

International Journal of Short-Term Psychotherapy (ISSN: 0884-724X) is published quarterly, (calendar) by John Wiley & Sons, Inc., 605 Third Avenue, New York, NY 10158. Application to mail at second class postage rates is pending at New York, NY and at additional mailing offices.

Copyright © 1989 by John Wiley & Sons, Inc. All rights reserved. Reproduction or translation of any part of this work beyond that permitted by Sections 107 or 108 of the United States Copyright Law without the permission of the copyright owner is unlawful.

The code and the copyright notice appearing at the bottom of the first page of an article in this journal indicate the copyright owner's consent that copies of the article may be made for personal or internal use, or for the personal or internal use of specific clients, on the condition that the copier pay for copying beyond that permitted by Sections 107 or 108 of the U.S. Copyright Law. The per-copy fee for each article appears after the dollar sign and is to be paid through the Copyright Clearance Center, Inc., 21 Congress Street, Salem, Massachusetts 01970. This consent does not extend to other kinds of copying, such as copying for general distribution, for advertising or promotional purposes, for creating new collective works, or for resale. Such permission requests and other permission inquiries should be addressed to the Permissions Dept.

Subscription price (1989): \$110.00 (institutional), \$52.00 (individual) per volume. Outside U.S.A.: \$141.00 (air service and handling included). Please allow four weeks to process a change in address. For subscription inquiries, please call customer service at (212) 692-6035 or write to the above address.

Claims for undelivered copies will only be accepted after the following issue has been received. Please enclose mailing label. Missing copies will be supplied when losses have been sustained in transit and where reserve stock will permit. If claims are not resolved satisfactorily, please write to Timothy B. King, Vice President and Director of Publishing Operations, Scientific & Technical Division, John Wiley & Sons, Inc., 605 Third Ave., New York, NY 10158.

Postmaster: Send address changes to *International Journal of Short-Term Psychotherapy*, Susan Malawski, Fulfillment Manager, Subscription Dept., John Wiley & Sons, Inc., 605 Third Avenue, New York, New York 10158.

Advertising/Reprints: Inquiries concerning advertising or reprints should be forwarded to Dora Castiblanco, John Wiley & Sons, Inc. Sales Dept., Sci/Tech Div., 605 Third Avenue, New York, NY 10158 (212) 692-6026.

Manuscripts should be sent to Habib Davanloo, M.D. Editor-in-Chief, *International Journal of Short-Term Psychotherapy*, Montreal General Hospital, Department of Psychiatry, 1650 Cedar Avenue, Montreal, Quebec H3G 1A4, Canada. Correspondence concerning other matters should be sent to Jeremy Robinson, Publisher, Scientific & Technical Division, John Wiley & Sons, Inc., 605 Third Avenue, New York, New York 10158.

The Central Dynamic Sequence in the Unlocking of the Unconscious and Comprehensive Trial Therapy. Part I. Major Unlocking

HABIB DAVANLOO*

McGill University, Department of Psychiatry, The Montreal General Hospital, 1650 Cedar Avenue, Montreal, Quebec, H3G 1A4, Canada

This two-part article describes the discovery of the technique of the major unlocking of the unconscious by the author. The central dynamic sequence which brings about direct access to the unconscious is illustrated by process analysis of the trial therapy of a patient suffering from a masochistic character pathology.

The discovery of the technique of unlocking the unconscious by the author provides a unique opportunity for both the therapist and the patient to have a direct view of the patient's multifoci core neurotic structure.

As I outlined in previous publications, this technique of a rapid uncovering of the unconscious offers the clinical researcher in the field of psychoanalytic psychotherapy an unrivaled opportunity to check aspects of psychoanalytic theory of neurosis against empirical evidence.

Handling the Resistance

I have already discussed the nature of resistance, resistance of repression, and superego resistance. I outlined that patients who are at the extreme left of the neurotic spectrum, who are highly motivated and responsive, show major fluidity in their character structure, and suffer from neither character pathology nor resistance arising from the superego. But as we move to the right-hand side of the spectrum of structural neurosis we see cases suffering from severe character and superego pathology. Here we can generalize based on our extensive clinical data and state that in all patients on the right side of the spectrum the ego and its major functions are paralyzed by powerful forces generated by: (1) repression, and (2) the superego, both of which manifest themselves as impenetrable resistance in the clinical situation. While in previous publications I described various types of intervention that can be used in handling resistance and making direct access to the patient's uncon-

*Please address reprint requests to: Dr. Habib Davanloo, Department of Psychiatry, The Montreal General Hospital, 1650 Cedar Avenue, Montreal, Quebec, H3G 1A4, Canada.

scious possible, in this two-part article I primarily will focus on the central dynamic sequence essential in the process of the unlocking of the unconscious. The process will be illustrated by an analysis of the trial therapy of a patient.

The Central Dynamic Sequence

The whole process which is used in trial therapy is divided into a series of phases, each consisting of a specific type of intervention with its corresponding response. But the phases tend to overlap, and most interviews contain a good deal of repetition and the process proceeds in a spiral rather than a straight line. The central dynamic sequence can be summarized as follows:

Phase (1) Inquiry. Exploring the patient's difficulties, initial ability to respond; is the phase of descriptive, dynamic phenomenological approach to patient's psychopathology.

Phase (2) Pressure. Leading to resistance in the form of a series of defenses.

Phase (3) Clarification and Challenge to Defenses. This phase can be summarized as:

- (a) Rapid identification and clarification of the defenses.
- (b) Challenge to the defenses, leading to rising transference and intensification of the resistance.
- (c) Further clarification of the defenses; casting doubt on the defenses.
- (d) Systematic attempt to make the patient acquainted with the defenses that have paralyzed his functioning.
- (e) To turn the patient against his resistance; the patient must clearly see that his resistance that has paralyzed his functioning is being challenged.
- (f) Challenge that is directed against the resistance; challenge to the resistance against experience of impulse/feeling outside of the transference; challenge to the resistance against experience of the impulse/feeling in the transference; challenge to the resistance against emotional closeness in transference.
- (g) Head-on collision with character resistance with special reference to the resistance against emotional closeness in the transference and resistance maintained by the superego.

Phase (4) Transference Resistance.

- (a) Clarification and challenge to the transference resistance. The emphasis is on the resistance in the transference.
- (b) Head-on collision with the transference resistance with special reference to that maintained by the superego.

- (c) Exhaustion of the resistance and communication from the unconscious therapeutic alliance.
- (d) To maximize the inner tension between unconscious therapeutic alliance and resistance.

Phase (5) Intrapsychic Crisis.

- (a) High rise in the complex transference feeling; direct experience of the C.T.F.; the triggering mechanism for the unlocking of the unconscious.
- (b) Mobilization of the unconscious therapeutic alliance; creation of internal conflict and tension between therapeutic alliance and resistance; finally to turn the therapeutic alliance against the resistance.
- (c) The first unlocking of the unconscious.

Phase (6) Systematic Analysis of the Transference. Leading to the resolution of the residual resistance with partial or major de-repression of the current or recent past (C) and distant past (P) conflicts.

Phase (7) Further Inquiry Exploring the Developmental History.

Phase (8) The Phase of Direct Access to the Unconscious. Direct view of the multifoci core neurotic structure and its relation to the patient's symptoms and character disturbance; and psychotherapeutic planning.

As I have already stated, not all therapies proceed in exactly this simple sequence. The phases tend to overlap and proceed in a spiral rather than a straight line. However, for those interested in learning the technique of Intensive Short-Term Dynamic Psychotherapy, the central dynamic sequence can be seen as a framework which the therapist can use as a guide, constantly working from one phase to another. With the exception of patients who suffer from severe fragile ego structure, the whole spectrum of structural neurosis are good candidates for Intensive Short-Term Dynamic Psychotherapy. But the evaluator should take into consideration that the ease with which the breakthrough can be achieved and the relative emphasis on different types of intervention depends on a number of variables. For example, the phase of inquiry which is a dynamic phenomenological approach to the patient's psychopathology outlining the patient's symptom disturbances and character disturbances varies from the left-hand side of the spectrum to the right-hand side of the spectrum. Patients on the extreme left are highly responsive with major fluidity in their unconscious and with great lucidity they describe their problems. But patients on the right-hand side of the spectrum, particularly those with ego-syntonic character pathology, are not able to respond. They have heavily identified with their resistance and they enter the interview with major character resistance, and the process immediately moves to the phase of identification and clarification of the patient's defenses.

