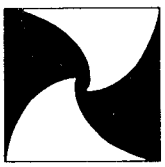

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Intensive Short-Term Dynamic Psychotherapy: Technique of Partial and Major Unlocking of the Unconscious with a Highly Resistant Patient— Part I. Partial Unlocking of the Unconscious

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Introduction

This is part one of a two-part article concerned with the technique of both partial and major unlocking of the unconscious in a single interview in the treatment of a certain kind of patient suffering from episodic depression, other psychoneurotic disturbances and major character pathology. In many of these patients their characterological defenses are syntonic. I have already both presented and published the discovery of the technique of unlocking of the unconscious and have demonstrated that this 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. Further, I have demonstrated that the degree of the unlocking of the unconscious is precisely in proportion to the degree that the patient is experiencing the transference feeling. I have already outlined the dynamic sequences used in trial therapy consisting of a series of a specific type of intervention with its corresponding response. Further systematic research in the eighties and the early nineties has resulted in both refinement in the technical interventions in Intensive Short-Term Dynamic Psychotherapy as well as the development of a

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highly powerful method of psychoanalysis which will be the concern of a series of publications to follow.

This two-part article primarily is concerned with the technique of Intensive Short-Term Dynamic Psychotherapy.

Spectrum of the Technique of Unlocking of the Unconscious

Based on the analysis of the clinical research data, there are four major techniques of unlocking:

(1) Partial unlocking of the unconscious.
(2) Major unlocking of the unconscious.
(3) Extended major unlocking of the unconscious.
(4) Extended, multiple major unlocking of the unconscious.

This two-part article concerns itself with partial and major unlocking of the unconscious. The technique of extended major unlocking as well as extended multiple major unlocking do not concern themselves with the standard technique. They have already been presented in a number of audiovisual symposia and courses and will appear in future publications.

Dynamic Sequence in the Process of Unlocking of the Unconscious

Updated analysis of our clinical research data requires certain modification and refinement of the central dynamic sequence, which will be the concern of this paper. The whole process is divided into a series of phases:

Phase 1: Inquiry

(a) Exploring the patient's difficulties: initial ability to respond.

Phase 2: Pressure

(a) Pressure, leading to resistance in the form of a series of defenses.
(b) Rapid identification of the patient's character defenses.
(c) Clarification and challenge to the defenses, leading to rising transference and increased resistance which gradually acquires transference quality.
(d) Psychodiagnostic function; this is of extreme importance particularly in patients that do not respond to inquiry and the therapist in the initial contact encounters with the patient's character resistance, as well as in patients who come into the interview in the state of resistance in the transference.

Phase 3: Challenge: Making the Patient Acquainted with his Character Defenses

(a) Challenging the resistance combined with the conveyed lack of respect for them.
(b) Challenge directed toward the therapeutic alliance.

(c) Systematic attempt to make the patient acquainted with the resistance that has paralyzed his functioning.
(d) Special form of partial head-on collision with the transference resistance with special reference to resistance against emotional closeness in the transference with the aim of speeding up the process of making the patient acquainted with the character defenses that have paralyzed his functioning.
(e) Crystallization of the character resistance in the transference; rise in the transference; mobilization of the therapeutic alliance.
(f) To turn the patient against his resistance; the patient must clearly see that his resistance that has paralyzed his functioning is being challenged.

Phase 4: Transference Resistance

(a) Mounting the challenge to the transference resistance.
(b) Head-on collision with the transference resistance.
(c) To intensify the rise in the transference feelings.
(d) To bring the patient face to face with the self-destructiveness of his resistance.
(e) Mobilization of the therapeutic alliance against the resistance.
(f) To loosen the patient's psychic system and make possible a partial unlocking of the unconscious.

Phase 5: Direct Access to the Unconscious: Partial Unlocking of the Unconscious

(a) Crystallization of the resistance and high rise in the transference feelings.
(b) Intrapsychic crisis; to create a state of high tension between the resistance and the therapeutic alliance in the transference.
(c) To maximize the inner tension between the unconscious therapeutic alliance and the resistance.
(d) Mobilization of the unconscious therapeutic alliance.
(e) Breakthrough of the complex transference feeling; the triggering mechanism for the *partial unlocking* of the unconscious.
(f) Direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.

Central Dynamic Sequence

Phase 5: Direct Access to the Unconscious: Major Unlocking of the Unconscious

(a) Interlocking chain of head-on collision with the character defenses crystallized in the transference.
(b) To mount a direct and systematic challenge to all the forces maintaining self-destructiveness and the major resistance of repression.
(c) Intensification of the rise in the transference feeling.
(d) High mobilization of the unconscious therapeutic alliance.
(e) Direct experience of the transference feeling; the triggering mechanism.
(f) Major unlocking with the passage of the murderous rage in the transference, emergence of sadness.
(g) Passage of the guilt-laden unconscious feeling.
(h) The unconscious now transfers the murdered body of the therapist to the genetic figure.

(i) Direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.

Central Dynamic Sequence

Phase 5: Direct Access to the Unconscious: Extended Major Unlocking of the Unconscious

(a) Interlocking chain of head-on collision with resistance in the transference with the aim:
(b) To mount a direct challenge to all the forces maintaining self-destructiveness.
(c) Systematic weakening of the major resistance of repression and all the tactical defenses entrenched in the major resistance.
(d) A very high rise in the transference feeling.
(e) Optimum mobilization of the unconscious therapeutic alliance.
(f) Direct experience of transference feeling; the triggering mechanism.
(g) Extended major unlocking with the passage and experience of the primitive murderous rage in the transference with its psychophysiological components.
(h) Instant emergence of the sadness, patient attentively looking at the murdered–damaged body of the therapist.
(i) The unconscious now transfers the murdered body of the therapist to the murdered body of the genetic figure.
(j) It is important to note that the murdered body of the therapist appears exactly as the murdered body of the mother, father or brother — in terms of color of hair, eyes — in every respect. The patient is seeing, for example, the dead body of the mother with blond hair and blue eyes. The dead body of the therapist is not there anymore.
(k) When the unconscious makes the transfer, instantly there is a major breakthrough of intense guilt-laden feelings.
(l) The duration of the passage of the guilt with all its psychophysiological components is on average 8–12 minutes in the first extended major unlocking.
(m) Passage of the grief-laden unconscious feeling.
(n) Direct view of the psychopathological dynamic forces.

