

Habib Davanloo

Intensive Short-Term Dynamic Psychotherapy Extended Major Direct Access to the Unconscious

ABSTRACT

In this article, the author gives an overview of his technique of Intensive Short-Term Dynamic Psychotherapy, and describes in detail the technique of extended major direct access to the unconscious.

My systematic research for nearly forty years, using videot technology as a research tool, combined with a number of discoveries, have enabled me to apply a scientific method to the understanding of the unconscious mind. I have been able to revise the whole metapsychology of the unconscious, a scientific psychology based upon empirical evidence - not theory or intuition. This work has resulted in the development of two highly powerful psychotherapeutic techniques: first, Intensive Short-Term Dynamic Psychotherapy; and, second, a new method of Psychoanalysis for the systematic exploration and investigation of the unconscious; which have the power to resolve the highly complex pathogenic organization of the unconscious of highly resistant patients who suffer from diffuse symptom and character disturbances.

The systematic work of the 80's concerned itself with the application of the technique with patients suffering from phobic, obsessional, depressive, functional, somatization and panic disorders; and this work clearly demonstrated that the technique is highly effective in the above disorders (Davanloo 1987b,c, 1989 c,d, Zaiden 1979). Then I concerned myself with the application of the technique to patients with fragile character as well as those suffering from psychosomatic conditions. and that research clearly showed that the technique, with some modification, can successfully be applied to patients with structural pathology, and those with psychosomatic disorders. The work of the 80's and 90's resulted in major refinements of the technical interventions in Intensive Short-Term Dynamic Psychotherapy, as well as the development of a very powerful new method of Psychoanalysis with the aim of systematic investigation and exploration into the unconscious. This work shows that both techniques have the power to bring multidimensional structural character changes, particularly in extremely resistant patients with the most pathogenic unconscious. The truth of this statement has been demonstrated unequivocally, the work has

been presented at a large number of audiovisual symposia and training courses and programs to professional audiences, both in North America and in Europe for the past twenty-five years (Davanloo 1975, 1976a,b, 1977, 1978, 1980b, 1984b, 1985, 1999a,b).

The technique of rapid and direct access to the unconscious will be discussed in great detail in this article. I have already both presented and published the technique of the direct access to the unconscious, which we may call the "Unlocking of the Unconscious" (Davanloo 1975, 1976a,b, 1980a, 1984a, 1988b,c, 1990). This provides a unique opportunity for both patient and therapist to have a direct view of the psychopathological dynamic forces responsible for the patient's symptoms and character disturbances (Davanloo 1975, 1976a,b, 1977, 1978, 1980a, 1990). One of the most important early findings is that the degree of unlocking of the unconscious is precisely in proportion to the degree that the patient is experiencing the transference feelings (Davanloo 1980b, 1981, 1988b,c, 1992). One of the very early discoveries that I made had to do with the direct management of the resistance and the direct access to the unconscious, and the interrelation between major resistance and what I call "unconscious therapeutic alliance" (Davanloo 1975, 1976a,b, 1980b, 1985, 1987a). This series of early observations indicated that the first breakthrough into the unconscious is the first dominance of the unconscious therapeutic alliance over the resistance, and partial and major unlockings of the unconscious are partial and major dominance of the resistance by the unconscious therapeutic alliance (Davanloo 1988b,c, 1989a,b). This led to further research in the area of the technique of mobilization of unconscious therapeutic alliance over the forces of the resistance.

The earliest observation and the discovery of the direct handling of the major resistance and the direct rapid access to the unconscious is the presence of the murderous rage and guilt-laden unconscious feeling in the resistant patient. There I established a clear correlation between the intensity of the murderous rage/guilt-laden unconscious feeling and the degree of the resistance. In the highly resistant group of patients, direct access to the unconscious showed the presence of a high degree of primitive murderous rage/intense guilt-laden unconscious feeling toward one or both parents and/or siblings. In this research, I clearly demonstrated that in patients who are highly responsive to dynamic psychotherapy with circumscribed problem and single psychotherapeutic focus, there was virtual absence of the murderous rage within their unconscious. They had a healthy relationship with both parents as well as with their siblings, with a virtual absence of major resistance. The resistance was primarily of a tactical nature (Davanloo 1977, 1983, 1995a, 1996a,b).

Before I present the technique of direct access to the unconscious, I will outline briefly two major spectra of patients who can successfully be treated with Intensive Short-Term Dynamic Psychotherapy, namely: Spectrum of Psychoneurotic Disturbances; and Spectrum of Patients with Fragile Character Structure.

Spectrum of Psychoneurotic Disorders

Based on the clinical research data, we can classify the spectrum of the psychoneurotic disorders into five major groups (Davanloo 1982, 1986a,b,c, 1995a). This spectrum is based on the degree of the resistance.

1) Patients on the Extreme Left on the Spectrum

These patients were the focus of my earliest research. They are patients who are highly responsive to psychotherapeutic intervention, some of them suffering from mild obsessional neurosis of recent onset, others suffering from mild phobic disorders or other forms of neurotic disorders. We can summarize briefly the main features of all patients on the extreme left:

- highly responsive to psychotherapeutic intervention
- circumscribed problem
- single psychotherapeutic focus
- no major resistance whatsoever, the only resistance being of a tactical nature
- absence of unconscious murderous rage and guilt in relation to early figures.

What we have seen in a number of research, both in North America as well as in Europe, is that the number of patients from the extreme left are indeed very few, and in some major psychotherapeutic centers quite rare.

2) Mid-Left Side on the Spectrum

This second major group shows a moderate degree of the resistance, and the main features of this group can be summarized briefly as follows:

- moderate degree of the resistance; presence of major resistance
- diffuse symptom disturbances
- some degree of characterological disturbances
- a definite presence of unconscious violent rage and guilt-laden unconscious feeling, as well as grief, in relation to the early figures, such as parents, siblings, etc.

3) Mid-Spectrum

We can briefly summarize the characteristics of this third major group:

- the presence of high degree of resistance; presence of major resistance as well as the tactical organization of the major resistance
- they suffer from diffuse symptoms as well as character disturbances
- presence of unconscious murderous rage and guilt feeling in relation to early figures, such as parents, siblings, etc.
- in many of them there is fusion of sexuality and murderous rage
- the core pathology is complicated.

4) Mid-Right Side on the Spectrum

These patients are highly resistant and suffer from life-long psychoneurotic disturbances. The following is a brief summary highlighting their characteristics:

- very high degree of the resistance

- diffuse symptom and character disturbances; life-long character neurosis
- the core pathology is highly complicated
- direct major access to the unconscious shows the presence of an unconscious primitive murderous rage, guilt- and grief-laden unconscious feelings toward parents, siblings, and others in their early life orbit, which I call the Perpetrator of the Unconscious
- sexualized feelings, when present, are deeply fused with the primitive murderous rage.

5) Extreme Right Side on the Spectrum

We can summarize briefly the following as the main features of this group:

- extreme degree of the resistance
- symptom and major character disturbances
- high degree of masochistic character traits
- highly complicated core pathology
- direct and extended unlocking of the unconscious shows the presence of highly primitive unconscious torturous murderous rage and intense guilt and grief, multidimensional in relation to the early figure(s)
- sexualized feelings, when present, are deeply fused with the unconscious primitive murderous rage.

Structure of the Pathogenic Organization of the Unconscious

Obviously, space does not permit us to cover this subject in a short article as such. I would like in a few lines to highlight my findings in the spectrum of the resistant patients. We can summarize by stating the following: the presence of trauma, covert or overt, or a series of traumatic experiences; attachment, bond, traumatization, the major pain of trauma; primitive murderous rage, intense guilt-, grief-laden unconscious feeling; character resistance and resistance against emotional closeness. A metapsychological analysis of the structure of the pathogenic organization of the unconscious responsible for the patient's symptoms and character disturbances is what I have called "the perpetrator of the unconscious," and will be the subject of a series of future publications (Davanloo 1977, 1987d,e, 1988a, 1994c, 1995b,c).

Application of the Technique to Patients with Structural Pathology

Here we might consider three major groups of patients, some with mild to moderate degree of fragility and others with severe fragile character structure. One of the major features of this group of patients is the fact that they cannot withstand the impact of their unconscious during the first interview. This group of patients does not have the capacity to experience and tolerate anxiety and painful feelings; they have life-long access to a spectrum of primitive defenses. I will here mention a few: temper tantrums; explosive discharge of the affect; poor impulse control; projection; double and multiple projective identification; the phenomenon of drifting; drowsiness; dissociation; and disruption of their cognitive and perceptual function with hallucinatory experiences. My research

here clearly demonstrates that patients with fragile character structure can be successfully treated with Intensive Short-Term Dynamic Psychotherapy. The technique requires certain modifications: in the first phase, the therapist must aim at bringing about sufficient psychic integration and multidimensional unconscious structural changes before he undertakes a direct access to the murderous rage, which in all these patients is highly primitive, and, in many cases, is primitive murderous torturous rage. The application of the technique to this group of patients was the subject of six intensive training courses in North America, and I have already presented five immersion training programs on the treatment of the fragile character structure in Switzerland, Germany, and Italy in the past six or seven years (Davanloo 1993, 1994c, 1995d, 1996c, 1997a,b, 1998a,b,c). The following disorders can be successfully treated with the technique, and here I enumerate them briefly, based on the evolution and application of the technique:

- phobic and obsessional neurosis
- severe obsessional neurosis
- obsessive-compulsive disorders
- somatization disorders
- panic disorders in patients with obsessive, as well as those with fragile, character structure
- functional disorders, such as irritable bowel syndrome, migraine headaches, etc.
- depressive disorder
- suicidal patients with a history of major clinical depression
- suicidal patients with character disturbances
- the whole spectrum of psychoneurotic disorders
- patients with structural pathology such as fragile character (some modification)
- patients with psychosomatic disorders (certain modifications of the technique).

The Spectrum of the Technique of Direct Access to the Unconscious

If we present the analysis of our research data, there are four major techniques:

- 1) Partial unlocking of the unconscious which is partial dominance of unconscious therapeutic alliance against the forces of the resistance
- 2) Major unlocking of the unconscious which is the major dominance of unconscious therapeutic alliance
- 3) Extended major unlocking of the unconscious. Here we have a major mobilization of the unconscious therapeutic alliance, and the forces of the resistance are weakened to a great extent
- 4) Extended multiple major unlocking of the unconscious where we have maximum mobilization of the unconscious therapeutic alliance.

Partial and major unlocking are very much practiced in Intensive Short-Term Dynamic Psychotherapy, but extended mobilization of the unconscious therapeutic alliance or optimum mobilization of unconscious therapeutic alliance against the forces of the resistance is very much practiced in the new form of Psychoanalysis.

Central Dynamic Sequence in the Process of Direct Access to the Unconscious; Mobilization of the Unconscious Therapeutic Alliance Against the Forces of the Resistance

The central dynamic sequence consists of:

- 1) Phase of Inquiry
- 2) Phase of Pressure
- 3) Phase of Challenge
- 4) Transference Resistance
- 5) Partial or Major direct access to the unconscious
- 6) Analysis of the Transference
- 7) Dynamic Exploration into the unconscious.

Here I briefly highlight the central dynamic sequence and I refer the reader to the four-part article written by my German colleagues in this journal.

Phase of Inquiry:

Exploring the patient's difficulty; patient's ability to respond. Technically, inquiry should move rapidly to dynamic inquiry.

Phase of Pressure:

One of the basic principles in both techniques is exerting pressure; the therapist attempts to reach the patient's feelings directly via resistance and the transference, increasing the pressure toward the avoided feeling with the aim of bringing resistance and the transference into the open. The therapist must exert pressure with the major aim of rapid development of the twin factors of the resistance and the transference feelings. The major aim of exerting pressure can be summarized as follows: tilting the patient's character defenses in the transference; mobilization and intensification of the resistance; to create some degree of crystallization of the resistance in the transference; and rapid development of the twin factors of the resistance and the transference feelings.