4 DAVANLOO

Partial and Major Unlocking of the Unconscious

The degree of unlocking of the unconscious is exactly in proportion to the degree that the patient has experienced the complex transference feeling. In major unlocking of the unconscious under systematic challenge and pressure to the patient's resistance there is a breakthrough of the impulse in the transference which is accompanied by the breakthrough of the guilt and grief-laden unconscious feelings (the case of the machine gun woman, the case of the woman who frequently bruised her leg). But if the therapist aims at the partial unlocking of the unconscious the therapist must monitor the central dynamic sequence in such a way that the breakthrough of the impulse in the transference is partial. In this procedure the breakthrough of the aggressive impulse in the transference is partial but the breakthrough of the guilt and grief-laden unconscious feelings is at a much higher degree. The partial breakthrough into the unconscious is extremely important in controlled clinical research where a waiting list is essential.

I have repeatedly emphasized the care and vigilance with which this technique must be used and the therapist must undergo extensive training in utilizing such a powerful technique. In this two-part article I give an example and analyze the case in depth and again emphasize the technical skill and vigilance in the process of the unlocking of the unconscious.

The Case of the Fragile Woman

The patient is a 32-year old divorced woman. She had been interviewed one week previously by a relatively experienced trainee who had suspected the presence of a severely fragile ego structure. The present author, the second independent evaluator, undertook to interview her not knowing anything about the patient except a question mark of the possibility of a severely fragile ego structure. The interview needs to be considered in advance in terms of the phases listed above. As described, the therapist usually opens with a question about the patient's presenting complaints and continues with a certain amount of psychiatric inquiry. However, many patients—including the present one—arrive at the interview betraying obvious feelings which usually have an important transference component. The therapist then opens with a question, "How do you feel right now?", and begins to clarify and then challenge the patient's resistance against acknowledging transference feeling, at first cautiously and then with increasing power. When this happens not only does the central dynamic sequence begin at once, but the phases of pressure (2) and challenge to the resistance outside the transference (3) are bypassed. The therapist proceeds immediately to phase (4), namely, *Challenge to the resistance in the transference*, while as always vigilantly monitoring the patient's responses for danger signals. However, because the present patient had already been described as potentially fragile and entered the interview with a great deal of anxiety, the therapist had to modify his technique and proceed with much greater caution. In the opening phase, therefore, he employed the following devices:

- (1) exerting gentle pressure toward transference feelings;
- (2) concentrating on physical manifestations rather than actual feelings;
- (3) frequently taking pressure off the transference by inquiring about situations outside the interview;
- (4) avoiding challenge;
- (5) allowing the patient escape routes by which she would describe something less anxiety provoking than feelings; and
- (6) proceeding less fast.

As will be seen, these interventions to a great extent decrease the level of anxiety and the patient is able to describe the disturbing transference feelings stirred up in her by her previous interview, and doing so in such a way as to make it absolutely clear that she was not suffering from a fragile ego structure at all and was a good candidate for Intensive Short-Term Dynamic Psychotherapy. (See Davanloo, Trial Therapy as a Psychodiagnostic Tool.)

Therefore, the therapist quickly passed over into systematic use of the central dynamic sequence, putting pressure on the patient to experience her transference feelings, steadily escalating his challenge, and finally bringing about a head-on collision with the transference resistance (Phases 3 and 4 of the Central Dynamic Sequence). This resulted in a major breakthrough (Phase 5). There followed a phase of inquiry alternating with both challenge and interpretation directed against the defenses in general and the residual resistance, culminating in a second head-on collision. From then on it was possible to move to the phase of direct access to the unconscious, which consisted of exploring first the patient's sexual fantasies, and then past events and relationships. The therapist was now able to bring to the surface some of the patient's deepest pain.

It is worth mentioning also that this interview, similar to those I have already published, demonstrates signs indicating the operation of an unconscious therapeutic alliance, which in the author's opinion is the most reliable criterion for Short-Term Dynamic Psychotherapy.

The "Fragile" Woman: Interview

For the sake of brevity the dialogue has been shortened and paraphrased in places, but nothing important has been omitted.

**The Phase of Gentle Pressure toward the Transference
Alternating with Inquiry**

The patient enters the interview visibly anxious, and the focus is immediately on her anxiety here and now, exploring the physiological concomitants of the anxiety and reducing the level of her anxiety.

TH: How do you feel right now?
PT: A little bit nervous.

The patient has mentioned a feeling, and the natural step is to direct her

toward her actual experience. Here, however, the therapist carefully allows the escape route of describing only the physical manifestations of her nervousness:

TH: What is it like right now physically?

PT: My hands are cold. I feel my heart is racing a bit. It feels somewhat uncomfortable.

The therapist knows that this nervousness is likely to be concerned with the patient's feelings about the present interview. He seeks confirmation of this, and having received it, he directs the patient's attention toward these feelings. Thus he is already approaching the transference.

TH: How long have you been like that?

PT: Since about five minutes after arriving here.

TH: So you didn't have it before, you mean?

PT: Uh hmm.

TH: So it has to do with here?

PT: Yeah, I'm fearful, I'm not really sure what's going to happen.

TH: What do you have in mind about what's going to happen?

PT: I don't know.

Thus the patient has avoided the question, but the therapist makes no attempt to challenge this. Instead, he continues with a question which is purely factual and leads away from the transference—thus serving to reduce the pressure—but at the same time is designed to throw light on the transference indirectly:

TH: Usually you are like that? You get nervous in situations like this?

PT: Not all situations, but there is a certain reaction that I have in going for interviews or meeting people for the first time professionally. Not so much in personal interactions like meeting friends.

The therapist asks a question which gives the patient the choice of speaking about feelings or continuing with physical manifestations. She chooses the latter:

TH: What else do you experience besides pounding of the heart?

PT: And cold hands.

The therapist receives the message that she would rather not talk about feelings. He does not challenge this for the moment.

TH: Your hands get cold. Any other experiences physically?

PT: Uh, I have to urinate more often.

The therapist has noted that her present anxiety is a general phenomenon, and he now asks a question which is part of the psychiatric inquiry (Phase 1), but can also be used to lead naturally into the psychodynamics.

TH: How long would you say you have been like this, that when you meet a new situation or person professionally you develop this?

PT: Probably . . . the first time I was aware of this was when I was about ten. I was aware of being nervous and having to urinate. I wasn't so aware of my heart racing or cold hands but I remember cold.

TH: You are talking about elementary school, am I right?

PT: Yes, when I had to put on a performance I was very nervous.

TH: Were there incidents when you were called to the front of the class and you would become anxious and nervous?

PT: I went first to a parochial school which was very strict, and we weren't allowed to speak out of turn—so that was a very nerve-racking situation, and I really was never asked to . . . Oh no, wait a minute, when I was in first grade, first year, the teacher humiliated me in front of the class.

The therapist's exploration of the physiological concomitants of anxiety and his cautious approach are paying dividends. She is feeling more at ease with an indication that the conscious therapeutic alliance is being cemented. Moreover, as will emerge much later, this memory is actually a "cover memory" for one of the most significant situations in her early life. The therapist continues his line of inquiry.

TH: What age would you say?

PT: Six, seven, eight.

TH: What was the humiliating situation?

PT: I was given a series of photographs, and I had to draw lines to indicate the way they related to each other, and I went up to the front of the class and gave it to her, and she smacked me across the face because I had done it incorrectly.

