

The Central Dynamic Sequence in the Major Unlocking of the Unconscious and Comprehensive Trial Therapy. Part II. The Course of Trial Therapy after the Initial Breakthrough

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In this Part II of a two-part article the author presents his technique of comprehensive trial therapy. The central dynamic sequence for the major unlocking of the unconscious is described by a complete account of the interview which was used as an example in Part I.

Recapitulation

In Part I of the present article I described the phases of the central dynamic sequence in the major unlocking of the unconscious, which may be summarized as follows:

- Inquiry: exploring the patient's difficulties and the patient's initial ability to respond
- Pressure: leading to resistance
- Clarification and Challenge to Resistance: with particular emphasis to make patient acquainted with the defenses that have paralyzed his functioning and turning the patient against his resistance and emphasized challenge to the resistance against experience of impulse-feelings in the transference and challenge to resistance against emotional closeness in the transference.
- Transference Resistance: with special emphasis on head-on collision with transference resistance; mobilization of the unconscious therapeutic alliance and to maximize the inner tension between the unconscious therapeutic alliance and the resistance.
- Intrapsychic Crisis: breakthrough of the complex transference feelings; the triggering mechanism for unlocking the unconscious.

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- Systematic Analysis of the Transference
- Further Inquiry and Developmental History
- Phase of Direct Access to the Unconscious and Direct View of the Multifoci Core Neurotic Structure

I emphasized that these phases tend to overlap and proceed in a spiral rather than a straight line.

The Case of the "Fragile" Woman

In Part I, I gave an example and analyzed the process of a trial therapy of a 30-year old divorced woman who suffered from a masochistic character pathology, depression, diffuse anxiety which had permeated most aspects of her life, and major disturbances in inter-personal relationships. She entered the interview with a great deal of anxiety. The therapist modified his technique and bypassed the transference resistance for a moment, to determine if she suffered from a fragile ego structure as was diagnosed by the first evaluator. After the therapist had determined that she did not suffer from a fragile ego structure, he moved to putting pressure on the patient to experience her transference feelings, progressively escalating the degree of challenge, and finally bringing about a head-on collision with her transference resistance (Phases 3 and 4). This led to systematic challenge to and pressure on her resistance to experience the impulse in the transference, the link between the impulse of anger and anxiety, challenge to her resistance against emotional closeness in the transference, which finally led to the breakthrough of the aggressive impulse in the transference (Phase 5) and emergence of a deep sadness and the breakthrough of grief-laden unconscious feelings, and in a state of sadness and crying saying that "the disappointment is so deep that I wonder if I can ever love anyone." At this point we resume a detailed account of the rest of the interview.

After the first breakthrough was achieved the therapist embarked on fact gathering.

Inquiry, Alternating with Challenge and Interpretation Directed toward Various Defenses

As I indicated before, the aim is to explore the patient's adult life and her present life orbit. This will give a clear picture of the disturbances that need to be explained, and most importantly will help the therapist in his later exploration of the past.

This phase proceeds in a spiral: it starts with purely factual inquiry, but very quickly the therapist has to deal with the return of resistance in the transference. In fact this is the last occasion on which transference needs to be mentioned until the very end of the interview. The therapist then begins to explore current relationships and finds an opportunity to show her the various mechanisms that she uses in order to avoid anger. He resumes factual inquiry and meets her most important—and most pathological—recent rela-

tionship, and from now on the inquiry becomes completely psychodynamic. This leads into an area which she finds the utmost difficulty in discussing, and he has to carry out a great deal of work on her defense, which involves a second head-on collision. The result is a deep exploration of her fantasy life.

The question-and-answer parts of this phase will be summarized.

TH: Now you said that you got a separation, am I right?

She met her husband while travelling in Mexico and married him at the age of 21. The marriage lasted seven years. She described him as very active physically and mentally, very athletic, intellectual, and musical. Throughout their marriage he was a student, doing his undergraduate degree followed by a master's degree.

TH: What type of person was he besides athletic and intelligent?

PT: He was a demanding type of person.

TH: In what way demanding?

PT: Uhh . . .

As will emerge later, the patient's relation with difficult men is a very sensitive area, and the therapist detects nonverbal signs of mounting resistance which need to be challenged.

Phase (5) Resistance in the Transference

TH: May I ask you, how do you feel when you look at my eyes, because I have a feeling that you don't feel comfortable?

PT: No I don't, I don't know why.

Challenge to the resistance against emotional closeness in the transference.

TH: How do you feel when you look at my eyes?

PT: Uhh, that you're looking through me.

TH: But that doesn't say how you feel, that is a description of me.

PT: Uh, I feel it's too personal. I want to hide from you.

TH: Do you usually have difficulty with eye contact or is it specifically with me?

PT: I don't know.

TH: I am not sure that you don't know. This is a way of avoiding again. You see, we know about the facade and the way you hide, and "I don't know" is another way. "I don't trust you" is another way. These are all mechanisms you use to avoid. If you move to avoidance we are not going to get there, and I hope your decision is that we get there.

PT: Okay.

Return to Inquiry

In answer to the therapist's questions the patient said that her husband demanded both that she should be as physically active as he was and that she should have the same intellectual interests. He wanted her exclusively to himself, to be with him all the time.

The therapist detects the issue of control, which had emerged as a problem in the transference, and he underlines this:

TH: So he was a very controlling person?

PT: Yes.

TH: Something that is always very disturbing to you.

PT: Yes.

The therapist searched for the possibility that she already knew her husband to be controlling before she married him, to which she said that he was the leader and she was something of a follower. The quality that had attracted her was his "versatility," which she admired. It seemed that their relation began to deteriorate a few months after they were married. Her husband had been very inexperienced sexually, but their sexual relation had become more fifty-fifty as he became more confident. In the first two or three years, sex was not too satisfactory and she had experienced orgasm, but she said that he had not been sensual or caressing enough.

The therapist then asked a question which led back into a crucial dynamic issue.

Analysis of Triangle of Conflict in Relation to Her Ex-Husband (C)

TH: Did you look forward to sex or were you forcing yourself to go through it?

PT: Sometimes I looked forward to it and sometimes when there was animosity between us I resented it.

TH: When you say animosity, what was that?

PT: Anger.

TH: What was the anger like?

PT: (She hesitates) . . . I got very excited, I would yell and scream, I would talk very fast.

TH: So your way of expressing anger is screaming, hmm?

PT: That's right.

Just as it is crucial to be able to distinguish between true grief and the defense of "weepiness," it is crucial to distinguish between anger as an Impulse and Anger as a defense, screaming, temper tantrum, etc.

TH: I see. It is like a form of temper tantrum?

PT: Uh, yeah.

TH: So then one of the ways you deal with anger is getting anxiety, hmm? Another way is in the form of a temper tantrum?

PT: Uh hmm, that's right.

Analysis of the Mechanism Responsible for Her Depression

The therapist now seeks to acquaint the patient with the link between anger and depression:

TH: Now the other thing that is very important to look at: have you noticed that when you get angry and then get anxious, you get depressed as well?

PT: Yeah, withdrawn, which I guess is synonymous with depression.

TH: Because one of the mechanisms you use to deal with anger is becoming detached or withdrawn, hmm?

PT: That's right.

TH: Another one is that massive anxiety takes over. Another is that you get depressed, hmm?

PT: Yes.

TH: Because a while ago I was asking, where does the anger go? You know it doesn't evaporate. So one way of dealing with anger is detachment, another way is to become withdrawn, and another is to have a temper tantrum, which is a helpless position. Another way is to get depressed, hmm? Have you had thoughts about that? One of the ways of dealing with anger is getting depressed and weepy?

