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

THE ENTRY OF THE TRANSFERENCE

(Part IV)

ABSTRACT

This is the fourth of four articles on basic technical interventions in Dr. Davanloo's system of Intensive-Short-Term Dynamic Psychotherapy (pressure, challenge, the entry of transference and head-on collision), bases on the proceedings of a five-day immersion course presented by Dr. Davanloo. Part 4 focuses on the head-on collision (technical element of the Cetral Dynamic Sequence) as the most powerful form of challenge, mobilizing the patient's unconscious therapeutic alliance against the destructive forces of the resistance. To illustrate various forms and indications of head-on collisions clinical vignettes from three different patients were selected.

Introduction

This paper is based on proceedings of a five day immersion course presented by Dr. Davanloo to the Training Program of the German Society of Davanloo's Intensive Short-Term Dynamic Psychotherapy (June 17-21, 1998, Nuernberg, Germany).

In this section of the program, with extensive use of audiovisual clinical material, the major focus of Dr. Davanloo's presentation was on direct access to the unconscious; he emphasized the specificity of the intervention with the specificity of the response; he further emphasized the twin factors of the transference and resistance. In this article, we focus on and summarize his presentation on the subject of the entry of the transference.

"Transference" in Intensive Psychodynamic Psychotherapy

Davanloo began by emphasizing that his conceptualization and technical approach to „transference" in IS-TDP differs radically from transference neurosis in classical psychoanalysis. Based on Davanloo's extensive clinical research using video technology transference neurosis can best be described as a situation, in which the patient has transferred all of his character resistances and underlying complex neurotic feelings on to the therapist, while maintaining all these neurotic forces deeply locked within his unconscious. Once this state has materialized itself, it is very hard to reach the dynamic forces responsible for the neurotic suffering. The therapist has become a parental figure, gratifying the patient's needs. Why should the patient give it up? Clearly, this situation cements the neurosis rather than lifting it.

He therefore concluded that the therapist has to do everything to prevent the development of a transference neurosis from the first encounter with the patient, onward. To start with, he has to maintain a firm and clear position of neutrality. Taking neurotic suffering and the power of neurotic forces seriously leads to the consequence of assuming an active attitude against the patient's need to repeat his destructive pattern in his relationship with the therapist. Neutrality can not equal passivity. In this attitude in working with the patient, he makes sure that he takes and sticks to a clear, firm and neutral position. Whenever indicated, or even as a preventive measure, he spells out his position of being a therapist to the patient. Davanloo described the technique of undoing transference and undoing defiance. The last of this series of papers expands on examples of this technique during head-on collision.

He further emphasized the need for the therapist to take a firm and active approach in structuring the process by spelling out the therapeutic task in the general form of: "We are here together to explore, to understand what your problems are, and to get to the engine of your problems". Most patients are lay people in terms of psychotherapy. At the beginning of the treatment, they can not know, what psychotherapy can offer to them. Even if a person is psychologically minded and introspective, his neurosis itself and inherent defense mechanisms (especially the defense of externalization), prevent him from being able to see his psychic problems clearly, and from being in touch with their unconscious feelings maintaining the symptoms and character problems.
Even the goal of the therapy is spelled out explicitly in the form of freedom: freedom from the need to suffer, freedom to live a life in full possession of one's potential, and to live a life in peace. Especially patients who were traumatized early in their lives, and who grew up in a traumatic environment, have not much hope for leading a peaceful life, nor have they a sense of their potential. They need the therapist as a guide who knows there is a "peak of the mountain", not just "dark and dirty ditches", and who knows the patient has the capacity to reach the peak, and who knows the techniques of mountain climbing - although he does need the patient's activity in exploring his individual "ditches" and in finding his individual "mountain peak"; and in finding out together what are the factors inhibiting the patient in climbing. This attitude of knowing

that there is freedom and that the patient can reach it mobilizes a lively force within the patient, which is inherent in any human being but is often deeply buried. In the therapeutic situation, Davanloo calls this the unconscious therapeutic alliance.

