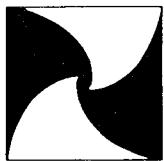


Intensive Short-Term Dynamic Psychotherapy: Selected Papers of Habib Davanloo (2001)

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Intensive Short-Term Dynamic Psychotherapy: Spectrum of Psychoneurotic Disorders

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In this article the author first describes the spectrum of patients that can successfully be treated with his technique of Intensive Short-Term Dynamic Psychotherapy and then he describes the application of the technique in the treatment of patients who are highly responsive with a single psychotherapeutic focus. There is an in-depth analysis of the process of a patient who was treated in a single interview.

Introduction

During the past 30 years, I have developed a method of Intensive Short-Term Dynamic Psychotherapy with extraordinary power, capable of resolving the core neurotic structure of the most resistant longstanding psychoneurotic disturbances. In the development of this technique, I have used audiovisual recording for teaching and research purposes.

The work of the early sixties primarily focused on the patients who are responsive with a single psychotherapeutic focus. The work of the latter part of the sixties and seventies primarily focused on patients suffering from severe phobic and obsessional disorders and those highly resistant suffering from life-long character neurosis. This systematic work resulted in the discovery of the technique of unlocking of the unconscious by the author, which provides a unique opportunity for both the therapist and the patient to have a direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances. I was able to demonstrate that the direct access to the unconscious is possible, in a single interview, with every resistant patient and that the degree of the unlocking of the unconscious is exactly in proportion to the degree that the patient has directly experienced the transference feelings. The clinical data clearly demonstrated the interrelation between the rise in the transference feelings, character resistance and unconscious therapeutic alliance.

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The systematic work of the early eighties was concerned with the application of my technique with patients suffering from depressive, functional, somatization and panic disorders. This work clearly demonstrated that the technique is highly effective in the treatment of the whole spectrum of psychoneurotic disturbances.

Then I concerned myself with the application of the technique to patients with fragile character structure. There I have been able to demonstrate that the technique can be applied even with patients with severe fragile character structure.

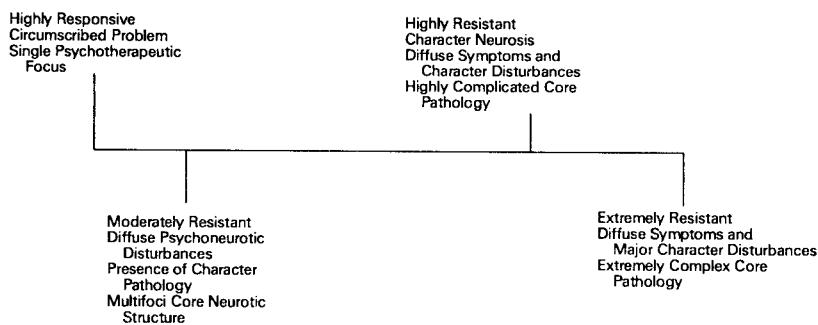
The work of the eighties and the early part of the nineties resulted in a great deal of refinement in the technical interventions in Intensive Short-Term Dynamic Psychotherapy, as well as in the development of a very highly powerful method of Psychoanalysis which has the power to bring multidimensional structural character changes in the extremely resistant patient with the most complex pathogenic unconscious (which will be the concern of a series of publications to follow). The truth of this statement has been demonstrated unequivocally, it has been presented at a large number of audiovisual symposia, courses and training programs to professional audiences in both North America and Europe.

The first few series of articles will be concerned with my technique of Intensive Short-Term Dynamic Psychotherapy and its application to two major spectrums of patients that can be treated successfully with the technique:

- (a) Spectrum of psychoneurotic disturbances
- (b) Spectrum of patients with fragile character structure.

Spectrum of Psychoneurotic Disorders

Based on the clinical research data, patients on this spectrum can be classified into five major groups.



(1) Extreme left on the spectrum

These patients are highly responsive to psychotherapeutic intervention. They might suffer from mild obsessional neurosis of recent onset, or mild phobic

disorder, or other forms of neurotic disorder. The main features of all patients on the extreme left of the spectrum can be summarized as follows:

- * High responsiveness
- * Circumscribed problems
- * Single psychotherapeutic focus
- * Very mild degree of resistance
- * Absence of unconscious murderous rage

(2) Mid-left side on the spectrum

The second major group are patients with a moderate degree of resistance. Briefly, the main features of this group can be summarized as follows:

- * Moderate degree of resistance
- * Diffuse symptom disturbances
- * Presence of some degree of characterological disturbance
- * Presence of unconscious violent rage and guilt- and grief-laden unconscious feelings toward early figure(s), e.g., parent(s), sibling(s), etc in their life orbit
- * Multifoci core neurotic structure

(3) Mid-spectrum

The third major group, which we may call mid-spectrum cases, are patients who suffer from character neurosis. They demonstrate:

- * Moderate to high degree of resistance
- * Suffer from diffuse symptom and character disturbances
- * Presence of unconscious murderous rage, guilt- and grief-laden unconscious feelings in relation to early figure(s), e.g. parent(s), sibling(s), etc in their life orbit
- * Fusion of sexuality and murderous rage
- * Presence of masochistic character traits
- * Complicated core pathology

(4) Mid-right side on the spectrum

Patients in this group are more complex and more resistant. They suffer from long-standing psychoneurotic disturbances. They demonstrate:

- * High resistance
- * Life-long character neurosis
- * Diffuse symptom and character disturbances
- * Highly complicated core pathology
- * Presence of an unconscious primitive murderous rage, guilt- and grief-laden feelings toward both parents and others in their early life orbit—"The Perpetrator of the Unconscious" (Davanloo)
- * Unresolved oedipal and sexualized feelings, when present, are deeply fused with the primitive murderous rage

(5) Extreme right side on the spectrum

These are patients with the most complex character neurosis, highly syntonic character resistance. They demonstrate:

- * Extreme resistance
- * Diffuse symptom and character disturbances
- * Presence of a punitive superego pathology, high degree of masochistic character traits
- * Highly complicated core pathology
- * Highly primitive unconscious torturous murderous rage and intense guilt and grief, multidimensional in relation to early figure(s), e.g., parent(s), sibling(s), etc
- * Unresolved oedipal and sexualized feelings, when present, are deeply fused with the primitive murderous rage of the unconscious.

The profile of patients on the right side of the spectrum, based on the research data, demonstrates with no exception:

- (a) The presence of trauma, abandonment and/or series of traumatic experiences in the very early phase of life.
- (b) The presence of a highly painful feeling in relation to the trauma and abandonment.
- (c) The presence of an unconscious murderous rage or primitive murderous rage or even primitive torturous murderous rage in relation to parents, siblings and other figures in their early life orbit.
- (d) The presence of intense guilt- and grief-laden unconscious feelings.
- (e) They demonstrate a high to an extremely high degree of resistance.
- (f) The presence of resistance against emotional closeness.
- (g) The presence of a masochistic component in their character.

Based on this data, I introduced a concept which I called "The Perpetrator of the Unconscious."

Spectrum of Patients with Fragile Character Structure

The second spectrum, as I have already indicated, are those suffering from fragile character structure. If we place these patients within a spectrum we might consider three major groups: patients with mild and moderate degree of fragility, and those with severely fragile character structure. Patients with severe fragility cannot withstand the impact of their unconscious during the first interview, that is, during the trial therapy. These patients do not have the capacity to experience and tolerate anxiety and painful feelings, and they have life-long access to a spectrum of primitive defenses such as temper tantrums, explosive discharge of affect, poor impulse control, projection, projective identification and double projective identification. These patients easily become flooded with a high degree of anxiety and a major disruption of their cognitive and perceptual functions with hallucinatory experiences. They easily become light-headed, experience the phenomena of "drifting," drowsiness and dissociation.

I have demonstrated that the whole spectrum of patients with fragile character structure can be treated successfully with my technique, and the course of therapy

has a number of phases. Briefly, in the first phase the task of the therapist is to bring about sufficient unconscious structural changes to enable the patient to withstand the impact of his/her unconscious. As a result of such structural changes, the discharge pattern of the anxiety shifts from cognitive and perceptual functions to anxiety in the form of tension in the striated muscles. When the therapist has accomplished this task and has brought about sufficient cognitive and psychic integration, then he can proceed with the technique of repeated, first partial then major unlocking of the unconscious. The technique of bringing about structural changes with fragile patients will be the focus of a series of articles in the future. It has already been presented in many symposia and courses, both in North America and Europe; but, briefly the research data demonstrates the presence of an extremely high degree of primitive murderous rage within the unconscious.

Intensive Short-Term Dynamic Psychotherapy with Highly Responsive Patient

The rest of this article will focus on the application of the technique in patients who are highly responsive and so-called "motivated." The course of the initial interview of a patient who was treated in a single session will be analyzed in depth.

The Case of the Salesman and His Sister-in-law

At the time of the initial interview he was a 26-year-old married man. As will be seen, he is exceedingly responsive and in the early stages is willing to talk freely and meaningfully about difficult and painful subjects. He goes into a very mild degree of resistance comparatively late in the interview, and as a result the therapist is able to complete a large part of the inquiry before any sustained dynamic interaction begins. When this does happen, some of the interventions making up the Central Dynamic Sequence are used, though continuing to alternate with the phase of inquiry throughout the interview.

Initial Exploration, Psychiatric Inquiry

In the following passage the therapist opens with the standard question about the nature of the patient's presenting complaint. He learns that this is an obsessional symptom, and he sets about inquiring into its severity, the extent to which the patient's life is affected and whether there are any other difficulties. This is part of the psychiatric inquiry and the psychodiagnostic function of the trial therapy, the aim of which is to assign the patient at once to his correct position on the spectrum of severity of psychoneurotic disturbances, which obviously has importance in determining the roadmap to the unconscious. At one end of the spectrum he may be a basically healthy young man suffering from a mild obsessional symptom with a very mild degree of resistance; in the middle he may be a severely obsessional character with a very high degree of resistance; while at

the other end his whole life may be affected or even crippled by rituals and other obsessive-compulsive phenomena with a major degree of resistance.

In fact, it rapidly becomes clear that he suffers from only a single type of symptom, that this is relatively mild, and that although it pervades his life it does not seriously affect his functioning.

Initial Contact

TH: Could you tell me what seems to be the problem that you are facing?

PT: Well, the main thing is this repeating of, like checking my work and everything—almost like an obsession with it. I will take figures and transfer them from one sheet to the sheet that I am working on, and I go back and recheck them; and even then I am still checking and rechecking, and I get almost like a phobia—that I have done it wrong. Yet I know that I have done it right. I have been doing this work for many years now, and even checking it I can see that I have done it right. But it just seems to nag, like at the back of my head, that I have done it wrong. Sometimes after I have done something and I think back afterwards and think—did I do that right? Sometimes it bothers me so much I go back and check it again. Other times I can say, "No, I have done it right," and try to forget about it.

TH: You get these intruding, nagging thoughts if you have done it right . . .

PT: Yes, and I go back and check it over and over.

TH: Could you give me a specific example?

This seemingly innocent question is one of the standard moves toward exerting pressure. In response to it some patients immediately become alarmed and go into resistance, already sensing that they are going to be asked to be specific about more difficult areas as well; but, as will be seen, it takes much more than such a mild degree of pressure to alarm this particular patient. The indicator from the beginning is that the unconscious is in a fluid state. The therapist therefore continues with a straightforward question to clarify the psychiatric picture.

PT: For example, we have a statement in our office we send out every month, and there is like a correction routine that we have. I do it, but I have these nagging thoughts that it is not right, and I have to repeat it over and over. I know the code number and the information laid out on the sheet, and I know it is correct; but I have to check and recheck with no end. The thing is, now while I am doing my work I look at figures and I transfer figures from one place to another, and I worry whether I have done them correct or not. As I told you, I go back and check them, and check, and still I check back; and I end up checking . . . and rechecking, you know—still I have these doubts, and I get like a funny feeling in my legs and like in my head a kind of fuzzy feeling—like almost like my nerves, every one of my nerves are just sort of on edge.

TH: Is this only in your job—this need to check and recheck?

PT: No, like I will go into the carport at home and take out a bag of chips, read all the stuff on it—almost like I have to remember exactly what it says on that bag of chips, you know, how many ounces, which company, made by such and such, checking . . . well, I always check. Then read it over again, memorizing what it

says on the bag of chips. And this is not only with potato chips—labels at home on other packages, everything—street signs—keeping my mind occupied.

TH: *So there is this nagging doubt if what you have done is right, and there is a constant need to keep your mind occupied.*

PT: *Even when I leave my job a couple of hours later I just sit there and start worrying about what I have done at work, even though I know I have done it right, which becomes very painful.*

TH: *These intruding thoughts and your need to check and recheck, is it interfering with your job?*

PT: *I have got that almost—lack of self-confidence, sort of; and I just sit there. I keep thinking about it, and people will talk to me and it will seem that they are not there—I am so busy concentrating on these other things.*

TH: *Hm. Hmm. Does it interfere with your personal life?*

PT: *Oh yeah. My mind still is there, and my wife is talking to me and I have to concentrate, you know, as if my mind is still on my job, on those figures.*

TH: *Are there any other areas that you have difficulties?*

PT: *Putting the lights off in my car at night. Like I will get home and automatically put it in "park," turn the lights off, turn the key off, get out, lock the door and close it. And now I have to check and recheck, trying to convince myself that they are off. I go in, and I have the thought that the lights are on. "Look, it is automatic, you do it, so." I know I turned the lights off, but then I have to go and check them. But again the thoughts and the doubts. And I say to myself—"Aw, I checked it," you know, I say I checked them, and I say to myself, convince myself that the lights are off. And sometimes I am successful.*

The therapist now asks about the duration of this symptom. This question serves to place the patient on another spectrum, namely that of chronicity. It will then lead to the question of whether the onset can be traced to a particular moment, or at least a particular period in the patient's life. When this is possible, the evaluator must always think in terms of searching for a precipitating factor, of which the patient may or may not be aware. Such factors are usually of great dynamic significance, so that the therapist's question about duration is preparing the way for moving beyond the purely psychiatric inquiry into the exploration of the psychodynamics.

At this stage of the interview, the patient is showing no resistance. In answering the question about the duration he reveals not only the time of onset but also the precipitating factor, of which he is well aware. (It is worth mentioning here that the ambiguous term "sister-in-law"—a person who figures so prominently as the clinical material unfolds—clearly refers to his wife's sister rather than to his brother's wife.)

TH: *How long is it that you find yourself in this state?*

PT: *About a year or so—but very bad for the last few months.*

TH: *Is it getting worse?*

PT: *Right. It started out—I was married for about a year (the patient has been married 3 years) and got involved in a sort of an affair with my sister-in-law that lasted for a month and a half . . . a couple of months. And I started to have guilt feelings about it. So I broke it off and told my wife about it. She was upset but she forgave me and said, "Well, it happened"—sort of thing. "Forget*

about it. Look, it is done. It is over. Forget about it. You have done it. You can't undo it"—sort of thing. "You can't go back and say I didn't do it." Well, really I did not forget about it. The memory of it sort of kept coming back into my mind, and you know, without trying to think about it I would be doing my work and they would sort of come back. I would start thinking about my sister-in-law and I would feel worse. I would feel guilty again, almost as if I was recommitting the act, sort of thing. So what I started doing, really, was reading street signs, forcing myself . . . like . . . when I was doing my work to really concentrate on it—to keep these other, these thoughts of my sister-in-law out of my head. The thing is, over the . . . this went on for 6, 8 months, and I sort of succeeded in forgetting about it. Then it started . . . I thought everything was all well, and then it started coming back again so I started forcing even more so. I just seem to have transferred it from one problem to another.

The above passage shows one of the main features of patients who are responsive, with a single psychotherapeutic focus; namely here how clearly and lucidly he talks about his symptom, the onset of his symptom, the mechanism of displacement; and later on he talks about transferring it from one problem to another. The above information also poses an important question. Since his wife forgave him, it would seem that the episode should have been forgotten. Instead, he has not only continued to feel very guilty but has developed a neurotic symptom. The therapist knows that the reason is likely to be that the episode has reactivated guilt-laden feelings belonging to the past, the figures in his early life; but in no way does he impose this idea upon the patient; but he uses it to guide his exploration which starts with a simple question,

TH: Could we look into this incidence?

PT: I had my affair—I call it my affair—with my sister-in-law and after a month and a half I felt guilty, I cut it off and I told my wife, all at about the same time.

TH: How did the relationship develop?

PT: She and her husband and their three children were living on the East Coast and were moving to the West and they had a stop-over here. She and the three kids stayed with my mother-in-law while her husband went to the West Coast to get a house, or make arrangements for a house . . . and my wife and I went over there. Well, you know how it is with relatives . . . you haven't seen a relative for a while . . . you give a kiss . . . sort of hello, how are you sort of thing. When I gave her a kiss, I don't know, I felt as though there was more to the kiss than just "hello."

TH: On whose part?

PT: Uh, on my part, on her part, like the way she kissed me, I felt that there was more than "hello."

TH: How old is she?

PT: 2 years older than my wife.

TH: So what happened?

PT: Well, we started doing . . . it started working up to the fact that she used to come over to our place after they had eaten their supper, and my wife and I had eaten our supper, and she sort of come over to my wife and sometimes my wife would go out into the garden and I would kiss my sister-in-law and feel her, and she would do the same.

TH: Hmm.

PT: Well, I never had intercourse with her, just more or less playing around . . .

The therapist now begins searching for further precipitating factors. The patient does not demonstrate any resistance, and it is important to note that he is ahead of the therapist and spontaneously answers the question about sex, which had been implied but not directly asked. The absence of any obvious factors is clearly significant but deepens the mystery.

TH: This started a year after your marriage. How was your relationship with your wife during that year?

PT: Always happy. Our sexual relationship fine.

TH: Any problems?

PT: There were no problems.

TH: Could you tell me more about your sister-in-law?

PT: She used to come here and at every opportunity we would end up kissing and feeling each other, and it gradually led on.

TH: Led on?

PT: Yeah. At the time I was getting my car painted, and so I asked her to give me a lift in her car to go and get the car. So we stopped on the way back and fooled around. Like I said, I never had intercourse; but we messed around.

TH: Did you have the desire?

PT: Oh yes. We never really had the chance, the opportunity, enough time, really, to, to have intercourse.

TH: But the thought was there.

This is the second point at which the therapist has exerted a very mild degree of pressure. What he has done here is to underline the impulse. However, the patient is well aware of this.

PT: Oh yes, definitely.

TH: And how did you feel toward the thoughts?

PT: Er . . . at the time I felt it was going to be great. Now I feel differently.

Now the therapist exerts some pressure

TH: You were not decisive about it? Wanting and not wanting?

This communication needs considerable analysis. First of all, it transfers the patient's indecision from a pure symptomatic situation—whether or not he had checked the figures or the car lights—to an emotionally charged situation. Second, it describes the patient as indecisive, which is entirely accurate on the one hand but which the patient will not like on the other. He might first experience irritation and then suppress it, which will increase the tension. But, deeper than this, the therapist is by implication making a connection between the symptom of indecisiveness with the basic guilt-laden conflict. As he is doing this only by implication and not overtly the evaluator is communicating with the patient's unconscious as well as his conscious. He thus conveys the hidden message that he understands more about what is happening than the patient would wish him to know, which is intended to heighten the tension further. But this communication does not produce any resistance.

PT: Yes.

Pressure, the First Challenge, the Search for Resistance

The therapist has a fairly complete knowledge of recent precipitating events, about which the patient has been willing to talk quite freely. But the therapist has not yet identified the anxieties that have given these events pathological significance. Whatever these anxieties are, they must be in an area that has not yet been touched on.

An important feature of this technique of trial therapy can be described as follows. The therapist welcomes the resistance and he knows that the resistance can be reliably overcome and that the very act of overcoming it has far-reaching beneficial effect. It is an actual therapeutic tool to help break into the patient's unconscious. When, as here, the patient is responsive to the preliminary inquiry, the next stage therefore consists of searching for resistance. In accordance with this, the therapist asks a question which, without the patient knowing it, was destined to lead into the core of his neurotic structure. This exploration was based on extensive clinical experience, which consisted of the following repeated observations: when male patients were asked to describe the body of their current sexual partners, many had great difficulties and became resistant. The problem often seemed to center around describing the breasts as well as other parts of the body, and the reason is the unconscious connection between the patient's current sexuality and the patient's feeling for his mother or other figure in his early life orbit. Now we return to the interview.

TH: How would you describe your sister-in-law in terms of physical appearance?

PT: Physically she is a very attractive girl, very well built.

The therapist asks the patient to be more explicit.

TH: Hm hmm. In what way?

The patient now shows the beginning of a very mild degree of resistance by using a series of tactical defenses. It is important to note that none of these defenses are major defenses. It is essential to rapidly identify these tactical defenses and to know how to handle them. In the following passage, the defensive words and phrases which mark the beginning of a mild degree of resistance are put in quotation marks to draw attention to them. The patient already shows his reluctance to answer the question by hesitating; he puts it in the word "well" to make his statement more indirect, and he uses paraphrases to avoid the explicit word "breasts."

PT: Er . . . "Well" she is very pretty, she has a "big chest" . . . The rest of her body is nice.

This gives some rise in transference feeling, and his resistance becomes somewhat more intensified with the use of two further tactical defenses, namely vagueness and obsessional ruminations, which are designed to avoid a direct experience of feeling. We have the first indication of a rise in transference feeling. In the following sentence the words "I think" makes the statement hypothetical; "I don't know" largely nullifies his true feeling; and "sort of" makes the word "attracted" weak and indefinite. These are all tactical defenses.

PT: Yeah. "I think" that is what . . . "I don't know" . . . I have always been "sort of" attracted to that.

The therapist notes all this but he, once more, makes the patient's statement explicit and continues his exploration.

TH: Would you say that that was the part that attracted you the most?

PT: Yeah. Right.

TH: I see. Hm hmm. During this period that you were necking and petting, that was the part that you were very much . . .

PT: Yes. Right.

TH: Could you tell me how you ended your relationship with your sister-in-law? Was it your decision?

PT: Yes. It was my decision.

TH: Was it a sudden decision?

PT: Yes.

TH: And what was her reaction?

PT: Very surprised—really. What happened was that I told her that I couldn't go on any more, and I felt the nerves in my legs, the fuzzy feeling in my head, like all my nerves were sort of tense. My legs were twinging, just before deciding to tell her. I was in a separate world, enclosed in a bubble. I could hear you talk but it was as if you were far away. I told her this was wrong . . . I can't go on, sort of thing. I guess the weekend that I told her my wife and myself were going up to visit friends, going out for a wedding, out of town; so we went up, and so that sort of put her out . . . sort of out of sight, but not out of mind. I was still remembering it, really, you know. It really bothered me; and I guess we came back, and she stayed another week or two. And then they went . . . she went out to live on the West Coast. And then I told my wife . . .

TH: What forced you to talk about it to your wife?

PT: Because I felt so guilty about it. I knew I had done wrong. And, you know, I just had those feelings in my head and in my nerves, and I just figured that by telling her that that would, you know, clear everything up . . . my nerves. I wouldn't get that fuzzy feeling in my head, or anything else.

TH: You thought her being understanding would resolve the problem. . . . What happened then?

PT: I started, you know, to think of her, to think back about the time kissing in the kitchen, feeling her body, stuff like this. And I think partially what it was—I tried so hard to put it out of my mind that it would keep coming back in rather than . . .

TH: Could we look to those thoughts that were coming back to your mind after you terminated with her?

It is important to note that in the following passage the patient shows no resistance and is being absolutely explicit about sexual incidents with his sister-in-law, whereas he had shown some resistance against describing her body.

PT: Oh . . . incidents when we were together. I think about one time when my wife was out in the garden, and she was in . . . where she was staying at my in-laws, it is an old house. They don't have hot water, so they don't have a shower, so

she was taking a shower at our place. So, anyway, my wife was outside and I said, "Can I come in?" She said "Yes." So I opened the door, I walked in, and opened the curtain. She was standing there naked, so I look at her and said, "Do you want to see me?" She said, "Yes." So I exposed myself. Stuff like this.

TH: *So you had these flashbacks to that incident?*

PT: *Yeah. There were a few other episodes like that. There was a time, almost the same thing. She was in the shower . . . uh . . . in the bath . . . and the same sort of thing. . . . Another time coming back from baseball we went back to my place, our place, my wife, myself and my sister-in-law—and I drove a friend of mine home. She came with us 'cause she was sort of friendly with the guy anyway; and we came back and stopped off and started necking, petting . . . she did fellatio on me . . . then I took her home. Another time we were starting for a party. We had to pick up soft drinks, and we went somewhere else and she did fellatio again, and I felt her . . . uh . . . I felt her breasts . . . uh. . . . These were the recurring thoughts that were coming after I stopped the relationship.*

Challenge Alternating with Exploration

In this interview which is with a patient from the extreme left of the spectrum of psychoneurotic disorders, exploration, pressure and challenge proceed in a cycle, so that there is no clearcut point at which the phase of challenge begins. However, the following passage contains a second mild degree of challenge.

TH: *In these incidents, then, you were intimately involved with each other?*

PT: *Right. Yeah.*

TH: *But you say you did not have an opportunity for intercourse.*

PT: *Yeah. There was not enough time.*

TH: *How could that be? Obviously if you had time for fellatio and playing with her breasts you could have had time for intercourse.*

This mild degree of challenge produces some resistance in the form of vagueness as is shown by the words in quotation marks, all of which are tactical defenses to avoid making a direct statement.

PT: *"I guess." Yeah. "I guess." really if . . . we "probably" could have.*

At this point, it would obviously be possible to interpret the defensive moves. For example, to bring to the patient's attention that he was becoming vague in order to avoid openly acknowledging his anxieties about having intercourse. This, in my view, would move the process to intellectualization. The present technique aims to create greater tension by taking the position of adversary against the part of the patient identified with his defenses. The vagueness is therefore challenged. Many patients would then employ a series of other defenses, each of which would be challenged in turn. But this highly responsive patient responds immediately, which is the characteristic of all patients on the extreme left of the spectrum. Now we return to the interview.

TH: *When you say "probably," is it or isn't it? And you already have said that you entertained the thoughts.*

PT: If we had time to do that, obviously we could have had time to . . . yeah. There was. You're right. I was worried about going too far. It was a sort of wanting and not wanting.

Now, the therapist resumes his exploration.

TH: So these intruding thoughts involved her being naked, the intimate relations. Were they pleasureable?

PT: Oh, at first, yeah . . . were pleasant. But after they kept coming back and back and back then they became disturbing, and I felt guilty. I think it started to make me feel guilty again almost as if I was recommiting the act.

TH: There was a conflicting situation. And this went on for how long?

PT: This went on for a while . . . a few months, I guess. And then gradually I sort of half forgot about it. And it didn't bother me so much for a while. Then it started to come back and the thoughts would start coming again; and I think that is when I started with . . . like reading, and all the doubts, and checking and rechecking . . . like reading a newspaper and reading the same thing over and over. I go back and read it, and I go back and read it again—the same article. Then I moved to this checking and rechecking. My concentration is not good when I am in the office. In the office there are six of us. But you know, sometimes you get one person talking to you—but your mind is not there. I find I can't concentrate.

TH: Your mind wanders.

PT: Yeah. I hear them.

TH: Going back to your sister-in-law, do you see her?

PT: Well, they are . . . She is living with her family on the West Coast. Once in a while she comes down, to visit, with her husband and children.

TH: Hm hmm.

PT: And sometimes when they first come down . . . I don't want to go over there. I don't want to see her sort of thing. But once I get over there it is fine. I just sort of say "hello" and . . .

TH: Does her husband know about this?

PT: As far as I know, no.

TH: After you stopped seeing her, you kept having thoughts about her. My question is this, do you get these intruding thoughts about your sister-in-law at the present time?

PT: Sometimes. It is sometimes, and it doesn't bother me as much. Really less. Occasionally, when I am making love with my wife she comes to my mind, but immediately I put her out.

TH: So the thoughts about your sister-in-law are much less. But these obsessive thoughts, these doubts, this checking and rechecking, they have taken over.

Now the process moves to the following piece of insight, which contains four components: (1) his obsessional symptoms express his need to be punished, which (2) he has had to take into his own hands, because (3) his wife was too understanding, and . . . (4) did not punish him herself. Once more the patient demonstrates his extraordinary degree of responsiveness. The therapist only mentions component (3), but the patient immediately responds with component

(4), thus enabling the therapist to add component (1) and (2) quite naturally, in the form of a first interpretation.

It is important to note that so far in the present interview there have been only two moments of a mild degree of challenge, and so far the transference has not needed to be mentioned at all.

It is important to emphasize that my research with a large series of patients has shown, without any question, that bringing out the need for self-punishment and self-defeat is an essential part of the therapy of many patients, particularly those who—in contrast to the present patient—suffer from severe character neurosis and are located within the right side of the spectrum. There I have introduced the concept of the perpetrator of the unconscious, which will be discussed in greater length in future publications. But this in no way applies to the patient on the extreme left of the spectrum. Now we take up the interview just before the point where we left off.

TH: . . . this checking and rechecking they have taken over. You said your wife was very understanding.

PT: More understanding than I figured she would be. I don't know. I wonder, myself. . . . Maybe she didn't give me, you know, really . . . give me shit sort of thing rather than . . .

TH: You wanted her to punish you. But you are, yourself, doing a good job. What you are doing, really, is punishing yourself.

PT: Right. I think so, basically.

TH: You are punishing yourself because of these guilt feelings that you have talked about. And the way in which you do it is by doubting yourself, by torturing yourself, by being obsessed with these statements, by checking and rechecking, this obsessive type of thinking—which on the surface is linked with your sister-in-law and your wife.

PT: Yeah. Right.

Once more the therapist resumes his exploration

TH: How long have you been married?

PT: 3 years.

TH: How old is your wife?

PT: She is 24.

TH: And you have been married for 3 years.

PT: Yeah.

TH: Any children?

PT: She wants children. And my idea was that it is better that we wait.

In view of what emerges later, this communication is highly significant.

TH: How about after the incident with your sister-in-law?

PT: She still talks about having children. But I said to her that I want to see if I can get whatever is wrong with us, or whatever thoughts, or I want to try to get that cleared up before I take on the responsibility of having children, really.

TH: Could we look to the way you met your wife and decided to get married?

PT: Well, I met her on the commuter train. I had seen her for a while, but I hadn't talked to her. One day I ended up sitting . . . like they have bench seats, and end

up sitting beside her. We started talking, and I asked her if she wanted to go out and have a drink. She said, well she was engaged. So I said, "okay—if you change your mind." Then after that I would meet her every night sort of thing. She would save a seat for me, and I would sit and talk with her. And finally I convinced her to go and have a drink together. Then I . . . one night I said, "What are you doing Friday night," or something; and she mentioned, well, you know, she wasn't doing anything. So I asked her if she wanted to go out. She said "Well, I don't know about going out, but come over to my place." So I went over there. Her parents were out, and we started necking; and then we had intercourse, and she broke off her engagement and I went out with her for about a year—and then we got married.

One of the important features of this technique is that it reveals, with utmost clarity, certain ever recurring patterns that lie behind human neurotic suffering. This enables a therapist to direct the process toward significant areas with the help of minimal clues. In the present interview the therapist perceives a further occurrence of a triangular relation created by the patient in which it was the patient who came off best. In the incident with his sister-in-law he both caused her to betray her husband and made his wife jealous, while in his winning his wife he competed successfully with another man. Most patients on the extreme left of the spectrum show a high degree of fluidity of their unconscious, and the unconscious therapeutic alliance either is in operation or easily comes into operation. In this patient, the unconscious therapeutic alliance indicates that the patient has a need to create such situations because of unresolved feelings about some previous triangular situations. Now the question is this, is he trying to perpetuate a situation in which he was the winner, or to undo a situation in which he was the loser? Obviously, the therapist does not know; but he decides to underline the triangular relation immediately.

TH: *So in a sense you managed to take her away from her fiancee.*

PT: *Yeah.*

TH: *And that she preferred you.*

PT: *Yes.*

TH: *So in a sense, he lost her, then, to you.*

The therapeutic alliance has made another communication. The patient had emphasized that his sister-in-law was "very well built . . . a big chest." Now the question is this: how about his wife? The therapist follows the path, breaking in with the question:

TH: *How would you describe your wife in terms of body build and otherwise?*

PT: *She is a nice looking girl. Average build, not big.*

TH: *Hm hmm.*

PT: *Uh . . . gee, really . . .*

TH: *If you compare her to your sister-in-law, how would you describe . . .*

PT: *Well . . . my sister-in-law is built a lot bigger.*

TH: *Hm hmm. But there are things about her that attract you.*

PT: *Yeah. Her breasts. Yeah "I think" that is it.*

TH: *And your wife?*

PT: *And my wife is not nearly as big.*

TH: How would you say it is?

PT: She, "I guess," "you could say" she is a small-breasted woman.

The patient has become uneasy by this subject and still is trying to maintain his vagueness. An effective way of dealing with many defenses is simply to draw attention to them, which communicates to the patient's unconscious that the therapist knows only too well that something anxiety-laden is being defended. This the therapist does, and then he makes another communication, putting into words the possibility that beneath the surface the patient is dissatisfied with the size of his wife's breasts:

TH: You say, I "could say." Is your wife a sort of flat-chested type?

PT: Er . . . yes . . . toward that . . . more than big.

TH: What else about your sister-in-law attracted you, besides her large breasts?

PT: Nothing else. She is attractive, the same as my wife.

TH: If you think about it, besides her body what else was there about her that attracted you as well?

PT: "I think" I know what "you have in mind" . . . that she was married . . .

Although this is a major piece of collaboration on the part of the therapeutic alliance, it is still hedged with tactical defenses. At a later stage of the interview, when resistance is at a minimum, the patient will respond to questions from the therapist with much more spontaneous insight. But at this stage he employs some tactical defenses.

The therapist's next intervention illustrates very clearly a fundamental principle of this technique; namely, where a response contains a mixture of communication and resistance, no matter how genuine the communication, the element of resistance must still be challenged. This particular defense is challenged.

TH: That she belonged to someone else. Her husband is on the West Coast, and she is preferring you to her husband. And you a minute ago told me that your wife was engaged and you finally managed to convince her to drop her fiancee for you. So what is there that I have in my mind?

The patient responds to this challenge without defensiveness:

PT: Wow

Further Inquiry and Part of the Developmental History

Since the patient has responded so positively, the therapist resumes further exploration. His aim is to assess both the quality of the marriage, the sexual relation, and the degree to which the affair with the sister-in-law has threatened it. All of the information is reassuring, indicating that the patient is an emotionally healthy young man, with a good close relationship, suffering from a single obsessional symptom—a symptom neurosis rather than a character neurosis. The patient indicated that the sexual relationship has been good since the beginning of the marriage. For a few months, when the sister-in-law was in the picture, there was a decline; but at the present time it is very satisfactory. During intercourse

with his wife he may get flashbacks of his sister-in-law, mainly her face, which he is able to put out of his mind; it does not interfere with his erection, and he has never had an incident while having sex with his wife of imagining he was having sex with his sister-in-law.

The therapist now fills in further detail about the history of the patient's relations with girls, still checking on whether there is any disturbance or any further evidence for recurrent pathological patterns. The information is typical of the development of a healthy young man in North American culture, and the whole picture is entirely reassuring.

Here, for the sake of brevity, this part of the exploration is summarized. Questioned about his mother's attitude about his dating and sexual issues, he said, "She never said watch yourself or anything. . . . She was very understanding and always figured that I know." Exploration was made on the issue of sex education, and he said that one of the teachers conducted sex education classes after school with parents' permission. He indicates that he had an open system of communication with his parents.

PT: I asked her how the baby was . . . how it was formed in the stomach, I remember asking her about stuff. I was interested because I wanted to find out certain things.

His relation with girls before the marriage was explored. He had three relationships with no indication of any problem. He had many close friends and was involved in hockey and baseball. After he finished high school he went to work, and his work record is good. No previous psychiatric history. All of his symptomatology started after the incident with his sister-in-law.

Developmental History

The therapist now embarks on exploring the patient's family background.

TH: You are from where?

PT: I was born in Toronto and later the family moved further East.

Both parents are living. He has one brother 7 years younger than the patient. His father, an industrial chemist, is 58 and his mother is 50, a housewife.

Dynamic Exploration of the Patient's Early Life

Having obtained this information, the therapist explores the dynamic aspect of the patient's early life.

TH: What is your earliest memory of life, as far back as you can remember?

PT: One is of going to . . . first starting school. That is when I was six. That always seems to come to my mind because I didn't want to go to school until a few friends came over, like, a couple of friends. One of them had an older brother, and he was sort of going with us to go to school. So once they came over it didn't bother me. I went off alone to school.

TH: This memory is around the age of . . .

PT: I think six.

TH: Were you closer to your father or to your mother?

PT: My mother, because whenever I had any problem or anything I always went to my mother—because she was always there, whereas my father was at work. So I don't know whether that was . . . I guess . . . well, it was love, too. But it was more or less that she was there all the time, whereas my father was not there . . . he would leave early in the morning and get home at night.

TH: What are your earliest memories of your father? The sort of things you did together?

PT: I remember he always took us on vacation. Whenever he was on vacation from work we always went somewhere. And it was always fun.

TH: Did your father show interest in you when you were growing up?

PT: Not in the younger years. In the younger years he was mostly at work.

TH: How would you describe your father as a person and . . .?

PT: Fair, fairly strict . . . well, used to be. I think he is mellowing now with getting older. Good to be around.

TH: Now?

PT: Yeah.

TH: You said he was strict.

PT: Yeah. He was, but he wasn't an authoritarian type. Just if you were supposed to do something, do it, get it done. Don't mess around. If you have homework to do, do that. If you have chores to do, do them . . . you know? Then once you have done that, whatever free time you have is yours. He had pretty high standards. If you've got to do something, do it right sort of the thing, you know? During the week I would come home from, let's say, high school or whatever. And I knew I had to pick up the mail. This and this. Okay, once I did that then you could, you know, go out and see your friends, whatever. But, you know, do whatever has to be done first.

TH: I see. How about your mother?

PT: My mother? . . . I got along great with my mother. Uh. . . . She was more of a disciplinarian than my father was.

TH: She was more?

PT: Yeah. Like she would . . . like, because, well I have got a younger brother and having a younger brother I had arguments with him, and battles, and . . .

TH: How much younger is he?

PT: He is seven years younger. He is now 19.

TH: He is now 19?

PT: Yeah. She would get upset with us and pick up, like, a fly swatter and give us a smack with it and tell us, you know, stop whatever you are doing or one of you get out—one in one room and one in another, or, you know. This was much more so than my father. Whereas he would come home, you know—my mother would say, well what they did today.

TH: Was there a lot of fighting between you and your brother?

PT: Yeah.

The data seems to suggest that the major source of tension for the patient in the family was his younger brother. The question for the therapist: is a close early relation with the mother disrupted by the birth of his younger brother? The therapist seeks further evidence, and as has already been mentioned several times,

this patient has shown a marked lack of resistance throughout the interview; and when he has become resistant he has responded quickly to minimal challenge. It is clear that this minimal challenge has still been enough to keep him nonresistant; his therapeutic alliance now produces a piece of spontaneous insight.

TH: *What was your relationship with your mother like in the early years before your brother was born?*

PT: *Far back in the very early phase I had a close relationship, and much more so than with my father because he went to work and he was mostly away, and being four, five and six, you are at home all the time. So naturally you relate more to your mother than your father, really. Now what comes to my mind also is you asked about my earliest memory. This was at age 6, and I really had a fear of going to school.*

TH: *You had fear to go to school then?*

PT: *Was it fear? I don't know, maybe I just wanted to stay with my mother.*

The therapist decides not to pursue this for the time being. He is well aware of the theme of triangular relationships in the patient's current history, and he needs to establish which of the earlier triangles, the triangle involving his father or the one with his brother, was the more important. He decides to explore the former triangle first.

Dynamic Exploration: The Triangle Involving the Patient, His Mother and His Father

TH: *And your relationship with your father then?*

PT: *(pause) I don't really remember.*

TH: *Did you feel close to your father? Did you look forward to his coming home?*

PT: *My memories of the early years are mostly when we used to go on vacation, and sometimes my grandmother and grandfather.*

TH: *Then when your father was around, what was your relationship with your mother like then?*

PT: *I think I was still with my mother more than really with my father.*

TH: *What was the relationship between your parents like?*

PT: *As far as I can remember they always got along fine . . . uh. . . . A few years ago they had a falling out, and this was when I was 16 or 17.*

TH: *So around age 16 then there were problems between your parents?*

PT: *Yeah. They started to have arguments.*

TH: *We can get to that in a minute. What was the sexual life of your parents like? What were your thoughts about your parents' sexual life?*

The patient responds with a mixture of therapeutic alliance and the tactical defense of rumination. Once more, when there is such a mixture it is the defensive aspect that must be challenged and the challenge must be kept up so long as a significant degree of resistance is present. The following passage very clearly illustrates this process, which ends relatively quickly with this patient, and there is emergence of an important piece of insight.

PT: I would really say no idea. I don't know for some reason. I never really pictured them as having sex together for some reason. I don't know why.

TH: So your memory collapses on you. You say you never really pictured them as having sex, but obviously they must have, because after all there you are . . . and . . .

PT: And there is my brother.

TH: Then obviously there was a wish on your part that you would not think of sex in terms of your parents.

The patient responds with rumination.

PT: It might have been. I can't really . . . it is . . . I was thinking back to then, and it is hard to say.

TH: But that doesn't help us. We need to look at your thoughts.

PT: It seems I didn't want to recognize the fact that maybe I was jealous of my father in a way.

TH: From where does the idea of being jealous of your father come?

PT: I don't know. It suddenly came to my mind if I didn't picture them having sex, you know, maybe I wanted my mother like for me.

TH: Hm hmm. Have you had these thoughts?

PT: Not really before. It came to my mind now that I am talking to you.

TH: So far the picture is that you have a very close relationship with your mother, and your father is only somebody who is working hard day and night and he is not very much in the picture. And even during vacation when he was around or other times you maintained a close relationship with your mother. At least this is the picture until your brother was born.

PT: But when I was around 16 or 17 I saw more of my father. By then I sort of had an interest in going out. . . . He used to talk about going to the tavern and playing shuffleboard and stuff like that. So that sort of interested me. I wanted to see, you know, exactly what it was so I asked him if I could and he said yes. So when I first went, of course, he let me have one or two beers; and that was it. He didn't want to get me drunk and take me home to my mother or something. We used to go out together. Then he sort of switched jobs so I was getting a ride home, a ride into work with him, and a ride back so I was more with him more than before.

TH: So, around this time you developed a much closer relationship with your father. But did your feelings about your mother at that time change?

PT: No. I have always been close to my mother. Still I am now. Uh . . . My father started to drink a little too much and wouldn't show up for supper, and stuff like that. Finally, well . . . I . . . one time my mother sort of, well . . . she never told him but she mentioned to me that she was thinking of taking off, going back to England . . . while her father was still alive. At the time I just thought to myself, it is just anger toward my father, that it was just like a threat, really, sort of an expression of just pure frustration.

TH: That was the first time that your mother talked to you about your father?

PT: Yeah. That was the first time.

TH: Prior to that?

PT: No. She never talked behind my father that I remember. That was the first time, and anyway that's been patched up. So my father cut down on his drinking.

What emerged was that his father drank some beer, but never to excess. It was only when the patient was about 16 that his drinking increased and became a source of conflict. Then the focus of the session is on the relationship between his parents, and the patient indicated that as far as he can remember they had a very good relationship. His positive feelings for his father in the very early years relate to vacations. Then the session focuses on the patient's feelings at the age of 16.

- TH: *If we go back to the age of 16, how did you feel when your mother was talking to you about leaving your father? How did you feel about that?*
- PT: Uh . . . it didn't bother me, really. It didn't bother me, really, 'cause, just the way they got along other than when he went out on, like he didn't do it every . . .
- TH: You mean you didn't have any feelings either way toward your mother, talking to you about her bitterness and wanting to leave your father?
- PT: Uh . . . I worried, I wondered, you know, what I'd do and, I'd stay with my mother or stay with my father.
- TH: And what were your thoughts and ideas—to stay with which one?
- PT: Uh . . . I think I was more inclined to stay here, to stay in Canada with my father. My brother, well he wouldn't have much choice—he was only eight at that time.
- TH: But this doesn't fit. You had a close relation with your mother—then your brother and your mother would have ended up to go together.
- PT: Well, all my friends were here. As I got older I was more drawn to my father than my mother.

Important material has emerged in the above passage, and the therapist's conclusion is that the triangle involving the father does not relate to the patient's core problem. Then the process of the interview moves to the other triangle.

Dynamic Exploration: The Triangle Involving the Mother and the Brother, Leading to Resistance

- TH: *What do you remember about when your brother was born? You were then seven.*
- PT: *I remember writing notes to my mother. She was in the hospital . . . I think that she was in the hospital for a week. I am not sure.*
- TH: *Do you remember when she was pregnant?*
- PT: *I saw her pregnant, and I remember I thought it would be great, you know, to have a baby brother.*
- TH: *How did you feel?*

The focus is on the patient's feelings. It should be noted that behind the denial the dynamic force of the therapeutic alliance is in operation.

PT: *I felt okay, except that he got a lot of attention.*

The therapist asks for a specific example.

TH: *Can you give me a specific example of how he got special attention?*

PT: Well, when I was 10 or 12 I used to have chores. I would have to do . . . like go for bread, to get things. I remember I used to have to get wood for the fire. I used to have to do a lot of things, but he didn't have to do any of these things. Even she would get after me to do things like shovelling, cleaning.

TH: I see. You were glad to have a baby brother, but at the same time this baby brother is getting a lot of attention from your mother.

PT: Right.

Again focusing on feelings.

TH: Could we look to your feelings about that?

At this point, there emerges a communication of the type when both resistance and the dynamic force of the unconscious therapeutic alliance are both in operation. This takes the form of a negative statement, unconsciously implying a positive one. Here the statement "I never had temper tantrums" (who said anything about temper tantrums?) implies that he wanted to have them. This communication from the therapeutic alliance indicates: (1) that there was indeed hostility against the brother, (2) that it did arise from jealousy, (3) that here lies the core of the patient's neurotic problem, and therefore (4) that when the patient shows resistance against examining this area, then here is the point at which the head-on collision must be brought into play. The therapist is acutely aware that this leaves a crucial question still unanswered — where does the sister-in-law fit in?

PT: What I remember is that I never had temper tantrums. What I remember is a few years later when he wanted to tag along with me I didn't want him with me.

TH: But you said there were fights between you and your brother.

PT: Over anything. I guess there was so much of an age difference. He used to want to follow me around, and I didn't want that. He was too young.

TH: You mean that was the factor?

PT: Yeah, yeah.

TH: Was that the factor, or was it that he had become the favourite of your mother? Was there any favouritism?

The patient begins with a denial and then, once more, the therapeutic alliance comes into operation. The therapist reinforces this and the patient immediately goes into rationalization and rumination. At this point the head-on collision begins.

PT: No. No favouritism. No, I think I used to think there was.

TH: You used to think?

PT: Yeah.

TH: Could we look at that?

PT: I guess because he was the youngest, sort-of-thing. So I guess I used to think that he got more or really he didn't. But . . .

Head-On Collision with the Resistance: Further Rise in Transference Feeling

TH: I wonder if you notice that when we want to talk about your relationship with your brother—the fights, your relationship with your mother, that are obviously very important for us to understand—you have become vague and ruminate and rationalize away, because he was the youngest, because this and that. For instance, you said that you had to do all the chores and he didn't. You were the only child, then your brother comes along. And you must have a lot of feelings that we have to understand.

PT: Yeah. Right. But I really know . . .

TH: But . . . this way by ruminating and rationalizing we are not going to understand where the core of your problem lies.

PT: I don't really know whether I had that feeling or not, you know. It is . . .

TH: Now you are questioning whether you even had that feeling. But where did the idea come from a moment ago when you said you felt that your brother was getting a lot of attention and you were forced to do a lot of dirty chores?

PT: Yeah. I guess really I did.

TH: You see . . .

PT: Yeah. Right. I see what you mean.

TH: The only way that we can understand the problem is to look to your memories rather than to rationalize things. So obviously there was a feeling in you that your brother had disrupted the close relationship you had with your mother, the relationship where there was no competition—you and your mother together and your father busy.

PT: Uh hmm.

TH: Now what are your memories about your brother getting more?

PT: Uh . . . gee . . . (pause) . . . getting more . . .

TH: It had to do with the attention of your mother.

PT: Yeah . . . it always, like to me I guess it seemed that he used to be able to stay up later than I did at his age, you know. Not to do chores.

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

PT: I guess you could say that, yes.

TH: That he was the favourite of your mother? That he became the star?

PT: Yeah . . . okay.

Now, the therapist challenges the patient's passive compliance, which is a tactical defense to prevent him from experiencing his true feelings.

TH: Why do you say, "Yes . . . okay"? Is it, or isn't it?

Tactical defense of rumination.

PT: Yes. I guess he was then, but. . . . We are looking at it then . . . okay . . . favourite? . . . favourite? He was the favourite because he was the youngest.

Tactical defense of "because" used to avoid feeling which is challenged.

TH: Let's not get to "because."

Challenge to the tactical defense of vagueness

PT: Yeah. Right. I guess so. I guess he was.

TH: Why "guess so"? Was he or wasn't he?

Return to tactical defense of rumination

PT: It could. I don't know whether, you know . . . she intentionally did it.

TH: There again you are moving to "because"—rationalizing.

PT: Okay. Yeah. Then to me, then, yes. He was the favourite at that time—the way I saw it then.

TH: And you were after him to fight, and you were seven years old.

Vagueness again

PT: Possibly right.

TH: Again, "possibly"?

There is further rise in the transference and concomitantly we see a rise in the unconscious therapeutic alliance which acknowledges the resistance openly.

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

This communication has transference implications. The process focuses on the transference and this is the first time that this has been mentioned. Then the process maintains its focus on the defenses and further the focus is on the underlying feelings, not only about the brother but about the mother as well. Then the focus is on the anger towards both of them.

TH: Now let us look at your relationship here with me. You prefer to hang things in the middle of nowhere, okay? Look at it. When you are describing your relationship with your brother, with your mother, you cannot commit yourself to what really was there, okay? In all—"guess," "perhaps," and "maybe." You give me a picture that your brother became the favourite of your mother and that your mother replaced you with your baby brother, then you move to rationalize. You become vague. And obviously you wanted to pick a fight, and you were older and stronger, and to get at him—who had replaced you in relation to your mother. And obviously, also you have feelings about your mother, who replaced you like that. And not only that, is giving all the attention to your brother and the dirty chores to you.

PT: Yes. I would say yes. Right. I resented it.

TH: When in a fight he was obviously the loser to you.

PT: Well . . . uh . . . There was more arguing than fighting. Physically I hit him once or twice.

TH: So you had the upper hand.

PT: Oh, yes. Definitely.

TH: Hm hmm. In terms of your mother, what was her feeling? That there were two of you instead of one? Would you say that you lost that privileged, number one position in relation to your mother?

PT: Well . . . I lost it.

TH: And how do you feel about it? She has your brother, and all the attention goes to him . . .

Then the focus is on the patient's smile and then on the patient's transference feeling.

- TH: . . . You are smiling. How do you feel right now when I . . .?
- PT: The thing is . . . back . . . you know . . . I don't, can't really remember what I thought back then.
- TH: I am not sure if it is that, that you don't remember—or somehow you want to leave it in the middle of nowhere.
- PT: Possibly. But . . . like I said, I don't remember how I thought.
- TH: Let me question you about one thing . . .
- PT: Hm hmm.

Further Challenge to the Tactical Defense

- TH: If you look here with me, you often say "possibly," "perhaps," "guess so"—rather than look at things. Do you see what I mean?
- PT: Yeah. I see what you mean.
- TH: That you say, "possibly," "guess so," and so forth. Is it like this with everybody else?
- PT: No.
- TH: It is here only?
- PT: Maybe it is, I don't know . . . 'cause I just . . .
- TH: And how do you feel about me questioning you and . . .

The patient declares that he has feelings but in a vague and evasive way.

- PT: I guess . . . Not "I guess"—that is part of it. I feel, you know, feel "kind of funny" talking about—you know—"everything."
- TH: How do you feel when I constantly keep you on the issue rather than to . . .

The patient's therapeutic alliance now openly acknowledges his defensive maneuvers and his appreciation of what the therapist is trying to do, at the same time making clear that he did not expect exploration into the painful issues of the past.

- PT: Let me off the hook . . . yeah. I don't know. The thing is . . .
- TH: You are smiling.
- PT: I know what I am doing. I am trying to avoid the direct question. I didn't want to get . . . I didn't know, like, you would go back into my problems or back to my parents and all this.

The therapist now applies one of the important components of the head-on collision.

- TH: Okay. You said that you are trying to avoid. Now let's look at it. Obviously you have a problem and this problem is a source of misery and suffering for you.
- PT: Hm hmm. Right.
- TH: And you have, on your own will, come to find an answer to your problem—with the help of each other to get to the bottom of your problem, to get to the core of your problems. This is your goal. Right?
- PT: Right. Yeah.

TH: Now if here you are going to avoid, then obviously you are not going to reach your goal, that you have set for yourself. In other words, it becomes useless to you—and there will be self defeat in it, isn't that?

PT: Yeah.

TH: Now my question is this, why should you on your own will come here and see if we can get to the bottom of your problem yet at the same time another part of you wants to defeat the purpose, the goal, and the aim you here set for yourself—because if you are going to avoid to face with many of these complicated feelings then obviously we are not going to get anywhere.

PT: Well . . . I didn't realize that we'd have to go back, you know, all that far. I figured we'd just go back to where it started.

For the time being the therapist decides that this head-on collision and the resulting open acknowledgement by the patient of his defensive position are sufficient. He resumes his exploration about the mother.

Exploration of the Relationship with the Mother, Resistance and Challenge

TH: Now could you tell me more about your mother, you know . . . then . . . the way you remember her. Her physical appearance, her . . .

Challenge to the resistance has given rise to transference feelings and further mobilization of the therapeutic alliance to such a degree that this question results in major communication.

PT: Er. She's nice looking. She's small—small build. She looks like my wife.

TH: Hm hmm.

PT: About the same height, same weight.

TH: I am talking about when you were a child—your memories of her body and her build.

Return of resistance, the defense of evasiveness and challenge

PT: Uh . . . not really anything to speak of . . . nothing in particular.

TH: You mean you don't have any memory of your mother as a child?

PT: I remember . . .

TH: What do you remember?

PT: She was there sort of . . .

Challenge to tactical defense of evasiveness

TH: I know she was there, but what do you remember?

PT: I don't really, you know, in particular, nothing.

TH: Huh?

PT: In particular, nothing. Always she was good and loving, taking really good care of me.

TH: Hm hmm.

PT: You know . . . I used to have problems in school.

TH: Again you avoided my question. We were focusing on her physical appearance. Again you avoided to tell me about her physical appearance when you were a child.

Previous head-on collision and challenge to the defense of evasiveness now produces a major communication from the therapeutic alliance which clearly throws light on where the sister-in-law fits in.

PT: One thing I do remember is . . . I probably . . . not probably—sorry, I do remember, is that I always thought that she was small in the chest as compared to other mothers. That is one thing that I can remember . . . I remember that. I remember . . . well . . . I used to look at others, my friends' mothers, and think they are fairly big. And I used to wonder why, sort of wonder, why my mother isn't, you know. At that time I didn't realize, you know, probably different people are different sizes sort-of-thing. I guess I sort of had it fixed that all mothers should sort of be the same size.

TH: So, you were comparing the breasts of your mother with the breasts of your friends' mothers—that they had large-breasted mothers and you had a small-breasted mother.

PT: Yes. But some of the other mothers had smaller, too.

TH: I see. How old were you then?

PT: Seven, eight, nine . . .

TH: Then these relate to the early years?

The therapist now first makes a connection between the past and the present then asks a crucial question about the past. Once more, the therapeutic alliance makes another highly significant communication, giving even further point to the connection with the current problem.

TH: You said that your wife looks like your mother. Have you thought of it that way?

PT: O yeah. I have seen it. Well . . . people have said, people that don't know my wife and my mother that will have asked if she was her daughter sort-of-thing. They are quite similar.

TH: Your memory indicates, then, that you were very conscious of the breasts of your mother; and you said this was around the age of eight or nine. But how did you become aware of the size?

PT: (pause). I remember one time, I don't remember how old I was, she was, I guess she was in the bath or getting dried and my father had to go to the bathroom and he went in, and I remember she was standing sideways and I saw her.

TH: She was in the bathroom, but where were you standing?

PT: There was like a hallway, and I was just standing in the hallway; and as the door opened I happened to look up and I saw her breasts. I don't know how old I was.

TH: You are saying you "happened" to look up? Only later you became curious?

PT: Not so much about my mother but about other women.

TH: If you compared your mother's breasts with other women's breasts, obviously you were curious. You thought, "Why have I got a mother with small breasts?"

PT: I never tried to peek into her room.

Again the negative statement implying positive, which is a function of the therapeutic alliance to which the therapist immediately draws attention.

TH: I didn't say that! In that memory, did your father go into the bathroom?

