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# TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY

# CENTRAL DYNAMIC SEQUENCE: PHASE OF PRESSURE

## ( Part I )



ABSTRACT

This is the first of four articles on basic technical interventions in Dr. Danvanloo's system of Intensive Short-Term Dynamic Psychotherapy (pressure, challenge, the entry of transference and head-on collision), based on the proceedings of a five-day immersion course presented by Dr. Davanloo. This article gives an introduction to his conceptualisation of the metapsychology of the unconscious (new concept of transference and unconscious therapeutic alliance; discharge pattern of unconscious anxiety; neurobiological pathway of the murderous rage and guilt; the direct access to the unconscious dynamic forces, responsible for the patients disturbenaces). Then this article elaborates on the Dr. Davanloo's psychotherapeutic technique, introducing the Central Dynamic Sequence and focusing on a set of technical interventions, designed to exert pressure (Phase of Pressure), by presenting audiovisually recorded vignettes of sessions with different patients, elaborating on the nature of the technical interventions and their major aim, namly bringing rise in the complex transference feelings.

## Introduction and overview

This is the first of four articles on basic technical interventions in Dr. Davanloo's system of Intensive Short-Term Dynamic Psychotherapy ( pressure, challenge, the entry of transference and head-on collision). These articles are based on the proceedings of a five-day immersion course presented by Dr. Davanloo at the training program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany. The clinical vignettes come from Dr. Davanloo's Research Library, and they represent a small sample of the audiovisually-recorded clinical vignettes in this course. Research data mentioned in this proceedings is Dr.

Davanloo's audiovisually-recorded clinical research, and all the metapsychological concepts and technical interventions presented are those of Dr. Davanloo.
Dr. Davanloo gave an in-depth presentation of the Central Dynamic Sequence based on the technical and metapsychological roots of his system of Intensive Short-Term Dynamic Psychotherapy (IS-TDP). The goal was to give a much deeper knowledge of how the unconscious is functioning and how one can work with the unconscious in order to approach the psychopathological dynamic forces responsible for the patient's symptom- and character disturbances, that is how to achieve the breakthrough into the unconscious and the unlocking of the unconscious.
Based on his work of more than thirty years with the dynamic unconscious - with extensive use of videotechnology - Dr. Davanloo has developed a new conceptualization of the metapsychology of the unconscious, that is, the way it is and the way it operates. Further he has developed a set of powerful technical interventions such as pressure, challenge and head-on collision on the one hand, and the various phases of the Central Dynamic Sequence on the other.
He emphasized that clinicians must become familiar with his new concept of transference and unconscious therapeutic alliance. They must observe with utmost vigilance all the parameters, which indicate that the rise of complex transference feelings has become a major factor between the patient and the therapist in the interview. It is the rise in transference feelings, that gives rise to the unconscious therapeutic alliance and it is the unconscious therapeutic alliance which in connection with the technical interventions among the phases of the Central Dynamic Sequence guides the whole process of the unlocking of the unconscious.

During the whole process the therapist keeps his eye on the important parameters such as:
- unconscious anxiety
- rise in transference feelings
- resistance and all its tactical organization
- unconscious therapeutic alliance
- reactive murderous or reactive primitive murderous rage
- guilt and grief-laden unconscious feelings

## The Discharge Pattern of Unconscious Anxiety

Davanloo emphasized the need for clinicians to have a good knowledge of the discharge pattern of the unconscious anxiety. Throughout the whole process, unconscious anxiety shows up as a signal from the dynamic unconscious giving the therapist a clue as to whether and how the patient's unconscious is responding to each intervention. He presented his systematic research on the discharge pattern of unconscious anxiety:
The first is unconscious anxiety channeling itself in the form of tension in the striated muscles. This starts from the muscles in the thumbs, then goes in the muscles of the hand. If there is further increase of unconscious anxiety it moves to the supinator and pronator namely into the

muscles of the forearm. If it increases further, then it goes to the muscles of the arms and shoulders and to the sternocleidomastoid muscles, creating stiffness in the neck. Then it travels to the intercostal muscles, in which case the patient starts to have a deep, sighing respiration. He now has tension in the intercostal and sub-diaphragmatic muscles. If it increases further he may have tics in the muscles of the face, tics around the preorbital muscles, perioral tics as "rabbit" movements and, finally, anxiety goes into the muscles of the legs. This is the pathway for the unconscious anxiety when it channels itself as tension in the striated muscles. Patients belonging to this group have very high capacity to experience and tolerate anxiety, and therefore a high capacity to withstand the impact of their unconscious.