Based on the fact that the patient has come to seek help, it can be assumed that his neurotic system is giving him more suffering than gratification, and that he wants freedom from neurotic patterns, at least part of him. In order to avoid transference neurosis, it is very important to spell out to him the two sides in the patient to him from time to time, and spell out that the patient is the one to choose which of his two sides he wants to follow. In this intervention, the therapist has to make sure within himself that he thoroughly stands behind, giving the patient the freedom of choice, that he is clear of any dependency or need for success with the patient. The intervention in the form of "your life is yours, misery is yours and happiness is yours, failure and success, clinging to neurotic suffering and freedom is yours", with the addition of "I am here to help you on your road to a free person, I would rather be successful, but my life does not depend on your success" is very helpful, clearing the relationship of any trace of transference neurosis. This intervention is forcing the patient to acknowledge his wish for health from time to time and is strengthening his unconscious therapeutic alliance.

While in IS-TDP the therapist does everything to prevent transference neurosis, Davanloo found that the mobilization of complex transference feelings and mobilization of transference resistances is the unrenouncable key to the unconscious pathological dynamic forces responsible for neurotic symptoms and for maintaining neurotic suffering, and the key for change.
The previous articles elaborated on the phase of pressure and the ways in which pressure and pressure and challenge is stirring up the repressed complex transference feelings. Since the old feelings in neurosis are often murderous feelings and /or very painful feelings of traumatization of the bond and attachment, a great deal of anxiety is also stirred up. The art (and the difficulty in learning the technique) is to mobilize sufficiently to get the dynamic process going, but not more than the patient (or the therapist in his state of learning) can tolerate.
The present article will deal with the moment the situation is "ripe" for taking up the transference with the patient.

Central Dynamic Sequence

Davanloo continued his presentation on the Central Dynamic Sequence, by emphasizing that each phase is a direct consequence of the one before; pressure from the therapist mobilizes resistance in the patient; resistance leads to challenge by the therapist; now challenge results in the mobilization of transference feelings and further increase in resistance; resistance rapidly acquires a transference quality, transference component of the resistance is mobilized. The therapist in turn responds by challenge to the transference resistance; the process eventually leads itself to the patient's direct experience of transference feelings.

The phases of the Central Dynamic Sequence form an interconnecting sequence. On that basis, it is artificial to single out any one phase and describe it as being more important than the others, but it is definitely true that the direct experience of the transference feelings is the goal towards which the therapist is working, and it is this that will lead to the unlocking of the unconscious. On that basis, transference must be regarded as the central and the key issue, and the therapist must watch vigilantly for indications that the transference is becoming a factor in the interview. He pointed out that the indications that the transference is becoming a major issue in the interview often may be subtle and indirect, but it is important that the therapist takes note of them and acts upon them. He emphasized that the therapist should watch for the following:

a) Partial breakthrough of the underlying feeling
b) An intensification of the resistance
c) Signals of increasing tension together with the indication that it is the transference that is involved.

Indications that Transference is Becoming an Issue

Here, we briefly summarize some of the signals as indicators of the entry of the transference:

a) A partial breakthrough leading to some remark by the patient which has a direct or indirect bearing on the transference,
b) Crystallization of a relationship with the therapist, which almost always contains both defensive and expressive components, with the defensive predominating and often showing a clear parallel with other relationships out of the transference,
c) Signal from the discharge pattern of the anxiety in the form of tension in the striated muscle, clenching of the fist, taking a deep sigh or gripping the arm of the chair,
d) Involuntary smile,
e) Avoidance of the eye, etc.

Then he presented a series of vignettes of twelve different patients to elaborate on the subject of the entry of the transference and the search for the resistance. Here, we summarize a few of these cases.