In the following question the therapist uses the word "reaction," which allows the patient the escape route of saying what she did without describing how she felt:

TH: And what was your immediate reaction?

PT: I cried and I know . . .

TH: So it is a situation that in front of the class she humiliated you, but then your reaction was weepiness, hmm?

The use of the word "weepiness" needs to be discussed. At first sight it may seem rather unfair on the therapist's part—after all a child of eight is humiliated by a person in authority has little option but to cry and (as we see later) to appeal to her parents for help. At the same time, however, the therapist knows that crying can be used as a way of avoiding massive underlying anger; and moreover that this defense can become ingrained and be used in later life at times when the expression of anger would be much more appropriate. Also, the patient has made the link between this incident and her current anxiety in interview situations, and she has arrived at the present interview

in a state of considerable anxiety which is giving rise to somatic symptoms. The therapist knows that anger is likely to be one of the underlying feelings that the patient is avoiding. Thus the use of the word "weepiness" constitutes a subtle indirect message to the patient's unconscious that he knows all about defenses against anger, including anger in the here and now, and this can be considered as his first and only challenge in this early phase. He repeats the word, for emphasis:

TH: Any other reaction besides weepiness?

PT: Well, I don't remember reactions in the classroom. I remember crying to my father. I refused to go to school.

TH: Oh I see, you did actually refuse?

So, another of the patient's character defenses may be avoidance.

PT: Yes, so I was changed into another class and had a new teacher. It seems my parents took great offense to me being slapped, my father more so.

TH: You say the teacher humiliated you in front of the class, and it was so bad that you didn't want to go back to the class anymore. And you got your parents to help, and finally you went to another class. But if you go to that situation, you are weepy and crying, but what other physical reaction did you have?

PT: It's a blank in my mind. All I remember is being smacked and the feeling of shame and humiliation, and crying.

TH: So the only manifest things are weepiness and crying. You don't know what was your physical reaction, hmm?

PT: I don't remember.

The therapist begins to exert a little more pressure: (Phase 2)

TH: Any other incidents of a similar kind that mobilized anxiety in you? This is very important to look at, because you say it goes back to the very early part of your life.

PT: Before that, no, I don't remember anything. Uh, after that . . .

The therapist draws attention to the here and now. He notices nonverbal clues which presumably betray the patient's reaction to the pressure. He decides to bring this into the open at once, but mentions only "tension" without making any attempt to ask about the cause of the tension:

TH: How do you feel right now? Still you are tense?

PT: A little tense.

TH: And usually you clench your . . . ?

PT: Yeah, my hands are very cold right now, I want to put them under my arms.

TH: The nervousness is still as bad as a few minutes ago, or a little better or what?

PT: It feels a little bit less.

TH: Uh hmm. Okay.

The content should be avoided in this phase, should only be acknowledged. This intervention of bringing into the open the patient's immediate reaction in the here and now even though it is only her anxiety has helped a great deal. Anxiety has been reduced and we have a manifestation of her conscious therapeutic alliance. Then she mentions recurrent dreams which might have a bearing on her psychopathology; but the therapist should keep in mind that resistance is in operation and moving to content while the patient is in a state of resistance would be totally counter-productive. In addition he has to clear up the transference. Moving into content would lead to pure intellectualization, but at the same time the therapist should not convey an atmosphere of rejection. He therefore carefully acknowledges her communication and then goes back to trying to understand the reason for her anxiety. In the early stages of this exploration his whole approach is still very cautious and he confines himself to asking about outside situations, but his ultimate aim—provided there are no contraindications—is that this will eventually lead him to the transference.

PT: What comes to my mind is that there are many things I'd like to understand about myself. Since I was a child I have been plagued by a certain type of dream which I feel is "somewhat representative of some of my behavioral patterns."

TH: You mean you have recurrent dreams?

PT: Uh hmm, and I think it's indicative of a certain split sometimes in the way I feel.

TH: And what you say is that those dreams reflect on some of your problems in life?

PT: Yes.

This apparently rich content is in the service of resistance, would only lead to intellectualization of the dream, an attempt to move away from the transference. The therapist gently moves to the anxiety.

TH: Okay, let's stay with this anxiety for a moment. Do you have any other incidents in recent years? When you are in front of a crowd, for example, do you experience it?

PT: Uh, in general no, I've always felt fairly comfortable speaking in front of crowds. It's when I feel that I'm being tested in some way that I feel this.

TH: Like an examination, or going to an interview to see if they're accepting you for a job?

This is a message to the patient's unconscious about the parallel situation of being accepted for therapy. The phase of inquiry continues.

PT: Yes.

TH: Could we look to the examination, because that is a situation in which you have to perform? Let me ask you, what is your occupation?

PT: Right now I'm a graduate student in economics.

TH: What is it like in examinations?

PT: Uh . . . I feel anxious. My hands are cold, my heart is racing when I go into the classroom and sit down.

TH: How about before? Do you have anticipation anxiety?

PT: Some anticipation. I'm not too bad where I know it's something I have to write down. The anxiety is more when I'm being tested verbally.

TH: In written you have less? What is the extent of the anxiety then? Is it to the level that your hands shake?

PT: No, I just notice that what I have to do is urinate, or I sweat.

TH: Does it interfere with your sleep the night before?

PT: Yeah, yeah, sometimes it does. Usually after an exam I feel worse than before. I usually dream more profoundly.

TH: After the exam you are worse in the form of a dream. Now in oral you say it is much worse? So you have gone through many oral exams?

PT: No, I haven't.

TH: You said you are a graduate, maybe I . . .

The patient makes a disguised reference to her previous interview, which takes the form of a mis-statement about what happens in the class. This is a clear indication that she is ready to deal with transference issues. The therapist notes this and decides to keep it at bay. He continues to check further on the degree to which she experiences somatization of her anxiety.

PT: No . . . I'm just saying that when I'm being asked a question in class — "Elena, what do you think?" or "Elena, what's the answer, how do you feel?" . . . not "How do you feel?" . . . they don't ask how do you feel, they ask you what do you think—I feel intimidated.

TH: What are the physical symptoms that you get?

PT: Tightness, choking uh . . .

TH: And then what else? Heart pounding?

PT: Yes, not very heavily, but I feel all of a sudden a sensation of stopping.

TH: Do you get severe tremors, shaking?

PT: No.

TH: Any other physical experiences such as faintness?

PT: No.

TH: Finally what happens? Do you overcome this?

The therapist continues in the line of psychiatric inquiry, phase (1), to determine the extent the cognitive function of the ego becomes disrupted under the impact of anxiety.

PT: I'm able to sometimes muster up some words, but I feel that my mind goes blank and I can't think of an answer, so I feel frightened.

The therapist is immediately on the alert, since this is one of the important signals.

TH: You mean you lose track of your thoughts?

PT: Yeah.

TH: How do you master that situation, because if you lose track of your thoughts then it obviously must be very difficult for you?

PT: I don't think I do it very successfully. I might sometimes keep very quiet, or just say any answer, or talk about the question, or try to divert the question in some way.

TH: So this is quite a disturbing symptom for someone in academic life?

PT: Yes.

TH: How was it in high school, was it better or worse than now?

PT: I don't remember all that well. I did well and I was generally well liked by my teachers. I don't remember being nervous. I think my anxiety in front of people started when I came to Canada because all of a sudden I was in a new uh . . . a new . . .

TH: When did you come to Canada?

PT: Eleven years ago.

TH: From where?

PT: Philadelphia.

TH: Okay. Now you said that when you have to perform, like a test or an examination, then this anxiety mobilizes?

PT: Uh hmm.