PT: Weepy?

TH: You know, crying and then depressed.

PT: Oh yes, I do that. I feel helpless when I have anger and I can't express it, so I get very depressed and I cry.

Return to Inquiry: Previous Therapy

The therapist asked how the marriage ended, and the patient mentioned that she was pushing her husband to go with her to a (woman) counselor. Her aim had been to find some way of making him understand what was wrong in their relationship. However, he had refused, and she had gone by herself intermittently for about two years, continuing after the separation, which was about four years ago. They are now divorced. There are no children.

TH: Then any other men in your life?

PT: While we were approaching a separation I felt close to another man. His name was Kirk.

TH: Could you tell me about him? What type of person was Kirk?

At this point the severe pathology in her relation to men begins to emerge and the inquiry becomes entirely psychodynamic.

Psychodynamic Exploration of Adult Life

PT: Uh, he was a very athletic person. Very explosive.

TH: So you gravitate toward athletics mostly, hmm?

PT: Uh hmm, mind you, I hate people in sports. I think they're stupid most of the time.

TH: Paradoxical, hmm?

PT: I don't have such respect for big football players and people who spend their whole lives watching—I don't even watch sports. I abhor them and people have to drag me.

TH: But you marry them, hmm?

PT: There's a difference between being athletic and physically active and being a sports-person.

TH: Okay. What else would you say about Kirk?

PT: Uh, he was the most difficult person I've ever met in my entire life.

TH: In what way?

PT: I felt he deceived me. He extended his friendship and understanding to me, and really he was a very insecure human being. He was three or four years older than me, and when I became more open and told him about the things that had happened between myself and my husband, it all boomeranged back to me. He became abusive verbally and physically.

TH: In what way? Could you give me an incident?

PT: I remember once we were talking about something, and I disagreed with him. He slapped me across the head really hard and my head went banging into a wall. I had a lump on my head afterwards.

TH: You were living together?

PT: Yeah. We lived together for about five months.

TH: How many times did this happen, that he slapped you or physically hit you?

PT: Uh, three distinct times.

TH: So it is the kind of situation that you end up to be abused by him?

PT: Yes, very badly.

TH: Do you remember the incident when he became so violent and your head was bruised?

The patient explained that she identified herself with her husband's politics, with which Kirk violently disagreed.

PT: And he yelled and screamed at me and threw me across the room.

TH: Are you saying that he threw you across the room?

PT: Yeah, and he humiliated me verbally.

TH: He verbally attacked you and physically, and you were on the floor?

PT: Yeah, I was petrified.

The relation with Kirk indicates that a punitive superego is in operation; her need to be used and abused. The therapist now employs a general principle of dialogue with the unconscious, which was contained in his handling of the issue of "trying to get the patient angry"—that is, he goes straight for the simple emotional truth, ignoring the fact that the whole truth is more complicated than this. The patient is describing a state of fear, which is a natural response to an external danger. There is no doubt that this is part of what she felt; but the therapist knows that she is also using this description as a defense against describing her fear of her own violent reaction, which would be experienced not as fear but as anxiety. The objective truth is that she probably experienced a mixture of the two, and it would be easy to get drawn into a sterile intellectual discussion of the exact proportion of each that were present in her state of mind. Instead of this he ignores objective reality and implies that all she felt was anxiety, which is too black and white to be literally true, but which tears aside the defense and confronts her unconscious—which deals largely in black and white—with the psychodynamics of the inner situation. This leads at once into her fear of her own impulses, and very shortly into a central aspect of her psychopathology:

TH: Petrified. You mean a great deal of anxiety? And what else did you feel, because it is a situation where Kirk in a very brutal way is abusing you. But then you are on the floor and have a massive amount of anxiety, but what else did you feel toward him?

PT: Immense hatred.

The word "hatred" does not imply any impulse.

Challenge and Pressure to the Resistance against Experience of Impulse Outside of the Transference

TH: But what else?

PT: Immense anger.

TH: How did you experience that immense anger?

PT: Oh, I felt paralyzed.

TH: So, you see, you have a lot of anger and rage toward him but what comes to the surface is being paralyzed, hmm?

PT: Well, I was defenseless. If I raged against him my life would be in danger.

TH: That intellectually is one thing, but again there is massive rage, and a great deal of anxiety to the level that you are helplessly paralyzed.

The therapist recognizes an all too familiar pattern which seemingly is more often encountered in women than in men: the patient is terrified of her own violent impulses and full of guilt about them, and therefore needs both to defend herself against them and to punish herself for them. She can combine the two by turning them against herself and becoming the "professional victim," seeking out men who will use and abuse her. (Clinical manifestation of superego pathology by the author (Davanloo, 1987c, d). The therapist prepares the way for bringing this mechanism into the open:

TH: You are the victim, hmm? (She is the victim to her punitive superego.)

PT: I did react once when I was outdoors and he started getting abusive and I screamed at the top of my lungs.

A less experienced therapist might be forgiven for thinking that this was the full expression of her rage, but here the therapist recognizes the crucial fact that it was a regressive defense, a helpless ego in relation to a highly punitive superego.

TH: What happened to your rage with Kirk? What happened to that rage?

PT: Oh, it was sublimated.

TH: Yeah, but sublimation means what? It is very important this, you see.

The true extent of her rage now emerges:

PT: Well it . . . it . . . what happened . . . it manifested itself in very mean devious thoughts of hurting men.

TH: You mean in fantasy you wanted to get at him? What was the fantasy?

PT: I wanted to see him dead. I wanted to see him killed.

TH: In what way did you want him dead? Was it in the form of murder?

PT: Beaten.

TH: By who?

PT: By somebody that I hired to kill him.

TH: In what way would that somebody kill him?

PT: To verbally and physically brutalize him.

TH: But in what way? With a knife? What equipment would be used?

PT: Bashing his head. I don't know . . . to tell you the truth, I don't remember.

TH: I'm not sure you don't remember. These are the things you wipe out. Because the idea is that you hire a person to brutally murder him, and then obviously who is that someone who is going to brutally murder him?

PT: I don't know.

TH: It is you! (The patient laughs.) The impulse is within you. But you prefer somebody else to commit the murder rather than yourself.

PT: That's right.

The therapist now interprets the mechanism of turning her aggression against herself:

TH: So the rage with Kirk has the quality of murdering him, but then who gets murdered really? Who is crippled?

PT: Me.

TH: You are crippled.

PT: Uh hmm.

Distributional Pathway

There is further analysis of triangle of conflict; the therapist summarizes mechanisms for avoiding anger and continues the process of driving home insight into her manifold defenses against the impulse.

TH: So then what is the pathway of this massive rage? It is multiple now. One pathway is massive anxiety, or you take it out on your G.I. tract. You develop gas and diarrhea. And another way is turning these massive murderous impulses against yourself in the form of depression. And I think it is very important that you keep your eye on the way you deal with these impulses. One way is to be detached and withdrawn, another way is to be crippled with anxiety, another way your poor G.I. tract has to suffer. Another way is that you become depressed, and sometimes you have the idea that you wish you were dead. Then it is very clear that the rage doesn't evaporate, hmm?

PT: No.

TH: This is how you deal with the rage.

Further Exploration Leads To a Crucial Issue

TH: Now you left him or he left you?

PT: I left him.

TH: How was the sexual aspect of your relationship?

PT: It was very intense.

TH: You mean it was better than with your husband?

PT: Yeah, in some ways it was better. He was very seductive.