Case 1: The Case of the Salesman

The vignette of this case that he presented is representative of a patient on the extreme left of the spectrum of psychoneurotic disorders, who are highly responsive and can be treated in a single interview. During the phase of inquiry into the past, the therapist questions the patient as to whether his younger brother had become their mother's favorite. This mobilizes some resistance; the therapist, sensing that this was a crucial area, used challenging phrases by making explicit in order to crystallize and highlight the resistance:

TH: Your mother was more lenient with him and more strict with you? ... And your brother had a heavenly deal ... he became the star?

This mobilized a series of tactical defenses: passive-compliance, rumination, rationalization and vagueness.

PT: Yeah, okay ... I guess he was then, but...

.....

PT: He was the favorite because he was the youngest ... possibly right.

Each of these defenses was challenged, and then the patient made an open statement of his resistance:

PT: I don't want to answer the question directly.

Transference resistance is crystallized. The therapist challenged the vagueness „I guess" and the need to rationalize "because he was the youngest". This leads immediately to crystallization of resistance in relationship with the therapist in form of open defiance. This means that he now behaves with the therapist in just the same way as he behaves with his parents.

Now, the therapist opens up the transference immediately:

TH: Now, let us look to your relationship here with me. You prefer to hang things in the middle of nowhere, okay?

(Entry of transference by addressing transference).

The therapist returned to the same issue on two subsequent occasions; and finally the following passage occurred which entirely confirmed the therapist's original perception.

TH:... was there any time that you felt resentful towards me?

(asking for transference feelings)

PT: Yeah, sure, you can sense it when I don't answer you. I go all around the issue. The issue is resentment, not that I dislike you ...

The patient is reacting with positive response, making himself the connection between his feeling of resentment and defenses.

Indication for the Entry of the Transference from the Parallel with the Relation Outside of the Transference

Here, he presented a few vignettes from the following case.

Case 2: The Case of the Chess Player

In the early part of the interview, the therapist explored a situation between the patient and his supervisor, and mobilization of hostility in the patient from his feeling of being in the power of the

supervisors and not himself being in control. As soon as the therapist mentioned this, there was intensification of the patient's intellectualization, obsessional defenses. This mobilization indicated that this was an anxiety-laden area.

In this case, the dynamic inquiry was soon leading to a specific situation (patient not being in control of the situation of his life, which mobilized hostility, defiance and obsessional defenses) The therapist is applying challenge by framing.

TH: So then we see in all these situations that you are describing, when you are not in control then that mobilizes anger and anxiety in you, and the mechanism with which you deal with it is already clear.

(challenge by making explicit).

PT: I would say that certainly applies to a lot of my interpersonal relationships.

Positive response of patient followed by entry of transference by drawing the parallel between specific situation and transference situation: "How does this apply here with me?"

TH: If we focus on the issue of control, how does this apply here with me?

PT: I think that is something very much understood ... that you are in the position ...

TH: Now you are going into the intellectual issue. I am talking in terms of your feeling.

Another positive response by the patient enables the therapist to focus directly on transference feelings.

PT: Yeah, okay, I'm just trying to get in touch with that. The more that I am able to find out where you are coming from, which really comes down to being able to trust you, the less it is an issue for me.

The therapist exerted further pressure which brought out the underlying transference feelings and his major problem with intimacy and closeness. It brought into the open his resentment towards the therapist's "professionalism" perceived by him as lack of warmth. This eventually led to his feeling about a detached, emotionally non-involved father, and further to his murderous rage towards his mother who was ineffective and always sick.

Now, we will summarize another patient presented which again highlights indication for the entry of the transference from the parallel with outside of the transference relationship.

Case 3: The Case of the Machine Gun Woman

The initial contact started with the phase of inquiry and dynamic inquiry. A woman in her thirties suffered from disturbances in the interpersonal relationships, episodes of depression, two major clinical depressions, sexual problem, being anorgastic; major problem with intimacy and closeness. During this very early phase of the interview, the therapist also focused on her earlier treatment which indicated that she had passively complied with her therapist and ended up being exposed

to humiliation. This was, by itself, an expression of her characterological problems, such as her inability to assert herself, and the tendency to enter into situations in which she was used and abused. In the following passage, the therapist focuses on some aspects of the patient's characterological problems.