Transference

At last the therapist is ready to open up the issue of transference directly. However, it is not the present transference that the patient wants to talk about, but her transference in the previous interview. This is a crucial issue and the therapist concentrates upon it. By this time the level of anxiety is greatly reduced. Here it is worth summarizing the sequence of events in advance. The patient described the disturbing effects of the previous interview and mentions that very soon after the end of the interview she felt great anger. She is able at the cognitive level without anxiety to declare anger in relation to the first evaluator. So far for the therapist there is no sign of fragility and he concentrates her attention on the actual experience of anger and the impulses it involved. The patient becomes resistant. Now the process enters the phase of clarification and challenge to the patient's resistance. She finally is able to acknowledge the way she would have wanted to verbally lash out at the first evaluator with no sign of anxiety. This is further reassurance about her supposed fragility. The therapist then undertakes a very important step which will be discussed more fully later, namely to acquaint her with the inner mechanism responsible for one of her major symptoms. He

points out to her repeatedly and with great emphasis the fact that she doesn't feel anger but feels anxiety in its place, so that at least part of the mechanism responsible for her anxiety has to do with her inability to face her anger. It must be mentioned, too, that she began to suffer from anxiety soon after she entered the hospital for the present interview, so that opening up this will lead to dealing with the present transference as well. From now on the therapist can proceed relentlessly with the whole of the central dynamic sequence though by concentrating at first on the physical manifestation of her anger.

TH: And then how does that apply here with me, because here also you say you are very anxious? What is the nature of the performance here?

As mentioned above, it is not the present but the previous interview that the patient wants to speak about:

TH: What was it about that shook you?

PT: Well uh . . . (she laughs).

TH: You smile when I say . . .

The focus of the session is further on transference, countertransference evaluation, and her feeling toward the first independent evaluator; she indicates that she felt under attack.

Parenthetically it is important to emphasize, based on the clinical data that emerges, that the first evaluator had not done work on phase (3) of the central dynamic sequence, and also the patient left the interview with unresolved transference feelings which have to be worked through in this interview. Now we return to the interview. The therapist is still troubled by the patient's previous mention of thought block:

TH: When you say you didn't know what was going on, did you lose track of your thoughts?

PT: I don't know exactly what you mean.

TH: I mean that you are talking about a subject but then suddenly you don't know what you were talking about.

PT: That happened, yeah. Because he kept on asking me, how do you feel, or what do you think, what do you feel, what do you feel? And when I said I didn't remember, "what do you mean you don't remember?" I said I can't remember.

TH: So actually during the interview you lost the train of your thoughts?

The patient's answer is very reassuring—she does not run away from disturbing feelings:

PT: Well immediately after I walked out I felt, uh, anger, immense anger toward him.

TH: You mean you felt anger toward him after you left, but not while you were there?

PT: I . . . I . . . for some reason I couldn't feel anger while I was here. I was so frightened that I couldn't feel my anger.

The therapist now prepares to make the link between the underlying feeling and the anxiety:

TH: So then let's look at it. While you were with him you had a lot of anxiety. Am I right?

PT: Yeah.

TH: There was no anger.

PT: I didn't feel anger.

TH: I know, that is what I mean. You did not experience the anger while you were with him. What you experienced was anxiety, hmm?

PT: Uh hmm.

TH: But how long after you left did you start to experience the anger?

PT: About five minutes.

TH: So you were still in the hospital when you had this anger toward him?

PT: Yeah.

Throughout the following passage he takes her through her impulses in detail, challenging her resistance as necessary, but at the same time supporting her by constantly reassuring her that what she is describing consists only of thoughts and ideas:

TH: How then did you experience that anger? You know, physically? When you are anxious we know how you experience anxiety—you have palpitations, tension, tightness. How do you physically experience the anger?

PT: (She sighs.) The same way almost.

TH: You mean anxiety?

PT: Except that there's a switch, that I want to lash out verbally or physically in some way.

TH: Both physically as well as verbally.

PT: Or I feel that my physical movements become, uh, more pronounced.

TH: Uh hmm. These were the thoughts and ideas in your head, that you wished you could have verbally and physically lashed out at him?

PT: Yes.

She has frequent sighs in talking about her anger toward the first evaluator which indicates that the impulse of anger gives rise to the anxiety which discharges itself in the form of tension in the intercostal muscles as well as the subdiaphragmatic muscles. The therapist moves to challenge.

TH: Now this is only thoughts and ideas, hmm?

PT: Uh hmm.

TH: Now in terms of thoughts and ideas, if you had lashed out—I mean you didn't—but if you had, what would that have been like? What are you like when you lash out verbally?

PT: Uh . . . my voice is raised, I yell.

TH: You yell, your voice goes up, uh hmm.

PT: I . . . I have not too much control on exactly what I'm saying.

TH: What would you have told him? . . . You smile.

PT: (Laughing) What would I have told him?

TH: I know it is difficult to tell me what you wanted to tell him. We are talking about thoughts and ideas.

PT: I . . . I don't remember what I would have told him.

The therapist begins his systematic challenge to the resistance against experience of the impulse in relation to the (C), the first evaluator.

TH: We are not talking about remembering. Let's portrait a situation like that. It's not too far, it's a week ago, hmm? You smile again, hmm?

PT: (Laughing) I'm feeling embarrassed.

TH: Why? Because you want to tell me you wanted to tell him off verbally?

PT: Yes.

TH: So let's see in terms of thoughts and ideas how you would have told him off?

Finally she indicates that she would have verbally lashed out at him. Then the therapist turns his attention to the physical impulse, which is likely to be even more disturbing than purely verbal.

TH: If you physically had lashed out what would that have been like? You didn't do it but if you had done it? In terms of thoughts again?

PT: I . . . uh . . . I wanted to smack him across the face with the back of my arm.

TH: How?

PT: I'd like to go . . . wham! Across his face.

TH: And then? Only once?

PT: Yeah, that would have been sufficient.

The therapist sees a parallel with the distant past which seems to still live on her.

TH: But you had the impulse to verbally tell him off, and there was also the impulse, like the teacher in school did to you . . . (The patient laughs.) You smile when I say that. Then you had the impulse to smack him in the face, hmm?

PT: Uh hmm.

The next passage needs discussion. One of the principle manifestations that has been brought to light is that in the previous interview instead of anger the patient experienced anxiety. This must mean that she has a powerful unconscious anxiety of the expression of anger, which needs to be brought into the open.

Analysis of Two Triangles—An Important Principle of Technique

During the course of this work I have become quite certain that it is extremely important for the patient not merely to respond to interpretation about some of her inner mechanisms, but to achieve lasting insight into them—particularly the way in which some fleeting feeling or impulse is immediately replaced by something else. If the patient is not given this insight there will be a failure of prophylaxis, and it will be only too easy for the same mechanism to re-establish itself as an automatic reaction on future occasions. Since there is a considerable amount of unconscious resistance against this insight, it is often necessary to repeat the interpretation over and over again in order to consolidate it.

It is very important to give a full impression of this process, so that I shall include almost all the therapist's interventions; but for brevity, I shall omit many of the patient's responses, almost all of which consisted simply of showing that she was following what the therapist said.

Link between the Impulse of Anger and Anxiety, Phase (3)

TH: But do you think the anxiety is a mechanism of dealing with the anger? Do you see what I mean? . . . The anger is not experienced in the moment, what is experienced is more the anxiety . . . There was a situation that mobilized anger in you but you did not immediately experience the anger . . . And what you experienced immediately was anxiety. You see? . . . It is very important that we see this: that the immediate reaction is anger but the mechanism that comes to the fore is anxiety . . . And anger is pushed underneath but later on it comes out . . . And what did you do with the anger? You wanted to lash out, but what happened to that anger? Where did it go?

Making the patient well acquainted with the impulse, anxiety, and defense [Phase (3)].

PT: I don't know where it went.

TH: It's very important we look at it, because you cannot say the anger evaporates.

PT: In other situations the anger does not evaporate, it stays with me for a long time; but with him for some reason there was a part of me that was very accepting of the whole process.

TH: That is intellectually true; but still, where does the anger go?

PT: Well, immediately after I felt angry, which didn't last very long, I felt very shaken.

TH: Oh I see. First anger, and then again the anxiety.

PT: No, this was more trembling, total body trembling. I felt as if, uh, I had just been through a cyclone, or that something very traumatic just happened and the after-effects finally hit me.