PT: *I heard the door open and looked up. It was a fraction, it was just for a fraction of a second, and then the door closed.*

The therapist now explicitly makes the link with the sister-in-law.

TH: *Still you prefer not to declare that you were actively interested. And obviously what took place between you and your sister-in-law, in that episode you were an active participant . . .*

The process now returns to the triangle involving the patient, his mother and his brother and the issue of hidden resentment against the brother, and the patient gives evidence that he is working on this.

PT: *Resentment? (quietly) mm . . . gee . . . I don't . . .*

TH: *Something that you always have difficulty about. Do you have difficulty about the issue of resentment?*

PT: *(pause) Maybe I don't want to admit . . .*

This admission that he does not want to admit is enough for the therapist to sense an opportunity to bring the patient's negative transference feeling into the open.

TH: *Now let's look at another issue. Here during this time that we have been together going over these complicated issues, was there any time that you felt resentful toward me?*

PT: *A few times, yes.*

TH: *And I sense it, too.*

PT: *Yes . . . 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, it is just, maybe, you know, I . . .*

The patient has openly acknowledged his defense against underlying negative feeling in the transference. Although this is a very important communication, he has still ended by denying the true impact. As always, it is the element of resistance that must be brought into the open. The therapist immediately points out the denial.

TH: *Right away, also, you are reassuring me about liking and disliking. Immediately you said, "not that I dislike you."*

The therapist now gives an interpretation of the resistance, resentment of him intruding now between the patient and his mother with the brother's intrusion in the past.

TH: *So obviously what we have seen here in relation to me is that you resent my getting into your personal, intimate life, and that you resent my getting into your intimate relationship with your mother—the same way that you were angry that your brother got between you and your mother. In terms of your father, he was too busy—either at work or in the tavern, so he wasn't a threat.*

PT: *Yeah . . . right.*

TH: *And the way you are dealing with your negative feelings is ice skating around the . . .*

PT: Yeah. Right. Beating around the bush.

TH: Beating around the bush and becoming vague and nonspecific. That is the way you are handling your negative feelings here.

PT: Yeah. Okay.

TH: So that is when I said . . .

PT: Yeah, "get to the point."

Recapitulation

One of the important features of this technique is the way in which the process proceeds in a spiral: exploration, resistance, challenge to the resistance, rise in transference, further resistance, intervention aimed at weakening transference resistance, return to exploration and so on. But the reader should keep in mind that this process, both quantitatively and qualitatively, is extremely different with patients on the extreme left of the spectrum compared to those who are highly resistant on the right side of the spectrum.

Looking back over the mid phase of this interview, we can see the following:

- (1) The therapist began to explore the triangular relation involving the brother. This led to;
- (2) The patient going into some resistance, employing rumination;
- (3) The therapist begins with the head-on collision with the resistance which leads to;
- (4) The patient's admission of his defense, that he does not want to answer the question directly;
- (5) The therapist first draws attention to the transference component in this and then continues his challenge;
- (6) The patient admits the underlying feeling of resentment towards his mother;
- (7) The therapist presses the patient for further feelings at which point the patient gives an involuntary smile and the therapist presses for further feelings;
- (8) The patient at first manages to avoid answering this question and later gets no further than saying he feels "kind of funny talking about the past";
- (9) The therapist applies head-on collision to bring further rise in transference feelings and further mobilization of the therapeutic alliance;
- (10) The head-on collision has the desired effect, and the focus is on the mother's body;
- (11) Important material about the mother's small breasts and the large breasts of the sister-in-law;
- (12) The therapist then returns to the early triangular relation to bring up that the patient felt resentment towards his brother;
- (13) Then the focus is on the transference with the question whether the patient at any time felt resentment towards the therapist;
- (14) Now, for the first time, the patient admits the transference feelings;
- (15) His resistance has been sufficiently weakened and he makes his own interpretation of the defense and his underlying feeling in the transference, namely that when he started "beating around the bush" it meant that he was feeling resentment; defense against underlying feelings in the transference;
- (16) The therapist gives further interpretation, spelling out the issue of resentment at the therapist intruding between the patient and his mother and linking it with that towards his brother;
- (17) Now the therapist and the patient are able to collaborate actively in elucidating the links between the current pathogenic situations and the buried feelings about the past. There is no need for any further mention of either resistance or transference.

Uncovering of the Core Neurosis

The process now returns to the patient's feelings in the original triangular situation, and eventually this brings the following:

- PT: *I felt like punching him.*
- TH: *What was your feeling for your mother?*
- PT: *I resented it. I kept it in. I did not talk about it. But in the past two or three years I have talked about it.*
- TH: *Do you remember exactly when?*
- PT: *Somewhere around the, around 3 years. Somehow I started to mention to her . . . I mentioned to her that I thought he didn't do stuff, he didn't have . . . well . . . well . . . as, as rough a life as I had. I had more responsibilities. I also had to take care of him. I remember my parents would go bowling, and I had to stay home to take care of him.*
- TH: *So you have been talking about your resentment.*
- PT: *And she agrees with me. She agrees that in some ways she was unfair.*
- TH: *This talking to your mother about preferring your brother, was it before you got married or after?*
- PT: *I think . . . no, definitely it was after I got married. It was then that these things came out.*
- TH: *Then a part of you must have been really angry at your mother and wanted to get at your mother, wanted to punish your mother, who preferred your brother to you and replaced you with your brother.*
- PT: *Yeah. It is clear.*
- TH: *The question is, where the anger is directed. Is it displaced onto someone else?*
- PT: *You mean my wife?*

The patient responds by first reaching a fresh memory and then by giving his own interpretation and, as we see, his previous defenses (vagueness, rumination, avoidance and intellectualization) are not functioning.

- TH: *What do you think?*
- PT: *Now that I look at it . . . it must be that, you know, without really planning it subconsciously. I remember, you know, I told you about my fear of going to school. Now I remember I had trouble in Grade 2, and that was then I was eight. And that was the year my brother was born.*
- TH: *Hm hmm.*
- PT: *That was the only teacher I didn't like . . . the one I had in Grade 2 . . . the only teacher, really, that I didn't get along with . . . that teacher . . . I didn't like her at all.*
- TH: *Hm hmm. What are your thoughts?*
- PT: *When I think about it now, I had been angry with my mother; and when I think of it I must have taken my anger out on the teacher rather than on my mother.*

In this phase of an interview, when the resistance has been dissolved, it is possible to survey every facet of the patient's neurosis—all of the ramifications of events and of family relationships that have led to repressed feelings. With a case as simple as this, which is a representative of the cases on the extreme left of the spectrum, it is possible to reach all of the important feelings within a single

interview. With more complex patients (those who are highly resistant) the therapist can achieve similar results and have direct access to the psychopathological dynamic forces responsible for their symptom and character disturbances within a single interview, which is usually of longer duration.

In the final phase of this interview, the following issues are covered: (1) the link between the mother, the teacher and the wife; (2) the way in which the relation with the sister-in-law expressed not only love, but also hostility; (3) his feelings for his mother, the issue of the women's breasts; (4) the link between the present and the past; (5) the patient's need to be the victor in triangular situations and its link with the fact that he was the loser in the past; (6) self punishment expressed in the patient's compulsive symptom. As will be seen in the following passage, the patient listens intently and appreciatively, following everything the therapist says and creatively putting it into his own words.

TH: Obviously this is very important to look at, this mechanism of displacing your anger at your mother first onto your teacher, and then onto your wife. It obviously involves your sister-in-law as well — this tendency to take it out on other people. Obviously it involves not only anger — it involves other feelings as well. Now going back to your wife, as we have established, both your mother and your wife have the same name. They are both Mrs. _____. And as you described so clearly, they are also very similar physically. So your wife was a convenient person to displace all these negative feelings for your mother onto, to punish her for what your mother did.

PT: Somebody I could sort of take it out on.

TH: So your mother was unfaithful to you, and you managed to be unfaithful to her.

PT: To my wife. Wow . . . it is not my wife's fault.

TH: But also, obviously, there is your sister-in-law, who became the target as well. And if we look at it carefully, one can say that your crime was not so much against your wife. In a direct way you did something to your wife, and to your sister-in-law; you were punishing your wife, but really the reason why you felt that way was primarily because you felt that you were doing some punishment of your mother. That was much more serious. You see, the root of it comes from way, way back and involves your mixed feelings for your brother as well.

PT: I felt very bad for my sister-in-law, as well. Her husband away struggling to find a house.

TH: How old is her husband?

PT: 28.

TH: And you were highly attracted to her breasts. And in a sense you wanted to take over his wife. At the same time there was a major conflict within yourself. You entertained the thought of having intercourse and going further . . .

PT: I was really postponing it.

TH: And if we go far back to the early years and look at the triangle of you/your mother/and your brother, your mother was unfaithful to you and your brother took your mother away from you.

PT: Yeah, I see what you mean.

TH: But do you think something repeated itself?

PT: Yeah.

- TH: You, your mother, your brother and the issue of a small-breasted vs. large-breasted woman.
- PT: Something was taken away from me so I was trying to get back by taking something away from somebody else, without realizing it.
- TH: But if you look at it, there have always been these attached women. There was your brother, and we know you had 7 or 8 years of devoted attention from your mother.
- PT: Right. Just to myself.
- TH: You had the exclusive relationship with your mother.
- PT: Right.
- TH: Then we saw the way you met your wife, who was engaged to another man—and you managed in some way that she dropped the other man and preferred you. Then we see your sister-in-law, who is married. Her husband was struggling to find a house, and she is preferring you to her husband; and the affair.
- PT: Yes. I see the forbidden fruits.
- TH: So you see, there are all these triangles all the time.
- PT: Hm hmm.
- TH: Did this idea of forbidden fruit occur to you then?
- PT: I would say yes, it did.
- TH: In any event, what we see is—now you are punishing yourself, your obsessional symptomatology, your doubts, obsessional thoughts about the lights of the car, checking and rechecking, and the agony.
- PT: Like my mind just scattered all over.
- TH: And what you said was very interesting because you expected that she would have punished you.
- PT: Now I am doing my own punishment.
- TH: You are punishing yourself much harder, and you are paying a very high price. Obviously there are a lot of mixed feelings, a lot of mixed feelings in relation to your mother, your brother, your father, that you might want to examine and put into perspective. We have already brought into the open many of these issues. But if you try to force these thoughts, these ideas and feelings out of your mind, as you have been doing, then you will continue to punish yourself, the obsessional thoughts.
- PT: Now I see why you want me to answer straight. Very good. You can pick out stuff like that, whereas, I see it, if I just beat around the bush you can't. You can't, you can't, pick out—uh—the relationship. And I think that one of the bad things that I have done, too, is that I have waited so long to come.

There remains one important issue that does not appear in the interview, which has not been transcribed. Why was it at that particular point, after a year of marriage, that these events occurred? Clearly, the reason had to do with the fact that it was around that time that the patient's wife began raising the question of having children. He was ambivalent about it. The wife's wanting to have children was threatening him with the repetition of the original trauma of the birth of his younger brother. It was then that his earlier feelings were reactivated, so that he set about creating a triangular situation in which he was the victor rather than the loser.

Another question had to do with the issue of small breasts v. large breasts, an ever recurring issue in many of our patients. We may note that it was the sister-in-law's large breasts that particularly attracted him. Why therefore did he marry a woman with small breasts? In his background, he asked himself why his mother did not have large breasts like the mothers of the other children. Here we can say that his original attraction was to his mother's small breasts, and that he turned against her, feeling that other women were more attractive when she betrayed him with his younger brother. This would account for his choice of partner, both in his marriage and in his affair.

Technique of IS-TDP with Patients on the Extreme Left of the Spectrum

The trial therapy with this group of patients should result in at least some of the following, and the Case of the Salesman is more or less a representative.

- (1) Self-examination and high responsiveness to inquiry. This patient showed this throughout the interview, and the evidence hardly needs to be spelled out:
 - (a) he was able to clearly describe the development of his obsessional symptoms;
 - (b) he's speaking fully and honestly about his guilt-laden relation with his sister-in-law;
 - (c) his open acknowledgement of his own resistance "I don't want to answer the question directly."
- (2) A positive response to the therapist's interventions. The patient himself made the link between the defense "going all around the issue" and the underlying feeling of "resentment." The therapist made the link between himself and the brother over the issue of intrusion into the relation with the mother.
- (3) Experience and acknowledgement of transference feelings and the mobilization of the therapeutic alliance. When the patient finally admitted that there had been occasions in the interview when he had experienced resentment toward the therapist and that he had used the defense of "going all around the issue under discussion." Manifestation of the therapeutic alliance, which has already been elaborated on in the text of the interview.
- (4) Dissolution of resistance and access to the core neurosis. With the rise in the transference and mobilization of the therapeutic alliance, the therapist was more able to interpret the whole of the patient's pathology and make all of the links with the current situation. On several occasions the patient actively gave his own interpretation, for example the recent link between his mother and his wife, and in his early years the link between his mother and the teacher.
- (5) Reconstruction of the core neurosis and acquainting him with it in a meaningful way.

Conclusion

I have described two spectrums of patients who can be successfully treated with my technique of Intensive Short-Term Dynamic Psychotherapy. The first spectrum consisted of five major groups of patients; on the extreme left highly responsive and on the extreme right extremely resistant. Then I described the application of my technique to fragile character structure and very briefly indicated that the technique needs certain modifications. Then the major focus of

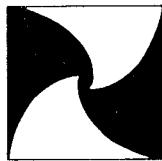
the article was on the analysis of the initial interview of a patient on the extreme left of the spectrum. Now we can briefly summarize the major features of the majority of patients on the extreme left of the spectrum as follows:

- (1) They have the ability to respond to inquiry in a very meaningful way.
- (2) They show clear fluidity in their unconscious and as a result the unlocking of the unconscious technically does not apply to this group of patients.
- (3) There is a virtual absence of unconscious murderous rage and intense guilt-laden feelings in relation to early figures in their life orbit.
- (4) As a result, a punitive superego pathology is not present.
- (5) The nature of the resistance is very much different.
- (6) The duration of the comprehensive initial interview is 1 hour to 1 hour and a half.
- (7) With this technique, the course of the therapy is anywhere between one and five psychotherapy sessions, each of 1 hour duration. With the above patient, the therapy consisted of a single psychotherapy session. The second session took the format of outcome evaluation.
- (8) My extensive experience, in both North America and Europe, in university clinics and in private practice, indicates that indeed the number of patients who are responsive ("motivated") with circumscribed problems and a single psychotherapeutic focus are definitely very few. The large majority of patients are those who are highly resistant with a highly complex pathogenic unconscious, suffering from life-long character neurosis and those who suffer from fragile character structure. These patients are the major focus of this technique.

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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

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Introduction

This is part one of a two-part article concerned with the technique of both partial and major unlocking of the unconscious in a single interview in the treatment of a certain kind of patient suffering from episodic depression, other psychoneurotic disturbances and major character pathology. In many of these patients their characterological defenses are syntonic. I have already both presented and published the discovery of the technique of unlocking of the unconscious and have demonstrated that this provides a unique opportunity for both the therapist and the patient to have a direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances. Further, I have demonstrated that the degree of the unlocking of the unconscious is precisely in proportion to the degree that the patient is experiencing the transference feeling. I have already outlined the dynamic sequences used in trial therapy consisting of a series of a specific type of intervention with its corresponding response. Further systematic research in the eighties and the early nineties has resulted in both refinement in the technical interventions in Intensive Short-Term Dynamic Psychotherapy as well as the development of a

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highly powerful method of psychoanalysis which will be the concern of a series of publications to follow.

This two-part article primarily is concerned with the technique of Intensive Short-Term Dynamic Psychotherapy.

Spectrum of the Technique of Unlocking of the Unconscious

Based on the analysis of the clinical research data, there are four major techniques of unlocking:

- (1) Partial unlocking of the unconscious.
- (2) Major unlocking of the unconscious.
- (3) Extended major unlocking of the unconscious.
- (4) Extended, multiple major unlocking of the unconscious.

This two-part article concerns itself with partial and major unlocking of the unconscious. The technique of extended major unlocking as well as extended multiple major unlocking do not concern themselves with the standard technique. They have already been presented in a number of audiovisual symposia and courses and will appear in future publications.

Dynamic Sequence in the Process of Unlocking of the Unconscious

Updated analysis of our clinical research data requires certain modification and refinement of the central dynamic sequence, which will be the concern of this paper. The whole process is divided into a series of phases:

Phase 1: Inquiry

- (a) Exploring the patient's difficulties: initial ability to respond.

Phase 2: Pressure

- (a) Pressure, leading to resistance in the form of a series of defenses.
- (b) Rapid identification of the patient's character defenses.
- (c) Clarification and challenge to the defenses, leading to rising transference and increased resistance which gradually acquires transference quality.
- (d) Psychodiagnostic function; this is of extreme importance particularly in patients that do not respond to inquiry and the therapist in the initial contact encounters with the patient's character resistance, as well as in patients who come into the interview in the state of resistance in the transference.

Phase 3: Challenge: Making the Patient Acquainted with his Character Defenses

- (a) Challenging the resistance combined with the conveyed lack of respect for them.
- (b) Challenge directed toward the therapeutic alliance.

- (c) Systematic attempt to make the patient acquainted with the resistance that has paralyzed his functioning.
- (d) Special form of partial head-on collision with the transference resistance with special reference to resistance against emotional closeness in the transference with the aim of speeding up the process of making the patient acquainted with the character defenses that have paralyzed his functioning.
- (e) Crystallization of the character resistance in the transference; rise in the transference; mobilization of the therapeutic alliance.
- (f) To turn the patient against his resistance; the patient must clearly see that his resistance that has paralyzed his functioning is being challenged.

Phase 4: Transference Resistance

- (a) Mounting the challenge to the transference resistance.
- (b) Head-on collision with the transference resistance.
- (c) To intensify the rise in the transference feelings.
- (d) To bring the patient face to face with the self-destructiveness of his resistance.
- (e) Mobilization of the therapeutic alliance against the resistance.
- (f) To loosen the patient's psychic system and make possible a partial unlocking of the unconscious.

Phase 5: Direct Access to the Unconscious: Partial Unlocking of the Unconscious

- (a) Crystallization of the resistance and high rise in the transference feelings.
- (b) Intrapyschic crisis; to create a state of high tension between the resistance and the therapeutic alliance in the transference.
- (c) To maximize the inner tension between the unconscious therapeutic alliance and the resistance.
- (d) Mobilization of the unconscious therapeutic alliance.
- (e) Breakthrough of the complex transference feeling; the triggering mechanism for the *partial unlocking* of the unconscious.
- (f) Direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.

Central Dynamic Sequence

Phase 5: Direct Access to the Unconscious: Major Unlocking of the Unconscious

- (a) Interlocking chain of head-on collision with the character defenses crystallized in the transference.
- (b) To mount a direct and systematic challenge to all the forces maintaining self-destructiveness and the major resistance of repression.
- (c) Intensification of the rise in the transference feeling.
- (d) High mobilization of the unconscious therapeutic alliance.
- (e) Direct experience of the transference feeling; the triggering mechanism.
- (f) Major unlocking with the passage of the murderous rage in the transference, emergence of sadness.
- (g) Passage of the guilt-laden unconscious feeling.
- (h) The unconscious now transfers the murdered body of the therapist to the genetic figure.

- (i) Direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.

Central Dynamic Sequence

Phase 5: Direct Access to the Unconscious: Extended Major Unlocking of the Unconscious

- (a) Interlocking chain of head-on collision with resistance in the transference with the aim:
- (b) To mount a direct challenge to all the forces maintaining self-destructiveness.
- (c) Systematic weakening of the major resistance of repression and all the tactical defenses entrenched in the major resistance.
- (d) A very high rise in the transference feeling.
- (e) Optimum mobilization of the unconscious therapeutic alliance.
- (f) Direct experience of transference feeling; the triggering mechanism.
- (g) Extended major unlocking with the passage and experience of the primitive murderous rage in the transference with its psychophysiological components.
- (h) Instant emergence of the sadness, patient attentively looking at the murdered-damaged body of the therapist.
- (i) The unconscious now transfers the murdered body of the therapist to the murdered body of the genetic figure.
- (j) It is important to note that the murdered body of the therapist appears exactly as the murdered body of the mother, father or brother—in terms of color of hair, eyes—in every respect. The patient is seeing, for example, the dead body of the mother with blond hair and blue eyes. The dead body of the therapist is not there anymore.
- (k) When the unconscious makes the transfer, instantly there is a major breakthrough of intense guilt-laden feelings.
- (l) The duration of the passage of the guilt with all its psychophysiological components is on average 8–12 minutes in the first extended major unlocking.
- (m) Passage of the grief-laden unconscious feeling.
- (n) Direct view of the psychopathological dynamic forces.

Phase 6: Systematic Analysis of the Transference

Leading to the resolution of the residual resistance; and is extremely important in patients suffering from panic, somatization, functional and depressive disorders.

Phase 7: Dynamic Exploration into the Unconscious

- (a) Unconscious therapeutic alliance is in command of the process and;
- (b) Spontaneously introduces traumatic events and incidences with;
- (c) Repeated breakthrough of guilt and grief-laden unconscious feelings.
- (d) Consolidation, recapitulation and psychotherapeutic plan.

As I have already stated, not all the therapies proceed in exactly this sequence. The phases tend to overlap and proceed in a spiral rather than in a straight line. For those interested in learning the technique, the dynamic sequence can be seen as a framework which the therapist can use as a guide, constantly working from one phase to another. We should keep in mind that the emphasis on the different

types of interventions depends on a number of variables. For example, the phase of inquiry is always possible in patients on the extreme left on the spectrum of psychoneurotic disorders. The best example is the case of the Salesman. Another one is the Case of Henry IV Man. Both of them, with great clarity, responded to the phase of inquiry. But patients on the right side of the spectrum, particularly those with syntonic character resistance, are not able to respond to the phase of inquiry. The therapist immediately encounters with the syntonic character defenses the minute the interview starts.

In the first part of this two-part article the early phase of trial therapy of a patient on the mid-right side of the spectrum of psychoneurotic disorders will be analyzed to highlight the technique and the process of partial unlocking of the unconscious.

The Case of the Strangler

At the time of the trial therapy he was in his forties. The therapist starts with the phase of inquiry.

Phase of Inquiry

The therapist does not know anything about the patient and starts the session by asking the patient "What are the difficulties that you want to get help for?" The response to the inquiry is very limited. He indicates that he and his wife have been in couple therapy for the past year, but the therapy was not helping. He was told by the therapist that "My problems are deeply rooted in the preverbal phase of my development; which needs years of individual treatment," and the plan was for the couple therapist to carry the individual treatment of his wife and that he should seek treatment for himself.

Phase of Pressure

He has been married for 20 years, but the problems in his marriage date back to the 7 months they knew each other prior to the marriage. He indicated that the marriage has deteriorated over the years. Then the session focused on his difficulties, and he said that one of his major problems is that "I act like a child," "I become paralyzed;" but he cannot give a specific example.

It becomes immediately clear that the phase of inquiry is not possible. He is not able to respond to the question *re* a specific example of the problems in his marriage, uses vague generalizations; and the therapist immediately introduces pressure, asking for some specific incidents, to which the patient declares "it is difficult." As a result of this pressure to the resistance there is mobilization of some degree of anxiety and the therapist focuses on the patient's feelings.

Further Pressure by Focusing on his Feelings

As we will see, the process immediately moves to the phase of rapid identification, clarification and some degree of challenge to the patient's character defenses, and to the psychodiagnostic phase.

TH: How do you feel right now here?

PT: Not too bad, uh I'm, I'm having difficulty thinking clearly so I'm a bit . . . I guess I'm a bit ah, a bit nervous.

TH: I say how do you feel right now? You say you guess.

PT: (small laugh) I feel nervous.

TH: You feel nervous. Then why you say "guess?"

PT: It's a way I have of speaking, I think I say that a lot.

TH: You mean that you are not definite about . . .

Challenge to the Tactical Defenses

PT: Yeah, that's part of the problem, I seem to . . . I don't . . .

TH: You see again you say "I seem to."

PT: I often don't know what it is that I want, how I feel.

TH: Now let's to look to this here with me. My question was how do you feel right now and you say you are nervous really.

PT: Hm hmm.

TH: But you have to say "it seems" that you are nervous, as if you are not . . .

PT: Hmm.

TH: Hmm?

PT: That's, that's certainly what comes out all right.

TH: Hm hm, that you are always indefinite, or is here with me?

PT: Am I always indefinite? (low voice)

TH: You know what I mean by indefinite? That you say "perhaps, guess."

PT: Yeah, I see what you mean.

The Phase of Pressure and Challenge to the Resistance

As we saw, the therapist immediately is focusing on the patient's tactical defenses, such as "perhaps," "guess," being indefinite, "I think,", and making the patient acquainted with these defenses to which the patient responded positively, "Yeah, I see what you mean." This challenge to the tactical defense mobilizes anxiety which is the indicator of further rise in the transference feeling. There is further challenge to the patient's character defenses, which gives further rise to transference feeling and crystallization of the patient's character defenses in the transference. It is important to note that almost always the phase of pressure, as we saw in the above passage, may contain passing moments of challenge, but systematic challenge is not to begin until resistance has been tangibly crystallized between the therapist and the patient. Then, not only must the resistance be challenged, but the patient's attention must be drawn to it and its nature clarified for him. This will have the maximum affect when the patient cannot avoid recognizing it. Now we return to the interview.

TH: That you cannot . . .

PT: Yeah I, I think I do qualify.

TH: You see "I think I . . ."

PT: I do qualify yeah, I . . .

- TH: But there is "think"; it means that in a sense still you are not definite.
- PT: I'm not sure of things . . . (mumbling)
- TH: If you are anxious right now why "it seems" or "I think"? Either you are nervous or you are not nervous.
- PT: I have a hard time identifying that.
- TH: You mean you are nervous and you have difficulty to identify you're nervous?
- PT: Yeah.
- TH: Then why you say you are nervous?
- PT: Because when you ask me about it then I perhaps become more aware of it.
- TH: Again you become indefinite.
- PT: I don't know the answer to that.
- TH: Now you say you don't have an answer to that, hmm. Now, what is it like when you're nervous?
- (Pause)
- TH: Now you notice you also avoid me?
- PT: Yes I'm, I'm withdrawing.
- TH: You're withdrawing?
- PT: Yes. I have . . . I don't feel comfortable.
- TH: I said how do you physically experience your nervousness?

As we see, there is further crystallization of the patient's character defenses in the transference.

PT: I feel defensive, I feel . . .

Exploring the Physiological Concomitant of the Anxiety

He indicates that he is perspiring and that he feels cold in his shoulders. This exploration of the anxiety is of great importance, and the therapist puts the question very specifically, "How do you physically experience this nervousness?" Exploration into the physiological and psychological concomitants of anxiety indicates that overall, the psychological concomitant of anxiety exceeds the physiological concomitant, which is an indicator that his capacity to tolerate unconscious anxiety is at a high level; and the therapist knows, based on the research data, that this has important psychodiagnostic implications.

Challenge to the Resistance

As he constantly avoids eye contact with the therapist, this is brought to his attention and the process continues with further challenge to the resistance, which now has definitely acquired a transference quality and the therapist begins to make him acquainted with the resistance against emotional closeness in the transference, which is syntonic.

TH: You see you use words. I said how do you physically experience this nervousness? One, you say you have some perspiration . . .

PT: Yeah.

TH: . . . and then the other one you say you feel cold in your shoulders and so forth and some tightness in your chest. What else do you experience while you are nervous? And your eyes are on the carpet. I mean you are . . .

PT: I'm trying to concentrate, and I'm having difficulty.

TH: Is it that, or is it that there is a need in you to avoid me?

PT: I don't know.

Psychodiagnostic Function

In this initial contact, the therapist first introduced pressure which gave rise to transference feeling and anxiety in the transference. This led to resistance in the form of a series of defenses as well as resistance against emotional closeness, and finally there was crystallization of the resistance in the transference. Throughout this process, the therapist monitors:

- rise in transference
- rise in anxiety
- crystallization of the resistance in the transference.

The therapist's task is to determine the discharge pattern of the unconscious anxiety as soon as he introduces the pressure. Here, the therapist introduced the pressure. There was a rise in the transference, anxiety which was in the form of tension in the muscles of the hands, the supinator and pronator of the forearms, and anxiety in the form of tension in the intercostal muscles. The nonverbal cues were: with a high pressure pressing his thumbs against each other; clenching his hands together with high pressure; and a deep sigh. All this indicates:

- (1) Discharge pattern of anxiety is exclusively in the form of tension in the striated muscles.
- (2) No discharge pattern of anxiety in the form of disruption of cognitive and perceptual function (which is the characteristic of patients with fragile character structure).
- (3) Rise in the transference gives rise to unconscious anxiety, which then results in intensification of the resistance in the transference.

On the basis of this, the therapist concludes that the patient suffers from character neurosis and can withstand the impact of his unconscious in a single interview. With this in mind, still the therapist wants to further evaluate and reconfirm his decision.

Now the therapist moves to challenge the resistance against emotional closeness in the transference, which leads to further rise in the transference feeling and further rise in anxiety in the form of tension in the striated muscles, which further indicates that there is no trace of fragility and he can use the standard technique of rapid and direct access to the unconscious.

Further Challenge to the Resistance in the Transference

Systematically Making the Patient Acquainted with his Resistance

TH: Again you move to the "I don't know." Moving to the helpless position. How do you feel when you look to my eyes?

PT: I don't know.

TH: Hm hmm. So "I don't know" is another system like "I guess so," "perhaps," huh?

PT: Yeah.

TH: Now this is another format of the . . . huh?
(Pause)

TH: Do you notice that you are very much detached from me?

PT: Yes.

TH: What?

PT: Why?

TH: And there is some kind of a wall between you and me.

PT: Hm hmm.

TH: Avoiding my eyes, avoiding me, hmm. Could we look into that? Could we look into that . . . to the fact that you want to avoid me.

Further Challenge and Crystallization of Character Defenses in the Transference

Making the Patient Acquainted with his Character Defenses

TH: To the fact that you avoid my eyes, and that you don't want to be involved here in a sense.

PT: Hm.

TH: Detachment, withdrawal, hmm?

PT: Can you help me to avoid that? I want that.

TH: Yeah, but you see you move again to a position that is helpless, taking a helpless position with me.

PT: Hm hmm, hm hmm.

TH: And nodding your head and saying "hm hmm" doesn't do anything.

PT: (laughs) I don't know what else to do.

TH: And now you smile.

PT: Yeah.

TH: Really you felt your smiling?

PT: Did I feel my . . .

TH: You smiled. I said did you really feel like smiling or . . .

PT: Yeah.

TH: . . . this is a cover-up of something? the smile?

PT: Hm hmm.

TH: What hm hmm?

PT: I don't know what hm hmm. (laughs)

TH: You see again your eyes are somewhere else.

PT: Well I find it hard to concentrate if you ask me a direct question.

TH: What do you mean by difficulty to concentrate? I mean what is that?

PT: Well you ask me a direct question.

TH: Hm hmm.

PT: And in trying to answer it I find that . . . it very difficult to think if I'm looking directly at you.

It is important to note that the rapid rise in the transference has rapidly crystallized the patient's character resistance in the transference. The therapist now applies one of his most powerful technical interventions, the technique of the interlocking chain of head-on collision with the transference resistance, with the goal of a rapid partial unlocking of the unconscious.

The "Technique of Interlocking Chain of Head-on Collision with the Patient's Character Resistance Heavily Crystallized in the Transference" (Davanloo)

The interlocking chain of head-on collision is always used within the setting of resistance in the transference. In the following passage the therapist challenges four components of the head-on collision:

- * Pointing out the nature of the resistance;
- * Emphasizing the problems that he has in his marriage;
- * Communicating the masochistic component of his character and the self-destructive element of the resistance, the self-defeating and self-sabotaging aspect of the resistance;
- * Bringing into the focus his treatment with Dr. X, which was a failure, which is establishing a parallel between his previous treatment and the transference, the failure that might come.

TH: You are like this usually? . . . detached, noninvolved, taking a sort of the passive, detached . . .

PT: I don't think of myself as . . .

TH: But you see you ruminate "I don't think." I'm talking right now with me. Look at it, aren't you totally walled off, and totally noninvolved? And this is very important we look at it, because you say you have a set of problems. So far we don't know anything about it except a piece of it, that is you have a problem in your marriage, hmm? and that it has been going on for 20 years, okay. And you have been in treatment with Dr. X, hmm, and the problem still is there I assume, otherwise you wouldn't be here. So that you have a problem which so far we only know the marriage part of it, superficially okay? And has been going for 20 years, hmm?

PT: Hm hmm.

Continuation of Head-on Collision

In the following passage the therapist continues with the technique of interlocking chain of head-on collision, which consists of:

- * Emphasizing the patient's will, that the patient is the prime mover in seeking help "and that is your own will to come here," to which the patient responded "yes." Then the therapist moved to another component;
- * Emphasizing the partnership between the patient and the therapist, "that

- with the help of each other." Then the therapist moved to another element;
- * The therapeutic task, emphasizing the therapeutic goal "to see what is the core of your difficulties."

TH: *And I assume now that you have come here — this is your will to come here or that Dr. X thinks this is the best for you?*

PT: *No it's . . .*

TH: *This is your own will?*

PT: *Yes.*

TH: *This is. huh?*

PT: *Yes.*

TH: *And this is your own will to come here, hmm. That with the help of each other we can first understand your difficulties and hopefully we can get to the engine of your difficulties.*

PT: *Hm hmm.*

TH: *To see what is the core of your difficulties that creates all these disturbances that you have, which we know a little bit, only marriage okay?*

PT: *Hmm.*

Continuation of Head-on Collision

In the following passage, the therapist continues the interlocking chain of head-on collision consisting of:

- * Addressing the nature of the resistance;
- * Emphasizing the resistance against emotional closeness in the transference, and he immediately moved to the following component:
- * Bringing into focus the consequences "if you keep this wall," and this is immediately followed by another element:
- * The destructive aspect of the resistance; the self-defeating and self-sabotaging component and the failure "doomed to fail." This follows:
- * Deactivating the transference and bringing the patient into the reality of the process "at some point today we say goodbye," "You go your way and I go my way," "and I tell to myself I did my best;" then he immediately moved to:
- * Undoing the omnipotence and keeping the responsibility with the patient, which is immediately followed by addressing:
- * "The perpetrator of the unconscious" (Davanloo) "perpetuate whatever misery you have," reemphasizing the masochistic component of his character.

TH: *Now if you take a detached position with me, and if you take a noninvolved position with me, and if you erect a wall — you know what I mean by wall? by distancing, by putting a barrier between yourself and me, avoiding me and not wanting me to get to know you — then this process is doomed to fail. In a sense if you keep this wall, this distancing, this barrier, and not wanting me to get to your intimate thoughts, your intimate feelings, then this process is doomed to*

fail. So then at some point today we say goodbye to each other and you go your way and I go my way.

PT: *Hmm.*

TH: *And I tell to myself, Okay I did my best to understand this man's problem; I failed. But then you go and perpetuate whatever misery you have.*

PT: *Hm hmm.*

Continuation of Head-on Collision

In the following passage he addresses various elements of the interlocking chain of head-on collision:

- * the perpetrator of the unconscious; the punitive superego "going to perpetuate your suffering" and then;
- * Puts pressure on the unconscious therapeutic alliance "Why do you want to do that?", to which the patient responded "I don't," and then he;
- * Reemphasizes the self-destructive element of the resistance, challenging the self-defeating and self-sabotaging aspect of the resistance and reemphasizes that "it is here with me."

TH: *How old are you?*

PT: *46.*

TH: *46. So still you have a long way ahead of you.*

PT: *Hmm.*

TH: *Why you want then to go on and perpetuate the suffering?*

PT: *Until what? (laughs)*

TH: *Now your smile is still . . .*

PT: *No I don't feel like smiling.*

TH: *Then you are going to perpetuate your suffering until your grave. Now why do you want to do that?*

PT: *I don't.*

TH: *But immediately some important aspect is here. I have a feeling that you have a need to sabotage, you have a need to defeat, that you are a self-defeating and self-sabotaging man. That there is a need in you to defeat and sabotage. Of course you have lived with yourself for 46 years, you know it better than I. Are you the type of the person who sabotages his potentiality, sabotages and becomes a victim of situations and so forth? Are you the type of the person who constantly finds himself into defeating and sabotaging? Because it is here with me hmm?*

PT: *Hmm.*

Now, the therapist immediately returns to the component of the resistance against emotional closeness and follows it with another component of the chain, namely the consequences, driving home the message that if the patient continues in a state of resistance the goal in therapy will not be achieved, "This process is doomed to fail."

TH: *Because if this process of you maintaining a wall, not wanting me to get to your intimate thoughts and intimate feelings continues, this process is doomed to fail.*

PT: *Hm hmm.*

In the following passage, the head-on collision continues from one component of the interlocking chain to another:

- * Indirect challenge to the defiance;
- * Deactivating the transference;
- * Establishing parallel between transference and other relations "20 years of marriage," "you yourself say paralyzed," "this process will be paralyzed like the other";
- * Undoing the omnipotence, "there is nothing one can do."

TH: *So if this is your will that you want to fail, then there is nothing one can do about it. So you have had 20 years of marriage that you refer to . . . in a sense has been crippled. You yourself say paralyzed.*

PT: *Hmm.*

TH: *So this process will be paralyzed like the other.*

PT: *Hm hmm.*

Continuation of Head-on Collision

In the following passage, one component of the head-on collision is interlocked with another component:

- * Pressure to the unconscious therapeutic alliance "why you want to do that," and then;
- * Emphasizing that he is the prime mover in seeking help "come on your own will," which then follows;
- * Challenging the self-defeating, self-sabotaging and self-destructive aspect of the resistance "at the same time set the stage to sabotage it;"
- * Emphasizing the consequences, emphasizing that if his will is to sabotage then he has to suffer the consequences;
- * Deactivating the unconscious defense mechanism of defiance;
- * Deactivating the transference.

TH: *So why do you want to do that? To come on your own will but at the same time set the stage to sabotage it. If that is your will, to sabotage it, then there is nothing anybody can do about it.*

PT: *Hm hmm.*

TH: *Why do you want to do that?*

PT: *Hm hmm.*

The therapist throughout the process is putting pressure on the unconscious therapeutic alliance to get it mobilized against the forces of the resistance.

TH: *"Hm hmm" is not enough, let's to see what are we going to do about it.*

Here, the therapist emphasizes another component of the head-on collision, pressure on the resistance and the unconscious therapeutic alliance, rhetorical question to the therapeutic alliance.

Major Aim of Head-on Collision

As we will see, this head-on collision results in the partial unlocking of the unconscious. Pressure and then challenge to the patient's character resistance brought about a rise in the transference, and rapidly we saw the crystallization of the patient's character defenses in the transference. The therapist had determined that the patient has the capacity to withstand the impact of his unconscious as rapidly as possible. Then he introduced one of his most powerful technical interventions, namely the interlocking chain of head-on collision with the aim:

- (a) To mount a direct challenge to all the forces maintaining self-destructiveness, his self-defeating and self-sabotaging pattern and masochistic component of his character;
- (b) To intensify the rise in the transference feeling;
- (c) To loosen up the patient's psychic system in such a way as to make the unconscious more accessible;
- (d) To mobilize the therapeutic alliance against the resistance; to tilt the balance between the two forces in favor of the therapeutic alliance;
- (e) To bring the patient face-to-face with his self-destructiveness. Such communication as "misery," "we say goodbye," "your will to sabotage" and "doomed to fail" both shocks him out of the syntonic part of his resistance and challenges his therapeutic alliance to make a supreme effort;
- (f) To create a state of high tension between resistance and therapeutic alliance in the transference.

The First Partial Breakthrough into the Unconscious

Gradually, during the last part of the head-on collision, the patient becomes increasingly sad; and the indicator is that an initial breakthrough into the unconscious is eminent. It is important to note that when a therapist applies the technique of interlocking chain of head-on collision with the crystallized character resistance in the transference, which aims at the first breakthrough into the unconscious, he must carefully monitor the signaling system that indicates that some breakthrough is imminent. The most important are nonverbal cues indicating drop in tension in the striated muscles and the emergence of sadness. When a breakthrough into the unconscious takes place, be it partial or major, it is always associated with a major drop in the unconscious anxiety and tension.

At this point in the interview, the therapist observes this phenomenon and knows that the breakthrough is imminent. He is aware that the unconscious therapeutic alliance is mobilized against the resistance, but at the same time he is well aware that resistance remains in operation; and for the moment he focuses on the patient's sadness, but at the same time maintains challenge to the resistance. Now we return to the interview.

TH: I feel also that there are certain feelings within you—I feel, I don't know I might be wrong. That from your eyes I have a feeling that you have a certain feeling within yourself which you are very heavily controlling.

PT: No, I feel very sad.

TH: You feel very sad. And there also you don't want to have the full impact of your sadness.

In the following passage, he remains sad and tearful, and the therapist further links this with his problem with intimacy and closeness "you're terrified of closeness with me."

PT: That's right (barely audible)

TH: You don't want to share with me the full impact of your sadness, which is another side of a paralyzed man. Why?

PT: (exhalation)

TH: And still you are trying to hold in this sadness and the tears that you have in your eyes. Why? why don't you want to have the full impact of it?

PT: I don't know, I'm afraid.

TH: Let's to see why you don't want to. It's not the fear; it has to do with the issue, as I said, of closeness and intimacy, and the barrier that I talked of. You're terrified of closeness with me.

(Pause)

TH: And look, again you are trying to hold in this sadness and tears . . . not to have the full impact of your feelings, why?

PT: What comes to me is that I don't know you.

TH: So then, in a sense, I am a stranger.

PT: Yeah.

After the kind of initial breakthrough that we see, the patient is usually in an altered inner state. His whole psychic system has been loosened and the balance between the opposing forces within him has been tilted in favor of the therapeutic alliance. This manifests itself as an increased responsiveness, which may be observed in a number of different ways such as when he says "what comes to my mind is that I don't know you." But at the same time the therapist knows that the resistance is still in operation and therefore he adheres to the central principle of the technique, that when these two forces are in operation the most important task is to maintain challenge to the resistance with further pressure to the unconscious therapeutic alliance. Here, the therapist moves to further head-on colliding with the resistance against emotional closeness in the transference, addressing the consequences of maintaining this resistance, and then moves to another component which has to do with deactivating the transference—"what can I do? I have to admit to failure." Then he introduces pressure to the unconscious therapeutic alliance. This results in further mobilization of the unconscious therapeutic alliance, and he declares "I don't want to do that."

Further Head-on Collision with Resistance: Emphasizing the Resistance Against Emotional Closeness

TH: And that is what I am talking about. You don't want this stranger to get into your intimate thoughts and feelings. You don't want me to get into your life. And that is what I call the barrier and the wall.

PT: Hm.

TH: But up to the time you don't want me to get into your life, to your intimate thoughts, into your intimate feelings, then what I'm saying is this process is doomed to fail. But if this is your will then it means you have to carry this to your grave. I don't know what has happened in your life that you are so terrified

of this closeness, and as you put it, you referred to a "stranger" to get into your private life. And you are putting a barrier between yourself and me as a stranger. And what I'm saying is up to the time we have this barrier we are doomed to fail. Our goodbye would be a sad goodbye. You know what I mean by sad goodbye? That I say okay I did the best but he is going to carry his crippled life. But what can I do? I have to admit to failure. But for you it is a different story; you have to perpetuate your suffering to your grave. Why do you want to do that?

PT: I don't want to do that.

TH: But this would be.

(Pause)

TH: Your previous treatment has been a failure, 20 years' marriage has been . . . so why do you want to do that?

PT: I don't.

TH: Then let's to see what are you going to do about the barrier between you and me.

In the above passage the therapist continues with further head-on collision with the patient's resistance in the transference. He heavily emphasizes the resistance against emotional closeness and its consequences, and once more he brings the patient face to face with the self-destructiveness of the resistance; challenges the self-defeating and self-sabotaging component of the resistance in the transference. He makes communication such as "we are doomed to fail," "our goodbye would be a sad goodbye," putting further pressure on the unconscious therapeutic alliance.

Breakthrough of Major Wave of Painful Feeling

There is further mobilization of the unconscious therapeutic alliance against the resistance, and there is further passage of a major wave of painful feeling. The patient is highly choked up, with frequent deep inhalations. Now the therapist's task is to ease off the breakthrough of this major wave of painful feeling and at the same time to search for the communication from the unconscious therapeutic alliance for the signal of the direct access into the unconscious.

TH: Because these tears and sadness must come from somewhere, I don't know from where.

PT: It comes.

TH: Hm hmm.

PT: At times when I feel . . . (sigh) . . . that I just can't . . . I'm only half a person. (choked voice)

TH: Right now you are fighting a major wave of painful feeling that you have. Even there you avoid my eyes.

PT: (deep exhalation—pause)

PT: I just don't know how to describe it, it's a . . .

TH: I'm talking about this wave of painful feeling that even is interfering with your talking. Why you are holding onto it? Why don't you want to fully experience your painful feeling?

PT: I don't know what else to do with it.

TH: Why don't you want to have the full impact of it, to experience the whole?

(Pause)

TH: Again your eyes avoid me.

PT: (sniffling) I feel it come in waves and then sometimes, then it, then it subsides, it goes back down again.

As I have indicated before, after the kind of initial breakthrough that we see in this patient, he is definitely in an altered inner state. There is definite evidence that his whole psychic system has been loosened and the balance between the opposing forces has markedly tilted in favor of the therapeutic alliance. But if any resistance still is in operation, technically one should move to challenge or even head-on collide with the resistance. With this in mind, the therapist applies a composite form of head-on collision, emphasizing the therapeutic task; head-on collision with resistance against emotional closeness; emphasizing the parallel between self-defeating and self-sabotaging pattern in the transference and in other relations, and continues to further emphasize the therapeutic task, the patient's goal, then puts further pressure on the unconscious therapeutic alliance.

Further Head-on Collision

TH: I'm suggesting obviously it must have to do with me. Because you don't want me fully into your life. I'm referring to your private thoughts, private intimate thoughts, intimate feelings, the distancing, and as you put it the stranger. Why should you let a stranger to get into your intimate thoughts and feelings, why should you? This is what you are saying in a sense. And I would assume you must have a tremendous problem with closeness and intimacy unless it is only specifically with me. Either you must have this problem with every relationship in your personal life or what, or must be exclusively with me. This problem about intimacy, closeness, and letting me to get to your intimate life and intimate thoughts, intimate feelings, must be in other relationships as well. And it's very important for you to identify, hmm? Is this the case, that you have a problem in that way?

PT: That I distance myself?

TH: Intimacy, closeness and . . .

PT: I'm . . . I try not to.

TH: But I'm saying do you have?

PT: I, I ah . . .

TH: You see it's very important for us because we are here . . .

PT: Yes.

TH: . . . with the help of each other to understand your difficulties and get to the core of your difficulties. And it's very important we step by step examine this process. Unless you want to carry the crippled life.

PT: No, I don't, I don't want to do that.

Further Breakthrough of Painful Feelings

Patient is sobbing so intensely that it interferes with his talking.

TH: So then we have a major job here, to examine them. Because you said that these tears and sadness that you had here had to do with something.

PT: Well they, they have to do with . . . no I don't want it to go on. (voice breaks)

There is further mobilization of the unconscious therapeutic alliance against the resistance, and the therapist knows that the balance between the two has tilted strongly in favor of the therapeutic alliance. The therapist is well aware that the unconscious therapeutic alliance has not yet introduced the dynamic events of his very early life that have had such a negative impact on his character. He continues emphasizing why should he sentence himself to suffering, why should he continue to punish himself, addressing the perpetrator of the unconscious, his need to go from the frying pan into fire, "Why is there a need in you to continue your suffering?", addressing the punitive superego, the guilt and punishment. He further addresses the unconscious "What have you done?", "Why is there a need in you to continue a paralyzed life?"; and the patient in a painful state repeatedly declares that he does not want to continue with his suffering. Now we go back to the interview.

PT: (weeping) It's the way you say it, that I act as though I want them to go on, but I don't. (crying) I don't. And yet I can form . . . because . . .

TH: Hmm?

PT: I can feel myself pulling back from it because I know I can live . . .

TH: You can live a crippled life, no question about it.

PT: But sometimes that seems safer.

TH: But my question is why?

PT: (sob) Why do I have to?

TH: Why do you have to sentence yourself to a paralyzed crippled life? What have you done that you are sentencing yourself to this crippled, paralyzed life? What have you done?

PT: I don't know.

TH: Why is there a need in you to continue a paralyzed life?

PT: (sniffling) Well . . .

(Passage of painful feeling continues.)

Direct Access to the Unconscious

Waves of Very Painful Feeling

TH: From where do you think they come?

PT: I think they come from my childhood, I think they come from . . . at least they might be from being . . . It comes to my mind as a child being left.

In a painful state he talked about his father who went to the Second World War in Europe. The patient was 1 year old. He comes with the memory of a picture when he was 1 year old which was taken before his father left. In the picture are he, his brother, mother and father.

TH: And who is in that picture? You . . .

PT: My mother, my brother, and I.

TH: You, your mother and your brother. And your father? The four of you?

PT: *Hm hmm.*

TH: *In the front. Who is next to your father?*

PT: *My brother is next to my father, I'm next to my mother. My brother is 4 years older.*

In a very sad and painful state he talked about the breakdown of the nuclear family and painfully said "my mother also left." She went to another city; and he and his brother, with a number of other children, were placed with his grandmother, Blanche, and with his aunts. Then he comes with another memory with a wave of very painful feeling and said that once in a while he would be taken by one of his aunts to the city where his mother was, for a visit; but he had always thought that his mother came to visit him.

Dynamic Exploration

TH: *The wish was that she had come to see you.*

PT: *Hmm.*

TH: *But then the reality was that . . .*

PT: *And then I was also . . .*

TH: *So then you must have a lot of feeling about that as well.*

PT: *Yes, I feel a great sadness that I never knew my mother . . .*

TH: *That you never knew . . .*

PT: *I never knew her at all, and . . .*

TH: *As if she had died in your life when you were a year old.*

PT: *Hmm.*

TH: *That she died that early in your life.*

PT: *She never . . . but neither of my parents ah . . .*

TH: *I'm talking about your mother. Is that the idea that she died in your life in the very early . . . In a sense this is what you describe.*

PT: *Yes.*

TH: *Psychologically as if she disappeared in your life.*

PT: *Hmm.*

TH: *And then your father, also you lost him in the early phase to the war, hmm.*

PT: *Yes.*

TH: *Did you see him while he was in the war?*

PT: *No.*

Exploring the Patient's Feeling

He remains somewhat sad and for the moment there is no passage of painful feeling, and now the therapist asks the patient, "How do you feel?"

TH: *How do you feel right now?*

PT: *I feel tired, but I don't feel as nervous. You see, I don't feel as cold.*

TH: *Hm hmm.*

PT: *A bit drained.*

TH: *You feel drained you said?*

PT: *Yeah.*

TH: *In what sense drained?*

PT: *It's like being stretched or . . .*

Then he said "a song goes through my mind, it is 'Be not afraid'." This triggers off a breakthrough of another major wave of painful feeling, with heavy crying.

TH: *But you see the wave of painful feeling comes and then you try to put the shutter. I think this is a major problem.*

PT: (sniffling) *You mean because I hold it in?*

TH: *Because you don't want to have the full impact of these waves of the feelings that you have.*

PT: (deep heaving breaths)

TH: *Because somehow . . .*

PT: (deep breathing)

TH: *. . . you have this constant need to control, hmm, and maintain a paralyzed position, hmm.*

PT: *Yeah, I'm afraid of it.*

The above passage clearly demonstrates that for the time being, the powerful dynamic force of the unconscious therapeutic alliance is in command and has introduced, at least, the very center of the patient's major traumatic experiences. At the same time the therapist is well aware that in this kind of partial breakthrough into the unconscious the return of the resistance is unavoidable. The therapist, for the time being, is waiting for the passage of the waves of painful feeling so that he can move to the phase of analysis of the transference and consolidation, and then to the phase of inquiry: developmental history, alternating with dynamic exploration until he meets the resistance again. Then the process is ready for the technique of major unlocking of the unconscious. Now we return to the interview.

TH: *You lost your father to war at the very early phase of your life, hmm. Then also you lost your mother. In a psychological sense they died in your life. What I said is maybe it is the engine or maybe it is the force behind the fact that you don't want me to get to your intimate thoughts and feelings, in a sense when I said about the issue of intimacy and closeness, hmm.*

PT: *In looking back my experience is that all intimate relationships have been ah, have been a disaster. The only reason the marriage has survived . . .*

TH: *You mean is death?*

PT: *Sorry?*

TH: *Like death, they died.*

PT: *They died. (sad voice)*

TH: *Hmm?*

PT: *Yes. (whispers) They died.*

TH: *Is something like that isn't it?*

PT: *I never thought of that. (low voice)*

TH: *As if your mother died in your life in the very early phase, hmm.*

PT: *Hm hmm.*

TH: *And then your father died in the sense that he was taken to the war, hmm.*

The Issue of Resistance against Emotional Closeness

As we saw in the above passage, the therapist made an interpretation which linked the resistance against emotional closeness in the transference with his father who went to the war and his mother who dumped him, and drives home insight into one of the dynamic forces which is responsible for such a resistance. It is also important to note that he clearly makes communication referring to the death "They died in your life," to which the patient responds with extraordinary clarity and says "all intimate relationships have been a disaster," and then he says "I never thought of that."

Most Recent Precipitating Event which has Created a Major Disequilibrium

The patient now makes an important communication which clearly outlines the most recent precipitating event, the possibility of the breakdown of the marriage which might disrupt the close relationship with his two children. The therapist had communicated to him "your mother died in your life," "your father died in the sense." Now the patient spontaneously talked about his marriage which might end in disaster, and in a very sad and tearful state he talked about the pressure during the past year, the breaking point in his marriage. Then in a painful state he mentioned that this might cause a breakdown of his relationship with his daughter and his son, and the fact that couple therapy had not brought any changes. He further says that all of his relationships have ended in disaster.

Any therapist trained in the traditional psychoanalytic model might here make an interpretation involving the two triangular situations; he, his father and mother, and he, his daughter and son. But in this technique this would be considered a major technical error. The therapist knows that the important task ahead is the major resistance against the murderous rage and intense guilt-laden unconscious feeling in relation to mother and/or father and so forth. Now the therapist returns to the *systematic analysis of the transference* and the phase of consolidation, followed by the phase of inquiry and developmental history.

Developmental History

The patient was born in eastern Canada. Then shortly the family moved to the mid-west. There were major problems in his parents' marriage. After the breakdown of the nuclear family, he and his brother lived with his grandmother (Blanche), two aunts and an uncle. There were seven other children. They lived in a poor section of the city. Then he talked about his Aunt Elizabeth, who was kind. He has a memory of this aunt telling him that he was a very sad child and never smiled. She was the one who dressed him up and would take him to visit his mother in the city where she was living.

Phase of Inquiry

Now the therapist returns to the phase of inquiry and explores the patient's difficulties. He suffers:

- (1) *Disturbances in the interpersonal relationships* with both men and women. He emphasizes that in his interpersonal relationships he finds himself "paralyzed" and has a fear of being abandoned. This is with both men and women.
- (2) *Major problem with intimacy and closeness* with both men and women, much more pronounced with women.
- (3) *Chronic state of anxiety.*
- (4) *Somatization disorder* such as pain in his neck, stiffness in his neck, frequent headaches and at times generalized stiffness.
- (5) *Functional bowel disorder*, occasional looseness of the bowels with diarrhea.
- (6) *Sexual problem*, a decline in sexual desire. During the sexual relationship with his wife he has to resort to the mental image of another woman in order to be able to have intercourse and describes it as a totally mechanical act. This has been throughout the 20 years of marriage.
- (7) *Problem in his marriage.* He describes a major problem and refers to it as being paralyzed in relation to his wife. He describes her as being highly critical, demanding, criticizes everything that he does, and further points out that she becomes explosive and at times physically violent. The way he handles himself is by either taking a passive, detached, compliant position, trying to do everything according to her wishes, or by moving to a silent defiant position which angers her. On a number of occasions he has had explosive discharge of affect, which makes the relationship worse.
- (8) *Episodes of clinical depression.* He has suffered from a number of clinical depressions, a few of them were before the marriage, and each of them followed a breakdown of a relationship with a woman. Since his marriage he has had a number of clinical depressions, most of them in the recent years when the marriage has been on the verge of breakdown and there has been the threat of losing his children.
- (9) *Character disturbances.* Either he becomes an extremely passive, compliant, silent and detached person or he may move to the opposite and become defiant. Masochistic character traits are evident. As we see, now during the inquiry he demonstrates a high degree of responsiveness and clarity.

The therapist knows that the major resistance is ahead, that he is working with a person who has been badly traumatized in the very early phase of his life and who suffers from characterological depression with a masochistic component in his character. The therapist moves to dynamic exploration alternating it with inquiry until he has the opportunity to meet the major resistance.

