then work as a team to explore the unconscious and to put unconscious processes and elements into a different perspective.

(4) Davanloo's technique of rapid breakthrough into the unconscious represents a major discovery and is an invaluable tool that allows the therapist to relieve a wide range of patients from their neurotic suffering.

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Intensive Short-Term Dynamic Psychotherapy with Highly Resistant Depressed Patients: Part II—Royal Road to the Dynamic Unconscious

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This is the second part of a series of articles concerned with the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of certain kinds of patients suffering from depressive, functional, and psychosomatic disorder. Part I was concerned with the restructuring of a depressive patient's defenses, leading to a full experience of complex transference feeling in particular anger in the transference. The patient came back to a second interview in a state of renewed resistance, but now this could be penetrated safely with the use of unremitting pressure and challenge. In this part of trial therapy a second experience of complex transference feeling resulted in the unlocking of her unconscious and a direct view of her core neurotic structure.

This is the second part of a series of articles concerned with the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of certain kind of patients suffering from depressive, functional, psychosomatic and panic disorder. In my previous publication I described a powerful technique of Short-Term Dynamic Psychotherapy which is highly effective to the whole spectrum of neurotic disorder and gave a general account of the phases of trial therapy with highly resistant patients suffering from life-long character neurosis. The standard technique that I have developed may be summarized as follows:

Pressure toward the experience of feeling, which leads to increased resistance.
Systematic challenge to and pressure on the resistance, which leads to a rapid rise in transference feelings and a further intensification of the patient's resistance.
Systematic challenge to the resistance in the transference leading to direct experience of transference feelings, which leads to the first breakthrough into the dynamic unconscious.
Systematic analysis of the transference to remove residual resistances, which finally leads to the unlocking of the unconscious, with a direct view of the core neurotic structure and mobilization of the unconscious therapeutic alliance.

In Part I, I described certain variations in the technique of the trial-therapy model of the initial interview, which depend on the structure of the patient's

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psychopathology and the patient's ego-adaptive capacity. One of the variations I outlined is the application of my technique to patients suffering from certain types of depression, namely chronic depression and characterological depression. These patients in addition to depression suffer from a wide range of ego-syntonic character pathology.

One of the features of these patients is the inability to distinguish between the corners of the triangle of conflict, especially the impulse of anger or rage, on the one hand, and anxiety or defense, on the other. The unconscious defense mechanism responsible for depression instantly internalizes the rage. These patients do not experience the repressed sadistic impulses; instead they experience anxiety and depression, together with a wide range of ego-syntonic maladaptive character defense. In many of them unconscious homicidal impulses are instantly internalized and what we see clinically is a depressed suicidal patient. In turn, these suicidal impulses might be defended against by psychomotor retardation.

It is found with these patients that if the therapist uses the standard technique described above, which involves *unremitting* pressure and challenge, it arouses more anxiety than the patient's ego can bear, and the end result is that the depression becomes intensified. However, I have systematically demonstrated that this can be avoided if a two-phase technique is used, as follows:

The first phase consists of restructuring the ego's unconscious depressive defense mechanism. The therapist works on the triangle of conflict in the area of C (current or recent relationships) and T (transference). He employs gentle pressure toward the experience of feeling and gentle challenge to the defenses, monitoring the patient's reaction with the utmost vigilance. As soon as he observes that too much anxiety is being aroused he immediately reduces the pressure. He can do this in three main ways: (1) by returning to pure enquiry; (2) by switching from one area to another, e.g., T to C or C to T; or (3) by asking the patient to describe the experience of anxiety. He then returns to pressure and challenge at an increased level, again monitoring the response, and so on. In this way he systematically reworks and clarifies the triangle of conflict in relation to C and T, finally bringing the patient to the direct experience of the impulse in relation to T. The therapist drives home the lesson of the difference between the impulse and the other two corners of the triangle of conflict, defense and anxiety. He then continues with a systematic analysis of all aspects of transference, including the links between T and C, making sure that the patient both experiences these and understands them cognitively. Now the phase of restructuring the depressive defense is completed, and the therapist can proceed to the second phase, in which he can employ unremitting pressure and challenge in order to break in to the unconscious, without the fear that this will result in making the depression worse.

In Part I the restructuring phase was illustrated by means of the first interview with a patient suffering from chronic depression. This will now be summarized before the second interview is presented.