Phase of Challenge:

Challenge is the key intervention in the whole technique, and it lies on a spectrum from relatively mild at one end to exceedingly powerful at the other, culminating in the head-on collision. One of the essential ingredients of the therapist's attitude in this technique is that, while maintaining the greatest sympathy and respect for the patient, he has neither sympathy nor respect for the patient's resistances, and conveys an atmosphere of considerable disrespect for the resistance. As a large part of the patient is identified with his defenses, this part of him becomes angry at having them treated with such disrespect; but, underneath, there is another part of him that begins to turn against them. This sets up tension between one part of the patient: the resistance, and another part: the therapeutic alliance. Until a major breakthrough has been achieved, the two opposite parts of the patient, the resistance and the therapeutic alliance, are always both in operation at the same time, and the therapist's task is to tilt the balance between these two

opposing forces in favour of the therapeutic alliance. In the first breakthrough, we see a major change from the dominance of the resistance to the dominance of the unconscious therapeutic alliance, and in major breakthrough we have a major mobilization and dominance of the unconscious therapeutic alliance against the resistance. In an extended repeated major unlocking, which is the subject of this article, we have an optimum mobilization of unconscious therapeutic alliance and, correspondingly, a major weakening of the resistance. For more detail on the phase of challenge, the reader is referred to the article in this journal by my colleagues.

Transference Resistance:

Crystallization of the resistance in the transference; head-on collision with the transference resistance; to bring the patient face-to-face with the self-destructiveness of his resistance; mobilization of unconscious therapeutic alliance against the resistance; and to loosen the patient's psychic system and make possible direct access to the unconscious.

This is then followed by the phase of direct access to the unconscious which, as I have already indicated, can be partial, major, extended major, or extended multiple major. It is always extremely important that, after the direct access to the unconscious, at the completion of the passage of the guilt and the grief, the therapist moves to a systematic analysis of the transference and to the phase of consolidation.

EXTENDED MAJOR DIRECT ACCESS TO THE UNCONSCIOUS

This format is most often used in highly or extremely resistant patients. The trial therapy consists of three parts which can be conducted on the same day, with an interval of fifteen to twenty minutes between each part. But these three parts can also be conducted on three consecutive days. The total duration of the three-part interview in either format averages four to five hours. These patients do not respond to the phase of inquiry, and the process rapidly moves to the phase of pressure. The phase of pressure plays an important part, and aims at the rapid crystallization of the patient's character defenses in the transference, and extensive mobilization of transference feelings, with extensive mobilization of the transference component of the resistance. The therapist now systematically challenges the patient's character defenses, and every tactical defense which is mobilized is rapidly challenged. Finally, the therapist meets a major resistance in the transference, and now he applies his most powerful technique of head-on collision with the major resistance in the transference, with the aim of mounting a direct challenge to all the forces maintaining the resistance and self-destructiveness; and systematic weakening of the major resistance, as well as all of the tactical defenses entrenched in the major resistance. This finally results in a major breakthrough into the unconscious with the passage of the primitive murderous rage in the transference and its neurobiological and somatic pathway.

The Process of Extended Major Unlocking can be summarized as follows:

- 1) Passage of the primitive murderous rage in the transference, with its somatic pathway and actual experience of the primitive murderous rage. This is immediately followed by:

- 2) Emergence of Sadness, indicating that the guilt- and grief-laden unconscious feelings are mobilized;
- 3) The patient attentively looks at the murdered damaged body of the therapist, then:
- 4) There is transfer of the murdered body of the therapist to the murdered body of the biological figure of the early life orbit of the patient - mother, father, sibling, etc.. It is important to note that in this mental imagery, the murdered body of the therapist appears exactly as the murdered body of the mother, father, or brother, in terms of the colour of the hair, eyes, in every respect. This visual imagery is extremely intense. The patient is, for example, seeing the dead body of the mother with blond hair and blue eyes. The dead body of the therapist is no longer there. This is then followed by:
- 5) Major breakthrough of intense guilt-laden unconscious feeling, a very painful experience which involves the neck and upper part of the chest. The duration of the passage of the guilt averages eight to twelve minutes in the first extended major unlocking. This is then followed by:
- 6) Passage of the grief-laden unconscious feeling, which is then followed by intense positive feeling;
- 7) Now, both the patient and the therapist have a first direct view of the psychobiological dynamic forces responsible for the patient's symptom and character disturbances.

Major unlocking is the standard technique used in Intensive Short-Term Dynamic Psychotherapy. Extended major unlocking of the unconscious and extended major mobilization of unconscious therapeutic alliance can also be used in Intensive Short-Term Dynamic Psychotherapy, but is used most often in the new form of Psychoanalysis. Here I will attempt to do an in-depth analysis of the process of an interview with a patient from the mid-right of the spectrum of psychoneurotic character neurosis, highlighting some of the important technical and metapsychological issues in achieving a rapid and direct access to the pathogenic organization of the unconscious.

The Case of the Man with Crushing Chest Pain

At the time of the initial interview, the patient was in his thirties, and suffered from arthralgia of many years duration, frequent episodes of crushing chest pain, severe panic attacks, diffuse characterological problems, disturbances of the interpersonal relationships, a major problem with intimacy and closeness, and disturbed relationships with his three children. He had been treated by a number of internists and had had long periods of physiotherapy. He had been very reluctant to see a psychiatrist, which was a source of tension between himself and his wife, who insisted that he should search for psychological help. He had been defiant and stubborn about it. The circumstance that brought him to this interview was a major crushing chest pain. While driving his car, he had a crushing chest pain and an attack of panic. He had to pull the car to the side of the road, and an ambulance had to take him to the coronary intensive care unit with a tentative diagnosis of a heart attack. He was admitted for twenty-four hours. A full investigation,

which included a serial EKG, showed no physical findings. He was discharged and referred to the therapist. A brief intake evaluation indicated that he suffered from a wide range of disturbances, the most important being panic disorder with blurring visual disturbances, crushing chest pain simulating a heart attack, double knee arthralgia of a functional origin, disturbances of interpersonal relationships, in his job as well as with his family, major problem with intimacy and closeness, masochistic character traits, self-defeating and self-sabotaging patterns which permeated many aspects of his life. He suffered from somatization disorder in the early part of his life.

Now we will focus on the interview with this patient.

Initial Contact

He enters into the interview visibly anxious, and the therapist focuses on the anxiety to see if it has transference implications.

TH: How do you feel right now? I notice you 're anxious.

PT: I am anxious.

TH: You took another sigh.

A very brief exploration into the physiological concomitant of the anxiety is made which indicates that the discharge pattern of the anxiety is exclusively in the striated muscle, clenching of the hands, and sighing respiration indicating tension in the intercostal muscle. The therapist concludes that there is no sign of the fragility.

Now we return to the interview.

TH: What do you account for your anxiety?

PT: Well, I, I was trying to analyze, trying to see why I am...

TH: What is there to analyze? What do you account for your anxiety?

Phase of Pressure

The main factors that influence the course of an interview are the degree of resistance and the extent of the transference component of the resistance. The technical interventions that I have introduced to exert pressure aim at the rapid development of the twin factors of resistance and the transference feelings. Based on that principle, the therapist maintains a structured interview: probing questions focusing on the patient's feeling underlying the anxiety in the transference.

Now we return to the interview.

PT: I, I ... the only thing I can see is, is, uh, I presume, presume it is ... coming here.

TH: You presume? Why presume, either is or isn 't?

PT: Yes, it definitely is. Yes.

TH: So then why you don't want to be specific?

With a tone which contains reluctance, he says "Okay, it is not. Okay maybe."

TH: Why you say 'Okay'?

PT: Uh, I guess my wording is not correct, uh.

TH: Now you take the position that your wording is not correct.

As I have emphasized, the phase of pressure might have passing moments of challenge, but systematic challenge should only begin when the resistance is well crystallized in the transference. In other words, the therapist should aim via the phase of pressure to mobilize and intensify the transference component of the resistance (Davanloo 1995a,b,c). This is particularly important if the therapist is aiming at major mobilization and dominance of the unconscious therapeutic alliance against the forces of the resistance.

PT: Hm hmm.

TH: You don't want to directly address it at me, that the anxiety has to do with seeing me.

PT: Yes, it's, it's, it is, it is ...

TH: Unless you want to say it has to do with the hospital.

PT: No, no.

TH: So has to do with seeing me?

PT: Yes, yes, hm hmm.

Exerting Pressure:

Pressure toward the Underlying Feeling

TH: So could we look to see how you feel about seeing me?

PT: Well, I. I don't feel uncomfortable in the sense that I, I...

TH: 'I don't feel uncomfortable' doesn't say how you feel.

PT: Uh ah...see I, I ...

Further Rise in the Anxiety:

Further Pressure toward the Underlying Feeling

TH: How do you feel about seeing me?

PT: Well I don't... see I don't have a...

TH: Still we don't know how you feel about seeing me.

PT: Hmmmm, maybe I'm not ...

TH: How do you feel about seeing me, because obviously it makes you very anxious.

PT: Yes. it does.

TH: So then you must have a certain feeling besides anxiety about seeing me.

PT: Uhhhhh ... feeling in the sense that uh ...

TH: 'Feeling in the sense' doesn't say how you feel towards me.

PT: Well, it's, it's a negative feeling uh I don't know ah, ah to ...

TH: You mean you feel negative about seeing me?

PT: Yes. yes.

TH: Negative refers to what?

PT: Not anger, no, no uh...

TH: But negative refers to what feeling?

PT: In, in a, in a sense I don't look forward to come because ...

TH: Now you want to qualify.

PT: Hm hmm.

TH: You don't look forward to come here, hmm.

PT: Yes and no.

The process remains on the phase of pressure. He uses the tactical defense of negation. On the one hand, he talks about negative and anger, but immediately he also negates it. The therapist maintains the process by exerting further pressure and further mobilization of the transference feelings. Now the patient moves to another tactical defense, "yes and no." We return to the interview.

PT: Because I, I see it from two points of view.

TH: What two points?

PT: One that it, it will be good for me but on the other hand ...

TH: So in a sense part of you wants to come here and to do something about your paralysing life, your misery, but another part of you says, look, let's to carry the misery and the paralysed life?

PT: Hm hmm.

TH: Hmm?

PT: Yes.

TH: Okay, so a part of you wants to maintain a paralytic life full of misery and suffering but a part of you says something good might come of it, which might result in your freedom and putting an end to your misery. The point that we have here to begin with is this part that wants to continue the suffering.

The focus of the session is on his ambivalence, a part of him; the destructive organization of the resistance searching for the perpetuation of his suffering, and the fact that for years he has procrastinated about doing something for his suffering, and the reason that he has come to the interview was a crushing chest pain which had a similarity to a heart attack. Then the therapist moves to exert further pressure:

TH: Now, let's to see what you are going to do about that part that doesn't want to?

PT: What am I going to do about it?

TH: Hm hmm.

PT: Ah... Well I wish to cooperate, ah express what I feel but uhh...

Pressure and Challenge

In the following passage, the therapist uses both pressure and challenge, mobilization of the patient's will, emphasizing the destructive component of the resistance which demands perpetuation of suffering: the masochistic component of the character. For the sake of brevity, the dialogue has been shortened and paraphrased in places, but nothing important has been omitted.

.....

TH: *But it is very important, a part of you wants to perpetuate, a part of you wants to maintain the suffering but a part of you is fed up with the suffering and wants to change.*

PT: *Yes I understand.*

TH: *But understanding is not enough. To do something about it is the task, unless you don't want to do something about it?*

PT: *No, I definitely do, yes.*

Return to the Phase of Pressure

Now the process moves to the anxiety in the transference and pressure toward the feeling in the transference. Throughout the process, he avoids the eyes of the therapist and looks at a different direction, and the therapist brings this to the focus.