Dynamic Exploration into the Marriage

He never felt close to his wife, which dates back to the year that they dated each other. "I married her knowing that there was detachment, noninvolvement and a total absence of emotional closeness." It is important to note that his communication is very meaningful and he talks about "detachment," "absence of emotional closeness," which was not the case in the beginning of the interview. Then he talked about his honeymoon and refers to it as having been an unpleasant experience "when we made love that night I made love because that is what one does on one's wedding night," and added "It was physical," "I made love and went through all the motions but I did not feel any . . ."

Then he indicates that when he makes love it is under the pressure of his wife, and that the only way he can have sex is to resort to the mental image of another woman. In recent years he actively brings the mental image of another woman

named Linda while having sex with his wife. When asked to describe the physical build of Linda he becomes more and more anxious and there is a return of the resistance in the transference, and the process moves to the phase of systematic challenge and pressure to the resistance. But this time the therapist's task is a systematic weakening of the major resistance, which is the resistance against the murderous rage and the guilt of the unconscious. This systematic work then results in a major unlocking of the unconscious, which will be analyzed in depth in Part II of this two-part article.

Summary and Conclusion

The article described the central dynamic sequence in the process of partial, major and extended major unlocking of the unconscious. It is important to recapitulate and summarize some of the main technical interventions in the process of partial unlocking of the unconscious with this patient:

- (1) The central dynamic sequence in the process of partial unlocking of the unconscious was described in a number of the phases:
 - (a) The phase of inquiry: exploring the patient's difficulties, with rapid identification of the patient's character defenses.
 - (b) Pressure leading to the resistance, rise in the transference, increased resistance and psychodagnosis.
 - (c) Challenge to the resistance, systematic attempt to make the patient acquainted with the resistance that has paralyzed his functioning, and crystallization of the character resistance in the transference.
 - (d) Transference resistance; head-on collision with the transference resistance to loosen the patient's psychic system; mobilization of the therapeutic alliance against the resistance.
 - (e) Breakthrough of the complex transference feelings; the triggering mechanism for the direct access to the unconscious and direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances.
 - (f) Systematic analysis of the transference.
 - (g) Dynamic exploration into the unconscious and psychotherapeutic planning.
- (2) The interview started with the phase of inquiry, which was not possible.
- (3) The therapist introduced pressure to the resistance of vague generalization, asking the patient for a specific example. This led to some rise in the transference and anxiety in the transference, and the therapist introduced further pressure by focusing on his feelings, which led to resistance in the form of a number of tactical defenses. Then, as we saw, there was a gradual transition from pressure to challenge to the patient's tactical defenses. There was gradual crystallization of resistance in the transference, and the therapist not only challenged the patient's character defenses but systematically made him acquainted with them.
- (4) From the psychodiagnostic point of view, the therapist concluded that the patient suffers from character neurosis and decided that a rapid breakthrough into the unconscious is the procedure of choice.
- (5) Now the therapist's technical intervention consisted of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference.
- (6) This powerful form of head-on collision resulted in the first partial breakthrough into the unconscious and major waves of painful feeling with

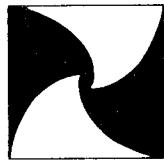
the mobilization of the unconscious therapeutic alliance and direct view of the psychopathological dynamic forces: the center of the patient's very early trauma, namely of being abandoned by both parents at the age of one. Then the process entered:

- (7) The phase of analysis of the transference and consolidation. Then the process returned to the phase of inquiry into the patient's areas of disturbances; the patient was quite responsive and every area of disturbance was explored.
- (8) The therapist was well aware that in a patient with such a complex psychopathology the major resistance, which consists of the major repressive mechanism, is in full operation in spite of the partial breakthrough into the unconscious and mobilization of the unconscious therapeutic alliance.
- (9) In search of the return of the resistance, he made a dynamic exploration into the marriage and his sexual life. What emerged was that the only way he could have intercourse with his wife was by bringing the mental image of a woman named Linda. In exploring the body of Linda there was mobilization of a major resistance in the transference. Now the therapist moves to bring about major unlocking of the unconscious and the weakening of the major resistance. The rest of the interview will be the subject of Part II of this two-part article.

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Intensive Short-Term Dynamic Psychotherapy Major Unlocking of the Unconscious—Part II. The Course of the Trial Therapy After Partial Unlocking

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

Recapitulation

In Part I of the present article I described the phases of the central dynamic sequence in the partial, major and extended major unlocking of the unconscious. Here, I will describe the dynamic sequence in major unlocking, which can be summarized as follows:

- * Inquiry, exploring the patient's difficulties; initial ability to respond.
- * Pressure, leading to resistance in the form of a series of defenses; challenge to the defenses leading to a rise in transference and increased resistance; rapid identification of the patient's character defenses.
- * Challenge to resistance and making the patient acquainted with the defenses that have paralyzed his functioning and turning the patient against his resistance; crystallization of the character resistance in the transference; rise in the transference and mobilization of the therapeutic alliance.
- * Transference resistance; mounting the challenge to the transference resistance with special emphasis on head-on collision with transference resistance to bring the patient face to face with the self-destructiveness of his resistance, and

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to intensify the rise in the transference feeling; mobilization of the therapeutic alliance against the resistance; to loosen the patient's psychic system to make the unlocking possible.

- * Direct access to the unconscious; interlocking chain of head-on collision with the character defenses crystallized in the transference; systematic weakening of the major resistance of repression and all the tactical defenses entrenched in the major resistance; a high rise in the transference feelings; high mobilization of the unconscious therapeutic alliance; direct experience of the transference feelings; major unlocking with the passage of murderous rage in the transference, emergence of sadness; passage of the guilt-laden unconscious feelings and grief-laden feelings; the unconscious transfers the murdered body of the therapist to the genetic figure; and a direct view of the psychopathological dynamic forces responsible for the patient's symptoms and character disturbances.
- * Systematic analysis of the transference.
- * Dynamic exploration into the unconscious; consolidation; recapitulation, and psychotherapeutic planning.

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

Case of the Strangler

In Part I, I analyzed the process of the early phase of the trial therapy of a man in his forties which can be summarized as follows:

- (1) The interview started with the phase of inquiry, which was not possible. Then the therapist introduced pressure to the resistance of vague generalization, asking the patient for a specific example, to which the patient responded "it is difficult." There was further pressure, which mobilized some rise in the transference feelings and anxiety in the transference. Then the therapist introduced further pressure by focusing on his feelings, which led to resistance in the form of a number of tactical defenses. Then process entered into:
- (2) Challenge to the resistance, which now has acquired a transference quality. Patient was systematically acquainted with his character defenses.
- (3) Psychodiagnostically, the therapist had come to the conclusion that the patient suffered from character neurosis, is highly resistant, and that rapid breakthrough into the unconscious was the procedure of choice.
- (4) On the basis of this, the therapist moved to a systematic challenge to the patient's character defenses with further crystallization of the character resistance in the transference and a further rise in the transference feelings. Then the process moved to the phase of transference resistance. Then:
- (5) He applied his most powerful technique of interlocking chain of head-on collision with the aim: to mount a direct challenge to all the forces maintaining self-destructiveness; to intensify the rise in the transference; to loosen up the patient's psychic system in such a way to make the unconscious more accessible; to mobilize the therapeutic alliance against the resistance; to create an intrapsychic crisis, which is a state of high tension between resistance and therapeutic alliance in the transference.
- (6) Partial unlocking of the unconscious with the passage of major waves of painful feelings and there was direct access to the center of the very early trauma, namely being abandoned by both parents at the age of one. Then the dynamic sequence moved to:
- (7) The phase of analysis of the transference, and then:
- (8) The therapist returned to the phase of inquiry into the patient's disturbances, to which the patient was highly responsive. The inquiry indicated that he

suffered from diffuse symptoms and character disturbances. He has suffered from life-long psychoneurotic disturbances, chronic anxiety, episodes of clinical depression, major disturbances in interpersonal relationships, somatization, pain in his neck, some functional disorders, major marital problems, characterological problems and masochistic character traits.

Further Exploration into the Marriage

In exploring his marriage, the patient indicated that he makes love with his wife only when she puts pressure on him, and spontaneously said that he has to bring the mental image of another woman. In recent years he brings the mental image of a woman named Linda.

At this point of the interview, the patient is highly responsive and highly collaborative and the unconscious therapeutic alliance is clearly in command of the process. The long passage of major waves of painful feelings has come to an end but still he is sad. The therapist knows that the resistance that so far has been the focus is not all of the story in a man who has been so badly abandoned in the very early phase of his life, and that the major resistance, which consists of the powerful defense mechanism of repression, must be in operation.

Search for the Resistance

For the time being the therapist continues the dynamic exploration and follows the lead of the unconscious therapeutic alliance, asking the patient to describe the body of Linda while monitoring the patient's unconscious responses. In exploring the body of Linda there is mounting anxiety and mobilization of resistance.

In Part II I will attempt to analyze the rest of this initial interview. We return to the interview where we had left it at the end of Part I.

Return of the Resistance

The therapist is putting pressure on the patient to describe the body of Linda, and he finally says that she has blue eyes and small breasts.

TH: *How about the rest of the body?*

PT: *Her eyes are blue.*

TH: *How about the rest of the body now?*

PT: *The rest of the body. Broad shoulders, uhh she's strong.*

As we see, resistance is being mobilized. He uses the tactical defense of cover words "broad shoulders," "she's strong."

Challenge to the Resistance

TH: *Do you notice, again, now that we want to focus on the body of Linda, now you are becoming detached and withdrawn, and erecting a wall?*

PT: *Hm hmm.*

Head-on Collision with the Resistance

The therapist progressively escalates the degree of challenge and brings about a head-on collision with the transference resistance, trying to mobilize the unconscious therapeutic alliance against the resistance. In the following passage, he introduces a composite form of head-on-collision.

- * Puts pressure to the resistance: "Hm hmm is not enough;"
- * Challenges the resistance against emotional closeness in the transference;
- * Emphasizing the consequences of the resistance in the transference;
- * Pressure, emphasizing the patient's will;
- * Challenging the self-defeating, self-sabotaging, self-destructive aspect of the resistance in the transference, the masochistic component of his character;
- * Challenge to the defiance;
- * Keeping the responsibility with the patient;
- * Further pressure to unconscious therapeutic alliance.

TH: "*Hm hmm*" is not enough. If you want to go that way then the barrier and the wall is here with me. In a sense you don't want me to get to your intimate thoughts and feeling; and if you what to do that then this would be a crippled, paralyzed process.

PT: No I don't want.

TH: Then let's to see what you are going to do about this first. Because from the beginning I have told you that if you want to censor yourself, if you want to erect a wall between yourself and me, this process is doomed to fail and you'll carry a crippled life to your grave. Now you have a right to do that if you want to do that. If you want to keep your paralyzed life, after all that is your life and you have the right to do that. But the question in why you want to do that?

PT: No I don't want to do that. (very low voice)

As we see, in spite of the patient's declaration "No I don't want to do that" with a very low voice, the balance between resistance and the therapeutic alliance is in the direction of increasing resistance. The therapist is well aware of this and moves to further crystallization and intensification of the resistance in the transference. He asks the patient to compare the body of Linda with that of his wife.

TH: If you compare her breasts with your wife's breasts what would be the difference?

PT: I've never seen her breasts.

TH: In terms of thought I mean, a picturing. If you compare hmm.

PT: Her breasts are small.

TH: Hmm?

PT: Her breasts are small.

TH: The breasts of Linda are small. And your wife's breasts?

PT: Are large.

TH: Large. So compared would be small breasts vis-à-vis large breasts.

PT: And my wife is very heavy and Linda is slim.

TH: Heavy where?

PT: Big, she's . . .

Then the patient says "my wife is fat"—but Linda is very slim and athletic. Linda has blond hair, small breasts and the pubic hair is dark. The therapist questions about the rest of the body, but he says that he cannot remember and he cannot describe the rest of her body.

TH: *What else you could say about the body of Linda?*

PT: *Ohh . . . ohhh.*

Escalating the Degree of Challenge

TH: *We have again a paralyzed . . . do you notice again your memory collapses?*

PT: *Yes.*

TH: *Yes what!*

PT: *Yes it collapses, I don't remember it.*

TH: *I mean you say you are an engineer.*

PT: *Yes.*

TH: *As an engineer you have a problem with your memory?*

PT: *No.*

TH: *Then how come here your memory with me immediately collapses? Do you notice the position here?*

PT: *Hm hmm.*

TH: *What "hm hmm?"*

PT: *I feel . . .*

In some patients, "I don't remember" can be a tactical defense, but in this patient this defense is well entrenched with the major resistance. In the following passage the therapist mounts the challenge to the resistance, which results in a rise in the transference, rise in anxiety and further crystallization of resistance in the transference. The important task is that every character defense which is mobilized rapidly be identified and challenged with the aim of further intensification of the rise in the transference. By doing so, the process rapidly moves to the major resistance in the transference, which the therapist is looking forward to. We return to the interview.

TH: *Holding your hand like that. Do you notice?*

PT: *Yes I notice.*

TH: *But admitting that you are paralyzed doesn't help us. Look at it. My question was, was there any other woman besides Linda? but now you move towards the collapse of your memory.*

(Pause)

TH: *So you have a need to actively censor yourself. And nodding your head is not enough.*

PT: *I don't feel that.*

TH: *You see your rumination "I don't feel that." You are actively doing it and then at the same time actively denying that you do it. That is the portrait of the paralyzed man.*

PT: *Hmm.*

TH: *But nodding your head is not good enough. So let's see what you are going to do about this need in you to censor yourself and take a crippled position. Your*

- hand again is like that, eyes closed, half opened. (Pause) And the paralyzed crippled position you take.*
- PT: That's exactly the . . .
- TH: But that is not good enough.
- PT: It's very frustrating.

It is important to note that during this process the therapist must monitor and address the nonverbal signals, such as clenching of the hands, the rate of deep sighing respiration and so forth. They are the indicators for the rise in the transference and rise in unconscious anxiety in the form of tension in the striated muscles; a rise in the transference feelings and the direct experience of the transference feelings is the goal toward which the therapist is working.

The patient has declared frustration. Frustration is a tactical defense against anger and, in many patients, anger by itself, can be a tactical defense against rage, and the rage can be a tactical defense against murderous feelings. It is important to note that the patient declares "I feel frustration." Here we see another tactical defense, the fact is that the patient is bypassing the transference "well, I'm frustrated." This again is a form of tactical defense that is well entrenched with the major resistance. Technically, the therapist must maintain a systematic challenge to this tactical defense and consider it as part of the major resistance. In the following passage the therapist maintains systematic challenge and pressure to the resistance.

- TH: You mean it is frustrating here with me?
- PT: Yeah you're aah . . .
- TH: You are frustrated here with me?
- PT: I don't know what to think.
- TH: No you are not answering the question, I say is this . . .
- PT: I feel frustration.
- TH: You feel frustrated with me. Is this what you say?
- PT: I feel frustrated, that's what I'm saying.
- TH: You feel frustrated at who? Again you are crippled, to say you are frustrated . . . is a cut-off sentence. "I feel frustrated" is a cut-off sentence. Frustrated at who?
- PT: I'm . . .
- TH: Again you're crippled, frustrated at who? Your hand again.
- PT: I'm frustrated.
- TH: Frustrated at who; First let's to establish at who are you frustrated. Now your head goes there, your hand goes there . . .
- PT: (makes growling sound) Orrrrrh . . .
- TH: . . . and then you move toward this crippled position. Frustrated at who? You said you are frustrated, frustrated at who?
- PT: Do I have to be frustrated at someone?
- TH: Again you ruminate.
- PT: Well I'm frustrated!
- TH: Yeah but frustrated at who?
- PT: I'm just frustrated, I'm not frustrated . . .
- TH: At who are you frustrated?

Now, he moves to the defense mechanism of denial and negation and says "I am not frustrated at anybody."

PT: *I'm not frustrated at anybody.*

TH: *Again you take a crippled position, cut-off position. You see a cut-off position is exactly like Linda, has a head and hair but the rest of the body is cut-off.*
 (Pause)

Do you notice how crippled you are? You say you are frustrated, but at the same time you don't want to really spell out at whom you are frustrated. Look to your hand. Now you are fidgeting.

PT: *Hm hmm.*

TH: *'Hm hmm'.*

PT: *(laughs)*

TH: *Admitting you are crippled is not going to solve anything . . . Now you are avoiding my eyes.*

PT: *I...*

TH: *At who are you frustrated? Let's first establish that. You have a tendency to flight, you have a tendency to run away from any issues.*

PT: *Yes.*

In the following passage there is head-on collision with the defiance, deactivation of the transference, and emphasizing the consequences of maintaining the resistance in the transference.

TH: *You have done it 46 years of your life, and if you want to do it you can do it and go to your grave.*

Often, tactical defenses are strategic satellite defenses and are different from so-called major defenses. But our research data indicates that tactical defenses can be well entrenched with the major resistance and should be considered as such. As we see, the process is still a systematic challenge to this defense "Do I have to be frustrated at someone," which is totally avoiding the transference. The challenge in the above passage has further intensified the rise in the transference, and the therapist monitors it via unconscious anxiety in the form of tension in the striated muscles. He has deep, sighing respiration, the rate of which has increased and which clearly indicates to the therapist that the rise in the transference feelings is in the upward position. It should be emphasized that it would be a major mistake for the therapist to explore the patient's feelings. That is what the resistant part of the patient would like. The therapist well knows that the nature and the degree of the resistance and the complexity of the psychopathology are extremely different from those of the Case of the Salesman, or of any other patient who is placed on the extreme left of the spectrum of psychoneurotic disorders. We return to the interview where we had left it.

PT: *No I don't want to do it.*

TH: *So let's to see at whom you are frustrated.*

(Pause)

Again you are terrified at looking at my eyes and declaring.

PT: *(deep sigh)*

TH: Again your sigh. Do you notice your hand? You are totally crippled to look at my eyes and tell me at who you are frustrated. Because frustration refers to something negative huh?

PT: Yes.

TH: But you are paralyzed to look to my eyes . . . Let's establish at who are you frustrated?

PT: (mumbles)

TH: And we know your father died in your life in the very early years and your mother died in your life in the very early years, and you want to relate to me as if I am dead as well.

(Pause)

Now let's to see at who you are frustrated. Now your hand is like this.

PT: (laughs) Is there no place to put my hand? I'm frustrated, frustrated.

TH: Hm hmm. But you are paralyzed to declare at who you are frustrated.

PT: Yes that's right.

Finally, in the following passage he declares "I am frustrated at you."

TH: That is right is not enough. Admitting you are crippled doesn't help. And that is another part of you; you resort to the crippled, paralyzed position. Because you are totally crippled to declare where the direction of the frustration is. In a sense you don't want to declare that I am a part of this system. That is why I say you want to dismiss me.

PT: Hmm.

TH: 'Hm hmm' and repeatedly another part of you is admitting to a crippled position. Do you notice that in a sense you don't want to involve me in this process. "I am frustrated."

PT: I'm frustrated at you.

The question that we might raise, why such a defense "Do I have to be frustrated at someone" should require this degree of challenge and pressure? As I have already indicated, such a tactical defense is well entrenched with the major resistance, which is the resistance against the experience of the unconscious murderous rage and guilt. It is equally important to note that when such a resistance is timely identified, challenged, pressured and head-on collided with, it functions in the service of mobilization of transference feelings as well as mobilization of the therapeutic alliance, which is the goal toward which the therapist is working.

Head-on Collision with Resistance

In the following passage, the therapist applies his technique of head-on collision:

- * Pointing out the nature of the resistance;
- * Emphasizing the therapeutic task "to get to the engine or the core of your problem,"
- * Emphasizing the partnership "for you and I to see what are we going to do," "then the whole process of both of us working together;"
- * Addressing the resistance against emotional closeness;

- * Pointing out the self-destructive component of the resistance in the transference;
- * Pointing out the consequences of the resistance in the transference "the process is doomed to fail."

TH: *How do you experience this frustration with me? So far what you say is that you are frustrated with me, but your hand is clenching like that, your body is immobile and you are taking a detached, paralyzed position. So let's see what are we going to do about this crippled man? It is very important for you and me to see what are we going to do about this crippled man. Because this detachment . . . and that is very important for you to look at it, unless you want to dismiss this as well.*

PT: (deep sighing respiration)

TH: *If this paralyzed position continues, if you maintain this detached and extremely passive position, this process is doomed to fail and these mechanisms are the ingredients of the wall; and if this continues the whole process of both of us working together, trying to understand your difficulties, which we have understood, but equally important to get to the engine or the core of the problem is doomed to fail. So the important issue for both of us is what are we going to do with this massive wall? And it is very important to identify this, you see, because a part of you wants to give up your crippled life, okay.*

PT: Yes.

TH: *Okay? A part of you wants to give up the crippled life but another part of you wants to perpetuate the crippled life. The other part that wants to perpetuate the crippled life uses all kinds of systems and all kinds of mechanisms. But this part that wants to perpetuate is using all these mechanisms. Now the question for you and I is what are we going to do with that part of you who wants you to remain crippled?*

PT: Yeah.

TH: *It is very important to see what are we going to do for that part of you that wants to remain in a crippled paralyzed position? Do you follow me?*

PT: Yes, I understand.

The main aim of head-on collision at this point of the interview is:

- (a) To bring the patient face-to-face with his self-destructiveness.
- (b) To make him well acquainted with the nature of the resistance.
- (c) Further rise in the transference feeling
- (d) To maintain the resistance crystallized in the transference.
- (e) To mobilize the therapeutic alliance against the resistance.
- (f) To create a state of high tension between resistance and therapeutic alliance in the transference; the two major forces "a part of you wants to give up the crippled life" (therapeutic alliance), but "another part of you wants to perpetuate the crippled life" (punitive superego).

Anger in the Transference

TH: You said you are angry with me?

PT: Yes.

TH: *How do you experience your anger towards me? You are pressing your hand. We don't know how you physically experience your anger towards me. We know how you experience anxiety hmm.*

PT: *Hm hmm.*

TH: *What is the way you physically experience your anger in relation to me? Your head goes down.*

Almost all patients with character neurosis cannot differentiate between the physical experience of anger and that of anxiety, which is in the service of resistance. At this point, the task of the therapist is to maintain his challenge and pressure, and if necessary head-on collision to the resistance against physical experience of the anger in the transference. The therapist puts pressure on the physical experience of the anger and concomitantly challenges the resistance. Especially important, the therapist must see that the patient is well acquainted with the resistance that is being challenged, and that his communication is very specific. If we look to the following passage, the patients says "I have a hard time with anger," and the therapist's response is "immediately that part, that paralyzed part comes up," addressing the part of the patient that has heavily identified with the resistance. It is also important that the therapist himself does not use tactical defenses. For example, in the following passage "You see I questioned you how do you experience your anger in relationship with me" rather than to say to the patient "how do you experience your anger." Now we return to the interview.

PT: *Well I've . . . I have a hard time with anger.*

TH: *You see again immediately that part, that paralyzed part comes up. You see? You have a side of you that uses all kinds of mechanisms to maintain the paralyzed . . .*

PT: *I'm afraid of losing my temper.*

TH: *Yeah but we are looking to how you experience your anger here with me.*

PT: *Physically?*

TH: *Yeah. We know how you experience the anxiety, and it is important to see how you experience your anger in relationship with me. How do you experience your anger in relationship with me? So far we see a paralyzed . . .*

PT: *I feel tense, I tense.*

TH: *Yeah okay. You see I questioned you how do you experience your anger in relationship with me; you say you feel tense, but that is anxiety.*

PT: *Yeah.*

TH: *But anxiety is not the anger. Do you follow that?*

PT: *I'm not sure I see the difference.*

TH: *You see I question you how do you experience your anger in relationship with me? You say you feel tense. Tension is a part of one's anxiety. When you are anxious there is a tightness in your chest, that is tension. But that is not anger. What you describe is anxiety. Do you notice your hand? What you describe is anxiety. Do you notice your hand?*

PT: *Yeah.*

TH: *What? What do you notice?*

PT: *I'm I'm . . .*

TH: *Clenching.*

PT: *Clenching and . . . but that's anxiety too. I don't . . .*

TH: Tension.

PT: Tension.

TH: But maybe there is another feeling underneath of this tension because you say you're angry hmm.

PT: So they're both gonna be there.

TH: But obviously there must be some link between the anger and the anxiety.

PT: Yes.

TH: But we know how you experience the anxiety but we don't know how you experience the anger. (Pause) You see when we focus on your anger towards me how paralyzed you become?

PT: Yes I block it.

The process demonstrates systematic weakening of the repressive mechanism which is the major resistance against the murderous rage and guilt. It is important to note that one of the defense mechanisms that can easily complicate the process, which is often syntonic, is the mechanism of defiance. For that reason it is important that the therapist moves to the deactivation of this defense. This can be done by pointing out to the patient "unless you don't want to do anything about it," "maybe your decision is to carry your misery the rest of your life." This form of intervention at the same time contains deactivation of the transference and keeping the responsibility with the patient. Now, we return to the interview.

Challenge, Pressure Combined with Repeated Partial Head-on Collision

TH: But that is the part, the side, the part that I said that a part of you wants to perpetuate this miserable life., So then we have to do something about it, unless you don't want to do something about it.

PT: No I want to, uh a . . . I want to do something about it.

It is important to note that the therapist repeatedly puts pressure on the patient's will, to the patient's therapeutic alliance to make a supreme effort.

TH: So do you see there is a part of you that wants to sabotage the whole process. (superego resistance)

PT: Yes, yeah I can see that.

TH: But a part of you wants to say goodbye to the crippled life. (therapeutic alliance)

PT: Yes.

TH: So then we have a major problem ahead of us. (employing the partnership)

PT: Yes.

TH: That part of you that wants to sabotage the whole process. (destructive aspect of resistance in transference) And the issue is this, what are you going to do about it? (question to the unconscious therapeutic alliance)

Further Challenge

PT: I find it so hard to say how I experience . . .

TH: You see again the paralyzed part comes immediately to the front, you see?

PT: (deep sighing)

TH: Do you notice?

PT: Yes.

TH: Immediately crippled "I don't know."

PT: Yes.

TH: 46 years you have been on that boat.

PT: I don't know how to . . .

Challenge, Pressure and Head-on Collision

TH: And I assume you want to say goodbye to it.

PT: I do, but I don't know how.

TH: Let's to see how you experience your anger in relation to me. (pause) Let's to see how you experience your anger. Your hand is like that, your leg you are keeping it tight. Do you notice the position of your hand?

PT: It's . . . I'm protecting myself.

TH: Hm hmm. So let's to see how you're experiencing your anger. So far you're a cut-off man. (pause) Let's to see how you experience your anger. Moving to the crippled position is not going to help us. 46 years you have done it anyway. Let's to see how you experience this anger. Again you want to move toward this . . . (PT deeply sighing) . . . paralyzing poofffff and so forth. Let's to see how you experience your anger.

PT: But that's how I experience it.

TH: And your head is down. Using all kinds of the mechanisms to avoid to see how you experience your anger. There is a part of you that wants to perpetuate this crippled position, and we have to see what we can do about that part. Unless you don't want to do something about it.

PT: I want to do something about it.

TH: The first issue is how do you experience your anger. Now, you are becoming more slow, looking puzzled; again further paralysis.

PT: Hm hmm.

TH: "Hm hmm" is not enough. You have lived this crippled life for 46 years; do you want to say goodbye to it or do you want to keep it?

PT: I want to say goodbye to it.

TH: Then let's to see how you experience your anger in relation to me. Now you move like this. (pause) Do you notice your body? Do you see your body?

PT: Hm hmm.

TH: You want to move toward that side, the paralyzed side. And we are here together to deal with that paralyzed side; unless you don't want to. (Pause) So then obviously you want to carry this to your grave. That is becoming clear.

PT: I don't! But I don't know what to do with it.

TH: To do with what? How do you experience your anger towards me, physically . . . we know when you are anxious, physically you have a certain way of experiencing anxiety, but how do you experience the anger that you have inside you towards me? Do you see how terrified you are?

PT: I am afraid . . . I am afraid of being violent.

In the above passage, the therapist maintains the challenge, pressure and a repeated composite form of head-on collision while carefully monitoring the signaling system; the nonverbal cues such as frequent deep sighs, clenching of both hands, etc. The process clearly indicates a steady rise in transference feelings. The systematic work on weakening the major resistance of repression is progressing and the patient now declares "I am afraid of being violent," "it is something totally irrational," "a loss of control." It is important to note that the process has moved from "frustration" to "violence" and we have a clear indication of the mobilization of the unconscious therapeutic alliance against the resistance. We return to the interview.

TH: Violent. You mean there is a volcano inside you?, a fireball inside you that you are afraid might come out? This is what you are saying? You mean there is a fireball inside you that . . . you are afraid that it might erupt.

PT: (deep sighing) It is something totally irrational, a loss of control.

TH: Losing control? but how do you physically experience this? How internally do you experience this wave that goes within you? We are talking about this violent rage. (pause) Again, you see, clenching. You are protecting me against your anger, isn't that?

PT: Yes.

TH: Hmm?

PT: Yes.

TH: Yes what?

PT: I'm protecting myself.

TH: But obviously protecting me as well. Because your hand is like this.

PT: But I think of it more as protecting myself.

TH: But still we don't know how you experience this rage inside. How you're experiencing it inside? We are not talking about putting it out, we are talking about how you're experiencing it inside.

PT: Just stays up in the head.

TH: But still we don't know how you physically experience this rage.

PT: I feel tight, I feel it.

TH: But that is anxiety, that is not rage. And what you experience is anxiety but underneath of it is rage. You experience the anxiety but we don't know how you experience the rage. Do you notice there is a link between anxiety and rage?

PT: Hmm, but they're not the same.

He indicates that he has "an awful temper" and that he is afraid of losing control, "might become destructive." The therapist brings his attention to the experience of rage. The deep sighing respiration has increased, which signals a further rise in the transference feelings. Referring to his inner rage he says "I don't feel a connection."

PT: I can't relate it to ah, to an experience.

TH: *How do you physically experience it?*

PT: *It all sounds like anxiety, I mean I felt a tightness in the chest and ah . . .*

TH: *But you see tightness in the chest means anxiety in this muscle.*

PT: *Yeah.*

TH: *But anxiety and rage are two different things. Underneath the anxiety obviously is the rage, and as soon as the rage is mobilized you become anxious. So anxiety is a mechanism of dealing with rage, detachment is a mechanism of dealing with rage, holding the fist like that is a mechanism of dealing with rage, making yourself tight like that is a way of dealing with the rage. But how do you experience the rage itself?*

For a moment, it is very important to summarize the process and discuss some of the technical and metapsychological issues *re* the way the unconscious functions:

- (1) There has been systematic challenge, pressure and repeated head-on collision with the patient's transference resistance, which gave:
- (2) A steady rise and a direct experience of the complex transference feeling, which was signalled by;
- (3) Rise in anxiety in the form of tension in the striated muscles and its nonverbal cues;
- (4) There is mobilization of the unconscious therapeutic alliance;
- (5) The process indicates that the repressive mechanism is in the process of being weakened, which has been mobilizing a high degree of anxiety, again in the form of tension. His body is immobile and other nonverbal cues already mentioned;
- (6) The unconscious murderous rage is close to breakthrough, which is a major source of mobilization of anxiety;
- (7) Therapists working with this technique must have a good knowledge about the somatic or the psychophysiological pathway of unconscious anxiety in the form of tension in the striated muscles (will be discussed briefly at the end of this article);
- (8) Therapists must have knowledge about the somatic pathway of the passage of the unconscious murderous or unconscious primitive murderous rage. I have clearly demonstrated in a large series of unlockings, that the passage of the murderous or primitive murderous rage has a definite somatic pathway, which has been presented in many symposia and courses; and I will briefly address it at the end of the article;
- (9) As soon as the unconscious murderous rage is experienced in the transference the whole anxiety and tension drop, signaled by the nonverbal cues.

Here it is important to very briefly summarize some of the fundamental principles of the way the unconscious functions:

- (a) Actual experience and passage of the unconscious murderous rage in the transference is instantly associated with a drop of anxiety and tension, and emergence of sadness is an indicator that the breakthrough of the guilt and grief-laden unconscious feelings is eminent.
- (b) Experience and the passage of the unconscious murderous rage in the transference, as I have indicated before, is instantly associated with sadness. The patient's attention is on the murdered body of the therapist and then his unconscious transfers the murdered body of the therapist to the genetic figure, namely father, mother or sibling.
- (c) As soon as this transfer takes place there is a breakthrough of intense major waves of guilt-laden unconscious feeling, which is then followed by a major passage of grief-laden unconscious feelings.

Principles (b) and (c) can be demonstrated with every extended major unlocking of the unconscious with every highly resistant patient with complex psychopathology. One of the main reasons has to do with the fact that the rise of and the direct experience of transference feelings is at its optimum level and there is optimum mobilization of the unconscious therapeutic alliance and the resistance has lost its power. This is what I have called mobilization of the "unconscious therapeutic alliance; *dreaming while awake*," (Davarloo) which has already been presented in many symposia and courses and will appear in future series of articles.

If we go back for a moment to major unlocking, there is some degree of variation and this depends on the extent of the rise and direct experience of the transference feelings. I have already indicated that the degree and the extent of the breakthrough into the unconscious is exactly in proportion to the degree that the patient has directly experienced his transference feelings. On that basis we can say that there is a spectrum of major unlocking of the unconscious. Now we return to the interview with this patient. The therapist maintains challenge to the resistance against the experience of his rage in the transference, asking how the patient experiences the rage. The specificity of this question is extremely important. The patient finally indicates that there is "something rising" and the therapist follows.

TH: *That fireball?*

PT: *Yeah, it's, rising up inside.* (referring to the somatic pathway) (hands are not clenched, his totally bent position becomes upright and he says, "rising up inside" referring to his abdomen and chest)

TH: *What is the way you are experiencing it?*

PT: *Well, it's to, it's to . . . it's to explode, you know it's to shout.* (the hand is in the upward position, his voice is loud, no tension in the vocal chords, indicating that the breakthrough is taking place)

TH: *Explode?*

PT: *It's to shout and . . .*

TH: *There is a rage in you like that?*

PT: *Yes.*

TH: *That you wanted to blast on me? That there is a rage in you toward me?*

PT: *No, rage is too big a word for it.*

TH: *And I think that it is very important that we examine this, unless you want to keep your misery the rest of your life.*

PT: *No. (deep exhalation)*

There is definite evidence that the breakthrough has taken place. Anxiety and tension have dropped. The therapist bypasses the tactical defense "No, rage is too big a word for it." Now the therapist explores how it would have been like if he had put his rage out (it is important to note that if this was an extended major unlocking, with an optimum rise in the transference feeling and optimum mobilization of the unconscious therapeutic alliance, direct experience and passage would have been spontaneous). We return to the interview.

Passage of the Murderous Rage in the Transference

TH: *If you lash out, how that would be like? In terms of thought and fantasy. You know the story of Dr. Jekyll and Mr. Hyde?*

- PT: Yes.
 (the atmosphere of the interview is different, there is no tension and no anxiety)
- TH: Now, if . . . you know, that monster comes out of you, what you would be like? and that is very important for you to look at because that has made your life miserable, that has paralyzed your life and why would you go to your grave in that way? If that monster comes out of you, what that would be like? In terms of thought and fantasy.
- PT: I would attack you directly, with my fists . . .
- TH: Then there would be attack on me? (he is sitting in the upward position. At this moment, his two hands are in the upward position, outstretched opposite to each other, and is demonstrating to the therapist how he would strangle the therapist)
- TH: Could you portray how you would attack me?
- PT: Throttle you around the neck . . . like that.
- TH: You mean your hands?
- PT: Right, right in. . .
- TH: Over where? Could you portray it?
- PT: Yeah.
- TH: Around here? (referring to the neck)
- PT: Yes.
- TH: So you would hold . . . put your hands around my neck, your thumb would be on my. . .
- PT: And choke.
- TH: Uh huh, and then choke me?
- PT: Yeah.
- TH: And then, how would you go further? If you let this . . . go further.
- PT: I would choke you and shake you until, until you stop moving.
- TH: Yeah, but then how it would be like? in terms of your thoughts.
- PT: My fingers would be just pressing (referring to the therapist's neck)
- TH: And push?
- PT: Push and push and shake.
- TH: And then?
- PT: And then, release.
- TH: But what happens? I mean finally I am. . .
- PT: You would fall to the ground.
- TH: You mean that I would be gasping for air.
- PT: No, you would be dead.
- TH: I would be dead hmm. In the chair there or where?
- PT: It wouldn't matter whether you're in the chair or fell to the ground.
- TH: Yeah but in terms of thought. I mean your hand is on that and then you are pushing and pressing and pressing and then I die. Could you portray the dead body of mine on the . . . Where?
- PT: You would be . . . you just slump back on the chair.
- TH: On the chair and the head back you mean?
- PT: Yeah like that.
- TH: And how about my eyes?
- PT: Wide open and staring.

TH: *Staring at where?*

PT: *Just staring up.*

TH: *The ceiling?*

PT: *The ceiling.*

The patient is becoming increasingly sad. There is no anxiety and tension and the patient is in an altered inner state. We continue the interview.

TH: *and then my hand?*

PT: *Just . . . like that.*

TH: *Like that. And then what do you do after that? After I am murdered?*

PT: *If I'm still angry? If I'm . . . if I'm full of remorse?*

TH: *No I mean what happens? Now you have put your hands on my neck and then I . . .*

PT: *I've killed you; remorse, guilt. I would. . . the rage would be gone.*

TH: *Rage is gone but what other feeling would you have? I mean I'm back there and I am dead.*

PT: *I, I . . .*

TH: *What would you do?*

PT: *I'm just totally stricken, I would just ah . . . (sighs)*

TH: *But then what would you do after that? How would you feel at that moment?*

PT: *Dreadful, I'd feel. . .*

TH: *Why?*

PT: *For having killed you.*

TH: *Why? Why would you have remorse?*

PT: *For having killed a human being.*

TH: *And what do you do with my dead body?*

PT: *Nothing. (sniffling)*

TH: *I mean what do you do with it? You mean you walk out or you . . .*

PT: *I can't . . . I would . . . I can picture a collapse, I picture not doing anything.*

TH: *I mean what do you do? I mean you leave me and walk out the door?*

The sadness is becoming intensified, tears are in his eyes.

PT: *No I would go and find someone.*

TH: *Who? What comes to your mind? (heavy sobbing)*

PT: *I picture going out that door and finding the first person and saying I've killed this man.*

TH: *Hm hmm. And how would you feel toward my dead body?*

Passage of Guilt-Laden Unconscious Feeling

There is a breakthrough of a major wave of guilt-laden unconscious feelings, with heavy sobbing. The guilt-laden unconscious feelings come in waves and involve the whole upper respiratory area. The interview continues.

TH: *How would you feel towards my dead body?*

PT: *(crying) I would be sorry.*

TH: *Hmm.*

PT: *I want to help bring you back to life.* (further breakthrough of guilt and painful feeling)

TH: *You mean there are positive feelings as well?*

PT: (further breakthrough of guilt)

TH: *Hmm?*

PT: (further breakthrough of guilt)

TH: *Positive feelings there also?*

PT: Yes.

TH: *And then my burial what. . .*

PT: *Ohhhh.*

TH: *How that would be like?*

PT: *Ohhhhh.*

TH: *Hmm? You would be at my burial?* (Breakthrough of waves of guilt-laden unconscious feeling).

It is important to note that the unconscious has not, as of yet, transferred the murdered body of the therapist to the dead body of the genetic figure, which shortly as we will see is the mother. Throughout that passage, there will be major waves of painful feelings. Now, we return to the interview.

PT: *I think I'd want to hide from it, but I'd be there. I'd be afraid.*

TH: *Afraid? Of who?*

PT: *Of those that loved you.* (cries)

TH: *Those?*

PT: *Who love you and seeing the person who'd murdered you.*

TH: *Because there is an element of death, murder and death hmm. But who comes to your mind, because the one who loved me who would be mostly affected by this, by my death? In terms of thoughts.*

PT: *Children.*

TH: *There would be children?*

PT: *All those who'd be close to you, friends, most, mostly family.*

TH: *Who would be most hurt about this death?*

PT: *Well a child.*

TH: *Child. In a sense the one that they would be mostly affected would be . . . children*

At this moment, there is another major wave of guilt-laden painful feelings; and the unconscious therapeutic alliance clearly identifies the identity of the murdered therapist, which is the dead mother. His voice is choked-up and what emerges is the murderous rage to strangle the mother. The focus is on the murderous rage towards "my mother," murderous rage to throttle her neck to death.

PT: *It is my mother.*

TH: *You say that, or that comes . . .*

PT: *I can see it, it is my mother.*

What we have seen so far indicates major weakening of the resistance and mobilization of the unconscious therapeutic alliance, which is now in command of the process.

Analysis of the Transference

Now the therapist returns immediately to the phase of analysis of the transference before he undertakes the dynamic exploration. For the sake of brevity, some aspect of this part of the interview is omitted, otherwise it remains verbatim.

TH: *It is very important we examine it.*

PT: *Well I think . . . so afraid to show it.*

TH: *I know, but you see that is what we see.*

PT: *I would die myself if I showed it.*

TH: *You see, you have developed a set of mechanisms for 46 years to deal with these buried feelings, with this buried murderous rage, the painful guilt feelings and obviously other feelings.*

PT: Yes. (he is sobbing)

TH: *Not only the murderous rage and the guilt but also other feelings, the feeling of sadness and the grief about the way life has gone for you.*

PT: (continues crying) (whispering)

TH: *There must be a tremendous painful feeling in you, the pain of being left by your parents . . . and that there are a lot of feelings that a big chunk of your life has gone in waste and misery, hmm.*

PT: Yes. (whispering)

TH: *Something has to explain why you are so terrified of anger, hmm. Obviously, as we see, there has been a major seething rage that you could murder her and the guilt feelings about it, but also the major pain of being dumped by her and the way you have dealt with this, the pain of being abandoned, the seething rage and the guilt that made you a paralyzed man and that this was a defense mechanism against all of these feelings, hmm?*

PT: (whispering) I can see that. (continues crying)

TH: *Do you follow me? don't agree with what I say. Here we are for you to examine them.*

PT: I can see . . . (whispering) (he is very sad, with a low voice)

TH: *That this need in you to suffer, this need in you to perpetuate suffering and misery, the need in you to destroy your potentiality, all are mechanisms of dealing with this pain, murderous rage and guilt which is within you, that you would put your hands over her neck and choke and choke until she would be dead. Do you follow me?*

PT: Yes.

TH: *And that the way you dealt with it is to become a paralyzed man, to lose your autonomy and freedom as well as a mechanism of dealing with that. But obviously, we haven't so far touched your feelings towards your father, your brother, and obviously there are other figures in your life such as your aunt and your grandmother as well.*

In the above passage, the therapist drives home insight into the aspects of the psychopathological dynamic forces that are responsible for the patient's disturbances, his masochistic character pathology, the "perpetrator of the unconscious" (Davanloo), which may be summarized as follows:

(a) Attachment and the bond:

- (b) Abandonment and the severe trauma;
- (c) The pain of the trauma;
- (d) Murderous rage toward the mother by strangling her;
- (e) Intense guilt-laden unconscious feelings and;
- (f) Intense grief-laden unconscious feelings;
- (g) the whole set of character defenses "you have developed a set of mechanisms for 46 years to deal with these buried feelings, with this buried murderous rage."

It is important to note that the therapist is clearly working with what the process so far has covered and what the unconscious therapeutic alliance so far has introduced. At no point he made a communication that the patient may have rage toward his father, brother and so forth; and this is an important aspect of the technique.

Major Communication from the Unconscious Therapeutic Alliance

Murderous Rage towards the Brother

Now the powerful dynamic force of the unconscious therapeutic alliance spontaneously introduces the patient's murderous rage toward his brother. He spontaneously talks about an incident in which he was near to murder (his brother).

PT: *Shame and guilt and . . . all because . . . is I tried to hurt my brother very much when I was very young; throwing scissors at him in a fit of rage.*

TH: *Fit of rage?*

PT: *Yeah.*

TH: *With your brother.*

PT: *I lost my temper and . . .*

TH: *I mean there was an incident?*

PT: *I have strong memory of this, of getting enraged with him. The last time I lost my temper and felt the rage I had scissors in my hand and I picked them up and I threw them at him.*

TH: *How big were the scissors?*

PT: *Big scissors.*

TH: *Oh one of those okay. How did you throw it at him? What was the incident?*

PT: *The incident uh I . . . he he got me angry, my brother and I could always get each other angry, very, very angry.*

TH: *Hm hmm.*

(the incident as he describes it is as follows. The brother had bent down to put his overshoes on, and the patient threw the scissors which could have got on the brother's neck, as patient shows it with his body movement, but the scissors went into the overshoes)

PT: *And I could get him very angry, he could get me very angry. I don't know what it was that he got me angry with, I was . . . all I know he was holding a pair of those overshoes that we would put on and I can remember just screaming in rage and throwing them and having them, having them stick with the knife into the shoe.*

TH: *Stick with the knife?*

- PT: Not stick with the knife, the scissors.
- TH: Scissors.
- PT: Into the, into the boot that he was holding.
- TH: How? You mean the scissors . . .
- PT: The scissors I threw them and sss . . . they went right into the boot that he was holding.
- TH: That bad? You mean that heavy?
- PT: Yes.
- TH: You mean then you were really enraged.
- PT: I was . . . yes I was totally out, enraged . . . totally out of control.
- TH: And then the scissors went . . .
- PT: Went right into the . . . these these rubber boots you know, went right into the boot.
- TH: And then?
- PT: I don't know what happened immediately after but I remember that being the last time; I said no more, that I'm going to . . .
- TH: I know but . . .
- PT: I don't know what happened right after. I don't have a recollection.
- TH: Now if it had got on his neck what would have happened?
- PT: Ohhh . . . (deep sigh)
- (The comment of the therapist "if it had got on his neck what would have happened"—at this moment he has shivering with some tremor. He is very sad and tearful).
- TH: If that scissors had got like that on the neck what do you think would have happened?
- PT: Ohh would have been awful.
- TH: Picturing I mean.
- PT: Picture him bleeding and I picture me just . . .
- TH: What part of the neck would catch?
- PT: Ah into the neck right there.
- TH: Like this?
- PT: Yeah.
- TH: So in a sense would go over the neck like that and then?
- PT: Then I see myself . . . I would . . . then we just dissolve, just, just be . . . the rage would be gone in in . . .
- TH: I know but what would happen to him?
- PT: He would die or he would bleed vey badly and I would try to stop it. I . . . I . . . I'd be . . .
- TH: So then he would be murdered.
- PT: He would be murdered.
- TH: Hmm?
- PT: Yes. (deep sighing with major wave of painful feeling)
- TH: So then there is also this murderous rage and guilt toward your brother.

His brother is 4 years older than the patient. In a painful state he says "He was the first baby and was privileged to have a mother and a father until the age of four." It is important to note that as he describes the incident he is fully in touch with the murderous rage the way he held the scissors, the way he threw the

scissors, and the way they would have gone into his brother's neck. A shivering moment indicated his reaction and his intense experience of the guilt and the whole psychophysiological concomitant characteristic of the passage of the guilt. In the summary of this article, I will briefly discuss my research data on the importance of the actual experience of the passage of the murderous rage, the intense guilt-laden unconscious feelings and their psychophysiological components in the here and now, and their relation to structural character changes.

Death and the Funeral of the Mother

After the passage of the guilt-laden unconscious feelings, the patient came with a memory of a picture with his brother smiling and "is happy with his mother." It is important to note that he refers to "his mother," referring to the mother of the brother. Then he comes with a vivid memory of his brother crying over "her death." Then he spontaneously talked about the death of his mother. She died at the age of 67, as a result of a massive blood clot. The therapist makes a dynamic exploration into the circumstances surrounding her death. On the way to attend her funeral, he shed tears. Then the focus of the process is on the funeral.

- TH: *How did she look like at the funeral . . . when you looked at the dead body?*
 (Patient is sad and tearful)
- PT: *Not my mother.*
- TH: *What did she look like I mean?*
- PT: *The body, the body was hard, the face was hard and bitter. The face was sharp and and, and uh . . . cold.*
- TH: *Hm hmm.*
- PT: *And I thought that's not my mother. But I didn't feel, I didn't feel, I didn't cry. I didn't feel that feeling of emotion until at the funeral the moment they closed the casket for the last time.*
- TH: *What was your goodbye to her? What did you tell her at the last goodbye?*
- PT: *(heavy sobbing) I just said goodbye.*
 (Breakthrough of a major wave of painful feeling.)
- PT: *I ju.. I just said goodbye. (very choked-up voice)*
- TH: *But what did you say to her?*
- PT: *It was something very simple like goodbye . . .*
- TH: *You touched her and said goodbye?*
- PT: *I did touch. (grasping her hand)*
- TH: *So you touched the hand and said goodbye.*

Two Hours with his Mother

Now, the *unconscious therapeutic alliance* introduces an incident which intensifies the patient's painful feeling. In a very highly charged, emotional state, he sobs. This is so intense that it interferes with his speech and he says that he only spent 2 hours in his life with his mother, and it was some months prior to her death. We return to the interview.

- PT: I said goodbye. (Pause) I think it's import . . . the year just before, I had not . . . I didn't see my mother, I hadn't known her as a person at all, and literally that happened in the winter, I guess it was the fall, that was in January. And in October she was in town, and for the first time she came to visit and we went out together for dinner . . . just for lunch, and spent 2 hours just talking. That's the first and the last time that's ever happened. (voice breaks) And I was very grateful. (sobs)
- TH: You mean that October was the first and the last time that you had together.
- PT: I get pretty . . . (major wave of painful feelings)
- TH: So you must have a lot of mixed feelings about life with your mother.
- PT: Yeah. We never lived as a family, even when we . . . after the war. We always lived with my grandmother and . . . aunts.
- TH: But where was that?
- PT: We are a rest . . . a little restaurant, went to a little restaurant.
- TH: You and your mother.
- PT: Just my mother.
- TH: And you say this is the first time that you . . .
- PT: First time I ever sat down and we talked about anything, anything that was personal . . . or . . . and even then it was a start, it was just a little . . . (loud sobs) (choked voice) I'd loved to have known her as a person.
- TH: What?
- PT: I'd have loved to have known her as a person and not as a mother, not as that . . . she was never part . . . my parents, neither of them had ever been people to me. Even my father, even now I can't reach him, not . . . I try and it's impossible.
- TH: Hm hmm. So then there is a lot of mixed buried feeling within you.

Further Dynamic Exploration

He further talked about his mother, he and her alone together in the little restaurant which he refers to "a lucky chance," "we spent a good 2 hours together," and that his talk with his mother was "at a much deeper level than I had ever experienced before." "She was in good health." He didn't see her again after that; she died suddenly. He again talks about their two hours together. "It was special, I hugged her." (breakthrough of another major wave of painful feeling) He indicated that it was something so different that had never happened before. Then a few months later, his father telephoned and told him that she had died suddenly. The patient felt numb. He thought of excuses, all of the reasons he could not go to the funeral. But finally he went and saw her on view the day of the funeral. It was during the winter, with heavy snow and they couldn't bury her. But then in the spring his father buried her and the patient couldn't go. In a sad state he talked about his early years and the memory of his aunt taking him to the city where his mother lived, while he always had the memory that his mother came to visit him. The realization of this, that she never came to visit him mobilizes further waves of painful feelings. In his memory his mother never showed any emotion. The focus is on his grief-laden unconscious feelings, and he indicated that he realizes that his feelings are deeply buried, "had been buried and controlled."

Further Analysis of the Transference

After the passage of these waves of painful feelings, once more the therapist moves to the analysis of the transference. First his rage, followed by murderous rage, and finally the murder of the therapist by strangulation. Here, the therapist once again recapitulates on the whole set of unconscious character defenses that he had used in the transference and its link with the unconscious anxiety, and its further link to the unconscious murderous rage. The therapist clearly and explicitly points out the whole set of character defenses in the transference. "These are all a set of mechanisms you used in dealing with your murderous rage towards me," and further points out that the murderous rage in the transference was the murderous rage towards the mother.

The therapist maintains the focus on the mother and further indicates the trauma of abandonment, the major pain of the trauma, the murderous rage, guilt-and grief-laden feelings and the whole set of character defenses that he has developed to defend against all these buried feelings. Then the therapist focuses on his mixed feelings in relation to his brother; the murderous rage, guilt and grief and the whole set of mechanisms he used to defend against these buried feelings. The therapist, so far, only emphasizes the mother and the brother and points out to the patient, "Of course we haven't touched your father yet." Patient's response indicates that he is well in touch with the process.

PT: Yes, I.. I.. I... it makes sense.

TH: Hmm?

PT: It makes sense to me.

TH: Now my question is this, do you get depressed?

Exploring the Episodes of Depression

After the first breakthrough into the unconscious murderous rage and guilt, for the first time the major defense mechanism responsible for the depression, namely the instant repression of the murderous rage, has been weakened to a major extent; and it is important that the therapist explores the episodes of depression and drives home further insight into that mechanism. He indicates that he suffered from episodes of depression. They always follow episodes of periods of major conflict with his wife, or when the marriage is threatened to break up which might result in the breakdown of the relationship with his two children. When depressed, he says he is like "half a person," "close to a state of paralysis." He stays in bed, suffers from poor concentration, and his thoughts become fatalistic and gloomy. In his younger years, before he got married, he had two major episodes of depression, each lasting a few weeks and both of them followed a breakdown of a relationship with a woman. Suicide was explored, and he has never been suicidal. Then the therapist further explores his relation with his wife.

Exploring his Relation with his Wife

He indicates that he has no joy in seeing her, fuming inside but silent, withdrawn and detached outwardly. Then he talked about a recent incident. He

had picked up his wife at the airport, had forced himself to show her that he had been looking forward to her return. "I didn't have the joy of seeing her back." He further emphasizes that throughout his marriage he had learned to put up a facade, to prevent her from getting angry, explosive, and critical. After they returned home from the airport that night she wanted him to make love to her, but he couldn't respond so she got angry with a biting temper, criticizing him and putting him down. "She knows my weaknesses." This went on until he got angry and the way he handled it was becoming totally detached, withdrawn and silent.

Now, the therapist makes a link between the transference and his wife. We return to the interview.

PT: I was very angry with my wife, but again I became withdrawn, silent and remote.

TH: So you withdraw then.

PT: I withdraw into silence, I . . . I . . . I don't say anything.

TH: So silence is another mechanism. Do you notice also silence was with me?, was another way of dealing with your anger. When you were enraged with me you took a silent position.

PT: Yes, I . . . I think.

TH: You say that because I . . .

PT: No, no, no you're right, you're right. You would say something and . . . then I got silent, detached . . . withdrawn.

TH: And then she is angry with you huh?

PT: Yes.

TH: And then what happens to you?

PT: And then, then it gets worse, then I withdraw even further or I . . .

TH: So that means there is more anger in you?

This might result to further escalation and she might threaten to terminate the marriage. The therapist knows that underneath the anger is murderous rage. It is important to note that the therapist can simply interpret this, but by doing so he is making a major mistake. As I emphasized earlier, the patient must actually experience, in the here and now, if he has murderous rage towards his wife, and most importantly interpretation should come from the unconscious therapeutic alliance. Again we see a major and fundamental difference between the traditional psychoanalytic system and my technique.

The therapist reemphasizes the set of mechanisms that he uses against his negative feelings in relation to his wife. "But this is important that you examine some of these sequences," emphasizing that the more angry he gets the more silent and withdrawn he becomes, which sets the stage for more anger in his wife with criticism; she becomes more demanding and puts him further down, then he becomes more detached, remote and more silent. Then he points out that his wife becomes physically violent, attacking him with her fists on his head, with him protecting himself, holding his hands over his face; and then she threatens to terminate the marriage. Then he indicates that he moves into a state of paralysis and then depression takes over. He emphasizes the two aspects of his wife, one being critical, demanding, explosive, etc.; but the pendulum can shift to the other side where she becomes distant, remote and wants to be left on her own, and

"none of us could feel her presence." Then he spontaneously said that there has been many incidents when he felt "so frustrated, where I wanted to strike out."

PT: *Again it . . . it . . . it would be.. as I say it's happened several times. It would be that point of her saying you know "You leave me in silence and you gotta stop doing that. Do something! You can do something. You can do something, you can do something, you can do something."*

TH: *And then she would be after you to do something.*

PT: *To do something. "You gotta do something!" . . . and demanding in a preaching voice.*

Direct Experience of the Murderous Rage in Relation to his Wife

Throughout this passage, he is clearly experiencing an intense violent rage towards his wife. He is sitting straight up, highly charged, his hands are in the upward position, outstretched, opposite to each other, exactly the same way he was when he wanted to throttle the therapist. He is experiencing his murderous rage. Now we return to the interview.

TH: *If you had let yourself go . . .*

PT: *What would I do?*

TH: *How the attack on her would have been? With your brother it was scissors on the neck, with me it was the hand on the neck to throttle and with your mother it was the hands on the neck and again to throttle.*

PT: *Well I certainly can see the hands on the neck too; choke and stop the, stop the talking and . . .*

(With his two hands he is showing how he would murder his wife by strangling her.)