The Case of the Woman with a Machine Gun

The patient was an unmarried woman aged 30. As we saw, the therapist started by focusing on her previous treatment, which she had undertaken because of depression. However, he rapidly moved to focusing on some of the patient's characterological problems which had manifested themselves in her previous treatment, such as

passivity, compliance, inability to assert herself, and flight from a conflictual situation, and their implications for the present transference. Taking her history, he learned that she had suffered from lifelong depression, including episodes of acute depression with suicidal ideation. She then described a more recent attack of depression which had occurred in response to two incidents in which she had been badly humiliated by a man. In response to one of these she had banged her hands against the wall and badly damaged them. It was clear that she was incapable of distinguishing the corners of the triangle of conflict—weepiness (defense) and self-directed aggression (defense) for her meant anger. There was systematic work on the triangle of conflict in relation to the recent past (C) and the transference (T), and finally for a short period her rage passed through the repressive barrier, and she was able to experience and describe her impulse to shake the therapist and throw him on the floor. Now she could clearly differentiate between her anger and her defenses against it. She also repeatedly told the therapist that she did not want to damage him. This enabled the therapist, in the phase of systematic analysis of the transference, to focus on her positive feelings and her conflict over intimacy and closeness. It was arranged for her to come for a second interview after one week.

She came to the second interview in a state of renewed resistance, appearing totally detached and noninvolved. However, the situation was now quite different from that at the beginning of the first interview. For now the therapist knows that the systematic work on restructuring the depressive defense has prepared the ground for unremitting pressure and challenge to the resistance, and that the patient now has the capacity to withstand the impact of her unconscious. As described in Part I, this relentless pressure and challenge represents the royal road to the dynamic unconscious and the exposure of the core neurotic structure.

We now take up the second interview. The therapist is referring to the obvious manifestations of the patient's resistance.

Pressure and Challenge to the Resistance in the Transference

TH: *Still you are like that.*
PT: *I could sit like this and we'd be no further ahead.*
TH: *You are looking at the carpet or the wall, avoiding my eyes and maintaining a paralyzed, detached, remote position. Why do you want to do that?*
PT: *I don't want to do it.*
TH: *But you are doing it right now.*
PT: *Yes, that's right. I am.*
TH: *Now let's see, what are you going to do about it?*
PT: *Ah, I'm . . .*
TH: *Your weepiness, avoidance, need to distance yourself. So let us see what you are going to do about it.*
PT: *I'm going to start by stopping crying,* (sniffs); *it's not going to do me any good.*
TH: *Uh hmm. That is another way of defending against your rage.*
PT: *Crying . . .*
TH: *This crying is another way of ah, avoiding the rage inside you. Another mechanism you use is putting your hands in the crippled position, totally immobile and paralyzed. Now let's see what you are going to do about it.*
PT: *I don't know what to do.*

TH: Again that is a helpless position.
PT: Yes, it is.
TH: But that is not good enough. I mean, that is what has destroyed your life up to now. Now you are fidgeting, holding your hands together. Let's see how you experience this rage.
PT: I can't let it out. I'm trying to, and it's not going anywhere.
TH: But you see, again you are ruminating. I say, how do you experience the rage?
PT: I'm not experiencing it, and I'm . . . I don't know how to get rid of it.
TH: But still you are ruminating on helplessness.
PT: Sitting here saying I know how won't make me know how.
TH: But that is helpless. You have taken this helpless position for years of your life, flight, running away.
PT: Which is what I want to do now.
TH: Again, you see, look to your hand. Still is crippled. So let's see what are you going to do about it. Now, sigh . . .
PT: Yeah.
TH: . . . holding the chair, still we don't know how you experience the rage.
PT: I'm not, I'm, I'm, I'm taking a deep sigh.
TH: And now you see you move toward the position that you don't.
PT: I'm not saying there is no anger.
TH: There is anger in you. We know but we don't know how you experience it. And look to your hand again.
PT: I'm pushing it down, I'm pushing it back, I'm pushing it so far back.

Further Challenge to the Patient's Characterological Defenses in the Transference

TH: So your defiancy is up again.
PT: Yes, there is.
TH: And that is what is in operation with me. You are taking a defiant, crippled position with me.
PT: I'm trying to do something.
TH: Still you are taking a crippled position with me. You are taking a defiant position, and defiancy is another part of this wall. The paralyzed, crippled woman, and becoming retarded. Now, you see, totally paralyzed.
PT: There's nothing I can do or say.
TH: You see, again that is helplessness.
PT: I know.
TH: You see how crippled you are in dealing with your negative feeling here with me?
PT: Yes, I see it. I see it.
TH: I see it is not good enough. We are looking how you experience this negative . . . your weepiness comes . . .
PT: Yes it does.
TH: . . there is a weepiness, there is a defiance, taking a crippled, helpless position.

Rise in the Complex Transference Feelings with Further Challenge to Resistance

PT: Well, how else does one communicate? (In a raised tone of voice) *I'm trying to get something out . . .*
TH: How do you experience this rage here with me, if you look into my eyes and tell me how you experience this.
PT: I'm not! (In a very raised tone of voice) *I don't know how. I don't know how to describe it.*
TH: How do you experience physically?
PT: I, I get tight.
TH: But that is anxiety, that is not rage.
PT: Well then to me it's the same thing! I get tight . . .
TH: Yeah, but . . .
PT: I get very tense.
TH: Yeah, but what else do you experience besides tightness?
PT: Uhh . . .
TH: If you put it out, how that would be like?
PT: I get tense, I get . . .
TH: You see.
PT: . . . I stop sweating . . .
TH: Uh hmm.
PT: . . . and I find it difficult to speak, I get very tight in the jaw and in the throat.
TH: But that is tension build up.
PT: Yes.
TH: These are mechanisms of dealing with the rage. That is a mechanism of dealing with rage.