TH: You go yourself on your own will, but then the focus is on sexual problem which you have okay?

PT: Uh hmm.

TH: But you say you have had other major difficulties, but the focus is on sex and you go along with it.

PT: Yeah, I know. It sounds funny.

TH: Let's not to call what it sounds. It looks like this: that you have gone for many major difficulties, most important of all your depression, but he decides to treat your sexual difficulties and you follow him without raising any question.

PT: Uh, hmm.

TH: Are you a follower type? Do you have problems with assertiveness? Hmm?

PT: Yes, I don't follow. I back off... If I am having a confrontation with someone and one of us has to assert, and one of us has to follow, I will do neither, I will just back away.

The therapist points out a situation to the patient where she reacts in a compliant way. She can recognize her pathologic behavior. With further and increasing pressure by the therapist, the patient eventually has a positive response: she even brings in a second character resistance, withdrawal.

TH: You mean you take flight.

PT: Yeah from the situation ... rather than say no, this is not ...

TH: So you are the type of person that you take flight.

PT: Yeah.

The therapist brings into focus the transference implication, particularly, her tendency to take flight as manifested in her previous treatment.

TH: My concern here is this: are you going to follow me or are you going to ...

PT: No, because I have been through that and I ... I want to get the most that I can get out of this session.

The patient, again, responds positively by bringing in herself the parallel to her previous treatment. Especially in view of previous treatment, the therapist has to make sure that the character resistance is thoroughly worked through.

TH: You have problems with assertiveness, either you don't assert yourself or you take flight from the scene.

PT: Right.

TH: Which is similar.
PT: Yes basically the same thing but uh ...

What emerges is that her inability to assert herself is much more pronounced with men: "I will either go along or I will run away from the situation completely."
TH: Which is worse?
PT: Neither is worse, they are both bad.
TH: And you smile and say it is.
This is a first signal of transference anxiety.
PT: Well running away is lonelier in the long run, but being too compliant is uh, ... uh .... is not satisfying on any level, it may not be as lonely.

The patient is more and more capable of understanding the defense mechanism which implies that transference feelings are rising steadily and constantly.
TH: So either you take flight from the scene or you bend over backwards to please the other person.
PT: Yeah, yeah.
TH: You have any hesitation about that?
PT: No, that is pretty much what I do.
TH: Are you saying that to agree with me?
(Picking up on transference by questioning on character resistance in the transference).
PT: No, I'm ... I'm ... at the same time I'm learning the difference between running away and complying, uhh, I'm not ...
(positive response)
TH: You see in every relationship you say you are either very passive, compliant or you take flight.
PT: Right.
TH: Now my question is this. How would that apply here? Is it going to be compliant in relation with me or are you going to take flight from here?
(Entry of transference by questioning character resistance in the transference).

PT: No, I am not going to run out because I have made up my mind.
TH: That there would not be a flight.
PT: No ... no. I won't do that. I want to work these things out.
TH: How about the other side, submissiveness and bending over backwards to please, how that would apply here with me?
PT: That would be something I have to fight, of I did not agree I would have to say it, but it will definitely demand an effort on my part cause on my part it is not something I would normally do.

Still, the therapist maintains his focus on her character resistance even longer. The patient further mobilizes her forces against her defenses which is the result of a further rise in the transference. Now, the therapist brings in an even stronger emphasis on the transference in the following form, followed by a positive response.

TH: Uh hmm. So you see, to begin we have a problem in front of us which might interfere in what we want to do.

PT: Yeah, but it is a recognized problem, recognized by me.

TH: But this is an important issue, do you see what I mean?

PT: Yes, I do, but I don't think it is a major problem because now I recognize it, and therefore can just ...

TH: Okay, hopefully then you would be able to exercise that as we go on.