TH: *Have you experienced it like this with your wife?*

PT: *Not at the time. It was just when you asked me what would I do and and . . .*

TH: *What comes to your mind if you . . .*

PT: *It's the throttling that would stop the, stop the talking.*

TH: *How would you go on her neck?*

PT: *Again it would be in the bed and I'd be on . . .*

TH: *In bed.*

PT: *She would be in the bed.*

TH: *And then you are?*

PT: *I'm, I'm over her and throttling her saying "shut-up, shut-up, shut-up I don't wanna here anymore."*

TH: *How would you do that?*

PT: *And I would uh and hit it up and down and up and down on the bed; shut-up, shut-up.:*

(Intense sadness; breakthrough of a major wave of painful feeling)

TH: *Yeah but how your voice would be like if . . .*

PT: *I would be screaming. (weeping)*

The strangling of his wife takes place in bed. The therapist emphasizes the similarity of the passage of the murderous rage in the transference to that with his

mother and now to that with his wife. Then the patient says "Yeah, a very strong hand motion." Now the therapist moves to some analysis of the process, reemphasizes the similarity of the way he experienced the murderous rage towards the therapist, his brother, his mother and now to that with his wife, and he follows it clearly.

It is important to note that the forces of resistance to a major extent have been weakened and the unconscious therapeutic alliance has been mobilized to a degree that it is in command of the process. The therapist continues his dynamic exploration into the patient's marriage. He explores the patient's sexual life and questions him how his detachment, withdrawal and silence affects his sexual life and his erection.

TH: So then in a sense, your relationship with your wife is quite stormy and as you, yourself, put it, you are paralyzed, you have to comply, you have to perform and you have to do your best by putting on a facade. But at the same time there is a major volcano within you.

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

TH: Then she is like a pain on your neck.

PT: Like a pain in the neck. Get rid of the pain in the neck.

TH: You smile when I say she is a pain in the neck.

PT: No, I . . . well it was the relationship to throttling her by the neck and the pain in the neck.

It is important to note that this man suffers from frequent episodes of pain in his neck and also the murder of his wife, his brother and his mother is at the neck level, which demonstrates the mechanism of projective identification and symptom formation. But at this moment the therapist concerns himself with the incident at the airport, which the unconscious therapeutic alliance has introduced. The therapist raises the question how he would have felt if her plane had crashed? This technical intervention, as we will see, is important.

TH: Now, if the pain in the neck, say from ___ to ___ had . . . there was a crash and your wife had died. What would have happened to you and your life?

PT: I'd feel free, first of all I would feel free, and no . . . I've often thought of it.

TH: You've had often thoughts that if she drops dead then you would be . . .

PT: It would be a relief.

TH: A free man you mean.

PT: That's the first thought, that, that is the initial . . . that's, that's . . . I think beyond that but yes there is a sense of relief.

TH: Relief.

PT: If it would end.

TH: Could we look to your thoughts. Again we are examining these thoughts.

PT: Yeah.

TH: What way she would die?

PT: It doesn't seem to be specific, it doesn't seem to matter, cause I also think if she were to walk out the door tomorrow and say I'm leaving I would feel relieved. So its the going away.

TH: So in a sense she is such a pain in the neck that you look forward to her death in a sense.

PT: (sighing) I don't knowwww.

TH: But its very important you examine your feelings.

PT: Yes, that's right, that's right.

TH: You have to face with the truth.

PT: Yes.

TH: You see, even if that truth is an ugly truth. I mean "trooth", you have to face with it.

PT: Yes, it is quite right.

In the above passage, with a great feeling of relief he talked about the death of his wife; and the process clearly demonstrates that the resistance is not present and that the unconscious therapeutic alliance is in command, and the therapist emphasizes the ugly truth that he has to face. Patient has already admitted to active death wishes for his wife and the therapist moves to the incident that he wanted to strangle his wife. The therapist attempts to explore his feelings in relation to the murder and the death of his wife.

TH: ... and if she dies, and ahead you have described how you throttle her to death. What she would be like when you strangle her in the bed? You have strangled.

PT: I strangle her and I see her then at peace.

In the following passage, the therapist focuses on the dead body of the wife, and it is important to note that he spontaneously links it with the portrait that he had already made of the throttling and murdering of the therapist. Suddenly there is a major passage of guilt-laden unconscious feeling.

His Feeling for his Wife

TH: She's at peace.

PT: And I'm at peace because she's at peace because she . . .

TH: But how does she look in bed?

PT: Her eyes are closed and her hair is framing her head like an Ophelia or someone like that who is lying dead and is now peaceful.

TH: And how do you portray her body in bed?

PT: Just lying and ah with her head on a pillow and she's got long dark hair and just framing her face and she's . . . and and she's not saying anything anymore, eyes are closed and her face is in repose. If I also see in my mind's eye her face all distorted as I pictured yours as eyeballs staring out and tongue protruding and the violence of having killed her that would be awful.

TH: And how would you feel towards her?

PT: Aaah if . . . again . . . Having killed her, if it's violent and and the eyeballs are staring and so on and then the rage is gone then, then again the remorse because I care for her too.

TH: You mean there are also positive feelings for her?

PT: Yes I've got a lot of positive feeling.

(low voice) (Intense sadness and the passage of waves of painful feelings)

TH: One of the other issues is this, do you notice that as much as you have problems with the the negative you have problems also with the positive?

PT: Aw yes.

It is important to note that while portraying the face of the murdered body of his wife, he spontaneously brought the portrait of the murdered body of the therapist "eyeballs staring out and tongue protruding" (and after the passage of the murderous rage towards the therapist, the murdered body of the therapist was transferred to the murdered body of the mother.) This form of interpretation usually is made by the patient after high mobilization of the unconscious therapeutic alliance.

The process now enters to the phase of consolidation, and the therapist analyses the mechanism of projective identification and symptom formation. He further reemphasizes the murderous rage in the transference, which was the murderous rage toward his mother and the guilt-laden unconscious feelings and murderous rage toward his brother and the intense guilt-laden feelings; and brings into the focus the murderous rage toward his wife with intense guilt, as well as his positive feelings.

The therapist is well aware that the major resistance was mobilized when he focused on the body of Linda, whom he brings into the bed when he has intercourse with his wife. The identity of Linda so far has been a mystery, but now the unconscious therapeutic alliance makes it absolutely clear.

Major Communication from the Unconscious Therapeutic Alliance

After he talked about his positive feelings for his wife he spontaneously talks about his two children, a daughter aged 18 and a son aged 16 and emphasizes that his life centers around his two children. "All the passion that I don't feel in the marriage I feel it with my children." Then he talked about his daughter Isabel, saying that "she is brilliant."

PT: *She is slim, blond, with blue eyes.*

TH: *Is blond?*

PT: *She is fair haired, it's honey blond, it is fair.*

TH: *Okay, she is blond.*

PT: *Blond and slim and both passionate and worried and frustrated about life and we talk a lot, uh, about all kinds of things she shares with me, how she feels about things, and her troubles. So we share a lot of things. Uh blue-eyed, and she worries a lot.*

TH: *How is the physical expression of affection like between you and your daughter?*

PT: *I hug her a lot and she hugs me a lot.*

TH: *Really you feel open?*

PT: *Ohhhh yeah, oh yeah.*

TH: *Oh I see.*

PT: *And yet I don't think she . . . she's physically emotional.*

TH: *When you hug her and hold her do you get flashes of the past?*

PT: *(deep sigh) Uhhhhh I think out . . . like it's certainly. . .*

TH: *You see one thing significant in your past is the absence.*

PT: *That's right, I mean I think it's because of the absence of that connection that I feel so, so strongly. There came a time last year when we almost separated, my wife and I. And when it came to it, if the children hadn't been there I was gone, I wouldn't have stayed. But when it came to the actual night to go and I told the children I just . . . just . . . (cries) . . . just couldn't leave.*

- TH: So with Isabel you capture the past in a sense.
- PT: And with my son, we're very close.
- TH: I know, but we can go to that as well.
- PT: Yeah, yeah. Very close. Uh yeah but it's a . . . but I can see a very close link there. I couldn't leave them for one minute (choked-up voice) (breakthrough of waves of painful feelings)
- TH: When you hold her or hug her you get the flashes of . . .
- PT: I . . . is that what it is? Like am I consciously . . .
- TH: Is buried and repressed in you but unconsciously you must be feeling . . .
- PT: Yes.
- TH: . . . the experiences that you wish you could have had in the past. You see what I mean? Because there is a major gap in you about your life in these early years you see. The craving for a tender affectionate relationship hmm with . . .
- PT: Yeah, and I think I crave that from my wife, and I don't get it because she's not my mother and she refuses to be a mother. And I think also that relates to in this other woman Linda I was mentioning, is that my . . I sense that my passion for her or my sense of wanting to be with her is because I sense the mothering and caring. She's a close friend.
- TH: Yeah I'm talking about the affectionate.
- TH: But if we keep with Isabel.
- PT: Yeah.
- TH: You say your daughter reciprocates and you are able to both exchange a tender affectionate feeling for each other?
- PT: Yes, yes.

In the above passage the unconscious therapeutic alliance clearly identifies the woman that he brings into bed during intercourse is his daughter, who is slim, blond, with small breasts and blue eyes. The unconscious has introduced two portraits: one is the portrait of Linda, the other is the portrait of his daughter, which are exactly identical. The therapist follows the communication and raises the question to the patient if he had had a wife like his daughter.

- PT: Look, if you carefully examine your mind hmm, if you had a wife like your daughter, how would you portrait that? Again we are talking about something that is heavy but is again very important. Has it ever passed through your mind that if you had a woman like Isabel?
- PT: No I think not.
- TH: I know because you suppress it. You have a tendency to suppress. You know what I mean by suppress?
- PT: Push it aside.
- TH: But the most important for you is not to go to that.
- PT: Yes.
- TH: Very carefully examine even if it is painful because she's your daughter.
- PT: Yes.
- TH: But a part of you might at times have flashes that if you had a wife, or a woman . . .
- PT: Yes.
- TH: Now has such a thing, like a flash, a split-second, at times has passed through your mind?
- PT: Well not that thought.

TH: What thought?

Now the unconscious therapeutic alliance brings into the open his incestuous feelings for his daughter.

PT: I know that . . . what . . . as she was becoming a woman I was certainly aware of how easy it must be sometimes for incest to occur. I was certainly aware of a physical response to my daughter.

TH: In a sense you have some incestuous thought about her.

PT: Yeah, yeah.

TH: What exactly your incestuous thoughts are?

PT: Well I mean I can feel a stirring of my body, my my . . . I get an erection.

TH: You would feel an erection?

PT: Oh yeah I would, I would, I would feel it and and be aware of it and . . .

TH: While she was . . .

PT: While, while I was . . . yeah while I was sitting and talking with her on her bed or it could be some intimate, intimate situation.

TH: Again these things are painful.

PT: Yeah, uh . . .

TH: But our job is to examine them carefully.

PT: The flash is as if what it would be like to make love to her.

TH: And you have also erection with it?

PT: Yeah.

TH: Hm hmm, that she would be nude?

PT: Nude yes, or partly so.

TH: You have seen her nude?

PT: I see her, I mean even now.

TH: How she looks, . . . her body?

PT: She's beautiful.

TH: I know but how would you describe?

PT: I describe her as uh . . .

TH: She's blond in the hair.

PT: Blond in the hair and black in the pubic hair.

TH: Her genital is black.

PT: Yes black. Uh and she's very slim.

TH: Slim.

PT: Yeah she's . . .

TH: And small.

PT: . . . she's not big at all.

TH: Hm hmm.

PT: Uh and you know her breasts are just small.

TH: Small.

PT: Small breasts

TH: So then in actuality your daughter is slim, with small breasts, blond hair.

PT: Yes.

TH: Dark genitals.

PT: Hmm.

TH: And you have had passing thoughts about a sexual relationship with . . .

PT: Yes.

TH: *And that obviously is something that passes through your mind and you even have erection.*

PT: *Yeah, it has.*

It is important to note that the unconscious therapeutic alliance has made two major communications: that he has incestuous feelings, even erection, in relation to his daughter and that the woman he brings into the bed during intercourse with his wife is his daughter, which clearly explains why when the therapist was exploring the body of Linda the resistance was mobilized. Now we return to the interview.

TH: *And very important again you examine this, when you are making love to your wife . . .*

PT: *Yes.*

TH: *. . . and you bring another woman . . .*

PT: *Yeah.*

TH: *. . . okay? Who is that woman that you bring into the bed?*

PT: *Well . . .*

TH: *It's very important because the woman you described . . .*

PT: *. . . is like my daughter. But it's not . . .*

TH: *But you see, look, you are here to examine rather than to repress these issues.*

PT: *Yeah.*

TH: *Okay, because the essence of all these things is to face with the truth . . . the ugly trooth, which is T-R-O-O-T-H.*

PT: *Yeah.*

TH: *Because the question is this, the one that you described was blond, slim, small breasts and genital dark.*

PT: *(mumbles)*

TH: *And then we know you get this kind of thought about the sex and sexual feelings for your daughter. Now the question is this, who is the woman when you are making intercourse with your wife?*

PT: *(sighs)*

TH: *I know as a father it's very painful to declare this, but at the same time you are here to face with the truth of your . . .*

PT: *Well it's . . .*

TH: *Because you are now 46 years, you have been running away from facing with your buried feelings.*

PT: *Yes.*

TH: *But it is time you examined them, face with them, and face with the truth. Then you would be a free man. Then your relationship with your daughter would also follow a different perspective rather than . . .*

PT: *You see, I haven't had the . . . I've never thought of that before. (sighing)*

TH: *I know, but that is exactly the woman that you describe when you are making love. It is exactly your daughter.*

PT: *But it's also a woman I know so I . . . see I've never . . . I can say I've never . . . I'm not even aware of trying to think a thought of my daughter when I've been in bed with my wife.*

TH: *I know, but the woman you describe is exactly your daughter.*

PT: *Yes, yes.*

- TH: How do you feel when we see a bridge . . . you see the middle of the bridge is wiped out.
- PT: Yeah.
- TH: The bridge between the bedroom; you are making love with your wife and then there is this slim blond . . .
- PT: Yes.
- TH: . . . petite and then genital dark and then the hair blond.
- PT: Yeah.
- TH: Which is your daughter. How do you feel when we bring this to . . .
- PT: Consciousness? I can see.
- TH: Because obviously there must be something like that there. You yourself said you get this when you sit with her and so forth; you have had such a feeling.
- PT: You see, I feel very close to her, but I don't want to affect her that way, and I have been very disturbed about this erection and the incest feeling, and I feel positive that we are able to examine some of this . . .

Then he talked about his concern that these feelings might affect his daughter negatively. He has a close relationship with his son, who is taller than he, and enjoys hugging and holding him. (It is important to note that a few weeks after the trial therapy, the patient entered into treatment and pointed out that his incestuous feelings for his daughter have been totally resolved, which was a great relief to him.)

Exploring his Relationship with his Father

His relationship with his father was explored. He says that he was not around to hug until the patient was seven, and after that he refused to hug him and remembers being told that "fathers did not hug sons." The therapist points out "you never had the taste of a tender, affectionate father-son relationship," "life has passed and the affectionate father-son relationship never was realized." He becomes more sad and says that must be the reason "I feel so good to hug my son, it feels so good to hug him," and his son reciprocates.

Exploring his Current Family

The therapist explores his current life orbit, which centers around his two children. Then he talked about his fear if something happens to them. The therapist explores his reaction and he said "I would become paralyzed . . . it would be a tremendous blow." Patient is sad and with a low voice said "Would I rage or . . . cry," "Yeah I think I would find it overwhelming, that loss." Then he added, "I would sob," "I would wonder whether I would have a rage against god," "I would go into shock."

Inquiry into the current family dynamics shows that there is a power struggle between mother and the children and indicates that the children handle it much better than he does, in particular his daughter. As the therapist must bring the initial interview to the end he must explore areas that so far have not been covered.

Inquiry into his Previous Treatment

The patient indicates that the conjoint therapy was totally unsatisfactory. It mainly focused on their system of interaction and how to bring about a better way of interacting on a day-to-day basis. What emerges is that he had negative feelings toward the therapist, and the way he dealt with it was taking a passive-compliant position with her. "At the time I just accepted it meekly, saying 'Well that seems reasonable', and so on." And finally she, the therapist, decided that his problem dates back to the "preverbal stage of my development," and she indicated to him that he needs long-term treatment. His wife decided that she wanted to continue in individual treatment with the same therapist. The therapist for a moment brings the transference to the focus.

TH: You see, in relationship with your wife, as well as Dr. X., you mould yourself and as you say it "I just accepted it meekly," and you complied and it is important . . . I want to make sure that . . . that has not been between you and me.

PT: I see what you mean. No, it is not.

TH: That you are doing it because you feel that this is important for you?

PT: Yeah. It's important . . . It is very important and I want to do everything that I can to overcome my difficulties.

Return to the Phase of Inquiry

Exploration into the developmental, medical and social history

The therapist begins by questioning, "Where were you born?" He was born in Eastern Canada, then the family moved towards the Midwest. As already indicated both of his parents left him when he was one. His father was an engineer before the war. After he returned from the war he worked as a manager in an apartment building. His earliest memory of life is of being left alone. In the early part of his life he lived with seven other children, his Aunt Elizabeth, two other aunts, his uncle, and grandmother Blanche. He comes with a memory that every morning he was put out into the street along with other children by his grandmother, as the uncle wanted to sleep. He comes with another memory as a little boy with a stick of wood and wanting to make a gun out of it. As a child he was shy, detached, passive, never a fighter, and didn't like other children. Then he talked about his grandmother Blanche, describes her as being highly controlling, demanding, critical and punitive both physically and psychologically, often with a vicious biting tongue that mobilized fear. Then he talked about Aunt Elizabeth, who was kind, affectionate. He came with vivid memories of her dressing him up, taking him by bus to the city where his mother was living. He has memories of her rocking him, as he used to cry a lot. During the interview he says "even right now here I can hear her voice telling me 'don't be afraid, don't be afraid'" and indicates that is what actually he does when he faces with a difficult situation at home, when things are falling apart, he whispers to himself and repeats to himself "don't be afraid, don't be afraid." In talking about Elizabeth he becomes sad, with tears in his eyes.

Then, in a sad state he talks about his brother, indicating that in the early years of his life he had looked up to him as a protector. Currently he has a detached relationship with him and refers to him as a man with a strong homophobia. In

talking about his closeness with his brother, there is a wave of sadness with tears in his eyes.

Further Dynamic Exploration

It is important to note that the unconscious therapeutic alliance is in operation. He is spontaneous, and very lucidly talks about aspects of his early life. In the following passage, he talks with a great deal of feeling about his brother as a protector and its link to his son.

PT: *I think that comes again from that feeling that my older brother was, was a protector.*

TH: *You know, when you talk about how you wish that you could have a physical closeness with your brother you become sad with tears in your eyes.*

PT: *Yeah.*

TH: *And when you talked about the physical closeness, hugging and holding with your son then also there were tears and sadness. Have you noticed that?*

PT: *Yes, definitely, I can see that.*

TH: *And immediately sadness and tears come. This raises the question if there isn't some connection between the two, that when your son hugs you and holds you, and he is quite taller than you, you might have some feeling about your brother that you looked up to as a protector, as you said.*

PT: *Yes, that's right.*

TH: *That a part of you has murderous feelings for him as we saw, but another part of you has positive... .*

In the following passage the process again moves to his father and the major gap within him about the father-son relationship, and the patient responded "the male connection too, yes."

TH: *In a sense there is a major big vacuum within you for the father-son relationship that died by virtue of the war or whatever, doesn't make a difference you see, and as you yourself said, you looked up to your brother as a protector, and when you talk about him in the early years you become sad and tearful. But there also, that relationship ended up in an exchange of rage as we saw the scissors incident that you were near to murder him. And now in your current life you are recapturing these elements in the relationship with your son. But still you have major mixed feelings.*

PT: *Hm hmm.*

TH: *Because when you talk about your brother, true a part of you has had murderous feelings, but at the same time what we can see is a part of you has a lot of positive huh?*

PT: *Very positive.*

Further Exploration into his Early Life

It is important to note, and this is always the case in trial therapy with patients with complex psychopathology with moderate to high degree of resistance as well as those who are extremely resistant, that the phase of inquiry and exploration into the developmental history becomes possible after direct access to the

unconscious has been achieved and there is a major weakening in the forces of the resistance with a strong mobilization of the unconscious therapeutic alliance. So far, the unconscious therapeutic alliance has made clear the two aspects of his feelings toward his brother, the murderous rage and guilt and his positive feeling as a protector. At the same time he has emphasized that his son is taller than he, and when they hug each other patient said, "it feels so good": and what we see is the link between his brother and his son, which later on becomes linked to his father, to which the patient refers "male connection".

Our knowledge about the father is not clear. But it is important to note that it is not the function of the trial therapy to cover all areas, particularly in a patient with as complex a psychopathology as this. This will be covered in the body of the treatment after a series of repeated breakthroughs into the unconscious take place. Now the therapist explores what he remembers about his father. "What happened when your father came back from the war?" He remembers getting dressed up and going to meet the train, but "I don't remember meeting him, all I remember is meeting the train and all the soldiers looking out of the window." He does not remember which train station it was. He remembers his Aunt Elizabeth being with him, along with his brother. Then he added "of course, I wouldn't recognize him"; and he further added "but I don't remember." "Do you remember the contact with him?" Patient answered "No I don't. I don't remember it at all," and added "I have no . . . totally blanked out."

After the return of the father, his mother returned and they moved into the same house. The family configuration consisted of the patient, mother, father, brother, two aunts and grandmother Blanche. The situation became very difficult. Then he talked about the conflictual years with grandmother Blanche, who was controlling, domineering and demanding, with a vicious temper, manipulating one against the other; and the patient refers to himself as the gofer. "There was a battleground." With bitterness he talked about Blanche, who put him down, was critical of him. "Don't do this, don't do that." No matter how he did it "still she would put me down," "She had a vicious biting tongue." He continues: "Uh, you left the toaster on."

The therapist is well aware that there are many aspects, or character traits, of his wife that are similar to those of his grandmother Blanche, and during the interview the patient becomes well aware of the similarities. At the same time, the therapist knows that access to his unconscious repressed buried feelings in relation to his grandmother requires another unlocking and systematic work on another major layer of resistance against the experience of murderous rage. As this is a trial therapy in the standard technique and the therapist has to accomplish the task of completing the initial interview, he should avoid further unlocking—which would turn the trial therapy into the process of treatment. At this point the therapist simply makes some further exploration about his grandmother.

Further Exploration of Grandmother Blanche

The Pathogenic Situation

TH: But you see one of the major problems that you have which you want to really start to look at; intellectualizing is a process that doesn't help one's feelings.

PT: I do a lot of it yeah.

TH: You see? You can intellectualize okay your father had to go to the war but still you have the feeling about it. Now your grandmother is critical, is demanding, everything has to be her way and so forth. At one level you can intellectualize, but the other side is to look to the feelings.

PT: Hmm.

TH: That she is critical, she's demanding, and she is running . . .

PT: Yeah . . . she's the headmaster . . . hmm, a malignant headmaster.

TH: On the one hand your mother . . . who, the way you describe, is like a dead person, your father is in the war and when he comes back he's not there neither.

PT: Yeah.

TH: Then you are left into a situation . . . your grandmother also is critical, "Don't do this, don't do that, don't move this way." You must have a lot of feelings towards her.

PT: They were anger, angry.

TH: Hmm. How did it express itself?

PT: I don't think it did, I think again I didn't express it.

TH: Hm hmm.

PT: I remember my brother expressing it.

It is important to note that the therapist, here, asks the patient how he expressed his anger; while during the major unlocking he repeatedly pressed for the physical experience of anger. The major reason is obvious. He has decided to terminate the initial interview and the process of bringing him in touch with his unconscious murderous rage is the task for the first few psychotherapy sessions, which is the phase of repeated unlocking. Return to the interview.

TH: So your brother was more assertive, bouncing back, and then you were the compliant . . .

PT: Yeah. The pattern, yes that's right.

TH: So then you took a beaten position with your grandmother as well.

PT: Yeah.

TH: The beaten position with her as well. As if in a sense the law that you set for yourself was set up from the very early years huh. Once beaten always the beaten hmm. Once crippled the crippled.

PT: Hm.

His grandmother died when he was 24. He avoided the funeral in spite of the encouragement of Aunt Elizabeth. Then spontaneously he talked about the similarity between Blanche and his wife. "The one thing that stands out, as I am talking about my grandmother, is the way my wife demands where things must be done in a certain way, and uh, like my grandmother, she comes down and says this plate is not put away." Patient with a high pitched voice and anger talks about his wife "It is not put away," "why isn't . . . why aren't people putting plates away?" "Why is the toaster in the middle of the counter?" Then patient says "When I look at it, that is my grandmother, no question about it."

PT: You mean there are patterns of behavior of your wife that is similar to the pattern . . .

PT: Very, very close.

TH: . . . of your grandmother and so forth?

PT: Yeah, very close.

TH: What you say is this, with your grandmother this had to be this way, that way, you had the rage and the anger and wiped it out and tried to be a goody-goody boy.

PT: That is right, with anger; but that is what exactly I do with my wife.

TH: Detached, compliant, silent and so forth.

PT: This is exactly.

TH: You see, I don't know if you remember when we met today and I asked you about your difficulties you said "I act like a child" . . .

PT: Yeah, that's right, that is the way I deal with my wife. This is the time to make love, this is the time to do this, this is the time to do that. Then I freeze. Then I fume and I push it aside and go paralyzed.

TH: But we saw under the paralysis is the murderous rage to throttle her to death.

In the above passage:

- (a) he clearly sees the similarity of the pattern of behavior of his wife to that of his grandmother;
- (b) once more the therapist drives home insight into the nature of the defenses that he has used in relation to his grandmother, and he responded that that is exactly what he does with his wife;
- (c) the significance of "I act like a child" becomes clear;
- (d) patient very clearly and explicitly indicates that "I fume" and the defense mechanisms that he uses "freeze", "go paralyzed";
- (e) and the therapist points out that underneath the paralysis is murderous rage to throttle his wife to death.

The therapist here is implying that his rage towards his grandmother must have that murderous quality; but as we see, technically, he leaves this for the first phase of the treatment, which consists of repeated major unlocking of the unconscious.

Consolidation; Bringing the Interview to a Close

At this point of the interview, as the therapist has decided to bring the interview to an end, he usually recapitulates some of the key points of the process; briefly summarizes what has been brought to the focus; explores the patient's feelings, particularly transference feelings; outlines a general frame of the course of treatment, and finally asks the patient if he is determined to do so. Return to the interview.

TH: So, you see, you have a major diffuse problem with life. Isn't that?

PT: Yes, indeed.

TH: You have a problem in relationship with people, you have suffered from many disturbances, such as anxiety, depression of which you are well aware.

PT: Yes . . .

TH: There are many problems; is not a new problem, it is a problem that is a life-long problem.

PT: Yes, I see that. It is misery.

TH: There is a need in you to go from one disastrous situation to another, which goes to the very early phase of life . . . throughout your life, hm?

PT: Hm hmm.

TH: But at the same time, obviously on one side you have made something out of this disastrous situation of the past, you have become an engineer.

PT: Yes.

TH: Yes . . . but the other side is a disaster.

The therapist once more recapitulates on the self-destructive aspect of his resistance and the masochistic component in his character.

PT: If we look to this pattern, what we see . . . there is a major problem which roots itself in the earliest phase of your life, and you have a lot of mixed and buried feelings in relation to many of these figures.

PT: Hmm.

TH: There are a lot of mixed and buried feelings that go back to the first year of your life which have carried on up to now, huh, okay?

PT: Hm. I can see that.

TH: As we have seen, there are many other problems; passivity, detachment, going to silence or going to defiance, becoming detached, remote, depression, and pain in the neck, huh?

PT: Yes.

TH: So there is this pattern that you have been carrying all your life, but you have not done anything about it. That is another issue . . .

PT: I . . . I've not . . . yeah.

TH: Because you are intelligent, you are an engineer, and you know that these major difficulties might even permeate and negatively affect your work . . . I don't know, they may not . . . anyway you have not done anything about it. You, yourself, have said that you are like "half-a-person"; but if you look at what we have seen so far, you are going from the frying pan into the fire, from one disaster to another.

PT: Yeah, but I want to change. I don't want to go to my grave a crippled man.

The therapist once more drives home insight into aspects of the dynamic forces that are responsible for the patient's disturbances, his masochistic character pathology, the perpetrator of his unconscious.

TH: That there is a need in you to suffer, this need in you to perpetuate suffering and misery, and all the mechanisms of dealing with the pain, murderous rage and guilt, which as we saw was toward your mother, and your brother, and also we saw toward your wife. We haven't explored your father or your grandmother yet. Do you follow me?

PT: Yes.

TH: And the way you dealt with this dilemma and the pathogenic situation has been to lose your autonomy, to give up your freedom.

Here the therapist is reemphasizing:

The breakdown of the nuclear family,
Abandonment and severe trauma,

The pain of trauma,
Unconscious murderous rage and guilt in relation to his mother,
Murderous rage and guilt in relation to his brother and wife (diagram).

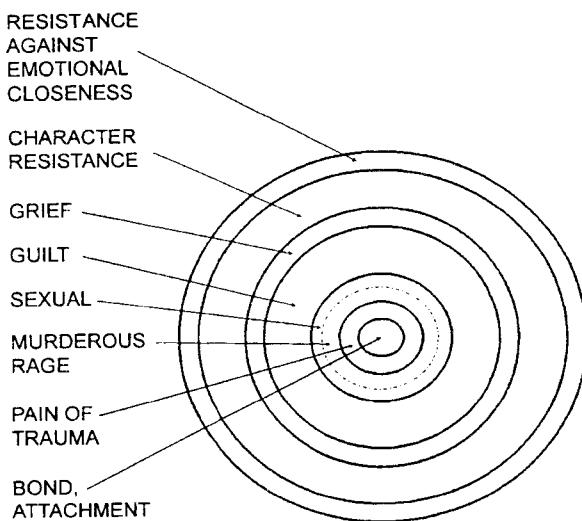


Figure 1. (Davanloo) Psychopathological dynamic forces.

The focus is on the guilt and punishment, and the therapist once more drives home further insight between the pathogenic situation of the past and his need to let himself be used and abused, self-defeat and self-sabotage. The response to these interventions are highly positive, and he further says that he wants to do everything to change, "I want to change and want to do everything that I can to free myself." Now we return to the very last part of the interview.

TH: *But do you think what we did today, which was touching the top of the iceberg, to say, if you do it more systematically, this would be of help to you, to resolve all of these mixed buried feelings from the past? Not only the top of it, the whole, and to become a free man with your own . . .*

PT: *I want to be a free man. I don't want to continue . . .*

TH: *You see, what I am looking at is this; we have touched the top of that iceberg but my question is this, do you want to do it more systematically . . .*

PT: *I want it all cleaned up. It frightens me as well, but you know, I, I don't wanna stop now. Cause you are right. I can see the pattern going on and on forever and that's just . . . I . . . am appalled that I have gone so long. I want to change. This session has been helpful in making that much more real, what has been building up and what I have started to see, and I can see that there is a part of me that doesn't want to solve it. And you have made it clear how . . . how deep and pervasive, I guess all those mechanisms that I use.*

The patient's response to the trial therapy is highly positive and indicates determination to work and liberate himself. Then the therapist brings in the

transference before he terminates. In the following passage he asks the patient how he feels towards him.

- TH: How do you feel toward me?
- PT: (laughs) How do I feel?
- TH: Part of you wanted to do away with me.
- PT: Yes.
- TH: What happened to that part?
- PT: Well . . . I don't wanna do away with you. (smiles) What happened to that part? It is gotten out, I . . .
- TH: It is not there anymore you mean?
- PT: Yes, that was quite an experience
- TH: So then what is the feeling?
- PT: Feeling. Well I feel close, uh, but not very close. If feel very . . .
- TH: Do you notice also you have difficulty about the issue of positive as well?
- PT: Yes. That has become very real today.
- TH: As if you are terrified to verbalize positive feeling.
- PT: Yeah, I can see that, and today it has become very real to me.
- TH: Now that we say goodbye to each other, is the net—if you put the positive negative, is the net positive or negative?
- PT: It's positive.
- TH: Hmm.
- PT: It's positive.
- TH: This is compliance or . . .
- PT: No. No. It is positive. This is really what I feel. It is hard but it is positive.
- TH: Hmm.
- PT: It has been painful, but at the same time it has been positive.
- TH: But before we say our goodbye another thing about you is you underestimate your potentiality, because let's to face with it, under extreme difficult circumstances of life you have made a profession for yourself, you have a family.
- PT: Yes.
- TH: And under very difficult circumstances of this meeting with each other we got to some of the very fundamental issues, which is the beginning of the road to the future.
- PT: Hm hmm.
- TH: But you have a tremendous tendency to underestimate your potentiality. Do you follow me?
- PT: Yes, I can see that.

Recapitulation

Here it is important to recapitulate the main technical interventions and the process of the initial interview—the trial therapy, which was presented in this two-part article. The process of the whole interview can be summarized as follows:

- (1) The interview started with the phase of inquiry, which was not productive.

- (2) The therapist introduced pressure on the resistance of vague generalization, asking for a specific example. This led to a rise in the transference and anxiety. The therapist introduced further pressure by focusing on his feelings. This led to further resistance in the form of a series of defenses. The resistance was tangibly crystallized in the transference. There was a gradual transition from pressure to challenge. The result was crystallization of the patient's character defenses in the transference, and the therapist systematically challenged the patient's character defenses and concomitantly made the patient acquainted with them.
- (3) From the psychodiagnostic point of view the therapist's conclusion was a man in his forties suffering from character neurosis and decided that a rapid unlocking of the unconscious is the procedure of choice and decided on his technique of a two-stage unlocking: partial, followed by a major unlocking in a single interview.
- (4) As already indicated, the process started with the phase of pressure on the patient's resistance. As soon as there was evidence that the resistance to some degree had become crystallized in the transference, the therapist introduced challenge to the resistance with further crystallization of the patient's character defenses in the transference and at the same time systematically made the patient acquainted with his character defenses.
- (5) Then the therapist's technical intervention consisted of his most powerful technique of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference.
- (6) This resulted in a partial breakthrough into the unconscious and major waves of painful feelings with the mobilization of the unconscious therapeutic alliance and a direct view of the psychopathological dynamic forces; being abandoned by both parents at the age of one year.
- (7) This was followed by a phase of analysis of the transference and consolidation.
- (8) Then the process returned to the phase of inquiry, which indicated that he suffered from diffuse symptoms and character disturbances. Now the patient was exceedingly responsive.
- (9) The therapist in search of a return of resistance undertook a dynamic exploration into the patient's marriage. There emerged that the only way he could have intercourse with his wife was to bring the mental image of a woman named Linda. Under pressure the unconscious therapeutic alliance described her as blond, blue eyed, slim, with small breasts and dark genital. This was the last communication of the unconscious therapeutic alliance as a major resistance was mobilized in the transference in describing Linda's body.
- (10) The therapist introduced challenge and pressure to the transference resistance, resistance against emotional closeness which further intensified the resistance.
- (11) The therapist mounted the challenge, which was followed by his technique of repeated short-range interlocking chain of head-on collision to the transference resistance. This led to frustration in the transference, and the patient declared, "Well I'm frustrated." This tactical defense was considered well entrenched in the major resistance, and there was considerable challenge and pressure. Then finally the patient declared, "I'm frustrated at you."
- (12) This led to anger in the transference, pressure to the physical experience of anger, with challenge and pressure, with repeated partial head-on collision aiming at a systematic weakening of the major resistance of repression which led to:
- (13) Major unlocking. The direct experience of a murderous rage in the transference. The impulse to murder the therapist by strangulation, the emergence of guilt-laden unconscious feelings and mobilization of the unconscious therapeutic alliance.
- (14) The unconscious transferred the murdered body of the therapist into the murdered body of his mother with the emergence of intense waves of guilt-laden unconscious feelings. Then the process entered:

- (15) The phase of a systematic analysis of the transference, followed by:
- (16) Major communication from the unconscious therapeutic alliance. The incident when he nearly murdered his brother: direct experience of murderous rage toward his brother with the breakthrough of intense waves of guilt. The process spontaneously moved to:
- (17) Death and funeral of his mother with the passage of intense waves of painful feelings. He came with the incident of the only 2 hours he had with his mother. Then the process entered:
- (18) Once more into the phase of systematic analysis of the transference and consolidation. Then the therapist made a dynamic exploration into this marriage, which led to:
- (19) Major communication from the unconscious therapeutic alliance. His murderous rage toward his wife, which led to:
- (20) Direct experience of murderous rage toward his wife; the passage of waves of guilt-laden feelings and the emergence of positive feelings for his wife. Then came:
- (21) Another major communication of the unconscious therapeutic alliance which clearly identified that the woman he brings to bed during intercourse with his wife is his daughter. This led to:
- (22) Another communication from the unconscious therapeutic alliance, his erection and incestuous feelings for his daughter.
- (23) As the initial interview is coming to an end, the therapist explores the patient's relationship with his father. There emerged an absence of a father-son relationship. In his early years he turned to his brother as a protector. Then the therapist made further dynamic exploration into his early life, which clearly indicates that after the breakdown of the nuclear family the patient lived with seven other children with his grandmother, a clearly pathogenic situation; and the therapist explored further. There emerged that she was both physically and psychologically abusive. He refers to her as a "malignant headmaster."
- (24) By now both the patient and the therapist have a much better view of the perpetrator of the patient's unconscious, namely the original trauma, being abandoned by both parents, and the subsequent disastrous traumatic situation with his grandmother. Here the patient introduced the link between his wife and his grandmother, saying that much of his wife's behavior is similar to that of his grandmother.
- (25) Then emerged a very important relationship, his Aunt Elizabeth. The data clearly indicates that she was a kind, affectionate woman who was like a substitute mother to him. Then the interview entered:
- (26) The phase of recapitulation, consolidation and finally exploring the patient's transference feelings, which clearly indicated his will and determination to change the course of his life. Around the end of the interview he clearly declares "But I want to change. I don't want to go to my grave a crippled man." Emphatically, he said, "I have got to change."

It is important to note that after the major unlocking of the unconscious the patient became exceedingly responsive and communicative. The process clearly indicates that the powerful unconscious therapeutic alliance has had total command of the process.

Summary and Conclusion

Here it is important to recapitulate the main technical interventions and highlight some of the important technical and metapsychological roots of my technique.

(1) I emphasized that the technique can be applied to the whole spectrum of psychoneurotic disturbances, no matter the degree of resistance. I summarized the features of patients on the extreme left of the spectrum—highly motivated, highly responsive, with a single psychotherapeutic focus. I emphasized a total absence of an unconscious murderous rage in this group of patients and further indicated that the nature of the resistance is very different than that of patients on the right of the spectrum. The course of treatment of one patient, the Case of the Salesman, was presented to demonstrate the extreme ease with which one can achieve therapeutic results.

(2) Then I emphasized some of the main characteristics of patients on the right side of the spectrum of psychoneurotic disorders and indicated that they suffer from life-long character neurosis, highly complex core pathology, are highly resistant; and in all of these patients there is the presence of an unconscious murderous rage or primitive murderous rage or a primitive, murderous, torturous rage and intense guilt- and grief-laden unconscious feelings.

(3) Then I briefly discussed the application of my technique to patients with severely fragile character structure, and pointed out: (a) they do not have the capacity to experience and tolerate anxiety. The discharge pattern of anxiety is heavily in the form of a major disruption of the cognitive and perceptual functions; (b) They have easy access to a spectrum of primitive defenses, explosive discharge of affect, poor impulse control, projection, projective identification and double protective identification, the phenomena of drifting and dissociation; (c) The unconscious murderous rage is extremely primitive; and (d) There is no discharge pattern of unconscious anxiety in the form of tension in the striated muscles.

Briefly, unlocking the unconscious within 30–45 minutes is contraindicated. My current data clearly demonstrates that this technique can be applied to the whole spectrum of patients with fragile character structure, and the course of therapy has a number of phases. The first phase aims at bringing about sufficient unconscious structural changes to enable the patient to withstand the impact of the unconscious. In this research I have clearly demonstrated that as a result of such structural changes, the discharge pattern of the unconscious anxiety shifts from cognitive and perceptual functions to anxiety in the form of tension in the striated muscles. Then the process enters the second phase consisting of repeated unlocking of the unconscious and the direct experience of the unconscious primitive murderous rage and guilt- and grief-laden feelings. By the second and third phases, the unconscious therapeutic alliance is at a very high level. I have called this the “optimum unconscious therapeutic alliance, dreaming while awake.” In this phase there is repeated breakthrough of a primitive murderous rage with guilt- and grief-laden unconscious feelings in relation to parents, sibling(s), and other early figures. Then the process enters the phase of multidimensional structural character changes. It is important to note that this treatment is highly effective in the treatment of this group of patients provided the therapist has extensive knowledge of the structure and function of the unconscious and is in tune with all the intricacies of the unconscious universe.

(4) Then four major techniques of unlocking the unconscious were presented: partial, major, extended major and extended multiple major unlocking.

(5) Then the dynamic sequences in the process of unlocking the unconscious were discussed, and it was indicated that these phases tend to overlap and proceed in a

spiral rather than a straight line, that these dynamic sequences can be seen as a framework which the therapist can used as a guide, constantly working from one phase to another.

(6) It is important to note that the phase of pressure may contain passing moments of challenge, but systematic challenge should not begin until the resistance has been tangibly crystallized in the transference. Then not only must the resistance be challenged but the patient's attention must be drawn to it and its nature clarified for him. Making the patient acquainted with his resistance is an essential part of the early process.

(7) Challenge consists of calling upon, countering, or blocking the resistance in such a way to convey an attitude of no respect for it. Challenge is a central intervention in my technique and is foreign to the therapist trained in psychoanalysis and traditional dynamic psychotherapy.

(8) It was emphasized that the course of an interview depends to a great extent on the rapidity of the development of resistance and transference feelings. Where these two factors are not detectable and are slow to develop, the therapist must move to the phase of pressure in a search for resistance.

(9) I emphasize that the transference holds a very important key position, and the therapist must watch with utmost vigilance for indications that the transference is becoming a major factor in the interview and should take note of it and act upon it. It is important to keep in mind that pressure from the therapist leads to resistance in the patient, resistance leads to challenge from the therapist. Challenge leads to a rise in transference feelings and increased resistance. This leads to further challenge by the therapist. Now the resistance becomes crystallized in the transference in the form of transference resistance. Then the therapist's intervention is head-on collision with the transference resistance, and this eventually leads to the patient's direct experience of transference feelings, mobilization of an unconscious therapeutic alliance, and direct access to the unconscious.

(10) In the process of direct access to the unconscious I emphasized the phase of intrapsychic crisis: a state of tension between two major forces, namely resistance and therapeutic alliance. The act of challenging the defenses with the conveyed lack of respect for them creates an extremely complex state within the patient, one in which the patient wishes to both hold onto his defenses even more strongly and also begins to turn against them. He becomes both angry and deeply appreciative of the therapist's relentless determination to help him. This creates a tension between the resistance and the therapeutic alliance.

(11) Then I presented the technique of head-on collision, with heavy emphasis on the technique of an interlocking chain of head-on collision with the patient's character resistance crystallized in the transference. I consider it one of the most powerful technical interventions. It has been an integral part of my technique and has been the by-product of a series of systematic research with the aim:

- (a) To block all the defenses maintaining the force of resistance.
- (b) To mount a direct challenge to all the forces maintaining self destructiveness.
- (c) To intensify the rise in transference feelings.
- (d) To mobilize the therapeutic alliance against the resistance.
- (e) To create a state of tension between the resistance and the therapeutic alliance.

- (f) To loosen the patient's psychic system; to change the situation from the dominance of the resistance to the dominance of the unconscious therapeutic alliance, which is the first breakthrough, and finally a partial or major unlocking in which there is major mobilization of the unconscious therapeutic alliance.
- (12) Throughout this two-part article I emphasize the triple factors: resistance, transference, and unconscious therapeutic alliance. The concept of the unconscious therapeutic alliance takes a very central position throughout the history of the development of my technique, and the way I have described it is fundamentally different from psychoanalysis or any other form of dynamic psychotherapy. In all resistant patients, and in particular those on the right side of the spectrum who are highly resistant with complex psychopathology, this dynamic force is not in operation; and the powerful force of resistance has paralyzed all the patient's major functions. It is the power of this technique via pressure, challenge, rise in the transference, intensification of resistance, further challenge to the resistance, a further rise in transference feelings, crystallization of resistance in the transference, head-on collision with transference resistance, which have been described in these two articles, which mobilize the unconscious therapeutic alliance against the forces of resistance. This powerful dynamic force first emerges in the form of tension with the resistance. Then we see a dominance of the therapeutic alliance against the resistance, which shows itself in the form of the first breakthrough, which demonstrates that the whole psychic system has been loosened and the balance between these two forces then moves in the direction of an increased therapeutic alliance. The degree of unlocking of the unconscious is exactly in proportion to the degree that the patient has experienced transference feelings and the mobilization of an unconscious therapeutic alliance. In a partial unlocking the unconscious therapeutic alliance is mobilized and has clear dominance over the force of resistance. In extended major unlocking the mobilization of the unconscious therapeutic alliance is at its optimum level. The task of the therapist in the first few psychotherapy sessions is to bring the unconscious therapeutic alliance to the optimum level.
- (13) One extremely important aspect to emerge from my research is the interrelation between the rise in the transference, mobilization of the unconscious therapeutic alliance, and resistance, which I summarize very briefly:
- (a) In cases of partial mobilization of the unconscious therapeutic alliance, the patient has frequent dreams with latent and manifest content.
 - (b) In cases of major unlocking and high degree of mobilization of the unconscious therapeutic alliance, there is passage of murderous rage in the transference with the passage of guilt- and grief-laden feelings; and finally the murdered body of the therapist is transferred to the early figure. These patients dream often. The latent and manifest contents of the dreams become closer, and the dreams are much more vivid.
 - (c) In the extended-major and multiple-major unlockings, which is the basis of my method of psychoanalysis, there is direct experience of the primitive murderous rage in the transference; but instantly during the passage the unconscious transfers the therapist to the genetic figure, which is then followed by passage of highly intensive guilt feelings, then grief. These patients do not dream. The unconscious therapeutic alliance is at optimum level, and they dream while awake. (This whole subject will appear in future publications.)

- (14) Another important aspect of the technique is that the therapist must have extensive knowledge of the pathway of unconscious anxiety in the form of tension in the striated muscles which starts from the muscles in the hands and spreads to the forearm, arm, shoulder, intercostal, back and legs.
- (15) Equally important is the somatic pathway of the direct experience of the murderous or primitive murderous rage in the transference. I have established that this pathway starts with the pelvis, then lower and upper abdomen, then chest, then moves to the head, shoulder, arm, forearm, and hand, which patients often refer to as a "fireball" or "volcano," "a buildup of heat moving upward."

Finally, in this brief exposé I want to say that I have unequivocally demonstrated that in all resistant patients with highly complex psychopathology a multidimensional structural character change is easily possible, but it clearly depends on the patient's direct experience of all the layers of unconscious primitive murderous rage and intense guilt feelings and eventually the experience of the pain of the very early trauma. Therapies that focus primarily on the experience of grief-laden unconscious feelings without direct and actual experience of the murderous rage and the guilt do not bring about structural character change.

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Management of Tactical Defenses in Intensive Short-term Dynamic Psychotherapy, Part I: Overview, Tactical Defenses of Cover Words and Indirect Speech

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In this two-part article the author presents the management of tactical defenses in his technique of intensive short-term dynamic psychotherapy (IS-TDP) as well as in his method of psychoanalysis. He describes the spectrum of tactical defenses. Part I primarily focuses on the management of the tactical defenses of cover words and indirect speech.

Introduction

I have already both presented and published the discovery of the technique of "Unlocking the Unconscious" and have demonstrated that this provides opportunity for both the therapist and the patient to have a direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances. I have described a powerful technique of intensive short-term dynamic psychotherapy (IS-TDP) as well as the highly powerful method of psychoanalysis. I have emphasized that the technique can be applied to the whole spectrum of psychoneurotic disturbances as well as those with fragile character structure.

Briefly, the major features of the patients on the extreme left of the spectrum are: high degree of responsiveness; single psychotherapeutic focus; absence of the unconscious murderous rage; and the nature of the resistance is very much different than that of patients on the right side of the spectrum.

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I have outlined some of the main characteristics of highly resistant patients within the spectrum and indicated that all these patients demonstrate a highly complex core pathology and there is the presence of major trauma, the pain of the trauma and reactive murderous rage or primitive murderous rage and intense guilt- and grief-laden unconscious feelings. In all of these patients we see the presence of the major resistance.

The "central dynamic sequence" in the process of unlocking the unconscious and the technique of handling major resistance have been described. The dynamic sequence consists of a series of phases: inquiry; pressure; challenge; transference resistance; direct access to the unconscious; and systematic analysis of the transference.

Here I will summarize some of the important features of the technique:

- (1) Pressure leading to rise in the transference and to resistance in the form of a series of defenses.
- (2) Challenging the resistance; heavy crystallization of the patient's character defenses in the transference; transference resistance.
- (3) Mounting the challenge to the transference resistance; head-on collision with the transference resistance.
- (4) Rapid breakdown of the major resistance and direct access to the unconscious.
- (5) To loosen the patient's psychic system and to change the situation from the dominance of the resistance to the dominance of the unconscious therapeutic alliance, which is the first breakthrough into the unconscious.
- (6) The most impressive fact in this whole transformation is reorganization of the unconscious and optimization of the unconscious therapeutic alliance.
- (7) With direct and optimum experience of the transference feeling and optimum mobilization of the unconscious therapeutic alliance we see the passage of the murderous rage or primitive murderous rage in the transference; the transfer of the murdered body of the therapist to the murdered body of the mother, father or brother, etc; with the instant passage of the intense guilt-laden unconscious feeling; in this whole process the patient is in direct relationship with his or her early biological figure.
- (8) I have described a new concept of transference. In contrast to all other forms of psychoanalysis, here we don't have any traces of the transference neurosis.

It has been emphasized that in patients suffering from psychoneurotic disorders, from the very early phase we should maintain predominantly our focus on the process rather than on the structure of the psychic system. But in patients suffering from fragile character structure, in the early phase we should maintain our focus on the structural pathology and then on the process. I have further indicated clearly that the therapists who want to work with this technique must have a comprehensive knowledge about the *new metapsychology of the unconscious* which I have introduced over the course of 30 years of systematic research.

Having given some general overview, now I want to focus on one of the important features of this powerful technique. Rapid mobilization of the unconscious mobilizes what I call "tactical" defenses and this has been presented in a large number of symposia, courses and other publications. It is essential for the therapist to be absolutely familiar with these tactical defenses used by the patient in the service of resistance so that he can be ready, when

appropriate, to challenge each one the moment it appears. They show an extraordinary uniformity across a wide range of patients.

Defense and Resistance

I have freely used these two terms without explicitly making clear the relation between them. These can be very easily defined as follows:

- (1) Defense is any mechanism used for the avoidance of the true feeling.
- (2) Resistance is the use of such defenses in the therapeutic situation.

Continuum of Tactical and Major Defenses

These two categories of defense form a continuum, and any attempt to draw a sharp distinction between them would only result in hair-splitting. In highly resistant patients, those with complex pathogenic unconscious, tactical defenses are aspects of major defenses and they can be considered the frontline defensive structure of the major resistance. While in patients with no major resistance, the resistance predominantly consists of a series of tactical defenses.

For example, the case of the "sister-in-law", a man in his twenties, married, who suffered from obsessional neurosis from the extreme left of the spectrum of the resistance, when the therapist inquired about the physical appearance of his sister-in-law:

TH: How would you describe your sister-in-law in terms of physical appearance?
PT: Physically she is a very attractive girl, very well built.

The therapist asks the patient to be more explicit.

PT: Hm hmm. In what way?

What happens now is of immense importance to anyone learning the technique. The patient showed his resistance by using a series of *tactical defenses*. These are not major defenses such as repression, projection, etc. Nevertheless, they are almost universal and appear over and over again in different patients, often in a regular sequence, as a response to pressure from the therapist. It is essential both to be able to recognize them immediately and to know how to handle them.

Now let's take another patient, this time from the mid-left of the spectrum of the resistance. He described an incident that he and his wife had quarrelled a few days before the interview. The therapist questioned him about his feeling toward his wife and he responded:

*PT: "I must," "maybe" I am feeling resentful...
 I "must" be resentful.*

By such devices the true experience of the feeling can be largely avoided. In interviews with patients, these kinds of devices are encountered again and again—the use of indirect and hypothetical phrases such as "maybe," "I think,"

"I guess," "I suppose," "sort of" provide as cover words to avoid or weaken an open declaration of something painful or anxiety-laden, and when the therapist puts pressure and challenges these defenses a stronger word may appear in their place, but the therapist should not necessarily be satisfied for such tactical defenses might be used to avoid the actual feelings.

As I have already mentioned, tactical defenses may be aspects of the major defenses and in patients with major resistance they can be considered the front-line defensive organization of the major resistance. This can be illustrated by focusing on the very early part of the interview with a young man in his thirties. He entered into the interview anxious, which had transference implication. The therapist exerts pressure towards his feeling:

TH: Let's to see how you feel about your coming here and seeing me.

PT: I felt nervous.

TH: That is one, what else?

PT: Uhh.

Here, anxiety is a defense against the underlying feeling and the therapist exerts further pressure "What else do you feel besides anxiety?" This immediately gives rise to the patient's transference feeling and mobilization of resistance. He puts his head down and says:

PT: I don't know, I don't know what my feelings are uhmm...other than feeling nervous about it and the nervousness comes from...

Now we see mobilization of the tactical defense of *diversification*, which is immediately blocked with pressure to the underlying feeling.

TH: Now you move to where the nervousness comes from. My question is what else do you experience besides nervousness?

Now the patient spontaneously introduces anger, but immediately also moves to *diversionary tactic* "my need to..." which is immediately blocked and then there is mobilization of the tactical defense of *retraction*.

PT: Uhmmm...I'm trying to think of anger, anger over my need to...

.....

PT: Well I don't know if I'm angry or not.

Then he again declares anger but with *diversionary tactic*.

PT: Yes I'm angry, at myself.

TH: You say you are angry but then you move and say you are angry at yourself. First let's to establish are you angry or aren't you angry, then second we go to ...

PT: Yes.

The therapist exerts pressure on the actual experience of the anger and he moves to another tactical defense "*invisible frown*." The therapist challenges this "that is a sentence," and exerts pressure to the actual experience of anger. The patient then moves to the tactical defense of *passive-compliance*. Then another tactical defense emerges, "*I don't know*."

PT: What are we going to do about it? I don't know.

TH: "I don't know" is another helpless position.

The results in further intensification of the resistance crystallized in the transference with the emergence of *defiance*.

PT: You're asking me to give you words that will satisfy your question. I don't . . .

.

PT: The anger I'm experiencing now is towards you. I don't wanna talk about it anymore.

What the therapist has done is exerting pressure to the underlying feeling, the anger, and this immediately mobilized a set of tactical defenses such as diversionary tactic, retraction, passive-compliance, vagueness, rumination etc. Each of these defenses was immediately challenged; immediate rise in the transference feeling; intensification and crystallization of the front-line character defenses in the transference. The therapist's pressure to the experience of anger immediately reactivates the unconscious defensive organization against the patient's unconscious murderous rage towards his sister, to a much higher extent towards his mother and to a lesser degree towards the father as well as intense guilt- and grief-laden unconscious feelings as well as the very center of his unconscious psychopathological dynamic forces: the attachment; the trauma; the pain of the trauma; reactive murderous rage; and subsequent traumas.

The therapist must always take into consideration that the two categories of the defense, tactical and major, form a continuum. The continuum can be illustrated by a frequently used defense of 'not remembering.' At one end, the patient may use the tactical defense of pretending that he can not remember something of which he is fully aware but which he does not wish to admit to the therapist; at the other end, he may genuinely be unaware of something held at bay by the major defense of repression; while in the middle are all gradations of not wanting to admit something to himself, which involves repression to a greater or lesser degree.

These two articles describe, with clinical examples, the categories of the tactical defenses most commonly encountered. The first article would address two major categories of commonly used tactical defenses, the tactical defense of cover words and the tactical defense of indirect speech. The second article would focus on the wide range of other tactical defenses that the therapist might see in the course of the work with their patients.

The Tactical Defense of Cover Words

Call defense in question

Challenge defense in question

This tactical defense is frequently encountered. The patient uses a weaker, watered-down word for the one he doesn't wish to say. Of all types of tactical

defense of cover words, those expressing anger and murderous rage are the most frequent. The following are examples: "upset me," "bothered me," "humiliated," "embarrassed," "unhappy," "frustrated," "annoyed," "irritated," "aggravated," "confusion," "uncomfortable," "dislike" and "pissed off."

Cover words	Intervention
" "	"'I felt terrible' is just a sentence."
" "	"You are back again to the issue of 'embarrassed.'"
" "	"You are helpless to tell me what your inner experience was."
" "	"Do you notice you are totally incapable of telling me how you felt?"
" "	"'Embarrassment' is just a word. It doesn't tell us how you felt."
" "	"What is that? What is 'confusion'?"
" "	"You use the word 'confusion' for being uncomfortable?"
" "	"Now you move to 'confusion.' Still we don't know how you experience your anger."