TH: But, you know, there is something there. You might want to look at it. Kirk is brutal and aggressive and sexually you respond better, while your husband is not outwardly sadistic or aggressive.

PT: Oh, he was to some degree.

TH: You mean physically also? Like Kirk, you mean . . . ?

PT: When he got really angry, he wasn't—I never met anybody like Kirk—but he would lash out at me sometimes physically, push me—but I wasn't afraid of his anger. Well in the moment I was but not as a rule.

TH: Have you ever had thoughts that in situations where there is brutal and aggressive behavior toward you, like with Kirk, that you would have more pleasure sexually?

Major Increase in the Unconscious Therapeutic Alliance

At this point the work on the defenses is shown to be paying dividends, for the patient comes out with a revelation that lies at the heart of her pathology:

PT: Yeah, there is problem sexually, because I notice that my sexual fantasies were always of me being brutalized, and that's how I was excited.

This information would not have been reached by direct questioning, without all the work on her defenses. The information emerged spontaneously in a highly dynamic fashion, in the context of the description of her relations with men and interpretations about self-directed aggression. This marked a major increase in the unconscious therapeutic alliance, but it cannot yet be described as the beginning of the phase of major direct access to the unconscious, because—as will be seen—superego resistance is very far from being at an end.

TH: In sexual fantasies you are always being brutalized? You mean sex and aggression are mixed together?

PT: Yes.

TH: Could we look to one of the fantasies?

PT: Uh, being raped, in a way.

TH: Could you describe the situation?

PT: Uh, being held down, being . . .

TH: Could you give a specific fantasy?

PT: That's too hard.

Phase (5) Head-On Collision with Transference Resistance

It is absolutely essential to handle this resistance, and the therapist brings in a second head-on collision:

TH: Again I'm passing the barrier, hmm? (The patient sighs.) Because again we are getting to the intimate thoughts, hmm? And now as soon as we want to get to your intimate thoughts, then you want to put again the barrier, and I have told you that as long as this barrier is put up this process is going to be crippled.

PT: Uh hmm.

TH: Now do you want it crippled or do you want that we . . . ? It is your choice.

PT: I'll try.

This is not enough, and the therapist redoubles his challenge on her defenses. "The resistance must be not merely knocked out but counted out."

TH: Let's face it, if we don't pass the barrier and get to your intimate thoughts and fantasies—we have to come a long way and understand many things much better, okay?—but if we don't pass this barrier and get to the very important issues which are the sources of your suffering, then this process will fail, okay?

PT: Uh hmm.

TH: You fail, the process fails, and you go on perpetuating your suffer-

ing. Now let's face it. I can walk out when we say good-bye to each other, and accept that I failed. I can afford to be a failure—what can I do? I can do my best and say, okay I failed, what can I do further? But can you afford to be a failure? You are young and intelligent and have potentiality, which are all crippled. So as long as you put up this barrier the process is doomed to fail, but you are going on to suffer. Now let's see what is your specific sexual fantasy.

The Patient's Sexual Fantasies

The following passage needs considerable discussion. In it the therapist relentlessly extracts from the patient every intimate detail of a number of highly embarrassing sexual fantasies. The therapist's reasons for doing this are twofold: First, only if such details are known will it be possible to understand her psychopathology in depth; and second, this process provides an exercise in self-revelation which will have a "desensitizing" effect and will facilitate the later exploration of other difficult and painful areas.

However, the therapist must exert the utmost care. The common theme running through the patient's sexual fantasies is getting sexual pleasure from being humiliated—does not the very act of making her tell her fantasies collude with this need in the actual therapeutic situation? At first sight it would seem that this is inevitable, but in fact it is not so, provided two essential conditions are fulfilled: The first is that, as mentioned before, the therapist must be comfortable with his own unconscious impulses and must make clear by his attitude and manner and his unconscious communication that his relentlessness contains no trace of sadism and is entirely in the interests of helping the patient. The second is that the transference—especially the anger—must have already been thoroughly brought into the open and experienced, and thus resolved. Since the patient's masochism is a way of dealing with her anger, there is now no need for a masochistic relation with the therapist; and in fact the therapeutic alliance is powerful enough to respond to the reality of the therapist's efforts to help, and to override completely the transference fantasy that might otherwise develop.

Now we return to the interview.

TH: Okay, the one that you used to have, what was that?

PT: Being captured by a gang of people, men and women, and abducted.

TH: Where are you captured by these people?

PT: I'm in a city. I'm abducted by a group of people, brought blindfolded. I'm brought to a basement or a dark place, and both men and women have sex with me and force me to have sex with them.

TH: You mean your eyes are closed but . . . ?

PT: Well maybe when I'm there my eyes are not closed.

TH: How do they look? They are recognizable people?

PT: Uh hmm.

TH: What type of men and women are they?

PT: Young, my age.
 TH: What color?
 PT: White.
 TH: How many are they?
 PT: Six, seven.
 TH: And then all of them are having sex with you?
 PT: Not all, maybe two or three, and the others are watching.
 TH: But they are forcing you against your will?
 PT: Uh hmm.
 TH: How do they do that?
 PT: I guess they threaten my life.
 TH: The ones that have sex with you, are they men or women?
 PT: Both.
 TH: And the ones who are watching?
 PT: Both.
 TH: In what way are the men making love to you?
 PT: Uh, forcing me to perform fellatio, having intercourse, having anal sex.
 TH: So first they demand you suck their penis, and then they have intercourse, and then they force you to anal intercourse. How about the women? How do they make love to you?
 PT: I have to perform cunnilingus.
 TH: Oh, there you have to suck their genitals and oral sex. And the other ones watch. They don't touch you, you mean?
 PT: No.
 TH: And then what happens?
 PT: It ends. Uh . . . uh . . . I'm left feeling brutalized. I never imagine the ending, or maybe I don't remember. I don't know.
 TH: After anal intercourse it stops, or there is something else?
 PT: I relive the fantasy many times until I feel, I guess, either somewhat disgusted with myself, or physically satisfied in some way.
 TH: You lie down in bed when you have this fantasy?
 PT: Yeah.
 TH: And what do you do while you have this fantasy?
 PT: Uh, I don't remember.
 TH: I mean, you're masturbating, or . . . ?
 PT: I think I'm touching myself.
 TH: You see, again you are censoring yourself: "I think I'm touching myself."

Her vagueness having been challenged, she tries generalization:

PT: Well, because each type of fantasy is different.
 TH: We are talking about one of them.
 PT: Well . . .
 TH: Do you masturbate when you have this fantasy?
 PT: Masturbate? Yes, I touch myself. Whether I'm actually masturbating to bring myself to a certain sexual peak, no, I have not. With that fantasy, no.