Phase 6: Systematic Analysis of the Transference

Leading to the resolution of the residual resistance; and is extremely important in patients suffering from panic, somatization, functional and depressive disorders.

Phase 7: Dynamic Exploration into the Unconscious

(a) Unconscious therapeutic alliance is in command of the process and;
(b) Spontaneously introduces traumatic events and incidences with;
(c) Repeated breakthrough of guilt and grief-laden unconscious feelings.
(d) Consolidation, recapitulation and psychotherapeutic plan.

As I have already stated, not all the therapies proceed in exactly this sequence. The phases tend to overlap and proceed in a spiral rather than in a straight line. For those interested in learning the technique, the dynamic sequence can be seen as a framework which the therapist can use as a guide, constantly working from one phase to another. We should keep in mind that the emphasis on the different

types of interventions depends on a number of variables. For example, the phase of inquiry is always possible in patients on the extreme left on the spectrum of psychoneurotic disorders. The best example is the case of the Salesman. Another one is the Case of Henry IV Man. Both of them, with great clarity, responded to the phase of inquiry. But patients on the right side of the spectrum, particularly those with syntonic character resistance, are not able to respond to the phase of inquiry. The therapist immediately encounters with the syntonic character defenses the minute the interview starts.

In the first part of this two-part article the early phase of trial therapy of a patient on the mid-right side of the spectrum of psychoneurotic disorders will be analyzed to highlight the technique and the process of partial unlocking of the unconscious.

The Case of the Strangler

At the time of the trial therapy he was in his forties. The therapist starts with the phase of inquiry.

Phase of Inquiry

The therapist does not know anything about the patient and starts the session by asking the patient "What are the difficulties that you want to get help for?" The response to the inquiry is very limited. He indicates that he and his wife have been in couple therapy for the past year, but the therapy was not helping. He was told by the therapist that "My problems are deeply rooted in the preverbal phase of my development; which needs years of individual treatment," and the plan was for the couple therapist to carry the individual treatment of his wife and that he should seek treatment for himself.

Phase of Pressure

He has been married for 20 years, but the problems in his marriage date back to the 7 months they knew each other prior to the marriage. He indicated that the marriage has deteriorated over the years. Then the session focused on his difficulties, and he said that one of his major problems is that "I act like a child," "I become paralyzed;" but he cannot give a specific example.

It becomes immediately clear that the phase of inquiry is not possible. He is not able to respond to the question *re* a specific example of the problems in his marriage, uses vague generalizations; and the therapist immediately introduces pressure, asking for some specific incidents, to which the patient declares "it is difficult." As a result of this pressure to the resistance there is mobilization of some degree of anxiety and the therapist focuses on the patient's feelings.

Further Pressure by Focusing on his Feelings

As we will see, the process immediately moves to the phase of rapid identification, clarification and some degree of challenge to the patient's character defenses, and to the psychodiagnostic phase.

TH: How do you feel right now here?
PT: Not too bad, uh I'm, I'm having difficulty thinking clearly so I'm a bit . . . I guess I'm a bit ah, a bit nervous.
TH: I say how do you feel right now? You say you guess.
PT: (small laugh) *I feel nervous.*
TH: You feel nervous. Then why you say "guess?"
PT: It's a way I have of speaking, I think I say that a lot.
TH: You mean that you are not definite about . . .

Challenge to the Tactical Defenses

PT: Yeah, that's part of the problem, I seem to . . . I don't . . .
TH: You see again you say "I seem to."
PT: I often don't know what it is that I want, how I feel.
TH: Now let's to look to this here with me. My question was how do you feel right now and you say you are nervous really.
PT: Hm hmm.
TH: But you have to say "it seems" that you are nervous, as if you are not . . .
PT: Hmm.
TH: Hmm?
PT: That's, that's certainly what comes out all right.
TH: Hm hm, that you are always indefinite, or is here with me?
PT: Am I always indefinite? (low voice)
TH: You know what I mean by indefinite? That you say "perhaps, guess."
PT: Yeah, I see what you mean.

The Phase of Pressure and Challenge to the Resistance

As we saw, the therapist immediately is focusing on the patient's tactical defenses, such as "perhaps," "guess," being indefinite, "I think,", and making the patient acquainted with these defenses to which the patient responded positively, "Yeah, I see what you mean." This challenge to the tactical defense mobilizes anxiety which is the indicator of further rise in the transference feeling. There is further challenge to the patient's character defenses, which gives further rise to transference feeling and crystallization of the patient's character defenses in the transference. It is important to note that almost always the phase of pressure, as we saw in the above passage, may contain passing moments of challenge, but systematic challenge is not to begin until resistance has been tangibly crystallized between the therapist and the patient. Then, not only must the resistance be challenged, but the patient's attention must be drawn to it and its nature clarified for him. This will have the maximum affect when the patient cannot avoid recognizing it. Now we return to the interview.

TH: That you cannot . . .
PT: Yeah I, I think I do qualify.
TH: You see "I think I . . ."
PT: I do qualify yeah, I . . .

TH: But there is "think"; it means that in a sense still you are not definite.
PT: I'm not sure of things . . . (mumbling)
TH: If you are anxious right now why "it seems" or "I think"? Either you are nervous or you are not nervous.
PT: I have a hard time identifying that.
TH: You mean you are nervous and you have difficulty to identify you're nervous?
PT: Yeah.
TH: Then why you say you are nervous?
PT: Because when you ask me about it then I perhaps become more aware of it.
TH: Again you become indefinite.
PT: I don't know the answer to that.
TH: Now you say you don't have an answer to that, hmm. Now, what is it like when you're nervous?
(Pause)
TH: Now you notice you also avoid me?
PT: Yes I'm, I'm withdrawing.
TH: You're withdrawing?
PT: Yes. I have . . . I don't feel comfortable.
TH: I said how do you physically experience your nervousness?