TH: *Well, let's to see how you feel.*

PT: *Well, I feel uh ...*

TH: *You avoid my eyes, particularly when you want to say how you feel. Do you notice you are constantly avoiding me?*

Pressure and Challenge

Head-On Collision with the Resistance Against Emotional Closeness

Every person who has been traumatized, particularly in the very early phase of their life, almost all patients on the right side of the spectrum, have major problems with intimacy and closeness. Focusing on and working through of this resistance, technically, is always in the transference. As the process goes on, this resistance becomes crystallized in the transference, and the therapist has a unique opportunity, first to make the patient acquainted with the nature of the resistance, then to apply the technique of pressure and challenge or head-on collision with this resistance. Having said that, I want to point out that there are patients for whom this resistance, in a powerful way, manifests itself in the forefront of the major resistance, and pressure, challenge and head-on collision can be applied in the very early part of the interview. In this patient, the resistance against emotional closeness manifested itself from the beginning of the interview, but the therapist waited that it becomes further intensified in the transference. In the following passage, he brings this into focus:

TH: Do you notice, you avoid my eyes and you are constantly avoiding. Another issue with you and me has to do with this problem which is a major problem for you - the problem of intimacy and closeness hmm that you want to constantly put a barrier between you and me. The barrier we see; you cannot look to my eyes and directly tell me how you feel. There is a need in you to put a wall between yourself and me, there is a need in you to put a barrier between yourself and me, there is a need in you not to let me to get to your intimate thoughts, intimate feelings, there is a need in you to keep me on the other side of the wall and not wanting me to get to your intimate thoughts and feelings. So, then to begin with, this barrier, this wall is another destructive force, because up to the time there is a need in you to distance yourself and put a wall between yourself and me, then the process is doomed to defeat, is doomed to fail.

PT: Hm, hmm. (sighing)

TH: Then, to begin with, we have an impasse between you and me. The impasse is the wall, is the barrier. And this impasse is going to cripple this process as well and the question is this: what are you going to do about this one also ?

PT: Well, I, I wanna make a conscious effort to, to, to, to not have this.

TH: Then let's to see what are you going to do. You keep avoiding my eyes.

In the above passage, the therapist applied the technique of head-on collision with this resistance. His major technical interventions consisted of: pointing out to the patient the nature of the resistance; emphasizing its effect on the patient's life; challenging the destructive aspect of the resistance, self-defeat and self-sabotage; and then the therapist introduced pressure and challenge "Let's to see what are you going to do?"

Pressure, challenge and head-on collision to the resistance against emotional closeness mobilizes anxiety and further intensification of the transference component of the resistance. Metapsychologically, it mobilizes and activates the centre of the core neurotic organization which is well defended by the major resistance, namely, attachment, bonding, traumatization of the bond, the pain of the trauma, murderous rage and guilt- and grief-laden unconscious feelings. Now the therapist moves to the anxiety and exerts pressure towards the transference feelings. We return to the interview.

Further Pressure

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

PT: I feel uncomfortable and anxious.

TH: What else do you feel besides anxiety?

PT: Just that, I don't know, whether I am not really in touch with my feelings uh ...

TH: Do you notice the way you hold your hands, you hold them on your crutch like this?

PT: Yes ... I feel defensive.

The hands are clenched, and the movement of the two thumbs against each other indicates anxiety in the form of tension in the striated muscles of the hands, the supinators and pronators of the forearms, and his sighing respiration also indicates anxiety in the form of tension in the intercostal and subdiaphragmatic muscles. All of the signalling systems indicate ongoing mobilization and intensification of the transference feelings, and the direct experience of the transference feelings is the goal towards which the therapist is working. It is this that finally would lead to the direct access to the central and pathogenic organization of the unconscious.

Further Pressure toward the Feelings

PT: I don 't feel anything else, maybe anger, I, I'm not sure uhh.

TH: Again, do you notice, you avoid me when you want to say anger and you don't want to be direct 'Maybe'? The issue is are you angry or aren't you angry? ... Again you look away from me as soon as it becomes the issue of anger.

PT: Cause for me it's difficult to, to ...

TH: Now, you want to move and take the position 'It is difficult.'

PT: Yes I see.

TH: ... and obviously you are both anxious and angry, and both of them they are interconnected. The anxiety part you experience, but the anger part is only a thought.

The focus of the session is on anxiety and anger in the transference, and the therapist on two occasions emphasizes "You shouldn't agree with what I say, but you are here to examine it, unless you don't want to," to which the patient responds affirmatively. (Deactivation of the transference as well as of defiance and stubbornness).

Pressure towards the Actual Experience of Anger in the Transference

TH: How do you experience this anger towards me, physically? This is important, when you 're tense, your muscles become tense; which indicates to you you are anxious, okay - and it is very important for you to examine this, not to agree.

PT: Hm, hmm.

TH: When you are angry, how do you physically experience the anger, actual physical experience of the anger?

.....

The focus of the process is on the actual experience of anger in the transference. All character neurotics have an inability to differentiate between anxiety and anger, and this is in the service of the resistance. The task of the process is that the patient can actually physically get in touch with the experience of anger. By virtue of the fact that anger itself is a tactical defense against violent rage, murderous rage, or primitive murderous rage, alarms the major resistance and its tactical organization. The major therapeutic task is the ongoing crystallization of the tactical defenses and aiming at the breakdown of the major resistance.

Pressure and Challenge to the Major Resistance

TH: How do you physically experience this anger?

PT: Other than the nervousness, anxiety, nervousness.

TH: But under the anxiety is the anger.

PT: Well.

TH: But how do you physically experience it?

PT: Uhhh, well I feel defensive uhh...

TH: Yeah, but that is a mechanism of dealing with anger. Anger gives rise to the anxiety, you become tense and then all the other hmm?

PT: Hmm.

TH: But that is a mechanism, but what is the way you actually and physically experience the anger? Now, you look puzzled.

PT: Yes, because I, I ... Other than what I feel I don't feel any ...

.....

PT: How do I feel? I feel uh helpless.

TH: That very well we know that you take a paralysed position.

.....

TH: You want to move away from how actually and physically you experience your anger and use a set of defenses, a set of mechanisms, detachment, being withdrawn. Right now you have become very slow and actually you are taking a board-like position.

.....

During this phase, there is mobilization of a wide range of tactical defenses; some of them are of a tactical nature, some of them are tactical defenses well-entrenched into the major resistance; and the task of the therapist is to apply challenge and pressure and render them ineffective. Throughout this phase, the therapist must be very specific and should keep in mind that the patient has clearly identified with these defenses for many years of his life. They are syntonik characterological defenses.

PT: But I don't understand where I, I'm ...

TH: You move towards this 'I don't understand.' Now the question is this, do you want to do something about it or do you want to keep it the rest of your life?

Throughout the early part of the interview, the patient's voice was low. Now, for the first time, there is a rise in the voice. We return to the interview.

PT: No. I definitely wanna do something about it. But ...

TH: But you are not doing anything about it.

PT: All I am doing is suppressing ...

TH: Suppressing what?

PT: My anger ... I don't know how to experience it.

.....

TH: You say you suppress it, there must be something you suppress. So how do you experience that something that you suppress? As if this is totally alien. You are puzzled as if you don't know what anger is.

PT: Oh yes I know what anger is.

What emerges is that with his wife and his children, he alternates between regressive, explosive discharge of the affect - thrashing, screaming, yelling, major temper tantrum or total withdrawal, detachment, not talking with them for days. The therapist makes systematic clarification, and makes the patient well acquainted with the regressive defense of explosive discharge and its defensive function, as well as with the defense mechanisms of withdrawal and detachment.

During this process, there is further increase in the level of anxiety with frequent deep sighs, which are reflected upon, further intensification of the patient's characterological defenses and increase in the patient's level of the resistance.

TH: Again you want to move toward this position 'I don't know,' explanation. This is the make-up of your character. They are the golden fabric of your character, and definitely you want to treat them as a golden fabric, you don't want to give it up. Either you move to because, explanation, rumination, intellectualized rumination or you move to sarcasm, stubbornness, procrastination or defiance.

.....

Further Challenge and Pressure

What we have is the intensification of the resistance in the transference, the high level of anxiety in the form of tension in the striated muscles, and intensification of the transference component of the resistance. This indicates that the breakthrough is going to be imminent. The major task of the therapist in this process is a very short form of a head-on collision with the aim to deactivate the transference, which in turn deactivates the defiance; reemphasizing the therapeutic task; pressure to the unconscious therapeutic alliance. Major interlocking chain of head-on collision is not indicated as it might trigger off grief-laden unconscious feeling which means bypassing the unconscious murderous rage and guilt. The actual experience of the murderous rage and guilt is the key and central task which cannot be compromised. The therapist's task is the activation of the somatic pathway of the murderous rage or primitive murderous rage. At this time of the process, the major goal of the therapist is major mobilization and intensification of the transference feelings which finally creates a major and extended unlocking of the unconscious.

Now what follows is the declaration of being terrified of his rage "Might erupt like a volcano," and the therapist points out "You are terrified that it might erupt toward me." He responds "Towards anybody." The therapist, once more, focuses on the somatic pathway of his rage. He points to his lower abdomen and says "It is like a fireball, it's like heat moving." There is further pressure for the actual experience of the somatic pathway and he points to his chest that the fireball is now in the mid-part of the chest. He takes a deep sigh. He wants to diversify and elaborate on an incident when he was fuming with rage. The diversification is immediately blocked, and challenge and pressure to further experience the somatic pathway continue.

Further Challenge

TH: You love the crutch, you love to use the crutch, and if your life goes like this you will be on the crutch unless you do something about it. This crutch has many components: your voice is low, your hand is in a paralytic position, there is a major buildup of rage inside you but then you are more and more tense because you are terrified that it erupts on me.

PT: I am terrified (deep sigh).

TH: You are terrified to let it go.

PT: (Deep sigh)

TH: And you took a sigh, you are terrified to let it go. You prefer to be civilized rather than honest with your feelings.

PT: I'm, I'm confused. (Tactical defense)

TH: Let's not to get to confusion. Let's to see how you experience this rage toward me.

The process indicates a high mobilization of the transference feelings. The somatic pathway has been activated and is located in the upper chest. The frequent sighs indicate that the buildup of the transference feelings is close to breakthrough.

TH: You know the story of Dr. Jekyll and Mr. Hyde.

PT: Hm hmm.

TH: It was the transformation of an intellectualized man to a homicidal man.

There is a sudden change in his voice which indicates the absence of tension in the vocal cords, and, with a strong tone, he declares that he is not going to his grave in a crippled fashion: "I don't want to live on the crutch anymore." (While he has his two hands in a fist-like position). The therapist again goes to the Dr. Jekyll and Mr. Hyde.

TH: Now, if that takes place, if you put all these destructive defenses aside, and if you put all these paralyzing defenses aside and get in touch with the rage that is within you, how would you be like?

Passage of the Primitive Murderous Rage in the Transference

In the following passage, we see a major change which is extremely important. There is no tension in the vocal cords, and total absence of anxiety. The facial expression is one of vicious rage, there is a passage of a primitive murderous rage in the transference.

TH: Let's to see, if you go berserk here what it would be like. If you go berserk what would it be like?

PT: I would start hitting, punching and ... screaming.

TH: How would you go on me? With what power?

PT: Well, I would punch very hard, uh.

He is moving his two hands which here now become fists. Again, it should be emphasized that there is a total absence of anxiety. He is sitting in his chair and, in a vicious way, is demonstrating how hard he would punch and attack the therapist. We return to the interview.

TH: *How hard?*

PT: *As hard as I could. (By moving his fists he shows how hard). My fist would go through ... I would hit so hard (indicating the face and the chest), on your head, your chest or ... and then right and left.*

TH: *And if you go further berserk, how would you attack me?*

PT: *I would kick and punch. (Patient is sitting in his chair and shows with his leg how he would kick and with his fists how he would punch). Kick with my feet, my left foot, my right foot.*

TH: *How hard you would kick?*

PT: *I would kick with all my might, uhh ... I would kick very hard.*

TH: *If you go further berserk?*

PT: *I would kick, and kick with other foot.*

TH: *Where?*

PT: *Anywhere, chest, abdomen. I keep kicking, ah.*

TH: *And how would you go further?*

PT: *I'm trying to see, I'm trying to picture. I'd probably keep kicking you here within the chest and the abdomen.*

TH: *In the chest and abdomen, and then I am where? In my chair or on the floor?*

PT: *You are lying on the ground, uh.*

TH: *And then where else you would attack now? If you let this vicious animal in yourself loose.*

PT: *I, I would punch you on the face (Holding his hand in a fist-like position), uh ... after I stop kicking you I would hit you in the face.*

TH: *Kick face?*

PT: *Keep punching you in the face.*

TH: *Hm hmm, and then where else would you damage further?*

PT: *I can't see anything else, other than ... if there was a piece of block or something, I would pick it up and smash it.*

TH: *Piece of block?*

PT: *A block of cement or something and ... I would smash it on you until there was nothing left.*

TH: *Until I am squashed?*

PT: *Squashed and there is nothing.*

The above passage demonstrates the passage of the murderous rage which, as we see, is primitive. The following should be emphasized: total absence of anxiety; absence of any resistance, any form of a defense; throughout, the patient is in his chair, actually experiencing his murderous rage; and unconscious therapeutic alliance has taken a major-dominant position in relation to resistance. At this point, the therapist should very carefully monitor for the unconscious signaling system, which comes from the unconscious therapeutic alliance, that the passage has come to

an end. The most important is the emergence of sadness, and, at this point of the interview, the patient is sad. Now we return to the interview where we had left.