It becomes more and more clear that she has a very powerful unconscious anxiety in relation to the expression of the anger, and the therapist continues to make her well acquainted with the three parts of the triangle of the conflict: the impulse-feelings, anxiety, and defense.

TH: The reason I say it is very important is because first there is the anger, but it immediately mobilizes a great deal of anxiety in you. In the session, obviously the anger was there but then you had anxiety. Then away from here the anger comes out, but then the massive anxiety takes over again, hmm? . . . As if the anger is something that disturbs you a great deal.

PT: Well, I was taught not to express anger.

The therapist dismisses this attempt to avoid the central issue:

TH: We can get to that, but first is to see that you are really terrified of a situation that mobilizes anger.

We saw the repeated emphasis on the link between anxiety and anger. Then she talked about the way she felt after the first interview.

PT: That is exactly what I realized after I left. After I got angry and then I felt trembling, all of a sudden I had a feeling of calmness; and, I don't know if it was a sadness, but I felt as if something had been exposed inside of me and chiseled out, or a hole poked in; and the release of emotions associated with that, psychologically, physically, made me feel very centered and very solid within myself, almost withdrawn but very much myself; and my actions the rest of that day were very quiet and more observant of people, but I felt better about myself for some reason, because I realized that I have to deal with my anger. I have to learn how to express it, I have to say it when it comes out.

The therapist does not want her to form the impression that she has to go around expressing her anger on all occasions:

TH: But obviously expressing it is not necessarily going to be constructive. I mean if you slap another person . . . The most important thing for us to see is what it is that happens when something mobil-

izes anger in you and this tremendous anxiety takes over. Do you see what I mean?

PT: Yes.

The therapist searches for confirmation that talking about her anger has led to relief in the here and now.

TH: How do you feel right now?

PT: Better.

TH: Because I have a feeling that you have a tremendous difficulty to even talk about anger. Am I right to say you prefer I don't talk about anger?

PT: I think I prefer you talk about anger. I need to talk about my anger.

TH: But talking about anger disturbs you? Is painful?

PT: Yes.

The therapist now approaches the issue of her transference in the present interview:

TH: Then do you think that something like that would happen here with me? Namely it might mobilize the impulse in you to lash out at me? You see, if I focus on something painful you don't want to focus on, then . . .

PT: I won't feel that I'll want to lash out with you right here. If anything I'll start feeling my hands getting cold.

TH: I know, the anxiety takes over.

PT: I'll just keep on being anxious, I feel that.

At this point the therapist delivers a message to both the patient's conscious and her unconscious therapeutic alliance, speaking of the devastating effect that this mechanism of replacing anger with anxiety has on her life. His aim is to prepare the way for much later work about her self-destructive tendencies which arise out of the repressed impulses, with guilt and grief-laden unconscious feelings.

Challenge to the Patient's Defenses, Leading to Rising Transference Phase (3)

TH: Okay, so one thing so far we can understand is that it is very crippling, this anxiety—I don't know, you can say it is or it isn't—and it is very diffuse in many areas of your life. And then when a situation mobilizes anger, you don't experience anger but anxiety; and later anger comes, and then you become anxious again . . . But my question was, where does the anger go?

PT: It goes (smiling) somewhere here inside. That's where it goes.

The therapist takes the smile as an indication of transference feelings:

TH: Do you feel like smiling or is this a cover-up of something else?

PT: I feel embarrassed.

TH: Is it embarrassed or something else?

PT: (Smiling again) I don't know.

TH: I don't know, you know yourself better. I only met you for a short period I have a feeling that you have a tendency to cover up, to put up a facade.

PT: That's right.

TH: And do you think there is something of a facade with me?

PT: No, I feel that you see through the facade, and it makes me embarrassed. I feel a little bit naked. It's almost as if I'm sitting here with no clothes on and you're just looking at me.

The Issue of Emotional Closeness

Extensive clinical data indicates the importance of realizing that many patients defend themselves as strongly against the positive feelings as against their negative, and therefore they put up a barrier against any form of emotional closeness. In some patients resistance against emotional closeness is much more extensive than others. Here the therapist senses that the word "naked" refers to such a problem in the transference, and immediately sets about trying to bring this into the open.

(It is worth noting that at this moment many therapists might feel inclined to take up the sexual implications of the patient's remark. I am quite convinced that this would completely miss the point and would divert the whole interview and put the process of unlocking into impasse. There are indeed sexual implications present, but their relevance is quite secondary—in this context sexuality is merely an aspect of closeness, and closeness is the issue that needs to be dealt with, so that sexuality does not need to be mentioned at all.)

TH: "Naked" has to do with closeness, if you carefully look at it, hmm?

PT: Closeness?

TH: Yeah, that I am getting close to your intimate thoughts and feelings. Do you have a problem with closeness, intimacy?

PT: Uhh...

TH: I have a feeling that here with me you are trying to cover up your feelings.

PT: Yes.

The therapist's conclusion by this time is that there is resistance against emotional closeness in the transference which at the appropriate time needs to be systematically challenged. Then he decided to undertake the psychiatric inquiry.

Psychiatric Inquiry (Phase 1)

The patient has given conclusive evidence of her capacity to respond well to a rapid uncovering approach, but the therapist now needs to make doubly

sure. He carefully inquires about depression, quality and severity, assessment of suicide.

This part of the interview will be summarized because it consisted entirely of question and answer. On the other hand, the fact that it is summarized must not be taken as an indication of its lack of importance, since psychiatric inquiry, a comprehensive dynamic phenomenological approach, forms an essential part of every trial therapy.

Her answers made it clear that while she suffers from a fairly severe depressive illness, she has so far always possessed the strength to survive without breakdown.

The answers that indicated the fine balance between severity on the one hand, and absence of danger signals on the other, were as follows.

In her depressive states she feels indifferent and that life is a failure, but she does not suffer from more serious or delusional depressive ideation, examples of which might be the feeling that she is an "empty shell," or that she has "destroyed the world." She says she does get into a state of withdrawal and may cancel her activities for a day at a time; but on inquiry it emerges that she usually counteracts this state by going to school or by energetic physical activity. There was no evidence that such activities were hypomanic. Her longest attack of depression lasted two months, but this was clearly reactive—to a major life event, the separation from her husband.

She can trace some kind of depressive state back to her teens, her description of this is not of true clinical depression, and there is no evidence for an "endogenous" depressive cycle, i.e., attacks without obvious external cause. Finally, although she does entertain thoughts of suicide she has never attempted it nor made serious plans to do so.

When she was asked about other psychiatric disturbances she mentioned a "dream state," which could be manifestation of schizophrenia, and "confusion," which could indicate an organic condition; but on inquiry both of these seemed to be no more than states of indecision.

This part of the inquiry ended with the following statement by the patient:

PT: . . . I think all my anxiety comes from the fact that my personal—my intimate relationships have not been stable.

This immediately led the therapist back to investigating the psychodynamics.

Pressure, Challenge to the Resistance outside the Transference (Phases 2 and 3)

Since the only other disturbances that the patient has mentioned are concerned with personal relations, the therapist is satisfied that he has covered the psychiatric inquiry. He therefore asks about the nature of these disturbances, preparing to make the transition to more dynamic inquiry. In fact a brief passage of challenge to the resistance leads back into the transference in a way that could not have been foreseen.

The therapist asked first whether her problems in personal relationships

were more pronounced with men than with women. The answer was that they are more pronounced with men, but that she does have problems with certain women in her professional life. This led to the relation with a fellow student named Priscilla, by whom the patient felt rebuffed, which had caused the patient to feel anxious. In answer to the question of what else she had felt, she said that she felt angry, but that she had only become aware of the anger later. The therapist immediately made the link with the previous evaluation interview:

TH: It's always later on, like last week here, hmm?

PT: Yeah.

Pressure and challenge to the resistance against experience of anger in relation to (C) (Phases 2 and 3).