As we see, there is further crystallization of the patient's character defenses in the transference.

PT: I feel defensive, I feel . . .

Exploring the Physiological Concomitant of the Anxiety

He indicates that he is perspiring and that he feels cold in his shoulders. This exploration of the anxiety is of great importance, and the therapist puts the question very specifically, "How do you physically experience this nervousness?" Exploration into the physiological and psychological concomitants of anxiety indicates that overall, the psychological concomitant of anxiety exceeds the physiological concomitant, which is an indicator that his capacity to tolerate unconscious anxiety is at a high level; and the therapist knows, based on the research data, that this has important psychodiagnostic implications.

Challenge to the Resistance

As he constantly avoids eye contact with the therapist, this is brought to his attention and the process continues with further challenge to the resistance, which now has definitely acquired a transference quality and the therapist begins to make him acquainted with the resistance against emotional closeness in the transference, which is syntonic.

TH: You see you use words. I said how do you physically experience this nervousness? One, you say you have some perspiration . . .
PT: Yeah.

TH: . . . and then the other one you say you feel cold in your shoulders and so forth and some tightness in your chest. What else do you experience while you are nervous? And your eyes are on the carpet. I mean you are . . .
PT: I'm trying to concentrate, and I'm having difficulty.
TH: Is it that, or is it that there is a need in you to avoid me?
PT: I don't know.

Psychodiagnostic Function

In this initial contact, the therapist first introduced pressure which gave rise to transference feeling and anxiety in the transference. This led to resistance in the form of a series of defenses as well as resistance against emotional closeness, and finally there was crystallization of the resistance in the transference. Throughout this process, the therapist monitors:

— rise in transference
— rise in anxiety
— crystallization of the resistance in the transference.

The therapist's task is to determine the discharge pattern of the unconscious anxiety as soon as he introduces the pressure. Here, the therapist introduced the pressure. There was a rise in the transference, anxiety which was in the form of tension in the muscles of the hands, the supinator and pronator of the forearms, and anxiety in the form of tension in the intercostal muscles. The nonverbal cues were: with a high pressure pressing his thumbs against each other; clenching his hands together with high pressure; and a deep sigh. All this indicates:

(1) Discharge pattern of anxiety is exclusively in the form of tension in the striated muscles.
(2) No discharge pattern of anxiety in the form of disruption of cognitive and perceptual function (which is the characteristic of patients with fragile character structure).
(3) Rise in the transference gives rise to unconscious anxiety, which then results in intensification of the resistance in the transference.

On the basis of this, the therapist concludes that the patient suffers from character neurosis and can withstand the impact of his unconscious in a single interview. With this in mind, still the therapist wants to further evaluate and reconfirm his decision.

Now the therapist moves to challenge the resistance against emotional closeness in the transference, which leads to further rise in the transference feeling and further rise in anxiety in the form of tension in the striated muscles, which further indicates that there is no trace of fragility and he can use the standard technique of rapid and direct access to the unconscious.

Further Challenge to the Resistance in the Transference

Systematically Making the Patient Acquainted with his Resistance

TH: Again you move to the "I don't know." Moving to the helpless position. How do you feel when you look to my eyes?

PT: *I don't know.*
TH: *Hm hmm. So "I don't know" is another system like "I guess so," "perhaps," huh?*
PT: *Yeah.*
TH: *Now this is another format of the . . . huh?*
(Pause)
TH: *Do you notice that you are very much detached from me?*
PT: *Yes.*
TH: *What?*
PT: *Why?*
TH: *And there is some kind of a wall between you and me.*
PT: *Hm hmm.*
TH: *Avoiding my eyes, avoiding me, hmm. Could we look into that? Could we look into that . . . to the fact that you want to avoid me.*

Further Challenge and Crystallization of Character Defenses in the Transference

Making the Patient Acquainted with his Character Defenses

TH: *To the fact that you avoid my eyes, and that you don't want to be involved here in a sense.*
PT: *Hm.*
TH: *Detachment, withdrawal, hmm?*
PT: *Can you help me to avoid that? I want that.*
TH: *Yeah, but you see you move again to a position that is helpless, taking a helpless position with me.*
PT: *Hm hmm, hm hmm.*
TH: *And nodding your head and saying "hm hmm" doesn't do anything.*
PT: (laughs) *I don't know what else to do.*
TH: *And now you smile.*
PT: *Yeah.*
TH: *Really you felt your smiling?*
PT: *Did I feel my . . .*
TH: *You smiled. I said did you really feel like smiling or . . .*
PT: *Yeah.*
TH: *. . . this is a cover-up of something? the smile?*
PT: *Hm hmm.*
TH: *What hm hmm?*
PT: *I don't know what hm hmm.* (laughs)
TH: *You see again your eyes are somewhere else.*
PT: *Well I find it hard to concentrate if you ask me a direct question.*
TH: *What do you mean by difficulty to concentrate? I mean what is that?*
PT: *Well you ask me a direct question.*
TH: *Hm hmm.*
PT: *And in trying to answer it I find that . . . it very difficult to think if I'm looking directly at you.*

It is important to note that the rapid rise in the transference has rapidly crystallized the patient's character resistance in the transference. The therapist now applies one of his most powerful technical interventions, the technique of the interlocking chain of head-on collision with the transference resistance, with the goal of a rapid partial unlocking of the unconscious.

The "Technique of Interlocking Chain of Head-on Collision with the Patient's Character Resistance Heavily Crystallized in the Transference" (Davanloo)

The interlocking chain of head-on collision is always used within the setting of resistance in the transference. In the following passage the therapist challenges four components of the head-on collision:

* Pointing out the nature of the resistance;
* Emphasizing the problems that he has in his marriage;
* Communicating the masochistic component of his character and the self-destructive element of the resistance, the self-defeating and self-sabotaging aspect of the resistance;
* Bringing into the focus his treatment with Dr. X, which was a failure, which is establishing a parallel between his previous treatment and the transference, the failure that might come.