The following are a few examples to illustrate the tactical defense of cover words.

Masochistic Woman with Brutal Mother

When she entered into treatment she was 30 years old, divorced and suffered from masochistic character pathology, episodes of depression, diffuse anxiety, and major disturbances in interpersonal relationships.

PT: I notice you are using the word "crippled" again . . . well she could walk with a walker, but she was "handicapped."

Here again the avoided word was too explicit because it would face the patient with the reality of what had happened to her grandmother, and her infinitely painful and guilt-laden feelings about it.

Tactical Defense of Cover Words for Anger

As already mentioned there are a wide range of tactical defenses used to avoid the expression of anger, rage, violent rage and murderous rage; they can be classified into a number of broad categories. We should keep in mind that in a large majority of patients suffering from character neurosis, particularly those on the right side of the spectrum of resistance, the anger itself is a cover word to avoid the unconscious murderous rage and intense guilt-laden unconscious feeling. Here we focus on the range of tactical defense cover words used to avoid anger.

Describing Distress Rather than Anger

"Upset," "agitated," are tactical defenses against anger. This is one of the commonest tactical defenses encountered in the therapeutic situation for avoiding the experience of anger. If underneath the anger there is violent rage or murderous rage, the person who is angry avoids by converting it into an appeal for sympathy.

The Case of the Hyperventilating Woman

At the time of the interview she was in her twenties, suffered from chronic anxiety, conflict in her marriage, conflict with members of her family and frequent attacks of hyperventilation.

PT: ...and then I had a conversation with my sister which "bothered" me a lot, and then for the next few hours I hyperventilated quite badly.

.....

PT: Yes, it "upset" me quite a bit.

In the second interview she described her husband's neglect:

PT: He'd come home from school at 3 o'clock. We'd have supper together and then he would have to go out again.

TH: And how did you feel toward that?

PT: That "upset" me a lot.

TH: Let's look at your feeling.

PT: "Disappointed."

The degree to which these words were being used as a cover for her real feelings may be judged from the obvious spontaneity of the following passage, which emerged after challenge and work on the transference.

PT: I was angry and I felt he was unfair. When finally I got the courage to tell him he was unfair, he didn't agree. I was angry because one of the first things we had ever said was that in our marriage we would have communication; and he kept promising me, "If it's too much, I'll give the drama group up." I told him in the first couple of weeks of our marriage it was too much. He said, "Well we'll give it a try." I told him again it was too much. He didn't see it was too much...

Again I emphasize that here the anger to which she admits now by itself is a defense against her unconscious murderous rage, which in subsequent unlocking became her mother. She saw her mother in the entrance of her bedroom dressed up in a white coat, like a nun, with a butcher's knife in her hand wanting to murder her (projection) and in the following week she experienced intense murderous rage with the visual image of having murdered her mother with a butcher's knife and mutilated the upper-middle chest of her mother and there was the passage of intense guilt-laden feeling. It is on that basis that I would say that anger here is a cover word and has a defensive function.

The Case of the Real Estate Lawyer

When she entered into treatment she was 37 years old, married, and suffered from mild episodes of depression, anxiety, problems in interpersonal relationships, problems with her boss, marital conflict and a wide range of characterological problems.

This patient had been subjected to an extremely cruel practical joke by one of her male colleagues. This had been done to her at an office party in front of the entire staff. The patient could only describe her embarrassment and humiliation, while going to extraordinary lengths to avoid any description of anger.

TH: *And how did you feel?*

PT: "Stupid" and "embarrassed."

.....

TH: *What did you think?*

PT: *I was so "humiliated." I didn't think at all.*

.....

TH: *And then what else did you experience?*

PT: "Embarrassment."

TH: *Yes, but in terms of the inner feeling, what type of feeling?*

PT: *Let's see, "embarrassment," "shame."*

TH: *That is just words. It doesn't tell us how you felt.*

PT: "Terrible."

.....

PT: *...it's still an "open wound" "a little bit."*

.....

PT: *I was "not happy," let's put it that way.*

.....

PT: *I was "very unhappy" at that point.*

After a great deal of work on the therapist's part, the word "angry" did eventually creep into the patient's responses. She then proceeded to intellectualization, saying that on a scale of 1-10 she was "probably" "8 degrees angry."

TH: *What was that 8 degrees of anger like?*

PT: "Confused."

Here again the anger that she admits to, but at the same time intellectualizes it, is a tactical defensive organization of the major resistance. Underneath is a highly primitive murderous rage and guilt feeling in relation to her father and then her mother, both were alcoholics, highly explosive and physically as well as psychologically traumatizing.

Describing Anxiety Rather than Anger

Since many patients do in fact experience anxiety when anger is potentially aroused in them, the description of anxiety rather than anger is a defense that comes readily to hand. This is one of the major features of all character neurotics. Most of them don't experience anger; what they experience is anxiety which is in the service of the major resistance. Here I describe two examples:

The Case of the Manageress

She suffered from diffuse symptoms and character disturbances. She is describing an incident that she was angry at her mother. When pressed for the experience of anger she only could describe anxiety:

PT: All of a sudden I became so angry towards her and I just became very "agitated" and "nervous" and I wanted to...
 TH: What was the way you experienced your anger?
 PT: I just became very "agitated" and "nervous" and I wanted to...

.....

PT: Yes, and hatred towards her when she told me that.
 TH: But how did you experience the anger?
 PT: I felt very "agitated" inside.
 TH: What do you mean agitated inside?
 PT: "Nervous," I started getting "nervous" and "agitated."

The Case of the Man with Violent Dreams

When he entered into treatment he was 30 years old and suffered from symptom and character disturbances. The trial therapy started with the phase of pressure as he was anxious when he entered the interview.

TH: Let's to see how you feel about your coming here and seeing me.
 PT: I felt "nervous."
 TH: That is one, what else?
 PT: Uhh.

The therapist exerts pressure to the underlying feeling and then he declares anger in the transference.

TH: Now you say you feel, you feel angry, let's to see how you experience your anger.

Here again we see another example of the tactical defense of describing anxiety rather than anger and what emerges after a number of unlockings is a primitive murderous rage toward the mother and toward the sister. This is a universal phenomenon in all these patients suffering from character neurosis and it is a major mistake if the therapist thinks that all what the patient is defending against is anger.

Further Examples to Illustrate the Tactical Defense of Cover Words for Anger

The Chess Player

At the time of the initial interview he suffered from diffuse symptoms and character disturbances.

TH: *You say that your supervisor was a pain, he was demanding, he pushed you around. But how did you feel toward him?*

PT: *I felt "frustrated."*

.....

TH: *But how did you feel toward this man who was pushing you around?*

PT: *I eventually felt "hostile" toward him.*

Further pressure produced hints of death wishes and subsequent breakthrough into the major resistance unlocked his unconscious murderous feeling; first towards his sister, then towards his mother and we equally saw violent rage, but to a lesser degree, toward his father with intense guilt. Again we can reemphasize that the whole set of defenses such as "frustrated," "hostile," "anger," "death wishes" are tactical defenses of the major resistance in relation to the volatile murderous rage and guilt- and grief-laden feelings in relation to their biological figures.

The Hyperventilating Woman

In the following passage the patient steadily retreats from the idea of anger; first to "irritation" and then to "upset":

TH: *Have you ever thought of it like that? That there might be a connection between the anger and hyperventilation?*

PT: *I didn't think of it in terms of anger. I thought of it in terms of "irritation." "I guess" sometimes I realized that I got very "upset" after my mother phoned me every day.*

The Manageress

This patient has been describing an incident with her mother:

TH: *You said that the discussion was around pickling and the jars, and you were in such anger with your mother.*

PT: *Yes, and "hatred" towards her when she told me that.*

Further pressure and challenge.

PT: *I wanted to start telling her all kinds of things that I felt towards her.*

TH: *You mean you wanted to verbally...*

PT: *Yes, yes. Sometimes I wanted to "hit her," sometimes I feel I want to "kill her"...*

To "kill her" by itself is a defense as she actually is not experiencing her murderous rage toward her mother with intense guilt-laden unconscious feeling.

The Case of the Butch

When he entered into treatment he was 26 years old, suffered from diffuse symptoms and character disturbances. The session is focusing on his feeling in the transference:

PT: "Confusion."

TH: What is that? What is "confusion?"

PT: Confusion is...

TH: What is the way you experience your confusion?

PT: Uh... "uncomfortable."

PT: Yeah.

TH: So you use the word confusion for being uncomfortable?

PT: Hm hmm.

Pressure on the actual experience of the discomfort led to another defense "dislike." Then when there was pressure on the actual experience of the dislike there was mobilization of the tactical defense of rumination which was challenged. Then he declared being frustrated:

TH: And I question you how do you experience this dislike? You are not really answering how you experience that. You ruminate with a sentence.

.....

TH: You feel frustrated with me?

PT: Yeah, right now...

TH: Okay. Now what is the way you experience your frustration?

PT: I feel I am not able...

There is mobilization of the defense of rumination and diversification and the therapist exerts further pressure for the actual experience of the frustration. Then he declares:

PT: I am getting a bit, I'm getting a bit "aggravated."

TH: Aggravated?

PT: Yeah, "mad," a bit "mad."

TH: You feel mad?

"Confusion" as a Tactical Defense of Cover Word

This defense functions in the service of resistance in the form of diversification. It particularly comes into operation when there is a rise in transference feelings.

Case of Man with Foggy Glasses

When he entered into treatment he was in his forties, married and suffered from heavy drinking, chronic anxiety, episodes of depression, problems in interpersonal

relationships, marital conflict, sexual problems as well as major characterological problems. He had entered the interview with anxiety in the transference. The focus of the session was on pressure to experience his annoyance toward the therapist.

PT: I am a little "confused" because...

TH: Now you move to confusion. Still we don't know how you experience your annoyance.

PT: I'm tense, I'm trying to "explain."

The first defense, "confused," followed by the second, "because," wanting to give explanation. This often can function in the service of diversification; and often the therapist might explore the confusion, and the process totally moves away from the transference. This form of diversionary tactic is important to be identified. Here the annoyance is a tactical defense of cover word against violent rage, murderous rage; and that is the reason that the therapist's simple pressure to experience annoyance in the transference reactivated the tactical defense center which in this case is the major resistance against the patient's murderous rage and guilt.

The following is another example of confusion as a tactical defense of cover word.

The Real Estate Lawyer

The focus of the session was on the experience of her anger and the patient used the cover word "confusion."

TH: You say you are 8 degrees angry and I question you how you experience this anger, and now you say "confused."

PT: Okay, "when" "a person" is very angry or "when" I'm very angry...

The following is another example of tactical defense of cover word.

The Case of the Microphone Man

When he entered to treatment he was in his forties, suffering from long-life character neurosis with diffuse symptom disturbances. He described an incident that he felt mad:

PT: I felt "mad," I felt "aggravated."

Therapist's intervention: call upon the defense; ask for actual experience of aggravation.

TH: "I felt mad" is a sentence, "I felt aggravated" is a sentence.

.....

TH: How did you feel?

In the same interview the patient had described an incident with his landlord who slammed the door on him and the therapist focuses on his feeling:

PT: Well, "annoyance."

.....

PT: Oh, "very annoyed."

Anger as a Cover Word for Murderous Rage

As I have already mentioned, the anger is the very surface of a major column of murderous rage in one or multiple direction in relation to the early figures. This can be illustrated by the following case:

The Case of the Auto Mechanic with Somatization

When he entered into treatment he was 44 years old, suffered from chronic anxiety, sharp chest pain, pain in his neck, problem in his marriage and episodes of explosive discharge of affect in relation to his wife. All medical investigations were negative.

In the first four sessions there has been major unlocking of the unconscious with the passage of the murderous rage in the transference, and the transfer of the therapist to his father who was a traumatizing figure throughout his early life. He also came in touch with the actual experience of his murderous rage toward his wife, which also became transferred to his father with the passage of intense guilt. In the fifth session, he entered into the interview anxious:

- PT: *Well on my way here this morning I... (sigh) ...*
- TH: *How you feel right now?*
- PT: *Well I'm... I'm uh upset and...*
- TH: *Upset means what?*
- PT: *I'm "angry" at ...*

He has frequent deep sighs and the therapist focuses on his anxiety:

- PT: *Yeh. I'm anxious. Yeah I think I know exactly why I'm anxious too, but it has to do with something that just happened in traffic and ...*

He indicates that he has been anxious following a traffic incident before the interview:

- PT: *It is some insight I gained into how mad I got. How this therapy is going toward my "anger" and how the...*
- TH: *You see you talk about anger.*
- PT: *Yeah.*
- TH: *But we know so far it has been murder.*
- PT: *I know that's the part that produces ...*
- TH: *But do you notice you use cover words?*
- PT: *Yeh because it's anxious to say I'm a murderer and that is becoming more ...*
- TH: *But you use cover words. You know what cover words mean?*
- PT: *Yeah I know.*
- TH: *And a while ago you covered the anger by the word upset.*
- PT: *Yeah.*
- TH: *Do you notice that?*
- PT: *Yes, yeh.*
- TH: *So instead of you saying angry you say I am upset.*
- PT: *Yeah but I didn't wanna come in here and say I felt like murdering the woman because she cut me... well she cut me off.*

Tactical Defense of Cover Word for Emotional Closeness

Many patients defend themselves as strongly against positive feelings as against their negative feelings and they put up a wall against any form of emotional closeness. In some patients, resistance against emotional closeness is much more extensive. The center of this resistance lies within the center of the pathogenic dynamic forces of the unconscious, namely the bond, the trauma, the pain of the trauma, reactive murderous rage or reactive primitive murderous rage, intense guilt, grief, character defenses and the resistance against emotional closeness. On the basis of this, when the therapist focuses on this resistance, it might mobilize a set of tactical defenses to divert the therapist. An example:

Masochistic Woman with Brutal Mother

The therapist is focusing on the patient's facade and barrier in the transference:

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

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

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

PT: *Closeness?*

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

PT: *Uhh...*

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

PT: *Yes.*

.....

In the following passage the patient has become increasingly sad:

PT: *Sad.*

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

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

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

PT: *I'm trying to let go.*

TH: *You want to control.*

In the following passage the patient moves to the tactical defense: "I don't trust you:"

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

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

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

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

Patient's tactical defense is swept aside:

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

Then she moves to another tactical defense "make fun of me:"

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

The patient's tactical defense is again swept aside:

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

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

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

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

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

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

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

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

TH: So it has been more with men?

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

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

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

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

The point to emphasize here is that there are a set of tactical defenses that might come into operation when the therapist focuses on this major resistance. Here, we saw a few: "I don't trust you," "you make fun of me," "you reject me."

Cover-Words: "Silly," "Stupid," "Funny," "Dumb."

This form of tactical defenses such as "it was a funny situation," "I know it was stupid," or "silly," "I felt dumb," "I felt stupid," "I felt no good" are commonly encountered. The following will illustrate:

The Case of the Machine-Gun Woman

She suffered from episodes of clinical depression, sexual difficulties and characterological problems. She had seen a therapist who had decided that the major aspect of her problem that needed treatment was sexual difficulties. The treatment consisted of her laying down on a couch; the therapist was on the other side of the room with a curtain separating them from each other. The therapist would play music on a tape and the patient was masturbating with her clothes on and fantasizing.

PT: He had me doing various exercises "I guess."

TH: *What do you mean "guess?"*
(Tactical defense of indirect speech)

.....

TH: *And what was your fantasy?*
PT: *It was... it was more tied into the tape and I can't remember what the tapes were. I found the whole thing "silly."*
TH: *But now let us not call it "silly."*

The focus is on the situation that developed in her previous therapy in which she passively complied with her therapist's decision and ended up by being exposed to humiliation which was itself an expression of characterological problems; inability to assert herself, and the tendency to enter into situations in which she is used and abused.

TH: *You go yourself on your own will, but then the focus is on sexual problems which you have okay?*
PT: *Uhmm.*
TH: *But you say that 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."*

The following is another example of the tactical defense of cover word in a patient who wants to communicate that he may lose control over his violent rage.

The Case of Henry-IV Man

At the time of the initial interview he was 28 years old, married, suffered from symptoms and character disturbances.

The patient had been describing a confrontation with his wife and her lover:

TH: *Was your fear that you might do something drastic?*
PT: *Yes, or that I might lose my... "my reason," "or something."*

Cover Words, Rumination Ask for explicit statement

Case of Salesman

When he came into treatment he was 26 years old, married, suffered from mild obsessional neurosis of recent onset and problems with concentration.

TH: *How would you describe your sister-in-law in terms of physical appearance?*
PT: *Physically she is a very attractive girl, very well built.*
TH: *Hm hmm, in what way?*
PT: *Er... well: she is very pretty, she has a "big chest" ... the rest of her body is nice.*

Here the patient clearly felt that the word "breasts" was too explicit, the deep reason for this being that it led in the direction of his feelings about his mother.

Blanket Words**Challenge defense in question**

An example is a situation that mobilizes violent rage and the patient's response is using blanket words "I was very shocked," "backing up mentally," "pissed off mentally."

The Case of the Cement Mixer

At the time of the initial interview he was married and suffered from diffuse character and symptoms disturbances. He described an incident that he was enraged with his wife. The therapist is exerting pressure for the actual experience of the anger:

PT: I was "very shocked."

TH: That doesn't say how you experienced your anger.

PT: I was "backing up mentally."

TH: Still that doesn't say how you actually experience your anger.

PT: I felt an "empty, lonely space."

Jargon Words**Challenge defense in question***The Case of the Chess Player*

When the therapist questioned him about his difficulties he said "devastated and depressed."

The Tactical Defense of Indirect Speech; Hypothetical Ideas**Make explicit****Challenge defense in question****Call defense in question**

In interviews with patients this form of tactical defense is encountered very frequently. For example, "probably," "maybe," "I think," "I guess," "I suppose," and "sort of" to avoid the true experience of feelings, open declaration of something painful or anxiety laden. The technical interventions consist of call the defense in question; challenge the defense in question.

Indirect speech**Interventions**

- "I suppose so." "Why 'suppose?' You said he was a pain in your neck."
- "Sort of." "Again, 'sort of?' You see...you want to remain indefinite."
- "Probably." "Why 'probably?' Either you were angry..."
- "I guess we probably." "You see? Again you leave it in a state of limbo."
- "I guess so." "You 'guess so?' "
- "I think maybe, I must be feeling resentment." "You leave it in a hypothetical way...'think,' 'maybe'..."

The following examples illustrate this form of defense.

The Case of the Masochistic Engineer

A young man suffering from diffuse symptom and character disturbances. The focus is on his conflict with his son, and the therapist puts pressure on his feeling in relation to a recent incident:

TH: *How did you feel?*

PT: *I "think," "maybe," "I must," "perhaps" felt resentment.*

The Chess Player

TH: *You said that you wished that your supervisor would be out of your way? You mean he would disappear in your life?*

PT: *"I suppose so."*

The Henry-IV Man

The patient had been describing the incident that he was enraged with his wife:

PT: *My wife is a frail, I should say very girlish young person, "sort of." I never became physically violent with her, and the only thing I did "sort of," was that I gave her two slaps on the face at that time.*

The Masochistic Housewife

When she entered into treatment she suffered from diffuse symptom disturbances and major characterological problems.

PT: *Yes, "I must" feel resentful or angry toward him.*

The Real Estate Lawyer

PT: *I "probably" was angry.*

PT: *"I'm sure" "I must have been" angry.*

PT: *The "probability of me being angry..."*

The Salesman

PT: *"I guess" we "probably" could have had time for intercourse.*

PT: *I have always been "sort of" attracted to that (i.e. breasts).*

PT: *"I think" it was that that attracted me about my sister-in-law.*

PT: *"I guess," "you could say," my wife is a small-breasted woman.*

.....

PT: *"I guess" it seemed to me that my brother used to be able to stay up later than I did at his age, "you know."*

TH: *Your mother was more lenient with him and more strict with you?*

PT: *"I guess" "you could say" that, yes.*

PT: Yeah right. "I guess" so. "I guess" he was the favorite. "I guess" he was then but . . .
 TH: And you were right after him to fight, and you were seven years older.
 PT: "Possibly" right.

Masochistic Woman with Brutal Mother

TH: Could you give me one of the fantasies?
 PT: Uh, being raped, "in a way."
 PT: I relive the fantasy many times until I feel. "I guess," either "somewhat" disgusted with myself, or physically satisfied "in some way."
 TH: And what do you do while you have this fantasy?
 PT: "I think" I'm touching myself.
 PT: I'm nude or at least my genitals are showing "in some way."

The Hyperventilating Woman

Repeated attacks of hyperventilation occurred quite clearly in the context of situations that mobilized anger in her. The therapist eventually raised the question if hyperventilation is a mechanism of dealing with the underlying anger in relation to her mother:

TH: In other words the question is whether the hyperventilation is a way of dealing with the emergence of this anger, and then also getting depressed?
 PT: "Could be."

The Case of the Butch

A man in his twenties suffering from character neurosis. The interview started by him indicating that he had a warm feeling for the first evaluator, who was a female therapist, and he had feelings about the change. The therapist immediately focuses on the patient's warm feeling for the first evaluator. This immediately mobilized a set of tactical defenses, avoidance:

PT: Yeah "I guess so."
 TH: "I guess so" hmm. Do you notice you're avoiding me?
 PT: Yeah.
 TH: So could we look into that?

PT: Yeah "I guess so."
 TH: You "guess so?"

The Man with Foggy Glasses

The focus of the session is on his feelings toward the therapist:

PT: "I think," "maybe," "I must" be feeling resentment.

In the interview with patients, this kind of defense is encountered again and

again. The patient explicitly uses anxiety-laden words but incorporates them into indirect speech so that the impact is nullified. The following are some of them "I guess," "Probably," "Perhaps," "I think," "I guess you could say," "I must," "the probability of my being angry," "Sort of," "Somewhat," "I assume," "I must have been angry," "I think I am feeling resentful," "I think maybe I am feeling resentful."

The Strangler

A man in his forties, married, suffered from episodes of depression, anxiety, marital problems, conflict in interpersonal relationships and a wide range of characterological problems.

He entered into the initial interview anxious. There was pressure toward his feeling which mobilized a number of tactical defenses. In the forefront were "guess" and "perhaps."

- TH: *How do you feel right now here?*
 PT: *Not too bad, uh I'm, I'm having difficulty thinking clearly so I'm a bit... I "guess" I'm a bit ah, a bit nervous.*
 TH: *I say how do you feel right now? You say "you guess."*
 PT: (small laugh) *I feel nervous.*
 TH: *You feel nervous. Then why you say "guess?"*
 PT: *It's a way I have of speaking, "I think" I say that a lot.*
 TH: *You mean that you are not definite about...*
 TH: *But you have to say "it seems" that you are nervous, as if you are not...*
 PT: *Hmm.*
 TH: *Hmm?*
 PT: *That's, that's certainly what comes out all right.*
 TH: *Hm hmm, that you are always indefinite, or is here with me?*
 PT: *Am I always indefinite? (low voice)*
 TH: *You know what I mean by indefinite? That you say "perhaps, guess."*
 PT: *Yeah, I see what you mean.*

The Case of the Masochistic Secretary

When she entered into treatment she was in her thirties, suffered from episodes of clinical depression and long-life character neurosis. In the early part of the interview the therapist is focusing on her feeling toward her husband:

- PT: *"I think," "I guess," "perhaps" I do have some sort of resentment toward my husband.*
 TH: *Why do you say "perhaps"? Either you do or you don't.*

The Man from Southampton

When he entered into treatment he was 47 years old, married and suffered from a wide range of symptom and characterological problems. The therapist focused on his sex life:

- PT: *I "think" my sex life was not satisfactory.*

The Woman with Fainting Attacks

At the time of the initial interview, she was 43 years old, single, suffered from diffuse anxiety, panic attacks, fainting attacks and disturbances in the interpersonal relationships. She has been indecisive about getting help for herself. In the very beginning of the initial interview she indicated that she has been thinking about getting help for herself for the past 5 years. The focus of the session was on her indecisiveness and she indicated that she had mixed feelings about getting professional help. The therapist focuses on her feelings:

TH: So you have postponed to get help for yourself for some years.

PT: Yes

TH: Then you must have a strong feeling about getting help for yourself.

PT: I, "I guess," "I think" "I must" have feeling.

TH: But you say you "guess" and you "think."

PT: Well, because I've...

TH: I mean, either you do or you don't.

The Case of the Masochistic Woman with Migraine Headaches

When she entered into treatment she was 48 years old, divorced, suffering from almost daily attacks of migraine headaches, chronic state of anxiety, and major conflict in interpersonal relationships with a pattern of letting herself be used and abused by men.

PT: "I assume," "I must" be depressed, first of all it is a loss, secondly it is a letdown.

.....

PT: "I would say," "maybe" it is a depression.

The Case of the Microphone Man

A man in his forties, divorced, suffering from a wide range of characterological problems and major conflict in the interpersonal relationships with both men and women. To the question if his interpersonal difficulties are more with men or with women he responded:

PT: Uhh, "I think," "possibly" with men more.

He had described an incident where his girlfriend had kept him waiting and he was outwardly passive but indicated that he was in a boiling rage.

TH: Do you think passivity was a defensive way of dealing with this boiling rage inside?

PT: "Probably."

TH: "Probably" again. You are again in a state of limbo.

Later on he wants to describe an incident that he had a high degree of rage inside.

PT: Well, the worst situation, "I suppose," was the night ...

TH: Again "suppose."

TH: Do you notice ... you are leaving things in a state of limbo "yes perhaps," "may be," "I suppose."

The Case of the Maid with Dermatitis

When she entered into treatment she was 35 years old. She was referred by her gynecologist because of frequent dermatitis in her genital area. She suffered from a compulsion of washing her vagina repeatedly after each sexual relation with her husband and was frequently seen by her dermatologist as well as by her gynecologist. During the trial therapy the focus was on her feeling towards her husband:

PT: "Perhaps" I do have resentment ... my husband.

TH: Why do you say "perhaps?" Either you do or you don't.

Later on she declares anger and the therapist is exerting pressure to the actual experience of the anger.

PT: "May be" I have anger toward him.

TH: Again you say "may be." Do you feel angry or don't you?

.....

TH: How do you physically experience the anger towards your husband.

PT: I could "perhaps" kill him.

TH: But that is a thought, that is a sentence.

Summary and Conclusion

In this Part I of a two-part article I briefly described a powerful technique which aims at rapid mobilization of the unconscious, loosening the patient's psychic system, reorganization of the unconscious and changing the situation from the dominance of the resistance to a major dominance of the unconscious therapeutic alliance. I emphasized that the optimum mobilization of the unconscious therapeutic alliance against the forces of the resistance is one of the major aims of the therapist. It was emphasized that the therapist's comprehensive knowledge about the new metapsychology of the unconscious is essential to accomplish the task. Then I indicated that one of the major features of the technique is that it mobilizes what I call tactical defenses in the service of resistance.

In the first part of this two-part article two major sets of tactical defenses were discussed; namely the tactical defense of cover words and of indirect speech. A series of cases were presented as clinical examples. Part II of this article will focus on the wide range of other tactical defenses with case examples.

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Management of Tactical Defenses in Intensive Short-Term Dynamic Psychotherapy, Part II: Spectrum of Tactical Defenses

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Recapitulation

In Part I of the present article I described, very briefly, a technique of intensive short-term dynamic psychotherapy (IS-TDP) and emphasized that it can be applied to the whole spectrum of psychoneurotic disturbances as well as those with fragile character structure. Some of the major features of the technique were described which can be summarized as follows:

- (1) The technique of direct access to the unconscious; unlocking of the unconscious was briefly described.
- (2) The major aim of the technique; to loosen the patient's psychic system and to change the balance from the dominance of the resistance to the dominance of the unconscious therapeutic alliance was presented.
- (3) I further indicated that the most impressive fact in this whole transformation is reorganization of the unconscious; optimization of the unconscious therapeutic alliance; total breakdown of all the forces maintaining the major resistance; creating a situation which we may call 'Dreaming while Awake' which heavily speeds up the process and finally results in multidimensional structural character changes.
- (4) I emphasized that the therapist who wants to work with this technique must have a comprehensive knowledge of the new metapsychology of the unconscious which I have introduced over the course of 30 years of research.
- (5) It was emphasized that rapid mobilization of the unconscious mobilizes what I call tactical defenses. It is essential for the therapists to make themselves familiar with these tactical defenses used by the patient in the service of the resistance so that they can challenge each one the moment it appears.
- (6) The spectrum of these tactical defenses shows an extraordinary uniformity across the wide range of patients.

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- (7) The continuum of tactical and major defenses was discussed and Part I heavily emphasized on the management of two sets of tactical defenses namely cover words and indirect speech, and a series of cases were presented.

In Part II of this two-part article I continue to discuss the management of the spectrum of tactical defenses commonly encountered. An attempt will be made to present a series of case examples.

Rumination

**Make explicit
Ask decision, call defense in question
Challenge defense in question**

It is encountered in a variety of patients, its central characteristic is an element of intellectual repetitiousness, of going over and over some subject, often with an air of doubt and apparent searching for the truth, which in fact is being used to avoid the emotional impact of the truth.

Rumination

- ” “You are giving a description ‘that doesn’t make sense.’ How did you experience your annoyance?”
- ” “‘Stupid bloody doctors’ is again a sentence, but what was the way you experienced this annoyance?”
- ” “‘A stupid situation,’ ‘I felt heated,’ ‘I felt bothered’ doesn’t tell us how you experienced your annoyance.”
- ” “What do you mean by ‘unfinished task’?”
- ” “‘I know myself.’ You are ruminating on that. That doesn’t tell us anything.”

The following are a few examples.

The Case of the Salesman

Suffering from obsessional neurosis from the extreme left of the spectrum.

TH: *You mean the breasts? She's a large-breasted woman?*

PT: *Yeah. I think that is what...I don't know...I have always been sort of attracted to that.*

.....

PT: *I guess because he was the youngest, sort of thing. So I guess I used to think that he got more, or really he didn't. But...*

.....

PT: *Yes, I guess he was then but...We are looking at it then...Okay...favorite?...favorite? He was the favorite because he was the youngest.*

The Hyperventilating Woman

Some aspects of the interview with this patient were presented in Part I.

TH: *Was there a similar feeling with your husband for ignoring you? Were you angry with him?*

PT: *Well it wasn't anger. Or maybe it was. Or maybe I don't know what anger is.*

.....

The interview focused on her male teacher, who appeared in her recurrent dream.

PT: *At the time I thought I loved him, but I really just...*

TH: *You mean you loved him in what sense? You had sexual feeling for him?*

PT: *Yeah, but...*

TH: *But you say it in a hesitant way. Did you or didn't you?*

The Chess Player

The following is a passage from the interview with the "chess player", a segment of which was presented in Part I. It gives a striking illustration of obsessional rumination in which every sentence is factually true but which nevertheless blocks emotional communication. In the last sentence the intellectualization is heightened by the use of words that are hardly ever found in everyday speech:

PT: *I am defensive. I am aggressive. I become more defensive when I feel threatened. I am more threatened when I feel more worn down and less able to deal with situations which are confronted. And my "aggressivity" comes out in ways that I am not as "privy to" as I would like to be...*

Vague Rumination

Make explicit Pressure, challenge

Tactical defense of vague rumination is encountered frequently: "I am a little confused about that," "I don't understand you right," "Here we go again," "I felt okay," "I felt fine," "I felt myself running from myself," "I am feeling confused," "I felt ridiculous" and "I feel out on a limb." The following are a few examples:

Case of Man with Foggy Glasses

A segment of the interview with this patient was presented in Part I. The therapist is focusing on how the patient experiences his annoyance toward him, and the patient responds with a vague rumination—"that doesn't make sense."

PT: *Well I said to myself uh you know to me "It doesn't make sense."*

TH: *But that is a sentence.*

(Pause)

TH: You say you were annoyed but then I said how did you experience this annoyance. Now you are giving a sort of description: "that doesn't make sense." How did you experience your annoyance?

Further pressure on his feeling of annoyance mobilizes further tactical defenses—"stupid bloody doctors."

PT: Well in my...in my mind I said uh you know "stupid bloody doctors."

TH: "Stupid bloody doctors" is again a sentence, but what was the way you experienced this?

In addition to vague rumination there is the tactical defense of generalization, "doctors," avoiding to address the transference directly and the therapist immediately challenges that:

TH: How did you experience this annoyance? In terms of thoughts, was stupid bloody doctors...but then you also make it plural, doctors.

TH: Who is the stupid bloody...?

The Case of the Microphone Man

Which was discussed in Part I. Focusing on the experience of his annoyance toward his landlord:

PT: Well by a "feeling of heatedness" I guess.

.....

PT: I felt "bothered" and "burdened."

.....

PT: I felt "heated."

.....

The therapist questions him on the actual experience of the annoyance and he responds:

PT: "Stupid situation."

.....

The Case of the Bee-Bee Gun Man

When he entered into treatment he was in his thirties, married and suffered from diffuse symptoms and character disturbances. In focusing on the nature of his problem he said:

PT: Trouble with coping with everyday situation...Negative situations.

When the therapist asked for a specific example he responded with:

PT: Work not up-to-date. Car trouble...things like that.

Attempt to understand the nature of his difficulty, he responded by saying:

PT: Any unfinished task.

Intervention: Attempt to make the statement explicit

TH: And my question is this, what do you mean by "unfinished task?"

Masochistic Woman with Migraine Headaches

Aspects of the interview with this patient were presented in Part I.

PT: Would you give me an example? How I should express myself that we get to the point quicker.

TH: Hmm. Again that is vague...to get to the point. Which point?

In the same interview the therapist reflects on the patient's resistance against emotional closeness.

TH: How did you feel?

.....

TH: You don't want me to get to know you. You have a problem talking about yourself.

PT: I don't know what is really "the real self."

TH: Hmm. Do you notice you have a tendency to label?

PT: I am learning that right now. I sometimes think I know myself.

TH: You see again you are ruminating on that. That doesn't tell us anything.

The Case of the Butch

A segment of this interview with this patient was presented in Part I. The therapist is putting pressure to the actual experience of the anger towards his partner:

PT: What I felt...a "rushing feeling" of a, of a hate, of a feeling of a hate for the guy.

TH: Now you move to the "rushing feeling of hate" which is vague. You said that you felt angry towards him. How did you experience the anger.

PT: (stutters) If that is not anger I don't know, I don't know what anger is.

TH: Let's not to ruminate on what anger is. How did you physically experience the anger you felt.

The Man from the United Nations

When he was first seen, he was 54 years old and suffered from long-standing irritable bowel syndrome. He was referred from the coronary intensive care unit where he was admitted because of severe chest pain. He had a quarrel with his daughters and he was enraged, walked out of the house with an explosive discharge of affect. Shortly after that he had severe chest pains and had to be admitted, with no organic findings. During the initial interview the focus was on his feeling:

TH: How do you feel here, right now?

PT: I... "I clam into myself."

TH: That doesn't say how you feel. So let's see how you feel here with me?

PT: "I feel my life died."

.....

PT: "I feel confused" ... "confusion."

Intellectualized Rumination Challenge the defense

The Case of the German Architect

A man in his thirties suffering from major characterological disturbances and masochistic character traits. In the early part of the interview, the therapist is focusing on the patient's difficulties, the phase of inquiry. He is vague and then moves to ruminate in an intellectualized fashion:

PT: No, I'm not, I'm simply explaining that umm ...

TH: Now you are becoming slow.

PT: I beg your pardon? No, I'm trying to say that umm, it becomes a more "plausible thing", ah, with a more "plausible cause" when you realize ...

TH: Yeah, but you see this is very vague, you see you say the, still the question that I had was what seems to be the difficulties and so far you are in a sense ruminating in a vague fashion on the ...

PT: No, I'm not, I've definitely said I have a problem with commitment, and that very much came home when I discovered the same problem elsewhere in people related to me who have the same background, ah ...

TH: So one problem that you have has to do with commitment.

PT: Yes, but don't forget that of course it took me many, many years to even realize that I had a problem there. I mean I've been plodding in the dark for almost as long as I've been alive. Ah, which brings up another point, maybe I have a problem with feelings.

Rationalization

Ask for explicit statement Challenge, dismiss the defense

Rationalization

"

"

Intervention

"You see again you are not talking about feeling.

Again you move to 'because'."

Rationalization—the Word "Because"

The word "because" is likely to introduce a rationalization.

The Case of the Salesman and his Sister-in-law

The focus is on his mother's favoritism of his younger brother:

PT: *...he was the favorite "because" he was the youngest.*

TH: *Let's not get to "because."*

Rationalization that the Anger is Unjustified

Rationalizing away angry feelings is to find excuses for the other person's action, leading to the feeling that the anger is unjustified, keeping in mind that the anger by itself is a tactical defense against violent rage or murderous rage.

The Masochistic Housewife

Aspects of the interview with this patient were presented in Part I.

Here the subject under discussion was the way she is passively compliant with the demands of both her mother and her husband:

PT: *Yes, I do get angry with my husband. But then I tell myself, "What can he do?"—my mother dominates him as well.*

The Case of the Hyperventilating Woman

The subject is her husband's neglect of her:

TH: *Yes, but you see again you are not talking about your feelings.*

PT: *Well, I felt angry but I wasn't sure that I was justified.*

TH: *No, let's not get into the intellectual aspect of it. Let's look at your feelings.*

Intellectualization Make explicit, challenge

All defensive intellectualization consists of thinking rather than feeling.

Intellectualization Intervention

- " "If I had been a male...now you want to move to intellectualize."
- " "Still you haven't told me about your problems and now you want to intellectualize about where the problem comes from."
- " "You have not told me the dream, and now you are analyzing it."

The Case of the Real Estate Lawyer

A segment of the interview with this patient was presented in Part I. In the following passage in which she is still trying to avoid experiencing her anger, she

uses generalization, hypothetical ideas, cover words, while the whole passage consists of a theoretical discussion about the nature of her reaction:

PT: "When" blood surges there "has to be" "some sort of" emotional...there "must have been" a tremendous...there was an "emotional reaction" "for sure," "otherwise I would not" blush, my ears wouldn't get red.

Thinking Rather than Feeling

As I have mentioned before, all defensive intellectualization consist of thinking rather than feeling, but there is a type of defense of which this description is particularly appropriate: instead of reacting emotionally to a situation the patient makes some intellectual judgement about it. In the following example the patient avoids her intense feeling of rage by using the much more cognitive concept of curiosity and follows this by using yet another cover word.

Real Estate Lawyer

PT: *I just felt very "embarrassed."*

TH: *But you see it is not absolutely clear how you felt.*

PT: *I was "curious" as to who had done it, because at that point I was very "shocked."*

Intellectualization and the Word "If"

The word "if" will almost certainly be used to introduce some defensive intellectualization.

Real Estate Lawyer

PT: *I guess "if" I had been a male and someone had done that to me my reaction would have been...*

TH: *No, let's not move to if you were male.*

In the same interview the focus was how she felt about an incident:

PT: *Well it has made an impact, otherwise eight or 9 months later I would not still be...*

TH: *No, let's not go after that. Let's see how you felt.*

PT: *Okay, "if" I say I definitely was angry I would not be telling the truth, because at that point I didn't sort of mentally remark to myself all the feelings that I had, I mean I didn't analyze it. (Intellectualized rumination)*

Intellectualization, Cover Words

Henry-IV Man

A segment of the interview with this patient was presented in Part I. In the following segment the focus is his mother, who had had an affair with a friend of the family:

- PT: I felt first of all it was "shocking" that my mother...something must be wrong with her.
- TH: Did you feel rage with your mother?
- PT: Yes. I really felt that she's...I really put the world of people in two categories, people who are straight and people who have...
- TH: Did you feel rage with her?
- PT: Yes, I felt rage with her.

Intellectualization and Diversification

The Woman with the Fainting Attacks

A part of the interview with this patient was presented in Part I. In the following segment the therapist is exerting pressure to describe one or two incidents of her fainting attacks. First, she resorts to the defensive weepiness when she wants to move to intellectualize into the cause of her fainting attack and diversify from giving a detailed description of her actual fainting attack, which is anxiety provoking.

- TH: I mean to go to what is the cause of passing out is not going to help. It is very important for us to explore one or two incidences when you passed out that we can get a better picture of what it is like.
- PT: That's why I'm crying because it's it's difficult for me to talk about it. Okay I'll describe it.
- TH: Most recent one would be best.

Finally, she describes in detail two of her major fainting attacks.

Generalization

Make it specific Challenge the defense

As I have emphasized many times, the ultimate aim of every intervention that the therapist makes is to bring the patient to the direct experience of his feelings. Direct experience inevitably implies feelings about something specific, which is why the therapist asks the patient to describe a specific incident or to concentrate on his feeling at a particular moment, including the here and now. The patient resists this pressure by keeping his responses as general as possible continuing to describe general situations or make generalizations about his feelings instead of describing them in an actual situation—and the therapist's task is to ask for a specific situation or incident.

Generalization

- "
- "
- "
- "
- "
- "
- "

Intervention

- "Could you give me an example?"
- "But that is vague and general."
- "We are not talking about a 'person'. We are talking about you."
- "But, you see, you are not specific."
- "Could you give me a specific example?"

The Chess Player

TH: So your sister's relationship with you is a hostile one.

PT: Her relationship with "everybody" is a hostile one.

TH: But we are focusing on you.

The Bee-Bee Gun Man

When asked to give an example the patient continues to talk about general situations.

PT: I won't commit myself unless I'm sure of something.

TH: Could you give an example?

PT: I like "everything" done right.

TH: Yes, but that is vague and general.

PT: Whether I work on the house, whether I work...

The Case of the Manageress

A segment of the interview with this patient was presented in Part I. In the following passage the patient generalizes in response to the question 'What was it like?' The session was focusing on her anger toward her mother:

PT: I started fighting with her immediately, the moment she said that.

TH: What was it like when you were fighting with her?

PT: Well, we've had very big fights "all the time," and screaming back and forth.

TH: What was the way you wanted to lash out physically?

PT: Well, I feel like hitting her "sometimes" because I feel she doesn't react.

It is important to keep in mind that certain words "all the time" and "sometimes" in the patient's responses, indicate that he/she is not describing a specific moment but making a generalization about events over a period of time. The same function is served by the words "usually," "a lot," and by the word "when" when occurring at the beginning of a sentence. The therapist can be alerted, since it will almost certainly introduce a generalization.

The Case of the Hyperventilating Woman

The patient is describing a series of dreams she had had at one time about her teacher:

PT: Those were the dreams when I thought at one point I loved my teacher. "Most girls" fall in love with their male teachers, I think, but...

TH: Let's not get to "most girls." Let's focus on you.

The Real Estate Lawyer

In response to a question "what was that eight degree of anger like?" the patient used the cover word "confused." The therapist challenged this by simply pointing it out, and she responded by using two different forms of

generalization: the repeated use of the word "when," accompanied by the use of the words "a person" as a substitute for making a direct statement about herself. This latter kind of generalization, which includes the use of the word "one" as a substitute for "I," is also used frequently.

TH: You say you are 8 degrees angry and I question you how you experience this anger, and now you say "confused."

PT: Okay, "when" "a person" is very angry or "when" I'm very angry... "When" I'm very angry I don't think rationally.

The following responses of this same patient, to the implied question of why she was smiling at a particular point in the interview, also contain both forms of generalization:

PT: Okay "when" "people" tend to giggle for no reason... Smiling "usually" indicates happiness, comfort... "When" I smile it's a reaction which I give to "people" generally. I smile "a lot" for no reason.

"Usually," "all the time," "sometimes," "when," "one" as a substitute for "I," "a person," "a lot," "I feel frustrated," "I feel somewhat irritated," "I feel angry," "I had positive feeling." These are some of the most common forms of generalization encountered. It is of great importance to note that the therapist might often use these same defenses. For example, the patient might declare that he is frustrated and the therapist responds "How do you experience the frustration." The patient's frustration or anger is directed at the therapist but generalizes it in the form of being frustrated. Clinician's attention to these tactical defenses is extremely important. Some of these tactical defenses are well entrenched into the major resistance. The therapist should take into consideration that in a large number of character neurotics, frustration by itself is a tactical defense against anger and anger is a defense against violent rage, murderous rage or primitive murderous rage and intense guilt-laden feeling in relation to the murderous rage which in turn is connected with the trauma and the pain of trauma. Repeated bypassing of this form of tactical defense makes the access to the murderous rage and the guilt toward the early figure impossible. The following example illustrates this form of tactical defense and its management.

The Case of the Strangler

When he entered into treatment he was in his forties and suffered from diffuse symptoms and character disturbances. During the initial interview there was pressure toward his avoided feeling in the transference. There was clear evidence that his character defenses were crystallized in the transference and he declared frustration:

PT: I feel frustration.

TH: You feel frustrated with me. Is this what you say?

PT: I feel frustrated, that's what I'm saying.

TH: You feel frustrated at who? Again you are crippled, to say your are frustrated... is a cut-off sentence. "I feel frustrated" is a cut-off sentence. Frustrated at who?

PT: I'm...

TH: Again you're crippled, frustrated at who? Your hand again.

PT: I'm frustrated.

TH: Frustrated at who; First let's to establish at who are you frustrated. Now your head goes there, your hand goes there...

PT: (makes growling sound) Orrrrrh...

TH: ...and then you move toward this crippled position. Frustrated at who? You said you are frustrated, frustrated at who?

PT: Do I have to be frustrated at someone?

TH: At who are you frustrated?

Technically, the therapist should not exert pressure to the actual experience of frustration in the transference until this tactical defense is managed. The therapist continues systematic challenge to this tactical organization of the major resistance. Now the patient moves to the defense mechanism of denial "I am not frustrated at anybody:"

PT: I'm not frustrated at anybody.

TH: Do you notice how crippled you are? You say you are frustrated, but at the same time you don't want to really spell out at whom you are frustrated. Look to your hand. Now you are fidgeting.

PT: Hm hmm.

TH: "Hm hmmm."

PT: (laughs)

TH: At who are you frustrated? Let's first establish that. You have a tendency to flight, you have a tendency to run away from any issues.

PT: Yes.

In the following passage there is head-on collision with the defiance, deactivation of the transference, and emphasizing the consequences of maintaining the resistance in the transference.

TH: You have done it 46 years of your life, and if you want to do it you can do it and go to your grave.

PT: No, I don't want to do it.

Often the tactical defense can be well entrenched with the major resistance and should be considered as such. As we see, the process is on systematic challenge to this defense "generalization;" "Do I have to be frustrated at someone." The challenge in the above passage has further intensified the rise in the transference, and the therapist monitors it via unconscious anxiety in the form of tension in the striated muscles. He had deep, sighing respiration, the rate of which has increased and which clearly indicates to the therapist that the rise in the transference feelings is in the upward position. It should be emphasized that it would be a major mistake for the therapist to explore the patient's feelings. The therapist well knows that the nature and the degree of the resistance and the complexity of the psychopathology are extremely different from those patients who are placed on the left or the extreme left of the spectrum of psychoneurotic disorders. We return to the interview where we had left it.

TH: So let's see at whom you are frustrated.

(Pause) (Further challenge to generalization)

Again you are terrified at looking at my eyes and declaring.

PT: (deep sigh)

TH: Again your sigh. Do you notice your hand? You are totally crippled to look at my eyes and tell me at who you are frustrated. Because frustration refers to something negative huh?

PT: Yes.

TH: But you are paralyzed to look to my eyes... Let's establish at who are you frustrated?

Finally, in the following passage he declares "I am frustrated at you:"

PT: I am frustrated at you.

Now the therapist proceeds and exerts pressure to the actual physical experience of frustration in the transference and the process moves to pressure, challenge and composite form of head-on collision and finally to major breakthrough into the unconscious, his murderous rage toward his wife, his mother, his father and his brother with intense guilt and then grief-laden unconscious feelings.

Diversionary Tactics Block the defense

Diversionary tactic is a frequently used tactical defense, most frequently used in the early part of the trial therapy during the phase of rise in the transference when the forces of the resistance are still in a dominant position in relation to the unconscious therapeutic alliance. Definitely when the process enters to the phase of optimum mobilization of the unconscious therapeutic alliance against the resistance, one would not see the emergence of this form of tactical defenses.

Diversionary tactics

Intervention

- " "I questioned you, how did you experience the annoyance?
Now you are moving to something else."
- " "Do you notice I questioned you about the experience of
your resentment toward me, but you are avoiding my
question and want to talk about your childhood."
- " "We are focusing on your brother right now, you
repeatedly want to bring your sister into it."
- " "Let's focus on yourself first."

Case of Man with Foggy Glasses

When he entered into treatment he was in his early forties and suffered from a wide range of symptoms and character disturbances. He entered the interview with anxiety which had transference implication; started the session wanting to talk about his conflict with his wife regarding the issue of drinking in the garage, behind her back, using the diversionary tactic to avoid his feeling in the

transference. The therapist blocks the defense and focuses on his anxiety, his frequent deep sighs and what emerges is that he has feelings about having been on the waiting list:

PT: I had "called" back and I got no reply, I got no reply so . . .

TH: Let's to see how you felt about that.

PT: I was annoyed quite frankly.

TH: Annoyed?

PT: Annoyed. I mean I said to myself . . .

Diversification was blocked.

TH: You mean you were annoyed and that is past or you are annoyed?

PT: No I was annoyed at that time.

TH: Not anymore you mean?

PT: Uh no, when I called back and you know there was an immediately kind of reply.

TH: So what you say is this; you were annoyed but you are not annoyed anymore.
So that is the case you mean?

PT: Yes.

.

TH: How did you experience your annoyance?

PT: Well I said to myself uh you know to me it doesn't make sense.

TH: But that is a sentence.

(Pause)

TH: You say you were annoyed but then I said how did you experience this annoyance. Now you are giving a sort of description: "that doesn't make sense." How did you experience your annoyance?

The Case of the Microphone Man

In focusing on actual experience of annoyance there was mobilization of the tactical defense of diversification and the therapist's intervention is calling upon the resistance and blocking the diversionary tactic:

TH: Could you tell me how did you experience this annoyance?

PT: Well through . . . through two or three different mediums I think, one was . . .

TH: I questioned you how did you experience the annoyance? Now you are moving to something else.

The Case of the Butch

The focus of the session was on being "frustrated" and "aggravated" which immediately was followed by being "mad" toward the therapist, and the therapist was exerting pressure for the actual experience. He immediately uses diversionary tactic.

PT: I . . . I've never been through something like this. I . . . there is . . .

Here, the patient wants to diversify and the therapist immediately blocks it and brings him back to the actual experience of his feeling in the transference, which eventually leads to the breakthrough of the impulse in the transference.

The Case of the Manageress

The focus of the session is her problem with anger "it surfaces very easily" and the therapist asks her for a specific example:

PT: Well, I can give you an example of when I visit my parents. For some reason I try to, like, speak to my mother. She's always very nice and everything, but somehow just invokes this anger in me and I just remember all kinds of things from my childhood.

Intervention: therapist exerts pressure on the resistance, "could you give me a specific example in the current, most recent time?" Later on the focus was on her anger toward her mother. She described a recent incident when she was very angry but suddenly moved away and diversified speaking of a past situation that was highly significant. As I have indicated before, the therapist must vigilantly avoid this form of diversification, which is a trap, even if the content is highly significant.

TH: Could you give me a specific example in the current, most recent time?

PT: I spoke to my mother last week and she said, "I'm not pickling very many things because I don't have any jars," and I said to her, "Well, you can go and buy jars," and she said, "No, we don't buy jars, I don't have any jars," and I immediately became very angry and started fighting with her because... what it symbolized for me is that when we were young they neglected us, they never wanted to pay for anything.

The therapist blocked this diversion and brought her back to the recent incident, which led eventually to her murderous feelings toward her mother.

Chess Player

The focus is his brother:

PT: Yes, I have a recollection that my brother and I fought like hell, like cats and dogs all the time.

TH: Fighting like cat and dog.

PT: Wait, not just with my brother, with my sister too.

TH: I know, but we are focusing on your brother right now, hmm? You repeatedly also want to bring your sister into it.

Masochistic Woman with Brutal Mother

A segment of the interview with this patient was presented in Part I. The focus is on the patient's earliest memory:

PT: The first time my mother hit me,

TH: Hm hmm.

PT: I also remember ...

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

The Case of the German Architect

The initial interview started by the therapist questioning him about the nature of his difficulties. He was vague and the therapist's attempt was to make him more specific. Then he said "I guess it is uh... commitment." Then he moved to diversify and generalize and the therapist immediately blocks it:

PT: It seems to be very difficult and it seems to run in the family and since I've discovered that, uh that all my brothers and my sister have that problem ...

TH: Yeah but let's to focus on yourself first.

PT: Yes, well all I'm saying is that since they all have that problem uh we can point to a cause which is our upbringing.

TH: Yeah but you see let me to question you this; you are now moving to the cause of it before you tell me what the problem is. Do you notice that?

PT: Yeah yeah I understand that.

TH: You see my question was what is the difficulties that you have? But now you are moving to the issue of the cause.

Not Remembering Call defense in question Challenge defense in question

I have already described the continuum of not remembering. At one end of the continuum the tactical defense is quite conscious, pretending not to remember; at the other end the patient genuinely being unaware of something held at bay by the major defense of repression. Two examples of the former were shown by the "masochistic woman with the brutal mother", who first did not want to admit her feelings against the previous interviewer, and then did not want to give any details of her masturbation, which will be presented shortly. The following are some examples of the types of intervention.

Not remembering

- " " "How is your memory? You have problems with your memory?"
- " " "Now your memory collapses on you."
- " " "Now you move to the position that it is difficult to remember."
- " " "Why do you think you cannot remember?"
- " " "I am not sure it is that you don't remember, but that somehow you want to leave it in the middle of nowhere."
- " " "How long ago is that?"

Intervention

The following are a few case examples:

Masochistic Woman with the Brutal Mother

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

PT: *"I don't remember" what I would have told him...I'm feeling embarrassed...I would have called him a fucker.*

.....

TH: *And what do you do while you have this fantasy?*

PT: *Uh, "I don't remember."*

TH: *I mean you're masturbating and have this fantasy, or...?*

PT: *I think I'm touching myself.*

In the first of the above examples, the first independent evaluation had taken place about a week previously and was clearly quite fresh in the patient's mind.

In the following three examples the event in question had happened progressively earlier, so that each one in the sequence probably involved a greater degree of repression than the last. Nevertheless, in all three cases pressure and challenge were effective in bringing the relevant feelings to the surface.

The Real Estate Lawyer

The event was less than a year ago:

TH: *Are you talking in a hypothetical way or are you saying you were angry?*

PT: *Okay, for me to identify exactly how I felt is very difficult because "I don't recall" how I felt.*

The Chess Player

The situation under discussion had arisen 4 years ago:

TH: *And what was the way you felt when your supervisor was exerting power over you?*

PT: *That is "too long ago to get in touch with."*

TH: *You say you were pushed around. But how did you feel toward this man who was pushing you around?*

PT: *I eventually felt hostile toward him.*

The Masochistic Woman with the Brutal Mother

The patient's deeply loved grandmother had died 14 years ago:

TH: *Where is she buried?*

PT: *Near Philadelphia somewhere.*

TH: *You mean you don't know where she is buried?*

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

TH: *Do you remember the burial?*

PT: *Vaguely, vaguely.*

TH: You were 18 years old!... And this woman meant a lot to you obviously. So how come you don't remember?

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

TH: I know.

(The patient is crying)

The Strangler

After the first breakthrough into the unconscious, and mobilization of the unconscious therapeutic alliance against the forces of the resistance, the therapist moved to the phase of dynamic inquiry into his marriage. What emerged was that during intercourse with his wife he has to resort to the mental image of a specific woman. When asked to describe the body of the woman he could not remember and there was mobilization of the major resistance.

TH: ...do you notice again your memory collapses?

PT: Yes.

TH: Yes what!

PT: Yes it collapses, "I don't remember it."

TH: I mean you say you are an engineer.

PT: Yes.

TH: As an engineer you have a problem with your memory?

PT: No.

TH: Then how come here your memory with me immediately collapses? Do you notice the position here?

PT: Hm hmm.

TH: What "hm hmmm?"

PT: I feel...

The Case of the Cement Mixer

A segment of the initial interview with this patient was presented in Part I. The focus of the session is on an incident with his wife a few weeks prior to the interview:

PT: That is too long ago to get in touch with... "I can't remember."

TH: How is your memory? Do you have difficulties with your memory?

The Case of the Masochistic Woman with Migraine Headaches

When she entered into treatment she was a 48 year old divorced woman who suffered from migraine headaches—as often as 25 days a month—since the age of 6 years, as well as from episodes of major clinical depression. Her last relationship was with a man named Dick who was involved with another woman, Maria, who worked in the same office. The patient had given Dick an ultimatum "Either Maria or me," and Dick told her that he had dropped Maria.

The therapist exerts pressure toward her feeling for Maria being dumped by Dick and this mobilizes resistance:

TH: And how did you feel that he dropped Maria for you, because she was around 7 years with him, and you were 2 months hmm?

Further pressure and challenge to the resistance:

PT: I didn't feel too good about it.

TH: Yeah, but you see that is just a sentence, "I didn't feel too good about it." That doesn't say how you feel.

PT: I did not feel guilty.