TH: And then? Still there is rage there?

PT: Sadness.

There is a definite emergence of sadness which indicates that both guilt- and grief-laden unconscious feelings have been mobilized but remain within the unconscious. The following passage shows some of the technical and metapsychological considerations which are essential in conducting this technique. We return to the interview where we had left.

TH: Hm hmm, and how do I look? If you carefully examine my body, where do I look? My eyes are looking at you, or the ceiling or where? The rage is gone, now you look at my mutilated body which is squashed, where my eyes are looking? (Patient is very quiet and sad, looking to the floor, where the mutilated body is located).

PT: I have difficulty seeing the face and the eyes.

TH: What colour are the eyes, my eyes? What colour?

PT: I don't know. I have trouble seeing them. (His voice is low, talks very quietly, totally absorbed in this process, there is no anxiety and no traces of resistance).

TH: What colour is it?

(Pause)

PT: Green, green eyes.

TH: Green eyes and the hair?

PT: (Pause, silence)

TH: And the hair?

PT: Brownish, light brown.

TH: Light brown and the eyes are green, hmm? The eyes are green? You say the eyes are green. What is the colour of my eyes in actuality? (For a split second he looks up to see the colour of the eyes of the therapist).

PT: Dark, very dark.

TH: But that one is green.

PT: Yes.

TH: Hm hmm. Then who are you seeing there? Green eyes, brown hair?

PT: Trouble seeing.

(There is a silence. He is very quiet, sad, looking to the image of the murdered body with green eyes and brown hair).

Technically and metapsychologically, it is extremely important to take the following into consideration:

- There is absolute silence and no activity on the part of the resistance.
- There is a major mobilization of the unconscious therapeutic alliance.

- The murdered mutilated body of the therapist has been transferred to a person who has green eyes and brown hair.
- The person with the green eyes and the brown hair has not as yet been identified. The therapist must wait for a short moment until the green eyes become identified, then the patient is in a direct relation with his biological figure. Then, in a split second, there would be a heavy passage of the guilt-laden unconscious feeling.

We return to the interview where we had left.

PT: Well. I se I se ... I see my brother.

TH: Hm, hmm. It's a portrait of your brother with the light brown hair and the green eyes. So he's dead and murdered in a vicious way, hmm? And what do you do? And you are loaded with a major wave of painful feeling and you have full capacity to experience it.

Major Passage of Waves of Guilt-Laden Unconscious Feeling

There is a heavy passage of guilt-laden feeling with major waves of painful feeling. The patient is crying and sobbing.

TH: You have a major wave of painful feeling.

(Patient continues sobbing)

TH: Do you touch him?

PT: Yes.

TH: Where?

PT: (sobbing) I hug him.

TH: You have tremendous painful feeling.

(Patient sobbing heavily)

PT: I'm gonna miss you.

(Choke-laden voice, heavy sobbing which involves pharyngeal, laryngeal and upper thorax and it comes in waves. When it comes, it has high amplitude and his voice becomes choked).

The therapist's interventions are very minimal, only certain brief communication both to intensify the passage of the guilt and also to indicate that he is present, as the patient is heavily absorbed in this extremely painful intrapsychic process. There are further waves of passage of unconscious guilt. Now we take up the interview.

TH: What does he tell you before he dies eternally?

(Again there is another major wave of sobbing with heavy breaths which lasts for a few minutes).

TH: Does he say anything to you?

PT: No, I don't see anything, I don't hear anything right now.

(Patient continues deep sobbing. With a very choked voice not clear - he is talking to his brother).

PT: Why were you so mean? (Choked voice). Why were you so mean to me? (Heavy crying).

(Patient deep breathing and sniffing)

(Patient continues crying heavily)
(Sob-laden voice).

With a sob-laden voice, he continues, and the process enters into passage of the grief-laden unconscious feeling. It is important to note that both guilt and grief must actually be experienced. Guilt is far more painful, comes in waves with high amplitude and involves the whole upper respiratory area. Grief is far less painful and does not involve the upper part of the chest. It comes in waves, but the amplitude of its waves is far less than guilt.

The patient is in direct relation with his brother, and says:

PT: I feel like I am in nowhere. I feel (sniffing) ... so alone.

TH: With his death and murder.

PT: Feel like I'm all by myself. (choked voice, sobbing)

A Major Communication from Unconscious Therapeutic Alliance

There was rivalry with the brother. He became the black sheep and the brother became "Golden Boy." But, now that the brother is murdered, he is left alone with nobody. The communication from the unconscious therapeutic alliance is that unconsciously he is the murderer of both parents. Now we return to the interview.

TH: You mean after he is murdered, then you are alone by yourself.

PT: (Further sobbing)

TH: Then what do you do with his dead body?

PT: (Sobbing) I hold him.

TH: How do you hold the dead body?

PT: (High choked voice) I hold him tightly ... the chest and then the head on my chest and shoulder ... I see myself lying on the ground holding him (Sobbing)... tight.

TH: Do you say something to him before ... as your eternal goodbye to him, his dead body?

PT: (Sobs, very choked voice) I love you, I love you Peter.

TH: Hm hmm. So you hold him tight and you say to him as your eternal goodbye I love you Peter.

PT: (Cries heavily) I feel like my brother's not part of my life anymore. (Sob-laden voice)

TH: You said that you would lay down and hold him.

PT: In my vision I see him... I see him lying in a casket, doesn't look good, his face is white (Sobbing). He's dressed up in a blue suit. (Further sobbing) (Then he sees his brother being buried next to this grandmother, who was fond of him) (Continues sobbing)

TH: And what would be your eternal goodbye when the casket is being lowered? What would be your last goodbye to Peter?

(Patient cries heavily)

PT: I love you Peter. (Crying heavily)

TH: And what else would you say to him as your eternal, final...

PT: I will miss you. (Crying heavily, but more softly)

The above passage can be summarized as follows:

- 1) We saw the direct breakthrough into the unconscious and the passage of the primitive murderous rage in the transference
- 2) The emergence of sadness as an indicator that the guilt- and grief-laden unconscious feelings have been mobilized
- 3) A total absence of anxiety and no activity on the part of the resistance
- 4) Major mobilization of the unconscious therapeutic alliance; a major dominance of the unconscious therapeutic alliance over the forces of the resistance which is major unlocking of the unconscious
- 5) The visual imagery of the murdered body of the therapist being transferred to the visual imagery of the murdered body of the brother, and now the patient is in direct relation with his brother and his primitive murderous rage toward him
- 6) As we saw, instantly when the transfer took place, there was a heavy passage, actual experience of the guilt feeling which then follows with the passage of grief, his love for his brother at one level and his primitive murderous rage at another level
- 7) This was then followed by mourning the death of his brother, and he said "I feel like I am in nowhere," "Feel like I'm all by myself," which is a communication from unconscious therapeutic alliance that he has unconscious murderous rage toward his father as well as toward his mother.

Now, we return to the interview. The therapist waits for a moment to see that all of the waves of painful feeling have been consciously experienced. Then he moves to the phase of recapitulation and analysis of the transference and of the process.

Analysis of the Transference and the Phase of Consolidation

Recapitulation and analysis of the transference is an important part of the process and, at the end of each session, the therapist recapitulates the process, and it is extremely important in patients who suffer from major symptom disturbances. For example, in this man, in addition to characterological problems, he suffers from severe panic attacks, crushing chest pains, double arthralgia of the knees. Our systematic research in this area shows that if analysis of the transference and the phase of consolidation is done systematically, it would remove the symptom disturbances within one to three, maximum five, psychotherapy sessions. In this particular case, the phase of consolidation is rather extensive. For the sake of brevity, I will only highlight aspects of this process.

TH: You see, when we met you had anxiety and it is very important to recapitulate and examine what took place between you and me. When you came you had anxiety.

PT: Yes.

TH: *And then the focus was on your anxiety, and shortly after that you had anger towards me.*

PT: Hmm.

TH: *Then you were using a set of mechanisms to defend against the very deeply buried feelings.*

One mechanism to deal with this rage and anger was anxiety which was in the form of tension in the muscles of your hands, arms, chest, do you see what I mean ?

PT: Yes.

TH: *Another mechanism was becoming detached, remote and building up a barrier between yourself and me.*

PT: Hmm.

TH: *There was anger and rage, anxiety was one of the mechanisms, but you used another set of defenses such as detachment, withdrawal, distancing, intellectualizing, intellectualized rumination, going for the cause. There was a range of other defenses such as procrastination, stubbornness, defiance, which obviously are in relation to others, but they came into operation in relation to me ... What we saw was under the anger there was primitive murderous rage, but it's important that we keep in mind that under the anger, under the anxiety and anger there was a primitive murderous rage.*

PT: Hm hmm.

TH: *You see, at the very deep unconscious level is the murderous rage, the primitive murderous rage.*

PT: Yes, I can see that.

TH: *Then as soon as the focus is on anger, this gives rise to the signal of anxiety, because underneath the anger is violent rage and under that there is a primitive rage, which has been buried in you for years of your life.*

PT: Hm hmm.

TH: *Then as you saw there was a passage of this primitive murderous rage, the block of cement, the major attack on the head, the major attack on the chest and you well remember that I became transferred to your brother who is the person you really have the rage for.*

In this analysis of the process, the therapist emphasizes heavily the experience of the guilt and reemphasizes the unconscious murderous feeling toward his brother and the intense guilt and his need for punishment and suffering. Then the patient said that he had a disturbed relation with his brother and there have been many occasions he experienced a fuming rage inside, but he keeps it in and takes a totally mute, detached position. He describes an incident that he had gone to help his father to put up a window, he had done half of the work when his brother came to visit, found major fault in the patient's work and took over the job. The patient experienced a fuming rage "I became almost paralysed." What further emerges is that the brother was the golden boy of the family, he was the star in the eyes of the father and the mother, and there were other incidences where the patient was physically beaten by his brother who was much stronger.

Then he breaks into another wave of grief-laden feeling, the wish that he would have had a brother-to-brother relationship.

TH: So at one level there is love for him, there is love, that you wished that you had a brother-to-brother relationship which is gone with the wind, you see? So there is a love but at another level, which is very important that you get in touch with the full range of it and which you saw, is a primitive murderous rage which had been reactivated due to the fact, as you said, he was the golden boy both in the eyes of your mother as well as your father, and you were the black sheep of the system.

PT: Yes. I see that clearly.

TH: So, then it goes to the early phase of your life, this primitive murderous rage toward your brother which is sitting within your unconscious and is locked there. But also is important to see that you have a lot of other feelings. We saw the tremendous guilt, grief, love and so on and so on.

PT: Yes.

Projective Identification and Symptom Formation

Another major function of the phase of consolidation is analysis of the mechanism of projective identification and symptom formation which again is extremely important in patients with character and symptom disturbances. Again, space does not allow the part of the interview which focuses on this. The therapist must clearly recapitulate the manner in which he murdered his brother. In this particular case, the way the primitive murderous rage was acted out is a block of cement crushing the chest of his brother and his own crushing chest pain; in the early part of the passage, he attacked the body, the chest and the abdomen, stomping with his legs and feet, both left and right, with destruction of the body; and the fact that for years he has been suffering from chronic double arthralgia of the knees which, at times becomes severe, and prevents him from going bicycling with his children. He ends up sitting on the steps of his home watching his children and his wife going bicycling and participating in other sporting activities.

