your sister-in-law?
PT: She used to come here and at every opportunity we would end up kissing and feeling each other, and it gradually led on.
TH: Led on?
PT: Yeah. At the time I was geting my car painted, and so I asked her to give me a lift in her car to go and get the car. So we stopped on the way back and fooled around. Like I said, I never had intercourse; but we messed around.
TH: Did you have the desire?
PT: Oh yes. We never really had the chance, the opportunity, enough time, really, to, to have intercourse.
TH: But the thought was there.

This is the second point at which the therapist has exerted a very mild degree of pressure. What he has done here is to underline the impulse. However, the patient is well aware of this.

PT: Oh yes, definitely.
TH: And how did you feel toward the thoughts?
PT: Er . . . at the time I felt it was going to be great. Now I feel differently.

Now the therapist exerts some pressure

TH: You were not decisive about it? Wanting and not wanting?

This communication needs considerable analysis. First of all, it transfers the patient's indecision from a pure symptomatic situation—whether or not he had checked the figures or the car lights—to an emotionally charged situation. Second, it describes the patient as indecisive, which is entirely accurate on the one hand but which the patient will not like on the other. He might first experience irritation and then suppress it, which will increase the tension. But, deeper than this, the therapist is by implication making a connection between the symptom of indecisiveness with the basic guilt-laden conflict. As he is doing this only by implication and not overtly the evaluator is communicating with the patient's unconscious as well as his conscious. He thus conveys the hidden message that he understands more about what is happening than the patient would wish him to know, which is intended to heighten the tension further. But this communication does not produce any resistance.

PT: Yes.

Pressure, the First Challenge, the Search for Resistance

The therapist has a fairly complete knowledge of recent precipitating events, about which the patient has been willing to talk quite freely. But the therapist has not yet identified the anxieties that have given these events pathological significance. Whatever these anxieties are, they must be in an area that has not yet been touched on.

An important feature of this technique of trial therapy can be described as follows. The therapist welcomes the resistance and he knows that the resistance can be reliably overcome and that the very act of overcoming it has far-reaching beneficial effect. It is an actual therapeutic tool to help break into the patient's unconscious. When, as here, the patient is responsive to the preliminary inquiry, the next stage therefore consists of searching for resistance. In accordance with this, the therapist asks a question which, without the patient knowing it, was destined to lead into the core of his neurotic structure. This exploration was based on extensive clinical experience, which consisted of the following repeated observations: when male patients were asked to describe the body of their current sexual partners, many had great difficulties and became resistant. The problem often seemed to center around describing the breasts as well as other parts of the body, and the reason is the unconscious connection between the patient's current sexuality and the patient's feeling for his mother or other figure in his early life orbit. Now we return to the interview.

TH: How would you describe your sister-in-law in terms of physical appearance?
PT: Physically she is a very attractive girl, very well built.

The therapist asks the patient to be more explicit.

TH: Hm hmm. In what way?

The patient now shows the beginning of a very mild degree of resistance by using a series of tactical defenses. It is important to note that none of these defenses are major defenses. It is essential to rapidly identify these tactical defenses and to know how to handle them. In the following passage, the defensive words and phrases which mark the beginning of a mild degree of resistance are put in quotation marks to draw attention to them. The patient already shows his reluctance to answer the question by hesitating; he puts it in the word "well" to make his statement more indirect, and he uses paraphrases to avoid the explicit word "breasts."

PT: Er . . . "Well" she is very pretty, she has a "big chest" . . . The rest of her body is nice.

This gives some rise in transference feeling, and his resistance becomes somewhat more intensified with the use of two further tactical defenses, namely vagueness and obsessional ruminations, which are designed to avoid a direct experience of feeling. We have the first indication of a rise in transference feeling. In the following sentence the words "I think" makes the statement hypothetical; "I don't know" largely nullifies his true feeling; and "sort of" makes the word "attracted" weak and indefinite. These are all tactical defenses.

PT: Yeah. "I think" that is what . . . "I don't know" . . . I have always been "sort of" attracted to that.

The therapist notes all this but he, once more, makes the patient's statement explicit and continues his exploration.

TH: Would you say that that was the part that attracted you the most?
PT: Yeah. Right.
TH: I see. Hm hmm. During this period that you were necking and petting, that was the part that you were very much . . .
PT: Yes. Right.
TH: Could you tell me how you ended your relationship with your sister-in-law? Was it your decision?
PT: Yes. It was my decision.
TH: Was it a sudden decision?
PT: Yes.
TH: And what was her reaction?
PT: Very surprised—really. What happened was that I told her that I couldn't go on any more, and I felt the nerves in my legs, the fuzzy feeling in my head, like all my nerves were sort of tense. My legs were twinging, just before deciding to tell her. I was in a separate world, enclosed in a bubble. I could hear you talk but it was as if you were far away. I told her this was wrong . . . I can't go on, sort of thing. I guess the weekend that I told her my wife and myself were going up to visit friends, going out for a wedding, out of town; so we went up, and so that sort of put her out . . . sort of out of sight, but not out of mind. I was still remembering it, really, you know. It really bothered me; and I guess we came back, and she stayed another week or two. And then they went . . . she went out to live on the West Coast. And then I told my wife . . .
TH: What forced you to talk about it to your wife?
PT: Because I felt so guilty about it. I knew I had done wrong. And, you know, I just had those feelings in my head and in my nerves, and I just figured that by telling her that that would, you know, clear everything up . . . my nerves. I wouldn't get that fuzzy feeling in my head, or anything else.
TH: You thought her being understanding would resolve the problem. . . . What happened then?
PT: I started, you know, to think of her, to think back about the time kissing in the kitchen, feeling her body, stuff like this. And I think partially what it was—I tried so hard to put it out of my mind that it would keep coming back in rather than . . .
TH: Could we look to those thoughts that were coming back to your mind after you terminated with her?

It is important to note that in the following passage the patient shows no resistance and is being absolutely explicit about sexual incidents with his sister-in-law, whereas he had shown some resistance against describing her body.

PT: Oh . . . incidents when we were together. I think about one time when my wife was out in the garden, and she was in . . . where she was staying at my in-laws, it is an old house. They don't have hot water, so they don't have a shower, so

she was taking a shower at our place. So, anyway, my wife was outside and I said, "Can I come in?" She said "Yes." So I opened the door, I walked in, and opened the curtain. She was standing there naked, so I look at her and said, "Do you want to see me?" She said, "Yes." So I exposed myself. Stuff like this.

TH: So you had these flashbacks to that incident?

PT: Yeah. There were a few other episodes like that. There was a time, almost the same thing. She was in the shower . . . uh . . . in the bath . . . and the same sort of thing. . . . Another time coming back from baseball we went back to my place, our place, my wife, myself and my sister-in-law — and I drove a friend of mine home. She came with us 'cause she was sort of friendly with the guy anyway; and we came back and stopped off and started necking, petting . . . she did fellatio on me . . . then I took her home. Another time we were starting for a party. We had to pick up soft drinks, and we went somewhere else and she did fellatio again, and I felt her . . . uh . . . I felt her breasts . . . uh. . . . These were the recurring thoughts that were coming after I stopped the relationship.