TH: But that still doesn't say how you felt. "I did not feel guilty" is a sentence again. Do you notice, I question you how you felt but then you use sentences to describe your feeling?

Now she moves to the defense "I don't remember," which is immediately challenged:

PT: "I don't remember" how I really felt.

TH: Now, how is your memory usually?

PT: Very good.

TH: So, your memory is very good, so how come when it comes to your feeling for Maria who is dropped by Dick, suddenly your memory collapses? Now you look puzzled.

PT: Ja, because I try to put myself into that time.

TH: Do you notice how helpless you become when I question how you felt towards Maria being dropped by Dick after your demand?

PT: (Silence)

Denial

**Make explicit
Call defense in question**

A most frequently used major defense, but often is also used tactically. The following are a few examples from a number of cases:

The Case of the Hyperventilating Woman

First the patient actually declares that she is angry at her husband, but when pressed she moves to denial:

TH: Yes, but you see again, you are not talking about your feelings.

PT: Well, I felt angry but I wasn't sure that I was justified.

TH: But still, your feelings?

PT: Well, I didn't feel angry. I know I didn't feel angry then because ...

The Real Estate Lawyer

PT: I felt embarrassed, humiliated.

TH: Yes, but that doesn't tell us how ...

PT: I didn't feel angry, I just felt very embarrassed.

The focus of the session was on an incident with her boss in which she was badly humiliated. The therapist exerts pressure on the experience of her feelings and the patient uses cover words and employs denial.

PT: I was so humiliated I didn't think at all.

TH: Now what came to your mind? I'm trying to see what went to your mind immediately.

The Case of Henry-IV Man

The following examples are taken from the initial interview with this patient. In the first he is trying to deny that his father had any special interest in him, in the second that he had any interest in his mother's body. On both occasions the denial was very easily penetrated, revealing a highly emotionally-charged situation underneath.

PT: I've seen a picture of him holding me on his lap... It might have just been a photographer who put me on his lap and then took the snap, but it was maybe not representative of what he did all the time.

.....

PT: Oh yes, as a matter of fact he had great interest in me... Later he told me that I was his only son, that the two other boys had other fathers...

.....

PT: I saw her dressing, and... but I opened the bathroom door... but I never sort of noticed anything.

.....

PT: She had curves. She had a beautiful face also. She still has, and she has nice fingers, and a nice tone of voice, beautiful eyes...

.....

The Case of the Chewing Gum Man

When he entered into treatment he was 29 years old, married, suffered from panic attacks, somatization and functional gastro-intestinal tract disturbances, phobic symptoms and characterological disturbances.

During the phase of dynamic inquiry and the phase of exerting pressure the focus is on the regressive dependent secondary gain aspect of his phobic symptom. The therapist is inquiring into the ways his symptoms interfere with his functioning:

PT: Oh yeah. In the kind of work I am in I could go to Wisconsin. I would go to Texas. I could go anywhere, cause they have courses okay? That would mean I would have to leave Montreal, that that scares me no end. I think, "what if I got sick over there?", because here I know if I am sick or cannot drive, she can — somebody's there to take care of me. That is the same thing when I am at

home and she goes out and I am minding the kid. I get nervous, not for myself—I am afraid “what if I faint or get sick with the kid there?” you know. I am preoccupied with “what if I get sick.”

Here, the tactical defense of denial “not for myself.”

TH: *You said, “not for yourself”. What does that mean? Are you saying that you are more concerned about your daughter than yourself?*

Denial of New Ideas

There is a form of denial which does not emanate from resistance rather than from the unconscious therapeutic alliance. Here, for the sake of brevity, I will give two examples—one of a patient on the extreme left of the spectrum of psychoneurotic disorders and the other from the mid-right of the spectrum.

The Case of the Salesman

As I have described before, this man suffered from a mild obsessional neurosis and was treated in a single interview. The resistance that the therapist encountered was a series of tactical defenses. The focus of the session is on his baby brother:

TH: *You were glad to have a baby brother, but at the same time this baby brother is getting a lot of attention from your mother. Could we look to your feeling about that?*

PT: *What I remember is that I never had “temper tantrums.”*

In the above passage, no one had said anything about temper tantrums—why should such an idea be mentioned at all. The answer is that, under pressure from the therapist, the balance between the unconscious therapeutic alliance and the resistance has been shifted. The result is a compromise: the underlying feelings are brought to the surface but are mentioned only to be denied. It is essential for the therapist not to fall into the trap of taking the denial at its face value. On the contrary, he should use it as a highly important communication from the unconscious therapeutic alliance, indicating that the therapist's pressure is becoming effective and that as long as he persists he will reach the feelings that the patient is trying to avoid.

In the “case of the salesman”, these eventually emerged as follows:

PT: *I felt like punching him. I resented it. I kept it in. But in the past 2 or 3 years I have talked about it to my mother.*

In this example, the statement “I never had temper tantrums” was no doubt, literally speaking, true. What was being unnecessarily denied by implication consisted of underlying feelings which might have led to temper tantrums.

Now we turn our attention to another patient, a resistant patient with a more complex core-pathology, to elaborate on the denial as an indicator that the balance between unconscious therapeutic alliance and resistance has shifted, and the former has taken a dominant position *vis-à-vis* the latter.

The Case of the Man with Foggy Glasses

When he entered into treatment he was in his forties, suffered from diffuse symptoms and character disturbances and life-long characterological problems. He entered into the interview with anxiety in the transference. The process rapidly moved to pressure and challenge to the tactical organization of the patient's major resistance. There was rapid rise in the patient's transference feeling, intensification and crystallization of the patient's character defenses in the transference, and then the process moved to pressure and challenge to the major resistance. Then he spontaneously made the following communication:

TH: Now you become silent again.

PT: I didn't go around "thumping things."

TH: Now you are telling me you did not go around...

PT: Yeh, I did not go around "thumping things," okay.

Shortly after this, he emphasized:

PT: In my whole life I have never raised my hand against any creature.

This is exactly a communication from the unconscious therapeutic alliance, and the process indicates that the unconscious therapeutic alliance is taking a dominant position in relation to the resistance. Shortly after that, he talked about an incident in which he was enraged toward his brother-in-law. The patient's brother-in-law was angry with his wife, and the patient, in a state of rage, stood between his sister and his brother-in-law and told him that if he raises his hand "I would not be responsible for what I do." In describing this, all the indicators are that he is clearly experiencing his rage. Then there is a major communication from the unconscious therapeutic alliance describing an incident, some 30 years ago, that he was near to murder another student. He had the head and the hair of the student in his hands, and was banging his head against the wall.

PT: It's going to crack open or it's going to get badly damaged, squashed as they say.

TH: So it would have been squashed?

PT: Yeh.

TH: And that means what?

PT: Well he could have been severely damaged you know, like he could have had a bad concussion or it could even have gone to death. I don't know, it could have.

TH: So you could have killed him then?

PT: I could have probably.

TH: Again you immediately use the word probably.

PT: I would have okay, but it didn't happen so...

(The patient is experiencing the somatic pathway of his murderous rage)

What emerges later on is his murderous rage toward his brother, who became the extreme favorite of the mother, as well as guilt-laden feeling and subsequently his primitive murderous rage toward the mother with guilt-laden unconscious feeling, as well as a great deal of painful feelings about his life with his father and the pseudonym of this patient is related to the memory of his last goodbye with his father. He was at the bedside of the father until the last breath.

He used his eyeglasses as a detector of whether or not his father was breathing. During the last breath of his father his eyeglasses become foggy, he cleaned them and placed them back against his father's mouth and they didn't fog up again, which meant that his father had died.

Retraction

Challenge the defense

This is a common tactical defense, particularly in patients with obsessive character structure. The patient admits to a specific feeling and immediately retracts it. This can be illustrated by the following case. After the first breakthrough, the patient describes an incident with his partner who was angry with the patient. The patient was mad and angry. The therapist exerts pressure toward the experience of anger and he immediately used the tactical defense of retraction.

The Case of the Butch

TH: *He dumped you and you say you felt angry toward him. How did you experience the anger?*

PT: *Angry is not the right word, may be it is not . . . ah . . .*

TH: *And now you are moving away saying I did not feel angry.*

Then he moved to another tactical defense becoming slow and retarded, and the therapist moved to challenge that defense.

Externalization

Make explicit

Challenge the defense

The externalization is a form of defense often used to avoid the experience of anger and can very easily be missed; the following examples illustrate the point:

The Chess Player

This passage follows immediately the passage that I have quoted before in which the patient had got as far as saying that he felt "frustrated" by his supervisor.

TH: *You say "frustrated." What was the way you experienced this frustration?*

PT: *I felt "unfairly pushed."*

The Case of the Hyperventilating Woman

This passage also follows the one I have already quoted, in which the patient has just described being "upset" by her husband's neglect.

TH: *But again we don't know what you mean by "upset".*

PT: *I felt "it was unfair."*

TH: *And what does that mean? "Unfair," "upset," being "sandwiched" into his life?*

PT: *Well, "I felt he was being immature."*

In each example the sentence begins with the words "I felt," so that the therapist might be easily deceived into thinking that the patient is describing feelings at all. The first patient states "unfairly pushed" saying that he is the victim in relation with his supervisor. Often when the therapist does not detect the defense of externalization he might then move to the following intervention: "What did you feel about being unfairly pushed?" The same is with the hyperventilating woman: "I felt he was being immature." Here the patient is using impersonal construction "it was unfair" to describe a situation, followed by the word "immature" to describe her husband.

It is important to emphasize that externalization by the use of the past-participle passive is a trap against which the therapist needs to be constantly aware, especially when he is pressing the patient for feeling in the transference.

Vagueness

**Make explicit
Challenge the defense**

It is frequently used.

The Case of the German Architect

The therapist is focusing on the nature of the patient's difficulties and he remains vague. The therapist brings this to the focus:

TH: *My question is what seems to be the difficulty and you use a bunch of sentences that are vague. Do you notice that;*

PT: *Hm hmmm, hm hmm.*

TH: *Do you notice that you are vague?*

PT: *Yes I know, but I am. I mean I am very vague about...*

TH: *So the first question for us is what are we going to do about the vagueness because up to the time you are vague then we wouldn't have a clear picture of what seems to be the problem.*

PT: *Uhmmmm...*

Vagueness and Evasiveness

The Case of the Salesman with his Sister-in-law

In exploring his mother's physical appearance he became evasive; the tactical defense of evasiveness is mobilized, indicating the degree of anxiety that he felt about his eroticized relation with his mother.

TH: *I am talking about when you were a child — your memory of her body and her build.*

PT: *Uh... not really anything to speak of... nothing in particular.*

TH: You mean you don't have any memory of your mother as a child?
 PT: I remember...
 TH: What do you remember?
 PT: She was "there," sort of...(!)
 TH: I know she was "there," but what do you remember?
 PT: I don't really, you know, in particular, nothing...

The Henry-IV Man

In a passage quoted earlier this patient had used the cover phrase "lose my reason or something" in order to avoid admitting his fear of loss of control. Immediately before this he had tried to avoid the subject by the use of evasiveness.

PT: Because I was afraid of my reaction after slapping her.
 TH: What was your fear?
 PT: My fear was that I...I don't know, but I was...just...

Evasiveness

Make explicit Challenge the defense

The Chewing Gum Man

The focus of the session is on his dependence on his wife and on his boss and that whenever his boss leaves the working area he develops a panic attack. The therapist puts pressure to how he explains this and he becomes evasive and laughs:

TH: But in actuality when he is also around, when he was also around you were really doing the job isn't that?
 PT: Sure I was doing the job. Well I was doing a good job.
 TH: And then when he would uh move, you know he would go out and then suddenly you start to have all these thoughts...
 PT: Yes.
 TH: ...that something might go wrong with you.
 PT: Hm hmm, that's right.
 TH: What do you think about this?
 PT: I (laughs) I don't know what to think about it.

Evasiveness Followed by Diversionary Tactic

The Man from Southampton

A segment of the interview with this patient was presented in Part I. In the following passage the patient is trying to avoid the pain of remembering that his relation with his feared and hated father had once been a good one:

PT: That reminds me that before the War I remember looking for my father when he would return from work. I could see the pathway that he would take approaching the house.

TH: *What is your memory of that path?*

PT: *It was just a path across the field.*

.....

PT: *And I would see him walking from...he had to leave by the back and walk down by the river and across the pathway and I would see him. We lived in a block of flats...*

Further pressure brings out a memory of his being so excited on seeing his father that he fell down the steps and cut his chin, and had to be taken to hospital.

Obsessional Indecisiveness

**Make explicit
Challenge the defense**

The Case of the Butch

The focus of the session is on the patient's warm feeling for the female therapist who had seen him as the first evaluator and the patient has feelings for the second evaluator; and the therapist focuses on the patient's feeling, and he becomes indecisive:

TH: *And how do you feel about me being cold, because you don't like the way I am, hmm?*

PT: *Yeah, I...I don't know, I don't know why.*

TH: *You like it or dislike it? I mean which one?*

PT: *Well, I am not comfortable with it.*

TH: *Now, you are not answering the question, I said do you like the way I am?*

PT: *I sort of dislike it...I don't hate it, I don't ah...*

This form of tactical defense of obsessional indecisiveness needs to be challenged. Then the patient declares that he dislikes the way the therapist is. Then the process moves to the intervention of focusing on the actual experience of the patient's feeling.

Somatization

The development of physical manifestation can of course be used unconsciously as a major defense against the experience of feeling. For example, a total numbness described by the "masochistic woman with the daily attacks of migraine headaches" was a major defense against primitive murderous rage and guilt in relation to her son (which had its roots in relation to her mother). But in a somewhat similar "but much less unconscious" way the description of the physical manifestation can be used as a tactical defense against the experience of feeling. The following examples demonstrate this form of tactical defense:

The Case of the Real Estate Lawyer

The therapist is putting pressure for the experience of her feelings which has to do with anger.

PT: "I went flame red."
"My stomach was in an uproar."
"My stomach went flip-flop."
"When blood surges there has to be some sort of emotional reaction."
"My face went like a mask."

The Case of the Man with the Chewing Gum

He suffered from a wide range of symptom disturbances, functional gastrointestinal tract disturbances, complained of dizziness, "I feel fragile," "I am not sure of my footing." In his job he becomes pale, his hands shake then he becomes panicky whenever his boss leaves the counter or when his wife leaves the house for shopping. The patient's use of symptoms, many of which were somatic, as a way of avoiding his true feelings has already been noted.

TH: So in your job you have to have your boss around in order to function. And in your personal life you cannot function without your wife. What do you think about all this?

PT: I don't have any thoughts. What can one do when one has all these symptoms?

The Case of the Masochistic Secretary

A segment of the trial therapy of this patient was presented in Part I.

TH: You said you feel uncomfortable, what is the way you experience this being uncomfortable?

PT: I "Blush," I feel "hot in my face," I chew and bite my lips.

In this case the patient is describing two different manifestations, blushing which is an involuntary reaction while chewing lips or biting her finger is a nervous habit and more or less under conscious control, and as we saw in the "real estate lawyer" "going flame red" is an involuntary reaction.

Action as a Defense Against Feeling

If we return to the Case of the "masochistic secretary", the therapist has focused on her feeling and she responded:

PT: I "blush," I feel "hot in my face," I chew and bite my lips.

As I have already indicated chewing her lips, a nervous habit, is more or less under conscious control. The "real estate lawyer" also described the nervous habit of "biting my fingers."

The Real Estate Lawyer

TH: But saying you felt terrible doesn't tell us how you experienced ...

PT: Okay, I left very soon afterwards.

TH: What was it that you experienced?

PT: I tried to mask it. I tried to laugh about it in front of everybody.

TH: It is not clear how you experienced your feelings at that moment.

PT: I got very embarrassed. I put his so-called gift away and threw it in the garbage.

TH: What was the way you experienced this 8-degree anger?

PT: I didn't say a word and I walked away. My face went like a mask.

Body Movement as a Defense Against Feeling

A wide range of body movements; movement of the hand, the restless movements of the legs, rhythmic movements of the pelvis are seen during the passage of the primitive murderous rage, and in particular primitive murderous torturous rage, in the transference and when the therapist becomes actually transferred to the biological figure. What follows is a major guilt-laden unconscious feeling. It is important to note that as soon as the passage of the primitive murderous rage takes place there is no trace of these body movements.

"*Explosive discharge of the affect*" in the form of banging the fist on the table with a loud voice or even breaking some object can be used defensively to abort the buildup of violent rage and homicidal impulses.

Stubbornness; Defiance

Confronting comment Challenge Head-on collision

Defiance and stubbornness can be purely tactical defenses or can be part of a major resistance. They are almost universal and appear over and over again in different patients, particularly those suffering from long-life character neurosis often in a regular sequence as a response to pressure from the therapist. Here I will highlight this with the following example:

The Praying Mantis

This young woman's pseudonym arises from her fantasy of murdering a man during sexual intercourse by stabbing him with a knife at the neck level of the vertebral column. At the time of the trial therapy she was 22, complained of severe phobias of seeing doctors, injections, genital examination, and of sexual penetration. She has always refused gynecological examination and currently suffers from vaginal infection. The gynecologist had failed to do a gynecological examination. It was arranged for the nurse to introduce a speculum, which was not possible. She has suffered from disturbances in the interpersonal relationships, major conflict with her parents so that she has moved to another city as a college student.

In the early part of the interview she described how her phobia went back to childhood. The result had been that for years she refused to be seen by her doctor, and her mother has had to describe her symptoms over the phone and receive instructions about how to treat her. She described incidences around the age of four and five in which stubbornly "I turned his office upside down," and from thereon her pediatrician treated her over the phone, via her mother.

The therapist made a summing up remark:

TH: Then you were stubborn in a way.

PT: Very, I still am.

TH: Was it only with the doctor? Or were you stubborn with others?

PT: I was quite stubborn as a child.

Through the whole of the early part of the interview the patient used the defense of *belle indifference*, talking in a cheerful way about even the most intimate and distressing subjects. She has never had sexual intercourse. She goes out with men and attempts to have intercourse but because of vaginismus and severe pain the intercourse becomes totally impossible. Then the therapist focuses on her masturbation:

PT: I have had orgasms from masturbating ever since I can remember. And I have been masturbating ever since I can remember.

The therapist went on to ask about details, receiving an initial reply which was the epitome of belle indifference:

TH: What are the fantasies you have during masturbation, and how do you do it?

PT: I just sort of grab my crotch with my hand (spoken with apparent relish)

TH: And then what type of fantasies do you have? (The patient smiles in a coy and embarrassed fashion)

PT: I just really don't want to go into it. They embarrass me very much.

The patient's smile might have been taken simply as expressing her embarrassment at being asked such an intimate question, but there is more to it than that. She is now embarking on the same kind of defiant stubbornness as she has described with a number of gynecologists and pediatricians and other relationships, so that there is an obvious parallel between these and the transference.

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 your 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.

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

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

TH: You are smiling.

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

The therapist must be extremely careful not to allow himself to be drawn into the battle of will. The simple technical intervention is a special form of head-on

collision pointing out the therapeutic task, deactivation of the transference, deactivation of the defiance. The details of this technique will be described in another paper; the application of head-on collision in the management of defiance and other malignant character defenses.

Tangents Confronting remark Challenge

Tangents	Intervention
”	“Usually it is like this... you go round about the way.”
”	“You have a tendency to go to tangents.”
”	“You have to give a lot of preamble.”
”	“Could you describe that incident without circling around?”

This defense can be seen in the whole spectrum of psychoneurotic disorders, with the exception of those cases on the extreme left of the spectrum. We see it more frequently in patients on the right side of the spectrum. It is one of those defenses that needs immediate intervention, first by clarification then, if necessary, with pressure and challenge.

The Case of the Masochistic Woman with Frequent Migraine Headaches

The therapist has asked for a specific example and she soon started to go into tangents, unnecessary detail about irrelevant matters, and the therapist's intervention is clarification rapidly followed by challenge and pressure to the defense:

- TH: You see, you want to tell me about ... and your relationship but now you are moving...
- PT: Yes, I am getting there, no I'm getting there.
- TH: Usually is it like this. That when you want to describe an incident you go round about the way.
- PT: Ja, tangents (laughs).
- TH: But labelling it is not ... We have to see what are you going to do about it.

The Case of the Englishman with Fainting Attack

When he entered into treatment he was 51 years old, married and suffered from a chronic state of anxiety with attacks of hyperventilation and an episode where he had fainted, functional disorder of the gastro-intestinal tract with diarrhoea, flatulence and sharp-shooting stabbing abdominal pain, major conflict with his wife and daughters, sexual difficulty with an inability to have an erection and characterological problem.

The initial phase of the trial therapy interview consisted of inquiry, dynamic inquiry, the phase of pressure and the mobilization of the twin factors of the

resistance and the transference. The process then moved to the phase of pressure and challenge alternating with dynamic inquiry. The therapist was exploring the family dynamics and the patient described an incident where his wife had had a big argument with one of her daughters, with exchange of anger, and the next day she was withdrawn and detached. While describing the incident he becomes circumstantial and goes into tangents:

- TH: Now what way did you get involved? Still you have not...
- PT: Well I'm trying to get to that, I'm trying to get to that.
- TH: But do you know you have a tendency to go to tangents? Do you know what is tangents?
- PT: Yeah, yes I understand.
- TH: Now you have to give a lot of preamble, to go on and on, circle around subject until you could describe that issue. Do you notice that? My question is this, is it here with me or this is per se you? That when you want to describe an event you have to circle around and around until you come to the point. The point is, at what point you got into this battleground between Susan and your wife?

Then he described an incident of exchange of anger with the loss of control.

Defensive Weeping, Crying and Spectrum of Regressive Defenses

A spectrum of regressive defenses can be used tactically, these are frequently encountered and the therapist should look out for their emergence. A few examples:

The Woman with the Fainting Attacks

At the start of the initial interview she indicated that one of her problems is fainting and the therapist asked the patient "Could you give me a specific example of you passing out?" This mobilized anxiety and she responded "You want the most dramatic one or you want the one that is..." The therapist's response was "Obviously, if you choose the worst one it would give us a better picture." There was further mobilization of anxiety and she started crying, became weepy.

- PT: Here I go. (sniffling)
- TH: What do you mean "here you go?" because of your tears you mean?
- PT: (blowing nose, sighing)
- TH: From where these tears come from?
- PT: (deep sighing, sounds of weeping)
- TH: How long have you felt like this? This morning?
- PT: (choked-up voice) No this is...when I think about passing out I guess I have a phobia in uh situations so...because I'm afraid I'll pass out.

Then she wants to move to intellectualize into the cause of her fainting attack:

- TH: I mean to go to what is the cause of passing out is not going to help. It is very important for us to explore one or two incidences when you passed out that we can get a better picture of what it is like.

PT: *That's why I'm crying because it's difficult for me to talk about it. Okay I'll describe it.*

TH: *Most recent one would be best.*

Then she described a major fainting attack that she had 2 years ago in a subway. Now the therapist moves to explore in detail two of her major fainting attacks.

The Case of the Masochistic Secretary

The patient had declared that she frequently gets angry with her husband and the therapist is focusing on how she experiences her anger in a specific incident:

TH: *How did you experience your anger toward him?*

PT: *I cried.*

What emerges is that she becomes withdrawn and detached and further indicates that at times she screams and resorts to the regressive defense of temper tantrum "I want to hit him."

Talking to Avoid the Experience of Feelings

Clarification

It is a tactical defense seen in a wide range of situations, particularly to avoid the actual experience of painful feeling. We encounter with this defense when the breakthrough of intense guilt-laden and grief-laden feelings is eminent. It is particularly seen in partial unlocking of the unconscious at the time of the passage of painful feeling. Technically, the therapist would not encounter this defense during the passage of the intense guilt in major unlocking as well as in major extended unlocking. The main reason for that is optimum mobilization of the unconscious therapeutic alliance.

The following are a few examples:

The Case of the Microphone Man

Immediately after partial access to his unconscious the patient has become visibly sad. He was describing his last visit with his father, who looked older and tired. This intensified his sadness and the therapist continues focusing on the patient's feeling, which is very close to breakthrough and the patient uses the tactical defense of talking over and over to abort the breakthrough of the painful feeling:

TH: *Now when you say that, I have a feeling here that there is a lot of feeling in you. But then you keep talking and talking. Do you notice this here? It is very important...*

PT: *The feeling is that I wished that we had been really closer together. That we could have talked...*

TH: *Yeah, but let's to look to the feeling.*

PT: *That we could talk with depth you see, and be close.*

TH: *I see now there is this, uhh, deep-seated feeling that you have for your father, but by talking and talking we cannot understand this feeling. Why is it that you don't want to look to your feelings rather than to...*

.....

PT: *Yeah it is.*

TH: *Hm hmm. Silence is threatening to you because under that we see there is a lot of feeling for the man. (patient is sobbing heavily)*

The Case of the Bee-Bee Gun Man

The therapist has achieved the first breakthrough at which the situation changed from the dominance of the resistance to dominance of the unconscious therapeutic alliance and the patient has become increasingly sad, with tears in his eyes and he uses the tactical defense of talking to avoid the experience of the intense painful feeling.

PT: *I have tears in my eyes and I don't even know why.*

TH: *I know, let's get to the tears first and then to see why and see from where do they come from. Underneath there is a major wave of feeling, but you want to talk to avoid to experience the painful feeling.*

PT: *You see, I have the tears.*

TH: *You want to talk, feeling, feeling.*

Nonverbal cues

Call defense in question

Challenge defense in question

* Nonverbal cues are extremely important to monitor during the process and they can be considered as a signaling system of the unconscious; for example, any degree of the rise in the transference feeling or any degree of mobilization of the twin factors, namely the transference and the resistance, can express themselves in a nonverbal way. The following are a few examples:

The Case of the German Architect

The focus is on his problem with feelings and the therapist exerts pressure by probing for feeling.

Rise in transference feeling:

Increased resistance:

TH: *Problem with feelings.*

PT: *Yeah.*

TH: *Could you tell me about that, I mean that is a sentence "problem with feeling".*

PT: *Yes it is a sentence. Uhmm maybe my reactions to things that I should feel are...*

TH: *Yeah but that again is vague, "my reaction to things"...*

PT: Okay.

TH: Now you turn your head on the other side, do you notice that?

PT: Beg your pardon?

TH: You move your head on... Do you notice that in a sense your head moved?

PT: Yes I'm looking for another tack you see.

TH: Another?

PT: Tack.

TH: What does that mean?

PT: A...another approach.

TH: Hm hmm. Another approach to what?

PT: To explaining maybe why I'm here.

Challenging nonverbal cues and pressure toward the transference feeling:

TH: Now your eyes also avoid me.

PT: Well, I mean I can't look at you all the time, one hundred percent of the time.

TH: Do you notice that you avoid my eyes?

PT: No, I don't avoid your eyes. I look at your eyes when you talk to me.

TH: Uh hmm.

PT: But then I look away so I can, ah, think for myself where I don't have to concentrate on your eyes, umm...

TH: And how do you feel when you look at my eyes?

PT: Fine, I...

TH: Fine means what, I mean fine is another vague...you smile now.

PT: Is that okay, I mean I smile?

TH: uh hmm. Now your eyes go toward the ceiling.

PT: Right, that's quite right.

TH: Right, huh?

PT: Umm, how do I feel when I look at you.

TH: You are avoiding me. This is the real issue.

PT: I'm avoiding you?

TH: Yeah, is it or isn't it? I mean you can tell me.

PT: No, I don't think I'm avoiding you particularly.

TH: Now look, you have been vague so far...

PT: No.

TH: ...you have not been specific so far and now we are focusing on your feeling, you say fine.

PT: Well, that's what everybody in this country says, ah...

It is extremely important to take into consideration that one of the major features of all patients suffering from long-life character neurosis is the presence of the resistance against emotional closeness which immediately comes into operation in the transference. The therapists who are well in tune with the unconscious universe can detect the presence of such a resistance in the transference behavior and nonverbal character defenses.

The Real Estate Lawyer

TH: And do you notice, also you look somewhere else, you avoid my eyes.

PT: Oh.

- TH: Do you notice that?
- PT: It's not intentional.
- TH: It doesn't make a difference, still you do. Do you notice that?
- PT: Yes.
- TH: How do you account for that? Avoiding my eyes. (Once more the patient smiles)
- TH: A smile again.
- PT: Not smiling, maybe it's because you can see something, or you understand why I don't express any feeling and ...
- TH: And still you avoid my eyes.

This repeated confrontation with the nonverbal signs, avoidance of eye contact and other indicators of the presence of the resistance against emotional closeness, aims at mobilization of the twin factors of the transference and the resistance and brings her nearer to acknowledging her transference resistance.

- PT: I have never in my entire life expressed feeling to anyone.
- TH: Hm hmm.
- PT: To myself, to my parents, to my husband.
- TH: But you see again you are avoiding my eyes. (Again she smiles). A smile comes ...

The Case of the Butch

He described an incident with his partner who was angry with the patient. The therapist was exerting pressure to the actual experience of the anger towards his partner. His fist is clenching and he has frequent deep sighs.

- PT: It was like, ah... (deep sigh), like a boiling feeling.
- TH: Uh hmm.
- PT: ...like getting very warm, very hot, physically getting hot.
- TH: Uh hmm.
- PT: My body was hot, my hands started to sweat, and I was shaking.
- TH: Uh hmm.
- PT: I was shaking.

Further pressure to experience his anger.

- PT: A feeling of... (deep sigh)...
- Th: And again you make a fist.
- PT: Yeah... a fist.
- TH: Uh hmm.
- PT: That's a kind of, that's the physical feeling I had.
- TH: Uh hmm.
- PT: ...I am trying to... It's a reenactment of that particular moment.

The passage of violent rage toward the partner is mobilizing anxiety in the form of tension in the striated muscles; muscles of the hand; supinator and pronator of the forearm; making fist; tension in the intercostal muscles with sighing respiration. The boiling, heated feeling in the abdomen indicates that the somatic pathway of the violent rage is being mobilized.

Passive-Compliance

Make Explicit Challenge

Passive-compliance can be a defense to prevent the patient from experiencing his true feeling. For example, in the case of the "salesman and his sister-in-law", a young man in his twenties suffering from mild obsessional neurosis; the therapist focused on his rivalry with his brother, who had become the favorite of the mother. First he used rationalization and rumination, then he moved to passive-compliance to prevent him from experiencing his true feeling.

Case of the Salesman

TH: Now what are your memories about your brother getting more?

PT: Uh... gee... (pause)... getting more...

TH: It had to do with the attention of your mother.

PT: Yeah... it always, like to me I guess it seemed that he used to be able to stay up later than I did at his age, you know. Not to do chores.

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

PT: I guess you could say that, yes.

Th: That he was the favorite of your mother? That he became the star?

PT: Yeah... okay.

TH: Why do you say "yes... okay?" Is it, or isn't it?

Passive-Compliance, Rumination, Rationalization, Vagueness

The Case of the Salesman

The therapist used the challenging phrase of whether his younger brother had become their mother's favorite. This led to mobilization of a series of tactical defenses.

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

PT: "Yeah, okay." (passive-compliance)

PT: "I guess he was then, but..." (Rumination)

PT: "He was the favorite because he was the youngest." (Rationalization)

PT: "Possibly right." (Vagueness)

The Strangler

The trial therapy started with the phase of pressure and as soon as there was tangible evidence that his character defenses were crystallized in the transference the therapist moved to the phase of challenge. There was mobilization of the tactical defense of passive-compliance "I don't know" and mobilization of the resistance against emotional closeness:

TH: Again you move to the "I don't know." Moving to the helpless position. How do you feel when you look to my eyes?

PT: *I don't know.*
 TH: *Hm hmm. So "I don't know" is another system like "I guess so," "perhaps," huh?*
 PT: *Yeah.*
 TH: *Now this is another format of the...huh? (Pause)*
 TH: *Do you notice that you are very much detached from me?*
 PT: *Yes.*
 TH: *What?*
 PT: *Why?*
 TH: *And there is some kind of a wall between you and me.*

The Case of the Woman with the Diamond Ring

She was 35 years old when she entered into treatment, gave abundant evidence of a pattern of passivity, compliance and self-depreciation in most of her interpersonal relationships. Her first marriage was to a man who was paranoid and she allowed herself to be used and abused by him and finally ended up in divorce. She had problems in her second marriage, suffered from episodes of clinical depression, masochistic character traits letting herself be used and abused. She had had a baby during her first marriage who died at birth and she had passively complied with the doctors who discouraged her from going to the funeral. Her behavior in the initial interview showed a similar pattern of passivity, compliance, vagueness and self-depreciation. The therapist had clearly established the parallel between her behavior in the transference and that of the outside relationships; the entry of the transference. The focus is on the set of tactical defenses "I don't remember," "I don't know," "I was so dumb," "It was absurd."

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...*

.....

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?*

Later on she declared anger in the transference. Then the process moved to pressure for the actual experience of the anger in the transference. It is important to note that anger by itself functions as a defense against the violent primitive murderous rage and intense guilt, in relation to her mother, her father as well as her brother, which is under the major resistance of repression.

Generalization, Vagueness, Vague Rumination, Cover Word, Jargon Word and Sarcastic Laughter

The Case of the Son of the Australian Journalist

When he entered into treatment he was in his forties, suffered from symptoms and character disturbances and a long-life character neurosis. The session starts with the phase of inquiry:

TH: What is the problem that you want to get help for it?

PT: Either behavioral problems or if not that then what I feel I have uh by ways of blocks okay.

.....

PT: Well I feel at times uhmm . . . there are certain times that I'm functioning on about seven or eight pistons and there's other times I'm working on a . . . a couple of cylinders.

TH: You mean seven to eight percent of your potentiality?

PT: Pistons, seven or eight cylinders, okay. (sarcastic laughter)

Therapist attempts to make it specific; he further moves saying "Just to improve myself," then he says "Personal growth . . . I think I have some blocks."

Cover Words, Generalization, Indirect Speech, Rumination and Nonverbal Character Defenses

The Case of the Board-Like Professor

At the time of the initial interview he was 56 years old and suffered from a wide range of symptom disturbances and major syntonic character pathology. He suffered from chronic anxiety, somatization and depressive disorders, problem in his marriage and with members of his family, episodes of explosive discharge of affect in relation to his wife, and at times actively suicidal. He has been treated by his family physician for the past 20 years for various functional disorders. Because of the research protocol, he had seen the first independent evaluator and when he arrived for the second independent evaluation he had feelings about repeating himself. The process moved to the phase of pressure toward his feeling, rapid rise in the transference and mobilization of a set of tactical defenses:

PT: I feel "irritated."

TH: Irritated at who? (Pause)

TH: Now you see you look down there.

PT: Well, you, I "guess."

TH: Yeah, that is "guess," that is a state of limbo. Are you irritated with me or aren't you irritated with me? Let's first establish that.

PT: I don't see where, where we are going.

TH: Let's not go to where we are going . . .

During this very early part of the trial therapy he has had a number of "smiles," avoidance of eye contact, looking at the wall, rise in anxiety in the form of tension in the striated muscles in the form of clenching of the hands, deep sighs, tension in the intercostal, tic in the facial muscles, tic in the periorbital muscles in the form of closure of the eyelids, immobile board-like position and each of these nonverbal defenses is clarified and challenged.

Vagueness, Rumination and Intellectualization

The Case of the German Architect

The trial therapy started with the phase of inquiry. In answer to the question "could you tell me what seems to be the problem?" patient responded with vagueness, rumination, and wants to intellectualize if his difficulties are normal or abnormal:

PT: Uh... no, not exactly. This is one...

TH: So you don't know exactly what the problem is, hmm?

PT: I'm here, ah, I only have ah, some hazy idea what might be the problem.

TH: Now if I question you what seems to be the difficulties that you have, what then you would say there? Because you are saying you have a hazy idea about your difficulties which is...

PT: Which I'm not even sure whether those difficulties are my re... normal part of being a human being, ah, however...

TH: So you have several difficulties that you question if is normal or...

.....

PT: Yes, I know, but I am vague, I mean I am very vague about...

TH: So the first question for us is what are we going to do about the vagueness? because up to the time you are vague then we wouldn't have a clear picture of what seems to be the problem.

.....

PT: If, maybe if I knew what the difficulty was I wouldn't be here.

Passive-Compliance, Rumination, Indirect Speech, and Nonverbal Character Defenses

The Case of the Board-Like Professor

The therapist is putting pressure to the actual experience of irritation in the transference. There is further rise in the transference, further crystallization of the patient's character defenses in the transference in the form of a set of tactical defenses:

TH: How do you experience your irritation towards me?

PT: (Pause)

TH: Now your head goes like this.

PT: Uh huh.

TH: We know your hand is in clenching state like that; your body is totally immobile.

PT: I sit like this many hours of the day.

TH: Doesn't make a difference your rumination that I sit like this. Right now you say you are irritated with me and my question is this: how do you physically experience your irritation? And your hand is clenching and your body is immobile...

TH: Now you are ruminating still. You are not telling me how you experience physically your irritation.

PT: I, I feel tense here, I feel ...

TH: So that is anxiety.

PT: Yes, Well I "guess" so.

TH: "Guess" so.

PT: I don't, I don't know how to, I don't know.

TH: "I don't know" is a helpless position.

PT: Well...

From the above case-examples, it becomes clear that the tactical defenses appear in many different forms, and that they occur in similar forms over and over again in different patients. The classification given above is not hard-and-fast and there is a very considerable degree of overlap between one type of the defense and another. What is important for the therapist is to make himself familiar with them. This is summarized in Table 1.

Summary and Conclusion

Here it is important to summarize what has been presented in this two-part article:

- (1) I briefly described a powerful technique which aims at a rapid breakdown of all forces maintaining the major resistance and rapid mobilization of the unconscious therapeutic alliance.
- (2) I emphasized that the task of the trial therapy is loosening the patient's psychic system, reorganization of the unconscious; changing the situation from the dominance of the major resistance to a major dominance of the unconscious therapeutic alliance and mobilization of the whole unconscious system.
- (3) Our clinical research clearly shows that the optimum mobilization of the unconscious therapeutic alliance against the forces of the major resistance is one of the basic aims of the therapist and it can be achieved in every patient, no matter what the degree of the major resistance.
- (4) It was emphasized that one of the features of the technique, that is rapid mobilization of the unconscious, instantly mobilizes what I call tactical defenses in the service of resistance, and it is essential for the therapist to be familiar with these defenses.
- (5) The continuum of tactical and major defenses was discussed and it was indicated that these two categories of defense form a continuum and any attempt to draw a sharp distinction between them would only result in hair-splitting.

Table 1. Management of tactical defenses in intensive short-term dynamic psychotherapy

Defense	Intervention
Cover words	Call defense in question; challenge defense in question "I felt terrible,' is just a sentence." "You are back again to the issue of 'embarrassed.'" "You are helpless to tell me what your inner experience was." "Do you notice, you are totally incapable of telling me how you felt?" "What is that? What is 'confusion'? Still we don't know how you experience your irritation." "I felt mad' is a sentence." "I felt aggravated' is a sentence." "I felt terrible' is just a word, it doesn't tell us how you felt. "Let's not to call it 'silly.'" "'It sounds funny' doesn't tell us how you felt." "Is it 'trust' or is it a tremendous fear of intimacy and closeness?" "Is it 'rejection' or is it that you are terrified to let me get to your intimate thoughts and feelings?" Challenge defense in question "I was very shocked' doesn't say how you experience your anger." "Backing up mentally' doesn't say how you felt." "I felt empty, lonely space,' that doesn't say how you felt." Challenge defense in question "Devastated and depressed,' what is that?" Make explicit
Blanket words	Challenge defense in question Call defense in question "Why 'suppose'?" "Again 'sort of'?"
Jargon words	"Why probably? Either you were angry or you were not." "Again you leave it in the state of limbo, 'guess,' perhaps." "You leave it in the hypothetical way," "You 'guess' so?" "Again you move to 'I think,' may be' you felt resentment." "Again you move to you 'guess' you could say." "Again you move to assumption."
Indirect speech	

(Continued)

Table 1. (Continued)

Defense	Intervention
Rumination	<p>"I say how do you feel right now, you say you 'guess' you are nervous."</p> <p>"You have to say 'it seems' that you are nervous, you are indefinite here with me."</p> <p>"You know what I mean by indefinite? You say, 'perhaps,' 'guess.'"</p> <p>"Why do you say 'perhaps' you have resentment? Either you do or you don't."</p> <p>"But you say 'guess,' you 'think' that you must have feelings. Either you do or you don't."</p> <p>"Probably again."</p> <p>"Again 'suppose.'"</p> <p>"You are leaving it in the state of limbo, 'perhaps,' 'maybe,' 'I suppose.'"</p>
Make explicit	<p>Ask decision, call defense in question</p>
Vague rumination	<p>Challenge defense in question</p> <p>"You are giving a description 'that doesn't make sense.' How did you experience your annoyance?"</p> <p>"Stupid bloody doctors' is again a sentence, but what was the way you experienced this annoyance?</p> <p>"A stupid situation,' 'I feel heated,' 'I felt bothered' doesn't tell us how you experienced your annoyance."</p> <p>"What do you mean by 'unfinished tasks?'"</p> <p>"I know myself. You are ruminating on that, that doesn't tell us anything."</p> <p>Make explicit</p> <p>Pressure, challenge</p> <p>"But that is a sentence."</p> <p>"That doesn't make sense,' doesn't tell us how you experience your annoyance."</p> <p>"Stupid, bloody doctors' is again a sentence."</p> <p>"Again that is vague ... to 'get to the point,' which point?"</p> <p>"You see, again you are ruminating in a vague way. That doesn't tell us anything."</p> <p>"Rushing feeling of hate' is vague, doesn't tell us how you actually experience your anger."</p> <p>"Let's not to ruminate on what anger is."</p>
Rationalization	<p>Ask for explicit statement</p> <p>Challenge, dismiss the defense</p> <p>"Again you move to 'because.'"</p> <p>"Let's not get to 'because.'"</p> <p>"Let's not get into intellectual aspect, let's look at your feelings."</p>

Intellectualization	Make explicit, challenge	"Now you want to move to intellectualize 'if I had been a male.'"
		"You haven't told me about your problems, now you want to intellectualize where the problem comes from."
		"You haven't told me the dream and now you are analyzing it."
Generalization	Make it specific	
	Challenge the defense	"But, you see, you are not specific."
		"Could you give me an example?"
		"But that is vague and general."
		"We are not talking about a 'person,' we are talking about you."
		"But we are focusing on you."
		"Let's not get to 'most girls,' let's focus on you."
		"Just frustrated' doesn't tell us at whom are you frustrated."
		"You say you feel irritated, irritated at whom?"
		"It is important, could you give a specific example?"
Diversionsary tactics	Block the defense	"Again you avoided my question."
		"You are avoiding my question and want to talk about your childhood."
		"I question you how did you experience your annoyance, now you are moving to something else."
		"We are focusing on your brother right now, but you repeatedly want to bring your sister into it."
		"Let's to focus on yourself first."
Not remembering	Call defense in question	
	Challenge defense in question	"How is your memory? You have problems with your memory?"
		"Now your memory collapses on you."
		"Now you move to the position that it is difficult to remember."
		"Why do you think you cannot remember?"
		"You mean you don't have any memory of your mother as a child?"
		"I am not sure it is that you don't remember, but that somehow you want to leave it in the middle of nowhere."
		"How come you don't remember?"
		"How long ago is that?"
Denial	Make explicit	
	Call defense in question	"You said 'not for yourself,' what does that mean?"

(Continued)

Table 1. (Continued)

Defense	Intervention
" " Externalization	"Now you move to the position that you did not feel angry." Make explicit Challenge the defense
" " " " Vagueness	"'Unfairly pushed,' what does that mean?" "What does that mean? 'Unfair' . . ." Make explicit Challenge the defense
" " " " Obsessional indecisiveness	"Why don't you want to be specific, repeatedly saying 'I don't know?'" "I wonder if you notice that you repeatedly use the phrase 'I don't know?'" "So the question for us is what are you going to do about the vagueness?" "Up to the time you are vague, we wouldn't have a clear picture of what seems to be the problem." Make explicit Challenge the defense
" " " " Stubbornness; defiance	"You are not answering the question, do you like the way that I am or do you dislike it?" "You are not decisive about it, wanting and not wanting." Confronting comment Challenge
" " " " Tangents	Head-on collision "You said that you have always been a stubborn person, hmm?" "You said that when you see a doctor you manage to get your own way." "You have lived with all these problems as long as you have been alive, why now should you want to do something about it?" "You have done it all your life, and if you want to do it you can do it for the balance of your life." Confronting remark Challenge
" " " " "	"Usually it is like this . . . you go round about the way?" "You have a tendency to go to tangents." "You have to give a lot of preamble." "Could you describe that incident without circling around?"

Talking to avoid the experience of feelings	Clarification	"You keep talking and talking. Do you notice this here?" "By talking and talking we cannot understand this feeling." "Silence is threatening to you." "You want to talk to avoid to experience the painful feeling."
Nonverbal cues	Challenge defense in question	"Now you turn your head on the other side, do you notice that?" "Now your eyes also avoid me." "Now your eyes go toward the ceiling." "But you see again you are avoiding my eye. A smile come . . ." "And again you make a fist."
Passive-compliance	Call defense in question	Make explicit Challenge "Why do you say 'Yes . . . okay?' Is it or isn't it?"

- (6) These tactical defenses show an extraordinary uniformity across a wide range of patients. A spectrum of tactical defenses most commonly seen was presented with their management (see Table 1). It will have become clear both that tactical defenses appear in many different forms and that they occur in similar forms over and over again in different patients. The classification given above is not hard-and-fast and there is a very considerable degree of overlap between one type of defense and another.

In conclusion, what is important for the therapist is to be familiar with these tactical defenses which I hope this two-part article has succeeded in conveying. Only if a therapist can recognize them can he know how to challenge them; and only if he can recognize them instantly can he challenge them quickly enough to be truly effective.

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Intensive Short-Term Dynamic Psychotherapy— Central Dynamic Sequence: Phase of Pressure

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In this article the author presents on the application of the phase of pressure. The major aims of exerting pressure and the main technical interventions to exert pressure are outlined. The phase of pressure is further discussed by presenting a number of patients from the spectrum of resistance, all suffering from psychoneurotic disturbances. Copyright © 1999 John Wiley & Sons, Ltd.

Introduction

I have already both presented and published the technique of rapid unlocking of the unconscious, and indicated that this provides the unique opportunity, both for the patient and the therapist, to have a direct view of the psycho-pathological dynamic forces responsible for the patient's symptoms and character disturbances (Davanloo, 1975, 1976a,b, 1977, 1978, 1980a, 1990). Long-term systematic research has demonstrated 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). I have already outlined the dynamic sequence used in trial therapy, consisting of a series of specific interventions with its corresponding responses (Davanloo, 1989a,b, 1995b).

The result of this long-term systematic research is a major refinement of the metapsychology of the unconscious and the development of a new metapsychology (Davanloo, 1987d,e, 1988a,e, 1992). Based on this work, I have developed two systems of highly powerful techniques. The first one is Intensive Short-Term Dynamic Psychotherapy, and the second is a highly powerful method of psycho-analysis of short-term duration (Davanloo, 1980b, 1982, 1983, 1985, 1993, 1994c, 1995d).

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Central Dynamic Sequence in the Process of Rapid and Direct Access to the Unconscious and Rapid Mobilization of the Unconscious Therapeutic Alliance against the Forces of the Resistance

The dynamic sequence consists of a number of phases:

- (1) Phase of inquiry
- (2) Phase of pressure
- (3) Phase of challenge
- (4) Transference resistance
- (5) Partial or major dominance of the unconscious therapeutic alliance against the resistance and the direct access to the unconscious
- (6) Analysis of the transference
- (7) Dynamic exploration into the unconscious

This article primarily focuses on the phase of pressure.

Phase of Pressure

One of the basic principles of the technique is exerting pressure. The therapist tries to reach the patient's feeling directly via resistance and the transference. He steadily increases pressure toward the avoided feeling with the aim of bringing resistance and the transference into the open as soon as possible. Then the therapist could increase his pressure systematically. I will present the list of a set of interventions that the therapist can use for exerting pressure. These interventions tend to shade into one another and also some of them shade into the next phase which is the phase of challenge. The therapist should keep in mind throughout the process that 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 therapist's task is to pursue his inquiry, making it dynamic and exerting increasing pressure toward the avoided feeling. As I have indicated previously, all the technical interventions that I have introduced to exert pressure are with the major aim of the rapid development of the twin factors of the resistance and the transference feelings. Throughout the interview, the therapist is communicating as much with the patient's unconscious as with his conscious. When the therapist introduces probing questions, it is to convey to the patient's unconscious that the therapist is not going to stop until he has reached the core of the avoided feeling. When the therapist applies confronting remarks, that consist of pointing out something which is entirely true but which the patient does not wish to look at, this intervention conveys that the therapist is well aware of the patient's defensive maneuvers and their self-destructive nature. The immediate effect is that the patient's unconscious becomes alarmed and he goes into resistance.

Major Aims of Exerting Pressure

- (a) Tilting the patient's character defenses in the transference
- (b) Rise in the transference feelings
- (c) Mobilization and intensification of the resistance
- (d) To create some degree of crystallization of the resistance in the transference

- (e) Rapid development of the twin factors of resistance and transference feelings
- (f) Mobilization of the unconscious therapeutic alliance (in some patients)

In summary, one of the most important aims of the phase of pressure is to bring the resistance out in the open.

Technical Interventions to Exert Pressure

We should keep in mind that pressure and challenge are not entirely separate. Some pressure clearly contains an element of challenge:

- Asking patient to be more specific; asking for a specific example
- Probing questions
- Directing the interview toward significant areas; asking for further information in these areas
- Focusing on the actual experience of feelings
- Focusing on the impulse
- Clarifying remarks
- Confronting comments consisting of pointing out some issues which are entirely true but which the patient does not wish to look at
- Repeating a question to block diversionary tactics
- Focusing on fantasies
- Introducing an anxiety-laden area
- Directing the patient's attention to the use of certain words
- Making explicit what the patient has implied but is avoiding
- Underline patient's disturbing feelings
- Confronting comments
- Directing patient's attention to non-verbal cues: Somatic pathway
- Blocking in the form of non-responding
- Directing the interview toward a specific area where the patient has difficulty

To reemphasize, the aim of the phase of pressure is the mobilization of the resistance to the point of some degree of crystallization of the resistance in the transference. The phase of pressure will be discussed in greater detail by presenting a number of patients from the spectrum of resistance, suffering from psychoneurotic disturbances.

The Case of the Salesman

I have already presented this case (Davanloo, 1977, 1983, 1995a), a young married man who suffered from a mild obsessional neurosis, highly responsive, from the extreme left of the spectrum of psychoneurotic disorder with no major resistance. He responded well to the phase of inquiry, gave a clear and lucid account of the evolution of his symptom. He spontaneously mentioned the precipitating factor which was the affair with his sister-in-law. In search of the resistance the therapist focuses on the incident with his sister-in-law: 'Could we look into this incident?' The patient spontaneously gives details and the therapist, knowing that the patient's choice of his sister-in-law must in itself be significant, employs pressure: 'Could you tell me more about your sister-in-law?' The patient speaks of having stopped short of intercourse with her and the therapist moves to the question: 'Did you have the desire?' Patient responded: 'Oh yes, but we never had really time.' 'But the thought was there?' asked the therapist. 'Oh yes, definitely' replied the patient.

The therapist now focuses on feelings: 'How did you feel towards the thought?' The patient speaks of how his feelings have changed: 'At that time I felt it was going to be great. Now I feel differently'. At this point, the therapist makes a confronting comment: 'You were not decisive about it, wanting and not wanting'. It confronts the patient with his indecisiveness, and by implication makes the connection between indecision in a trivial area and indecision in a highly emotionally charged area.

The therapist, in search of the resistance, introduces an area likely to be anxiety-laden: 'How would you describe your sister-in-law in terms of physical appearance?' The patient said: 'She's very well built'. The pressure was asking the patient to be more specific: 'Hm hmm, in what way?' Here, for the first time, the therapist meets the beginning of resistance. But, at the same time, we should clearly understand that the resistances of this patient are simply in the form of some tactical defenses (Davanloo, 1996a,b). We cannot expect major resistance. Then the patient responded: 'Er ..., well, she's very pretty. She has a big chest ... the rest of her body is nice'. The therapist makes an explicit statement, confronting the patient with what he was trying to avoid saying: 'You mean the breasts? She's a large-breasted woman?' Further resistance of vagueness and rumination: 'Yeah. I think, that is what ... I don't have ... I have always been sort of attracted to that'. The therapist again makes an explicit statement, countering the vagueness: 'Would you say that was the part that attracted you the most?' 'Yeah, right' was the patient's reply. The therapist returns to exploration and shortly after that employs his first challenge.

The Case of the Man with the Chewing Gum

Now we can discuss the phase of pressure in a patient with a moderate degree of the resistance: a married man in his late twenties, a blue-collar worker who suffered from a wide range of symptoms and character disturbances, panic, phobic, somatization and functional disorders.

The following vignette is from the phase of inquiry. The patient begins to speak of his symptoms:

PT: *I get dizzy.*
 TH: *Dizzy?*
 PT: *Yeah. I feel faint sometimes.*
 TH: *Faint?*
 PT: *I feel fragile ... is how I feel.*

The therapist focuses on the experience of the feeling:

TH: *What is it like when you feel fragile?*
 PT: *I feel fragile because I am not sure of my footing. And I feel shaky ... and you know ... I feel tense. I am tense.*
 TH: *You feel tense and shaky, what is it like? (Pressure)*

Now the patient responds with a specific example:

PT: *It is hard to explain what it is like. I went into a department store with my wife about a month ago and I had to get out. I thought I was going to*

faint. Then I panicked. My face was pale and my hand was shaking and that is what happens ... I feel faint and then I panic.

The patient gave further details. The important feature that emerged was that his wife had to give up her shopping and accompany him back to their car. The therapist then took some further history. From this, we may pick out the fact that the patient's first attack occurred 5 years ago in a barber shop, and since then his wife has had to cut his hair at home. Later, he mentioned his job where he had recently been promoted to be in charge of a section:

PT: *I was in charge of the whole section, Okay? When my boss was there I was okay. But whenever he said 'I am leaving. I will be back in a couple of hours', then I would start getting worried that I would get this feeling. And I thought ... and it is just ridiculous ... because it builds up in my mind, okay?*

'Secondary gain' of the patient's symptom expresses an underlying regressive defense. Like a child he gets anxious when people of importance leave him while, when possible, his anxiety serves a secondary purpose of keeping them with him.

One of the interventions used in the phase of pressure consists of making confronting comments, pointing out some issue which is entirely true but which the patient does not wish to look at. In this specific patient the issue of secondary gain is used to exert pressure. Now the therapist prepares the ground for highlighting it, knowing that it must inevitably lead to resistance:

TH: *Hm, hmm, up to the time he was there you were doing well.*

PT: *Yeah.*

TH: *But as soon as he would go then you would start to become anxious.*

PT: *Yeah.*

Now a confronting question, inviting the patient to do exactly what his defenses are designed to prevent, i.e. look beneath the surface:

TH: *Why do you think it is that as soon as he would leave, your anxiety would start?*

The patient offers his symptom as the only possible explanation:

PT: *Because I was worried that I would get this feeling, and then if I had that I couldn't do the job.*

TH: *Hm hmm.*

PT: *And that is what happens. It is stupid, but it is there. It is a building process in my head ... the constant thoughts 'you might get a spell; you might get anxious; you might lose your balance; might lose control over your ...'*

TH: *And then what would happen?*

PT: *Nothing has happened.*

TH: *But in your head, what do you anticipate?*

PT: *That I might collapse and nobody would be there to run the place.*

TH: *But when your boss is present, you don't have any of these experiences.*

PT: *Hm hmm. Sure, because I know that if I got sick I would leave and he would ... you know ... take charge of the place.*

Now the invitation is to look beneath the surface again with confronting comments which are put in quotation marks for emphasis:

TH: What do you think about this—his presence, and the impact of his presence? Your being heavily 'dependent' on his presence, and becoming almost 'disorganized' as soon as he walks out?

The patient evades the question and it touches off an involuntary reaction indicating irritation and annoyance with the therapist:

PT: (smiles) I don't know what to think.

The therapist immediately draws attention to the nonverbal cues:

TH: You are smiling.

Eventually the therapist sums up, confronting the patient with the truth:

TH: So ... in your job you have to have your boss around to function, otherwise you become anxious and panicky. And in your personal life you can not function without your wife. She is even the one who has to cut your hair. What do you think about this?

PT: I don't have any thoughts. What can one do when one has all these symptoms.

By this time, the patient is detached, has adopted a distant posture, there is an increase in the rate of his smoking, and he is clearly in a state of major resistance. The phase of challenge begins, which then follows with head-on collision.

TH: How do you feel right now? Have you noticed that you have become much more slow and passive?

PT: (Smiling) I don't think so.

Further Example of the Phase Pressure

The Case of the Chess Player

The following passage is from an interview with a patient with a high degree of resistance, with obsessive character structure, who has major problems in the interpersonal relationships, major problems with intimacy and closeness, self-defeating and self-sabotaging patterns, masochistic character traits, going from frying pan into the fire.