TH: Not with that fantasy?
 PT: No.
 TH: What part of your body do you touch?
 PT: I touch my genitals but I just touch them. It's like I'm holding onto myself.
 TH: And this brings pleasure to you?
 PT: Uh, yes.
 TH: Does it lead to orgasm?
 PT: It leads to intense sexual excitement but not to orgasm.
 TH: The sequence is oral sex, then vaginal, and then rectal?
 PT: Uh, yeah.
 TH: I see. Now you said you have another fantasy. This fantasy you don't have any more. Up to what age did you have it?
 PT: Up until two or three years ago maybe.
 TH: But then you have another fantasy that comes with masturbation? What is that like?
 PT: That I'm uh, performing on a stage for a group of people.
 TH: In what way are you performing?
 PT: I have to bring myself to orgasm and that's my only goal.
 TH: I know, but could you describe the stage?
 PT: Uh, I'm in some kind of sex bar or place where people perform sexual acts, and it's a performance.
 TH: And you're nude, you mean?
 PT: I'm nude or at least my genitals are showing in some way.
 TH: And then what else?
 PT: Uh, there are people watching. They are in an audience, it's like a bar and they're drinking and watching.
 TH: And what are you doing on stage?
 PT: To . . . masturbate myself. To touch my clitoris until I orgasm.
 TH: You have this fantasy at the present time?
 PT: Sometimes, yes.
 TH: But there is no violence toward you in this fantasy, am I right?
 PT: Yes.
 TH: In the first one . . .
 PT: There is violence.
 TH: How far back in time does the first fantasy go?
 PT: It started at about 13. I feel like, I told you . . . but there are others. I feel embarrassed a little bit, I guess.
 TH: Uh hmm. But obviously these are very important things, because in some of them you are being tremendously abused. Hmm? And if you look to your relationship with men, there is a tremendous amount of you being used and abused.
 PT: Uh hmm.
 TH: But you said there is another type of fantasy, and I have a feeling that there is some censorship with me. You don't want to tell me some of the other ones.
 PT: Uh hmm.
 TH: What is the nature of the other ones?
 PT: Hmm, involving animals.

TH: What animals?

PT: Ah, dogs.

TH: What is that fantasy?

PT: Having sex with the dog. Being forced to.

TH: Who are the people who are forcing you?

PT: Same people.

TH: What type of dog is it?

PT: Ah, a German Shepherd, I don't know, black dog, big dog.

TH: Uh hmm. And then in what way is the dog having sex with you? Because we know they would have oral, then vaginal, then anal, but how about the dog?

PT: Vaginal.

TH: Uh hmm. So, this dog is having sex with his penis, hmm? And this would bring you excitement?

PT: Yes, but not orgasm.

The therapist now needs to find out whether these fantasies are so powerful as to override her sexual response to an actual man:

TH: Did you have this kind of fantasy during the sexual relationship with Kirk, for example, or with your husband?

PT: No.

TH: Where was your mind when you had sex with your husband?

PT: Ah, wait a minute now, sometimes with my husband I felt it was more the performance type of fantasy, somewhat forced performance though. Because we were very sexually active, we danced for each other and umm, we created fantasies of seducing each other, imagining that we didn't know each other. And my husband, umm, ah, liked to force me sometimes to do certain things.

TH: Sort of pretending he is forcing you to have sex with him?

PT: No, actually the fantasies that we had together were not so brutal. They were more pleasurable and fun, and childlike in a way.

TH: I know, but a mild type of forcing you to have sex, as if you didn't want it but you did want it?

PT: Yeah.

TH: How about with Kirk? Was there the force element in it?

PT: Yes, yes, yes there was force.

TH: What we can see is this, that when you are forced into it, it is more intense.

PT: More exciting. Ah, with him there was a force element. He . . . he was physically very aggressive.

Here enquiry revealed that the main preference on both their parts was for straightforward sexual intercourse.

Relations with Other Men

In answer to further enquiry, it emerged that she had had two men friends since she broke up with Kirk. She described the first, John, as "a

very nice man, very gentle," but the relation only lasted for six months because they came from different religious backgrounds—a fact which she knew when she first started dating him. Soon after this she met a man called Charles, who came to live with her. This relation lasted for two years, up to four months ago. She described Charles as "very gentle and accepting," and she said she really loved him. He would listen to her and comfort her when she was upset, but he kept her at a distance emotionally and never let her into his world. She said that after about a year she had become very unhappy because their sex life was "very dispassionate."

The therapist summed up:

TH: So you see—it is very important that you look at this process—that all your relationships with men have turned out to be a severe disappointment, one way or another. In some of them you have been the target of being used and abused. In others you get emotionally attached, but then for whatever reason he cannot move toward you. So all your relationships with men end up in failure or disaster.

PT: Uh hmm. It's caused me a lot of pain.

Further Inquiry

Previous Therapy (In Addition to Marriage Counselling)

She went to a woman therapist for about seven months last year. She said they never touched on her problems in relation to men. "Overall it was rather boring. She wasn't good enough to get through the facades. I guess I never let her through."

Direct View of the Multifoci Core Neurotic Structure

The therapist has completed his survey of the patient's recent life and has exposed a very severe sado-masochistic character disorder. The time has now come to try and find out how this originated.

He opens with purely factual questions, but as soon as he begins to ask about relations within the family the enquiry inevitably develops more and more of a dynamic quality. As eventually becomes clear, all the previous work—the challenge to the resistance, the open emergence of anger in the transference, the head-on collision with the resistance against allowing emotional closeness, the emergence of deep sadness, the analysis of the transference, and the "desensitization" provided by refusing to allow her to gloss over her sexual fantasies—has led directly to Phase (7) of the central dynamic sequence, namely the phase of direct access to the unconscious. Now resistance is only minor and is easily penetrated, and there is no need to mention the transference again until the closing passages of the interview.

Family Background

The family on both sides is of Greek extraction, but both parents were

born and brought up in Philadelphia. The patient is 32 and has two younger sisters, one 28 and the other 24.

The Patient's Father

She said that her father was a very loving, emotionally expressive man, and that she got on well with him "until adolescence." The therapist noted this but did not ask for details.

The Mother

As soon as the therapist opened up the subject of the patient's mother, the enquiry rapidly became much more than purely factual:

TH: And then how do you remember your mother as a child?

PT: Very nervous.

TH: In what way was she the nervous type?

PT: Always yelling and screaming. Very loving and affectionate, but very abusive.

TH: Uh hmm. In what way was she abusive?

PT: Verbally and physically?

TH: Abusive of whom.

PT: Of me.

It emerged that she was probably most abusive with the middle sister, and least abusive with the youngest, whom she spoiled more. As far as being affectionate was concerned, the patient spoke of her mother as follows:

PT: She would always feel guilty after she was abusive and tell us that she loved us; and she would always try to blackmail us—not blackmail, but bribe our love back by buying us gifts or taking us to a store and buying us something that we liked.

Further enquiry established that in addition to being abusive she had also been physically affectionate, but that this was true only when the children were small. It changed after they reached the ages of eight to ten.

Thus it seems that the patient lost the love of both her parents, which must be linked with her statement, "the disappointment is so deep." Moreover, it seems probable that her pattern of taking up with men who abuse her must be linked in some way with her relation with her mother.

At this point the therapist proceeds to explore genetically structured conflict.

TH: What is your earliest memory of life? As far back as you can go, anything that stands out in your memory.

PT: Ah, the first time my mother hit me, I remember.

TH: Uh hmm.

PT: I also remember . . .

The therapist blocks this attempted diversion:

TH: What is that memory that your mother hit you?

PT: I was living in the house that I came home to after I was born. So I must have been less than three years old. When I was three we moved, and my mother was already having another child. She was washing or dressing me and she smacked me on my rear end for fooling around.

The therapist remembers both the teacher and the sexual fantasies:

TH: You mean there was an element of humiliation?

PT: I was shocked. I remember being shocked.

TH: Was this pleasant or unpleasant?

(Was there an element of masochism already present?)

PT: Very unpleasant.

TH: So your first memory relates to your mother smacking you on your rear end, hmm? Was she like that later?

PT: As the others came along she became more abusive, but not too much to me.

It is worth noting how easily this denial is penetrated. We are now entering the phase of direct access to the unconscious.

TH: Could you describe incidents that your mother was abusive? Because "abusive" doesn't tell us much.

PT: Ah, she would curse and say things like, she should have had her head examined when we were born, ah, she would take her shoe and whack me from behind ah . . .