TH: How did you experience the anger in relation to her?

This question produces some kind of inner turmoil, to which the therapist immediately draws attention:

PT: Uh . . . wheww . . .

TH: As soon as I asked how do you experience anger, you said "whewww."

The patient laughs in such a way as to indicate that some further reaction has been touched off in her. Once more the therapist immediately draws attention to this:

TH: Again the smile comes.

PT: Because I hide it so well I don't even feel it.

The therapist returns to challenging the defense:

TH: I know, you have a mastery of covering it up.

PT: That's right.

The therapist now introduces the word "crippling," repeating it for emphasis—an intervention that he could not have known would eventually lead into the depths of her pathology:

TH: You are the master of covering up, to put the facade. This is a "crippling" force in your life.

PT: That's right, yes.

Making the Patient Acquainted with the Defenses That Have Paralyzed Her Functioning (Phase 3)

TH: And as this is a crippling force in your life, it is very important

for you and I to examine it—unless you prefer not to examine it?

PT: No, I want to examine it.

TH: Because obviously this is a very crippling force for a young woman of your age, hmm?

PT: Yes.

TH: So then it is very important for us to examine it, for if we can see what it is like, then later on hopefully we can get to the core of it.

Rising Transference, Resistance, Challenge to Transference Resistance (Phases 3 and 4)

The following passage is extremely important because it illustrates almost all the aspects of transference that were described in my other publications. The therapist concentrates exclusively on the transference, employing challenge. He deals with all three corners of the triangle of conflict in connection first with negative and then with positive transference feelings, and ends up with a head-on collision with the transference resistance. The result is a major breakthrough. When this patient is compared with the left side of the spectrum the far greater complexity of the transference in a severe character neurosis, as opposed to a symptom neurosis, will be evident.

An overall view of this passage is as follows.

(1) The patient herself suddenly re-introduces the transference, saying that she is angry about the therapist's use of the word "crippling."

(2) The therapist focuses on the actual experience of anger. The patient responds with a mixture of defenses such as somatization and laughter on the one hand, and nonverbal cues betraying her inner feelings on the other, to both of which the therapist draws attention (two corners of the triangle of conflict in the transference).

(3) The patient's anger is now very close beneath the surface, and with the help of repeated challenge the therapist succeeds in bringing out the actual impulses involved.

(4) He then sees that in order to free her further it is important to deal with the third corner of the triangle of conflict, and he therefore focuses on the anxieties that make it difficult to express her anger.

(5) He makes a move toward positive transference feelings by mentioning her need to protect him from her anger, where by implication the anxiety is of causing him harm, but in fact this does not seem to be the important issue.

(6) She eventually names her anxiety as fear of his retaliating by rejecting her, either if she expresses her anger or, indeed, if she fails to do so.

(7) As she speaks of this she begins to betray an underlying sadness which she tries to control, and he draws her attention to this.

(8) He now focuses on her fear of emotional closeness in the transference and her defenses against it (two corners of the triangle of conflict involving positive feelings).

(9) He senses that this needs a major effort on his part, and therefore it is here that he introduces the head-on collision with the transference resistance.

(10) This brings out intense feelings about her disappointment and disillusion with close relationships, and her fear that she can never love anyone again. Her ability to share these feelings with the therapist represents the emergence of the underlying positive feelings, the third corner of the triangle of conflict in the transference.

(11) Now that this major breakthrough has been achieved, he suggests taking a five-minute break.

We may now take up the interview where we left off.

Negative Transference

PT: Well, I'll tell you, I'm experiencing anger right now because you keep on saying crippling force, crippling force. It sounds like . . . well what the hell are you trying to say?

TH: So you say right now you are angry with me?

PT: Yes! Yes.

TH: Then how do you experience this anger with me?

PT: Well I feel I want to tell you to stop saying crippling force, crippling . . .

The Link between Negative Transference and Various Defenses against It

TH: But how do you experience this physically? You didn't like me to use the word crippling?

PT: No, I didn't.

TH: And then this mobilizes anger in you? Let's see how you experience this anger physically?

Challenge and pressure to the resistance against experience of anger in the transference.

PT: I don't remember . . . I didn't feel anything. I felt maybe a little tension in my stomach.

TH: But that is anxiety, you see. What is the way you experience anger? It is very important you look at it because last time you walked out from here with your anger. Now are you going to repeat that this time as well?

PT: No.

TH: Or do you want to experience it?

PT: I want to experience it.

The therapist emphasizes that this is a golden opportunity to acquaint her with her mechanisms for avoiding anger while they are actually happening:

TH: So let's see, because it's a very split-second process that needs to be examined. I use the word crippling, and for whatever reason—it doesn't make a difference—you didn't like it.

PT: No.

TH: That mobilized certain irritation and anger in you.

PT: Yeah.

Nonverbal Cues

He now draws attention to a number of nonverbal cues betraying her inner feelings:

TH: And I don't know if you noticed, but immediately your fist also became clenched, like that. You see?

PT: Yeah.

*TH: And is still like that. (The patient starts giggling)
And I'm sure you don't like it when I tell you your fist goes like that.*

PT: No, it's okay.

TH: The smile comes to the forefront.

PT: I laugh, yeah.

TH: Which is a cover-up for your underlying feeling.

PT: That's right.

TH: Then let's see what is the underlying feeling. Is the anger, hmm?

PT: Yeah, that's right.

TH: Were you aware that when you got angry your fist went like that?

PT: No.

TH: But it is very important. And when you get angry, physically you take a very defensive, on-guard position, hmm?

PT: Yes, I'm feeling very anxious right now. Because you're probing me. I feel a tension here in my stomach.

TH: And you take a deep . . . (Patient has frequent deep sighs.)

PT: Yeah, I'm having trouble breathing.

TH: And then also you are holding onto the anger.

PT: Yes.

TH: So let's see how you experience the anger. You experience anxiety.

PT: That's right, yes.

TH: But let's see how physically you experience the anger. You see, a smile comes again. Let's face it, you can laugh . . .

PT: I know, I know, I know. But this defense mechanism is so good.

TH: But this defense mechanism is your worst enemy. Of course I am not the one to decide that. You have to decide, because that is your life.

PT: Well I don't know if laughing is my worse enemy.

TH: No, I'm not talking about laughing. It is the cover-up.

The patient is now using the defense of somatization against her anger. The therapist explores the extent of her somatic symptoms:

PT: I feel such pain right now. I think I have indigestion.

TH: Usually when you become very anxious you get indigestion?

PT: Yes.

TH: By indigestion you mean what? Vomiting or . . . ?

PT: No, just a tightness, inability to eat.

TH: What else do you get when you say indigestion?

PT: Diarrhea, gas.

TH: Do you feel that way right now?

PT: Not that profound, but yeah, I feel a little bit of it. And I'm having trouble breathing.

TH: Now let's see how you experience this anger, because there is always a delayed reaction. With Priscilla you were angry, hmm? But then the anger came later on, hmm?

PT: That's right.

TH: And now you are angry with me because you don't like the word crippling.

Negative Transference, Impulse

There is a drop in the level of anxiety, and the process indicates that the physiological concomitant of impulse is surfacing, the therapist maintains the focus on the actual experience of impulse.

TH: Or, you don't like me to focus on your facade, hmm? Okay, let's see how you experience the anger. We know there is a link between anxiety and anger, but that doesn't tell us how you experience the anger. Did you feel you wanted to verbally lash out at me? Or physically? You mean I am the exception?

The patient avoids the impulse by rationalizing, which the therapist challenges:

PT: Why should I be that angry at you because you said crippling? I mean there are degrees of anger.

TH: Yeah, but you are rationalizing it . . .

The patient admits the impulse but then starts to weaken it by further rationalization, which the therapist interrupts, bringing her back to the impulse:

PT: I experience the anger by wanting to raise my voice, and I don't understand . . .

TH: You feel you want to raise your voice?

Absence of anxiety and tension in vocal cords.

PT: Yes.