The second discharge pattern of unconscious anxiety is to the smooth muscles, as in the GI-tract or the lungs. The patients may react with diarrhea or bronchospasm. With these patients, the task of the therapist is to raise the threshold for toleration of the anxiety and so to convert the discharge pattern of the anxiety from the smooth muscles to the striated muscles.
The third pathway for the unconscious anxiety is in the perceptual and cognitive field. These are patients with fragile character structure. They suffer from psychoneurotic disturbances, but when anxiety is mobilized in these patients - in the transference or out of the transference - a sudden disruption may be created. This group of patients has a very low tolerance to withstand or experience anxiety. Any mobilization of unconscious anxiety creates disruption of the cognitive and perceptual processes (for example, blurring of vision or buzzing in the ears). They move easily to dissociation and splitting, or even to hallucinatory experiences. A direct move into the unconscious with this group of patients is not possible. For these patients, it is necessary to modify the technique of unlocking the unconscious to first create structural changes.

## The Neurobiological Pathway of the Murderous Rage

Davanloo then presented on his discovery of the neurobiological pathway of the murderous rage, primitive murderous rage or primitive murderous and torturous rage, which starts from the solar plexus in the pelvis. The patients refer to it as having a hot feeling, that moves to the lower and upper abdominal zone. Some patients describe this as feeling like a "vulcano" or a "fireball" or a "force" or an "energy".
If you mobilize more rage, then it goes up to the chest, branches of it going to the head, moving up and down for a while. Finally, the murderous rage does not go to the head, but to the shoulders, arms and hands, and they want to grab. If the murderous rage reaches this zone and comes to the arms or legs, the patient is actually experiencing this murderous or torturous rage "as if he is doing it" without actually acting on his impulses. When the murderous rage passes to the conscious zone, unconscious anxiety is not there any more. Intense painful feelings of guilt and grief follow the rage, taking a somewhat different neurobiological pathway.
Dr. Davanloo emphasizes again and again, that only the actual and physical experience of the murderous rage, guilt and grief-laden unconscious feelings can create multidimensional

unconscious structural changes. In no way this would be possible on the cognitive level, but only on the gut level, that is, the patient's feelings must be materialized.

## The Spectrum of Psychoneurotic Disturbances

He then outlined his spectrum of psychoneurotic disturbances where on the extreme left are patients who are highly motivated, highly responsive, with a single psychotherapeutic focus and with an absence of unconscious murderous rage. Moving to the other extreme, patients on the extreme right side of the spectrum have life-long character neurosis, highly complex core pathology, with the presence of a major trauma, the pain of the trauma and reactive unconscious murderous rage, primitive murderous rage, or primitive murderous and torturous rage and intense guilt- and grief-laden unconscious feelings. Thus they have and use the major resistance with all its tactical organization to bury, cement or even to seal off these unacceptable, disturbing and most painful unconscious feelings, that is, the ugly "truth of their unconscious". IS-TDP can be applied to the whole spectrum of psychoneurotic disturbances, no matter the degree of resistance.

## Various Degrees of Unlocking the Unconscious

Dr. Davanloo's four major techniques of unlocking the unconscious: partial, major, extended major, and extended multiple major unlocking were then presented and he highlighted that the degree of unlocking the unconscious correlates with the degree that the patient has actually experienced the transference feelings, and with the degree of the dominance of the unconscious therapeutic alliance over the forces of the resistance.

## Unconscious Therapeutic Alliance and Complex Transference Feelings

Davanloo's concept of unconscious therapeutic alliance was then presented and it was emphasized that it is activated as a force against the forces of the patient's resistance by the proper application of the technical interventions of pressure, challenge, head-on collision. The resulting rise in transference, intensification and ultimate crystallization of the resistance in the transference and the mobilization of the unconscious therapeutic alliance sets the stage for the development of an intrapsychic crisis, which he defines as an intense tension and battle between the forces of the resistance and the forces of the unconscious therapeutic alliance with the final dominance of the unconscious therapeutic alliance over the resistance. The first dominance of the unconscious therapeutic alliance over the forces of the resistance is called "the first breakthrough".