TH: Was it mostly on your rear end . . . ?

PT: On my arms, with shoes.

TH: What else did she use to punish you? She was physically violent?

PT: Very physical. She'd chase after me with a belt. I, I, remember this in my later years. But I was always bigger than her, she's only five foot four and I grew tall very fast.

TH: It doesn't make a difference, there was physical punishment.

PT: Yeah, but I could escape though, because I could run faster.

TH: But you mean you managed to stay and get beaten by her?

(The therapist is still searching for early masochistic tendencies.)

PT: It was a surprise attack, I wouldn't stay there and allow myself to be hit by her. I would run, or sometimes I'd block her with my arm.

TH: You mean you would fight back?

PT: No, I didn't fight back, I would block her when I saw her arm or hand coming.

TH: What else did she use besides her shoe?

PT: A, a belt, a strap, she would grab my father's belt and chase me.
TH: Where would she hit you most?

PT: Anywhere, she just aimed, aimlessly. I remember one incident when she actually hit me with the buckle on my head and I started bleeding.

TH: Uh hmm. That bad!

The therapist is noting a link between the way she was attacked by her mother on her head and the way she was pushed by her boyfriend Kirk against the wall and she had a bump on the top of her head.

PT: But she started crying . . .

TH: And this violent behavior carried on until what age?

PT: Oh, 14 or so. She became less physically violent as I got older and more verbally abusive.

TH: Uh hmm. What was her verbal abuse like?

PT: She called me a whore, a tramp, a bitch, anything that was derogatory toward women.

TH: She would call you a whore.

(The therapist is noting a further link with her sexual fantasies.)

PT: Uh hmm. She would spit at me sometimes when she was really mad, spit in my face.

TH: So then you had a very disastrous relationship with your mother, didn't you?

PT: Uh hmm.

Another Very Important Relationship

Many patients who have had a disastrous relationship with their own parents have managed to turn for warmth to someone else, either a neighboring family, or some other relative—who may also be a member of the household. These substitute parents and families are of central importance, mitigating the traumatic nature of the early experiences—but in many cases something has gone wrong even with them, which intensifies the tragedy and solidifies and perpetuates the pathological patterns of relationships throughout the patient's subsequent life.

TH: Was there any other person in your life besides your mother and your father?

PT: My grandmother, my father's mother, lived with us.

TH: Uh hmm. How old was she when you were a little girl?

PT: She must have been in her late fifties, early sixties.

TH: Uh hmm. What type of woman was she?

PT: Ah, a little, sort of very loving, ah, little old peasant woman, very superstitious.

TH: She was born in Philadelphia or in Greece?

PT: Greece. She was quite sick.

TH: How do you remember her? Because, you see, you have a disastrous relationship with your mother, belted, the shoes . . .

Having previously reached the anger and the deep sadness, we now reach the pain: Patient is very sad, is choked up with waves of painful feeling, sobbing.

PT: Uh hmm. I remember her as my friend. (The patient is choked up, emotionally charged.)

TH: You had a close relationship with her?

PT: As close as a child can have, I think.

TH: Was she a loving woman?

PT: Yeah. (She is crying.) She always protected us. She'd scream at my mother.

TH: Was it effective, her protection of you?

PT: Sometimes, yeah.

TH: Uh hmm. So then you must have developed a much closer relationship with your grandmother, am I right?

PT: Yeah. But she didn't speak English that well, so it was very limited.

TH: But still, demonstration of affection doesn't have to be verbal, but there was a feeling of closeness, that she was interested in you. She was a loving woman?

She is crying, with the wave of emotional distress.

TH: Must be very painful, isn't it? . . . What happened to her?

PT: Oh, terrible things. terrible things. My father finally saved up enough money to take my mother and I, and my grandmother, to Greece to see her family, whom she had never seen since she left.

TH: And what happened?

PT: She, she broke her hip.

TH: Uh hmm. How old were you then?

PT: Oh, 16 I guess. She slipped on a step in the family room. She broke her hip and she had to walk around on a walker, and we couldn't go on the trip and she became so incapacitated and ah . . .

TH: Uh hmm. So then, what happened finally?

PT: Well, she became very difficult to live with because, ah, she needed constant care; she needed someone to give her a bath, put her in and take her out . . .

The therapist prepares to make a link:

TH: So she became really a "crippled" woman.

PT: Yeah, yeah.

TH: Uh hmm. So your grandmother was so loving and affectionate towards you, in this disastrous situation, then she breaks her hip and becomes crippled, so that somebody has to take care of her, hmm?

The patient is choked, cries, has waves of somatic distress, sighing respiration, indications of an active mourning process.

TH: Uh hmm. And what happened to her finally?

PT: She wound up in a nursing home in Philadelphia because no one could take care of her.

Unresolved Mourning for Grandmother

In trial therapy, after unlocking the unconscious and direct access to the unconscious the pathological mourning becomes transformed into acute grief reaction no matter that the loss may have occurred many, many years before. Here the task of the therapist is to set this process in motion in the initial interview. The following passage illustrates the technique of working through unresolved mourning. The process consists of detailed reconstruction of the events surrounding the grandmother's death.

TH: Do you remember her in the nursing home?

PT: Oh yeah.

TH: What do you remember?

PT: Ah, she was very sad. She was getting senile, she couldn't remember things that well. She was very unhappy. She was very confused.

TH: And what happened to her relationship with you? Because at one time she was . . .

PT: It, it, it deteriorated when she was in the nursing home because I didn't visit her that much. I was leaving home, ah, I had my own problems, I was too distracted to really pay attention to her.

TH: Yeah, but it is very important to look at it. We know already that you have a strong tendency to avoid painful issues, you see. Now, if you look to this early part of your life, you have a disastrous relationship with your mother, and then this woman with the difficulty with the language, really it is an intense relationship you have with her, hmm?

PT: Yeah. (She is crying.)

TH: As if she was your mother, hmm? But then she becomes crippled, and now she is alone, hmm? And maybe a part of you wished that you could visit her, but the part of you that didn't want to face the pain avoided it.

PT: Yeah.

TH: Do you remember, when did she die?

PT: Ah, when I was 18.

TH: She died in the nursing home?

PT: In the hospital. I think she got a bleeding ulcer and it could have been cancer.

TH: Uh hmm. Do you remember what hospital she was in?

PT: Yeah. I was, I was there when she was dying.

TH: You were at her bedside?

PT: Yeah.

TH: How did she look then?

PT: She was moaning, ah, constantly, ah with pain, moaning these repetitive moans, like a crescendo of pain, and I held her hand and told her it would be okay, and I, I gave the . . .

TH: You held her.

PT: . . . I was holding her hand and I gave her water because she couldn't sit up. She was in agony.

TH: Uh hmm.

PT: And I just, I couldn't do anything.

TH: Uh hmm. How did you feel toward her? Because at one time she was your major support. Now she's crippled.

PT: I felt, ah, ah, I felt, I couldn't feel anything. I just knew that I loved her but I couldn't really feel anything.

TH: You put up the wall.

PT: I, I, I could see her dying and I was holding her and I knew she was dying, but I couldn't feel anything. I stopped myself.

TH: So she died in a very lonely way, hmm?

PT: Yeah.

TH: Do you remember the funeral?

PT: Yeah.

TH: What do you remember?

PT: Ah, my cousins and I, with my sisters, we all sat around and we talked about all our memories of her. We called her Yia-yia, from a Greek word for grandmother.

TH: But in a sense she was your . . . like your . . . mother.

PT: Yeah. And we talked about her, we cried. I cried a lot, but I think I was crying . . .