Return to the Phase of Inquiry

Now the therapist moves to a systematic approach to the phase of inquiry and dynamic inquiry, exploring the patient's areas of disturbances, medical and social history, as well as the current family dynamics.

Exploring his recurrent episodes of chest pain - which at times are intense and he has to see his family physician. The worst one was the crushing chest pain which, as mentioned earlier, was so bad and resulted in his admission to the coronary care unit.

Exploring his chronic double arthralgia of the knee - indicates that he has had it for many years, at times mildly, but there are times that it becomes severe. He has been treated by an

internist. When pain is severe, he receives physiotherapy which helps him to some extent. Exploring episodes of panic - which at times are very intense. He is chronically an anxious person, with episodes of panic, always associated with blurring of vision. In addition, he has episodes of intense headache, with pressure on the top of his head. Exploring episodes of depression - he has had a number of clinical depressions, each of them being treated by his family physician with medication. Exploring his relation with his wife - it is problematic, alternates from episodes of regressive behaviour - explosive discharge of affect, screaming, yelling - to withdrawal, detachment, and not talking to her for days. Exploring his relationship with his three sons - with them, he is punitive, putting them down and always critical. His children are defiant, stubborn, perform poorly in school, which resulted in the family seeing a school counsellor to help the children not to fail in their exams. The counsellor recommended treatment which the patient did not follow up on. Exploring his work - he works hard, always afraid that he might get fired. There is a definite pattern of self-defeat and self-sabotage and, as a result, he has never received a promotion. As already mentioned, he has diffuse characterological problems and major problem with intimacy and closeness.

Closing Part One of the Interview

At this point, the therapist recapitulates and points out the therapeutic task by indicating: "We have only touched the top of the iceberg," and invites the patient's willingness to continue the session. The patient's response is positive. Then he was seen for the second part of the interview.

SECOND PART OF THE TRIAL THERAPY

Anxiety in the Transference: Phase of Pressure

He came into the second part of the interview with anxiety in the transference and the process immediately moved to the phase of pressure.

TH: How do you feel right now? What do you account for your anxiety?

PT: (Clears throat) Well ...

TH: You took a deep sigh.

PT: Yeah, cause I was thinking when I was young ...

He resorts to the defense mechanism of diversification, which is blocked, and the therapist moves to pressure to the underlying feeling. He says he is afraid of failure and has anxiety about

his performance. The process immediately moves to pressure and challenge; further mobilization and intensification of the transference feelings.

Phase of Pressure and Challenge

There is mobilization of the major resistance and the therapist systematically applies challenge and pressure with repeated short-range head-on collision with the resistance and deactivation of the transference. This results in major intensification of the transference component of the resistance. Finally, he declares anger and rage in the transference. Systematic pressure for the actual experience of the rage finally leads to the breakthrough of the murderous rage in the transference.

As the phase of pressure, challenge and head-on collision is very much similar to the first part of the interview, this is omitted for the sake of brevity, and we take up the interview where the therapist exerts pressure for the actual experience of rage in the transference.

TH: How would the violence on me be like, and you are looking somewhere else?

PT: Because I am trying to see.

TH: If you portray yourself as a violent person here with me, how it would be? How would the attack be like ?

All of the indicators point out that the neurobiological and somatic pathway of the murderous rage is well activated and he is actually experiencing his murderous rage in the transference.

Passage of the Primitive Murderous Rage in the Transference

TH: How would that be like?

PT: Well, I would punch. (He is sitting in his chair, his hands are upward in a punching position, there is no anxiety and with the movement of the hands he demonstrates how he would act on the murderous rage toward the therapist).

TH: Punch where?

PT: In the chest, in the stomach and then the face; both sides of the face, and I would just keep punching and punching and punching.

TH: And which side of my face would be the target more? Left, right or what?

PT: I don't think I would make a difference, it would be, be the same.

TH: But how would you. I mean ...

PT: One side and then the other side ... any part of the head really uh ... hitting in the face.

TH: And then if you let this vicious rage out further, in terms of this thought, where else would you attack besides the face?

PT: Ah. Oh. I'd probably kick uh ... kick with my feet, kick with my feet ... kick your abdomen and in, in the chest.

TH: *If you let this vicious rage out, how would you ... how the attack on the abdomen would be?*

PT: *I could just see myself standing beside and then with one leg ... (thumping sound)*

TH: *Beside me or beside who?*

PT: *Besides you, standing and pushing and banging and ... (thumping sound)*

TH: *Right or left?*

PT: *Banging with my right leg ... in the abdomen.*

TH: *Abdomen, upper or lower?*

PT: *(Pointing to lower abdomen) ... Well I would kick hard enough to, to, to crush, to put my foot almost to the ground.*

TH: *So in a sense it would pass my abdomen.*

PT: *Would go right through, if it, if it was capable, it would go right through you.*

(Thumping sound)

It is extremely important to note that in the whole process he is actually experiencing his vicious rage, and again the somatic and neurobiological pathway of the murderous rage is well activated. Further, we see again the mechanism of projective identification and symptom formation, namely, murdering with his legs and his double arthralgia.

Now we return to the interview where we were left.

PT: *Visually I see it crushed.*

TH: *And if you let this rage unleash further?*

PT: *Kick every part of your body (thumping sound). In the, in the arms and in the legs and in the head.*

TH: *And if you further unleash this rage on me?*

PT: *I would just keep kicking and kicking ... every part that was in front of me, I ... whether it be the head or the abdomen or the chest or the leg or the arm. Just keep kicking.*

TH: *And if you had lost total control over your rage, what else would you do?*

PT: *I just see me kicking you, kicking. You would be lying in front of me... (Forcefully stomping his leg) crushed, then I am kicking inside the genital and my foot would enter your body and your genital would be totally destroyed and I have made a hole in your body.*

He is enraged, and with his foot he shows how he would penetrate the cavity that he has created in the genital area of the therapist. It is important to note that on the research scale, both the degree of primitiveness of the murderous rage, as well as the intensity of his violent rage, are much higher than in the first part of the interview.

Now we return to the interview where we had left.

TH: *And then if you go further?*

PT: *I just can see myself banging on the chest, banging and banging on your chest. Then I would grab my fist and smash it on your face, on your nose like this.*

TH: *Hm hmm.*

PT: *And then punch from the side and finally terminate your life passing a stick through the chest.*

Again, we see the mechanism of projective identification and symptom formation, namely, his crushing chest pain and the symptoms related to his head.

Return to the interview.

TH: *So I'm murdered and then my eyes are looking at you or where? Do you see my eyes? When you look to my dead body, my abdomen is totally demolished, mutilated, my genital is mutilated, there is a cavity there, your foot has gone into the cavity, my face is severely damaged ... It is very important you look and keep looking at my eyes.*

PT: *I see ... (Patient whispers) I have trouble seeing the face.*

Emergence of Sadness

The emergence of sadness indicates the end of the passage of the murderous rage. The therapist is asking the patient to keep looking at the eyes of the murdered body of the therapist, waiting for the unconscious therapeutic alliance to identify who is being murdered. The therapist is waiting for a phenomenon of transfer. The emergence of the sadness also indicates that the guilt and the grief have been mobilized and are going to breakthrough as soon as the transfer takes place.

Now we return to the interview.

TH: *If you carefully examine my face and my eyes.*

(The patient is very sad. He is looking to the floor where the murder has taken place and there is a major wave of painful feeling which wants to surface).

Unconscious Murderous Feeling Toward the Mother

Passage of the Guilt-Laden Unconscious Feeling

TH: *There is a major wave of painful feeling, why you don't want to get in touch with the full range ...*

PT: *(Heavy wave of sobbing) I see my mother's face. I see my mother's eyes. (Heavy passage of the second wave of guilt) (Whimpering sound, heavily sobbing)*

TH: *You have another major wave of painful feeling.*

PT: *(Heavy sobbing)*

TH: *What colour are her eyes?*

PT: *Brown.*

TH: *Brown eyes?*

PT: *Brown eyes.*

TH: *How about her hair?*

PT: Brown, dark brown.

TH: At what age do you see her? Present age or younger age?

PT: No, younger age. Somewhere around forty. (Another wave of sobbing) I visually see her screaming at me.

TH: What way?

PT: I have been bad (choked voice, crying). What I visually am seeing right now is me being a little boy and I spilled ink on an encyclopedia ... on a new expensive set of books my parents bought.

TH: What age?

PT: Very young, I was so scared ... terrified that my mother would see that and... and my father would beat me. So I told my brother never to show them the book.

TH: You called your brother?

PT: He was there when it happened.

TH: But you were terrified?

PT: Ohh.

TH: ... that she finds out.

PT: Scared, (another major wave of sobbing, painful feeling)

TH: So you were terrified, hmm?

PT: I was so scared (High-pitched voice, continues with heavy sobbing) she was a forbidding figure. (Another wave of sobbing)

TH: Hmm.

PT: Every time it was parent and teacher's night at the school I used to hate it so much. (Patient is crying) My mother always went to school cause the teachers wanted to see her (further wave of sobbing). She would then have to go to see my brother's teachers. Ohh she'd be so mean when she came home. (Another wave of sobbing)

TH: And your mother's manner was what?

PT: Hitting me, physically ... may be not as much as my father (sobbing). She always ... (sobs)... why couldn't I be like my brother.

Some Early Memories of his Life with his Parents and his Brother

Aspects of Family Dynamics

What further emerges is that both parents constantly compared him with his brother, that he was the golden star and the patient was the black sheep. During the interview, he says he is hearing her voice "He is much smarter," "He never gets into any problem," "He did not break things," "I could never do anything right."

The focus is on the patient's grief-laden unconscious feeling and he talked of being humiliated. Then he said, "I usually see myself, my parents making me stand in the corner when we had

visitors." About his brother he says, "He was the favourite of both my mother and father." Then he says that he has another visual image that he was hiding under a bed, and his mother was swinging the broomstick at him underneath the bed. This is followed by another wave of heavy crying. He comes with memories of his mother having a vicious temper, and his way was always to hide under the bed "trying to get away from her."

The focus of the session is on the family dynamics in the early years of his life. Father was physically brutal, and he would frequently punish the patient with a stick or a strap. Mother also physically punished as well, with a broom, but at the same time would prepare the ground for the punishment by father. Then the punishment by the father would start. The target of the punishment would be the head or the legs.

Recapitulation and Analysis of the Transference

After the passage of the painful feelings, the waves of painful feelings, the therapist then moves to the phase of consolidation, analysis of the transference and recapitulation. As space does not allow the full verbatim analysis of the transference and the phase of consolidation, I will present only the passage which follows where we had left the interview.

TH: How do you feel right now?

PT: Tired a bit.

TH: How is your anxiety?

PT: I don't have any anxiety.

TH: There is no anxiety?

PT: No, I feel relaxed.

TH: Uh huh. Now if we look and it is very important at this moment that we can recapitulate and examine this process as we saw. When we met you were anxious again.

PT: Yes.

TH: And you indicated that your anxiety had to do with me, had to do with the issue that you might fail in relation with me, and you talked about the performance.

PT: Hm hmmm.

TH: So that is one; the anxiety if you will be able to perform and so forth. And it is very striking when you look at it; it is similar to the anxiety that you had always with your mother, hmm, that if you will be able to perform or if she would be satisfied with your performance, hmm?

PT: Yes.

TH: And we can see that you have always had the fear of whether your mother would approve, be satisfied with your performance or she would become punitive, humiliating and punishing, hmm?

PT: Hm hmm

TH: But it's also important to take again another look when we met, then I told you that you have a major problem with intimacy and closeness. Now we are getting to understand why you have this major need to defend yourself against intimacy and closeness. And I pointed

out to you that you don't want me to get to your intimate thoughts; intimate life and intimate feelings, hmm, that you erect a wall between yourself and me, that you don't want me to get to your intimate life, to your intimate feelings. And now, at this point of the interview, we can have some understanding, we don't have time to go into the detail at this time, the explanation is after these experiences that you are talking about, that your mother was punitive, your father was physically brutal, you had to escape under the bed, attacked with the broom, strapped, being humiliated in front of the others. So, as if in a sense at one level you have decided that you would not let anybody get close to you, hmm, but something has to explain because ...