## Central Dynamic Sequence

He then outlined the Dynamic Sequence in the unlocking of the unconscious which consists of:

- Phase I. Inquiry into the patient's difficulties rapidly moving to dynamic inquiry
- Phase II. Pressure leading to rise in transference and intensification of the resistance

- Phase III. Challenging the resistance , leading to heavy crystallization of the patient's character defenses in the transference and the transference resistance
- Phase IV. Mounting the challenge to the transference resistance and head-on-collision with the transference resistance
- Phase V. Intrapsychic crisis leading to rapid breakdown of the major resistance and direct access to the unconscious
- Phase VI. Systematic analysis of the transference
- Phase VII. Further dynamic inquiry , exploring the medical, social and developmental history, and it was emphasized, that theses phases can be seen as a framework which the therapist can use as a guide, and that they tend to overlap and proceed in a spiral rather than a straightforward line.

## Phase of Pressure

Here we summarize aspects of Dr. Davanloo's presentation on the phase of pressure. A number of patients were shown to demonstrate some of the important principles of exerting pressure. The therapist steadily increases pressure with the major aim to mobilize the triple factors: transference, resistance and unconscious therapeutic alliance . The main factors influencing the course of an interview are the degree of resistance and the transference component of the resistance. When we exert pressure in a proper way all the character defenses will be crystallized in the transference.

Dr. Davanloo presented a set of technical interventions that he designed to exert pressure and indicated, that these interventions tend to overlap.

The clinician's task is to pursue his inquiry to turn it to a dynamic inquiry, then exert pressure towards the avoided feeling and then toward the defense. The pressure must be sufficient in the preparatory phase, which includes the phases I through IV for sufficient mobilization of complex transference feelings so that the breakthrough in the unconscious can be achieved. This requires that the therapist holds tightly on the phase of pressure.

## Major Aim of the Phase of Pressure

The aim of the phase of pressure is to mobilize some parameters which are important in the whole process :

a) Mobilization and build-up of unconscious anxiety in the transference. As a result of pressure anxiety comes up as the first signal from the unconscious. For the therapist, unconscious anxiety is a guide throughout the whole process;
b) Mobilization and intensification of complex transference feelings;
c) Mobilization and intensification of the resistance;
d) Crystallization of some degree of the resistance in the transference. That means tilting and shifting all the character defenses in direction to the therapist;

e) The rise in the transference feelings eventually leads to the rise of the unconscious therapeutic alliance.

When we exert pressure towards the avoided feeling in the transference with the 'simple' question: "How do You feel right now towards me besides your anxiety?", this brings the unconscious anxiety into direct connection with all the forces of the buried feelings which are hidden behind the anxiety. If the therapist remains tightly on the phase of pressure, sooner or later there will be a constant rise in the complex transference feelings. From the very beginning of the interview, it is his task to create a dynamic and vivid process, that is, to move to the psychopathological dynamic forces into the patient's unconscious.

## Technical Interventions to Exert Pressure

We should keep in mind that pressure and challenge are not entirely separate. Some pressure clearly contains an element of challenge:

- Structured interview
- Inquiry and dynamic inquiry
- Asking patient to be more specific, asking for a specific example and framing
- Probing questions
- Directing the interview toward significant areas; asking for further information in these areas
- Focusing on feelings in these areas
- Focusing on the actual experience of feelings
- Focusing on the impulse
- Clarifying remarks
- Confronting comments consisting of pointing out some issues which are entirely true but which the patient does not wish to look at
- Repeating a question to block diversionary tactics
- Focusing on fantasies
- Introducing an anxiety-laden area
- Directing the patient's attention to the use of certain words
- Making explicit what the patient has implied but is avoiding
- Underlining patient's disturbing feelings
- Confronting comments on the patient's transference behaviour
- Directing patient's attention to non-verbal cues
- Blocking in the form of non responding
- Directing the interview toward a specific area where the patient has difficulty

These interventions of pressure make clear, that pressure is not only pressure to the avoided feeling. At any time, pressure must be very specific, as the whole system of intervention and

response is not like a "Procrustean bed", i.e. to have the same menu for every patient and at any given moment. The therapist's interventions must be in tune with the patient's unconscious. It is necessary to modify and adapt the interventions in dependence to the patient's responses in order to achieve a successful and satisfying process. This requires, on the side of the therapist, to not only have a vivid interest in the patient's life and suffering, but, also, to learn step by step in an exact way a technique and a method on the one hand, and to acquire deep knowledge of the metapsychology of the human unconscious on the other, as well as the ability to pick up the patient's unconscious clues at any given moment.