TH: You are like this usually? . . . detached, noninvolved, taking a sort of the passive, detached . . .

PT: I don't think of myself as . . .

TH: But you see you ruminate "I don't think." I'm talking right now with me. Look at it, aren't you totally walled off, and totally noninvolved? And this is very important we look at it, because you say you have a set of problems. So far we don't know anything about it except a piece of it, that is you have a problem in your marriage, hmm? and that it has been going on for 20 years, okay. And you have been in treatment with Dr. X, hmm, and the problem still is there I assume, otherwise you wouldn't be here. So that you have a problem which so far we only know the marriage part of it, superficially okay? And has been going for 20 years, hmm?

PT: Hm hmm.

Continuation of Head-on Collision

In the following passage the therapist continues with the technique of interlocking chain of head-on collision, which consists of:

* Emphasizing the patient's will, that the patient is the prime mover in seeking help "and that is your own will to come here," to which the patient responded "yes." Then the therapist moved to another component;
* Emphasizing the partnership between the patient and the therapist, "that

with the help of each other." Then the therapist moved to another element;

* The therapeutic task, emphasizing the therapeutic goal "to see what is the core of your difficulties."

TH: And I assume now that you have come here — this is your will to come here or that Dr. X thinks this is the best for you?
PT: No it's . . .
TH: This is your own will?
PT: Yes.
TH: This is. huh?
PT: Yes.
TH: And this is your own will to come here, hmm. That with the help of each other we can first understand your difficulties and hopefully we can get to the engine of your difficulties.
PT: Hm hmm.
TH: To see what is the core of your difficulties that creates all these disturbances that you have, which we know a little bit, only marriage okay?
PT: Hmm.

Continuation of Head-on Collision

In the following passage, the therapist continues the interlocking chain of head-on collision consisting of:

* Addressing the nature of the resistance;
* Emphasizing the resistance against emotional closeness in the transference, and he immediately moved to the following component:
* Bringing into focus the consequences "if you keep this wall," and this is immediately followed by another element:
* The destructive aspect of the resistance; the self-defeating and self-sabotaging component and the failure "doomed to fail." This follows:
* Deactivating the transference and bringing the patient into the reality of the process "at some point today we say goodbye," "You go your way and I go my way," "and I tell to myself I did my best;" then he immediately moved to:
* Undoing the omnipotence and keeping the responsibility with the patient, which is immediately followed by addressing:
* "The perpetrator of the unconscious" (Davanloo) "perpetuate whatever misery you have," reemphasizing the masochistic component of his character.

TH: Now if you take a detached position with me, and if you take a noninvolved position with me, and if you erect a wall — you know what I mean by wall? by distancing, by putting a barrier between yourself and me, avoiding me and not wanting me to get to know you — then this process is doomed to fail. In a sense if you keep this wall, this distancing, this barrier, and not wanting me to get to your intimate thoughts, your intimate feelings, then this process is doomed to

fail. So then at some point today we say goodbye to each other and you go your way and I go my way.

PT: Hmm.

TH: And I tell to myself, Okay I did my best to understand this man's problem; I failed. But then you go and perpetuate whatever misery you have.

PT: Hm hmm.

Continuation of Head-on Collision

In the following passage he addresses various elements of the interlocking chain of head-on collision:

* the perpetrator of the unconscious; the punitive superego "going to perpetuate your suffering" and then;
* Puts pressure on the unconscious therapeutic alliance "Why do you want to do that?", to which the patient responded "I don't," and then he;
* Reemphasizes the self-destructive element of the resistance, challenging the self-defeating and self-sabotaging aspect of the resistance and reemphasizes that "it is here with me."

TH: How old are you?

PT: 46.

TH: 46. So still you have a long way ahead of you.

PT: Hmm.

TH: Why you want then to go on and perpetuate the suffering?

PT: Until what? (laughs)

TH: Now your smile is still . . .

PT: No I don't feel like smiling.

TH: Then you are going to perpetuate your suffering until your grave. Now why do you want to do that?

PT: I don't.

TH: But immediately some important aspect is here. I have a feeling that you have a need to sabotage, you have a need to defeat, that you are a self-defeating and self-sabotaging man. That there is a need in you to defeat and sabotage. Of course you have lived with yourself for 46 years, you know it better than I. Are you the type of the person who sabotages his potentiality, sabotages and becomes a victim of situations and so forth? Are you the type of the person who constantly finds himself into defeating and sabotaging? Because it is here with me hmm?

PT: Hmm.

Now, the therapist immediately returns to the component of the resistance against emotional closeness and follows it with another component of the chain, namely the consequences, driving home the message that if the patient continues in a state of resistance the goal in therapy will not be achieved, "This process is doomed to fail."

TH: Because if this process of you maintaining a wall, not wanting me to get to your intimate thoughts and intimate feelings continues, this process is doomed to fail.

PT: Hm hmm.

In the following passage, the head-on collision continues from one component of the interlocking chain to another:

* Indirect challenge to the defiance;
* Deactivating the transference;
* Establishing parallel between transference and other relations "20 years of marriage," "you yourself say paralyzed," "this process will be paralyzed like the other";
* Undoing the omnipotence, "there is nothing one can do."

TH: So if this is your will that you want to fail, then there is nothing one can do about it. So you have had 20 years of marriage that you refer to . . . in a sense has been crippled. You yourself say paralyzed.
PT: Hmm.
TH: So this process will be paralyzed like the other.
PT: Hm hmm.

Continuation of Head-on Collision

In the following passage, one component of the head-on collision is interlocked with another component:

* Pressure to the unconscious therapeutic alliance "why you want to do that," and then;
* Emphasizing that he is the prime mover in seeking help "come on your own will," which then follows;
* Challenging the self-defeating, self-sabotaging and self-destructive aspect of the resistance "at the same time set the stage to sabotage it;"
* Emphasizing the consequences, emphasizing that if his will is to sabotage then he has to suffer the consequences;
* Deactivating the unconscious defense mechanism of defiance;
* Deactivating the transference.