Challenge Alternating with Exploration

In this interview which is with a patient from the extreme left of the spectrum of psychoneurotic disorders, exploration, pressure and challenge proceed in a cycle, so that there is no clearcut point at which the phase of challenge begins. However, the following passage contains a second mild degree of challenge.

TH: In these incidents, then, you were intimately involved with each other?

PT: Right. Yeah.

TH: But you say you did not have an opportunity for intercourse.

PT: Yeah. There was not enough time.

TH: How could that be? Obviously if you had time for fellatio and playing with her breasts you could have had time for intercourse.

This mild degree of challenge produces some resistance in the form of vagueness as is shown by the words in quotation marks, all of which are tactical defenses to avoid making a direct statement.

PT: "I guess." Yeah. "I guess." really if . . . we "probably" could have.

At this point, it would obviously be possible to interpret the defensive moves. For example, to bring to the patient's attention that he was becoming vague in order to avoid openly acknowledging his anxieties about having intercourse. This, in my view, would move the process to intellectualization. The present technique aims to create greater tension by taking the position of adversary against the part of the patient identified with his defenses. The vagueness is therefore challenged. Many patients would then employ a series of other defenses, each of which would be challenged in turn. But this highly responsive patient responds immediately, which is the characteristic of all patients on the extreme left of the spectrum. Now we return to the interview.

TH: When you say "probably," is it or isn't it? And you already have said that you entertained the thoughts.

PT: If we had time to do that, obviously we could have had time to . . . yeah. There was. You're right. I was worried about going too far. It was a sort of wanting and not wanting.

Now, the therapist resumes his exploration.

TH: So these intruding thoughts involved her being naked, the intimate relations. Were they pleasureable?

PT: Oh, at first, yeah . . . were pleasant. But after they kept coming back and back and back then they became disturbing, and I felt guilty. I think it started to make me feel guilty again almost as if I was recommiting the act.

TH: There was a conflicting situation. And this went on for how long?

PT: This went on for a while . . . a few months, I guess. And then gradually I sort of half forgot about it. And it didn't bother me so much for a while. Then it started to come back and the thoughts would start coming again; and I think that is when I started with . . . like reading, and all the doubts, and checking and rechecking . . . like reading a newspaper and reading the same thing over and over. I go back and read it, and I go back and read it again — the same article. Then I moved to this checking and rechecking. My concentration is not good when I am in the office. In the office there are six of us. But you know, sometimes you get one person talking to you — but your mind is not there. I find I can't concentrate.

TH: Your mind wanders.

PT: Yeah. I hear them.

TH: Going back to your sister-in-law, do you see her?

PT: Well, they are . . . She is living with her family on the West Coast. Once in a while she comes down, to visit, with her husband and children.

TH: Hm hmm.

PT: And sometimes when they first come down . . . I don't want to go over there. I don't want to see her sort of thing. But once I get over there it is fine. I just sort of say "hello" and . . .

TH: Does her husband know about this?

PT: As far as I know, no.

TH: After you stopped seeing her, you kept having thoughts about her. My question is this, do you get these intruding thoughts about your sister-in-law at the present time?

PT: Sometimes. It is sometimes, and it doesn't bother me as much. Really less. Occasionally, when I am making love with my wife she comes to my mind, but immediately I put her out.

TH: So the thoughts about your sister-in-law are much less. But these obsessive thoughts, these doubts, this checking and rechecking, they have taken over.

Now the process moves to the following piece of insight, which contains four components: (1) his obsessional symptoms express his need to be punished, which (2) he has had to take into his own hands, because (3) his wife was too understanding, and . . . (4) did not punish him herself. Once more the patient demonstrates his extraordinary degree of responsiveness. The therapist only mentions component (3), but the patient immediately responds with component

(4), thus enabling the therapist to add component (1) and (2) quite naturally, in the form of a first interpretation.

It is important to note that so far in the present interview there have been only two moments of a mild degree of challenge, and so far the transference has not needed to be mentioned at all.

It is important to emphasize that my research with a large series of patients has shown, without any question, that bringing out the need for self-punishment and self-defeat is an essential part of the therapy of many patients, particularly those who—in contrast to the present patient—suffer from severe character neurosis and are located within the right side of the spectrum. There I have introduced the concept of the perpetrator of the unconscious, which will be discussed in greater length in future publications. But this in no way applies to the patient on the extreme left of the spectrum. Now we take up the interview just before the point where we left off.

TH: *. . . this checking and rechecking they have taken over. You said your wife was very understanding.*

PT: *More understanding than I figured she would be. I don't know. I wonder, myself. . . . Maybe she didn't give me, you know, really . . . give me shit sort of thing rather than . . .*

TH: *You wanted her to punish you. But you are, yourself, doing a good job. What you are doing, really, is punishing yourself.*

PT: *Right. I think so, basically.*

TH: *You are punishing yourself because of these guilt feelings that you have talked about. And the way in which you do it is by doubting yourself, by torturing yourself, by being obsessed with these statements, by checking and rechecking, this obsessive type of thinking—which on the surface is linked with your sister-in-law and your wife.*

PT: *Yeah. Right.*

Once more the therapist resumes his exploration

TH: *How long have you been married?*

PT: *3 years.*

TH: *How old is your wife?*

PT: *She is 24.*

TH: *And you have been married for 3 years.*

PT: *Yeah.*

TH: *Any children?*

PT: *She wants children. And my idea was that it is better that we wait.*

In view of what emerges later, this communication is highly significant.

TH: *How about after the incident with your sister-in-law?*

PT: *She still talks about having children. But I said to her that I want to see if I can get whatever is wrong with us, or whatever thoughts, or I want to try to get that cleared up before I take on the responsibility of having children, really.*

TH: *Could we look to the way you met your wife and decided to get married?*

PT: *Well, I met her on the commuter train. I had seen her for a while, but I hadn't talked to her. One day I ended up sitting . . . like they have bench seats, and end*

up sitting beside her. We started talking, and I asked her if she wanted to go out and have a drink. She said, well she was engaged. So I said, "okay—if you change your mind." Then after that I would meet her every night sort of thing. She would save a seat for me, and I would sit and talk with her. And finally I convinced her to go and have a drink together. Then I . . . one night I said, "What are you doing Friday night," or something; and she mentioned, well, you know, she wasn't doing anything. So I asked her if she wanted to go out. She said "Well, I don't know about going out, but come over to my place." So I went over there. Her parents were out, and we started necking; and then we had intercourse, and she broke off her engagement and I went out with her for about a year—and then we got married.