PT: Yeah, I expect this to be hard work, I don't expect this to be easy.

Joining forces together with the therapist and going for the battle against her defenses is the result of high transference , mobilizing unconscious therapeutic alliance.

In the above passage, we saw intensive work on the transference, and emphasized two of her characterological problems, namely, passivity or flight might become an obstacle in the interview. The patient finally responded very positively, and the therapist then proceeds to the phase of inquiry and dynamic inquiry.

ENTRY OF THE TRANSFERENCE: CRYSTALLIZATION OF THE TRANSFERENCE RESISTANCE

Case 4: The Case of the Man with the Chewing Gum

One of the ways the therapist could exert pressure is by pointing out some issues which are entirely true, but which the patient does not wish to look at. There was the analysis of the early part of the interview of a man in his twenties, a blue collar worker who suffered from a wide range of disturbances, both symptom and characterological. He suffered from panic attacks, chronic anxiety, phobic symptomatology, somatization, dizziness and characterological problems such as compliance, passivity, dependency and others. In the very first few years of his life, he suffered from a number of physical illnesses which resulted in his hospitalization, and when he was brought home, his mother, grandmother and aunt would rock him on a three-shift basis.

The first part of the interview focused mainly on inquiry, to which he was responsive, and what emerged was that the regressive secondary gain expressed by these disturbances was very prominent. The therapist brings this into focus. This mobilizes anxiety in the transference and mobilizes resistance. Now, we will see a few passages from the early part of the interview:

TH: Then you run to your mother.
PT: Hm hmm ...
TH: To protect you.
PT: Yeah.
TH: How long that sickness went while your mother, aunt and your grandmother were shifting and then rocking you.

The therapist, continuing his dynamic inquiry, kept focusing on an area the patient did not want to look at. This intervention mobilized anxiety in the transference, which immediately turned to resistance in the transference: the patient became detached, slow with avoidance of the therapist.

PT: I don't know, must have been uh ... well I don't uh ... (a deep sigh) know. It couldn't have been more ah, than a year, because ah ...
TH: Again your mother comes to your protection.
PT: Yeah, in a sense sure.

The therapist was exerting pressure by making explicit. The patient responded positively: "Yeah, in a sense sure," and by increasing his transference resistance (becoming more slow, with a low voice and becoming silent). These are all indications that the therapist needs to bring the transference to the open.

TH: How do you feel right now? Have you noticed that you have become much more slow and passive ?
PT: (smiling) No, I don't think so.
(Entry of transference by asking for transference feeling and by questioning and at the same time spelling out transference resistance)

Exerting Pressure Toward the Transference Feeling

The therapist has pointed out the parallel between the past and the present: that, in the past, he was rocked on a three-shift basis by his mother, grandmother and aunt; and that in his current life, without his boss and his wife, he is helpless.
PT: Yeah ... mm hmm, one doesn't like to be told that one is so dependent.

After further pressure and challenge, he becomes more resistant and there is both anger and anxiety in the transference. He moves to his pocket, takes out a piece of chewing gum and starts to chew it (major resistance in the transference). Then the technical intervention that the therapist applies is head-on collision with the transference resistance which leads to the breakthrough into the unconscious.

INDICATION OF THE TRANSFERENCE FROM PARALLEL WITH RELATIONSHIPS OUTSIDE OF THE TRANSFERENCE

Case 5: The Case of Hyperventilating Woman

The case of a young woman suffering from chronic anxiety, attacks of hyperventilation, disturbances of the interpersonal relationships, letting herself to be used and abused, and masochistic component in her character. During the phase of inquiry, it became evident that the first attack of hyperventilation started after a telephone conversation with her sister. This is followed by the phase of pressure and challenge toward her feeling, and then she admits that the conversation had made her angry.