Direct Experience of Complex Transference Feeling

What has emerged is a high rise in transference feelings. The pitch of her voice is very high and communicates anger. There is a definite change in the patient's psychomotor activity, moving her clenched hands forward. She is bouncing back in the transference, which indicates that the anger in the transference has passed the repressive barrier. It is also extremely important that, side by side with an increase in tension and anxiety, she reports a *decrease* in one of the physiological concomitants of anxiety—"I stop sweating." This confirms that she is really beginning to experience her anger.

Since she suffers from chronic depression, it is essential to focus on the impulse in the transference until she can experience her anger fully. We take up the interview.

TH: But it is not clear how you experience the rage by itself.
PT: I, I'm describing it to you, and you're telling me that's not, that's not . . .
TH: I mean, if you put it out, how would this rage be like?
PT: The way it is right now.
TH: Yeah. How would you be . . . ?
PT: I, I, I'm, I'm yelling. I'm moving my, my arms slash around . . .
TH: If you put it out in terms of thought and fantasy, what would it be like?

PT: *This is it!* (with a loud voice) *This is it! This is what it is!*
TH: *But still it is not clear . . .*
PT: *Well, what do you want me to do, beat the wall I don't . . .*
TH: *Do you feel that way?*
PT: *No. I don't feel like beating the wall . . .* (moving her hands in fist-like position) *I don't know what else. I am sitting here angry, telling you I am angry, and you say . . .*
TH: *Are you angry right now?*
PT: *Yes, I am.* (Very firm and loud voice)
TH: *What else?*
PT: *I stop sweating.*

TH: *Uh hmm . . . You are angry and no sweating, what else?*
PT: *Shouting!*
TH: *What else do you experience?*
PT: (Referring to her head) *Ah, clarity up here.*

It is very important to note that as the physiological and psychological concomitants of anger have increased, the concomitants of anxiety have correspondingly greatly decreased. Thus again she says she has stopped sweating, and she does not want to use the defense of directing her aggression against herself by banging her hands against the wall. Moreover, whereas in the early part of the interview she used the word "confused," she now says "clarity up here," referring to her head. It is therefore quite clear that what we are seeing is a breakthrough of the aggressive impulse through the represssive barrier and a definite undoing of the depressive mechanism.

The therapist now exerts further pressure in order to get the ego to experience the aggressive impulses to the full, and follows this by returning to a systematic analysis of the transference, vigilantly monitoring the process of entry into the unconscious. We take up the interview.

TH: *You say you are enraged. If you look into my eyes, do you feel that you want to lash out?*
PT: *I am lashing out verbally . . . this is called verbally lashing out, what I am doing right now.*
TH: *Do you see how much, you have tremendous problems to experience the rage which has crippled your life and a while ago you felt banging against the wall and we know the incident with Tony . . . there you banged your hand against the wall and you were crippled for almost two weeks.*

Challenge and pressure are applied further, and what emerges is a sudden further rise in the intensity of her rage in the transference. Then the evaluator explored her thoughts and fantasies. "If you put your anger out, what would it be like?" The patient is repeatedly moving her hands up and down in front of her and once more she says she would grab the therapist by his lapels and shake him, and in her fantasy the therapist would be on the floor; and again she said, "I don't want to damage you." The therapist focused on her positive feelings and her defense against

them. Then the focus is on her hands which she had damaged badly in the second incident with Tony. We take up the interview.

TH: *You see, you describe some incidents with Tony that you were humiliated, but then you ended up banging your hands against the wall which as we know was turning the rage against yourself and it is important that we look that on two occasions when you felt to put your anger physically out, it was with your hands. Is there any other incident that involved your hands?*

The First Mention of the Past (P)

She described an incident that took place when she was an adolescent. Her year-younger brother Peter was aggressive, and she was humiliated by him, ended up crying. "I started crying, thrashing," and she ended up beating her hands against a tree and bruised them badly.

TH: *And it is very striking that we talk about the crippled, limp hands; and in that incident also beat up your hands and bruised your poor hands.*
PT: *Well . . . In that situation he was gone, so there was nothing I could do about it.*
TH: *What happened to the rage?*
PT: *I thought that was the rage.*
TH: *Weepiness is not rage. Beating up your hands is a way of dealing with rage. Let's see how you experienced the rage.*

P-T Link

PT: *I don't know; in retrospect I cannot tell.*
TH: *But it is very important you look at what happens to the rage.*
PT: *I can't tell what happened to it back then.*
TH: *You see in relationship with me what happens to the anger?*
PT: *I don't let it out.*

The focus of the session is further on analysis of the transference, the impulse, the anxiety, and the range of defenses she uses. The focus is on the experience of anger in the transference and its differentiation from anxiety.