At this point of the phase of consolidation, the patient said that in the early years he was searching for bonding with his brother, which was not possible. He ended up to develop a close relation with his grandmother who was living in the same house. The therapist acknowledges and points out "That is important, we can explore it in due time, but at this point it is important that we focus on the process as we went through it." The therapist briefly outlines the therapeutic task and brings this part of the interview to closure.

PART THREE OF THE INTERVIEW

Anxiety in the Transference: Return to the Phase of Pressure

The patient entered to the interview with the return of the resistance in the transference, anxiety in the transference, and the therapist immediately focuses on the anxiety. It is important to note, and this is an empirical clinical research, that after the first breakthrough and mobilization of the unconscious, the subsequent interviews during the first and second phases of the treatment, the patient enters into every session with anxiety which always has a transference implication. We see this in the standard technique in which the patient is seen in weekly intervals. We also, with no exception, see it in the extended and repeated major unlocking of the unconscious. The therapist's task is to focus on the anxiety and the dynamic forces underlying the anxiety. Now we return to the beginning of this interview.

TH: I notice you are anxious.

PT: There is something about you ... may be the session that makes me anxious.

TH: You took a deep sigh ... and you are fidgeting.

PT: Being uncomfortable uh ...

TH: You said something about me but at the same time you said something about the session, which one?

PT: Obviously it is you.

In the above passage, the patient uses a tactical defense, wants to move away from the transference to the session. This tactical defense is challenged and called upon. The patient responded: "Obviously it is you." Now the process enters into the phase of pressure.

Phase of Pressure

TH: So let's see how you feel toward me?

.....

The patient has entered to this interview with the return of the major resistance, and the therapist systematically applies the phase of pressure and challenge with the aim of mobilization and intensification of the resistance in the transference. There is further mobilization of the transference component of the resistance. Now, the phase of pressure and challenge alternates with repeated head-on collision to the resistance in the transference combined with deactivation of the transference. There is anger and rage in the transference with pressure for the actual experience of the anger and, finally, there is mobilization and activation of the somatic pathway of the primitive murderous rage and its breakthrough in the transference. It is important to note that the duration of this phase in the third part of the interview is quite a bit shorter than in the first two parts. As the technical and metapsychological aspects of this process is to a large extent similar to Part I, this part of the process is omitted, and we return to the interview where there is the passage of the murderous rage in the transference.

Passage of Primitive Murderous Rage in the Transference

Unconscious Murderous Feeling Toward the Father

TH: If you give up this paralysed position and let this rage out on me, what the attack on me would be like? If you let it loose? What it would be like? If the vicious animal is put out?

PT: Well, punch you in the chest.

TH: What force, the force of the punch?

PT: My fist would have infinite strength ... (It is important to note: absence of anxiety; facial expression of vicious anger; firmly sitting in the chair but in forward position; both hands are in the fist position and he is actually experiencing his rage). A heavy punch... with two hands punching the face, head, again punching the face and the head like this.

TH: And then?

PT: ... grab you by the shirt and smash you against the wall. (Patient is sitting in the chair, the two hands are in the forward grabbing position and he viciously says I will smash you against the wall)

His posture, tone of voice, and all of his nonverbal communications are indicative of a tremendous violent rage that he is experiencing, and he is totally absorbed in the process.

TH: What way?

PT: Push you against the wall ... probably break the wall ... if I hit you and crush you on the door, it'd go through the door.

TH: And then?

PT: Crush you again on the wall ... and then the other wall ... back and forth.

TH: And then?

PT: Throw you on the floor.

TH: And then?

PT: Start kicking you and stomp on you ... kicking you, keep kicking you. (Thumping sound - patient hitting the floor with his foot) Up and down, smashing with my foot. (Further stomping his foot)

TH: And then?

PT: On the chest... kicking you heavily in the chest and the legs.

TH: And if you unleash further?

PT: Further kicking on the chest ... step on your hands, (thumping noise) break your arms (thumping).

TH: And then?

PT: Break your feet.

In the above passage, we saw the breakthrough of a vicious murderous rage which is primitive. We still do not know who is the actual target of this primitive rage. The process clearly demonstrates, again, the mechanism of projective identification and symptom formation: his double arthralgia, crushing chest pain, and symptoms related to his head.

Major Unlocking of the Unconscious

Emergence of Sadness: which indicates the passage of the murderous rage has come to an end; guilt-and grief-laden unconscious feelings are mobilized and the major entry into the unconscious is taking place. Now we return to the interview.

TH: The rage is gone now?

PT: Hm hmm.

TH: And what is my position? My eyes look at you?

PT: (Sniffing and very sad)

TH: As you look at my eyes, what is the colour of my eyes?

PT: Green.

TH: And the colour of the hair?

PT: Light brown, light brown.

TH: Light brown, hm hmm. It's green eyes with light brown hair and these pair of eyes are looking at you or avoiding to look at you?

The patient is heavily absorbed, looking to the floor and to the identity of the person who has been murdered so primitively.

Passage of the Major Wave of Guilt-Laden Unconscious Feeling

PT: (Continues to be sad, then there is a sudden wave of a major guilt-laden feeling) My father. (He is sobbing, very choked voice)

TH: How old is he?

PT: He's forty ... I don't know exactly. (Patient continues looking to the floor, totally absorbed in this process)

TH: Your father is mutilated, the head is totally damaged, the chest is totally crushed, arms and legs are broken, when you approach his dead body, what communication you get from his eyes? ... There is a major wave of feeling in you and you want to experience it as fully as you can, the full impact of this major wave.

PT: (A second major wave of painful feeling is passing, heavy sobbing)

TH: Hmm.

PT: I hold him in my arms ... I bend down and then hold him in my arms (heavy sobbing, choked voice), hold him around his chest with both arms and put my head on his shoulder. (Another major wave)

TH: How his eyes look?

PT: (Pause) His eyes are just staring.

TH: Staring, does he say anything before he says goodbye to life? ... His eternal goodbye to life or he dies in silence?

PT: He is very dead.

TH: Does he say anything in his last struggle with life and death?

PT: He asks me to take care of my mother. (Heavy sobbing)

TH: How did he put it to you ?

PT: She's ... have her move in with you.

In a very painful state, he talks about his father telling him "Joseph ... Joseph ... take care of your mother ... hmmm?" In a very choked voice he says:

PT: I have mixed feelings ... (pause) I don't know whether to say I will or I won't. (Patient continues sobbing)

TH: What do you want to say?

PT: I wanna say yes (heavy crying), but I am not sure ... that I'll take care of my mother. (Crying)

TH: But it must be very painful because his request to you as he dies is to take care of your mother, you want to say yes, but a part of you has a lot of mixed feelings.

PT: Yeah (whispers).

TH: Hmm.

PT: (Choked voice) I think that it would not be good for my family (referring to his wife and three children).

TH: I know, in terms of your feelings, to say yes to your father about this would not be honest

because that is not the way you feel about it at this point in time. But at the same time you are afraid that she might have a negative impact on the family.

PT: Yes.

Emergence of Another Wave of Painful Feeling

TH: *You said that you have his head and chest in your arms. How you say your final goodbye?*

PT: *(Continuous heavy sobbing) I tell him ... (sobs)... that I'm gonna miss you.*

TH: *How would you verbalize it to him before he ... closes his eyes forever.*

PT: *(Continues sobbing heavily) I love you dad (sob-laden voice) ... I love you Dad, I hold him and I hug him.*

TH: *Hmm.*

PT: *I hold ... (sobs) ... and I hug him and I talk to him.*

TH: *You talk to him? What would you say further?*

PT: *(Heaving breaths, sniffing, then heavy sobbing) He never wanted to play with me.*

TH: *Hm.*

PT: *He didn't wanna play with me. (Pause, with intermittent sobbing and sniffing)*

TH: *So must be a lot of painful feeling about the wish that you could have played with him. Or he had spent time with you, hmm.*

PT: *We spent time together but we never really had quality, quality time together (continues crying).*

Further Grief-Laden Unconscious Feeling

In an intensely sad and painful state, he continues and talks about not having had time alone with his father who was not physically affectionate.

PT: *I don't remember much.*

TH: *Because it is very important, you said that before he ... I mean in his last struggle with life you will hold him and hug him.*

PT: *(Heavy sobbing)*

TH: *So as if in death only you could feel close to him and hold him and hug him, hmm?*

PT: *(Further sobbing)*

TH: *Not alive? You see what I mean? That in death you were holding him and hugging him, but not when he was alive.*

PT: *(Emotion-laden voice) I remember when I was a little boy I used to ... not often, but I used to hug my father, kiss him on both cheeks. Then, as I got older, I did not hug him anymore and now, when I kiss him hello or goodbye, I don't feel anything.*

Then the focus is on the burial and the funeral.

TH: *He is going to be buried in a mutilated way, hmm?*

PT: *Visually I see him dead but I don't see him mutilated in the coffin. I see him normal, skinny face, very thin face.*

TH: How is he dressed up?

PT: Visually, what I see, bluish, bluish-gray jacket (patient is sobbing), I hold him ... I hold his hand, his hand. (Sniffing)

TH: With which hand you hold?

PT: I hold his right hand with my right hand.

TH: In this last moment, what would you say?

PT: I'd tell him I'm gonna miss him. (Choked voice, sniffing)

TH: Where is he going to be buried?

PT: (sobbing heavily) Beside my grandmother.

In the above passage, we see intensification and systematic passage of the painful feeling and, in particular, grief-laden, while in the early part of the breakthrough, the passage was heavily on guilt-laden feelings.

Then the process of the interview enters the phase of consolidation, analysis of the transference and of the process which, because of the shortage of space here, is totally omitted. After the completion of the phase of consolidation, he spontaneously talked about his grandmother from the father's side, and at this point the pathological mourning becomes converted to a process of acute mourning.

In all the forms of direct access to the unconscious - be it partial, major or extended major - all pathological mourning becomes converted to a process of acute mourning. In this case, we see the acute mourning phase.

Mourning the Death of the Grandmother

The grandmother lived with the family until she died. She was always sick. There was a division in the family: father, mother and brother in one camp, and the patient, who became the favourite of the grandmother. Mother and father were very hostile towards the grandmother, with constant exchange of hostility; and, in the interview, the patient, in an intensely sad state, said:

"Actually, they tortured her to death." The process of the session now moves to mourning the death of the grandmother.

Emergence of Painful Feelings and Memories of his Life with his Grandmother

As I have already mentioned, in all life-long character neurosis, when there is a pathological mourning, as a result of the mobilization of the unconscious, they become converted to an acute mourning process. Now we return to the interview. The patient avoided the funeral of the grandmother, and has never gone to visit her grave. At this point in the interview, there are intermittently heavy waves of painful feelings and sobbing.

PT: She taught me ... (heavy breaths, sobs) ... my first prayer ... I remember ... (voice breaks) ... I don't remember any more the prayer, just the first few words. (Very choked up) She taught me three prayers, two I remember.

TH: How old you were?

PT: Five or six ... we used to say our prayers together before going to bed. They are pleasant memories, but also sad (choked voice), sad that she was tortured and died in suffering.

He talks further about his grandmother, "She was battered by her (referring to his mother)," "My father was reinforcing the abusive behaviour of my mother." He further says that his grandmother had a tough time. In the earliest phase, she used to fight back. But as she became very sick, she could not fight back any more. "She died in a very traumatic way." The patient often wished that he could have defended his grandmother. "I always saw her as a crippled person, or a weak person, not able to do anything."

The focus is on his idea of his father and his mother being buried next to the grandmother.

PT: I don't know if they would wanna be buried together (heavily choked voice). They were always fighting. There was always exchange of hostility between my grandmother and my mother ... always.

TH: Hmm.

PT: (Sniffing) Always.

TH: Hmm. Where is your grandmother buried?

PT: I think, she's buried near our house.