One of the important features of this technique is that it reveals, with utmost clarity, certain ever recurring patterns that lie behind human neurotic suffering. This enables a therapist to direct the process toward significant areas with the help of minimal clues. In the present interview the therapist perceives a further occurrence of a triangular relation created by the patient in which it was the patient who came off best. In the incident with his sister-in-law he both caused her to betray her husband and made his wife jealous, while in his winning his wife he competed successfully with another man. Most patients on the extreme left of the spectrum show a high degree of fluidity of their unconscious, and the unconscious therapeutic alliance either is in operation or easily comes into operation. In this patient, the unconscious therapeutic alliance indicates that the patient has a need to create such situations because of unresolved feelings about some previous triangular situations. Now the question is this, is he trying to perpetuate a situation in which he was the winner, or to undo a situation in which he was the loser? Obviously, the therapist does not know; but he decides to underline the triangular relation immediately.

TH: So in a sense you managed to take her away from her fiancee.
PT: Yeah.
TH: And that she preferred you.
PT: Yes.
TH: So in a sense, he lost her, then, to you.

The therapeutic alliance has made another communication. The patient had emphasized that his sister-in-law was "very well built . . . a big chest." Now the question is this: how about his wife? The therapist follows the path, breaking in with the question:

TH: How would you describe your wife in terms of body build and otherwise?
PT: She is a nice looking girl. Average build, not big.
TH: Hm hmm.
PT: Uh . . . gee, really . . .
TH: If you compare her to your sister-in-law, how would you describe . . .
PT: Well . . . my sister-in-law is built a lot bigger.
TH: Hm hmm. But there are things about her that attract you.
PT: Yeah. Her breasts. Yeah "I think" that is it.
TH: And your wife?
PT: And my wife is not nearly as big.

TH: How would you say it is?
PT: She, "I guess," "you could say" she is a small-breasted woman.

The patient has become uneasy by this subject and still is trying to maintain his vagueness. An effective way of dealing with many defenses is simply to draw attention to them, which communicates to the patient's unconscious that the therapist knows only too well that something anxiety-laden is being defended. This the therapist does, and then he makes another communication, putting into words the possibility that beneath the surface the patient is dissatisfied with the size of his wife's breasts:

TH: You say, I "could say." Is your wife a sort of flat-chested type?
PT: Er . . . yes . . . toward that . . . more than big.
TH: What else about your sister-in-law attracted you, besides her large breasts?
PT: Nothing else. She is attractive, the same as my wife.
TH: If you think about it, besides her body what else was there about her that attracted you as well?
PT: "I think" I know what "you have in mind" . . . that she was married . . .

Although this is a major piece of collaboration on the part of the therapeutic alliance, it is still hedged with tactical defenses. At a later stage of the interview, when resistance is at a minimum, the patient will respond to questions from the therapist with much more spontaneous insight. But at this stage he employs some tactical defenses.

The therapist's next intervention illustrates very clearly a fundamental principle of this technique; namely, where a response contains a mixture of communication and resistance, no matter how genuine the communication, the element of resistance must still be challenged. This particular defense is challenged.

TH: That she belonged to someone else. Her husband is on the West Coast, and she is preferring you to her husband. And you a minute ago told me that your wife was engaged and you finally managed to convince her to drop her fiancee for you. So what is there that I have in my mind?

The patient responds to this challenge without defensiveness:

PT: Wow

Further Inquiry and Part of the Developmental History

Since the patient has responded so positively, the therapist resumes further exploration. His aim is to assess both the quality of the marriage, the sexual relation, and the degree to which the affair with the sister-in-law has threatened it. All of the information is reassuring, indicating that the patient is an emotionally healthy young man, with a good close relationship, suffering from a single obsessional symptom—a symptom neurosis rather than a character neurosis. The patient indicated that the sexual relationship has been good since the beginning of the marriage. For a few months, when the sister-in-law was in the picture, there was a decline; but at the present time it is very satisfactory. During intercourse

with his wife he may get flashbacks of his sister-in-law, mainly her face, which he is able to put out of his mind; it does not interfere with his erection, and he has never had an incident while having sex with his wife of imagining he was having sex with his sister-in-law.

The therapist now fills in further detail about the history of the patient's relations with girls, still checking on whether there is any disturbance or any further evidence for recurrent pathological patterns. The information is typical of the development of a healthy young man in North American culture, and the whole picture is entirely reassuring.

Here, for the sake of brevity, this part of the exploration is summarized. Questioned about his mother's attitude about his dating and sexual issues, he said, "She never said watch yourself or anything. . . . She was very understanding and always figured that I know." Exploration was made on the issue of sex education, and he said that one of the teachers conducted sex education classes after school with parents' permission. He indicates that he had an open system of communication with his parents.

PT: I asked her how the baby was . . . how it was formed in the stomach, I remember asking her about stuff. I was interested because I wanted to find out certain things.

His relation with girls before the marriage was explored. He had three relationships with no indication of any problem. He had many close friends and was involved in hockey and baseball. After he finished high school he went to work, and his work record is good. No previous psychiatric history. All of his symptomatology started after the incident with his sister-in-law.

Developmental History

The therapist now embarks on exploring the patient's family background.

TH: You are from where?
PT: I was born in Toronto and later the family moved further East.

Both parents are living. He has one brother 7 years younger than the patient. His father, an industrial chemist, is 58 and his mother is 50, a housewife.

Dynamic Exploration of the Patient's Early Life

Having obtained this information, the therapist explores the dynamic aspect of the patient's early life.

TH: What is your earliest memory of life, as far back as you can remember?
PT: One is of going to . . . first starting school. That is when I was six. That always seems to come to my mind because I didn't want to go to school until a few friends came over, like, a couple of friends. One of them had an older brother, and he was sort of going with us to go to school. So once they came over it didn't bother me. I went off alone to school.
TH: This memory is around the age of . . .
PT: I think six.

TH: *Were you closer to your father or to your mother?*
PT: *My mother, because whenever I had any problem or anything I always went to my mother—because she was always there, whereas my father was at work. So I don't know whether that was . . . I guess . . . well, it was love, too. But it was more or less that she was there all the time, whereas my father was not there . . . he would leave early in the morning and get home at night.*
TH: *What are your earliest memories of your father? The sort of things you did together?*
PT: *I remember he always took us on vacation. Whenever he was on vacation from work we always went somewhere. And it was always fun.*
TH: *Did your father show interest in you when you were growing up?*
PT: *Not in the younger years. In the younger years he was mostly at work.*
TH: *How would you describe your father as a person and . . .?*
PT: *Fair, fairly strict . . . well, used to be. I think he is mellowing now with getting older. Good to be around.*
TH: *Now?*
PT: *Yeah.*
TH: *You said he was strict.*
PT: *Yeah. He was, but he wasn't an authoritarian type. Just if you were supposed to do something, do it, get it done. Don't mess around. If you have homework to do, do that. If you have chores to do, do them . . . you know? Then once you have done that, whatever free time you have is yours. He had pretty high standards. If you've got to do something, do it right sort of the thing, you know? During the week I would come home from, let's say, high school or whatever. And I knew I had to pick up the mail. This and this. Okay, once I did that then you could, you know, go out and see your friends, whatever. But, you know, do whatever has to be done first.*
TH: *I see. How about your mother?*
PT: *My mother? . . . I got along great with my mother. Uh. . . . She was more of a disciplinarian than my father was.*
TH: *She was more?*
PT: *Yeah. Like she would . . . like, because, well I have got a younger brother and having a younger brother I had arguments with him, and battles, and . . .*
TH: *How much younger is he?*
PT: *He is seven years younger. He is now 19.*
TH: *He is now 19?*
PT: *Yeah. She would get upset with us and pick up, like, a fly swatter and give us a smack with it and tell us, you know, stop whatever you are doing or one of you get out—one in one room and one in another, or, you know. This was much more so than my father. Whereas he would come home, you know—my mother would say, well what they did today.*
TH: *Was there a lot of fighting between you and your brother?*
PT: *Yeah.*