TH: So why do you want to do that? To come on your own will but at the same time set the stage to sabotage it. If that is your will, to sabotage it, then there is nothing anybody can do about it.
PT: Hm hmm.
TH: Why do you want to do that?
PT: Hm hmm.

The therapist throughout the process is putting pressure on the unconscious therapeutic alliance to get it mobilized against the forces of the resistance.

TH: "Hm hmm" is not enough, let's to see what are we going to do about it.

Here, the therapist emphasizes another component of the head-on collision, pressure on the resistance and the unconscious therapeutic alliance, rhetorical question to the therapeutic alliance.

Major Aim of Head-on Collision

As we will see, this head-on collision results in the partial unlocking of the unconscious. Pressure and then challenge to the patient's character resistance brought about a rise in the transference, and rapidly we saw the crystallization of the patient's character defenses in the transference. The therapist had determined that the patient has the capacity to withstand the impact of his unconscious as rapidly as possible. Then he introduced one of his most powerful technical interventions, namely the interlocking chain of head-on collision with the aim:

(a) To mount a direct challenge to all the forces maintaining self-destructiveness, his self-defeating and self-sabotaging pattern and masochistic component of his character;
(b) To intensify the rise in the transference feeling;
(c) To loosen up the patient's psychic system in such a way as to make the unconscious more accessible;
(d) To mobilize the therapeutic alliance against the resistance; to tilt the balance between the two forces in favor of the therapeutic alliance;
(e) To bring the patient face-to-face with his self-destructiveness. Such communication as "misery," "we say goodbye," "your will to sabotage" and "doomed to fail" both shocks him out of the syntonic part of his resistance and challenges his therapeutic alliance to make a supreme effort;
(f) To create a state of high tension between resistance and therapeutic alliance in the transference.

The First Partial Breakthrough into the Unconscious

Gradually, during the last part of the head-on collision, the patient becomes increasingly sad; and the indicator is that an initial breakthrough into the unconscious is eminent. It is important to note that when a therapist applies the technique of interlocking chain of head-on collision with the crystallized character resistance in the transference, which aims at the first breakthrough into the unconscious, he must carefully monitor the signaling system that indicates that some breakthrough is imminent. The most important are nonverbal cues indicating drop in tension in the striated muscles and the emergence of sadness. When a breakthrough into the unconscious takes place, be it partial or major, it is always associated with a major drop in the unconscious anxiety and tension.

At this point in the interview, the therapist observes this phenomenon and knows that the breakthrough is imminent. He is aware that the unconscious therapeutic alliance is mobilized against the resistance, but at the same time he is well aware that resistance remains in operation; and for the moment he focuses on the patient's sadness, but at the same time maintains challenge to the resistance. Now we return to the interview.

TH: I feel also that there are certain feelings within you—I feel, I don't know I might be wrong. That from your eyes I have a feeling that you have a certain feeling within yourself which you are very heavily controlling.
PT: No, I feel very sad.
TH. You feel very sad. And there also you don't want to have the full impact of your sadness.

In the following passage, he remains sad and tearful, and the therapist further links this with his problem with intimacy and closeness "you're terrified of closeness with me."

PT: *That's right* (barely audible)
TH: *You don't want to share with me the full impact of your sadness, which is another side of a paralyzed man. Why?*
PT: *(exhalation)*
TH: *And still you are trying to hold in this sadness and the tears that you have in your eyes. Why? why don't you want to have the full impact of it?*
PT: *I don't know, I'm afraid.*
TH: *Let's to see why you don't want to. It's not the fear; it has to do with the issue, as I said, of closeness and intimacy, and the barrier that I talked of. You're terrified of closeness with me.*
(Pause)
TH: *And look, again you are trying to hold in this sadness and tears . . . not to have the full impact of your feelings, why?*
PT: *What comes to me is that I don't know you.*
TH: *So then, in a sense, I am a stranger.*
PT: *Yeah.*

After the kind of initial breakthrough that we see, the patient is usually in an altered inner state. His whole psychic system has been loosened and the balance between the opposing forces within him has been tilted in favor of the therapeutic alliance. This manifests itself as an increased responsiveness, which may be observed in a number of different ways such as when he says "what comes to my mind is that I don't know you." But at the same time the therapist knows that the resistance is still in operation and therefore he adheres to the central principle of the technique, that when these two forces are in operation the most important task is to maintain challenge to the resistance with further pressure to the unconscious therapeutic alliance. Here, the therapist moves to further head-on colliding with the resistance against emotional closeness in the transference, addressing the consequences of maintaining this resistance, and then moves to another component which has to do with deactivating the transference—"what can I do? I have to admit to failure." Then he introduces pressure to the unconscious therapeutic alliance. This results in further mobilization of the unconscious therapeutic alliance, and he declares "I don't want to do that."

Further Head-on Collision with Resistance: Emphasizing the Resistance Against Emotional Closeness

TH: *And that is what I am talking about. You don't want this stranger to get into your intimate thoughts and feelings. You don't want me to get into your life. And that is what I call the barrier and the wall.*
PT: *Hm.*
TH: *But up to the time you don't want me to get into your life, to your intimate thoughts, into your intimate feelings, then what I'm saying is this process is doomed to fail. But if this is your will then it means you have to carry this to your grave. I don't know what has happened in your life that you are so terrified*

of this closeness, and as you put it, you referred to a "stranger" to get into your private life. And you are putting a barrier between yourself and me as a stranger. And what I'm saying is up to the time we have this barrier we are doomed to fail. Our goodbye would be a sad goodbye. You know what I mean by sad goodbye? That I say okay I did the best but he is going to carry his crippled life. But what can I do? I have to admit to failure. But for you it is a different story; you have to perpetuate your suffering to your grave. Why do you want to do that?