TH: *Obviously, if you put your rage out in the form of physical attack, that is not constructive either.*
PT: *No. Right.*
TH: *But if you also turn it to yourself, turn against yourself and get depressed or seized with anxiety or become paralyzed or take a crippled position, that is not constructive . . .*
PT: *Either.*
TH: *. . . way as well . . . is not constructive, okay?*
PT: *Yeah.*

T-C-P Links

The therapist links transference, recent, and past and once more drives home the lesson about her former inability to distinguish the corners of the triangle of conflict. Now she gives unmistakable evidence that the lesson has been learnt.

TH: Today when you experienced anger in relation to me your hands went like that (therapist demonstrates fists) *for a moment. There was an impulse to grab me with your hands, attack me with your hands; but with Tony you ended up beating your hands against the wall. And you could not use your hands for some time. Now it is important that you look at it again, the mechanism you used to deal with your rage.*
PT: I always thought that was the anger.
TH: And the same was with Peter. You ended up beating your hands against the tree.
PT: I realize it is the same. That is the way I always thought.
TH: Somehow, we don't know why, you are terrified to experience the negative impulse.
PT: The anger?
TH: And you have developed a set of mechanisms to deal with it. And I think this is of all the issues that you want to look at, this is a very fundamental issue. You see that when there is this rage in you, you don't experience it.
PT: Yeah, and I'm not even aware that I'm doing it.

She says that she has been like this all her life.

PT: Yes, I think I was like that. I mean I don't, I don't remember much of my childhood at all, okay. But I don't, umm, I don't remember a time when, umm, I didn't cry easily when I didn't express anger with tears.
TH: Uh hmm.
PT: I don't remember a time when I did it differently. I don't know if there ever was such a time.

Exploring Further the Extent of the Anger in the Transference

TH: What was the extent of your negative feelings toward me during that moment, when you became . . . ?
PT: Intense . . . yeah . . . it was intense. It was intense, umm, I, I felt it very strongly.
TH: Uh hmm. What did you feel strongly? For example, did you feel at any split-second that you wanted to really blast out?
PT: I was blasting out.
TH: More than that. Did you at any moment, for if you a split second examine it very carefully, was there any time that you felt like blasting out?
PT: It was, I was, I was blasting out. I was, umm, how can I , it was satisfying to blast out the way I was.
TH: Yeah, I know but was there more than that?
PT: No, there wasn't.

Unlocking the Unconscious

TH: Uh hmm. But do you think that in a sense maybe a part of you also wants to protect me against your anger? You know what I mean by protecting against the anger?
PT: Yes, yes.
TH: That in a sense if all of it comes out . . .
PT: God knows what I'll do. Ah . . .
TH: So you see, if all of it comes out you say God knows what you would do, okay?
PT: Yeah, I, I don't . . .
TH: Now, I am looking to the thoughts and fantasy.
PT: Yeah.
TH: Again it is very important to fantasize and we know you have indicated that in many other areas you have a very strong fantasy world.
PT: Yes.
TH: Yeah, what, you say God knows what I would do.
PT: Yeah.
TH: Now this means that then you would do something, huh, that you say God knows what I would do.
PT: Yeah.
TH: And I know you know very well what you would do. Let's see what in term of fantasy you would do here in this room . . .
PT: I, I, yeah . . .
TH: What would you do?
PT: Stand up and wave my arms . . . yes . . . very strongly . . . and walk around . . .
TH: But you said, God knows what you would do.
PT: No, I was just, that was just an expression, ah, I, I, I wouldn't do anything.
TH: How would you portray yourself if you became a very violent person? Remember, we talked about Dr. Jekyll and Mr. Hyde. Now the question is, what would you be like if you were to become a violent person?
PT: Yeah, yeah, very, very, umm, cold, ah . . .

The patient is heavily involved in this process.

TH: But that is not it.

The patient's resistance is now so reduced that so far from avoiding the subject, she makes plain that she wants to pursue it.

PT: No, no let me talk this through, umm, if I, if I'm very violent, cold and unfeeling, umm, umm, very efficient in the violence.
TH: But what would, could you portray yourself if . . .
PT: Umm . . .
TH: . . . the monster comes out of you what would that be like?
PT: What would I do?
TH: Uh hmm.

PT: *Ah, probably buy a gun.*
TH: *Uh hmm.*
PT: *And a big gun.*
TH: *Uh hmm. How big?*
PT: *Umm, one of these big, you know, a big gun.* (She demonstrates a machine gun.)
TH: *Uh hmm. Uh hmm.*
PT: *And learn how to use it.*
TH: *Uh hmm. And then?*
PT: *And get very good at it.*
TH: *Uh hmm. And who would be the target of that?*
PT: *Umm . . .*
TH: *In term of thoughts . . .*
PT: *Yeah, who, who would I most likely like to see . . .*
TH: *First . . .*
PT: *Ah, of my family.*
TH: *Uh hmm. Which one would be the first target?*
PT: *My mother.*

She has become intensely sad. Her eyes are filled with tears and she has waves of painful feeling that one can see from her face. The evaluator continues.