In the early part of the interview the patient described a situation with his supervisor. The therapist exerts pressure by asking the patient for specificity, then with probing question which then follows with pressure for the actual experience of the feeling leading to the intensification of the resistance in the transference:

PT: My tutor was postured, almost in the sense of 'I am the authority and you do that and I am mad that you are not doing that, and ...'

TH: Then he was exerting his power over you.

Obsessional intellectualization in the patient's reply is evident from the words in quotation mark:

PT: Right. And nothing I could 'feed back' to him could possibly 'modify'.

TH: And what was the way you felt when he was exerting power over you?

PT: That is too long ago to get in touch with, other than ...

At this point the process enters into the phase of pressure and challenge, as the patient's character defenses have become crystallized in the transference. The defense of not remembering can often be effectively challenged by the ironical question: 'How is your memory?' To which many patients answer 'Good', putting themselves open to further irony. At this point, the therapist moves and exerts pressure on the patient's feeling:

TH: How long ago is that?

PT: Four years ago.

TH: How is your memory?

PT: Well ... it depends. It is different.

*TH: You say that he was a pain, he was demanding, he pushed you around.
But how did you feel towards him?*

This repetition of the question produces a partial breakdown of the defense and the therapist then proceeds and exerts further pressure toward the actual experience of frustration:

PT: I felt frustrated.

TH: You say 'frustrated'. What was the way you experienced this frustration?

The patient moves to use the defense of vagueness.

Return to Pressure

PT: I am not sure, I felt unfairly pushed.

*TH: You say you were pushed around but how did you feel towards this man
who was pushing you around?*

The pressure produces a further partial breakdown of the defenses and the patient admits he felt 'hostile'. However, when the therapist asks how the patient experiences his feeling, the patient returns to vagueness:

PT: I eventually felt hostile towards him.

TH: What was the way you experienced this hostility?

PT: Hmm, I am not certain.

There is further intensification of the resistance by focusing on the impulse. The patient responds with intensification of intellectualization:

TH: Did you feel that you wanted to verbally lash out or physically?

*PT: Well that is exactly part of the problem. In that kind of situation you have
to negotiate almost by a certain set of rules or priorities, that kind of thing.
I couldn't say to him beyond telling him, 'well, look ...'*

The process from here enters to the phase of challenge. But the phase of challenge, as I have indicated above, is always in the form of pressure and challenge.

To recapitulate so far, the major aim of the phase of pressure is to crystallize the patient's character defenses until we have evidence that the resistance has tangibly crystallized between the therapist and the patient.

The Case of Butch

The following passage is from the beginning of the interview of another patient with moderate degree of the resistance, mid-left of the spectrum of psychoneurotic disturbances. When he entered into treatment he was in his mid-twenties. The setting of the interview is a closed-circuit live interview. Patient was interviewed by a female psychiatrist in training from the research team and then was interviewed by the supervisor. On the way to the interview he made a comment indicating that he had a warm feeling toward the female psychiatrist. The interview moves directly to the phase of pressure. The following passage is from the initial phase of the interview. For the sake of brevity the dialogue has been shortened and paraphrased in a few places, but nothing important has been omitted.

TH: *Let us see how you experience your warm feeling for her? (Pause)*
 TH: *Now you are looking also there.*
 PT: *Yes, I am thinking, I am thinking of ... thinking about what I feel with this ... I said I felt a warm feeling and you are asking me ...*
 TH: *But do you notice you are looking there? Now you move to the position that you don't know why you are looking somewhere else than at me. Because it is a way of dismissing me.*
 PT: *Yeah, I guess so.*
 TH: *'I guess so', hmm, do you notice you are avoiding me?*
 PT: *Yeah.*
 TH: *So could we look into that?*

The session started with the phase of pressure; pressure to his transference feeling towards the female therapist; rapidly to challenge to avoidance and absence of eye contact; some mobilization of the transference component of the resistance. The therapist maintains the focus on the patient's avoidance in the transference:

TH: *Could we look into you avoiding me?*
 PT: *Yeah, okay. I feel from you a cold, cold feeling.*
 TH: *That I am cold.*
 PT: *Yeah.*
 TH: *Could we look into that?*

Further Pressure to the Underlying Feeling

Further pressure to the patient's feeling in the transference; anxiety in the transference:

PT: *... Uncomfortable.*

TH: You feel uncomfortable, what else do you feel?
.....

PT: I feel I, I'm not ... my words aren't coming out freely. Feeling like I am on the guard, I feel like I am on guard for some reason.
.....

Further Pressure

PT: I feel like I am overconscious of myself, I am thinking of how I am sitting, where my hands are.

TH: Hm hmm.

PT: How I am looking at you, am I looking at you? Uh, uh does this mean I'm, you know, ... what does this mean?
.....

PT: Uh I can feel the presence of my body, it is aah.

TH: What way do you experience that? The presence of your body?

PT: I can ... well I'm noticing my body, I am consciously aware of it. I can feel my hands, I can feel my, I can feel my arms, my shoulders, feel my foot, my legs, I am conscious of them where usually ...

TH: What other parts do you feel?

PT: My legs, shoulders, my chest area.

The above passage demonstrates that, as a result of pressure and challenge, there has been rise in anxiety. The discharge pattern of the anxiety is in the form of tension in the striated muscles which starts from the muscles of the thumbs, moves to the forearms, shoulders, muscles of the neck, face, the intercostal muscles, muscles of the abdominal wall, thighs, legs and finally feet. This should be considered a classic discharge pattern of anxiety and this patient, like many others, clearly describes this phenomenon.

Rise in Transference Feelings: Further Pressure to the Patient's Transference Feelings

TH: Obviously you don't like the way I am hmm?

PT: Yeah, I, I don't know, I don't know why.

TH: You like it or you dislike it? I mean which one?

PT: Well I'm not comfortable with it.

TH: Now you are not answering the question. I said do you like the way I am or do you dislike the way I am?

PT: (Deep sigh) I sort of dislike it.

TH: You dislike the way I am?

PT: I don't hate it. I don't ah ...

TH: Now you immediately reassure that you don't hate it.

PT: Yeah.

TH: You say you dislike the way I am.

PT: Yeah, right now.

TH: *Is it similar . . . am I similar to that woman that you saw or am I different in that sense?*

PT: *You are different in that sense.*

The therapist explores the similarities and differences between her eyes and his eyes:

PT: *Her eyes weren't ah as penetrating.*

TH: *Uh huh, you said my eyes are penetrating.*

PT: *Yeah, your eyes are.*

There is some mobilization of unconscious therapeutic alliance and the patient makes a deep communication saying that the therapist's eyes are penetrating and her eyes were much less penetrating.

TH: *You said my eyes are penetrating. What way my eyes are penetrating you?*

PT: *Just very, very . . . you know looking, looking at me like . . .*

Further Pressure towards the Feelings

TH: *Let's see how you experience the dislike, this dislike toward the way I am.*

PT: *I am not comfortable.*

TH: *Yeah, but that doesn't say how you feel, that is a sentence.*

PT: *I feel ah . . .*

Further Pressure to the Transference Feelings

PT: *Essentially frustrated, yes.*

TH: *Hm hmm. Frustrated with who?*

PT: *With you.*

TH: *You feel frustrated with me?*

PT: *Yeah, right now.*

TH: *What's the way you experience your frustration?*

Here the therapist is putting pressure for the actual experience of the frustration in the transference. This mobilizes a set of tactical defenses, which are challenged, with further rise in the transference feelings, and the patient saying 'I am very stiff'.

In this patient, technically, the therapist must maintain pressure, challenge and pressure in the transference until he achieves breakthrough into the unconscious; a major dominance of the unconscious therapeutic alliance over the resistance.

Now I will present another patient; moderate to high degree of resistance, to further discuss the phase of pressure and the entry of the transference.

The Salesman with Somatization and Panic Disorder

When he entered into treatment, he was in his thirties and suffered from a wide range of disturbances, both symptoms and character disturbances, promi-

ment among them were chronic anxiety, panic, intermittent pain in his legs, episodes of intense crushing chest pain and major disturbances in the interpersonal relationships, either becoming distant, detached, totally non-involved or becoming stubborn and defiant. He suffered from a major problem with intimacy and closeness. The first part of the interview demonstrates the phase of pressure. He enters into the interview with anxiety which has transference implication. The therapist does not know anything about the patient. He immediately focuses on the patient's anxiety, makes a brief inquiry into the physiological concomitant of the anxiety then exerts pressure to the underlying feeling.

Pressure to the Underlying Feeling

TH: *I notice you are anxious.*
PT: *Yes ...*
TH: *What do you account for your anxiety? You also had a sigh.*
PT: *I see it as, as, as, as, as, as as ...*
TH: *What do you account for your anxiety right now?*
PT: *I know it has to do with the treatment.*
TH: *How long have you been anxious like this? You took a deep sigh.*
PT: *In the past fifteen to twenty minutes, while I was sitting in the waiting room.*
TH: *Would you say your anxiety has to do with coming to this session and seeing me?*
PT: *Not necessarily you, because I don't know you.*
TH: *But has to do with the session?*
PT: *Yes.*

The above passage is from an initial contact; the patient is visibly anxious, anxiety in the form of tension in the striated muscles; nonverbal cues of clinching the hands, rubbing the thumbs against each other and deep sighing respiration. The therapist directs the patient's attention to the nonverbal cues.

Further Pressure to the Underlying Feeling

TH: *And what else do you feel besides anxiety?*
PT: *Other than anxiety, other than ...*
TH: *What else do you feel besides anxiety?*
PT: *Well, I don't know what else I feel, it's that uh ...*
TH: *What else do you feel right now besides being anxious?*
PT: *I know this is going to be difficult ...*
TH: *Still we don't know how you feel here, towards me besides being anxious.*
PT: *Well, I'm trying to analyse ...*
TH: *Still we don't know how you feel here with me besides anxiety.*

The pressure so far is exerted by: structuring the interview; focusing on anxiety in the transference and pressure to the underlying feeling in the transference. The patient has eye avoidance with some smile, which are not challenged. The therapist should not enter into the phase of challenge until there is further crystallization

of the patient's character defenses in the transference. Now we return to the interview:

- PT: (Sighing) I am trying to understand ...
 TH: What else do you feel besides anxiety; let me to ask you this, how do you feel here with me?
 PT: I feel anxious.
 TH: But what else do you feel?
 PT: I don't know, what else should I feel?
 TH: Still we don't know how you feel here with me.
 PT: I am getting confused about—
 TH: Still, that doesn't say your feelings here towards me.

While I have outlined that the phase of pressure might have passing moments of challenge, but challenge should only start when the patient's character defenses are tilted in the dimension of the transference. I further emphasize that the phase of systematic challenge should only start when the resistance is much better crystallized in the transference. Our research data clearly shows a correlation between crystallization and the duration of the phase of pressure and challenge. In other words if the phase of pressure has been systematically applied with sufficient rise and mobilization of the transference feelings with intensification of the resistance in the transference, and then the therapist enters to a systematic application of the phase of pressure and challenge combined, this definitely shortens the time element necessary for the first direct entry into the unconscious, as compared to the cases where the character defenses are not tilted and crystallized in the transference and the therapist prematurely moves to the phase of challenge, which always leads to a protracted process. Now, we return to the interview.

Pressure and Challenge

- TH: You are anxious about seeing me, but it is important to see how you feel here with me.
 PT: (Deep sigh) I don't really feel anger, uh that's that's ...

Negation, communication from unconscious therapeutic alliance.

- TH: You said you are not angry, but you are the one who used the word anger.
 PT: (Sighs) I am not angry, what I wanted to say is that I feel uncomfortable.
 TH: But uncomfortable doesn't say how you feel here with me.
 PT: I feel inadequate.
 TH: Still, we don't know how you feel here with me. (Patient takes another sigh)
 PT: I'm getting somewhat irritated.
 TH: And you took a deep sigh.
 PT: Now I am getting irritated.
 TH: You say you are getting irritated, which means you are not fully irritated, and then it is not at all clear at whom are you irritated?
 PT: It is obvious it's towards you.
 TH: Then, you are irritated at me? And you have some kind of a smile ... but do you notice, you are also avoiding my eyes?

The above passage shows the phase of pressure and the transition to the phase of pressure and challenge.

Further Case Example

The German Architect

The following passage is from a patient who is highly resistant and suffers from disturbances of the interpersonal relationships, major problem with intimacy and closeness particularly with women, is highly stubborn and defiant with self-defeating and self-sabotaging pattern and masochistic character traits. He enters into the initial interview vague, with vague ruminations. The phase of inquiry is not possible and the process moves to the phase of pressure.

Phase of Inquiry

TH: *Could you tell me what seems to be the problem that you want to get help for it?*
PT: *Uhhh ... no, not exactly. This is one of ...*
TH: *So you don't know exactly what the problem is.*

Phase of Pressure

PT: *I am here, uh, I only have uh, uh ... some ... hazy idea what might be the problem.*
TH: *Now if I question you what seems to be the difficulties that you have, what then would you say?*
PT: *Yes, I am not ever sure whether those difficulties are maybe a normal part of being a human being, aah, however ...*

The patient is vague. He uses vague rumination and wants to intellectualize. The therapist maintains the phase of pressure.

TH: *You see, my question is the difficulties that you have, but now you are moving to the issue of the cause.*

The therapist is exerting pressure by returning to the original question; and we see passing moments of challenge. The aim is:

- (a) Further mobilization of the transference feelings
- (b) Intensification of the transference component of the resistance
- (c) Activation and crystallization of the characterological defenses in the transference

The process clearly demonstrates a rise in the transference feelings and a rise in anxiety in the form of tension in the striated muscles, particularly intercostal muscles. We return to the interview:

PT: *No, I am not. I'm simply explaining that (sighing) ...*
.....

Throughout the above passage, the therapist has avoided challenge to the patient's resistance and continues with the phase of pressure. The following

passage demonstrates a shift from the phase of pressure to the phase of pressure and challenge. Pressure is exerted by probing for feelings, which results in increase in the resistance in the form of a new set of character defenses, which then follows by challenge to the resistance.

- TH: *Problem with feelings. Could you tell me about that? That is merely a sentence. (Challenge)*
- PT: *Yes, it is a sentence. Umm. May be my reaction to things that I should feel are ...*
- TH: *Yeah, but that again is vague—'My reaction to things' ...*
- PT: *Okay.*
- TH: *Now you turn your head on the other side, do you notice that?*
- PT: *I beg your pardon.*
- TH: *You move your head on the ... do you notice that in a sense your head moved?*
- PT: *Yes. I am looking for ah, another tack, you see.*
- TH: *Another tack?*
- PT: *Tack.*
-

Pressure and Challenge to the Resistance

We see intensification of the transference component of the resistance, increased anxiety—in the form of tension in the striated muscles of the hands, of the forearms and intercostal—changing his position, looking away from the therapist and the therapist continues a combined challenge and pressure:

- PT: *Yes, I know, but I am vague. I mean I am very vague about ...*
- TH: *So, the first question for us, what are we going to do about the vagueness? Because up to the time you are vague then we would not have a clear picture of what seems to be the problem.*

The patient admits to his vagueness and the therapist exerts further pressure. There is the element of deactivation of the transference, deactivation of omnipotence and also pointing out the destructive component of remaining vague which, in turn, exerts pressure. We return to the interview:

- PT: *Umm.*
- TH: *Do you see what I mean?*
- PT: *Yes. I see what you mean.*
- TH: *Because up to the time you are vague, then ah we wouldn't understand what seems to be the nature of your problem.*
- PT: *Uh hmm, well I can't tell you why.*
- TH: *Yeah, but you say 'uh hmm', but that doesn't solve our problem here. Because our problem here is first to establish what seems to be the difficulty that you have. But now, if you want to be vague then we wouldn't understand even what is the difficulty. That is the first step.*
- PT: *Well, of course if, may be if I knew what the difficulty was I wouldn't be here.*

TH: Yeah, you see again you move to this 'may be'

PT: Yeah.

TH: ... In other words again limbo state.

In the above passage, the therapist has applied pressure and challenge as well as establishing the therapeutic task. The result has been further intensification of the transference component of the resistance and mobilization of character defenses such as sarcasm and his need to provoke. This finally follows by pressure towards the transference feelings and then by head-on collision with the resistance.

The clinical vignette presented highlights:

- Application of the phase of pressure with a patient with life-long character neurosis
- The importance of tilting the resistance in the direction of the transference
- Crystallization of the patient's character defenses in the transference
- Application of the phase of pressure and challenge, leading to major resistance in the transference and head-on collision with the resistance with the aim to create mobilization of the unconscious, loosening of the psychic system and preparing the ground for the direct access to the unconscious

Further Case Example

The phase of pressure is important in those who are highly resistant with syntonic character pathology. I will discuss two such cases to highlight the phase of pressure.

The Case of the Microphone Man

This patient is a resistant patient from the right side of the spectrum of psychoneurotic disorders. When he entered into treatment he was in his forties, an engineer, divorced and suffered from major disturbances in the interpersonal relationships. He was married to an explosive woman which ended up in divorce. Then he entered into a relationship with a married woman. He became heavily attached to her but she was also highly volatile and he found himself being used and abused, increasingly passive and submissive. He had major conflict over intimacy and closeness, masochistic character trait; self-defeating and self-sabotaging pattern; suffered from episodes of depression, chronic state of anxiety, sleep disturbances and had disturbed relationships with his son and daughter.

The therapist started with inquiry: 'Could you tell me what seems to be the problem?' and the patient responded: 'Well I think it is to have the courage of my conviction'. The therapist maintains the interview structured and exerts pressure by asking the patient to be specific: 'Now you say 'courage of your conviction', what does that mean?' The attempt on the part of the therapist is to help the patient be specific. He finally was able to indicate that one of his problems has to do with interpersonal relationships. The therapist asked for a specific incident. With the help of the therapist he described his landlord, Mr L.; in that incidence, Mr L. was angry at him and slammed the door on him. The therapist exerts pressure.

The following passage demonstrates the phase of pressure. The therapist is focusing on the patient's feeling in relation to Mr L.:

- TH: *How did you feel at that moment?*
 PT: *I just walked away.*
 TH: *But how did you feel? 'Walked away' does not say how you felt.*
 PT: *Well, annoyance.*
 TH: *He slams the door on you and now you say you felt annoyed with him.*
 PT: *Oh, very annoyed.*
 TH: *Could you tell me how did you experience this annoyance?*
 PT: *Well through ... through two or three different mediums I think, one was ...*
 TH: *I questioned you how did you experience the annoyance? Now you are moving to something else.*
 PT: *Oh yes, by ... by simply feeling that I shouldn't be treated that way.*
 TH: *But that is a sentence. Let's to see, I question you—the question is; how did you experience your annoyance? You're answering this by another sentence, you're not telling me how you experienced your annoyance.*
 PT: *Well by a feeling of heatedness I guess.*

This results in: a rise in the transference feelings; a rise in anxiety; the discharge pattern of anxiety in the form of tension in the striated muscles (clenching of the hands and some sighing respiration); further mobilization and crystallization of the resistance. The phase of pressure continues with the aim to make the patient well acquainted with his character defenses; to further crystallize and intensify the rise in the transference and mobilization of the transference component of the resistance. Now the therapist introduces challenge and the process enters into the phase of pressure and challenge to the resistance.

Challenge to the Resistance Outside of the Transference

- TH: *But still that doesn't give us a picture of how you experience your annoyance.*
 PT: *An entering into an unresolved situation.*
 TH: *But that is a description, is not giving us a picture of how you felt your annoyance. That is a sentence.*
 PT: *Well how does one describe things? By sentences right?*
 TH: *Now you said you feel annoyed by this old man okay? And he was in a rage with you and slammed the door on you, hmm?*
 PT: *Yes.*
 TH: *Still we don't know how you experienced your annoyance.*
 PT: *I felt bothered and burdened.*
 TH: *'I felt bothered' doesn't tell us what was the way you experienced your annoyance. Do you see? Still you are vague about telling me the way you experienced your annoyance. Do you notice you are vague about that?*
 PT: *Well I find doctor quite frankly that uh ... (there is anger and further mobilization of the resistance in the transference)*
 TH: *Now just a moment. Do you notice that you are vague?*
 PT: *Uhh ...*

Further Challenge to the Resistance Outside of the Transference

The following passage shows the phase of pressure with challenge:

- PT: Well I've just told you that I felt heated.
- TH: But 'heated' doesn't tell us how you experience your annoyance.
- PT: Well maybe you could explain to me, maybe you ... (Further intensification of the resistance in the transference)
- TH: Now you are moving that I could tell you how you experience annoyance.
- PT: No, no, no I didn't ask that, I didn't ask that. I asked you to give me an example because ...
- TH: Now you see you are now moving away again. I give you an example. I am not sure if you don't understand it. You say you are annoyed with this man.
- PT: I was. I definitely was.
- TH: Okay. Now my question is this; how did you experience your annoyance? Now you become helpless and ruminative—'you give me an example'.

The result is mobilization of the transference component of the resistance; sarcastic smile and with an angry tone he tells to the therapist: 'Maybe you can offer some suggestion, I suppose'.

- TH: And here we are to see how you experienced your anger.
- PT: Yeah but I'm at a loss as to how to explain it quite frankly.
- TH: You are at a loss or you are totally unable?
- PT: You are the psychiatrist doctor, not me.
- TH: Now you move that I am a psychiatrist, and you have also a smile, which is a sarcastic smile.
- PT: Well, that is why I came to you people ... Well, maybe you could offer some suggestion, I suppose.

Now the process enters the phase of challenge and pressure to the resistance in the transference. In the above passage we see further mobilization of transference feelings. In an angry tone, he tells the therapist 'You are the psychiatrist doctor, not me'.

The important technical considerations with such patients are: to apply to the phase of pressure; avoid challenge or systematic challenge until you have made the patient acquainted with his character defenses; rise in the transference feelings; intensification of the resistance; mobilization of transference component of the resistance; and attempt on the part of the therapist for a specific example.

Now we will focus on another patient who is within the range of high resistance, with syntonic character pathology. Some of the major aims of the phase of pressure consist of making the patient systematically acquainted with his character defenses; tilting the patient's character defenses in the transference; crystallization of the patient's resistance in the transference. As I have already emphasized, the therapist should avoid direct challenge to the resistance until he has tangible evidence of mobilization of the patient's character defenses in the transference.

The Man with the Broken Fist

The pseudonym of this patient has to do with a number of incidents in which he had become violent. In one of them, he had an explosive discharge of the affect and punched his girlfriend resulting in a fracture of her ribs. In another incident, he punched the head of another man, and he himself had a major fracture of his right hand. He has isolated himself and lives alone in a small country town. He is a professional artist and painter, suffers from chronic anxiety, disturbances of interpersonal relationships, major problems with intimacy and closeness with both men and women, episodes in which he has become physically violent and has episodes of depression and being suicidal.

Some weeks prior to this interview, he was seen by a psychiatrist and was told that he could not be treated with traditional long-term psychoanalytic psychotherapy. As already mentioned, there was an incident in which he lost control and physically attacked his girlfriend which resulted in a triple fracture of her ribs. Finally, he decided to live alone, has been suicidal, purchased a gun, has a canoe and has had an elaborate plan to go with the canoe to a small, isolated lake near where he lives, and shoot himself in the head in such a way that he would sink with the canoe and 'nobody will ever have a trace' of what happened to him. His physician in the village where he lives has been concerned by some of this behavior, particularly the issue of the gun.

The patient was seen in a closed-circuit setting for teaching and research, and the therapist does not know anything about the patient.

Phase of Inquiry

The following passage indicates that the phase of inquiry is not possible, and the process rapidly moves to the phase of pressure:

- TH: *Do you like to tell me what seems to be the problem that you want to get help for it?*
 PT: *Aah, I wouldn't say it was a specific problem. I would say that I would like to learn more about aspects of myself that I don't know about, I mean that, that ah ... I mean we know, I know of the things that, that I do, I can see that I am doing them but I don't know how.*

The above passage clearly shows vagueness and vague rumination and he did not respond to the therapist's question. He said: 'I wouldn't say it was a specific problem'. The pressure is exerted by structuring the interview and asking to be specific:

- TH: *Are you saying you don't have any identifiable difficulty and then you went to see a psychiatrist at——Institute?*
 PT: *Yeah.*
 TH: *... With no identifiable difficulties?*

The above passage shows the exertion of pressure by trying to be specific and focusing on identifiable difficulties.

- PT: *Well I would say more ... I'm talking more in the realm of exploration, than in the realm of fixing.*

TH: Yeah but what are the difficulties that you have?

The therapist is exerting pressure by repeating the question in the direction of the specificity:

PT: Yeah, well in that they don't pop to mind. Well I, I guess ... maybe I see it as not a difficulty.

TH: Why you say 'Maybe'?

PT: Well because you're, you're viewing it as a ...

TH: You say I view it. I said what seems to be the identifiable difficulty?

PT: I think I'm stuck with the word 'identifiable', I don't identify it.

As we see, the patient declares that he does not understand the word 'identifiable', and we cannot be surprised. In outcome evaluation, he clearly indicates that he was not able to understand; 'Everything was under the cement', 'It is like talking Chinese to a person who does not speak Chinese'.

In the following passage, the therapist exerts pressure by pointing out to the patient that he doesn't have any problems:

TH: Hm hmm, so what you say is this, you don't have any problem.

PT: Aahh I think more I don't identify.

TH: Why you say you 'think'?

PT: I don't identify it.

TH: So you don't have any difficulty.

The short passage of pressure has mobilized some transference feeling which, for the first time, is signalling itself by anxiety in the form of tension in the striated muscles as he takes a deep sigh. We return to the interview.

PT: Hmm, I'm sure I have troubles with aspects of my life.

TH: But you say you are 'sure' you have, as if in a sense you are not definite. You see you say you are sure you have difficulty.

PT: Hm hmm.

TH: But still that is not very definite. You say you are sure you have difficulty; why you say you are sure? (Pause) Either you have or you don't have?

PT: Yes. (Pause) I ...

TH: You have a hesitation here.

PT: Yes because I'm searching for ...

TH: You said you are sure you have some difficulty.

It is important to note that in the beginning the process is always slow and in a specific way is verbalized to the patient. Even if the therapist reflects on the patient's smile, it does not have a challenging tone. It is very much communicated in the form of a clarifying remark.

Often therapists are tempted to move to challenge, or to heavy challenge. Doing that is a major mistake. The patient can easily become confused. During the above passage, there is avoidance, avoidance of eye contact, other resistances such as the resistance against the emotional closeness, which the therapist only registers for future interventions.

PT: Hm hmm.

TH: So there must be something that you say.

- PT: Yeess.
- TH: But with hesitation you say yes.
- PT: Yes, in that I cannot identify it.
- TH: You smile and say that.
- PT: Yes, I cannot identify it.
- TH: Hm hmm. Then how come you come to the conclusion that you have difficulty?
- PT: Hmm ... (pause) Because to be human is to have ...
- TH: What you say is 'because one is human one must have difficulty'. That is abstract ... generalized way. We are not talking about every human, we are talking about you.
- PT: Yes.
- TH: So, here our focus is you. You say you have difficulties, but at the same time you are unable to tell me what are the difficulties.
- PT: Yes.
- TH: I mean you don't come for nothing a hundred miles?
- PT: No, no, no.

In the above passage, the therapist continues to exert pressure, further clarifying remarks, helping the patient see if he can identify the nature of his problem. As we saw, he generalized. This was not challenged but rather pressure was exerted by making a clarifying remark, undoing the generalization and also by emphasizing that the major focus is him. Now we return to the interview:

- PT: Yeah, Uhhmm ...
- TH: And now your head goes ...
- PT: Yeah as I'm trying to think, the areas I'm sure of might ... I say again I'm sure, are my parents.
- TH: Hm hmm.
- PT: But I don't know whether that's uh ...

The therapist avoids challenge. The patient's diversification and rumination are handled by not responding, and the therapist moves to the original question even in a more gentle way, as we see in the following passage:

- TH: I mean what are the difficulties that in a sense motivates you to tell to yourself I should get help or to do something about it?
- PT: Hmm ... of wanting to know ... of wanting to know.
- TH: Yeah you say you have difficulties so then? There must be some difficulty that you come to the conclusion that there is something wrong somewhere.
(Pause)

Further pressure is exerted by directing the interview toward a specific area where the patient has difficulty. He has become increasingly slow and the therapist asks him what he accounts for his slowness. He says:

- PT: Looking at ... looking for the problem, looking at the problem, trying to express the problem.

There has been a gradual but systematic rise in the patient's transference feelings and there has been a few sighing respirations, which indicate tension in the

striated muscles. At this point of the interview he declares that he is anxious. For a moment he declared that his heart was pounding and he felt butterflies in his abdomen. The focus is on his anxiety. The anxiety has a transference implication, has to do with feelings that are mobilized in him in the transference. As we will see in the following passage, the phase of pressure has moments of challenge:

- TH: *And that anxiety has to do with me then?*
PT: *You personally?*
TH: *Or what? You prefer the building or me?*
PT: *Oh oh no, it's the interaction with whoever I'm going to be interacting today.*
TH: *So then obviously is me.*
PT: *And tomorrow if it were somebody else it would be ...*
TH: *Now you see immediately ... you prefer not to ...*
PT: *Oh with you here now yes, with you.*
TH: *Hm hmm. Isn't that?*
PT: *Hm hmm.*
TH: *So could we look to your anxiety about seeing me?*
PT: *Okay. You would like me to describe it?*
TH: *Hmm? Because you have anxiety about seeing me.*
PT: *Yes I do.*

The above passage shows exertion of pressure by holding the process in the transference, which clearly the patient rapidly wants to move away from. The focus is on anxiety and the underlying feeling in the transference. What we can say is that the phase of pressure has resulted in mobilization of the transference feelings, crystallization of the resistance in the transference, as well as loosening of the psychic system.

Phase of Pressure and Challenge; Pressure towards the Transference Feelings

- TH: *What else do you feel about seeing me besides anxiety?*
PT: *Hmmm ... I know it will be tough, uhh ... It's, it's sort of ambivalent thing in that I know it'll be tough and that's fine but I ...*
TH: *You see you say there's a sort of 'ambivalent thing'.*
PT: *There is an ambivalence within me here.*
TH: *But you referred to it as 'thing'.*
PT: *Yes.*
TH: *What do you mean by 'thing'? Ambivalent thing; what do you mean by ambivalent thing?*

The Issue of Ambivalence

The patient has become anxious. There is clenching of the hands, pressing of the thumbs against each other, changing the position of his seating (a sort of a defensive position). The therapist exerts pressure by pointing out nonverbal cues. In the following passage, we see a shift from pure pressure to challenge, first a

passing moment of challenge and then clear challenge. The therapist makes sure that the patient becomes more and more acquainted with the process, his character defenses and so forth. Now we return to the interview and the focus is on ambivalence.

- PT: *Oh maybe I mean ambivalence. There is ...*
TH: *Ambivalence means one part of you wants to come and part of you doesn't want to come.*
PT: *Right.*
TH: *So this means that half of you is here and half of you is not here.*
PT: *Is resisting being here.*
TH: *Hm hmm so then let's to see, we have a major obstacle to start with. That a part of you is here, a part of you is not here. You are one foot in, one foot out. So let's to see.*
PT: *Yeah.*
TH: *But then if you are half-here, half-out ...*
PT: *Hm hmm.*
TH: *... Then this process is going to be defeated.*
PT: *I guess.*

Pressure and Challenge

The process now enters the phase of pressure and challenge.

- TH: *Because in a sense ...*
PT: *Yeah.*
TH: *... you are not here fully.*
PT: *Uhhh I don't know that I can attest to that.*
TH: *You see again you are ruminating about it.*
PT: *Yeah.*
TH: *'Yeah', what yeah?*
PT: *I, I'm not convinced of that.*
TH: *You say yourself that you are ambivalent about being here.*
PT: *Yes.*
TH: *Means namely part of you wants it and part of you doesn't want it.*
PT: *Hm hmm.*
TH: *And what I say is this, that the part that doesn't want is not here then. And that in a sense immediately creates a barrier here, huh?*

Further Pressure and Challenge: Further Mobilization of the Resistance in the Transference

- TH: *So then first we have to see what we are going to do about the part of you that doesn't want to be here?*
PT: *Okay.*
TH: *So could we see what we are going to do about that?*
PT: *Hm hmm.*
TH: *'Hm hmm' what?*
PT: *Yes I would be interested in seeing that.*

TH: *Seeing what?*

PT: *The barrier, I mean dealing with the barrier.*

TH: *No you say in a sense a part of you is not here, is resisting to be here.*

PT: *Hm hmm.*

TH: *Okay?*

PT: *Yes.*

What follows is deactivation of the transference, further challenge and head-on collision with the resistance. If the research protocol is a major unlocking, the process should remain in the transference and the breakthrough of the murderous rage in the transference; the transfer of the murdered body to the biological figure in this case is multiple—mother, brother and father. His unconscious murderous rage and intense guilt in the forefront is at his younger brother with whom he had a very disturbed relation from the early phase of life, and who eventually murdered himself by shooting himself in the head.

Summary and Conclusion

In this article, I briefly presented the central dynamic sequence in the process of rapid and direct access to the unconscious and the application of the phase of pressure. The major aim and the technical interventions of exerting pressure were discussed by presenting and analyzing a number of cases from the spectrum of resistance. The cases presented demonstrated that the phase of pressure aims at mobilization and intensification of the resistance; to create some degree of crystallization of the resistance between the patient and the therapist.

I emphasized strongly that the main factors that influence the course of an interview are the degree of resistance and the extent of the transference component in it. The therapist's task is to pursue his inquiry, make it dynamic and exert increasing pressure toward the avoided feeling.

I further emphasized that the technical interventions that I have introduced to exert pressure aim at the rapid development of the twin factors of resistance and transference feelings. I stressed that throughout the interview the therapist is communicating as much with the patient's unconscious as with his conscious.

It was emphasized that the resistance needs to be crystallized to the point at which it can be challenged meaningfully and effectively. When the resistance is mobilized, whether after a period of pressure or at once, there usually follows a period of intensification of resistance, and systematic challenge begins.

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Intensive Short-Term Dynamic Psychotherapy— Central Dynamic Sequence: Phase of Challenge

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In this article, the author primarily focuses on the phase of challenge as well as on the phase of pressure and challenge. He outlines the various types of challenge and with extensive use of vignettes from clinical interviews, demonstrates the application of challenge to the resistance, both in and outside of the transference. Copyright © 1999 John Wiley & Sons, Ltd.

Introduction

This article concerns itself with the central dynamic sequence in the process of rapid and direct access to the unconscious. I focus primarily on the phase of challenge. I have already indicated that the course of an interview depends very largely on the rapidity of the development of the twin factors of resistance and the transference feelings. Where these two factors are not immediately detectable and are slow to develop, the phase of pressure begins with the search for resistance. When the resistance is mobilized, whether after a period of pressure or at once, there usually follows a period of intensification of the resistance. I have emphasized that the resistance needs to be crystallized to the point at which it can be challenged meaningfully and effectively.

The Phase of Challenge

Challenge is the key intervention in the whole technique, both Intensive Short-Term Dynamic Psychotherapy as well as the new form of Short-Term Psychoanalysis, and lies on a spectrum from relatively mild at one end to exceedingly powerful at the other, culminating in the head-on collision.

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Challenge; Resistance and Therapeutic Alliance

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 resistance and conveys an atmosphere of considerable disrespect for it.

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, to appreciate profoundly the therapist's relentless determination to free him from his burden and to sense dimly the relief he would feel if this could be accomplished. 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 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, the situation changes from the dominance of the resistance to the dominance of the unconscious therapeutic alliance; and in a major breakthrough, we have a major mobilization and dominance of the unconscious therapeutic alliance against the resistance. In an extended repeated unlocking, we have an optimal mobilization of the unconscious therapeutic alliance and, correspondingly, a major breakdown of the resistance.

Relationship between the Phases of Pressure and Challenge

The phase of pressure may contain passing moments of challenge, but systematic challenge is not begun until resistance has tangibly crystallized between therapist and patient, i.e. the patient is not merely trying to avoid his painful feelings—which no doubt he does all the time—but is specifically and repeatedly resisting the therapist's attempts to reach them in the interview situation. Not only must the resistance be challenged, but the patient's attention must be drawn to it and its nature clarified for him. This will have the maximum effect when the patient cannot avoid recognizing it. Therefore, the therapist maintains and increases his pressure, but withholds his challenge until he judges this point has been reached.

It is obvious that the challenge needs to be adapted to the particular type of defense that the patient is using, and there are various types of challenge. The following are some examples:

- *Pointing Out*; drawing attention, always implies calling in question
- *Countering*
- *Blocking*

Challenge needs a great deal of discussion and is best introduced by a series of examples.

Challenge to the Resistance Outside of the Transference

The therapist is focusing on the impulse:

TH: Did you feel that you wanted to physically lash out at him?

PT: *I guess so.*

TH: *You say you 'guess'.*

Here the therapist is pointing out and questioning the defense. Challenge creates a state of tension between the therapist and the patient. The fact that in this particular intervention the therapist makes no attempt to explain why he is questioning the word 'guess' is an example of speaking to the unconscious and creating a state of mystification for the patient's conscious. This serves to further increase the tension.

The following is another example:

TH: *You had the idea that he might become sexually interested in you?*

PT: *Yeah, it was that, I guess.*

TH: *But you say you 'guess'.*

It is important to emphasize the choice of words in the various forms of challenge: 'Do you notice'; 'Now you are moving to the position ...'; 'Hanging it in the middle of nowhere'; 'Leave things in the state of limbo'; 'Is it like that always'; 'But you see'. All these phrases draw the patient's attention to the defenses and clarify them for the patient. But they do much more than this. They convey an atmosphere of considerable disrespect for the resistance.

Questioning, drawing attention and pointing out is the simplest form of challenge; to do no more than draw attention to the defense or to the fact that something is being avoided. Since this is always done in such a way as to call the defensive manoeuvre in question, it is a more powerful form of challenge than might appear at first sight. In the latter part of this article, it will be seen to be an extraordinarily effective way for the therapist to counter certain defenses in the transference without allowing himself to be drawn into the battle of wills.

Further Example of Challenge to the Resistance Outside of the Transference

The Case of the Real Estate Lawyer

PT: *Okay, I left very soon afterwards.*

TH: *You see, you are moving away from what you felt at that moment.*
(Questioning)

.....

PT: *I tried to mask it, I tried to laugh about it in front of everybody.*

TH: *But, still, you are not saying how you felt.* *(Pointing Out)*

.....

PT: *I didn't feel sick. I guess maybe it was ...*

TH: *But you are talking about what you did not feel. I am talking about what you did feel.* *(Pointing Out)*

The Man with the Chewing Gum

I have already discussed this case in the Phase of Pressure. The patient's wife will not travel with him in connection with his work (which he needs her to do to prevent the onset of his phobic anxiety), because she is unwilling to leave their small daughter. He tries to rationalize his feeling:

PT: But what else can she do?

TH: But still you are not talking about your feeling when she says no.

PT: I might get a little upset.

The Tickling Woman

During the interview, she speaks of having had an abortion and she tries to control the waves of painful feeling. When this is pointed out, she moves to rationalization:

TH: You see, I feel there is an upsurge of some feeling in you right now and you are trying to push it aside. Am I right?

PT: Yeah, you are, but it is 'because' I am finding it hard to get onto exactly what it is, because ...

TH: But, still, you are right now fighting the feeling by talking.

Here, I will present a series of abbreviated examples, all containing the element of *calling in question* explicitly and *pointing out*.

Challenge in the Form of Pointing Out and Calling the Defense in Question

'I felt terrible is just a sentence'.

'You are back again to the issue of embarrassed'.

'You are helpless to tell me what your inner experience was'.

'Do you notice you are totally incapable of telling me how you felt?'

'Now you are giving me a picture that you cannot in fantasy imagine ...'

'You move to the position that it is difficult to remember'.

'How is your memory? Do you have problems with your memory?'

'So your memory collapses on you'.

'I am not sure it is that you don't remember but that somehow you want to leave it in the middle of nowhere'.

The above are a few examples of challenges involving pointing out and calling in question the defense of **not remembering**. The following are examples of challenge in the form of pointing out the defense of **vagueness**: 'Why don't you want to be specific?' 'I wonder if you notice that you repeatedly use the phrase: 'I don't know?'

Diversionary Tactic—the patient uses a diversionary tactic and the therapist challenges it by pointing out: 'Again you avoided my question'.

Generalization—the patient is using generalization and the therapist challenges by pointing out: 'But, you see, you are not specific'.

Hypothetical Idea—the following is challenge involving pointing out and calling in question the defense of a hypothetical idea: 'You say you were angry, you are talking in a hypothetical way'.

Rumination, Denial and Avoidance—the following are more examples of challenges involving pointing out and calling in question the defenses of rumination, denial and avoidance: 'Do you see you are using a mere sentence to describe a feeling?' (rumination), 'You are attempting to give me a picture that you were not curious about your mother's body' (denial); 'Still, you prefer not to declare that you were actually interested' (denial); 'You mean you are smiling for no reason'; 'You see you prefer to talk to avoid experiencing how you feel' (avoidance).

The Case of the Man with the Broken Fist

I have already presented this case in the paper on the Phase of Pressure. The therapist is focusing on the patient's feeling:

TH: *So let's see, what is the way you feel?*
PT: *Inept.*
TH: *'Inept' doesn't say how you feel, that is a word.*

.....
TH: *What type of the feeling that generates in you?*
PT: *Not being able to function.*
TH: *But that is not a feeling.*
PT: *Not functioning.*
TH: *It's not a feeling.*

Countering Form of Challenge to the Resistance

This may take various forms. The therapist might ask the patient to make a decision, which is often used when a patient uses such defenses as indirect speech, vagueness and rumination. Another form of countering is 'tearing aside the defense'. Here the therapist makes explicit or asks the patient for an explicit statement of what the patient is avoiding. This form of challenge is often used against cover words, intellectualization and denial.

These forms of challenge are often used in sequence. As an example, the patient is describing his sex life: 'I guess', 'I suppose', 'it was satisfactory', and the therapist applies a countering form of challenge: 'Was it satisfactory or wasn't it?' The following are a few examples of countering form of challenge to the resistance:

The Case of the Salesman

A young married man suffered from a mild obsessional neurosis, from the extreme left of the spectrum of psychoneurotic disorders. He responded very well to the phase of inquiry and gave a very clear and lucid account of the evolution of his symptom neurosis.

In the following passage he uses cover words and rumination and the therapist is challenging it in the form of countering. The therapist is focusing on the Sister-in-Law:

- PT: Well, she is very pretty, and she has a big chest.
 TH: You mean the breast? She is a large-breasted woman?
 PT: Yeah, I think that is what ... I don't know ... I have always been sort of attracted to that.
 TH: Would you say that was the part that attracted you the most?

In another part of the interview, he uses rationalization and the therapist challenges in the form of countering, asking for an explicit statement. During the interview, the question was why the patient used to have fights with his younger brother:

- PT: He used to want to follow me around and I did not want that. He was too young.
 TH: You mean that was the factor?
 PT: Yeah, yeah.
 TH: Was that the factor, or was it that he had become the favourite of your mother? Was there favouritism?

The Case of the Hyperventilating Woman

This is a young married woman in her late twenties, suffering from chronic anxiety, performance anxiety, attacks of hyperventilation, major conflict in her marriage, characterological problems, the need to be used and abused, and inability to assert herself.

She uses rumination and the therapist challenges in the form of countering. The patient is speaking of her male teacher who appeared in a recurrent dream:

- PT: At the time I thought I loved him, but I really just ...
 TH: You mean you loved him in what sense, you had sexual feelings for him?
 PT: Yeah, but ...
 TH: But you say it in a hesitant way. Did you or didn't you?

The Case of Henry IV Man

This patient suffered from character neurosis and was married, and what precipitated his coming into treatment was finding his wife having an affair with her teacher. The pseudonym, Henry IV, is his memory of his father smoking his pipe and having his dog next to him, and the patient referred to his father: 'He was like Henry IV'. The patient uses denial that his father had any interest in him.

He is speaking of a photograph of himself when he was small and sitting on his father's lap, but he tries to deny that this meant that his father had any specialist interest in him:

- PT: It might have just been a photographer who put me on his lap and maybe it was not representative of what he did all the time.

TH: *He had arranged a photographer to take a picture of you on his lap—this means some interest in you. He wants to have a picture of you.*

PT: *Oh yes, as a matter of fact he had a great interest in me.*

In the following passage, the same patient uses the defenses of cover words and intellectualization. The therapist *challenges in the form of countering*, making it explicit. The patient had just described how his mother had had an affair with a friend of the family:

PT: *I felt first of all, it was shocking that my mother ... something must be wrong with her.*

TH: *Did you feel rage with your mother?*

PT: *Yes. I really felt that she's ... I really put the world of people in two categories, people who are straight and people who have ...*

TH: *Did you feel rage with her?*

PT: *Yes, I felt rage with her.*

Challenge in the Form of Blocking

This form of challenge consists of brushing aside the patient's defensive manoeuvre and bringing him back to the point. It is used with many different types of defenses, in particular diversionary tactics and various forms of intellectualizations. The following are a few examples.

The Case of the Chess Player

The following passage is from an interview with a patient with a high degree of resistance who had major problems in interpersonal relationships, problems with intimacy and closeness, a highly self-defeating and self-sabotaging pattern, and masochistic character traits; going from the frying pan into the fire.

The focus is on his brother. He uses diversionary tactics and the therapist challenges it by blocking:

PT: *Yes, I have a recollection that my brother and I fought like hell, like cats and dogs all the time.*

TH: *Fighting like cat and dog.*

PT: *Wait, not just with my brother, with my sister too.*

TH: *I know, but we are focusing on your brother right now, hmm? You repeatedly also want to bring your sister into it.*

In another part of the interview with the same patient, he again uses diversionary tactics:

TH: *What were your sister's and brother's reactions to your being your mother's favourite?*

PT: *Oh, of course they were jealous. My sister is a very sick person. She's still angry about the past—she's totally angry.*

TH: *Mm hmm.*

PT: *She's still living in ...*

TH: *So her relationship with you is a hostile one.*

The therapist focuses on the hostility and the actual experience of rage towards the sister, but the patient wants to diversify to his brother which is blocked. In the same interview, he used the defense of generalization and the therapist challenges by blocking:

- TH: *So your sister's relationship with you is a hostile one.*
 PT: *Her relationship with everybody is a hostile one.*
 TH: *But we are focusing on you.*

The Case of the Masochistic Woman with the Brutal Mother

When she entered into treatment, the patient was a thirty-two-year-old divorcee who suffered from chronic anxiety, performance anxiety, disturbances of interpersonal relationships, major problems with intimacy and closeness, self-defeating and self-sabotaging patterns, gravitating towards men who would use and abuse her, and masochistic character traits.

The therapist is focusing on the anxiety in the transference. She uses diversionary tactics to avoid the transference, and the therapist challenges in the form of blocking:

- PT: *What comes to my mind is that there are many things I'd like to understand about myself. Since I was a child I have been plagued by a certain type of dream which I feel is 'somewhat representative of my behavioral patterns'.*
 TH: *You mean you have recurrent dreams?*
 PT: *Uh hmm, and I think it's indicative of a certain split sometimes in the way I feel.*
 TH: *And what you say is that those dreams reflect on some of your problems in life?*
 PT: *Yes.*
 PT: *Okay, let's stay with this anxiety for a moment.*

The Case of the Man with the Broken Fist

This is a professional artist who suffered from disturbances of interpersonal relationships, chronic anxiety, major problems with intimacy and closeness, depressive episodes, being suicidal.

The focus of the session is on the anxiety in the transference. He uses diversionary tactics to move away from the transference, and the therapist challenges it by blocking:

- TH: *Anxiety has to do with me then?*
 PT: *You personally? ... It is the interaction with whoever I am going to interact with today.*
 TH: *So then obviously it is me.*
 PT: *And tomorrow if it were somebody else ...*
 TH: *Now you want to move away from your anxiety and feeling in relation to me.*

In the same interview, the focus was on the nature of his difficulties, and he was not able to identify them. Then he wanted to diversify to his parents:

- PT: *The areas I am sure I might ... I say again I am sure, are my parents.*
TH: *Now you want me to move to your parents before you tell me the nature of your difficulties.*

The Case of the Real Estate Lawyer

At the time of the initial interview, this patient was 37 years old, married, and suffering from long-term character neurosis. The precipitating factor that brought her to treatment was an incident in the office. Her boss had presented her with a gift box which he gave her in front of some thirty people working in her office. When she opened it, she found the replica of a penis with a note: 'A woman's best friend'. After this incident, she became symptomatic with anxiety, poor concentration, sleep disturbance, etc. During the trial therapy, she had smiled frequently and used generalizations.

The therapist's question is why the patient smiled. She uses generalization which the therapist challenges by blocking:

- PT: *Smiling usually indicates happiness, comfort ...*
TH: *I am talking about you, let's not get to the general.*

In the same interview, she uses intellectualization which the therapist again challenges by blocking:

- PT: *Well, it has made an impact, otherwise 8 or 9 months later I would not still be ...*
TH: *No, let's not go after that. Let's see how you felt.*

Later, she uses intellectualization and the use of 'If'.

- PT: *I guess if I had been male and someone had done this to me my reaction would have been ...*
TH: *Let's not move to if you were male.*

The Case of the Hyperventilating Woman

This patient has already been mentioned. She is describing a series of dreams that she has had at one time about her teacher:

- PT: *Those were the dreams when I thought at some point I loved my teacher. Most girls fall in love with their male teachers I think, but ...*
TH: *Let's not get to 'most girls', let's focus on you.*

In another part of the interview, she uses rationalization which is blocked:

- PT: *Well I felt angry but I wasn't sure that I was justified.*
TH: *No, let's not get into the intellectual aspect of it. Let's look at your feeling.*

The Case of the Salesman

This case has already been mentioned. In this part of the interview, he uses rationalization with the use of 'because'. The question at issue is whether his mother showed favouritism toward his younger brother:

PT: *He was the favourite because he was the youngest.*
 TH: *Let's not get to 'because'.*

This patient in the same interview uses rumination:

TH: *Then obviously there was a wish on your part that you would not think of sex in terms of your parents.*
 PT: *I might have been. I can't really ... It is ... I was thinking back to then, and it is hard to say.*
 TH: *But that doesn't help us. We need to look at your thoughts.*

Further Aspects of Challenge Outside of the Transference

Element of Drawing Attention to the Defense

In the following example, both the challenge and the element of drawing attention to the defense are made stronger by the words 'you see'.

PT: *... So I guess I was annoyed with my mother because even though ...*
 TH: *But you see you are using the word 'guess'.*

The challenge can also be strengthened by the use of a rhetorical question:

TH: *Then you were angry.*
 PT: *Yes, I guess I was.*
 TH: *Why do you say you 'guess'?*

The Case of the Cement Mixer

This was a married man suffering from character neurosis; obsessional neurosis and characterological disturbances, who entered into the interview with anxiety. The following passage is from one of the psychotherapy sessions; drawing attention to the defense.

TH: *You are anxious right now.*
 PT: *I guess I had rage with me. I guess on the way to here.*
 TH: *Why do you say you 'guess?' ... and it is not clear you are talking about rage or murderous feeling? ... We know from the previous sessions, underneath the anger is murderous feelings.*
 PT: *Probably ... it's very difficult to come and sit here and say I have murderous feelings towards my wife.*
 TH: *Why do you say 'probably'?*

A further example:

TH: *Were you jealous of her?*

PT: *I guess so.*

TH: *Why do you say you 'guess'?*

.....

PT: *I might get a little upset.*

TH: *You 'might'? You prefer not to be definite.*

In the following three examples the therapist uses a number of different types of challenge. In addition to some of those already encountered, the therapist asks for a direct answer as a counter to vagueness. In each example, as the resistance crystallizes more strongly, the therapist escalates his challenge in a systematic way.

The Tickling Woman

PT: *If I weren't married I would probably have gone out with him.*

TH: *But you say 'probably'.*

PT: *Well, I would have most likely, I can't see why not. I can't see any reason why I wouldn't.*

TH: *Do you notice that when you are talking about any issue you are using all kinds of sentences, which indicates that you don't want to commit yourself? Do you notice that?*

The Real Estate Lawyer

This case was described earlier, and the following passage is from the same interview:

PT: *I probably was angry but I ...*

TH: *Now you say 'probably' you were angry.*

PT: *Well I am sure I must have been angry. I mean, you know, like ...*

TH: *Now you are moving to the position that you 'must have been' angry, as if you are not sure.*

.....

TH: *But you see first you say you must have been angry, which is not committing yourself. Were you angry or weren't you angry?*

PT: *I probably was.*

TH: *'Probably' again is hanging it in the middle of nowhere.*

The Importance of Drawing the Patient's Attention to the Defense

In reviewing these challenges, it is important to note the choice of the words: 'Do you notice ...?' 'Now you are moving to the position ...'; 'Hanging it in the middle of nowhere'; 'Leaving it in the state of limbo'; 'Is it like that always?' 'Now you move to a silent position'; 'You prefer to look to the opposite wall'; 'Do you notice that your face has no expression and you retreat to a board-like position?'

All these phrases draw the patient's attention to the defenses and the therapist systematically clarifies them and makes the patient acquainted with them. But it is

extremely important to take into consideration that they do much more than this. They convey an atmosphere of considerable disrespect for them. I have already mentioned that one of the essential ingredients of the therapist's attitude in both techniques—Intensive Short-Term Dynamic Psychotherapy and the new form of Short-Term Psychoanalysis—is that, while maintaining the greatest sympathy and respect for the patient, the therapist has neither sympathy nor respect for the patient's defenses that have warped his character. The patient must come to realize that these defenses, the resistance, are in fact devastatingly counter-productive; both emotionally and intellectually they have to see the destructive organization of the resistance and its devastating impact on their life. Obviously, they have to have a direct experience of the pathogenic organization within their unconscious which is responsible for the patient's symptoms and character disturbances.

Fundamental Rules: Technical and Metapsychological Knowledge

Here I formulate very briefly a number of the rules and some of the important technical and metapsychological knowledge:

- (1) The therapist must be well acquainted with the nature of the resistance; major resistance and tactical organization of the major resistance.
- (2) He must have extensive metapsychological knowledge about the unconscious defensive organization; obsessional defenses, spectrum of regressive defenses as well as primitive system of defense.
- (3) Once the phase of challenge has begun, it is absolutely essential for the therapist to challenge and pressure each defense as it is mobilized to the front line of the psychotherapeutic process. This rapid challenge and pressure to the resistance is essential to mount the tension until the final breakthrough into the unconscious takes place. If he does not do this, the tension subsides and will never reach the threshold to achieve the direct access to the unconscious.
- (4) The therapist knows that a high rise in the transference feelings, the intensification of the transference component of the resistance, is the central triggering factor in breakthrough into the unconscious.
- (5) The threshold to achieve the direct access to the unconscious always correlates with the degree of mobilization and intensification of the transference component of the resistance and the direct experience of the transference feelings. But this threshold can be of moderate degree, which results in partial direct access to the unconscious; it might be of a high degree, which results in the spectrum of major direct access to the unconscious; the threshold might be achieved at an optimum mobilization which creates extended and rapid direct access to the unconscious. Optimum mobilization has a central and key position in the new form of Short-Term Psychoanalysis.
- (6) Direct access to the unconscious and unconscious therapeutic alliance. The whole descriptive term of unlocking of the unconscious refers to the dominance of the resistance by the unconscious therapeutic alliance and, as I have already mentioned, the first breakthrough refers to the first dominance of the resistance by the unconscious therapeutic alliance; in major unlocking of the unconscious, we have a major dominance of the resistance by the unconscious therapeutic alliance; in optimum mobilization of unconscious therapeutic alliance, there is a total breakdown of the resistance.

- (7) The therapist must not give up. He must be prepared to continue with his systematic work until he achieves breakthrough in the first session and then for session after session.
- (8) I would like to emphasize that I am not at all suggesting that every therapist who is working with the technique must use exactly the same form of words and phrases in the application of the phase of challenge. But as long as the therapist understands in depth the technical and metapsychological roots of the technique, he should be able to apply it with his own personality and style.
- (9) If we carefully review the examples of challenge given so far, it is possible to conceptualize challenge as follows: making a challenge consists of pointing out, questioning, countering or blocking a defense in such a way as to convey an attitude of scant respect for it.

Further Aspects of Challenge to the Resistance

Speaking to 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 in operation at the same time. It is obvious that this balance depends on where the patient is located within the spectrum of resistance. In highly resistant complex patients, those who are severely traumatized in the very early phase of their life, as well as in subsequent years, the resistance has a very strong hold. But, at the same time, it is the function of the technique and the therapist's task to mobilize the therapeutic alliance, first conscious and then unconscious, and tilt the balance between these two opposing forces in favour of the therapeutic alliance. The final breakthrough is a dominance of the resistance by the unconscious therapeutic alliance.

It is important to note that no matter how strongly the therapist is focusing on the resistance, any intervention that he makes will inevitably contain at least some kind of the implied message to the therapeutic alliance. It is also possible for the therapist to speak to the therapeutic alliance more directly. It tends to be used in its most direct form in the later stages of an interview, when the unconscious therapeutic alliance has been partly mobilized, but the major resistance is far from being at an end. I will further discuss this in a future forthcoming publication on head-on collision with the resistance.