In a painful choked and sniffing voice, he says that he has not visited her grave.

TH: Hm hmm. You mean that you want to visit and you don't?

PT: I find it too difficult, too painful ... too painful to visit her grave. (Sob-filled voice)

TH: Hmm.

PT: To visit my grandmother.

TH: Because it is going to mobilize a lot of feeling ... painful issues?

PT: Hmm. I'm so sad when I think about her. Brings memories ... very disturbing memories. (Patient crying heavily) Good memories (Sobbing) Hurts because it is only memories (crying as he says this) ... but also there are memories ... that she was tortured by my mother.

TH: Hmm.

PT: My mother was so mean to her and (sobbing), and my grandmother wouldn't defend herself.

Then he talked about his grandmother as his refuge, and about how he had replaced his mother with his grandmother. He became attached to his grandmother, but the relationship was an ambivalent one, as the grandmother, who was his protector, herself was the subject of constant

attack and humiliation. The focus is on his ambivalent feelings for the grandmother, and he said: "She was helpless to defend herself," "We were both treated the same way." The focus of the session is now on the process of mourning: a piecemeal review about his life with his grandmother, the way she died and, finally, her death and the fact that he totally avoided being present (Lindemann 1979).

The whole passage of the process of mourning the death of the grandmother is omitted, as it is beyond the scope of this article. At this point, as his painful feelings subside, the process enters into a comprehensive phase of consolidation and analysis of the process of the three parts of this interview, broadcasting the important task ahead; and assessing the patient's willingness to get to an in-depth exploration and investigation of his unconscious. At the end of such an interview, the unconscious therapeutic alliance is very much mobilized; we see a weakening of the major resistance; the patient's willingness for the future work is extremely high, and the therapist sets up the psychotherapeutic contract.

RECAPITULATION

It is important to recapitulate the major technical interventions and the process of this three-part initial interview, presented in this article. The process can be summarized as follows:

- 1) The interview started with the phase of pressure (the phase of inquiry and dynamic inquiry became the focus of the session at the end of Part I of the interview). The therapist exerted pressure to the underlying feeling which led to a rise in the transference and further anxiety; the therapist maintained his focus on pressure, and the patient's resistance became well crystallized in the transference; this was followed by systematic challenge to the patient's character defenses, concomitantly making him acquainted with these defenses.
- 2) From the psychodiagnostic point of view, the therapist came to the conclusion that the patient suffers from character neurosis with no fragility whatsoever, and the discharge pattern of the unconscious anxiety is exclusively in the form of tension in the striated muscles; and decided that a rapid direct access to the unconscious is the procedure of choice.
- 3) The process continued with the systematic application of challenge and pressure and, as the resistance against emotional closeness became well crystallized in the transference, the therapist applied head-on collision with the resistance, and continued with challenge and pressure; there is mobilization of anger in the transference. Then the process moved to:
- 4) Systematic challenge and pressure to the major resistance; pressure for the actual experience of anger in the transference; activation and mobilization of the neurobiological and somatic pathway of the primitive murderous rage; there is weakening of the major resistance and major mobilization of the unconscious therapeutic alliance against the forces of the resistance. This was followed by:

- 5) Passage of the primitive murderous rage in the transference; crushing of the chest, the head, and the murdered body of the therapist is on the floor. This was followed by:
- 6) Visual imagery - the visual portrait of the murdered, mutilated body of the therapist now becomes transferred to the portrait and visual imagery of the murdered body of the brother, with the green eyes of the brother looking at him. The transfer was instantly followed by:
- 7) The passage of guilt-laden unconscious feeling which is very intense, and after three to four minutes, the passage of grief-laden unconscious feeling and extremely painful feelings for the wish he could have had a positive relationship with his brother, and the emergence of his love, "I'm gonna miss you," and then:
- 8) A major communication from unconscious therapeutic alliance, which indicated that he must unconsciously be a criminal in relation to his parents, which is computerized by the therapist for future reference.
- 9) It is extremely important to emphasize that there is absolutely no anxiety, no tension in the striated muscles and no activity on the part of the resistance - major or tactical - from the moment of passage of the primitive murderous rage to the end of the interview.
- 10) The therapist immediately moved to the phase of consolidation, analysis of the transference, emphasizing the mechanism of projective identification and symptom formation. Then:
- 11) The therapist returned to the phase of inquiry and dynamic inquiry, exploring the patient's episodes of depression which are being treated by his family physician; and his chronic arthralgia, with episodes of exacerbation necessitating physiotherapy and treatment by an internist. The therapist then explored other areas of disturbances, as well as the current family dynamics.
- 12) In Part II of this initial interview, he came with anxiety in the transference and a return of the major resistance, and the process immediately moved to the phase of pressure, pressure and challenge, and repeated short-range head-on collision. He declared anger and rage in the transference. This was followed by:
- 13) Pressure for the actual experience of the rage, and, finally, activation of the somatic and neurobiological pathway of the murderous rage, then:
- 14) Passage of the murderous rage in the transference, then:
- 15) Transfer of the portrait and visual imagery of the murdered body of the therapist to the visual imagery of the murdered body of the mother, the brown eyes of the mother looking at him. Instantly, as the transfer took place, there was:
- 16) Major passage of unconscious guilt-laden feelings in relation to the murdered body of the mother which was then followed by grief-laden feelings, which were then followed by some of his earliest memories of his life with his parents and his brother, and some aspects of the family dynamics came into focus. The therapist then moved to the phase of analysis of the transference and of the process, explored how he felt, and the patient declared himself somewhat tired, but with no anxiety, and relaxed. Now, we summarize the process of the third part of the interview.
- 17) He returned with anxiety in the transference and a return of the major resistance. The

process immediately moved to the phase of pressure, anxiety in the transference, and pressure from the underlying feeling; systematic challenge and pressure with head-on collision, head-on collision with the resistance against the emotional closeness; anger and rage in the transference; pressure for the actual experience of anger, and activation of the neurobiological pathway of the primitive murderous rage, and then:

- 18) Passage of primitive murderous rage in the transference, visual imagery of the murdered body of the therapist on the floor, which then became transferred to the visual imagery and portrait of the father mutilated, looking at him with his green eyes and light brown hair. Then, instantly, with the transfer, followed by:
- 19) Passage of the major waves of guilt-laden feeling and then grief-laden feeling, and this was followed by the phase of consolidation and analysis of the transference. Then he introduced;
- 20) The death of his grandmother and there was the conversion of the pathological mourning to acute grief and passages of highly intense painful feelings; memories of his early life with his grandmother who was heavily used and abused by his parents. Then:
- 21) The session moved to a major recapitulation, analysis of the process and, once more, analysis of the mechanism of projective identification and symptom formation; the interconnection between the psychopathological dynamic forces within his unconscious and his symptom and character disturbances, and then setting up the psychotherapeutic contract, which was with this particular patient on an hourly, once-a-week basis.

SUMMARY, CONCLUSION AND GENERAL OVERVIEW

In this article, I have presented the technique of Intensive Short-Term Dynamic Psychotherapy and briefly highlighted a new method of Psychoanalysis. What I have presented can be summarized as follows:

- 1) The technique has proven highly effective in the treatment of phobic, obsessional, panic, somatization, functional and depressive disorders; on the whole spectrum of psychoneurotic character neurosis and, with some modification, is effective in certain kinds of psychosomatic disorders. Again with some modification, it is highly effective in the treatment of patients with fragile character structure.
- 2) Then I presented briefly the spectrum of resistance with particular emphasis on patients with psychoneurotic disorders; and I summarized briefly five major groups of patients on the spectrum, and indicated that at the extreme left are highly responsive patients with circumscribed problem, single psychotherapeutic focus, and virtual absence of unconscious murderous rage of guilt; and further indicated that this group of patients is very rare. Then I presented the extreme right on the spectrum and briefly summarized that these patients present a very high degree of the resistance, major symptom and character disturbances, with a highly complex core pathology; and emphasized the presence of a highly primitive unconscious murderous rage/intense guilt and grief, multidimensional in relation to the early

figure(s); between the extreme left and the extreme right there are various degrees of resistance, and that the unconscious of all resistant patients contains highly primitive unconscious murderous rage/intense guilt and grief.

- 3) Then I briefly presented the spectrum of the technique of direct access to the unconscious; partial, major, extended major and extended multiple major; and pointed out that the partial and major unlocking of the unconscious are most often used in Intensive Short-Term Dynamic Psychotherapy, and extended major mobilization of the unconscious, with maximum mobilization of unconscious therapeutic alliance, is practiced in the new form of Psychoanalysis.
- 4) Then I very briefly outlined the dynamic sequence in the process of direct access to the unconscious and mobilization of unconscious therapeutic alliance over the resistance: the phases of inquiry; pressure; challenge; transference resistance; direct access to the unconscious; and systematic analysis of the transference, were briefly outlined; and I referred the reader to the four-part article by my German colleagues in this journal.
- 5) I emphasized a spectrum of mobilization of unconscious therapeutic alliance against the forces of the resistance. Mobilization of the unconscious therapeutic alliance is of central importance in both techniques, but the difference is one of degree. Optimization of the unconscious therapeutic alliance, which I call "Dreaming While Awake," is the central feature of the new method of Psychoanalysis.
- 6) I emphasized the rapid mobilization of the triple factors of resistance, transference and unconscious therapeutic alliance. Again, this applies to both IS-TDP and the new method of Psychoanalysis, but there are quantitative and qualitative differences in the degree and rapidity of the mobilization.
- 7) As much as space permits in an article, there was an in-depth analysis of an extended major unlocking of the unconscious of a patient from the mid-right of the spectrum, with three major breakthroughs into the unconscious, demonstrating the technique of extended major direct access to the unconscious, which is often used in the new method of Psychoanalysis, but may also be used in Intensive Short-Term Dynamic Psychotherapy.
- 8) Spectrum of the Resistance and Duration of Trial Therapy : The duration of a comprehensive initial interview/trial therapy varies from ninety minutes to three and one half hours, and in some patients it might even extend from four to five hours. For patients on the extreme left of the spectrum, the initial interview lasts fifty minutes. Here, we obviously cannot talk about unlocking, there is no major resistance and no murderous rage within the unconscious. But, on the mid-left on the spectrum, there is the presence of the murderous rage/intense guilt; and there is resistance of moderate degree; and the duration of the trial therapy averages ninety minutes. On the right side of the spectrum - high degree of the resistance and major resistance - the duration increases from two to three and one half hours. It may be conducted in a single interview, or in two parts within twenty-four hours, but should not exceed a one week interval.

- 9) Psychotherapeutic Contract: In the standard technique of Intensive Short-Term Dynamic Psychotherapy, the psychotherapeutic contract can be presented after direct access to the unconscious (partial or major unlocking) at the end of the comprehensive initial interview which, as mentioned before, can last anywhere from one and one half hours to three and one half hours, based on the degree of the resistance. After direct access and direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances, the therapist sets up the therapeutic contract which consists of one hour per week.
- 10) Spectrum of the Resistance and Duration of the Course of Treatment: In patients on the extreme left on the spectrum, therapy lasts from one to five psychotherapy sessions. On mid-left of the spectrum of the resistance, it lasts between ten to fifteen psychotherapy sessions, and, on the right side of the spectrum, between twenty-five and thirty-five sessions. The upper limit of the treatment is forty sessions.
- 11) A total avoidance of the development of any trace of transference neurosis is central in this technique, which starts from the first session and continues throughout the process. By virtue of the fact that management of the resistance is direct - no free association technique - and strict avoidance of the transference neurosis with rapid mobilization of the unconscious and rapid and maximum mobilization of the unconscious therapeutic alliance, the technique is radically different from Freudian, neo-Freudian, Jungian or any other form of psychoanalysis.
- 12) Outcome: In terms of outcome, this requires the total removal of symptom and character disturbances, and this must be achieved during the course of the therapy, and by termination there should be a total resolution of the core pathology: a total resolution of the psychopathological dynamic forces responsible for the patient's disturbances.
- 13) Psychotherapeutic Setting: Briefly, in every centre, institute, and department of Psychiatry of major teaching hospitals, as well as in the consultation room of private practitioners, the interview is conducted face-to-face with a microphone between the therapist and the patient. The interview room is equipped with audiovisual recording and the whole process - from the initial interview, course of treatment, outcome and follow-up - is audiovisually-recorded for scientific research and teaching, with the aim of the development of a scientific psychology of the unconscious mind, a scientific psychology to explain psychological phenomena in neuroscientific and neurobiological terms.
- 14) Teaching and Supervision: Closed-Circuit Live Interview: This is an integral and important aspect of teaching and research. It is central to the training program where the patient is interviewed by well-trained supervisors, while members of the training program are observing the interview; or the trainee is interviewing the patient, and the process of the interview is supervised by the supervisor in the presence of the members of the training program. There are a number of variations in the format of closed-circuit, which is beyond the scope of this article; and from the beginning of my research, I considered it a vital artery in teaching and research of the science of psychodynamics. Without it, scientific research would not be possible.