Usually the therapist opens with the question - "Can you tell me what seems to be the problem?" As the patient responds, the therapist senses areas that are likely to be significant and directs the patient's attention to them. He might question the patient "Can you tell me more about that?" or "Could we look into that?" and the patient might respond and speak of some general situation that gives him difficulty. Then the therapist proceeds by asking for a specific example and focuses on the feeling "How did you feel in that situation?" and the patient responds "I felt such and such". The therapist focuses on the actual experience of the feeling "How did you experience your warm feeling?" or "How did you actually experience your anger?"

At any point in the above sequence, the patient's unconscious begins to sense that the therapist is searching for the very feeling which he has been trying to avoid for years of his life, and that the therapist will not stop until he finds it. This is the beginning of first tilting and shifting of anxiety and resistance into the transference and, eventually, crystallization of the resistance in the transference. (The third of these articles will elaborate on when to move to the transference). Here, we will condense and summarize a few of the clinical vignettes presented by Dr. Davanloo to further highlight the phase of pressure.

## Patient 1
## Phase of pressure when a patient is entering the interview with a series of defenses

Many patients make their resistance clear from the first moment that they speak. Dr. Davanloo presented a vignette from an interview with a male patient. The question of the therapist was "what seems to be the problem that you want to get help for?" "My problem is not knowing how to deal with the problem." This was the most revealing statement and in that clinical vignette there was a series of defenses of vagueness and evasiveness in the early part of the interview and , shortly, this resistance became resistance in the transference and we saw the crystallization of the resistance in the transference. Then the process entered into the phase of challenge.

## Patient 2
## Phase of pressure when a patient is entering the interview with anxiety in the transference

This patient entered the interview room with anxiety in the transference. The therapist opened the session by "How do you feel right now?"; the patient indicated anxiety; then the focus was on the patient's feeling in the transference; the process rapidly entered into the phase of pressure to the underlying feeling and then to resistance in the transference; which was then followed by the phase of challenge to the resistance in the transference.

## Patient 3
## Phase of pressure when the patient focuses on feelings

Then Dr. Davanloo presented a female patient in her thirties. In reply to the opening question the patient almost immediately speaks of her feelings.

*TH: Could you tell me what seems to be the problem?*
*PT: Well, one of the main difficulties is that I feel angry a lot of the time. I feel tremendously angry towards my family, towards my parents and ah I also feel angry toward many other things and it doesn't ...*

The therapist exerts pressure by blocking this attempt of moving away from people.

*TH: Things?*
*PT: You know, things that happen or people but this anger comes up a lot. It surfaces very easily.*

Exerting Pressure: Asking for a Specific Example.

*TH: Could you give me a specific example where anger comes up?*
*PT: Well I can give you an example of when I visit my parents. For some reason I try to, like, speak to my mother. She's always very nice and everything, but she somehow just evokes this anger in me and I just remember all kinds of the things from my childhood.*

The therapist has asked for a specific example of a situation, that arouses anger. The patient has partly responded, in the sense that she has specifically mentioned her mother; but she has gone on to speak only in general terms and now wants to diversify into the past, avoiding the therapist's question. While the data about the past is immensely important, moving to the past at this time, however, is diversification and is being used to avoid the true impact of her feeling in this recent situation. In fact, the patient's unconscious resistance is setting up a subtle trap, offering something of great dynamic significance in order to deceive the therapist into following her away from the

central issue, which consists of the details of the recent incident and what the patient felt in it. Dr. Davanloo points out a fundamental principle which can be summarized as follows: If the therapist asks a specific question, then he should accept nothing but an answer to his question; if the patient answers something else, no matter how significant it may appear to be, it should be regarded as resistance. At this point, the therapist exerts pressure to this resistance by simply repeating the question.

*TH: Could you give me a specific example in the current, most recent time?*
*PT: The most recent one, uh, I just spoke to her last week and she ... my mother loves to pickle, and she said to me, "I'm not pickling very many things because I don't have any jars," and I said to her, "Well, you can go and buy jars," and she said "No, we don't buy jars, I don't have any jars," and I immediately became very angry and started fighting with her because ... what it symbolizes for me is that when we were young they neglected us, they never wanted to pay for anything.*
*TH: But you see, you haven't yet described that incidence. You move to ...*
*PT: Right. Okay, so she said, "I don't have any jars" and I said "Well you can buy jars, they sell jars in the stores," and she said, "No."*

The therapist exerts pressure toward the feeling.