TH: *Uh hmm. Uh hmm. In a sense then you would have that gun and then target would be your mother.*
PT: *Yeah.*
TH: *How would you in fantasy and thoughts, how would your mother, you shoot her?*
PT: *I'd just pull the trigger.*
TH: *Trigger and then . . .*
(Pause) (Patient is crying heavily)

As the patient describes how she would murder her mother we see a breakthrough of a major degree of painful feeling. She is choked up and trembling. What we have seen so far is the emergence of the guilt-laden murderous impulses toward her mother which are grief-laden as well. It is important to note that the major work in restructuring the ego's unconscious regressive defense mechanism was the essential first step in the journey down the path to the unconscious. Now the ego has the capacity to withstand the painful feelings, the grief-laden feelings attached to her sadistic impulses in relation to her mother. A major phenomenon of entry into the unconscious is that neither the defense mechanism of isolation of affect nor repression is in operation. Metapsychologically, the whole system of resistance and unconscious defense mechanisms are no longer in operation, and the superego structure for the time-being is cornered against the wall; and the therapist has the unique opportunity to make a careful appraisal of the structure of the dynamic unconscious, and to explore the structure of the instincts and all the guilt-laden, grief-laden feelings within the unconscious.

We take up the interview where we left off. The patient is going through an intensely painful experience. The therapist should vigilantly monitor his own reaction so as not to lose sight and become supportive.

TH: *You must have a lot of painful feelings. There must be an agony in you.*
PT: *Yeah.* (She is crying intensely.)
TH: *And you see, you cover your face when your painful feeling comes; you cover your face from me. So then, where would the shooting take place? In the head or chest or where?*
PT: *Ah, no just without aiming, just, you know . . .*
TH: *But in terms of thoughts, what . . . The shooting be targeted against?*
PT: *Yeah.*

Her emotional turmoil continues.

PT: *Ah, nowhere in particular I would want to hit her, I'd just fire the gun, that's all.*
TH: *Uh hmm. And what happens to her after the, I am talking about thoughts.*
PT: *She'd die.*
TH: *Instantly die? And could you portray what she would be like dead?*
PT: *Just lying there that's all.*
TH: *But what way she is lying down there? In what position?*
PT: *Ah, just on her back, just ah . . .*
TH: *In the back.*
PT: *On her back.*
TH: *On her back, in a face . . .*
PT: *Face up.*
TH: *. . . up. And eyes?*
PT: *Ah, closed.*
TH: *Closed, the eyes are closed. And then what else? Mouth?*
PT: *I can't see it.*

The patient continues in a painful emotional state with genuine painful feelings. The evaluator continues with this piece by piece review of the murder of her mother. She is totally absorbed in this process.

TH: *Uh hmm. You cannot see the mouth.*

(She is crying)

TH: *Uh hmm. And then would be a painful death or would be . . .*
PT: *No, she would die right away.*
TH: *Instant death. Uh hmm. And the eyes you said closed, but mouth?*
PT: *Ah,* (She sniffs frequently) *Ah, the face is ah,* (she pauses frequently between words)
TH: *Uh hmm. Is not clear the, the face.*
PT: *No.*
TH: *Uh hmm. What color would be the face? There would be blood or anything?*
PT: *I don't see it on the face . . . more on the body . . . I see it coming out of the chest.*
TH: *Where in the chest?*
PT: *It is just covered, that's all.*

The patient suffers waves of emotional distress and crying.

TH: Uh hmm. And what do you do after now the gun and then you have shot her to death, so she is murdered, what do you do?

(Patient is crying)

PT: I don't know.
TH: In term of thoughts.
PT: Walk away.
TH: Walk away. You mean you wouldn't touch anything?
PT: No.
PT: You don't touch her body, hmm?
PT: No.
TH: Uh hmm. Do you look at her and walk away or . . .
PT: I just look to see that she's dead and then walk away.
TH: Uh hmm. And what would you say to her before you walk out, to the dead?
PT: Nothing, not a word.
TH: Uh hmm. Not a word. And walk a way and then what do you do when you walk away?
PT: I don't see me. Just walking . . .
TH: What happens to you in life, then? After that?
PT: Uh . . . I don't get caught.
TH: Uh hmm. What happens to her burial?
PT: I'm not seeing that.
TH: How would her burial be?
PT: I don't know. I wouldn't go.

The intensity of the patient's emotional turmoil has increased. The force of resistance has so far been in a paralyzed state, and the evaluator has clearly seen the way the murder of her mother has taken place and that she has "not left any trace." When he questioned her what happens to her life after the murder, she said, "I don't get caught". But the truth of the matter is that she has imprisoned herself behind a wall of suffering, like a criminal. But during the entire process we have seen no sign of a wave of return of resistance. We take up the interview where we left off.