PT: *I don't want to do that.*

TH: *But this would be.*
(Pause)

TH: *Your previous treatment has been a failure, 20 years' marriage has been . . . so why do you want to do that?*

PT: *I don't.*

TH: *Then let's to see what are you going to do about the barrier between you and me.*

In the above passage the therapist continues with further head-on collision with the patient's resistance in the transference. He heavily emphasizes the resistance against emotional closeness and its consequences, and once more he brings the patient face to face with the self-destructiveness of the resistance; challenges the self-defeating and self-sabotaging component of the resistance in the transference. He makes communication such as "we are doomed to fail," "our goodbye would be a sad goodbye," putting further pressure on the unconscious therapeutic alliance.

Breakthrough of Major Wave of Painful Feeling

There is further mobilization of the unconscious therapeutic alliance against the resistance, and there is further passage of a major wave of painful feeling. The patient is highly choked up, with frequent deep inhalations. Now the therapist's task is to ease off the breakthrough of this major wave of painful feeling and at the same time to search for the communication from the unconscious therapeutic alliance for the signal of the direct access into the unconscious.

TH: *Because these tears and sadness must come from somewhere, I don't know from where.*

PT: *It comes.*

TH: *Hm hmm.*

PT: *At times when I feel . . .* (sigh) *. . . that I just can't . . . I'm only half a person.* (choked voice)

TH: *Right now you are fighting a major wave of painful feeling that you have. Even there you avoid my eyes.*

PT: *(deep exhalation —* pause)

PT: *I just don't know how to describe it, it's a . . .*

TH: *I'm talking about this wave of painful feeling that even is interfering with your talking. Why you are holding onto it? Why don't you want to fully experience your painful feeling?*

PT: *I don't know what else to do with it.*

TH: Why don't you want to have the full impact of it, to experience the whole? (Pause)
TH: Again your eyes avoid me.
PT: (sniffling) *I feel it come in waves and then sometimes, then it, then it subsides, it goes back down again.*

As I have indicated before, after the kind of initial breakthrough that we see in this patient, he is definitely in an altered inner state. There is definite evidence that his whole psychic system has been loosened and the balance between the opposing forces has markedly tilted in favor of the therapeutic alliance. But if any resistance still is in operation, technically one should move to challenge or even head-on collide with the resistance. With this in mind, the therapist applies a composite form of head-on collision, emphasizing the therapeutic task; head-on collision with resistance against emotional closeness; emphasizing the parallel between self-defeating and self-sabotaging pattern in the transference and in other relations, and continues to further emphasize the therapeutic task, the patient's goal, then puts further pressure on the unconscious therapeutic alliance.

Further Head-on Collision

TH: I'm suggesting obviously it must have to do with me. Because you don't want me fully into your life. I'm referring to your private thoughts, private intimate thoughts, intimate feelings, the distancing, and as you put it the stranger. Why should you let a stranger to get into your intimate thoughts and feelings, why should you? This is what you are saying in a sense. And I would assume you must have a tremendous problem with closeness and intimacy unless it is only specifically with me. Either you must have this problem with every relationship in your personal life or what, or must be exclusively with me. This problem about intimacy, closeness, and letting me to get to your intimate life and intimate thoughts, intimate feelings, must be in other relationships as well. And it's very important for you to identify, hmm? Is this the case, that you have a problem in that way?
PT: That I distance myself?
TH: Intimacy, closeness and . . .
PT: I'm . . . I try not to.
TH: But I'm saying do you have?
PT: I, I ah . . .
TH: You see it's very important for us because we are here . . .
PT: Yes.
TH: . . . with the help of each other to understand your difficulties and get to the core of your difficulties. And it's very important we step by step examine this process. Unless you want to carry the crippled life.
PT: No, I don't, I don't want to do that.

Further Breakthrough of Painful Feelings

Patient is sobbing so intensely that it interferes with his talking.

TH: *So then we have a major job here, to examine them. Because you said that these tears and sadness that you had here had to do with something.*
PT: *Well they, they have to do with . . . no I don't want it to go on.* (voice breaks)

There is further mobilization of the unconscious therapeutic alliance against the resistance, and the therapist knows that the balance between the two has tilted strongly in favor of the therapeutic alliance. The therapist is well aware that the unconscious therapeutic alliance has not yet introduced the dynamic events of his very early life that have had such a negative impact on his character. He continues emphasizing why should he sentence himself to suffering, why should he continue to punish himself, addressing the perpetrator of the unconscious, his need to go from the frying pan into fire, "Why is there a need in you to continue your suffering?", addressing the punitive superego, the guilt and punishment. He further addresses the unconscious "What have you done?", "Why is there a need in you to continue a paralyzed life?"; and the patient in a painful state repeatedly declares that he does not want to continue with his suffering. Now we go back to the interview.

PT: *(weeping) It's the way you say it, that I act as though I want them to go on, but I don't.* (crying) *I don't. And yet I can form . . . because . . .*
TH: *Hmm?*
PT: *I can feel myself pulling back from it because I know I can live . . .*
TH: *You can live a crippled life, no question about it.*
PT: *But sometimes that seems safer.*
TH: *But my question is why?*
PT: (sob) *Why do I have to?*
TH: *Why do you have to sentence yourself to a paralyzed crippled life? What have you done that you are sentencing yourself to this crippled, paralyzed life? What have you done?*
PT: *I don't know.*
TH: *Why is there a need in you to continue a paralyzed life?*
PT: (sniffling) *Well . . .*
(Passage of painful feeling continues.)

Direct Access to the Unconscious

Waves of Very Painful Feeling

TH: *From where do you think they come?*
PT: *I think they come from my childhood, I think they come from . . . at least they might be from being . . . It comes to my mind as a child being left.*

In a painful state he talked about his father who went to the Second World War in Europe. The patient was 1 year old. He comes with the memory of a picture when he was 1 year old which was taken before his father left. In the picture are he, his brother, mother and father.