The process of supervision of the trainee, in addition to didactic presentation in terms of summary of the case and of the process, is done on the audiovisually-recorded interview. The process of ongoing video supervision is usually done in a small group setting, which consists of six to ten trainees. Obviously, such a powerful and effective technique as I am describing here requires systematic training on the technical and metapsychological roots of the technique in general, as well as on the more major revisions of the metapsychology of the unconscious: the new psychology of the unconscious mind.

The data in this area shows that, without question, the technique is absolutely transferable. To cite a few examples, on the European scene, there are the Swiss Associates, the German Society, the Dutch Association, and the Italian Institute for Intensive Short-Term Dynamic Psychotherapy - all with a sizeable faculty that has been trained directly by myself. Over the past number of years, they have set up their own training programs, providing training to other psychiatrists and psychotherapists in their own country in this technique. A similar trend exists in North America, and there are even major teaching medical centres that provide comprehensive training in this technique to the residency training program. The directors and supervisors were directly trained by myself and over the past number of years, they have been training others. This evolutionary trend, and the feedback from those in training in many centres, indicates that the technique is indeed transferable.

References

- Davanloo, H. (1975) Proceedings of the First International Symposium and Workshop on Short-Term Dynamic Psychotherapy, Montreal, Canada. March.
- Davanloo, H. (1976a) Proceedings of the Second International Symposium and Workshop on Short-Term Dynamic Psychotherapy, Montreal, Canada. March-April.
- Davanloo, H. (1976b) Proceedings of the Audiovisual Symposium on Short-Term Dynamic Psychotherapy. Tenth World Congress of Psychotherapy, Paris, France. July.
- Davanloo, H. (1977) Proceedings of the Third International Congress on Short-Term Dynamic Psychotherapy, Century Plaza, Los Angeles, California. November.
- Davanloo, H. (1978) Basic principles and techniques in short-term dynamic psychotherapy. New York: Spectrum.
- Davanloo, H. (1980a) Short-term dynamic psychotherapy. New York: Jason Aronson.
- Davanloo, H. (1980b) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the 133rd Annual Meeting of the American Psychiatric Association, San Francisco, California. May.
- Davanloo, H. (1981) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the 134th Annual Meeting of the American Psychiatric Association, New Orleans, Louisiana. May.
- Davanloo, H. (1982) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy with Resistant Patients presented at the 135th Annual Meeting of the American Psychiatric Association, Toronto, Canada. May.
- Davanloo, H. (1983) Proceedings of the First Summer Institute on Intensive Short-Term Dynamic Psychotherapy. Wintergreen, Virginia. July.

- Davanloo, H. (1984a) Short-term dynamic psychotherapy. In Comprehensive textbook of psychiatry (4th ed.. Chap.29.11), H. Kaplan and B. Sadock, (Eds.). Baltimore, MD: William & Wilkins.
- Davanloo, H. (1984b) Proceedings of the Second Summer Audiovisual Immersion Course on Intensive Short-Term Dynamic Psychotherapy. New York City, New York. July.
- Davanloo, H. (1985) Proceedings of the First Audiovisual Symposium on Intensive Short-Term Dynamic Psychotherapy sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Pfafers, Switzerland. June.
- Davanloo, H. (1986a) Intensive short-term dynamic psychotherapy with highly resistant patients. I. Handling resistance. *International Journal of Short-Term Psychotherapy*, 1(2), 107-133.
- Davanloo, H. (1986b) Intensive short-term dynamic psychotherapy with highly resistant patients. II. The course of an interview after the initial breakthrough. *International Journal of Short-Term Psychotherapy*, 1(4), 239-255.
- Davanloo, H. (1986c) Proceedings of the Second European Audiovisual Symposium and Workshop on Intensive Short-Term Dynamic Psychotherapy sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Bad Ragaz, Switzerland. June.
- Davanloo, H. (1987a) Unconscious therapeutic alliance. In *Frontiers of Dynamic Psychotherapy*, P. Buirski (Ed.). New York: Mazel and Brunner, Chapter 5, 64-88.
- Davanloo, H. (1987b) Intensive short-term dynamic psychotherapy with highly resistant depressed patients. Part I. Restructuring ego's regressive defenses. *International Journal of Short-Term Psychotherapy*, 2(2), 99-132.
- Davanloo, H. (1987c) Intensive short-term dynamic psychotherapy with highly resistant depressed patients. Part II. Royal road to the dynamic unconscious. *International Journal of Short-Term Psychotherapy*, 2(3), 167-185.
- Davanloo, H. (1987d) Clinical manifestations of superego pathology. *International Journal of Short-Term Psychotherapy*, 2(4), 225-254.
- Davanloo, H. (1987e) Proceedings of the Fifth Annual Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Intensive Short-Term Dynamic Psychotherapy. Killington, Vermont. August.
- Davanloo, H. (1988a) Clinical manifestations of superego pathology. Part II. The resistance of the superego and the liberation of the paralyzed ego. *International Journal of Short-Term Psychotherapy*, 3(1), 1-24.
- Davanloo, H. (1988b) The technique of unlocking of the unconscious. Part I. *International Journal of Short-Term Psychotherapy*, 3(2), 99-121.
- Davanloo, H. (1988c) The technique of unlocking of the unconscious. Part II. Partial unlocking of the unconscious. *International Journal of Short-Term Psychotherapy*, 3(2), 123-159.
- Davanloo, H. (1989a) Central dynamic sequence in the unlocking of the unconscious and comprehensive trial therapy. Part I. Major unlocking. *International Journal of Short-Term Psychotherapy*, 4(1), 1-33.
- Davanloo, H. (1989b) 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. *International Journal of Short-Term Psychotherapy*, 4(1), 35-66.
- Davanloo, H. (1989c) The technique of unlocking the unconscious in patients suffering from functional disorder. Part I. Restructuring ego's defenses. *International Journal of Short-Term Psychotherapy*, 4(2), 93-116.

- Davanloo, H. (1989d) The technique of unlocking the unconscious in patients suffering from functional disorders. Part II. Direct view of the dynamic unconscious. *International Journal of Short-Term Psychotherapy*, 4(2), 117-148.
- Davanloo, H. (1990) *Unlocking the unconscious*. Chichester, England. John Wiley & Sons.
- Davanloo, H. (1992) *Proceedings of the Eighth European Audiovisual Immersion Course on Technical and Metapsychological Roots of Intensive Short-Term Dynamic Psychotherapy* sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Glion-sur-Montreux, Switzerland. October.
- Davanloo, H. (1993) *Proceedings of the Eleventh Annual Audiovisual Exploration of the Unconscious: Technical a. Metapsychol. Roots of Davanloo's Psychoanalytic Technique. Fragile Character Structure*. Killington, Vermont. July.
- Davanloo, H. (1994a) *Proceedings of the Twelfth European Audiovisual Symposium and Workshop on Technique and Metapsychological Roots of Dr. Davanloo's Intensive Short-Term Dynamic Psychotherapy*, sponsored by the Dutch Associates for Short-Term Dynamic Psychotherapy. Amsterdam, The Netherlands. April.
- Davanloo, H. (1994b) *Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the Sesquicentennial Annual Meeting of the American Psychiatric Association*. Philadelphia, Pennsylvania. May.
- Davanloo, H. (1994c) *Proceedings of the Audiovisual Immersion Course: Fundamentals of the Metapsychology of the Unconscious in Davanloo's Psychoanalytic Technique*. Bad Ragaz, Switzerland. June.
- Davanloo, H. (1995a) Intensive short-term dynamic psychotherapy: Spectrum of psychoneurotic disorders. *International Journal of Short-Term Psychotherapy*. 10(3,4), 121-155.
- Davanloo, H. (1995b) Intensive short-term dynamic psychotherapy: Technique of partial and major unlocking of the unconscious with a highly resistant patient. Part I. Partial unlocking of the unconscious. *International Journal of Short-Term Psychotherapy*. 10(3,4), 157-181.
- Davanloo, H. (1995c) Intensive short-term dynamic psychotherapy: Major unlocking of the unconscious. Part II. The course of the trial therapy after partial unlocking. *International Journal of Short-Term Psychotherapy*. 10(3,4), 183-230.
- Davanloo, H. (1995d) *Proceedings of the Audiovisual Immersion Course on the Metapsychological Conceptualization of Character Resistance, Transference, Guilt and Unconscious Therapeutic Alliance in Davanloo's Psychoanalytic Technique*. Bad Ragaz, Switzerland. December.
- Davanloo, H. (1996a) Management of tactical defenses in intensive short-term dynamic psychotherapy. Part I. Overview, tactical defenses of cover words and indirect speech. *International Journal of Short-Term Psychotherapy*. 11(3), 129-152.
- Davanloo, H. (1996b) Management of tactical defenses in intensive short-term dynamic psychotherapy. Part II. Spectrum of tactical defenses. *International Journal of Short-Term Psychotherapy*. 11(3), 153-199.
- Davanloo, H. (1996c) *Proceedings of the Audiovisual Immersion Course on the Metapsychological Conceptualization of Character Resistance, Transference, Guilt, and Unconscious Therapeutic Alliance in Davanloo's Psychoanalytic Technique*. Bad Ragaz, Switzerland. December.
- Davanloo, H. (1997a) *Proceedings of the Fifteenth Annual European Audiovisual Symposium on Davanloo's Psychoanalytic Technique*, sponsored by the Italian Institute for Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of the University of Florence. Florence, Italy. March.

- Davanloo, H. (1997b) Proceedings of the Immersion Course on the Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique; Patient with Fragile Character Structure. Hotel Bristol Conference Centre. Bad Ragaz, Switzerland. December.
- Davanloo, H. (1998a) Proceedings of the Sixteenth Annual European Audiovisual Symposium on Davanloo's Psychoanalytic Technique, sponsored by the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of Friedrich-Alexander University. Erlangen, Germany. March.
- Davanloo, H. (1998b) Proceedings "Audiovisual Exploration of the New Metapsychology of the Unconscious; Technical and Metapsychological Roots of Davanloo's Intensive Short-Term Dynamic Psychotherapy" presented at the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy. Nürnberg, Germany. June.
- Davanloo, H. (1998c) Proceedings of the Seventeenth Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique. Technique and Metapsychology of the Process of Working Through: Fragile Character Structure. Montreal, Canada. November.
- Davanloo, H. (1999a) Proceedings of the Audiovisual Immersion Course: Audiovisual Exploration of the Metapsychology of the Unconscious in Davanloo's Psychoanalytic System, sponsored by the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of the University of Erlangen-Nürnberg. Erlangen, Germany. March.
- Davanloo, H. (1999b) Proceedings of the Nineteenth Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique. Montreal, Canada. August.
- Lindemann, E. (1979) Beyond Grief. New York. Jason Aronson.
- Zaiden, J. (1979) Proceedings of Audiovisual Symposium on Basic Principles of the Technique of Short-Term Dynamic Psychotherapy of Patients Suffering from Obsessional and Phobic Neurosis presented by H. Davanloo, M.D., Sheraton Hotel, New York, New York. March.

Habib Davanloo, M.D.
 Professor of Psychiatry
 McGill University
 The Montreal General Hospital
 1650 Ave Cedar, Montreal, Quebec
 H3G 1A4 (514) 937-6011