TH: Uh hmm. So then is there the indication that maybe on the very deep part of you maybe there is massive, murderous impulses toward your mother?
PT: Anger. Anger.
TH: Which is very painful to declare, but you know one of the things that I have been looking . . . that is very important for you to look at, if you face with all the painful feelings that you have buried for many years in yourself, if you look at them, if you examine them and face them, then you have a chance at freedom.
PT: (Continues to be in a painful state but with much less intensity.)
TH: Because your life is like the life of a murderer if you look at it.
PT: I'm in hiding.

TH: You are running and running and running, hmm? Hmm?
PT: I've been hiding for all these years.
TH: Uh hmm. But then underneath, there is a massive murderous impulse there, hmm? Which gives us a glimpse in one area that is why you are so terrified of anger. Do you see what I mean?
PT: Yes.
TH: And you have used a mechanism of depression as a way of dealing with these massive murderous impulses. This is very important for us to examine. You see, there are these buried represssed murderous impulses; and the way you deal with them, you turn it, you have turned it into a depression.
PT: I have turned it against myself.
TH: Yeah. Hmm? And suffered from depression, suffered from, you are crippled in that sense, hmm? Hmm?
PT: A great deal of rage.
TH: . . . of rage . . . and there are other feelings as well.
PT: Yeah.
TH: Which in a sense you are holding onto and then you are setting, you have set up a system of defense mechanisms as you say precise . . .
PT: Yeah.
TH: . . . to defend against these impulses. One of them above all is the depression which is a very crippling mechanism, you see? Hmm? Paralyzes you totally.
PT: Yeah.
TH: And of course you have experience of it, of depression when it comes, hmm?
PT: I'm useless, yeah. I go through the motions, that's all.
TH: Uh hmm. How do you feel right now?
PT: Very sad, choked up.
TH: Uh hmm.
PT: Physically very weak, and surprised, too. (Sighs deeply) *I wasn't expecting . . .* (sigh) *. . . thoughts like that to come into my mind.*
TH: Uh hmm. But obviously it is there.
PT: Yeah. (Sighs)
TH: Hmm? And has been there for years of your life hmm? A lot of mixed, buried feelings in relation, obviously, to many other people. Now, you said the first person that you would shoot would be your mother. Who would be the next?

Thus far we have seen the process of entry into the unconscious with mobilization of the unconscious therapeutic alliance which came into operation when the transference feelings reached the threshold. What emerged first was the patient's murderous impulses toward her mother. This was carefully explored, and she went through intensely painful feelings with waves of physical distress. In a sense, we saw her mourning the death of her mother, grief-laden feelings, the whole complex set of feelings. By this time the ego-adaptive capacity has reached a higher level and is ready to continue the journey to the dynamic unconscious. We take up the interview where we left off.

Return to the Trail

TH: Here we are travelling in this path of fantasy and thoughts.
PT: I'm afraid to go back into it.
TH: Uh hmm. But still we are climbing the mountain toward freedom.
PT: Uh huh. (She sniffs.)
TH: So we should climb rather than retreat.
PT: Ah, I would ah . . . , my, ah, I don't know. I can't distinguish between my father and my sister.
TH: Uh hmm.
PT: And for some reason or other . . .
TH: Yeah, but if you shoot, which one got it first? Your father would be the next or your sister?
PT: Yeah, ah, no, I, I can see them both standing there.
TH: Both, you mean, they would both be the target . . . ?
PT: Yes. Yeah . . .
TH: Who would be next?
PT: Peter.

As we see, the next target is her father and sister, then comes her brother. What emerged is that the next target is Tony. She has described two incidents. In one she had prepared to have sex with Tony, but he humiliated her. In the other incident, following the first, Tony and her sister Linda had sex in the room next to hers. She was very upset, couldn't sleep. For a few weeks she was very depressed. She ended up banging her hands against the wall and bruised them badly. The effects lasted two weeks. At this point the therapist brings up the incident.

TH: Hmm? You said the next would be your father and Linda, then Tony; and I raise the question, maybe that night that you got, that you couldn't sleep and for days you were depressed, hmm, maybe there was the impulse underneath that you could have the machine-gun and machine-gunned the whole room and blasted them hmm? But what did you do?
PT: I . . . That didn't come. I got depressed.

Then she remembers that for months afterward she begged her sister to keep Tony away from her.

TH: Begging her to keep Tony away from you?
PT: Yes. Yes.
TH: . . . because then the ideation is that if your fear was that you might murder him.
PT: I might act it out, yes. It might actually happen.
TH: Uh hmm. And where would they get the bullet?
PT: (She stutters a bit) *Again in the body, I don't aim for the head at all. Somewhere in the body.*
TH: It is very important along this path. The night that Tony was having sex with Linda you couldn't sleep. Was there the impulse to machine-gun, to blast both of them?
PT: Physically to retaliate?