Then, the therapist exerts pressure toward the experience of anger.
TH: Could you tell me how you experienced this anger?
PT: ... Cried.
As she spoke, she became tearful and began trying to control her tears in the interview. The therapist saw the obvious parallel between the transference and the relationship outside of the transference, namely, her sister and her mother, which, in a sense, was a communication about the transference.

TH: So you are holding onto your feeling right now, hmm? How did you feel when I repeatedly say "you guess so, " you don't commit yourself."
(Entry of transference by addressing transference resistance, "holding onto your feeling", immediately followed by pressure for transference feelings).

She finally admitted first to her irritation towards the therapist, and then to her anger toward the therapist.
It should be emphasized that here irritation by itself is a tactical defense against anger, and anger is a tactical defense against violent murderous rage. In this particular patient, it was demonstrated that, in the third psychotherapy session, she had come into the interview with a very vivid dream of her mother in the white dress in the entrance of the bedroom and wanting to murder her with a large knife. Patient woke up sweating and terrified. The following week, she reported another vivid dream in which with that large knife she murdered her mother, with blood all over the place. The focus of the subsequent sessions was on her unconscious murderous feelings towards her mother who was a demanding and controlling woman. She had terminated the relationship with the patient's father, and, subsequently, entered into a number of other relationships with other men with disturbed behaviour.
The technique used in the initial interview was a partial unlocking of the unconscious, with clear dominance of the unconscious therapeutic alliance against resistance.

INDICATION OF THE TRANSFERENCE: PARALLEL WITH OUTSIDE RELATIONSHIPS

Case 6: The Case of the Praying Mantis

Then he presented the initial part of the interview with a young woman. The major focus of his presentation had to do with the twin factors of transference and resistance. This young woman's pseudonym arises from intense elaborated fantasies of murdering men at the neck section of the vertebral column during sexual intercourse. She complained of chronic anxiety, disturbances of the interpersonal relationships, major problem with intimacy and closeness, severe phobic symptoms involving medical procedures, such as injection, and sexual penetration. The major reason for the referral was an acute vaginitis, and she was refusing gynecological examination and when she accepted to undergo an examination, the speculum could not be introduced.
The early part of the interview focused on inquiry, dynamic inquiry, and it became clear that her phobic symptoms dated back to her childhood. The result had been that, for years, her pediatrician had difficulty to examine her "turning the office upside down," and her mother had to describe her symptoms to the pediatrician and receive instructions over the telephone about how to treat her.

Here, we summarize a few vignettes to highlight the entry of the transference.
TH: Then you were stubborn in a way?
PT: Very, I still am.
Admitting to be stubborn is quite an achievement for a person.
TH: Was it only with the doctor or were you stubborn with the others?
PT: I was quite stubborn as a child.

One could expect that confirming this statement of her stubbornness should be accompanied by a rise in anxiety in transference, but it is of significance to note that throughout the whole of the early part of the interview, the patient used the defense of "La Belle Indifference," talking in a cheerful way about even the most distressing subjects. She even spoke in the same way about her masturbation.

PT: I have had orgasm from masturbating ever since I can remember, and I have been masturbating ever since I can remember.
The therapist went on to ask about the details , receiving an initial reply which was the epitome of "La Belle Indifference":
TH: What are the fantasies you have during masturbation and how do you do it?
PT: I just sort of grab my crutch with my hand.
TH: And then what type of fantasies do you have?
(The patient smiles in a coy fashion)

PT: I just really don't want to go into it. They embarrass me very much. Can we skip that one?

Now, for the first time, her cheerful chatting is changing to an embarrassed smile. She has a first subtle weakening of her resistance to any feelings. Now, we might say that the patient's smile is simply an expression of her embarrassment at being asked such an intimate question. But, it is an indication of mobilization of a major resistance in the transference; she is now embarking on the same kind of stubborn, defiant pattern she has described in other relationships, so that there is a definite parallel between these and the transference. The therapist now moves to a specific technical intervention:

TH: You said that you have always been a stubborn person, hmm, and that you always get your way. And this has been a pattern in both your current life and in the past with you pediatrician as a child and currently with your gynecologist.