TH: So if you raise your voice what will you be like here?

PT: Uhh . . .

Negative Transference, Anxiety

Having exposed part of the impulse, the therapist senses that further freeing can only take place if he exposes the anxiety:

TH: Because obviously you are protecting me against your anger.

PT: Yes.

TH: Why? Why do you want to protect me against your anger? Let's look to your thoughts and ideas of what my reaction would be.

The patient is evasive:

PT: I don't know what your reaction is going to be.

TH: No, I'm saying in terms of thoughts and ideas.

PT: Well, my reactions of your reactions?

TH: You said yourself that I would have a reaction to it. That it might hurt me or it might . . . hmm?

PT: I don't know. I imagine you will be hurt.

TH: What else besides me getting hurt?

PT: That you would get angry at me.

TH: Okay, could we look to this? Because it is very important. I am sure it is a pattern outside of here. I cannot be an exception, hmm?

The therapist now embarks upon an extremely important procedure with any patient who has such difficulty over anger, namely driving home cognitive insight about the inner mechanisms involved and the reasons for them.

TH: Let's look to the pattern step by step. First is me focusing on crippling.

PT: That's right.

TH: This immediately mobilizes anxiety, but under the anxiety you experience anger.

PT: That's right.

TH: Then verbally you want to tell me off, but the idea is that I would get angry at you, and then what would happen? In terms of thoughts again.

PT: I'm afraid that you might put me in my place or say something hurtful to me, which either means I'd have to cover up or be more angry.

TH: So then could we look to that? The idea is that I would become revengeful toward you.

The therapist introduces this word, because he knows that almost certainly it would be an appropriate description of someone in the past.

PT: That's right.

TH: That I would retaliate with you? Could we look to this?

The therapist now emphasizes the irrational nature of the anxiety thus informing her unconscious that he knows it comes from the past:

TH: Now could we look to see what evidence there has been that I would retaliate, or react with anger if you get angry with me?

PT: I have no evidence.

TH: So where does that come from? It is very important you look at it. So you say it comes from your head.

PT: That's right.

TH: Was there the thought also that I might terminate, or tell you, look, if you don't want it . . . did that thought pass through your head?

PT: It didn't pass through my head but it's maybe . . . I don't know.

TH: It is very important you examine that.

PT: Well yeah, maybe to some degree. It's something that passed through my head.

One of the fundamental principles of the technique is that the patient's whole psychic system is loosened by the direct experience of feelings about the therapist, of which a negative impulse is often the first component. These feelings are complex and they have their genetic roots in all the unresolved feelings and impulses in relation to the past. The patient's major unconscious anxiety has its links with repressed sadistic impulses as well as guilt-laden, grief-laden unconscious feelings in relation to the people in her past life orbit.

It is important to highlight that the challenging language such as crippling, in which many of the therapist's interventions are phrased, has come from patients themselves during the course of a large series of interviews over a span of 30 years.

Here it is worth anticipating; later in the interview it emerges that self-punishment in the form of crippling herself is a central part of her pathology. Not only this, but there is a link with the most important person in the patient's life, toward whom she felt the deepest guilt and remorse, who in the end had herself become crippled. This is why she reacts with anger every time the word is mentioned. We may now resume the interview.

Direct Experience of Anger in the Transference (Phase 5)

TH: What evidence is there that I intentionally want you to get angry? Because you are saying that I am dishonest, in a sense. If I do something intentionally to create a reaction in you then that becomes more dishonesty. So then you perceive me as a dishonest person, hmm?

PT: That's right.

TH: But what evidence have I given that I am intentionally doing something like that? Let's face it, you describe your life as paralyzed in many ways, I feel that your life is in some way crippled, okay? But now the issue is this: you are the master of your life.

PT: Right.

TH: Maybe you want to live in a crippled, paralyzed fashion. (Addressing superego resistance.)

PT: No.

TH: If you want to do it, so that is your life. But what I am saying is this: why does a young women of your age—and obviously you have potentiality, you have got yourself to college and so forth—want to carry on the life like this? (Putting further pressure toward unconscious therapeutic alliance.)

PT: Yeah.

TH: So where does the idea come from that I want intentionally to get you angry with me?

PT: That was the experience that I had last time I was here.

TH: You see, that is your perception of the situation, not that the situation is like that.

PT: That's right.

TH: Because you give me a single evidence.

PT: Wait, wait, wait, you're talking so much, though.

TH: How do you feel when I talk too much?

PT: (Laughing) You're getting on my nerves.

TH: My talking too much also gets on your nerves?

PT: Yeah.

TH: What else do you experience besides . . . ?

PT: I want to shrug you away. I want to say, stop it. Stop pushing me. Stop talking so much.

TH: How do you feel right now?

PT: Movemented.

There is a major change in her posture, her voice is loud, absence of tension in her vocal cords.

TH: So your position is no longer like that. Now it is like this, hmm? Which is more positive.

PT: That's right.

TH: Because this is a crippled position. The other one . . .

PT: That's right (laughing).

TH: You smile when I said that this is crippled.

PT: Right, it is.

TH: But you see it is very important that you look at it . . . One perception of me is that I would retaliate, okay? The other is that I would be dishonest in a sense. Of course later on we can look at it to see where this distorted perception of me comes from. Because I am sure if you examine it—you can laugh again—this is in operation in other relationships, because I cannot be an exception.

PT: Yeah.

TH: And if it is, then it is a fundamental job for us to examine it—unless you don't want to.

PT: Ohhh God, why do you . . . ? Yes! I want it. Yes, see I'm open. Okay that's what you want. Yes I want it. I want to examine my anger, my inability to express and feel it.

Sadness

Suddenly there is a major change in atmosphere:

TH: But I am sure it is not only anger, there are other things as well.

PT: I am sure there are too.

TH: How do you feel right now? Because one of the other things I feel—I might be wrong, I don't know—is that there are moments when there are waves of sadness coming. I see it in your eyes, but then you go dry. If you examine yourself, was there a moment that you had waves of sadness?

PT: I felt it more in my face, like a tightening here.

TH: How about your eyes?

PT: Throughout this, since I've arrived, yes.

TH: You try to control it, why?

PT: Because I feel that's another way of escaping.

Challenge to Resistance against Emotional Closeness in the Transference (Phase 3)

TH: Maybe it has to do with the issue of closeness with me. I have a feeling that you are terrified of closeness with me and you are putting a wall between you and me.

PT: Terrified?

TH: That I want to get to know you, I want to get to your intimate thoughts and feelings, but a part of you is very strongly fighting that.

PT: Yeah, because my feeling is, what gives you the right to be close to me?

TH: And that is very important that we look at it. What you say is what right has this stranger to pass the barrier and get to your intimate thoughts and feelings?

PT: That's right.

TH: So then we have a major obstacle between us, hmm?

PT: That's right.

Head-on Collision (Phase 4)

The therapist now embarks on a head-on collision with the resistance, speaking directly to the therapeutic alliance about the self-destructive consequences of maintaining her defense of distancing.

TH: But then as long as this barrier is there, this process is doomed to fail.

PT: Yes.

TH: Let's look at it.

One of the ways of dealing with major resistance is to look ahead in

imagination to the end of the interview, and to face the patient with the disappointment that she will feel if she goes away having made the whole undertaking useless:

TH: It's very important you look at it, because as long as that wall, that barrier, is there and you don't want me to get to your intimate thoughts and feelings, then in a while when this session finishes, at the end of it, then when we say good-bye to each other, we will not have been able to understand the central core of your problem. You say good-bye to me and I say good-bye to you, you go on your own and I go. But you go on and carry on your crippled life—you carry your problems with you and carry on the miserable life that you have. I don't know, you have to decide, is it or isn't it? And then I will be useless to you.

PT: You're talking too much.

This is a defense of diversification, the therapist challenges it.

TH: Again that is another way of distancing.

PT: Is it really?

TH: Because I will be useless to you.