TH: Yeah.
PT: Retaliate.
TH: But this is not retaliation. We are seeing murder. It is important for us to look at this because underneath your depression . . . now we know what is underneath. There is a machine-gun; and you are going first to murder your mother, then your father and sister together, then your brother, then Tony and your sister, and finally Tony's sister Gina.

The patient continued to be highly charged with painful feelings, and the therapist continues.

TH: And who else would be next in this target of this machine-gun?
(Pause)
PT: There's no one else that I would want to hurt that badly.

By now the therapist has got a good view of the patient's unconscious and has been able to map it out. Now he returns to some work on the transference, preparing the ground for completing a dynamic phenomenological description of the patient's psychopathology and then to complete the patient's developmental history.

Return to the Transference

TH: Now if we go back to you and me, there was rage in you toward me. If we put it on a continuum, where do I stand on that continuum?
PT: As I told you, I was angry to the level of visualizing grabbing you by the lapels and shaking you; but . . .
TH: Are you saying with your mother the rage was to the level of murdering her with a big machine-gun, and it was the same with your father and sister?
PT: The degree of violence is disproportionate. With you I don't see doing more than that.
TH: Uh hmm. Why do you think that is?
PT: The anger was not beyond that level.
TH: I know, but why? There must be something there.
PT: It is because I . . . I . . umm . . . the . . the caring is not there. I mean there is no way I can care for you as much as I care for my family.
TH: Uh hmm.
PT: Ah . . . If they hurt me, it hurts more than if you hurt me. Let's say hypothetically because you are not my family.
TH: Uh hmm.
PT: I . . . I . . . I cannot get as angry at you.
TH: Uh hmm.
PT: . . . Because there's, there's just . . . (sighs) there's no . . . mmm . . . no real connection.
TH: Then what you say is that with your family there was attachment and a severe let-down, then the pain of it. This is what you say?
PT: It is greater, yes, because it is attachment.

Exploring the Patient's Feelings about the Interview

PT: Yes, mmm, there is a feeling that although this is frightening it is vitally important. And that tempers the anger. It tempers it. And that is constructive. You are like a catalyst, okay? And that is good. And that's what I badly need. There is a feeling of confidence. There is a realization of being able to remember things and to talk about them that I didn't even know were there. And nobody dropped dead.

The patient again becomes choked up with emergence of painful feelings with eyes filled with tears.

TH: So it must be very painful. You see, the pain that you go through.
PT: It is also a relief.
TH: Uh hmm. I know. There is a lot of painful feeling in you.

As the patient is visibly anxious, the evaluator explores this.

TH: How do you feel right now?
PT: Relieved and shaky . . .
TH: Still you feel shaky?
PT: Yeah. It is frightening . . . the whole realization that I can turn into a madwoman.
TH: But obviously another thing about you is that you have a tendency to underestimate your potential.
PT: (She sniffs) *I don't have much belief in myself, yes.*
TH: This is what I am referring to—that you have tremendous underestimation of your own capacity and your own potential because you see the potential under such difficult circumstances to go through these experiences, hmm? Do you see? But you have been underestimating if you would have such a capacity and such a potentiality to go through it. Do you see? I am sure you do it in any other area of your life, that if your potential is at this level you treat it like this. I don't know. You know yourself better. You only can say, am I right or wrong.
PT: Yeah.
TH: Do you think that is the case?
PT: (She sniffs) *Yes.*
TH: And my question is this. Do you function at the level of your potential in life?
PT: No.
TH: Or do you function much below your potential?
PT: Considerably below.
TH: How is your anxiety right now?
PT: Right now it is much less, but I am still very sad, weak, and empty.

Now the therapist proceeds to complete the dynamic phenomenological description of the patient's psychopathology, a comprehensive psychobiosocial assessment, elementary and high school years, sexual history, and medical history. After completing these, he takes the developmental history, and finally he is able to formulate the multi-focal core neurotic structure responsible for all the patient's problems, both symptomatic and characterological.

Conclusion

These two articles have been concerned with the application of Intensive Short-Term Dynamic Psychotherapy in the treatment of patients suffering from chronic depressive disorder. These patients suffer from a deep-seated inability to distinguish between the impulse of anger, on the one hand, and the mechanisms that they use to defend themselves against anger, on the other. If the therapist uses the "standard" technique of unremitting pressure and challenge, intolerable anxiety is aroused, and the end result is a serious exacerbation of the original condition. However, this can be avoided by the use of *graduated pressure and challenge*. The therapist monitors the patient's responses with the utmost vigilance, and immediately reduces the pressure when he senses that the anxiety is approaching an intolerable threshold. After an interlude he can then return to pressure and challenge at an increased level. By repeating this cycle several times he can eventually bring the patient safely to the experience of anger in the transference; and after a further phase of *consolidation*, in which he uses a more interpretative technique to resolve residual resistance, the patient's defensive mechanism is restructured. The therapist can now use the standard technique of unremitting pressure and challenge with safety.