*TH: So this mobilized anger in you?*
*PT: All of a sudden, I became so angry towards her and I just became very agitated and nervous and I wanted to ...*

In the above passage, the patient is using the defense of moving away from the disturbing feeling of anger into the less disturbing feeling of anxiety. The therapist exerts pressure by blocking this and moving to the anger, by exerting pressure towards the experience of the anger.

*TH: What was the way you experienced your anger?*
*PT. I just became very agitated and nervous and I wanted to ...*
*TH: But what was the way you experienced your anger towards your mother?*
*PT. It is hard to explain. I just ...*
*TH: But you said you were in such anger, how did you experience this anger toward your mother?*

In the above passage, the patient again wants to move away from anger to anxiety, and the therapist exerts pressure by focusing on the experience of anger. This, obviously, is mobilizing feelings in the transference, feelings toward the therapist for refusing to go along with her defenses, manifesting itself by a smile which is a signal that heightened dynamic interaction is beginning to occur.

Now the therapist exerts further pressure to the transference simply by adressing the smile.

*TH. You smile also.*

Return to pressure to anger in the specific situation

*TH: You said that the discussion was around pickling and the jars and you were in such anger with your mother.*
*PT: Yes, a hatred towards her when she told me that.*
*TH: But how did you experience the anger?*

Anger is a tactical defense against rage and murderous rage and the patient's unconscious becomes alarmed at the therapist relentless insistence on the experience of anger. Now, she immediately retreats, going back to describing anxiety.

*PT: I felt very agitated inside.*

Further pressure

*TH: What do you mean by agitated inside?*
*PT: Nervous, I started to get nervous and agitated.*
*TH: You felt nervous?*
*PT: I wanted to hit her, I wanted to scream at her, I started fighting with her immediately as soon as she said that.*

Then the patient tries to move to generalization, which the therapist blocks. As now the resistance has become resistance in the transference, the process can move to the phase of challenge.

## Patient 4 (The Case of the Man with the Chewing Gum) Phase of pressure when the patient has masochistic character traits with transference implications

Dr. Davanloo emphasized one of the interventions used in the phase of pressure consisting of making confronting comments: pointing out some issues which are entirely true, but which the patient does not wish to look at. For example, making confronting comments about the patient's secondary gains in his symptoms. The patient's response always contains a strong transference component and intensification of the resistance.

This man, at the time of the initial interview, was twenty-nine years old, married and suffered from a chronic state of anxiety, panic attacks, wide range of functional and somatization disorders, phobic disorder and diffuse characterological problems. His severe anxiety would become intensified when he was away from home, or when he was left by his boss to cope with his work.

During the phase of dynamic inquiry, it became clear that he is highly dependent on his wife and that he uses the regressive secondary gain expressed by his symptoms in the form of trying to make his wife and his boss stay with him. The therapist exerted pressure with a number of confronting comments:

*TH: So in your job you have to have your boss around in order of function. Otherwise, you become anxious and panicky. And in your personal life, you cannot function without your wife. She is even the one who has to cut your hair. What do you think about this?*
*PT: I don't have any thoughts. What can one do when one has all these symptoms? (Silence)*

There is increase in his anxiety in the form of tension and becoming immobile and silent, and the rate of his smoking has increased. For the therapist, this is the clue that pressure has given rise to the transference feelings and has intensified the transference component of the resistance. Now, he puts pressure on the patient's feelings in the transference.

*TH: How do you feel right now? Have you noticed that you have become much more slow and passive?*
*PT: (smiling) No, I don't think so.*
*TH: Still you haven't said how you feel when I point out to you that without your boss and your wife you are helpless.*
*PT: Yeah ... mm, hmm. One doesn't like to be told that one is so dependent.*

.....

*PT: Yeah, I was annoyed ... because the idea was that I was like a child.*

Now, the process enters into the phase of challenge, pressure and challenge and head-on collision with the resistance, which is soon crystallized in the transference.