TH: *And who is in that picture? You . . .*
PT: *My mother, my brother, and I.*
TH: *You, your mother and your brother. And your father? The four of you?*

PT: Hm hmm.
TH: In the front. Who is next to your father?
PT: My brother is next to my father, I'm next to my mother. My brother is 4 years older.

In a very sad and painful state he talked about the breakdown of the nuclear family and painfully said "my mother also left." She went to another city; and he and his brother, with a number of other children, were placed with his grandmother, Blanche, and with his aunts. Then he comes with another memory with a wave of very painful feeling and said that once in a while he would be taken by one of his aunts to the city where his mother was, for a visit; but he had always thought that his mother came to visit him.

Dynamic Exploration

TH: The wish was that she had come to see you.
PT: Hmm.
TH: But then the reality was that . . .
PT: And then I was also . . .
TH: So then you must have a lot of feeling about that as well.
PT: Yes, I feel a great sadness that I never knew my mother . . .
TH: That you never knew . . .
PT: I never knew her at all, and . . .
TH: As if she had died in your life when you were a year old.
PT: Hmm.
TH: That she died that early in your life.
PT: She never . . . but neither of my parents ah . . .
TH: I'm talking about your mother. Is that the idea that she died in your life in the very early . . . In a sense this is what you describe.
PT: Yes.
TH: Psychologically as if she disappeared in your life.
PT: Hmm.
TH: And then your father, also you lost him in the early phase to the war, hmm.
PT: Yes.
TH: Did you see him while he was in the war?
PT: No.

Exploring the Patient's Feeling

He remains somewhat sad and for the moment there is no passage of painful feeling, and now the therapist asks the patient, "How do you feel?"

TH: How do you feel right now?
PT: I feel tired, but I don't feel as nervous. You see, I don't feel as cold.
TH: Hm hmm.
PT: A bit drained.
TH: You feel drained you said?
PT: Yeah.

TH: In what sense drained?
PT: It's like being stretched or . . .

Then he said "a song goes through my mind, it is 'Be not afraid'." This triggers off a breakthrough of another major wave of painful feeling, with heavy crying.

TH: But you see the wave of painful feeling comes and then you try to put the shutter. I think this is a major problem.
PT: (sniffling) *You mean because I hold it in?*
TH: Because you don't want to have the full impact of these waves of the feelings that you have.
PT: (deep heaving breaths)
TH: Because somehow . . .
PT: (deep breathing)
TH: . . . you have this constant need to control, hmm, and maintain a paralyzed position, hmm.
PT: Yeah, I'm afraid of it.

The above passage clearly demonstrates that for the time being, the powerful dynamic force of the unconscious therapeutic alliance is in command and has introduced, at least, the very center of the patient's major traumatic experiences. At the same time the therapist is well aware that in this kind of partial breakthrough into the unconscious the return of the resistance is unavoidable. The therapist, for the time being, is waiting for the passage of the waves of painful feeling so that he can move to the phase of analysis of the transference and consolidation, and then to the phase of inquiry: developmental history, alternating with dynamic exploration until he meets the resistance again. Then the process is ready for the technique of major unlocking of the unconscious. Now we return to the interview.

TH: You lost your father to war at the very early phase of your life, hmm. Then also you lost your mother. In a psychological sense they died in your life. What I said is maybe it is the engine or maybe it is the force behind the fact that you don't want me to get to your intimate thoughts and feelings, in a sense when I said about the issue of intimacy and closeness, hmm.
PT: In looking back my experience is that all intimate relationships have been ah, have been a disaster. The only reason the marriage has survived . . .
TH: You mean is death?
PT: Sorry?
TH: Like death, they died.
PT: They died. (sad voice)
TH: Hmm?
PT: Yes. (whispers) *They died.*
TH: Is something like that isn't it?
PT: I never thought of that. (low voice)
TH: As if your mother died in your life in the very early phase, hmm.
PT: Hm hmm.
TH: And then your father died in the sense that he was taken to the war, hmm.

The Issue of Resistance against Emotional Closeness

As we saw in the above passage, the therapist made an interpretation which linked the resistance against emotional closeness in the transference with his father who went to the war and his mother who dumped him, and drives home insight into one of the dynamic forces which is responsible for such a resistance. It is also important to note that he clearly makes communication referring to the death "They died in your life," to which the patient responds with extraordinary clarity and says "all intimate relationships have been a disaster," and then he says "I never thought of that."

Most Recent Precipitating Event which has Created a Major Disequilibrium

The patient now makes an important commmunication which clearly outlines the most recent precipitating event, the possibility of the breakdown of the marriage which might disrupt the close relationship with his two children. The therapist had communicated to him "your mother died in your life," "your father died in the sense." Now the patient spontaneously talked about his marriage which might end in disaster, and in a very sad and tearful state he talked about the pressure during the past year, the breaking point in his marriage. Then in a painful state he mentioned that this might cause a breakdown of his relationship with his daughter and his son, and the fact that couple therapy had not brought any changes. He further says that all of his relationships have ended in disaster.

Any therapist trained in the traditional psychoanalytic model might here make an interpretation involving the two triangular situations; he, his father and mother, and he, his daughter and son. But in this technique this would be considered a major technical error. The therapist knows that the important task ahead is the major resistance against the murderous rage and intense guilt-laden unconscious feeling in relation to mother and/or father and so forth. Now the therapist returns to the *systematic analysis of the transference* and the phase of consolidation, followed by the phase of inquiry and developmental history.

Developmental History

The patient was born in eastern Canada. Then shortly the family moved to the mid-west. There were major problems in his parents' marriage. After the breakdown of the nuclear family, he and his brother lived with his grandmother (Blanche), two aunts and an uncle. There were seven other children. They lived in a poor section of the city. Then he talked about his Aunt Elizabeth, who was kind. He has a memory of this aunt telling him that he was a very sad child and never smiled. She was the one who dressed him up and would take him to visit his mother in the city where she was living.