I illustrated this restructuring process in detail in Part I, using the initial interview with a woman suffering from chronic depression. The therapist finally succeeded in bringing her to the point of speaking with raised voice about her wish to grab him by the lapels and throw him on the floor. Thus for a moment her anger passed the repressive barrier; and she was able to experience to the full the difference between this and her previous defensive manoeuvres, which had included emotional withdrawal and banging her hands against the wall, and which hitherto she had mistaken for true anger. Thus her defensive system had been restructured. After some further work on the transference, now concerned with her resistance against positive feelings, the therapist was able to terminate the interview and make another appointment in a week's time.

In this second interview it became clear at once that she was in almost as resistant a state as before, but by now the therapist knew that it would be safe to escalate his challenge until he achieved a breakthrough. Accordingly he began a systematic challenge to a series of defenses that she was using against her impulse and feelings in the transference: detachment, avoiding eye contact, weepiness, helplessness, defiance. Her underlying feeling steadily increased, and this time her impulse consisted of verbal lashing out without any physical attack. Nevertheless it was quite evident that she was truly experiencing her rage, since she described the disappearance of both physiological and psychological manifestations of anxiety: "I stopped sweating," "Clarity up here" (i.e., in her head).

This led back, by contrast, both to the two recent incidents which had precipitated her depression, and to a previous incident long ago in which, in a rage with her brother, she had banged her hands against a tree and had bruised them badly. Once more the therapist drove home the lesson, and she said with insight, "I always thought *that* was the anger." He then concentrated both on the impulse of anger in the

transference and the need to protect him from it, and suddenly her unconscious therapeutic alliance delivered a cricual message: " . . . if it all comes out," "God knows what I'll do." Taking note of this, the therapist pressed her to say what she would be like if she became very violent. It now became clear that the direct experience of her feelings in the transference, both negative and positive, had begun the process of unlocking her unconscious. She became deeply involved in her fantasy world, determined to see it through to the end, and spoke with a mixture of astonishment, calculated violence, and profound grief, of a hitherto entirely unconscious impulse of killing her mother with a machine gun. Relentlessly, and entirely in the patient's interest, the therapist took her first through every detail of her mother's murder, and then through her impulse to do the same to most of the important people in her life, her father, sister and brother, and she had the impulse to murder Tony and her sister Linda, whose final insult to her had been to have sex together in the room next door—the event that had precipitated her most recent depression.

All this had been achieved with hardly any reference to the distant past, so that the therapist had no idea of the reasons for her violent feelings against her mother and all the other members of her family. Now that the breakthrough had occurred it was time to take all this history, which was accomplished without difficulty, and with which this article need not be concerned.

The work in this second interview ran a smooth and relatively rapid course from total resistance, through systematic challenge, to breakthrough; but this was only made possible by the careful and laborious restructuring process that had been carried through in the interview a week before.

Finally it is worth noting the extraordinary precision with which theoretical knowledge and clinical experience can be used to manipulate the forces within another human being in order to achieve a therapeutic result. Thus the therapist knows from previous experience that part of the mechanism underlying the patient's depression is likely to be her defense against intolerable rage; this is confirmed when he learns that her recent attack of depression had followed two episodes of quite deliberate humiliation at the hands of a man; he also knows that a chronically depressed patient of this kind is likely to suffer from a deep-seated inability to distinguish betwen *impulse* and *defense*; this is confirmed in turn by her total inability to describe the experience of anger, and her description of defensive moves such as withdrawal instead; he knows also that part of the mechanism underlying certain kinds of depression consists of self-directed aggression, and this is confirmed when she describes a recurrent pattern of banging her hands against some object to the point of severely bruising them; he knows that the use of unremitting pressure and challenge is dangerous, but that the patient can be brought to the experience of anger if his interventions are carefully graded; he is able to monitor the signs of anxiety in the patient so as to adjust the degree of pressure exactly; he knows that the restructuring of the depressive defense must come from the experience of anger in the *transference*, and this is confirmed when she first describes with raised voice her fantasy of throwing the therapist on the floor, then describes a state of mental clarity in contrast to her confusion in the recent incidents, and then states explicitly that her present experience is quite different "Now I can see the difference between what I have been calling anger and what I felt here"; he knows that resistance will return, but that now it will be safe to use unremitting pressure and challenge, and this is confirmed in the second interview when there is a smooth progression from apparently impenetrable defense, through relentless challenge, to the further clear experience of anger in the transference; and finally he has discovered that when this complex transference feeling reaches its threshold it would trigger off the mechanism of the unlocking of the unconscious and the direct view of the core neurotic structure, which is confirmed by her deeply felt fantasy of the murder of her mother—thus once more unmistakably illustrating one of the mechanisms underlying some kinds of depression, namely the repression of rage that is made intolerably painful by guilt and sorrow.

Yet the view is still widely held that, in psychodynamics, all theories are no more than speculation and scientific proof is inherently impossible.

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