PT: I don't know if I get my way always. Not anymore certainly. When I was a child I got my way always.

TH: Yeah. But you said that when you see a doctor you manage to get your own way.

PT: No ... I mean ... I have to submit to them eventually. I will go through a bit of trying to talk them out of it in order to stall.

TH: Finally you give in?

PT: Finally I give in.

The specific technical intervention consists of making explicit and putting emphasis on her stubborn behavior in her current and past life, again and again, until the patient starts backing off. This implies that, at least unconsciously, she can admit to the self-sabotaging aspect of her character resistance.

TH: And do you think that might be here with me?

(Entry of transference by questioning character resistance of stubbornness in the transference)

PT: Well ... I am not going to go into these fantasies.

TH: You are smiling.

PT: Maybe if I talk to you a second or a third time I might be willing to, but on the first meeting, No, I won't. Now maybe that is stubbornness.

Now, she behaves in the same way as with her gynecologist or other doctors. Her smile is a cover- up for rise in feelings. This indicates that her character resistance is softening, a sign of a rise in complex transference feelings.

Dr. Davanloo pointed out that all his cases that he has labeled "Praying Mantis" show a similar pattern. When the therapist wants to break through into the unconscious, they put a major resistance in the transference. The detail of the structure of the sexual fantasy is essential to make the first entry possible. He further pointed out that the therapist must be extremely careful not to allow himself to be drawn into a battle of wills. Then, he demonstrated a specific form of

head-on collision in handling such a transference resistance, and we saw a clear breakthrough into the pathogenic organization of the unconscious.

THE INDICATION OF THE TRANSFERENCE FROM PARALLEL WITH OUTSIDE RELATIONSHIPS

Case 7: The Case of Masochist Physician and the Big Eyes

Then he presented and analyzed a woman in her thirties who suffered from major characterological problems, passivity, compliance, self-depreciation, need to let herself to be used and abused, disturbance in the interpersonal relationships, specifically in her private life, sexual problems, episodes of clinical depression and a chronic state of anxiety. Her first marriage was to a man who was very disturbed, and she was badly abused and had intense dislike for him. She became pregnant before the marriage, she described herself as "scared to death" of her mother, and finally she had a baby who died at birth. She passively complied with the doctors who discouraged her from going to the funeral.

When the therapy started, she was married for a second time to a man who was highly controlling and domineering, and referred to herself as a masochistic partner. It also became clear that there was intensification of her character patterns in situations that would mobilize anger in her. During the interview, she showed a similar pattern of passivity, detachment, compliance, vagueness and self-depreciation, and the therapist, at first without mentioning the transference, brought this into the open.

TH: Did You feel that you wanted to see the baby?
PT: I don't remember. I think ... yeah, I wanted to see ...
TH: Did you?
PT: No. They didn't want me to see the baby.
TH: Why didn't they want you to?
PT: I don't know.
TH: I am not sure that you don't know, or is it that in a sense you ...
PT: You see ... I don't believe you know, I was so dumb... I just don't think ...

Instead of getting in contact with her angry feelings about this painful situation, she depreciates herself by declaring herself dumb. The patient, so far, has no awareness of this defensive character mechanism.

TH: Let me clarify one thing here. Have you noticed that during this period of time whenever we are getting into some of the important issues you say either it is "absurd," or "I don't remember," or "I don't know" and now you say you were "dumb"? Have you noticed that whenever we approach any of these painful issues you become very vague?

The therapist spells out the character defensive mechanisms to the patient in a very thorough and specific way.
PT: I notice I become vague, and I think it is because I don't remember that well.
This is a positive response , patient is starting to become aware.
PT: Well ... I asked if I could go and they said No. I didn't argue the point.
Why should an adult woman ask for a permission to go? Passivity and dependence are part of her masochistic character.
TH: If you wanted to go, what held you back?
PT: I was passive.
(Positive response)

Now the therapist opens up the transference by drawing the parallel between the outside resistance and resistance in the transference.