The data seems to suggest that the major source of tension for the patient in the family was his younger brother. The question for the therapist: is a close early relation with the mother disrupted by the birth of his younger brother? The therapist seeks further evidence, and as has already been mentioned several times,

this patient has shown a marked lack of resistance throughout the interview; and when he has become resistant he has responded quickly to minimal challenge. It is clear that this minimal challenge has still been enough to keep him nonresistant; his therapeutic alliance now produces a piece of spontaneous insight.

TH: What was your relationship with your mother like in the early years before your brother was born?

PT: Far back in the very early phase I had a close relationship, and much more so than with my father because he went to work and he was mostly away, and being, four, five and six, you are at home all the time. So naturally you relate more to your mother than your father, really. Now what comes to my mind also is you asked about my earliest memory. This was at age 6, and I really had a fear of going to school.

TH: You had fear to go to school then?

PT: Was it fear? I don't know, maybe I just wanted to stay with my mother.

The therapist decides not to pursue this for the time being. He is well aware of the theme of triangular relationships in the patient's current history, and he needs to establish which of the earlier triangles, the triangle involving his father or the one with his brother, was the more important. He decides to explore the former triangle first.

Dynamic Exploration: The Triangle Involving the Patient, His Mother and His Father

TH: And your relationship with your father then?

PT: (pause) I don't really remember.

TH: Did you feel close to your father? Did you look forward to his coming home?

PT: My memories of the early years are mostly when we used to go on vacation, and sometimes my grandmother and grandfather.

TH: Then when your father was around, what was your relationship with your mother like then?

PT: I think I was still with my mother more than really with my father.

TH: What was the relationship between your parents like?

PT: As far as I can remember they always got along fine . . . uh. . . . A few years ago they had a falling out, and this was when I was 16 or 17.

TH: So around age 16 then there were problems between your parents?

PT: Yeah. They started to have arguments.

TH: We can get to that in a minute. What was the sexual life of your parents like? What were your thoughts about your parents' sexual life?

The patient responds with a mixture of therapeutic alliance and the tactical defense of rumination. Once more, when there is such a mixture it is the defensive aspect that must be challenged and the challenge must be kept up so long as a significant degree of resistance is present. The following passage very clearly illustrates this process, which ends relatively quickly with this patient, and there is emergence of an important piece of insight.

PT: *I would really say no idea. I don't know for some reason. I never really pictured them as having sex together for some reason. I don't know why.*

TH: *So your memory collapses on you. You say you never really pictured them as having sex, but obviously they must have, because after all there you are . . . and . . .*

PT: *And there is my brother.*

TH: *Then obviously there was a wish on your part that you would not think of sex in terms of your parents.*

The patient responds with rumination.

PT: *It might have been. I can't really . . . it is . . . I was thinking back to then, and it is hard to say.*

TH: *But that doesn't help us. We need to look at your thoughts.*

PT: *It seems I didn't want to recognize the fact that maybe I was jealous of my father in a way.*

TH: *From where does the idea of being jealous of your father come?*

PT: *I don't know. It suddenly came to my mind if I didn't picture them having sex, you know, maybe I wanted my mother like for me.*

TH: *Hm hmm. Have you had these thoughts?*

PT: *Not really before. It came to my mind now that I am talking to you.*

TH: *So far the picture is that you have a very close relationship with your mother, and your father is only somebody who is working hard day and night and he is not very much in the picture. And even during vacation when he was around or other times you maintained a close relationship with your mother. At least this is the picture until your brother was born.*

PT: *But when I was around 16 or 17 I saw more of my father. By then I sort of had an interest in going out. . . . He used to talk about going to the tavern and playing shuffleboard and stuff like that. So that sort of interested me. I wanted to see, you know, exactly what it was so I asked him if I could and he said yes. So when I first went, of course, he let me have one or two beers; and that was it. He didn't want to get me drunk and take me home to my mother or something. We used to go out together. Then he sort of switched jobs so I was getting a ride home, a ride into work with him, and a ride back so I was more with him more than before.*

TH: *So, around this time you developed a much closer relationship with your father. But did your feelings about your mother at that time change?*

PT: *No. I have always been close to my mother. Still I am now. Uh. . . . My father started to drink a little too much and wouldn't show up for supper, and stuff like that. Finally, well . . . I . . . one time my mother sort of, well . . . she never told him but she mentioned to me that she was thinking of taking off, going back to England . . . while her father was still alive. At the time I just thought to myself, it is just anger toward my father, that it was just like a threat, really, sort of an expression of just pure frustration.*

TH: *That was the first time that your mother talked to you about your father?*

PT: *Yeah. That was the first time.*

TH: *Prior to that?*

PT: *No. She never talked behind my father that I remember. That was the first time, and anyway that's been patched up. So my father cut down on his drinking.*

What emerged was that his father drank some beer, but never to excess. It was only when the patient was about 16 that his drinking increased and became a source of conflict. Then the focus of the session is on the relationship between his parents, and the patient indicated that as far as he can remember they had a very good relationship. His positive feelings for his father in the very early years relate to vacations. Then the session focuses on the patient's feelings at the age of 16.

TH: If we go back to the age of 16, how did you feel when your mother was talking to you about leaving your father? How did you feel about that?

PT: Uh . . . it didn't bother me, really. It didn't bother me, really, 'cause, just the way they got along other than when he went out on, like he didn't do it every . . .

TH: You mean you didn't have any feelings either way toward your mother, talking to you about her bitterness and wanting to leave your father?

PT: Uh . . . I worried, I wondered, you know, what I'd do and, I'd stay with my mother or stay with my father.

TH: And what were your thoughts and ideas—to stay with which one?

PT: Uh . . . I think I was more inclined to stay here, to stay in Canada with my father. My brother, well he wouldn't have much choice—he was only eight at that time.

TH: But this doesn't fit. You had a close relation with your mother—then your brother and your mother would have ended up to go together.

PT: Well, all my friends were here. As I got older I was more drawn to my father than my mother.

Important material has emerged in the above passage, and the therapist's conclusion is that the triangle involving the father does not relate to the patient's core problem. Then the process of the interview moves to the other triangle.