## Patient 5 (The Case of the Man with the Celiac Disease) This is an example for the principle of applying pressure, challenge and head-on collision in a spiral way with a patient with a moderate degree of resistance

The therapist entered into the interview questioning the patient "Could you tell me what seems to be the nature of your difficulties that you want to get help for it?" He responds well to the phase of inquiry and indicates that he suffers from chronic anxiety which has become intensified since his present girlfriend has been pressing him to live together and talks about marriage. He suffers from episodes of depression, feeling of inferiority, insecurity, major problem in the interpersonal relationships, has no friends. He has suffered from gastrointestinal disturbances in his early and adolescent years, diagnosed as Celiac Disease. He is in his early thirties and works

as a teacher. He complains of being self-conscious about the size of his physique. He has problem in relationships with women. With women who are not intellectual, but are rather passive and compliant he feels comfortable but ends up by becoming bored and the relationship ends up terminated. With women who are warm, intellectual and assertive he experiences anxiety. His anxiety becomes much worse if the woman is also controlling. All of his relationships with women have ended up in disappointment. The only relationship that lasted three years was with Ms. L., who was extremely passive and intellectually inferior. The sexual relationship was good, but Ms. L. changed and pressured him for marriage. He felt trapped, with a high level of anxiety and the relationship was terminated. The issues of commitment and marriage end the relationships.
The phase of inquiry rapidly moves to the phase of pressure with the entry of the transference. The therapist exerts pressure by making a comment, pointing out the issue of the passive-compliant women towards which he gravitates. While this comment is entirely true, at the same time the patient does not wish to look at. As a result, there is a rise in the transference and some degree of crystallization of resistance between the patient and the therapist. The following passage demonstrates aspects of the phase of pressure:

*TH: How do you feel here when I focus on this issue off follower, passive-compliant type of women, or something like that? How do you feel toward me?*
*PT: Uhmm (Deep sigh) ... Well, as you've already seen, it is an awkward subject for me because I don't like to think of myself that way.*

Here the deep sigh is the unconscious response to the therapist's intervention. The rise in transference feelings is mobilizing unconscious anxiety which here is channelling itself in the striated intercostal muscles.

**Further Pressure toward his Feelings in the Transference**

*TH: How do you feel when I focus on that issue?*
*PT: Well, you saw I felt rather defensive.*
*TH: But how do you feel? I am talking about feeling towards me.*
*PT: I, I felt ahh ... I felt a little angry*
*TH: A little angry?*
*PT: Well I wasn't jumping up and down and yelling, but I felt angry.*

Pressure toward the Experience of Anger in the Transference

*TH: What was the way you, experienced the anger?*
*PT: That you were trying to fit me into a category that I vigorously resist being fitted into.*
(The focus of the session remains on the anger in the transference and the way he defended by dismissing the therapist).

*PT: Well, I did not express that I was angry, but I just denied what you were saying.*
*TH: Because my feeling was from the moment that I told you, and brought the issue to the focus, you became more ... moved to the position of censoring yourself. Do you notice that?*
*PT: (Rise in anxiety, deep sighing respiration) I hadn't noticed that I started doing it, particularly then. Uhhm. I will censor myself pretty easily under a lot of situations.*

In the above passage, the therapist turns to pressure to resistance by commenting the patient's needs to censor, which in a sense implies the need to exert control in the transference. Taking into consideration that this character trait of the need to control is disturbing to him mobilizes further rise in the complex transference feelings and he himself declares that one of his character traits is censoring himself under a lot of situations, which has transference implication. Now the therapist brings the transference into focus.

*TH: Do you think you are doing that here with me? Repeating certain patterns which are disturbing to you, need to control here with me?*

The patient clearly declares that his need to control is in the transference but is also in other relationships and that he does not like this character trait but he cannot help it.

**Mobilization and Intensification of Resistance in the Transference; Head-on Collision with the Resistance**

*TH: Repeating certain patterns which are disturbing to you and then you are the one, you had told to yourself how long further you are going to go and to repeat this pattern that you have, okay. You are the one who has decided ... and I again would assume that you have decided to come here on your own decision. Is it true or not? Is it that you come here because you want or Dr. whoever refers you wants you to come here? Or is it that you come here ...*
*PT: No, because I want to come here, because I'm ...*
*TH: Okay, so then you have set up a goal for yourself to come here and the goal is to get to the core of your problem, okay?*
*PT: Yeah.*
*TH: Now, if you censor yourself and if you control, and if you be evasive and if you put a wall between yourself and I then we are not getting to the core of the problem, okay. Now, if we do not get to the core of the problem then you go and you continue your suffering.*
*PT: True.*
*TH: Now my question is this: why an intelligent person like you sets up a goal for himself to come here to get to the core of the problem, but at the same time puts a goal to defeat? Because let's to face with it, if you exercise control and if you censor yourself and if you, put a wall between yourself and I, then at the end of this session we are not going to get anywhere. But who suffers from it?*

*PT: (deep sighing)*
*TH: So why you want to do that?*

The above passage shows a specific composite form of head-on collision which has two goals:
- Direct challenge to the character defense of the need to control, which has its roots far back in the early life of the patient.
- Further intensification of the rise in transference feeling and making the patient acquainted with the therapeutic task.