TH: This is something we should look into. You have your passivity in many situations, your passivity with your husband, your brother, and from the little we know it was the same with your mother, how about here with me?
PT: Probably passive.
TH: Are you passive or not?
PT: I would say I am even more passive.
Expressing to be „even more passive" is very honest.

After some further work, the therapist can proceed to transference feelings. He finally brought out that the patient had been angry with him when he focused on issues that she wanted to avoid, and that, just as in other relationships, her passivity was a way of dealing with her anger. It is important to highlight in the outline of this proceeding that Dr. Davanloo heavily emphasized again that anger is a tactical defense against the murderous rage; and the task for the direct access to the unconscious is the breakthrough of the primitive murderous rage and guilt in the transference which then becomes transferred to one, two, or more of the genetic figures. In this patient, the major column of the murderous rage is toward the mother, as well as toward the father. Equally important is the younger brother and the making of the perpetrator of her unconscious consists of this primitive murderous rage, and the guilt and the grief at the multidimensional level. She had an equally disturbed relationship with her father who went completely blind when the patient was young.

After a number of breakthroughs into her unconscious, when unconscious therapeutic alliance took a major dominance in relation to the major resistance, she had visual imagery of huge eyes around herself. Further, those huge eyes which she would see while driving would move over the windshield of the car, and also go under the car. Then, the process of working through focused

on the earliest trauma, her attachment, trauma, pain of trauma, primitive murderous rage, guilt and grief. Then, the focus was on the mutative law of the trauma under the dynamic system of the perpetrator of the unconscious.

Summary and Conclusion

This paper summarized Dr. Davanloo's presentation on the entry of the transference. As with other technical interventions in his system of IS-TDP, Dr. Davanloo, by his extensive research, has defined the exact moment when entry of transference is indicated. The phases of the central dynamic sequence have to be properly applied to prepare for the entry of transference. This paper emphasized:

1. Davanloo's conceptualization and technical approach to transference differs radically from that in classical psychoanalysis;
2. The direct experience of the transference feelings is the goal towards which the therapist is working, as it will lead to the unlocking of the unconscious;
3. The transference must be regarded as the central and key issue, and the therapist must watch vigilantly for indications that it is becoming an issue in the interview, and act upon them.

Several clinical vignettes were presented to elaborate on the subject of the entry of the transference, and to demonstrate various indications that transference is becoming an issue.

Case 1 is a patient of the extreme left side of Davanloo's spectrum of neurosis. The entry of the transference was by addressing the feelings of the patient towards the therapist directly. He was capable of responding to it immediately. The patient himself was able to make the connection between his defense of retreat and his resentment. In Case 4, the entry of transference also was by crystallization of transference feelings. This was evident when he became more slow with a low voice during the dynamic inquiry. But, in contrast to the salesman, he needed further pressure towards his transference feelings until he became aware "one does not like to be told that one is so dependent."

In case 2,3,5,6 and 7, the entry of transference was made by drawing a parallel of relationships out of the transference, and the relationship in the transference.
Finally, Dr. Davanloo emphasized the need for the therapist to monitor the process carefully. While he applies the phases of inquiry, pressure and challenge, he has to pay attention to signs from the unconscious. He has to be well acquainted with the signaling system of the unconscious to recognize the rise in the transference and the manifestation of the intensification of the patient's resistance in the transference. He must constantly adjust the impact of his specific technical intervention to the patient's unconscious. During his research studies and scrutiny, during more than thirty years, Dr. Davanloo evaluated thoroughly the patient's reactions to specific interventions

by videotape. Thus, he was able to give us a good knowledge of the metapsychology of the unconscious, based on research data and not on theory. It is obvious that a good knowledge of this metapsychology of the unconscious is required to master such a powerful technique. It requires systematic training to grasp all these subtle signs from the unconscious.

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Authors' Note

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