Dynamic Exploration: The Triangle Involving the Mother and the Brother, Leading to Resistance

TH: What do you remember about when your brother was born? You were then seven.

PT: I remember writing notes to my mother. She was in the hospital . . . I think that she was in the hospital for a week. I am not sure.

TH: Do you remember when she was pregnant?

PT: I saw her pregnant, and I remember I thought it would be great, you know, to have a baby brother.

TH: How did you feel?

The focus is on the patient's feelings. It should be noted that behind the denial the dynamic force of the therapeutic alliance is in operation.

PT: I felt okay, except that he got a lot of attention.

The therapist asks for a specific example.

TH: Can you give me a specific example of how he got special attention?

PT: Well, when I was 10 or 12 I used to have chores. I would have to do . . . like go for bread, to get things. I remember I used to have to get wood for the fire. I used to have to do a lot of things, but he didn't have to do any of these things. Even she would get after me to do things like shovelling, cleaning.
TH: I see. You were glad to have a baby brother, but at the same time this baby brother is getting a lot of attention from your mother.
PT: Right.

Again focusing on feelings.

TH: Could we look to your feelings about that?

At this point, there emerges a communication of the type when both resistance and the dynamic force of the unconscious therapeutic alliance are both in operation. This takes the form of a negative statement, unconsciously implying a positive one. Here the statement "I never had temper tantrums" (who said anything about temper tantrums?) implies that he wanted to have them. This communication from the therapeutic alliance indicates: (1) that there was indeed hostility against the brother, (2) that it did arise from jealousy, (3) that here lies the core of the patient's neurotic problem, and therefore (4) that when the patient shows resistance against examining this area, then here is the point at which the head-on collision must be brought into play. The therapist is acutely aware that this leaves a crucial question still unanswered—where does the sister-in-law fit in?

PT: What I remember is that I never had temper tantrums. What I remember is a few years later when he wanted to tag along with me I didn't want him with me.
TH: But you said there were fights between you and your brother.
PT: Over anything. I guess there was so much of an age difference. He used to want to follow me around, and I didn't want that. He was too young.
TH: You mean that was the factor?
PT: Yeah, yeah.
TH: Was that the factor, or was it that he had become the favourite of your mother? Was there any favouritism?

The patient begins with a denial and then, once more, the therapeutic alliance comes into operation. The therapist reinforces this and the patient immediately goes into rationalization and rumination. At this point the head-on collision begins.

PT: No. No favouritism. No, I think I used to think there was.
TH: You used to think?
PT: Yeah.
TH: Could we look at that?
PT: I guess because he was the youngest, sort-of-thing. So I guess I used to think that he got more or really he didn't. But . . .

Head-On Collision with the Resistance: Further Rise in Transference Feeling

TH: I wonder if you notice that when we want to talk about your relationship with your brother—the fights, your relationship with your mother, that are obviously very important for us to understand—you have become vague and ruminate and rationalize away, because he was the youngest, because this and that. For instance, you said that you had to do all the chores and he didn't. You were the only child, then your brother comes along. And you must have a lot of feelings that we have to understand.

PT: Yeah. Right. But I really know . . .

TH: But . . . this way by ruminating and rationalizing we are not going to understand where the core of your problem lies.

PT: I don't really know whether I had that feeling or not, you know. It is . . .

TH: Now you are questioning whether you even had that feeling. But where did the idea come from a moment ago when you said you felt that your brother was getting a lot of attention and you were forced to do a lot of dirty chores?

PT: Yeah. I guess really I did.

TH: You see . . .

PT: Yeah. Right. I see what you mean.

TH: The only way that we can understand the problem is to look to your memories rather than to rationalize things. So obviously there was a feeling in you that your brother had disrupted the close relationship you had with your mother, the relationship where there was no competition—you and your mother together and your father busy.

PT: Uh hmm.

TH: Now what are your memories about your brother getting more?

PT: Uh . . . gee . . . (pause) *. . . getting more . . .*

TH: It had to do with the attention of your mother.

PT: Yeah . . . it always, like to me I guess it seemed that he used to be able to stay up later than I did at his age, you know. Not to do chores.

TH: Your mother was more lenient with him and more strict with you? And your brother had a heavenly deal?

PT: I guess you could say that, yes.

TH: That he was the favourite of your mother? That he became the star?

PT: Yeah . . . okay.

Now, the therapist challenges the patient's passive compliance, which is a tactical defense to prevent him from experiencing his true feelings.

TH: Why do you say, "Yes . . . okay"? Is it, or isn't it?

Tactical defense of rumination.

PT: Yes. I guess he was then, but. . . . We are looking at it then . . . okay . . . favourite? . . . favourite? He was the favourite because he was the youngest.

Tactical defense of "because" used to avoid feeling which is challenged.

TH: Let's not get to "because."

Challenge to the tactical defense of vagueness

PT: Yeah. Right. I guess so. I guess he was.
TH: Why "guess so"? Was he or wasn't he?

Return to tactical defense of rumination

PT: It could. I don't know whether, you know . . . she intentionally did it.
TH: There again you are moving to "because"—rationalizing.
PT: Okay. Yeah. Then to me, then, yes. He was the favourite at that time—the way I saw it then.
TH: And you were after him to fight, and you were seven years old.

Vagueness again

PT: Possibly right.
TH: Again, "possibly"?

There is further rise in the transference and concomitantly we see a rise in the unconscious therapeutic alliance which acknowledges the resistance openly.

PT: I don't want to answer the question directly.

This communication has transference implications. The process focuses on the transference and this is the first time that this has been mentioned. Then the process maintains its focus on the defenses and further the focus is on the underlying feelings, not only about the brother but about the mother as well. Then the focus is on the anger towards both of them.

TH: Now let us look at your relationship here with me. You prefer to hang things in the middle of nowhere, okay? Look at it. When you are describing your relationship with your brother, with your mother, you cannot commit yourelf to what really was there, okay? In all—"guess," "perhaps," and "maybe." You give me a picture that your brother became the favourite of your mother and that your mother replaced you with your baby brother, then you move to rationalize. You become vague. And obviously you wanted to pick a fight, and you were older and stronger, and to get at him—who had replaced you in relation to your mother. And obviously, also you have feelings about your mother, who replaced you like that. And not only that, is giving all the attention to your brother and the dirty chores to you.
PT: Yes. I would say yes. Right. I resented it.
TH: When in a fight he was obviously the loser to you.
PT: Well . . . uh . . . There was more arguing than fighting. Physically I hit him once or twice.
TH: So you had the upper hand.
PT: Oh, yes. Definitely.
TH: Hm hmm. In terms of your mother, what was her feeling? That there were two of you instead of one? Would you say that you lost that privileged, number one position in relation to your mother?
PT: Well . . . I lost it.
TH: And how do you feel about it? She has your brother, and all the attention goes to him . . .

Then the focus is on the patient's smile and then on the patient's transference feeling.