The major ingredients of the above head-on collision can be summarized as follows:
1. Bringing into focus the nature of the resistance
2. Establishing a parallel between self-defeating and self-sabotaging pattern both in the transference and out of the transference
3. Emphasizing the patient's will; that it is his determination to seek help
4. Emphasizing the therapeutic task and the patient's goal
5. Emphasizing the destructive organization of the resistance
6. Pointing out self-sabotaging and self-destructive aspects of the resistance
7. Pressure to the therapeutic alliance
8. Deactivation of the transference

(For further elaboration on head-on collision, one should refer to part IV of these articles).

The following passage shows the impact of the head-on collision, a clear rise in the therapeutic alliance. The process has shifted to a partnership between the patient and the therapist.
Now we continue with the interview where we had left off:

*PT: Well, two things, two comments, first of all I don't think I'm doing it as much as you say that I'm doing it. Secondly, it is because I am uncomfortable and anxious. Since yesterday, I have been quite anxious and last night, uh ... about this session. I was ... I had ... (frequent sighs as he speaks) considered it ... I had expected it would be something of a, of a, of a difficult and ah I would have hoped that there would be some kind of time to psyche myself up for it, and ah also that it would be later in the day because I am a night person.*
*TH: Hm hmm.*
*PT: And ah, when I was told yesterday about the appointment at 8:00 a.m. I felt quite shocked cause I felt that I would be defenseless at that hour of the morning. And then I thought to myself that this is stupid, you ought to be defenseless because uh, things will come out better if you are, but that didn't make me feel any better.*
*TH: Hm hmm. But you see this is what really goes with, what I told you.*
*PT: Yes, it does.*
*TH: You were talking about defense. In other words, if you come later on or in the evening you are going to put all of the defenses in operation, hmm?*

*PT: Yeah, that is true.*
*TH: But now, when the defenses get into the operation who is defeated?*
*PT: Well, I think you are perfectly right.*
*TH: Hmm.*
*PT: You're right.*

## Further Inquiry

He has always been self-conscious about his body and has felt inferior in his relationships with both men and women. He was terrified to approach women and often had feeling that they were laughing at him: "I was skinny, unathletic; felt very inferior." Then he talked about a girl that he met at the age of twenty. He was desperately in love with her and was very passive and compliant. She became the leader and he the follower. She got bored with him and dropped him. He got depressed "I was devastated, cried all the time, it was a disaster." He further said "It was the most painful thing."

About his relationships with men, he said that he always ends up being the follower, which mobilizes anger in him and he ends the relationship "I cut off the relationship," and the result is he doesn't have any friends. As a teacher, he does a good job, but always has a preoccupation with whether his performance is as good as that of other teachers.

The focus is then on his feeling of inferiority "feeling of nothing," which is widespread in all of his relationships.

## Entry of the Transference

*TH: How do you find this in your relationship with me? How do you see that?*
*PT: Uhmmm (Pause).*
*TH: Because we know in every relationship if you are in control of that relationship you feel comfortable. And if you don't then you move away.*
*PT. Well, I don't think, I mean I don't think I'm in control but it is a professional relationship, and I find ...*
*TH: But that is intellectual.*
*PT. But this is generally true, I find that ... gonna lead to something else. I find that in dealing with things and people, I know that, I know that, that, eventually if, if I am going to get any benefit from this treatment, this cannot go on. I mean I can't deal with it in this way, but I, I find that, uhm dealing with, things in a professional way, that is dealing with organization and so forth I'm actually much more comfortable than dealing with, individuals on a person-to-person level, because the rules are set down.*

## Some Degree of Challenge and Some Elements of Head-on Collision with Resistance against the Emotional Closeness

*TH: You see because we are talking about putting a wall around yourself in relationship with me.*