TH: Where is she buried?

PT: Near Philadelphia somewhere.

TH: Uh hmm. You mean you don't know where she is buried?

PT: I never went, I never go back to her grave.

TH: Uh hmm. Do you remember the burial?

PT: Vaguely, vaguely.

TH: You were 18 years old!

PT: Yeah.

TH: And this woman meant a lot to you obviously, hmm? So how come you don't remember?

PT: I guess I don't want to remember.

TH: I know.

The technique of a piecemeal review with the patient about the last part of her life with the deceased was originally described by Eric Lindemann. She is highly charged, crying; and as we see the process of mourning is both a cognitive and an affective process.

TH: You must have a lot of feeling about this woman who died both crippled and lonely.

PT: Yes. Yes. I can somehow see myself standing in a cemetery, but it's so vague, it's so blurry.

TH: Uh hmm.

PT: Ah, there's a lot of pain. I left soon afterwards.

TH: Did you at any time wish that you could visit her grave?

PT: Yeah.

TH: And did you? Avoidance?

PT: I didn't live in Philadelphia anymore.

TH: I know, but we know a part of you—look to the waves of pain, hmm?

PT: Yeah.

TH: So you have a lot of mixed feelings about this woman who dies crippled and lonely, hmm? And then obviously a lot of it was so painful that you avoided it, isn't that so?

PT: That's right.

Direct Interpretation of the Core Pathology

(1) Identification with the Crippled Grandmother

The patient's unconscious therapeutic alliance now responds to the therapist's repeated use of the word "crippled," enabling him to make a link which marks the beginning of interpreting the core pathology.

PT: I notice that you're using the word crippled again.

TH: I use the word crippled because she was crippled. She had a fracture, she was crippled, wasn't she.

PT: Well, she could walk with a walker, but she was handicapped. Yes, she was crippled.

TH: But don't you think that she died crippled and lonely and you are leading your life . . .

PT: Yeah.

TH: . . . as a crippled, lonely life also? Hmm?

PT: Yeah.

(2) Death Wishes toward the Mother

The therapist now opens up a much deeper source of intense guilt, self-punishment, use and abuse of herself, which are some of the manifestations of a punitive superego pathology.

TH: Now what do you think would have happened if your mother in the early years—this disastrous relationship that she is abusing you, chasing you with a belt and so forth—had died, dropped dead, what do you think would have happened to your life?

PT: I think I would probably have been raised by my grandmother.

TH: What would your life have been like if she had died?

PT: It would have been calmer, a lot calmer. Peaceful.

TH: Do you think maybe a part of you at some point wanted her dead?

PT: Oh yeah. Yes.

TH: If she had died you would have had a different situation? You say so because I said that or . . . ?

PT: No, because it's true. My father was more calm, even though he had problems. He was very strict. But her abusive yelling and screaming were unbearable.

Throughout this passage the patient is emotionally charged and crying.

(3) Mixed Feelings toward the Father

TH: Your father in the face of this brutal relationship of your mother and you, what was his reaction?

PT: He asked me to understand my mother.

TH: So in a sense he would prescribe tolerance of abuse, hmm?

PT: Yeah, and he would talk to her sometimes, and she would calm down for a little while.

TH: So you must have a lot of feeling because, from what you describe, you have a lot of positive feeling for your father. You are caught in the situation that your mother is brutal and aggressive, then obviously you move towards a tremendously close relationship with your father.

PT: Yeah, yeah.

TH: But then at the same time you must have other kinds of feeling, because he is prescribing tolerance of abuse. So do you think that you also have some other mixed feelings towards your father for not standing up, hmm?

PT: Yes, anger at him for not putting my mother in her place.

TH: So at one level you had an intense close relationship with your father, but at another level it was negative because he is prescribing that you have to be tolerant of abuse, hmm?

PT: Yeah. So I distanced myself from him, I lost respect for him.

TH: Uh hmm. You mean that you started to punish him, hmm?

PT: Yes.

(4) Oedipal Feelings

TH: But it is very important to look at that also. You start to punish your father when you are becoming a woman, hmm? Have you had thoughts about that? You see, at age 13 or 14 your body is growing and you are becoming a woman, and then you start to punish your father, hmm? Distance yourself, hmm?

PT: Yeah, I . . .

TH: Maybe that was another way of defending against certain other feelings for your father, that now that you are becoming a woman, you start to distance, and in a sense you are punishing him, but at the same time you have a tremendous close relationship with him, hmm?

PT: Uh hmm.

TH: So the question is this. Why do you start to punish him when you are becoming a woman?

PT: I didn't trust him to understand.

TH: What was the relationship between your father and mother like?

PT: Well, they were very affectionate with each other.

TH: She wasn't brutal with your father?

PT: Sometimes. But she behaved herself in front of my father.

TH: Uh hmm. What was the sexual life of your mother like?

Exploring Her Parents' Relationship

PT: Ah, my father seemed to display physical affection to my mother in front of us, touching her rear, ah, grabbing her, holding her; not often, but enough to make me realize that they had some kind of physical contact behind closed doors.

TH: Uh hmm. You mean your father was sexually active?

PT: Sexually active . . . phew . . .

TH: Where does the idea come from that he was sexually active?

PT: Ah, there were condoms in his drawer.

TH: Uh hmm. So that was the indication that your father had an active sex life, hmm?

PT: Uh hmm.

TH: And how did you know that the condom was in the drawer?

PT: I looked.

TH: You mean you were curious about the . . .

PT: That's right. I was very curious about sex.

TH: You say you were curious about sex, but obviously you were curious about his sexual life, hmm?

PT: Yeah.

Link between the Past and the Current

It is now essential to try to clarify the way in which her current disturbances originated in the past.

(5) Brutal Mother Patient's Need to be Brutalized by Kirk

TH: Now—we haven't had a chance to go over your relationship with your sisters—and as we are running out of time, we want to look to what we have observed. You see, if you look at it, and it is very important that we examine these things, you had this very disturbed relationship with your mother, you see?

PT: Uh hmm.

TH: And now you end up to be treated in the brutal way by men, at least with two of them, hmm?

PT: Uh hmm.

TH: If you look at it, with Kirk, it is as if you repeated your relationship with your mother, and the question is whether you have a tendency to gravitate toward men like your mother in some sense?

PT: Yeah.

TH: That they are either brutal, or nonaffectionate and cold, hmm?

PT: (She takes a deep breath) But I think Charles is more like my father.

TH: I am not saying that all is black and white, but if you look at it your relationship with men has a certain pattern. Either they are brutal like your mother, or they have difficulty with emotional closeness and affection, like Charles for example. Now, if you look to your sexual fantasies; in all of them, in a devious way, you are pushed into being brutally treated, being forced to have oral sex, anal sex—there is the element of aggression toward you, the element of use and abuse of your body.

PT: Uh hmm.

TH: And strikingly there is a mixture of men and women who are using your body and abusing it, okay?

PT: Uh hmm.

TH: And then another thing is that your mother repeatedly calls you a whore, hmm? And in your fantasy isn't there that as well?

PT: Uh hmm.

TH: So the question is this, if you hated your mother so much, why is there a need to gravitate towards a situation in which either you are used and abused, or there is element of prostitution in it? Do you see, your fantasy is an active production by your own self? Something that comes from your mother, hmm?

PT: Uh hmm.

(6) Major Conflict over Intimacy and Closeness

TH: But then if you recall, I told you that you are terrified of closeness and intimacy, and I was raising the question of what has happened to you in life that you have decided not to let anybody close to you?

PT: Uh hmm.