A close examination of many examples of challenge will reveal the presence of this element. For example, in the words 'you see', or 'do you notice' the therapeutic alliance is addressed directly. In these examples, the emphasis was on pointing out or questioning the defense, but when the therapist includes an element of addressing the therapeutic alliance, he usually also points out what is being avoided, and the challenge may consist of little more than this. Here I give two examples.

The Real Estate Lawyer

In this passage from the same interview, the defense that she uses is somatization and the therapist's focus is on the inner experience of anger:

TH: ... Your face is red, your ears are red, your stomach goes flip-flop, but still we don't know what your inner experience was.

The following passage is from the same interview. The defense she uses consists of negative statement, thinking not feeling:

- PT: *I did not feel sick to my stomach. I did not feel angry. I just felt very embarrassed.*
- TH: *But, you see it's not absolutely clear how you felt. You say you did not feel angry, you did not feel sick to your stomach.*
- PT: *I was curious as to who had done it because at that point I was very shocked.*
- TH: *It is not clear how you felt. Do you see we are having difficulty to see how you felt?*

The Case of Henry IV Man

In the following passage of the same interview from the Henry IV Man, the therapist points out both the defense and what is being avoided; avoidance, denial. The patient is referring to his having failed to take note of the signs that his wife was having an affair:

- PT: *I must say I was very naive even though I ...*
- TH: *Let's not get into this. You see, now you prefer to use the word 'naive' as a way not to look at some of these problems.*
- PT: *Yes.*
- TH: *Because if you put in terms of being 'naive', then we are going to dismiss some of the very essential issues. Isn't that so?*
- PT: *Yes, that's right.*

In all these examples, the element of addressing the therapeutic alliance is reinforced by the words 'we' and 'us' which emphasizes that the relationship between the patient and the therapist is a partnership. When much of the patient is identified with his resistance, the result is a heightening of tension within him.

Challenge to the Resistance in the Transference

When a patient enters into the interview in a state of resistance in the transference, the phase of inquiry is kept at bay, and the process moves to the phase of challenge and pressure to the resistance in the transference. Similarly, when a patient enters into the interview with anxiety which has transference implications, again the phase of inquiry is kept at bay and the process moves to the phase of pressure for further crystallization of the resistance in the transference, and then to the phase of challenge to the resistance. And, obviously, there are many patients for whom the transference is not the issue in the very early phase of the interview. Rapidly, or gradually, the transference becomes a central issue and the therapist must be on the look out for when the patient's transference feelings are becoming an issue and he makes an intervention designed to bring them into the open. The intervention might consist of asking the question 'How do you feel right now?' or after describing a pattern in some outside relationship, of drawing attention to the parallel with the transference by asking, 'How about here with me?' The initial

response to such an intervention is almost invariably resistance. In the cases that I have presented so far, the Salesman avoids answering the question altogether; the Chess Player responded with intellectualization when the therapist focused on the transference, 'That is something very much understood'; the Real Estate Lawyer used denial, 'For no reason at all I am smiling'; the Man with the Chewing Gum used both indirect speech and cover words, 'One doesn't like to be told'; the Hyperventilating Woman gave an apparently relevant response which did not actually answer the question, 'I used to be very definite'; and the Praying Mantis maintained her resistance of stubbornness.

The therapist's immediate response to these manifestations of resistance included the following: pointing out and blocking, 'Now you are going into the intellectual issue'; 'You mean you are smiling here with me for no reason?' pointing out the avoidance to the Chewing Gum Man, 'Still you haven't said how you feel'; to the Hyperventilating Woman; 'But do you notice you are indefinite with me?' Thus, many of the patient's defenses are identical to those used in non-transference situations, and these are handled by the therapist with exactly the same kind of challenge. Here, I illustrate further by the following more extended example of a patient from the left side of the spectrum of resistance:

The Case of the Manageress

A young woman suffering from character neurosis; symptoms and character disturbances; disturbances in interpersonal relationships; conflict over intimacy and closeness. All her relationships with men end up in disappointment; she suffered from anxiety; longstanding conflict with her mother; episodes of verbal lashing out, particularly in relation to her mother. In the following passage, the patient has feelings in the transference that the therapist is going too fast:

- TH: *And how do you feel about me going fast?*
PT: *Well, I'd like you to go just a little slower, that is all.*
TH: *But that doesn't say how you feel.*
PT: *Well I don't know how I feel, I haven't thought about how I feel.*
TH: *But again you move to this position of 'I don't know'.*
PT: *Well, I don't.*
TH: *You see, one of the things we see here is repeatedly 'I don't know', which is a helpless position.*

In some cases, particularly on the left side of the spectrum of resistance, a single sustained period of challenge to the transference resistance leads to the first breakthrough.

The Chewing Gum Man

As already discussed, there was mobilization of the resistance in the transference and the patient became tense and immobile when the therapist brought to his attention the secondary gain in his symptoms:

- TH: *How do you feel right now? Have you noticed that you have become much more slow and passive?*

- PT: No, I don't think so.
- TH: Still you haven't said how you feel when I pointed out to you that without your boss and your wife you are helpless.
- PT: Yeah ... mm hmm. One doesn't like to be told that one is so dependent.
- TH: But still you are not talking about the way you feel.
- PT: Perhaps somewhat annoyed.
- TH: But still it is 'perhaps'.
- PT: Yeah, I was annoyed ... because the idea was that I was like a child.

Further Example of Challenge to the Resistance with Transference

The Hyperventilating Woman

As described above, the patient had suffered an attack of hyperventilation after a phone conversation with her sister. After some pressure and challenge, she admitted that her sister had made her angry. The therapist proceeded to the question: 'How do you experience your anger?' to which she answered, 'cried' and became tearful in the interview itself. This was the therapist's cue to open up the transference. This mobilized a series of defenses, each of which was challenged as it appeared:

- TH: So you are holding onto your feeling right now, hmm? Now how did you feel when I repeatedly say you use the words 'guess so', or that you don't commit yourself?

The patient attempts diversionary tactics:

- PT: Well I used to be very definite, over-definite.

The therapist blocks this, bringing her back to the transference:

- TH: But do you notice that you are indefinite with me?
- PT: Yes, I do.
- TH: How did you feel when I insisted on this issue? You are smiling.
- PT: Well ...
- TH: Hmm?
- PT: I find you very aggressive.

The therapist challenges the patient's perception:

- TH: What is it about me that is very aggressive? Because I tell you that you are leaving things in the state of limbo, guess so, hmm? That makes me aggressive, hmm?
- PT: No, it is your tone of voice.
- TH: But how did you feel?

Once more, the patient resorts to diversionary tactics:

- PT: (Giggling) I guess I wasn't prepared for that.

The therapist points out the avoidance:

TH: *You did not say how you felt towards me. Still you are avoiding how you felt toward me.*

She uses a diluted, watered-down phrase:

PT: *(Giggling again) Okay I didn't like it.*

TH: *'Didn't like it' means what?*

She digs in her heels:

PT: *I didn't like it, that's all.*

The therapist presses her further:

TH: *How did you feel when you say you did not like it? You dislike it, Okay? Did it irritate you? Did you get irritated with me?*

Now the patient uses denial followed by rationalization:

PT: *No, not really. I know that you have a method.*

The therapist blocks this diversionary tactic:

TH: *No, let's not get into rationalization about my method or this and that. Did you feel irritated for a moment with me?*

PT: *(She starts to giggle again)*

TH: *You are smiling.*

PT: *I'm going to answer 'I guess so' again, Okay, yes.*

TH: *You felt irritated? You felt angry?*

She resorts to denial again:

PT: *Not angry.*

This denial of a stronger word, anger, acknowledges the weaker one by implication, namely irritation:

TH: *Irritated, hmm? And what did you do with your irritation?*

PT: *I tried to calm myself and not to think of it, you know.*

TH: *But you are irritated?*

PT: *I tried to rationalize why.*

TH: *You started smiling and trying to rationalize, hmm?*

PT: *Yes.*

The therapist calls the defense in question:

TH: *Why? Why do you have to cover up your irritation with me?*

PT: *Because that is how I am with everybody.*

Suddenly the patient begins to talk much more spontaneously:

TH: *This is the way you are in every situation, you try to cover up your real feelings?*

PT: *I did not think about that myself before, but it is true, people always said that about me. 'I can't ever imagine Janet being angry', and they would*

say that to me. And I would say, 'Why do you say things like that? I could be angry'. She said no you couldn't. You can't say no and you can't be angry, because I always smile ...

It is highly significant that in the above passage, the patient has completely abandoned the diluted word 'irritated' in favour of the word 'angry', and it is also clear that she is able to see the connection between her defense of smiling and the feeling of anger. But it should also be taken into consideration that anger by itself, here, is a tactical defensive manoeuvre against underlying murderous rage and guilt. The therapist continues:

TH: *So there are two things about you, hmm? One is that you cannot say no, hmm? You smile when I say that. The other one is that you cannot get angry, and have you noticed that when you talk about anger you prefer the word irritation? Do you notice that?*

PT: Yes.

TH: *Because finally you come to say that you felt irritated with me. In a sense it is easier than to announce that you are angry with me, hmm?*

PT: Well, no, I don't get angry ever.

TH: *Let's face it, you were irritated with me, weren't you? And you tried to cover it up, hmm? But then you said this is a pattern in many other relationships, hmm? Okay, going back to yesterday, how do you feel right now?*

This leads to the first breakthrough as the patient, in a further outburst of spontaneous feeling, reveals the real reason why the phone conversation had made her so angry.

Further Example of Challenge to the Resistance with Transference

The Case of Butch

A young married man in his mid-twenties suffered from diffuse symptom disturbances and characterological problems. He entered the initial interview with some mobilization of the transference feelings and the process moved to the phase of pressure and rapidly to the phase of pressure and challenge, which resulted in further mobilization of the transference feelings and intensification of the resistance in the transference in the very early part of the interview.

The following passage is from the phase of challenge:

TH: *That is another problem you have. Have you ever considered that you might be a stubborn person as well?*

Pointing out, calling in question the stubbornness.

PT: *No, I've never considered it.*

The patient uses denial and the therapist challenges it:

TH: *Hm hm, could we look to that?*

PT: *I think everyone is slightly stubborn.*

The patient wants to resort to intellectualization and generalization, and the therapist challenges by blocking the defenses:

- TH: *Let's not get to everybody, we are talking about you. Because the focus is you here.*
PT: *Okay.*
TH: *Are you a stubborn and defiant type of the person?*
PT: *Yeah.*

The therapist challenges the defenses and underlines the transference implication of these defenses:

- TH: *That in a sense something like this, now he is going to be after my feeling I am going to take a stubborn, defiant, cut-off position with him. Do you see what I mean?*
PT: *Yeah, I see what you mean.*
TH: *Now that he focuses on my feeling, I am going to fight him by being stubborn, by taking a defiant position.*

Systematic challenge to the resistance shortly follows by head-on collision and the breakthrough into the unconscious, direct access into the murderous rage and guilt and grief-laden unconscious feelings.

Challenge to Transference Resistance

There are patients that enter into the interview with anxiety in the transference and some degree of resistance in the transference. In a research setting which depends heavily on closed-circuit live interviews, the procedure might stir up certain feelings in the patient. The patient is being seen either by two independent evaluators or by a psychiatrist-in-training and then by the supervisor. The first evaluator might indicate to the patient that he will be seen in one to three weeks by Dr. ——. But the patient, due to certain unfortunate circumstances (every effort should be made to avoid such unforeseen circumstances), might end up being seen in 2–3 months which mobilizes feelings in the patient, and when he enters into the interview he has anxiety and feelings about being kept waiting. In such circumstances, the phase of inquiry is kept at bay and the therapist focuses on the patient's feelings. The phase of pressure is always short and moves rapidly to the phase of challenge to the resistance in the transference.

Here I want to emphasize that the psychotherapeutic services must avoid any unfortunate circumstances. In the above, we are talking about a patient being kept on the waiting list two to three months in a research setting. But this should not be confused with manipulation of the transference. It should be emphasized that under no circumstances should the therapist manipulate the transference. Manipulation of the transference should be considered unethical and from the technical and metapsychological points of view would have a major negative impact on the process which heavily emphasizes and depends on the mobilization of the unconscious therapeutic alliance against the resistance.

Now I return to the issue of challenge to the resistance in the transference.

The Case of the Masochistic Engineer

When he entered into treatment, the patient was in his early forties and suffered from chronic anxiety, sexual problems, episodes of clinical depression, major problems in his marriage for which he and his wife have been in long-term treatment, with no change. He has characterological problems shifting from passivity and compliance to stubbornness and defiance, resorting to regressive defense of explosive discharge of the affect. He had been seen by a psychiatrist in training who had told him that he would be seen in a few weeks. He ended up being on the waiting list for 3 months.

The therapist might simply explain the situation and apologize, but obviously this is in no way going to help the patient's feeling. The session starts with the phase of inquiry, asking for the nature of his difficulties that he wants to get help for. He is anxious but wants to talk about his wife. The therapist immediately focuses on his anxiety which has a strong transference implication.

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

TH: He specifically told you three weeks? And then you have been three months waiting?

PT: Yeah.

.....

Pressure Toward the Feeling

TH: Let's see how you felt about that?

PT: I was annoyed, quite frankly.

TH: Annoyed?

PT: Annoyed. I mean I said to myself.

TH: You mean you were annoyed and that is past or you are annoyed?

PT: No, I was annoyed at that time.

TH: Not anymore, you mean?

PT: Uh, no, when I called back and you know there was an immediate kind of the reply.

TH: So what you say is this: you were annoyed but you are not annoyed anymore. That is the case you mean?

The above passage shows the application of the phase of pressure to further mobilize the patient's transference feelings and to further mobilize and crystallize the patient's character defenses in the transference. This results in further rise in anxiety and mobilizes a set of defenses. The phase of pressure continues. The discharge pattern of the anxiety is in the form of tension in the striated muscles. There is clenching of the hands and sighing respiration.

Pressure and Challenge

TH: How did you experience your annoyance?

PT: Well, I said to myself, uh, you know, to me it doesn't make sense.

TH: But that is a sentence. You say you were annoyed, but then I said how did you experience this annoyance. Now you are giving a sort of description 'That doesn't make sense'. How did you experience your annoyance?

At this very initial stage, resistance is in the transference. The process enters into the phase of pressure and challenge. As the patient's resistance is crystallized in the transference, the therapist now can systematically challenge the resistance. In the following passage, the therapist is pointing out and questioning the defense, which he follows by pressure toward the feeling:

- PT: Well in my ... in my mind I said uh you know stupid bloody doctors.
TH: 'Stupid bloody doctors' is again a sentence, but what was the way you experienced this?
PT: Oh I didn't show any outward uh yeh I felt uh ... uh ... well like you feel annoyed, I don't ...
TH: How did you experience this annoyance? In terms of thoughts, was stupid bloody doctors ... but then you also make it plural, doctors.
-

In the above passage there is pressure for the actual experience of the feeling and systematic challenge to the resistance.

Further Challenge and Pressure

- TH: Now you become silent again.
PT: Yeh but I'm trying to remember. I'm trying to remember, I mean I'm ...
TH: How you felt you mean.
PT: Exactly what ...
TH: The sentence you can remember but the other part of it you don't remember.
PT: No because you see ...
TH: Let's to look at it. Why? Why the sentence can be remembered but not the other part?

In the above passage, at one level the therapist exerts pressure but, concomitantly, he challenges the resistance of not remembering. The patient has frequent sighs and we see a further rise in the transference feelings. Shortly, he moves to the diversionary tactic of being confused. The diversionary tactic is blocked:

- PT: I am a little confused because.
TH: Now you move to the confusion. Still we don't know how you experience your annoyance.

The phase of pressure and challenge in the transference should systematically continue which finally would lead to the breakthrough of the transference feelings; direct experience of the murderous rage; mobilization of the unconscious therapeutic alliance; partial or major dominance of the resistance by the unconscious therapeutic alliance.

There are patients that enter into the interview and their characterological defenses immediately become a major resistance in the transference. The following is an example of a resistant patient on the right side of the spectrum of the resistance.

The Case of the German Architect

When the patient was first seen, he was in his thirties, suffered from major characterological problems, disturbances in interpersonal relationships, major problems with emotional closeness and long-standing conflict with his family. The therapist does not know anything about the patient. The setting of the interview is teaching and research; closed-circuit live interview. This case has been discussed in other publications.

The following passage is from the initial contact:

- TH: Could you tell me what seems to be the problem that you want to get help for it?
 PT: Uh ... no, not exactly. This is one ...
 TH: So you don't know exactly what the problem is, hmm?
-

The phase of inquiry is not possible. The process enters to the phase of pressure.

Probing for Feeling, Increased Resistance

- TH: Problem with feelings. Could you tell me about that? That is merely a sentence.
 PT: Yes, it is a sentence. Hmm, maybe my reactions to things that I should feel are ...
 TH: Yeah, but that again is vague. 'My reaction to things ...'
 PT: Okay.
 TH: Now you turn your head on the other side, do you notice that?
 PT: I beg your pardon?
 TH: You move your head on the ... do you notice that in a sense your head moved?
 PT: Yes, I'm looking for ah, another tack you see.
 TH: Another?
 PT: Tack.

The following passage shows the phase of pressure which has elements of challenge as the resistance rapidly has become crystallized in the transference:

- TH: What does that mean?
 PT: Ah, another approach.
 TH: Uh hmm.
 PT: Umm.
 TH: Another approach to what?
 PT: To explaining maybe why I'm here.
-

Challenge to the Resistance

The following passage shows the phase of challenge to the patient's resistance:

- PT: Yes, I know but I am vague. I mean I'm very vague about ...

- TH: So the first question for us, what are we going to do about the vagueness? Because up to the time you are vague then we wouldn't have a clear picture of what seems to be the problem.
- PT: Umm ...
- TH: Do you see what I mean?
- PT: Yes, I see what you mean.
- TH: Because up to the time you are vague then ah, we wouldn't understand what seems to be the nature of your problem.
- PT: Uh hmm. Well, I can't tell you why ...
- TH: Yeah, but you say 'uh hmm', but that doesn't solve our problem here because our problem here is first to establish what seems to be the difficulty that you have. But now if you want to be vague, then we wouldn't understand even what is the difficulty. Now, that is the first step.
- PT: Well, of course, if, maybe if I knew what the difficulty was I wouldn't be here.
- TH: Yeah, you see again you move to this, maybe ...
- PT: Yeah.
- TH: ... in other words again, limbo state.

There is further intensification of the resistance in the transference, and the process enters the phase of head-on collision with the transference resistance.

Summary and Conclusion

In this article, I primarily focused on the application of the phase of challenge in the process of direct and rapid access to the unconscious. Here I summarize the key points that were discussed:

- (1) I indicated that challenge is the key intervention in both the technique of Intensive Short-Term Dynamic Psychotherapy as well as in the new form of Short-Term Psychoanalysis, and it lies on a spectrum from relatively mild to exceedingly powerful, culminating in head-on collision.
- (2) I emphasized and pointed out that one of the essential ingredients of the therapist's attitude is that, while he maintains the greatest respect and sympathy for the patient, he has neither sympathy nor respect for the patient's resistance, and conveys an atmosphere of considerable disrespect for the resistance.
- (3) The relation between the phase of pressure and challenge was discussed. There it was emphasized that the phase of pressure may contain passing moments of challenge, but systematic challenge should start when the resistance has tangibly crystallized between therapist and patient. When the resistance is mobilized, whether after a period of pressure or at once, there usually follows a period of intensification of resistance. I emphasized that the resistance needs to be crystallized to the point at which it can be challenged meaningfully and effectively.
- (4) Challenge consists of pointing out, questioning, countering or blocking a defense in such a way as to convey an attitude of scant respect for it.
- (5) Some of the most important forms of challenge were presented and discussed systematically by the presentation of segments of interviews with a number of patients.

- (6) Challenge to the resistance outside of the transference as well as challenge to the resistance in the transference were discussed by presenting vignettes from a number of interviews.
- (7) I then presented a brief summary of the fundamental principles as they apply both to the technique of Intensive Short-Term Dynamic Psychotherapy as well as to the new form of Short-Term Psychoanalysis. There I emphasized that the therapist must have extensive technical and metapsychological knowledge of the technique. Systematic challenge should start after crystallization of the resistance in the transference, and rapid challenge and pressure to the resistance is essential to mount the tension until the final breakthrough into the unconscious takes place.
- (8) The triple factors of resistance, transference and unconscious therapeutic alliance were discussed; it was pointed out that the first breakthrough is defined as the first dominance of the resistance by the unconscious therapeutic alliance. The technique of direct access to the unconscious was briefly discussed, and it was pointed out that in partial and major unlocking, we have partial or major dominance of the resistance by the unconscious therapeutic alliance, which applies to the technique of Intensive Short-Term Dynamic Psychotherapy. In the technique of extended, repeated major unlocking, we have optimum mobilization of the unconscious therapeutic alliance, and there I pointed out that this specific technique is central to the new form of Short-Term Psychoanalysis which allows for extensive, in-depth systematic investigation of the unconscious, with the aim of bringing extensive multidimensional structural character changes.
- (9) Finally, I emphasized that I am not proposing that every psychotherapist who is working with the technique must use exactly the same form of words and phrases in the application of the phase of challenge, but he must understand, in-depth, the technical and metapsychological roots of the technique and apply it with his own personality and character style.

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Intensive Short-Term Dynamic Psychotherapy— Central Dynamic Sequence: Head-On Collision with Resistance

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In this article the author presents his technique of head-on collision with resistance and outlines the major aims and the main technical interventions in head-on collision. In the second part of this article there will be an in-depth presentation of the spectrum of head-on collision; a technical and metapsychological conceptualization. Copyright © 1999 John Wiley & Sons, Ltd.

Introduction

I have already outlined the Central Dynamic Sequence: the phase of inquiry; dynamic inquiry; pressure; challenge; transference resistance; direct and rapid access to the unconscious, and have emphasized that the resistance needs to be crystallized to the point at which it can be challenged meaningfully and systematically. I have already indicated that the course of any interview depends to a great extent on the rapidity of the development of the twin factors of resistance and transference. Where these two factors are not immediately detectable, and are slow to develop, the phase of pressure begins with the search for the resistance. In previous publications, I have presented the phase of challenge and emphasized that it is the key intervention in both the technique of Intensive Short-Term Dynamic Psychotherapy as well as in the new form of Short-Term Psychoanalysis; and I indicated that challenge lies on a spectrum from relatively mild at one end to exceedingly powerful at the other, culminating in the head-on collision. This article briefly presents aspects of the technique of head-on collision with resistance.

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Technique of Head-On Collision with Resistance

Head-on collision is used within the setting of resistance in the transference or when the patient's character defenses, as the result of the phase of pressure or pressure and challenge, have been crystallized in the transference. It may take various forms: there is a spectrum of head-on collision; from single format to composite forms, and at the other end of the spectrum interlocking chain of head-on collision, which is the most complex of all the therapist's interventions.

The Major Aims of Head-On Collision

These could be summarized as follows:

- (1) Total blockade against all defenses maintaining the forces of the resistance
- (2) To mount a direct assault on all the forces maintaining self-destructiveness, self-defeat and self-sabotage
- (3) To intensify the rise in transference feelings
- (4) Mobilization of the therapeutic alliance against the resistance; to tilt the balance between the two forces in favour of the therapeutic alliance. It is essentially addressed to the therapeutic alliance and directed against the self-destructiveness inherent in the patient's conscious or unconscious refusal to abandon his resistance
- (5) To create a state of high tension between resistance and therapeutic alliance in the transference; the act of challenging the resistance combined with the conveyed lack of respect for it creates an extremely complex state within the patient, one in which he both wishes to cling to his resistance ever more strongly and at the same time begins to turn against it, and becomes both angry and deeply appreciative of the therapist's relentless determination to help him. This is what is meant by the tension between resistance and therapeutic alliance. When the process has created tension between resistance and therapeutic alliance in the transference, it calls for further head-on collision with the aim of mobilizing unconscious therapeutic alliance against resistance
- (6) The patient is brought face to face with his self-destructiveness with such communication as 'good-bye', 'doomed', and 'misery' to both shock him out of the syntonic part of his resistance and challenge his unconscious therapeutic alliance to make a supreme effort
- (7) In many cases, the head-on collision results in major communication from unconscious therapeutic alliance
- (8) The aim is to loosen the patient's psychic system in such a way as to make the unconscious more accessible; mobilization of the unconscious
- (9) In the interlocking chain of head-on collision the aim is to loosen or to mobilize the patient's psychic system and to make a partial or major unlocking of the unconscious possible.

The Main Technical Interventions in Head-On Collision

Here I summarize the main technical interventions in head-on collision. But the therapist must keep in mind that in any given case some of them are used

more frequently and some of them are not needed. The following is a summary of the main technical interventions:

- (1) To point out and emphasize the problem and its effect on the patient's life
- (2) Keeping the responsibility with the patient: undoing the omnipotence
- (3) Emphasizing the patient's will: that the patient is the prime mover in seeking help
- (4) Emphasizing the therapeutic task and the patient's goal
- (5) Emphasizing the partnership between the patient and the therapist
- (6) To point out and emphasize the nature of the resistance
- (7) To point out the consequences of the resistance
- (8) Challenging and emphasizing the self-destructive aspect of the resistance; challenging the self-destructiveness in the resistance
- (9) Emphasizing and challenging the self-destructiveness in the transference resistance and emphasizing the consequences of the resistance in the transference
- (10) Establishing and emphasizing a parallel between self-defeating and self-sabotaging patterns in the transference and other relationships
- (11) Emphasizing self-sabotaging and self-destructive aspects of the resistance; the masochistic component of the patient's character resistance; need for self-defeat and self-sabotage; challenge directed at the perpetrator of the unconscious
- (12) Deactivation of the transference; refusing the transference role the patient wants to assign to the therapist
- (13) Deactivation of defiance
- (14) Challenging the dependent transference pattern: the need to use the therapist as a crutch
- (15) Challenge and pressure to the resistance against the emotional closeness
- (16) Pressure to the unconscious therapeutic alliance

Now we can discuss the main technical interventions in head-on collision. In any given interview, the therapist chooses those that he considers appropriate to a specific patient. As I have indicated, head-on collisions are within a spectrum, some fall within the short-range form of head-on collision, others fall in the category of a composite form and at the end of the spectrum is interlocking chain of head-on collision, all with specific indications.

In some cases, all the technical interventions, the making of the head-on collision, follow a logical progression, as in the Case of the Man with the Baseball Bat (Davanloo, 1984a, 1987a), but this is not necessarily the case with every patient. Further, I would like to emphasize that although the wording of all these interventions is very carefully thought out and is the result of the development and refinement over many years of audiovisually recorded research, it is obvious that every therapist must find for himself the particular language with which he feels comfortable. On the other hand, he should have a thorough knowledge about the technical and metapsychological roots of the technique.

Now I will discuss briefly some of the main technical interventions.

To Point Out and Emphasize the Problem and its Effect on the Patient's Life

The therapist must underline the patient's problem which causes him suffering and often must begin by reminding him of this fact in forceful terms. This is particularly important in patients who have a tendency to minimize their

problems and their suffering. Here the therapist might use the words 'Major'; 'Misery'; 'Suffering'; and when appropriate the word 'Agony'. The therapist should make an attempt to maximize the impact of this intervention: 'You see, you know yourself better, but you have a tendency to minimize your difficulties and your suffering'.

Undoing the Omnipotence: Keeping the Responsibility with the Patient

Undoing the omnipotence is closely linked with the deactivation of the transference. Many patients have a strong tendency to transfer to the therapist the role of someone from the past. The aim is to emphasize and bring the patient back into the reality of the task and to avoid getting involved in the patient's transference.

As the therapist's major task is to mobilize the unconscious therapeutic alliance against the resistance, he must at all costs avoid getting into the position of implying that the purpose of the interview is for him to change the patient, rather than for the patient to change himself. The therapist's task is to avoid getting into the position of being omnipotent and a figure of the past.

Throughout the head-on collision, the therapist repeatedly emphasizes the patient's responsibility, 'refusing the transference role' that the patient is trying to impose on him. To give an example: 'I don't know, you have to decide'. Or the head-on collision might contain the question: 'Is it or isn't it?' As a result of this form of head-on collision, the patient accepts responsibility explicitly. The following is from a head-on collision and the therapist is returning to this theme with the words: 'The problem ... suffering ... success or failure ... are yours'. In another head-on collision: 'If we fail, the misery and suffering is yours, but if this becomes a major success, then the happiness and the freedom is yours'.

Emphasizing the Patient's Will: That the Patient is the Prime Mover in Seeking Help

During both the initial interview and the course of the therapy, the therapist attempts to mobilize the patient's will and this can be in the form of head-on collision: 'You have come here on your own will?' Obviously, the therapist must check that the patient really is the prime mover, rather than that he has been 'sent' by another physician or another agent, or that he is only coming out of compliance with someone else. In that case, he should apply a technical intervention to create a shift and make it the patient's will. Always, one of the elements of head-on collision contains emphasis on the patient's will. For example:

TH: (The Case of the Praying Mantis) And you have decided on your own volition, I assume, to do something about it. Am I right in saying that it is your own decision? Or is it that you came because your counsellor referred you?

Emphasizing the Therapeutic Task and the Patient's Goal

This component of head-on collision is closely linked with the element of keeping the responsibility firmly where it lies. Reviewing a large number of head-on collisions, I notice that it is one of the most frequently used elements.

Emphasizing the Partnership between the Patient and the Therapist

Most of the head-on collision emphasizes the partnership, that the patient is a major partner. When the therapist is directly challenging a defense, he assumes the role of adversary against the part of the patient that is identified with his resistance. When he is speaking to the therapeutic alliance, he emphasizes his role as ally; the following is an example: 'One of the major tasks that you and I have is that you and I, with the help of each other, will explore and understand where the core of your problem lies'.

In many interventions forming part of the head-on collision, the therapist may use the word 'We'. Both 'You and I' and 'We' reemphasize the partnership.

To Point Out and Emphasize the Nature of the Resistance

The therapist must point out and specify the nature of the defenses that the patient is using: 'If you maintain a defiant, passive, cut-off position ...'; 'If you are going to avoid'; 'If you remain helpless and incapable of seeing how you felt'; 'As long as you are going to rationalize, intellectualize, ruminate and be vague'; 'You see you keep ruminating and now you want to procrastinate and take a stubborn, defiant position'.

Pointing Out the Consequences of the Resistance

This component is extremely important and sometimes it might be repeated a number of times. It addresses the destructive organization of the resistance. In the Case of the Praying Mantis:

TH: As long as you have a need to censor yourself, we will not be able to get to the core of your problem. What I really want to tell you is this: that you set up a goal for yourself to come here to understand your problem, but by censoring yourself you are defeating the goal. Now my question is this: if your need is to defeat your goal, then why should we meet and have this interview?

Emphasizing the Self-Destructive Aspect of the Resistance; Challenging the Self-Destructiveness in the Resistance

The therapist must introduce explicitly the self-destructive aspect of the resistance and then he can challenge it with a rhetorical question: 'And there will be a self-defeat in it, isn't that so? Now my question is this, why should you of your own will come here to see if we can get to the bottom of your problem and yet at the same time another part of you wants to defeat the aim you have set for yourself and perpetuate your own misery?' The following is another example of challenging self-destructiveness in the resistance (The Case of the Chess Player):

TH: Isn't there an element of self-defeat and self-sabotage? Why do you put a goal for yourself, to come here of your own volition so that together we can

get to the core of your problem, but at the same time you want to make it a failure, which obviously means perpetuating your own suffering?

Emphasizing and Challenging the Self-Destructiveness in the Transference Resistance and Emphasizing the Consequences of the Resistance in the Transference

Some form of the head-on collision is used after the resistance has been crystallized in the transference and has become a transference phenomenon. The therapist could open the head-on collision with the words 'Let's look at your relation here with me'. In the Case of the Praying Mantis, which will be discussed later, the patient was in a state of resistance in the transference and became defiant. The therapist introduces head-on collision: 'Let's look at your relationship here with me', and later on: 'Then I will be useless to you'. This was followed by the question: 'Why should you want to make me useless to you?' These communications carry deep messages.

The word 'useless' can have two distinct meanings. One is concerned with the negation of a person's 'active' role, where the meaning is powerless or ineffective; while the other is concerned with the negation of a more 'passive' role, where the meaning is no longer available for use. In using this word, the therapist is conveying both meanings, saying, on the one hand, that the patient is destructively trying to render him powerless, and that, on the other, this will make him unavailable, which is self-destructive. Based on our empirical clinical research data of the kind of psychopathology that the therapist is working with by means of this intervention, many patients, because of the buried rage, violent rage, primitive murderous rage and intense guilt, suffer from recurring pattern of forming relationships and then destroying them. This repeated pattern presents for a variety of reasons: overt trauma, covert trauma, attachment and bond, the traumatization of the bond, and the pain of the trauma as well as murderous rage and intense guilt. Such patients under the impact of this dynamic system, namely the perpetrator of their unconscious, may constantly try to frustrate and irritate another person to take away his power, or make the other person suffer as they have suffered.

But in the early stage of the interview, which we are considering here, the therapist knows little or nothing about the origins of such problems in the past life of any patient. But this does not matter. Based on our current knowledge about the metapsychology and structure of human neurosis, the therapist can use this form of intervention. In using these words, he has two aims: (1) to deliver a message to the patient's unconscious that he has sensed this kind of destructiveness in the transference, and (2) he is speaking to the unconscious therapeutic alliance directly about the self-destructiveness inherent in such a relationship. It is important to note that this source of resistance has its origin in unconscious rage, or murderous rage, and guilt- and grief-laden feelings. In addition, once the therapist has spoken in this way, he has covered resistance derived from all substructures of the psychic apparatus: destructive murderous rage, intense guilt and self-punishment, and unconscious defensive organization, and so on.

The therapist in using the word 'useless' carries all these highly significant messages and the therapist usually underlines it and repeats it. This underlining

and repeating is extremely important. I demonstrate this in the following passage from the Case of the Masochistic Woman with the Brutal Mother, which I have presented in other publications:

- TH: *If you don't want me to get to your intimate thoughts and feelings, I will be useless to you. It is as simple as that. But what I say is this; why does a young intelligent woman of your age want to do that?*
- PT: *Do what?*
- TH: *To make me useless to you.*
- PT: *No, I don't want you to be useless to me.*
- TH: *But it will happen if the 'wall' is there between you and me. If you don't want me to get to your intimate thoughts and feelings, then I will be useless.*

In the above passage, the word 'useless' was used four times, and it is also important to note that the therapist is focusing on the resistance against emotional closeness, which I will discuss briefly later in this article.

Establishing and Emphasizing a Parallel between Self-Defeating and Self-Sabotaging Patterns in the Transference and other Relationships

This is another component of the head-on collision, and usually the therapist has some information at this point about the patient's life in other relationships. Then, on that basis, he can include in the head-on collision the parallel in the transference with the relationships outside the transference. In the Case of the Praying Mantis; as a result of her refusal to allow sexual penetration, men would leave her with anger. She was stubborn and refused to undergo medical procedures, such as a gynecological examination, and in the beginning of the interview had indicated that she was obstinate with her pediatrician as a child. The therapist had focused on the patient's sexual fantasy during masturbation, the point where she goes to a major resistance in the transference:

- TH: *How do you feel right now when I confronted you with your need to make me useless to you, because if we follow your censorship I will be useless to you obviously? And let's face it, all men have been useless to you—your relationships with all men have been a failure.*

In the Case of the Teeth-grinding Woman:

- TH: *... We would not be able to understand your problem, and we would not be able to get to the core of your problem and then the end result would be that I would become useless to you, in the same way that many years of your treatment with other psychiatrists have been useless. But my question is this, why do you want to do that?*

and then the therapist moves to head-on collision with the resistance against emotional closeness in the transference.

Challenging and Emphasizing Self-Sabotaging and Self-Destructive Aspect of the Resistance; Masochistic Component of the Patient's Character Resistance; Need for Self-Defeat and Self-Sabotage; Challenge Directed at the Perpetrator of the Unconscious

This is extremely important, and there are many elements involved: a wish to avoid pain; far more important is the need for punishment; the presence of intense guilt which is a powerful force in maintaining the resistance; the central issue is the perpetrator of the unconscious which consists of the attachment and bond, the original trauma, the pain of that trauma, primitive murderous rage, intense guilt and grief, and subsequent traumas.

Deactivation of the Transference; Refusing the Transference Role the Patient Wants to Assign to the Therapist

The therapist must vigilantly monitor that the patient's conscious and unconscious perception of the therapist does not become coloured by the patient's perception of the people in his past. The aim of deactivation is to bring the patient into reality.

Challenging the Dependent Transference Pattern; the Need to Use the Therapist as a Crutch

This component of head-on collision is particularly important in patients who have been very badly traumatized in the early part of their lives, patients with fragile character structure who have had very traumatic experiences in the early years. Other examples would be the cases who had been hospitalized due to illness in the early part of their lives. An example would be the Chewing Gum Man, who was hospitalized a number of times in the first few years of his life; other cases would be those hospitalized in the very early phase of life such as premature births, which require incubators; and a pathogenic family life—a highly controlling, demanding mother with no capacity for affectionate bond with the child, and, equally, an absent, ineffective father.

The therapist must challenge any manifestation of the symbiotic transference neurosis in the form of head on collision: '... And now you want to use me as a crutch'.

Rhetorical Question to the Therapeutic Alliance To Mobilize the Therapeutic Alliance Against the Resistance

The focus here is usually on a specific resistance. It is often used when a particular defense has clearly crystallized and especially if the patient agrees; it can be used at any point during the head-on collision and also at other points of the interview as well. It might take the form of: 'What are we going to do?' 'What are you going to do?', or 'Let's see what we are going to do'. These phrases are going to address a specific resistance. As I indicated, it is often used in head-on collision but is also used out of head-on collision. For example, in the Case of the Man with the Baseball Bat, it followed the patient's agreement that, on the one

hand, he continued to be resistant, while on the other hand he could not afford to fail. Another example is the following patient who cannot remember the incident:

- PT: *Well, maybe it is difficult for me to remember the incident.*
TH: *So let's see what are we going to do about this because obviously if it goes on like this, that you have difficulty remembering, then how are we going to understand your problem?*

In the Case of the German Architect, which I have described previously, one of the defenses that crystallized very early was vagueness, which the therapist pointed out. Eventually, the dialogue continued as below, with the rhetorical question again forming the first element in the head-on collision:

- PT: *Yes, I know, but I am vague.*
TH: *So the first question is, what are we going to do about the vagueness?*

This type of intervention, like most of the others in head-on collision, is used to mobilize the therapeutic alliance against the resistance.

In the following passage the therapist uses head-on collision in a composite form. First, he points out and emphasizes the nature of the resistance and then points out the consequences of the resistance. This is then followed by challenging the self-destructiveness in the resistance and then by emphasizing the parallel between self-defeating and self-sabotaging pattern in the transference and other relationships:

- TH: *You see, if you continue to be vague and if you continue to be evasive and generalize and continue with vague rumination and keep things in the state of limbo, then we would not get to understand the core of your problem and the end result would be that I would be useless to you like the 20 years of your past therapy, okay? Now my question is this, why you want to do that?*

This composite form of head-on collision is followed by a rhetorical question to the therapeutic alliance. This passage is followed by the first breakthrough as the patient becomes very sad and holds his head in his hands with the passage of the painful feeling, and crying.

Composite Form of Head-On Collision

Now we can summarize the logical progression of a composite form of head-on collision with the resistance. What the therapist is communicating to the patient is as follows. You have a serious problem which is a major problem and which causes you pain and suffering. It is your problem; you have come here of your own volition seeking help for your problem and suffering. My goal is to understand your problem and my function is to help you achieve your goal. You are now using these resistances but if you continue to use these defenses the process will be a failure and you will be defeating your own goal. This is self-destructive, it can only result in perpetuating your own suffering and misery. Why do you want to do that? In addition there is destructiveness directed against me which is equally self-destructive. Moreover, this is an example of a pattern

which applies to other relationships as well. I don't accept the role of target for your destructiveness which you are trying to thrust upon me, I have no intention of allowing you to make your problem my problem.

TH: Let's look at it, obviously you have a major problem and this problem has been a source of misery and suffering and agony for you. Obviously you are the one to decide: is it a major source of suffering or isn't it?

PT: Yes.

Emphasizing the problem and its effect on the patient's life (1); keeping the responsibility with the patient (2); deactivation of the transference (12).

TH: And I assume you come here on your own volition and you must have a goal, otherwise you wouldn't come here.

Emphasizing the patient's will; the patient is the prime mover (3); emphasizing the therapeutic task (4).

PT: That's right.

TH: The major task that you and I have ahead of us is, with the help of each other, to understand your problem and where the core of your problem lies.

Emphasizing the partnership between patient and therapist (5).

PT: That's right.

TH: The fact is that the problem is yours, suffering is yours, happiness is yours, success is yours and the failure is yours. But if you maintain a defiant, stubborn position, then what will happen here with me?

PT: Nothing.

Keeping the responsibility with the patient (2); emphasizing the nature of the resistance (6); deactivation of the transference (12).

TH: So in a while the session comes to an end, we say goodbye, you go your way and carry on the miserable life you have, and I go my way and say I did my best but I failed. You see, as long as you take a defiant, stubborn position we would not reach the goal and we would not be able to understand the core of your difficulties and the whole process will be doomed to fail.

PT: Yes.

Emphasizing the nature of the resistance (6); and consequences of the resistance (7); in it there is deactivation of the transference (12).

TH: You see there will be self-defeat and self-sabotage in it. Isn't that so? Now, the question I have in my mind is, why should you of your own will come here with the aim to understand your problem and to get to the core of your problem but at the same time another part of you wants to defeat the goal that you set for yourself and wants the perpetuation of your misery and suffering?

PT: I know.

TH: *Then I will end up to be useless.*

PT: *Yes.*

Challenging the self-destructiveness in the resistance (8); challenging the self-destructiveness in the transference resistance (9).

(The first breakthrough is taking place. The patient is sad with tears in his eyes.)

TH: *Why you want to make me useless to you?*

PT: *I don't want that.*

TH: *And obviously throughout your life I assume many people have been useless to you. What I can say is that you have a major self-defeating and self-sabotaging element in you ... and this is right now in operation with me.*

Emphasizing self-destructiveness in the transference (9); and emphasizing a parallel between self-sabotaging pattern in transference and other relations (10).

PT: *Yes, I have ...*

TH: *It is important that we look at this self-defeating, and self-destructive pattern. If this process with me continues like this, we are bound to fail to understand your difficulties and to get to the core of your problem. Then you have to carry your problem the rest of your life ... So this would lead to failure.*

PT: *That's right.*

TH: *Then the question for both of us is what are we going to do about it?*

PT: *To overcome it.*

Pointing out the consequence of the resistance (7); challenging self-sabotaging and self-destructive aspect of the resistance; addressing the masochistic component in the resistance (11); pressure to unconscious therapeutic alliance (16).

The patient has been increasingly sad and tearful. Now the therapist moves to head-on collision with the resistance against emotional closeness and the breakthrough into the unconscious.

Further Example of Head-On Collision

The Case of the Chewing Gum Man

In other publications, I have described the phase of pressure and challenge with this patient, who was 29 years old when he entered into treatment and suffered from major symptom disturbances such as anxiety, panic, functional and somatization disorders, dizziness, loss of balance, staggering, blurring of vision, etc., as well as phobic symptoms and characterological disturbances.

The therapist exerted pressure which consisted of making comments about the patient's secondary gain. This mobilized resistance in the transference and the process then moved to further challenge and pressure to the resistance. Shortly after that, the therapist further exerted pressure, making the comment: as a child the patient was being rocked around the clock by his mother, aunts and grandmother. This mobilized a major resistance in the transference and the therapist moved to head-on collision with the resistance in the transference. The following

passage demonstrates the form of head-on collision which resulted in the breakthrough into the unconscious.

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

TH: Then you run to your mother.

.....

TH: How long that sickness went which your mother, your aunt and your grandmother were shifting and then rocking you?

(The patient becomes detached and distant, and has become vague with avoidance. 'I don't know', 'Well I don't')

PT: (sigh)

.....

At this point, the patient takes a bubble gum from his pocket and starts chewing the gum, which clearly has transference implications.

TH: How do you feel here when you talk about these things?

PT: I don't know, feel ...

TH: Because a while ago I felt that in a sense suddenly you had to go and have a gum.

.....

The focus is on chewing gum to overcome the patient's nervousness, the same way that he is dependent on tranquillizers to overcome his anxiety.

PT: Well I never, never looked at the fact that I chew gum as a, as a, you know, an escape or something.

TH: But you are doing it, you started to do it and still you are continuing chewing gum and you say ...

PT: (Laughs)

TH: You are smiling now. How did you feel when I said that you are still continuing with the chewing gum?

.....

PT: Yeah, it, it's a crutch.

.....

PT: Sure.

TH: So whenever you are anxious, Okay ...

PT: Yeah.

TH: Then you are looking for a crutch.

There is a clear intensification of the transference resistance. All the evidence indicates that he is angry, holding on his feeling and has become very detached, distant and non-involved.

PT: I am mad.

TH: Mad. What is the way you experience the madness?

There was a head-on collision with the intensified resistance in the transference and he finally took the chewing gum out of his mouth and became more angry and non-involved. This finally resulted in the breakthrough into the unconscious with the major passage of the painful feeling about his life with his father who had died from a major stroke, and most of father's symptomatology such as loss of balance, staggering, dizziness, visual experiences, etc., are the symptoms that the patient currently has.

The Case of the Praying Mantis

This form of head-on collision is very important because it illustrates a way of handling a frequently encountered situation that is likely to cause many therapists extreme difficulty. In our research we have a number of patients with a similar pattern and we have classified all of them under the heading of Praying Mantis. The situation is as follows. An attractive, seductive, viciously man-hating, sadomasochistic young woman does her best to involve the therapist in her transference, which consists of leading him into a battle of wills that she has every intention either of winning sadistically or of losing masochistically. The problem is how the therapist can prevent, at all costs, falling into her trap, and make the process a therapeutic triumph without creating a battle of wills and become angry or behaving sadistically himself.

The two key factors for the therapist are: (1) relentlessly throwing back the responsibility where it lies, and (2) equally relentlessly refusing the transference role into which she is trying to thrust him. Both of these themes are central to the head-on collision; in this particular case, as will be seen, they pervade all the therapist's interventions.

It may help any therapist who finds himself with a patient of this kind to remember that behind the vicious attack on men there almost certainly lies deep layers of great pain, the trauma, the covert or overt traumatic experiences of failed relations, the pain of trauma, murderous rage and guilt as well as grief-laden feelings. If the therapist can cling to his knowledge, both technical and metapsychological throughout all the stresses of the transference relationship, he can win through to a situation in which he and the patient are on the same side.

When the patient entered into treatment, she was 25 years old. The immediate cause of her seeking help was that she was suffering from an infection of her genital tract, but, because of her phobic symptoms regarding medical procedures, they could not insert the speculum and the gynecologist had been unable to perform the necessary vaginal examination. She had phobic symptoms, chronic anxiety and episodes of panic attack which dated back to her childhood. Her pediatrician refused to treat her directly as she was stubborn 'turning his office upside down'. Her mother had had to describe her symptoms to the pediatrician over the phone and then carry out her treatment under long-distance instructions. The patient has a major problem with intimacy and closeness, is living alone quite distant from her parents. Her current patterning with men consisted of nightly pick-up relations in which she led the man on and both of them became very sexually excited, but, because of vaginismus and severe pain, she pushed him away as soon as he tried to penetrate her.

The early part of the interview, namely the phase of inquiry and dynamic inquiry, proceeded smoothly until the therapist asked about her sexual fantasies during masturbation:

- TH: *What type of fantasies do you have?*
 PT: *(Patient is smiling)*
 TH: *You are smiling.*
 PT: *I just really don't want to go into it, they embarrass me very much. Can we skip that one?*
 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 your 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 therapist underlines the important—and hopeful—transference message.

- TH: *And do you think that might be here with me?*
 PT: *Well ... I am not going to go into those fantasies.*
 TH: *You're 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 but ...*

The above passage shows a major resistance in the transference which calls upon head-on collision, which now unfolds as follows:

- TH: *What I am struck by is the fact that you have a problem which is a major problem for you. I don't know, you have to decide whether it is or not. But it seems to be a major difficulty for a young woman of your age to face.*

In the above passage the therapist is using the following technical interventions: pointing out the nature of the problem (1); keeping the responsibility with the patient (2); and deactivating the transference (12).

- PT: *All right.*
 TH: *And you have decided on your own volition, again I assume, to do something about it. Am I right in saying that it is your own decision? Or is it that you come because your counsellor refers you?*

Technical intervention; emphasizing the patient's will (3).

- PT: *No, my coming is based totally on my own decision and I have severed my contact with him.*
 TH: *Let's look at it, you are in the state of suffering, you have a problem which is quite a difficult one. Of your own volition you have come here, now by*

censoring yourself we would not be able to get to the core of your problem. Of course it is your problem; but my question to you is this 'Why do you set up a goal to come to understand your problem but at the same time ...?

The above passage shows a number of technical interventions of head-on collision: Pointing out the problem and its affect (1); keeping the responsibility with the patient (2); emphasizing the patient's will (3); emphasizing the nature of the resistance (6); pointing out the consequences of maintaining the resistance (7); and challenging the self-destructiveness in the resistance (8).

PT: I don't see what my sexual fantasies have to do with it.

It is important to point out that at this point it would be very easy for the therapist to say something like: 'Obviously your sexual fantasies are a central issue'. This would be a major mistake as it would allow the process to move into a battle of wills, into an argument which the therapist should avoid at all cost. Moreover, her unconscious knows the importance of her sexual fantasies perfectly well and there is not a slightest need to spell it out. Therefore, he completely ignores her remarks and continues systematically with the next step in the head-on collision:

TH: As long as you have a need to censor yourself, we will not be able to get to the core of the problem. What I really want to tell you is this: that you set up a goal for yourself to come here to understand your problem, but by censoring yourself you are defeating the goal. Now my question is this: if your need is to defeat your goal, then why should we meet and have this interview? ...

In the above passage the therapist continues with head-on collision; emphasizing the nature of the resistance (6); challenging the self-destructiveness in the resistance (8); and challenging the self-destructiveness in the transference resistance (9). The intervention further aims at shocking the patient out of her identification with her own resistance and also deactivates the defiance (13). We return to the interview.

PT: Well ... I find that a very difficult and embarrassing area to talk about.

TH: I understand that, but at the same time if we are going to get to the core of your problem we have to understand them; and you know that very well, unless you want to see this to be a failure and useless to you?

In the above passage, the therapist again reemphasizes the consequences of maintaining the resistance (7) and the self-destructive aspect of the resistance in the transference (9) and keeping the responsibility with the patient (2). Now we go back to the interview.

PT: No, I would not like that.

TH: That is your choice (keeping the responsibility with the patient)

PT: I still ... if you ... I am willing to tell you certain things that are common to my fantasies, but I won't go into specifics. If I tell you the things that happen in every fantasy, time and time again, which I would say is perhaps significant.

Head-On Collision Continues

Here the patient is trying to reveal a little to gain a victory. This is not acceptable, and once more the therapist must not convert the interview into a battle of wills. What he does, therefore, is to change the subject abruptly by asking about the transference feelings, at the same time proceeding to the next two steps in the head-on collision:

TH: *How do you feel right now when I confronted you with your need to make me useless to you? Because if we follow your censorship I will be useless to you obviously. And let's face it, all men have been useless to you, your relationship with all men has been a failure.*

The therapist challenges the patient's self-destructiveness in the transference resistance (9), emphasizing the parallel with the self-sabotaging pattern outside of the transference (10).

PT: *Well, that is quite true.*

TH: *And I think you see it here with me ... that you want to ice skate around, you want to beat around the bush. My question is this: that is fine if you want to beat around the bush, but what would be accomplished here?*

In the above passage the therapist moves to another component of the head-on collision, namely, pointing out the consequences of the resistance (7).

PT: *Well ... it seems to me that you are perhaps not being fair. I mean I don't ...*

TH: *Now let us look into my not being fair.*

PT: *Because my counsellor and I, we have had an argument like this, and I have finally been ...*

Because, although the patient has been trying to argue, the therapist has refused to allow himself to be put in this position, he knows the truth that he has not been arguing, and avoids becoming involved in the patient's transference. The purpose behind this is that of another important technical intervention in the head-on collision, namely, to refuse the transference role that the patient is trying to thrust upon him (12).

TH: *Where have I given any evidence that I am arguing with you? Only what I am telling you is that if you want to get to the core of your problem ... (deactivating the transference and refusing the transference role)*

PT: *No, I am not talking about an argument. It is that we are having an argument/discussion. We have opposing viewpoints.*

TH: *But where is the argument?*

PT: *The argument is that you are trying to convince me ...*

TH: *I am not trying to convince you in any form. Give me a single piece of evidence of any way in which I have tried to convince you. (Further deactivation of the transference)*

PT: *You are telling me—and it is very reasonable, I must admit—that you cannot help me if I don't tell you things.*

In the above passage, the therapist returns to reiterate the head-on collision.

TH: *It is really your life and that is ...*

Here the therapist emphasizes the problem, 'It is really your life'.

PT: I am resisting, and you are correctly ...

TH: I think that is a problem you have. What you are really saying is this, that we have to leave things in a state of limbo and go on for a number of additional sessions.

PT: Now, I have been, look ... I have just offered ...

This word represents yet another attempt to involve the therapist in bargaining, and once more, the therapist continues as if he had not heard it:

TH: You are master of your life.

PT: Okay.

TH: Misery is part of your life and the same with happiness. If I could be of help to you.

PT: Certainly.

TH: There is nothing that I am convincing you. I am only pointing out your need to defeat. But who is the defeated person? It is you, because the problem is yours.

The components of head-collision consist of: keeping the responsibility with the patient (2); and challenging the self-destructiveness in the transference resistance (9).

PT: Well ... I have just ... Okay ... I am telling you that it is a very sensitive thing with me. However, I have said that you have a good point, and ... Okay ... can I tell you things that happen in every fantasy, but I don't want to go into a specific fantasy right now. But is it helpful to you if I tell you things that will come out in every fantasy that I have?

One of the basic principles, which is a dynamic principle of political bargaining, is that when you have won, you allow the other side a face-saving formula, which the therapist now does:

TH: Let's look at them.

PT: Well, at this stage, I will not tell you a specific fantasy. I am sorry. I just can't do that right now.

TH: What is the nature of your fantasies?

Now, there begins a process of relentless questioning about her fantasies, in which the therapist brings out far more than she imagined she was going to reveal. The fantasies usually involve knifing the man in the heart or, particularly, in the back, at the neck level of the vertebral column, during and after intercourse. What further emerged is that knifing at the vertebral column is always present in sexual fantasies with men. She came to realize spontaneously that in her homosexual fantasies there is the absence of murder.

Fusion of Sexuality and Primitive Murderous Rage

What emerges is a fusion of sexuality and the primitive murderous rage in her unconscious, and that her father had a phobia of knives and had a constant preoccupation that she might cut herself. Father was extremely possessive,

compulsively controlling and had preoccupations that she might be raped as well. Her unconscious primitive murderous rage fused with sexuality towards the father becomes the focus of the early phase of the therapy.

Summary and Conclusion

In this article, I have briefly outlined the technique of head-on collision with resistance, which can be summarized as follows:

- (1) I emphasized that the aim of the phase of pressure is to mobilize the resistance until it is tangibly crystallized between the therapist and the patient; then the resistance can be challenged effectively. It was pointed out that challenge is the key intervention and that it lies on a spectrum, from relatively mild at one end to exceedingly powerful at the other, culminating in head-on collision.
- (2) Head-on collision is often used within the setting of resistance in the transference; the therapist might introduce the head-on collision at the point of high tension between therapeutic alliance and resistance, his aim being to bring all forces to bear to tilt the balance in favour of the unconscious therapeutic alliance. If he has timed his intervention well, the therapeutic alliance begins to break through.
- (3) The major aim of head-on collision was discussed; in its composite and interlocking forms, it aims at the total blockade against all forces maintaining the resistance. It is a direct assault on all forces maintaining self-destructiveness, self-defeat and self-sabotage. I further indicated that it aims to loosen the patient's psychic system, mobilization of the unconscious in such a way as to make it more accessible.
- (4) The main technical interventions in head-on collision were presented and discussed by analyzing a few vignettes of specific forms of head-on collision with a number of the patients.
- (5) There are specific forms of head-on collision which are primarily designed for loosening the patient's psychic system; mobilization of the unconscious. They have major indications in patients who are extremely resistant with syntonic character pathology. These forms of head-on collision are of great importance psychotherapeutically and scientifically, as well as in clinical research.

In conclusion, there is a spectrum of head-on collisions, and each of them is with a specific indication, such as: head-on collision aiming at the mobilization of the unconscious and loosening of the psychic system; interlocking chain of head-on collisions; and various forms of head-on collision aiming at breakthrough into the unconscious when the resistance is heavily crystallized in the transference. These are presented in many audiovisual symposia, courses and training programs, and will be discussed in great detail in future publications.

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