*PT: Yeah.*

*TH: Hmm?*

*PT: Yes.*

*TH: Now is this going to be a barrier in exploring and pursuing to get to the core of the problem? Is this going to be a barrier? Because obviously we know that this is there in every relationship. And the, the question is this: is this going to be an exception here or what?*

*PT: Yeah, good point.*

*(Pause)*

*TH: Because what you say is if you put a barrier between yourself and the other then you feel comfortable, but if that barrier breaks down ...*

*PT: Yeah.*

*TH: ... then you start ...*

*PT: Yeah, yeah, yeah. Uhmmm ... well you want an honest answer it, it may be a problem uhmmm ... but you know you pointed it out and I guess I will just have to uh .. Make whatever kind of effort I can make, uh not to let that happen.*

*TH: Because you see one of the things that I am struck by is that in a sense you have had this problem - which is of many years duration, is not really anything new ...*

*PT: Yeah.*

*TH: ... and is a long-life problem that you have.*

*PT: That's right.*

*TH: And then somehow you have let it go and you have not ah, got ... if I understand it correctly no help for it.*

What emerges is that he has been in long-term psychoanalytic psychotherapy "for a long time," "It did not root it out and I put up a considerable barrier."

## Return to Dynamic Inquiry and the Search for the Major Resistance.

His father had a series of heart attacks when the patient was five. He worked at a university, was a detached and withdrawn person who was not athletic. The patient further describes him as a small, weak man and that he always compared him to the father of others. In spite of that, in the first few years of life he had a close relationship with him and enjoyed mechanical work. During the early phase of his life, the patient suffered from GI tract problems, which was diagnosed as Celiac Disease. His mother gave up all other interests and devoted herself to the patient and became overprotective. His relationship with his mother became closer at the age of five, after

his father's first heart attack. He describes his mother as aggressive, domineering and "Sexually aggressive". She was sexually active before she met his father.

Upon focusing on his mother, there is major mobilization of the major resistance and anger toward the therapist. The process now enters to the second phase of pressure; pressure for the actual experience of anger in the transference until the final breakthrough and passage of the primitive murderous rage.

## Recapitulation of Five Patients shown in the First Part of the Immersion Course

All vignettes were shown to demonstrate the application of some of the various forms of pressure in the initial contact with various patients.

Patient 1 entered with the sentence "My problem is not knowing how to deal with the problem" revealing a series of defenses. Pressure soon was turning the resistances to resistances in the transference.

Patient 2 entered with anxiety in the transference. By picking up the anxiety the process rapidly was moving to feelings and resistance in the transference.

Patient 3 replied to the opening question almost immediately by speaking of her feelings. The therapist exerted pressure by blocking the patient's attempts to diversify from the avoided feelings.

Patient 4 came with a variety of problems including characterological problems leading to highly dependent relationships and secondary gain of his symptoms. Since these character traits of the patient had serious transference implications the phase of pressure started with confronting comments on this issue. The therapist pointed out some issues which were entirely true, but the patient did not wish to look at.

Patient 5 responded well initially in the inquiry. The process began with the phase of inquiry until the patient showed the first signs of a rise in the transference. Here the phase of pressure included other elements, which followed one after another in a spiral way: the phase of pressure leading to resistance in the transference, a head-on collision with the resistance in the transference was followed by a continuation of the inquiry, pressure and challenge, and after a head-on collision with the resistance against emotional closeness there was the continuation of the inquiry again with elements of pressure which was leading to a mobilization of major resistance and anger in the transference. Pressure and the actual experience of the anger in the transference was leading directly to a major breakthrough.

## Summary

The main aim of the phase of pressure is, as we have seen, the mobilization of the avoided feelings in the transference. This intensifies and mobilizes all the character defenses of the patient in the dimension of the transference which sets the stage for the application of the phase

of challenge. In order to achieve the desired crystallization of all the patient's feelings and resistances in the transference, the therapist must constantly remain and glue onto the phase of pressure and later pressure and challenge, until the rise in the transference feelings is sufficiently high for the breakthrough to take place. Very often, the patient and also the therapist want to diversify from the transference out of the transference because of the anxiety of both of them. But the credibility and guarantee of the process depends on the rise in transference feelings and the transference component of the resistance. We will see in the following articles, how the application of the two other technical interventions (challenge and head-on-collision) will influence the unconscious therapeutic alliance and also the process of breakthrough into the unconscious.

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## Author's Note

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