TH: Because if you look to your relationship with your mother, your father, even your grandmother, all of them are full of pain and disaster. The one that you had a very close relationship with ends up to have a fracture, becomes crippled and then dies in a very lonely way, hmm? So there is something about all these relationships—and we haven't touched your sisters—all these are playing in a very devious way into the core of your problem, hmm?

PT: Yeah.

(7) Murderous, Sadistic Impulses and Self-Punishment; Further Link between Mother and Current Relationships with Men

TH: Now, as far as relations with men are concerned, you end up wishing you could murder Kirk. In terms of the fantasy that you hire somebody to blast him to the level that his brain is out. Now, who do you really want to murder?

PT: My mother.

TH: So Kirk was the representation, hmm?

PT: Yeah.

(8) Brutality and Better Sexual Response

TH: But then another thing is that when there is brutality in the system then you respond better sexually because there is an element of punishment, hmm?

PT: Yeah.

(9) Need to Prolong and Perpetuate Suffering:

Masochism and Superego Pathology

TH: But then, on the other side of the picture, these things have been going on until the age of 32 and somehow you have never wanted to do something about it. Maybe a part of you wants to carry on the crippled life and die like your grandmother. Hmm?

PT: Yeah, maybe.

TH: Because why is it that an intelligent person like you postpones and postpones and postpones up to this time, hmm? Obviously we have been only touching the surface of these problems, and the core problem is not as simple as that, it is much more complicated. But we touched on some aspect of it, hmm?

PT: Yeah.

TH: Have you ever had thoughts that when you have the impulse to blow up the head of Kirk, it was your mother?

PT: (She sighs) Yeah.

TH: That had entered your mind?

PT: Yeah.

TH: Have you had thoughts that there is some feature of men that is like your mother and some feature that is like your father?

PT: Oh yes. I see those patterns sometimes. I see those characteristics manifest themselves in people.

Bringing the Interview to a Close

Exploring the patient's unconscious therapeutic alliance, setting up psychotherapeutic contact:

TH: But the question at this moment is, do you want to do something

about it? Or do you want to carry the . . . ? I know you don't like the word crippled, but let's face it, it is a crippled life.

PT: Ah, I wouldn't be here if I didn't want to do something about it.

TH: Because, you see, you said in the beginning that you don't want us to focus on painful issues. but obviously the major work requires a lot of painful issues.

PT: I know.

TH: Now the question I want to raise is this: Today we have sort of rapidly gone to the tip of the iceberg, the surface of all these issues. Do you think that if you do this in a more systematic way with a therapist, it would be of help to you? Is this something you want to do?

PT: Yes, I do.

TH: And obviously it requires a lot of hard work and a lot of pain.

PT: I'm very willing to put the energy, I want to do it, I'm desperate to do it, to learn . . .

TH: Because really, if you look at it, you are not a free woman. All your potentiality is crippled. Under very difficult circumstances I can see you have made a major achievement in other areas, but then a major part of you is crippled.

PT: Yeah.

TH: But obviously avoidance wouldn't do it.

PT: Yeah.

Handling Residual Transference Feelings

In conducting a trial therapy as such, which is a single interview and took just over three hours, it is extremely important before closing the interview to bring into the open any residual transference feelings. This applies to both negative and positive transference feelings.

TH: How do you feel now?

PT: Very choked up with emotions. My head hurts.

TH: How do you feel toward me now? Because we have to say good-bye.

PT: (She takes a deep sigh) Ah . . .

TH: You took a deep sigh when I say, how do you feel?

PT: Somewhat angry for, for, for ah, umm, for focusing on my pain. Even though I want to be focused on my pain.

TH: Uh hmm. So then let's see what we are going to do about that.

The therapist moves to the major power of the unconscious therapeutic alliance in resolving the patient's negative feelings in the transference.

TH: Because a while ago I told you that if you want to do this you have to go through a lot of painful issues. But then at the same time you say you are angry about these painful issues.

PT: (She sighs) But I'm, I feel less anger . . . I mean I don't feel angry now, but I, maybe angry's the wrong word, I don't know.

TH: Uh hmm. But still you don't say how you feel toward me.

PT: I don't know how I feel. I, I can't identify it right now. When I leave the room I'll realize it.

TH: Always the delayed reaction, hmm?

PT: I want to like you but there's a part of me that says, hold reservation.

Defense against Positive Feelings in the Transference

PT: I mean hold, ah, hold yourself, don't like him too quickly.

TH: But maybe that is a part of your conflict about positive feelings.

PT: Yeah.

Link with Mother

TH: You see, because we shouldn't really say that the major conflict is about anger. I think also there is a major conflict about closeness, because I am sure that in the depths of your mind there is a craving and a wish that your life with your mother had gone differently. You see, I am sure there is a very painful area there, the wish that your relationship with your mother had gone in a very positive and tender way, hmm? And then maybe there must be some thoughts that, if you become a mother, what would happen between you and your child? Have you had thoughts about that?

PT: Yeah. It worries me.

TH: The nagging fear that the same pattern might repeat itself with them?

PT: I might be cold with my children.

Interpretation of Unresolved Attachment to Father

TH: But, you know, obviously another side is a tremendous tender feeling for your father, which was there in the very early years, hmm?

PT: Yeah.

TH: But also you are very angry with him for letting you down, hmm?

PT: Yeah.

TH: And then, in a roundabout way, if your relationships with men go in a disastrous way, then at the very deep level of your mind, whom do you remain faithful to? The wonderful, tender relationship that you had in the very early years. That in a sense you remain faithful to him, hmm?

This deep interpretation is also confirmed.

PT: I've often thought, if I could find a man like my father . . .

TH: Uh hmm. So no man is going to replace him. And that is another thing that you have to put in the right perspective, you see. Because in the very early phase, obviously you move toward your father because things with your mother were going in a very negative way.

PT: Yeah.

TH: Okay? But then what happens later on is a severe letdown, as we have discussed, hmm?

The patient's next remark shows that her repeated agreement is not just compliance, but that she is following what the therapist says and actively working on it.

PT: And I move towards my grandmother. That's what happens.

TH: So then obviously at the very deep level there is a tremendous attachment to your father, but at another level there is a tremendous rage toward your father for letting you down. Okay?

PT: Uh hmm.

TH: Now when your relationship with all men turns out in this disastrous way, then in the back of your mind you remain faithful to who? Your father.

PT: Uh hmm.

TH: But then if you look to your fantasies, also there are men and women and everything is mixed. Because, as I said, also another part of you craves tremendously for a different relationship with your mother, hmm? Have you had thoughts about this?

PT: No, I, my, my thoughts have always been more towards finding a man who is, ah, as adoring as my father.

TH: So no man is going to replace him, the way it goes. So then really the issue is this: that the essence of the work that you want to do is to explore all these areas and to put all of your feelings in relation to your father, your mother, your grandmother, in the right perspective, to see them exactly as they are rather than to run away from them. You see the positive, negative, all these mixed bags are there.

Comparison of the Interview with Previous Therapy

TH: Now, you said that you had experience of a previous therapist. If you compare this interview with that, what differences do you see?

PT: Ah, well, ah, she ah, she couldn't trap me.

This highly ambivalent remark needs to be dealt with immediately.

Further Work on the Transference, the Transference-Current Link

TH: You see, you refer to what we did as a trap, hmm?

PT: You have to trap me in order to make me be honest. (She laughs.)

This leads to another deep transference interpretation – here it must be remembered that some of her sexual fantasies are of being abducted and having sexual activities forced on her.