The resistance is swept aside in favor of the therapeutic alliance. The patient opens up an important issue contributing to her resistance in the transference.

The Issue of Control

PT: How can I feel that you want to get to know me if you're trying to overpower me? This is what I feel. You're trying to overpower me. You're trying to take control.

TH: So passing the wall becomes the issue of control, hmm?

PT: That's right.

TH: If I pass the wall and get to your intimate thoughts and feelings . . .

PT: Maybe I'll feel that you have more control and I don't like having less control.

TH: So that is another problem.

PT: That's right.

TH: So then let's see what you are going to do about it. Because, let's face it, if the distance remains there, if you don't want me to get to your intimate thoughts and feelings, I will be useless to you. It's as simple as that. But why does a young intelligent woman of your age want to do that?

PT: I don't want you to be useless to me.

TH: But it will happen if the wall is there, if you don't want me to get to your intimate thoughts and feelings, then I will be useless. Look, right now you have a lot of feeling. Tears are there but you are very strongly fighting them. Why?

PT: I'm not (she smiles).

TH: You are, with a smile. If you be honest with your feeling right now, if you really let your feelings come out what would you feel right now?

PT: Sad.

TH: And you don't want to share it with me.

PT: It's very painful. I don't understand you.

TH: I'm not sure it's that. You see, right now you are very sad and you don't want to let it go.

PT: I'm trying to let go.

TH: You want to control.

PT: But I'm afraid you're going to talk so much that you're not going to let me let it go.

In the following passage the therapist carefully avoids getting involved in what the patient is saying, and repeatedly confronts her with the central issue.

TH: Right now I am saying you are fighting the feeling. Let's look to your feelings.

PT: I feel very tight in my throat and I feel my eyes . . .

TH: You see, right now you talk, not to let the feeling come out. And I don't know why.

PT: Because I don't want you to come too close to me. I'm afraid of you in some way. I don't trust you.

Patient's tactical defense is swept aside.

TH: I'm not sure it is trust. It is tremendous conflict and fear, I don't know from where it comes. There is a tremendous fear of intimacy and closeness. Obviously it is sad.

PT: Somehow I'm afraid you'll make fun of me or something.

The patient's tactical defense is again swept aside.

TH: You see, these are all mechanisms you use to avoid your painful feelings. You know it well.

PT: (Pause) Maybe I don't believe that you can . . .

TH: Yeah, but right now you know that these are all mechanisms for fighting your very painful feelings.

PT: I can't go around crying in front of people every time they hurt me.

Direct Experience of Sadness, Breakthrough of Grief-Laden Unconscious Feelings (Phase 5)

TH: The issue really is this: I don't know what has happened in your life that you are so terrified of closeness. You want to keep all these painful feelings to yourself. You don't want me to get there.

There is a long pause. The patient is charged with feeling.

TH: You see, a while ago I was saying that you have a tremendous problem with the issue of intimacy and closeness.

PT: (Whispering, hardly audible) I keep people very far away.

TH: Far away, uh hmm. (Pause) Is it much more with men or women?

PT: (She sighs deeply.) I don't know. (Hardly audible) I don't know. I really don't know. Men have hurt me more, but I don't know if it's . . .

TH: So it has been more with men?

PT: Only because I've had a series of relationships with men that didn't work out.

TH: You mean a series of relationships with men that ended up in disappointment?

PT: Uh hmm. (She is very sad, crying.) The disappointment is so deep. (She is very emotionally charged.) Disillusionment is so deep that I wonder if I can ever love anyone.

TH: I don't know what has happened, but maybe a part of you has decided that you will never let any person get close to you again.

PT: (Whispering) I think so.

TH: What in a sense you have decided that you are going to live the rest of your life in a cave, so to say.

PT: Yeah. Do you have any kleenex?

TH: Conflict over control, conflict over closeness and intimacy. And hopefully you and I today will get to the core of your problem and get that into the open, so that you can see what it is. And we both can see where it originates and then a new avenue opens for you in life, hmm? And then there is a hope that, for the balance of your life—because you are very young now, you have a long way ahead—you can live the way you want to live rather than be affected by all these problems that you have. Then if we achieve that today, we can say good-bye to each other in a positive atmosphere. How do you feel toward me now?

PT: I feel better, but I can tell you honestly I think I'd feel differently if you were a woman . . .

This also is being used as a defense and must be challenged:

TH: But that doesn't solve the problem.

PT: No, but I have difficulty being close to you.

TH: I know, but we are here to solve the problem. You have been trying to avoid the problem. "If I was a woman"—still, avoidance. But avoidance doesn't solve the problem. You don't need me to expound on that. Running away, closing your eyes, facade, avoiding, doesn't solve it. We have to examine it. I am sure it is painful, but that is the only way we have, hmm?

PT: That's right.

At this point the therapist suggests having a five-minute break.

Now that the first breakthrough has been achieved the therapist embarks on fact-gathering. As always the aim is first to explore the patient's adult life and relationships. This will give him a picture of the disturbances that need to be explained, which will help to direct him in his later exploration of the past.

Summary

In the first part of this two-part article I have outlined the central dynamic sequence in the process of direct access to the unconscious and pointed out that the whole process can be divided into a series of phases, each consisting of a particular intervention with its corresponding response, and emphasized that these phases tend to overlap and proceed in a spiral rather than a straight line. The central dynamic sequence can be seen as a framework which the therapist can use as guide. The two major protocol, partial and major unlocking of the unconscious, were presented; and the trial therapy of a case, the "Fragile" Woman, was presented to demonstrate the technique of the major unlocking of the unconscious.

She entered the interview with a great deal of anxiety and in a state of transference resistance. The therapist for a moment bypassed the transference resistance and employed a set of interventions and came to the conclusion that there was no sign of a severely fragile ego and there is a major anxiety in relation to aggressive impulses. Then he quickly moved to pressure and challenge to the transference resistance and there was a head-on collision with the transference resistance. This finally led to a breakthrough of the aggressive impulse in the transference and the emergence of a deep sadness with a major communication from the unconscious therapeutic alliance. Here we break off the interview, which will be continued in the next article.

References

- Davanloo, H. (1978). *Basic principles and techniques in short-term dynamic psychotherapy*. New York: Spectrum.
- Davanloo, H. (1980). *Short-term dynamic psychotherapy*. New York: Jason Aronson.
- Davanloo, H. (1984). Short-term dynamic psychotherapy. In *Comprehensive textbook of psychiatry* (4th ed., Chap. 29.11), H. Kaplan and B. Sadock (Eds.). Baltimore, MD: William & Wilkins.
- Davanloo, H. (1986a). Intensive short-term dynamic psychotherapy with highly resistant patients I. Handling resistance. *Int. J. Short-Term Psycho.*, 1, 107-133.
- Davanloo, H. (1986b). Intensive short-term dynamic psychotherapy with highly resistant patients. II. The course of an interview after the initial breakthrough, *Int. J. Short-Term Psycho.*, 1, 239-255.
- Davanloo, H. (1987a). Intensive short-term dynamic psychotherapy with highly resistant depressed patients: Part I. Restructuring ego's regressive defenses. *Int. J. Short-Term Psycho.*, 2, 99-132.
- Davanloo, H. (1987b). Intensive short-term dynamic psychotherapy with highly resistant depressed patients: Part II. Royal road to the unconscious. *Int. J. Short-Term Psycho.*, 2, 167-185.
- Davanloo, H. (1987c). Clinical manifestations of superego pathology. Part I. *Int. J. Short-Term Psycho.*, 2, 225-254.
- Davanloo, H. (1987d). Clinical manifestations of superego pathology. Part II. *Int. J. Short-Term Psycho.*, 2, 225-254.
- Davanloo, H. (1988a). The technique of unlocking of the unconscious. Part I. *Int. J. Short-Term Psycho.*, 3(2), 99-121.
- Davanloo, H. (1988b). The technique of unlocking of the unconscious. Part II. *Int. J. Short-Term Psycho.*, 3(2), 123-159.