Phase of Inquiry

Now the therapist returns to the phase of inquiry and explores the patient's difficulties. He suffers:

(1) *Disturbances in the interpersonal relationships* with both men and women. He emphasizes that in his interpersonal relationships he finds himself "paralyzed" and has a fear of being abandoned. This is with both men and women.
(2) *Major problem with intimacy and closeness* with both men and women, much more pronounced with women.
(3) *Chronic state of anxiety.*
(4) *Somatization disorder* such as pain in his neck, stiffness in his neck, frequent headaches and at times generalized stiffness.
(5) *Functional bowel disorder*, occasional looseness of the bowels with diarrhea.
(6) *Sexual problem*, a decline in sexual desire. During the sexual relationship with his wife he has to resort to the mental image of another woman in order to be able to have intercourse and describes it as a totally mechanical act. This has been throughout the 20 years of marriage.
(7) *Problem in his marriage.* He describes a major problem and refers to it as being paralyzed in relation to his wife. He describes her as being highly critical, demanding, criticizes everything that he does, and further points out that she becomes explosive and at times physically violent. The way he handles himself is by either taking a passive, detached, compliant position, trying to do everything according to her wishes, or by moving to a silent defiant position which angers her. On a number of occasions he has had explosive discharge of affect, which makes the relationship worse.
(8) *Episodes of clinical depression.* He has suffered from a number of clinical depressions, a few of them were before the marriage, and each of them followed a breakdown of a relationship with a woman. Since his marriage he has had a number of clinical depressions, most of them in the recent years when the marriage has been on the verge of breakdown and there has been the threat of losing his children.
(9) *Character disturbances.* Either he becomes an extremely passive, compliant, silent and detached person or he may move to the opposite and become defiant. Masochistic character traits are evident. As we see, now during the inquiry he demonstrates a high degree of responsiveness and clarity.

The therapist knows that the major resistance is ahead, that he is working with a person who has been badly traumatized in the very early phase of his life and who suffers from characterological depression with a masochistic component in his character. The therapist moves to dynamic exploration alternating it with inquiry until he has the opportunity to meet the major resistance.

Dynamic Exploration into the Marriage

He never felt close to his wife, which dates back to the year that they dated each other. "I married her knowing that there was detachment, noninvolvement and a total absence of emotional closeness." It is important to note that his communication is very meaningful and he talks about "detachment," "absence of emotional closeness," which was not the case in the beginning of the interview. Then he talked about his honeymoon and refers to it as having been an unpleasant experience "when we made love that night I made love because that is what one does on one's wedding night," and added "It was physical," "I made love and went through all the motions but I did not feel any . . ."

Then he indicates that when he makes love it is under the pressure of his wife, and that the only way he can have sex is to resort to the mental image of another woman. In recent years he actively brings the mental image of another woman

named Linda while having sex with his wife. When asked to describe the physical build of Linda he becomes more and more anxious and there is a return of the resistance in the transference, and the process moves to the phase of systematic challenge and pressure to the resistance. But this time the therapist's task is a systematic weakening of the major resistance, which is the resistance against the murderous rage and the guilt of the unconscious. This systematic work then results in a major unlocking of the unconscious, which will be analyzed in depth in Part II of this two-part article.

Summary and Conclusion

The article described the central dynamic sequence in the process of partial, major and extended major unlocking of the unconscious. It is important to recapitulate and summarize some of the main technical interventions in the process of partial unlocking of the unconscious with this patient:

(1) The central dynamic sequence in the process of partial unlocking of the unconscious was described in a number of the phases:
(a) The phase of inquiry: exploring the patient's difficulties, with rapid identification of the patient's character defenses.
(b) Pressure leading to the resistance, rise in the transference, increased resistance and psychodiagnosis.
(c) Challenge to the resistance, systematic attempt to make the patient acquainted with the resistance that has paralyzed his functioning, and crystallization of the character resistance in the transference.
(d) Transference resistance; head-on collision with the transference resistance to loosen the patient's psychic system; mobilization of the therapeutic alliance against the resistance.
(e) Breakthrough of the complex transference feelings; the triggering mechanism for the direct access to the unconscious and direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.
(f) Systematic analysis of the transference.
(g) Dynamic exploration into the unconscious and psychotherapeutic planning.
(2) The interview started with the phase of inquiry, which was not possible.
(3) The therapist introduced pressure to the resistance of vague generalization, asking the patient for a specific example. This led to some rise in the transference and anxiety in the transference, and the therapist introduced further pressure by focusing on his feelings, which led to resistance in the form of a number of tactical defenses. Then, as we saw, there was a gradual transition from pressure to challenge to the patient's tactical defenses. There was gradual crystallization of resistance in the transference, and the therapist not only challenged the patient's character defenses but systematically made him acquainted with them.
(4) From the psychodiagnostic point of view, the therapist concluded that the patient suffers from character neurosis and decided that a rapid breakthrough into the unconscious is the procedure of choice.
(5) Now the therapist's technical intervention consisted of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference.
(6) This powerful form of head-on collision resulted in the first partial breakthrough into the unconscious and major waves of painful feeling with

the mobilization of the unconscious therapeutic alliance and direct view of the psychopathological dynamic forces: the center of the patient's very early trauma, namely of being abandoned by both parents at the age of one. Then the process entered:

(7) The phase of analysis of the transference and consolidation. Then the process returned to the phase of inquiry into the patient's areas of disturbances; the patient was quite responsive and every area of disturbance was explored.

(8) The therapist was well aware that in a patient with such a complex psychopathology the major resistance, which consists of the major repressive mechanism, is in full operation in spite of the partial breakthrough into the unconscious and mobilization of the unconscious therapeutic alliance.

(9) In search of the return of the resistance, he made a dynamic exploration into the marriage and his sexual life. What emerged was that the only way he could have intercourse with his wife was by bringing the mental image of a woman named Linda. In exploring the body of Linda there was mobilization of a major resistance in the transference. Now the therapist moves to bring about major unlocking of the unconscious and the weakening of the major resistance. The rest of the interview will be the subject of Part II of this two-part article.

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