TH: You see, because you said that with your husband there is always the pretence that you are forced to have sex, hmm? But now if we look to the work that we have done, you want to say that it is forced on you rather than that you want it, hmm? Do you see some parallel?

PT: Uh hmm. Yeah, it's like my fantasies.

TH: But then obviously if that is the case it is of no use to you, hmm? Because what you say is that you are not an active participant.

PT: But I want to be an active participant. That's why I'm here.

TH: The active participant means fifty-fifty, hmm?

PT: Yeah. Maybe sometimes I felt that my therapist was so quiet that it drove me mad. I didn't know what she wanted me to do, she was too quiet.

TH: Uh hmm. You mean she portrayed you.

PT: Yes, yes.

TH: Because you started to be passive, noninvolved, hmm? Now what would you say at this moment? You're passive, noninvolved, or are you the active participant.

PT: I feel more emotionally active. I feel I'm experiencing many different emotions. I'm feeling a lot of physical pain right now.

TH: Physical pain means what?

PT: In my chest, in my body, my head.

TH: So how about we stop here. Are you going back to College? Uh hmm. So, how about you have a seat in the waiting room.

Summary and Conclusion

Here it is important while recapitulating the main technical interventions with which this article has been concerned also to summarize the course of the trial therapy that was used in illustration.

(1) The two-part article described phases of the central dynamic sequence in the major unlocking of the unconscious: (a) the phase of inquiry, exploring the patient's areas of disturbance; (b) pressure leading to resistance; (c) clarification and challenge to the resistance, turning the patient against his own defense; (d) transference resistance, head-on collision with the transference resistance, mobilization of the unconscious therapeutic alliance against resistance; (e) breakthrough of complex transference feelings, the triggering mechanism for the unlocking; (f) systematic analysis of the transference; (g) exploration of the past; and (h) direct view of the multifoci core neurotic structure responsible for the patient's symptom and character disturbances and setting up psychotherapeutic planning.

(2) The trial therapy of a 30-year old woman who suffered from: (a) diffuse anxiety, (b) G.I. tract symptomatology, (c) somatization, (d) major disturbances in interpersonal relationships and (e) masochistic character pathology was presented.

(3) She entered the interview in a state of transference resistance with a great deal of anxiety, and the therapist for the time being bypassed the transference resistance and rapidly moved to a set of interventions to determine if

she suffered from a severely fragile ego structure. He rapidly ruled out a severely fragile ego structure and concluded that she had a major unconscious anxiety in relation to aggressive impulses.

(4) Then the therapist focused on the transference resistance and put pressure on the patient to experience her transference feelings, bringing about a head-on collision with her transference resistance (Phase 4).

(5) Then the process led to further challenge and pressure on her resistance against experience of aggressive impulses in the transference and resistance against emotional closeness in the transference (Phase 3).

(6) Finally, the process led to the breakthrough of the aggressive impulses in the transference with direct experience of grief-laden unconscious feelings with a major communication from the unconscious therapeutic alliance. "The disappointment is so deep that I wonder if I can ever love anyone."

(7) Then the therapist moved to explore the patient's adult life. What emerged was major problems in her previous marriage. Her ex-husband was controlling. Their sexual relationship was unsatisfactory, she could get pleasure only if there was an element of force, he forcing her to have sex in the form of play.

(8) After she left her husband she became depressed. Then the process focused on her episodes of depression, and a systematic analysis of the mechanisms responsible for her depressions.

(9) Then the session focused on other men in her life, and all of the relationships had been terminated with severe disappointment. Then she talked about a man with whom she had lived, Kirk, which threw further light on her severe pathology in relation to men. Kirk was highly explosive and abusive, verbally and physically. She described an incident when he became very violent, banging her head against the wall. As a result she had a lump on her head, which indicated that her punitive superego was strongly in operation. The process led to challenge and pressure on her resistance against the experience of impulse outside the transference. What emerged was a sadistic impulse to have Kirk brutally murdered.

(10) This led to the exploration of her sexual fantasies in which she is always brutalized. Focusing on the structure of her sexual fantasies brought about transference resistance, followed by a second head-on collision (Phase 5).

(11) Details of her sexual fantasies threw further light on the depth of her psychopathology. When there is an element of humiliation and brutalization forcing her to have sex, that produces intense sexual excitement. With men who are nice and gentle, sex becomes very dispassionate.

(12) The therapist, having completed his survey of the patient's recent life, then moves to developmental history and a direct view of her core pathology. There what emerged was a highly explosive, abusive mother. She came with the memory of an incident when her mother attacked her physically with a buckle on her head, and she was bleeding. She used to call her a "whore" and a "tramp." This was from the early years to early adolescence. Her relationship with her father was highly affectionate, but he was highly ineffective in dealing with the violent behavior of the patient's mother.

(13) Then the process focused on her paternal grandmother, who was substitute mother for her. We saw the transformation of a pathological mourning to acute grief, and the focus then was on her unresolved mourning in relation to her grandmother.

(14) Now that the direct view of the multifoci core neurotic structure by both therapist and patient had become possible, the process moved into a direct interpretation of the patient's core pathology, and finally handling residual transference feelings bringing the interview to a close and setting up psychotherapeutic planning.

In conclusion, as I have indicated before our extensive clinical research data emphasize the immense importance of the punitive superego in the causation and maintenance of neurosis. In all these cases the punitive superego has eroded the patient's ego functioning with major impoverishment of the ego structure. Another point, which again we see in this patient, is the issue of the superego and the compulsion to repeat. What emerges from our clinical data is that repetition compulsion is one of the clinical manifestations of superego pathology. In closing, clinicians who are working with this technique should take into consideration that the major unlocking of the unconscious requires that the patient enter treatment without a waiting list. In the technique of major or massive de-repression of the unconscious, the patient should enter treatment immediately. This applies to the present patient. The clinical picture of massive de-repression of the unconscious will be the subject of another article in this journal.

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Intensive Short-Term Dynamic Psychotherapy in the Treatment of Chemical Dependency. Part I

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Alcohol and drug dependency are major problems throughout the world. In general, there is agreement that intensive psychotherapy, designed to expose and interpret unconscious material with chemically dependent patients, is usually more deleterious than helpful. Davanloo's system of IS-TDP may be an exception to this guideline for chemically dependent neurotic patients without ego fragility. Edited transcript material from a trial therapy evaluation is presented to demonstrate treatment techniques of IS-TDP and its potential use for a specific subset of patients with this illness.

I. Introduction

Chemical dependency, in light of its morbidity as contrasted to mortality, is probably the number one health problem in the United States (Gill, 1987; Selzer, 1980). Treatment of these patients is difficult and expensive. Poor motivation creates a high initial dropout rate. Unfortunately, there is also a high rate of recidivism for patients who are able to achieve abstinence (Smart, 1978).

Since chemical dependence is a term encompassing a heterogenous set of conditions and treatment population, no single treatment protocol or theoretical perspective has yet been designed that integrates the numerous facets and interactions involved. The importance of behavioral, learning, pharmacologic, psychodynamic, biologic, and environmental influences has been substantiated, although debate over primacy fruitlessly continues.

Given the multiple factors that play a role in the causes of chemical dependency, it is not surprising that no treatment modality yields successful treatment results. Clinical trials showed that a combination of two or more treatment modalities substantially increased the number of patients with a favorable outcome (Selzer, 1980). Hence, we have seen the development of multimodal treatment approaches, which include a combination of individual and group psychotherapy, medication, and self-help groups. Psychoanalytically-oriented psychotherapy has either been ineffective or detrimental in the treatment of this illness (Woody et al., 1986).

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