TH: . . . You are smiling. How do you feel right now when I . . .?
PT: The thing is . . . back . . . you know . . . I don't, can't really remember what I thought back then.
TH: I am not sure if it is that, that you don't remember—or somehow you want to leave it in the middle of nowhere.
PT: Possibly. But . . . like I said, I don't remember how I thought.
TH: Let me question you about one thing . . .
PT: Hm hmm.

Further Challenge to the Tactical Defense

TH: If you look here with me, you often say "possibly," "perhaps," "guess so"—rather than look at things. Do you see what I mean?
PT: Yeah. I see what you mean.
TH: That you say, "possibly," "guess so," and so forth. Is it like this with everybody else?
PT: No.
TH: It is here only?
PT: Maybe it is, I don't know . . . 'cause I just . . .
TH: And how do you feel about me questioning you and . . .

The patient declares that he has feelings but in a vague and evasive way.

PT: I guess . . . Not "I guess"—that is part of it. I feel, you know, feel "kind of funny" talking about—you know—"everything."
TH: How do you feel when I constantly keep you on the issue rather than to . . .

The patient's therapeutic alliance now openly acknowledges his defensive maneuvers and his appreciation of what the therapist is trying to do, at the same time making clear that he did not expect exploration into the painful issues of the past.

PT: Let me off the hook . . . yeah. I don't know. The thing is . . .
TH: You are smiling.
PT: I know what I am doing. I am trying to avoid the direct question. I didn't want to get . . . I didn't know, like, you would go back into my problems or back to my parents and all this.

The therapist now applies one of the important components of the head-on collision.

TH: Okay. You said that you are trying to avoid. Now let's look at it. Obviously you have a problem and this problem is a source of misery and suffering for you.
PT: Hm hmm. Right.
TH: And you have, on your own will, come to find an answer to your problem—with the help of each other to get to the bottom of your problem, to get to the core of your problems. This is your goal. Right?
PT: Right. Yeah.

TH: Now if here you are going to avoid, then obviously you are not going to reach your goal, that you have set for yourself. In other words, it becomes useless to you—and there will be self defeat in it, isn't that?

PT: Yeah.

TH: Now my question is this, why should you on your own will come here and see if we can get to the bottom of your problem yet at the same time another part of you wants to defeat the purpose, the goal, and the aim you here set for yourself—because if you are going to avoid to face with many of these complicated feelings then obviously we are not going to get anywhere.

PT: Well . . . I didn't realize that we'd have to go back, you know, all that far. I figured we'd just go back to where it started.

For the time being the therapist decides that this head-on collision and the resulting open acknowledgement by the patient of his defensive position are sufficient. He resumes his exploration about the mother.

Exploration of the Relationship with the Mother, Resistance and Challenge

TH: Now could you tell me more about your mother, you know . . . then . . . the way you remember her. Her physical appearance, her . . .

Challenge to the resistance has given rise to transference feelings and further mobilization of the therapeutic alliance to such a degree that this question results in major communication.

PT: Er. She's nice looking. She's small—small build. She looks like my wife.

TH: Hm hmm.

PT: About the same height, same weight.

TH: I am talking about when you were a child—your memories of her body and her build.

Return of resistance, the defense of evasiveness and challenge

PT: Uh . . . not really anything to speak of . . . nothing in particular.

TH: You mean you don't have any memory of your mother as a child?

PT: I remember . . .

TH: What do you remember?

PT: She was there sort of . . .

Challenge to tactical defense of evasiveness

TH: I know she was there, but what do you remember?

PT: I don't really, you know, in particular, nothing.

TH: Huh?

PT: In particular, nothing. Always she was good and loving, taking really good care of me.

TH: Hm hmm.

PT: You know . . . I used to have problems in school.

TH: Again you avoided my question. We were focusing on her physical appearance. Again you avoided to tell me about her physical appearance when you were a child.

Previous head-on collision and challenge to the defense of evasiveness now produces a major communication from the therapeutic alliance which clearly throws light on where the sister-in-law fits in.

PT: *One thing I do remember is. . . . I probably . . . not probably—sorry, I do remember, is that I always thought that she was small in the chest as compared to other mothers. That is one thing that I can remember . . . I remember that. I remember . . . well . . . I used to look at others, my friends' mothers, and think they are fairly big. And I used to wonder why, sort of wonder, why my mother isn't, you know. At that time I didn't realize, you know, probably different people are different sizes sort-of-thing. I guess I sort of had it fixed that all mothers should sort of be the same size.*

TH: *So, you were comparing the breasts of your mother with the breasts of your friends' mothers—that they had large-breasted mothers and you had a small-breasted mother.*

PT: *Yes. But some of the other mothers had smaller, too.*

TH: *I see. How old were you then?*

PT: *Seven, eight, nine . . .*

TH: *Then these relate to the early years?*

The therapist now first makes a connection between the past and the present then asks a crucial question about the past. Once more, the therapeutic alliance makes another highly significant communication, giving even further point to the connection with the current problem.

TH: *You said that your wife looks like your mother. Have you thought of it that way?*

PT: *O yeah. I have seen it. Well . . . people have said, people that don't know my wife and my mother that will have asked if she was her daughter sort-of-thing. They are quite similar.*

TH: *Your memory indicates, then, that you were very conscious of the breasts of your mother; and you said this was around the age of eight or nine. But how did you become aware of the size?*

PT: (pause). *I remember one time, I don't remember how old I was, she was, I guess she was in the bath or getting dried and my father had to go to the bathroom and he went in, and I remember she was standing sideways and I saw her.*

TH: *She was in the bathroom, but where were you standing?*

PT: *There was like a hallway, and I was just standing in the hallway; and as the door opened I happened to look up and I saw her breasts. I don't know how old I was.*

TH: *You are saying you "happened" to look up? Only later you became curious?*

PT: *Not so much about my mother but about other women.*

TH: *If you compared your mother's breasts with other women's breasts, obviously you were curious. You thought, "Why have I got a mother with small breasts?"*

PT: *I never tried to peek into her room.*

Again the negative statement implying positive, which is a function of the therapeutic alliance to which the therapist immediately draws attention.

TH: *I didn't say that! In that memory, did your father go into the bathroom?*

PT: *I heard the door open and looked up. It was a fraction, it was just for a fraction of a second, and then the door closed.*

The therapist now explicitly makes the link with the sister-in-law.

TH: *Still you prefer not to declare that you were actively interested. And obviously what took place between you and your sister-in-law, in that episode you were an active participant . . .*

The process now returns to the triangle involving the patient, his mother and his brother and the issue of hidden resentment against the brother, and the patient gives evidence that he is working on this.

PT: *Resentment?* (quietly) *mm . . . gee . . . I don't . . .*
TH: *Something that you always have difficulty about. Do you have difficulty about the issue of resentment?*
PT: (pause) *Maybe I don't want to admit . . .*

This admission that he does not want to admit is enough for the therapist to sense an opportunity to bring the patient's negative transference feeling into the open.

TH: *Now let's look at another issue. Here during this time that we have been together going over these complicated issues, was there any time that you felt resentful toward me?*
PT: *A few times, yes.*
TH: *And I sense it, too.*
PT: *Yes . . . sure . . . you can sense it, when I don't answer you. I go all around the issue. The issue is resentment. Not that I dislike you, it is just, maybe, you know, I . . .*

The patient has openly acknowledged his defense against underlying negative feeling in the transference. Although this is a very important communication, he has still ended by denying the true impact. As always, it is the element of resistance that must be brought into the open. The therapist immediately points out the denial.

TH: *Right away, also, you are reassuring me about liking and disliking. Immediately you said, "not that I dislike you."*

The therapist now gives an interpretation of the resistance, resentment of him intruding now between the patient and his mother with the brother's intrusion in the past.

TH: *So obviously what we have seen here in relation to me is that you resent my getting into your personal, intimate life, and that you resent my getting into your intimate relationship with your mother—the same way that you were angry that your brother got between you and your mother. In terms of your father, he was too busy—either at work or in the tavern, so he wasn't a threat.*
PT: *Yeah . . . right.*
TH: *And the way you are dealing with your negative feelings is ice skating around the . . .*

PT: Yeah. Right. Beating around the bush.
TH: Beating around the bush and becoming vague and nonspecific. That is the way you are handling your negative feelings here.
PT: Yeah. Okay.
TH: So that is when I said . . .
PT: Yeah, "get to the point."

Recapitulation

One of the important features of this technique is the way in which the process proceeds in a spiral: exploration, resistance, challenge to the resistance, rise in transference, further resistance, intervention aimed at weakening transference resistance, return to exploration and so on. But the reader should keep in mind that this process, both quantitatively and qualitatively, is extremely different with patients on the extreme left of the spectrum compared to those who are highly resistant on the right side of the spectrum.

Looking back over the mid phase of this interview, we can see the following:

(1) The therapist began to explore the triangular relation involving the brother. This led to;
(2) The patient going into some resistance, employing rumination;
(3) The therapist begins with the head-on collision with the resistance which leads to;
(4) The patient's admission of his defense, that he does not want to answer the question directly;
(5) The therapist first draws attention to the transference component in this and then continues his challenge;
(6) The patient admits the underlying feeling of resentment towards his mother;
(7) The therapist presses the patient for further feelings at which point the patient gives an involuntary smile and the therapist presses for further feelings;
(8) The patient at first manages to avoid answering this question and later gets no further than saying he feels "kind of funny talking about the past";
(9) The therapist applies head-on collision to bring further rise in transference feelings and further mobilization of the therapeutic alliance;
(10) The head-on collision has the desired effect, and the focus is on the mother's body;
(11) Important material about the mother's small breasts and the large breasts of the sister-in-law;
(12) The therapist then returns to the early triangular relation to bring up that the patient felt resentment towards his brother;
(13) Then the focus is on the transference with the question whether the patient at any time felt resentment towards the therapist;
(14) Now, for the first time, the patient admits the transference feelings;
(15) His resistance has been sufficiently weakened and he makes his own interpretation of the defense and his underlying feeling in the transference, namely that when he started "beating around the bush" it meant that he was feeling resentment; defense against underlying feelings in the transference;
(16) The therapist gives further interpretation, spelling out the issue of resentment at the therapist intruding between the patient and his mother and linking it with that towards his brother;
(17) Now the therapist and the patient are able to collaborate actively in elucidating the links between the current pathogenic situations and the buried feelings about the past. There is no need for any further mention of either resistance or transference.

Uncovering of the Core Neurosis

The process now returns to the patient's feelings in the original triangular situation, and eventually this brings the following:

PT: I felt like punching him.
TH: What was your feeling for your mother?
PT: I resented it. I kept it in. I did not talk about it. But in the past two or three years I have talked about it.
TH: Do you remember exactly when?
PT: Somewhere around the, around 3 years. Somehow I started to mention to her . . . I mentioned to her that I thought he didn't do stuff, he didn't have . . . well . . . well . . . as, as rough a life as I had. I had more responsibilities. I also had to take care of him. I remember my parents would go bowling, and I had to stay home to take care of him.
TH: So you have been talking about your resentment.
PT: And she agrees with me. She agrees that in some ways she was unfair.
TH: This talking to your mother about preferring your brother, was it before you got married or after?
PT: I think . . . no, definitely it was after I got married. It was then that these things came out.
TH: Then a part of you must have been really angry at your mother and wanted to get at your mother, wanted to punish your mother, who preferred your brother to you and replaced you with your brother.
PT: Yeah. It is clear.
TH: The question is, where the anger is directed. Is it displaced onto someone else?
PT: You mean my wife?

The patient responds by first reaching a fresh memory and then by giving his own interpretation and, as we see, his previous defenses (vagueness, rumination, avoidance and intellectualization) are not functioning.

TH: What do you think?
PT: Now that I look at it . . . it must be that, you know, without really planning it subconsciously. I remember, you know, I told you about my fear of going to school. Now I remember I had trouble in Grade 2, and that was then I was eight. And that was the year my brother was born.
TH: Hm hmm.
PT: That was the only teacher I didn't like . . . the one I had in Grade 2 . . . the only teacher, really, that I didn't get along with . . . that teacher . . . I didn't like her at all.
TH: Hm hmm. What are your thoughts?
PT: When I think about it now, I had been angry with my mother; and when I think of it I must have taken my anger out on the teacher rather than on my mother.

In this phase of an interview, when the resistance has been dissolved, it is possible to survey every facet of the patient's neurosis—all of the ramifications of events and of family relationships that have led to repressed feelings. With a case as simple as this, which is a representative of the cases on the extreme left of the spectrum, it is possible to reach all of the important feelings within a single

interview. With more complex patients (those who are highly resistant) the therapist can achieve similar results and have direct access to the psychopathological dynamic forces responsible for their symptom and character disturbances within a single interview, which is usually of longer duration.

In the final phase of this interview, the following issues are covered: (1) the link between the mother, the teacher and the wife; (2) the way in which the relation with the sister-in-law expressed not only love, but also hostility; (3) his feelings for his mother, the issue of the women's breasts; (4) the link between the present and the past; (5) the patient's need to be the victor in triangular situations and its link with the fact that he was the loser in the past; (6) self punishment expressed in the patient's compulsive symptom. As will be seen in the following passage, the patient listens intently and appreciatively, following everything the therapist says and creatively putting it into his own words.

TH: Obviously this is very important to look at, this mechanism of displacing your anger at your mother first onto your teacher, and then onto your wife. It obviously involves your sister-in-law as well — this tendency to take it out on other people. Obviously it involves not only anger — it involves other feelings as well. Now going back to your wife, as we have established, both your mother and your wife have the same name. They are both Mrs._____. And as you described so clearly, they are also very similar physically. So your wife was a convenient person to displace all these negative feelings for your mother onto, to punish her for what your mother did.

PT: Somebody I could sort of take it out on.

TH: So your mother was unfaithful to you, and you managed to be unfaithful to her.

PT: To my wife. Wow . . . it is not my wife's fault.

TH: But also, obviously, there is your sister-in-law, who became the target as well. And if we look at it carefully, one can say that your crime was not so much against your wife. In a direct way you did something to your wife, and to your sister-in-law; you were punishing your wife, but really the reason why you felt that way was primarily because you felt that you were doing some punishment of your mother. That was much more serious. You see, the root of it comes from way, way back and involves your mixed feelings for your brother as well.

PT: I felt very bad for my sister-in-law, as well. Her husband away struggling to find a house.

TH: How old is her husband?

PT: 28.

TH: And you were highly attracted to her breasts. And in a sense you wanted to take over his wife. At the same time there was a major conflict within yourself. You entertained the thought of having intercourse and going further . . .

PT: I was really postponing it.

TH: And if we go far back to the early years and look at the triangle of you/your mother/and your brother, your mother was unfaithful to you and your brother took your mother away from you.

PT: Yeah, I see what you mean.

TH: But do you think something repeated itself?

PT: Yeah.

TH: *You, your mother, your brother and the issue of a small-breasted vs. large-breasted woman.*

PT: *Something was taken away from me so I was trying to get back by taking something away from somebody else, without realizing it.*

TH: *But if you look at it, there have always been these attached women. There was your brother, and we know you had 7 or 8 years of devoted attention from your mother.*

PT: *Right. Just to myself.*

TH: *You had the exclusive relationship with your mother.*

PT: *Right.*

TH: *Then we saw the way you met your wife, who was engaged to another man — and you managed in some way that she dropped the other man and preferred you. Then we see your sister-in-law, who is married. Her husband was struggling to find a house, and she is preferring you to her husband; and the affair.*

PT: *Yes. I see the forbidden fruits.*

TH: *So you see, there are all these triangles all the time.*

PT: *Hm hmm.*

TH: *Did this idea of forbidden fruit occur to you then?*

PT: *I would say yes, it did.*

TH: *In any event, what we see is — now you are punishing yourself, your obsessional symptomatology, your doubts, obsessional thoughts about the lights of the car, checking and rechecking, and the agony.*

PT: *Like my mind just scattered all over.*

TH: *And what you said was very interesting because you expected that she would have punished you.*

PT: *Now I am doing my own punishment.*

TH: *You are punishing yourself much harder, and you are paying a very high price. Obviously there are a lot of mixed feelings, a lot of mixed feelings in relation to your mother, your brother, your father, that you might want to examine and put into perspective. We have already brought into the open many of these issues. But if you try to force these thoughts, these ideas and feelings out of your mind, as you have been doing, then you will continue to punish yourself, the obsessional thoughts.*

PT: *Now I see why you want me to answer straight. Very good. You can pick out stuff like that, whereas, I see it, if I just beat around the bush you can't. You can't, you can't, pick out — uh — the relationship. And I think that one of the bad things that I have done, too, is that I have waited so long to come.*

There remains one important issue that does not appear in the interview, which has not been transcribed. Why was it at that particular point, after a year of marriage, that these events occurred? Clearly, the reason had to do with the fact that it was around that time that the patient's wife began raising the question of having children. He was ambivalent about it. The wife's wanting to have children was threatening him with the repetition of the original trauma of the birth of his younger brother. It was then that his earlier feelings were reactivated, so that he set about creating a triangular situation in which he was the victor rather than the loser.

Another question had to do with the issue of small breasts v. large breasts, an ever recurring issue in many of our patients. We may note that it was the sister-in-law's large breasts that particularly attracted him. Why therefore did he marry a woman with small breasts? In his background, he asked himself why his mother did not have large breasts like the mothers of the other children. Here we can say that his original attraction was to his mother's small breasts, and that he turned against her, feeling that other women were more attractive when she betrayed him with his younger brother. This would account for his choice of partner, both in his marriage and in his affair.

Technique of IS-TDP with Patients on the Extreme Left of the Spectrum

The trial therapy with this group of patients should result in at least some of the following, and the Case of the Salesman is more or less a representative.

(1) Self-examination and high responsiveness to inquiry. This patient showed this throughout the interview, and the evidence hardly needs to be spelled out:
(a) he was able to clearly describe the development of his obsessional symptoms;
(b) he's speaking fully and honestly about his guilt-laden relation with his sister-in-law;
(c) his open acknowledgement of his own resistance "I don't want to answer the question directly."

(2) A positive response to the therapist's interventions. The patient himself made the link between the defense "going all around the issue" and the underlying feeling of "resentment." The therapist made the link between himself and the brother over the issue of intrusion into the relation with the mother.

(3) Experience and acknowledgement of transference feelings and the mobilization of the therapeutic alliance. When the patient finally admitted that there had been occasions in the interview when he had experienced resentment toward the therapist and that he had used the defense of "going all around the issue under discussion." Manifestation of the therapeutic alliance, which has already been elaborated on in the text of the interview.

(4) Dissolution of resistance and access to the core neurosis. With the rise in the transference and mobilization of the therapeutic alliance, the therapist was more able to interpret the whole of the patient's pathology and make all of the links with the current situation. On several occasions the patient actively gave his own interpretation, for example the recent link between his mother and his wife, and in his early years the link between his mother and the teacher.

(5) Reconstruction of the core neurosis and acquainting him with it in a meaningful way.

Conclusion

I have described two spectrums of patients who can be successfully treated with my technique of Intensive Short-Term Dynamic Psychotherapy. The first spectrum consisted of five major groups of patients; on the extreme left highly responsive and on the extreme right extremely resistant. Then I described the application of my technique to fragile character structure and very briefly indicated that the technique needs certain modifications. Then the major focus of

the article was on the analysis of the initial interview of a patient on the extreme left of the spectrum. Now we can briefly summarize the major features of the majority of patients on the extreme left of the spectrum as follows:

(1) They have the ability to respond to inquiry in a very meaningful way.
(2) They show clear fluidity in their unconscious and as a result the unlocking of the unconscious technically does not apply to this group of patients.
(3) There is a virtual absence of unconscious murderous rage and intense guilt-laden feelings in relation to early figures in their life orbit.
(4) As a result, a punitive superego pathology is not present.
(5) The nature of the resistance is very much different.
(6) The duration of the comprehensive initial interview is 1 hour to 1 hour and a half.
(7) With this technique, the course of the therapy is anywhere between one and five psychotherapy sessions, each of 1 hour duration. With the above patient, the therapy consisted of a single psychotherapy session. The second session took the format of outcome evaluation.
(8) My extensive experience, in both North America and Europe, in university clinics and in private practice, indicates that indeed the number of patients who are responsive ("motivated") with circumscribed problems and a single psychotherapeutic focus are definitely very few. The large majority of patients are those who are highly resistant with a highly complex pathogenic unconscious, suffering from life-long character neurosis and those who suffer from fragile character structure. These patients are the major focus of this technique.

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