The Technique of Unlocking of the Unconscious. Part I

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This two-part article focuses on the discovery of the technique of unlocking the unconscious and the direct view of multifoci core neurotic structure by the author. The process of the unlocking of the unconscious can be divided into a number of phases. The aim of the first seven phases is to create an intrapsychic crisis between the patient's resistance and his therapeutic alliance, which results in the breakthrough of very complex feelings mostly in the transference. This breakthrough represents the essential triggering mechanism for unlocking the unconscious. Then the process enters to the interpretative phase and the direct view of the multifoci core neurotic structure responsible for patient's symptoms as well as character disturbances. In the second part of this two-part article a verbatim account of complete interview will be used for illustration.

While in a previous article I discussed the nature of resistance and the various types of intervention that can be used to overcome it, in the present two-part article I shall describe the whole process in which these interventions are used, and the way in which they eventually make possible direct access to the patient's unconscious.

The complete process, which is used at trial therapy in the initial evaluation interview, can be divided into a series of phases, each consisting of a particular type of intervention with its corresponding response. These together make up what I call the *Central Dynamic Sequence,* which may be summarized as follows:

Phase (1)
- (a) Inquiry, exploring the patient's difficulties; initial ability to respond.
- (b) Rapid identification and clarification of patient's defenses.

Phase (2) Pressure, leading to Resistance in the Form of a Series of Defenses.

Phase (3) Clarification of Defenses
- (a) Clarification, challenge to defenses, leading to rising transference and increased resistance.
- (b) Challenge directed against the defenses; recapitulation of the defenses and casting doubt on the defenses.
- (c) Challenge directed toward the therapeutic alliance.
- (d) To make the patient acquainted with his defenses so that he can see that his defenses have paralyzed his functioning.
- (e) To turn the patient against his own defenses.

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Phase (4) Transference Resistance
- (a) Clarification and challenge to transference resistance.
- (b) Head-on collision with the transference resistance with special reference to that maintained by the superego.
- (c) Exhaustion of resistance and communication from the unconscious therapeutic alliance.

Phase (5) Intrapsychic Crisis
- (a) High rise in the complex transference feeling, breakthrough of the complex transference feeling—the triggering mechanism for unlocking the unconscious.
- (b) Interpretative phase.
- (c) The first direct view of the multifoci core neurotic structure.

Phase (6) Systematic analysis of the transference leading to resolution of the residual resistance with partial or major de-repression of current or recent past (C) and distant past conflicts (P).

Phase (7) Inquiry, completing dynamic phenomenological approach to patient's psychopathology, medical psychiatric and social history and developmental history.

Phase (8) Direct view of the multifoci core neurotic structure and its relation to patients symptom and character disturbances and psychotherapeutic plan.

Of course not all trial therapies consist exactly of this simple sequence. The phases tend to overlap and most interviews of necessity contain a good deal of repetition and thus proceed in a spiral rather than a straight line. Nevertheless careful dissection will almost always reveal all these phases in their natural order. The central dynamic sequence can therefore be seen as a framework which the therapist can use as a guide, constantly working from one phase to another.

However, the first subject to be discussed must be the classification of patients, with reference to the types for whom the technique either is indicated or contraindicated.

Contraindication

The main general contraindications to Intensive Short-Term Dynamic Psychotherapy are severe fragile ego structure; major affective disorder; manic depressive disorder; psychotic breakdown; developmental neurosis such as borderline disorder, severe alcoholism, or drug abuse; serious sociopathic tendencies; an inability to function without constant support and certain potentially life-threatening psychosomatic conditions such as ulcerative colitis. These contraindications may be detected from the history, from the signal appearing in the interview such as disruption of the cognitive function of the ego, disorganization of the thought process, and the ego's very low capacity to tolerate anxiety. The clinician's clinical skill to detect the danger signal in the first few minutes of the interview is obviously important and his ability to modify the technique accordingly is essential.

Indication

Spectrum of Structural Neurosis

With the exception of patients with severe fragile ego structure, all neurotic patients are suitable for Intensive Short-Term Dynamic Psychotherapy. However, the ease with which the breakthrough can be achieved, and the relative emphasis on different types of intervention, depend on a number of different variables. In this connection I arrange patients in a spectrum running from the least difficult on the left, to the most difficult on the right as follows:

On the left are highly motivated and responsive patients with single psychotherapeutic focus based either on an inability to face grief, or on conflict in uncomplicated triangular family relationships. These patients suffer neither from character pathology nor from resistance arising from the superego.

As one passes toward the right, motivation decreases and the following variables increase: resistance, severity and diffuseness of character pathology, impoverished relationships, and involvement of a punitive superego leading to self-destructiveness; and finally toward the right-hand end the character pathology becomes increasingly ego-syntonic, i.e., the patient becomes identified with his defenses.

In this right-hand part of the spectrum, therefore, the following elements in the central dynamic sequence must be given more and more emphasis:

- acquainting the patient with the fact that he is using defenses, clarifying what they are, and pointing out their self-destructiveness;
- sustaining and steadily increasing the power of the challenges used;
- dealing with the inability to allow emotional closeness in the transference;
- challenging the resistance of the superego.
- in highly resistant patients with ego-syntonic character pathology the phase of clarification and elaboration of the patient's ego syntonic character defenses is an essential step before the therapist undertakes a relentless challenge and pressure to the patient's resistance;

sufficient work must be done to restructure the ego-syntonic defenses to ego-dystonic before the therapist proceeds to the unlocking of the unconscious. In patients with severe character pathology who suffer in addition from (a) chronic depression with major depressive episodes, (b) panic disorders, (c) somatization disorders, (d) functional disorders such as irritable bowel syndrome, restructuring of the ego's regressive defenses is an essential step before the unlocking of the unconscious. These patients suffer from a deep-seated inability to distinguish between the impulse of anger and the other two corners of the triangle of conflict, namely defense and anxiety. If the therapist, without restructuring, attempts to achieve a breakthrough by means of steadily increasing pressure and challenge, the only result is creation of misalliance.

The therapist should apply the restructuring technique, the essential features of which consist of (a) regulating the pressure very carefully and immediately reducing it when there are signs that too much anxiety is being aroused, and (b) repeatedly driving home cognitive insight into the connection between defense, anxiety and impulse. The main way of regulating the pressure is to proceed in a spiral deliberately, repeatedly moving the focus from the area of current relationships (C) to the transference (T) and back again. Nevertheless this part of the interview contains all the elements of the central dynamic sequence, the difference being essentially quantitative rather than qualitative. By this means the patient's defensive system can be gradually restructured, and now the therapist can go on to a steadily progressive technique and achieve a breakthrough without risk. (For a full description of this technique, with a detailed clinical example, see Davanloo, 1987, a, b, c, d).

The rest of these articles will be mainly concerned with the use of the central dynamic sequence in the right hand half of the spectrum. In the first part of the present article I shall use brief illustrative excerpts taken from interviews with patients who have already been described in detail in previous articles, namely the Man from Southampton and the German Architect and three other interviews. These patients were poorly motivated and suffered from diffuse, ego-syntonic character pathology, impoverished relationships, self-destructive life patterns, and resistance maintained by the superego. In the second article I shall illustrate the technique in greater detail by means of a full interview.

It should be added here that although these patients lie in the right hand half of the spectrum, they should not by any means be considered the most difficult patients on the right side of the spectrum.

Detailed Description of the Central Dynamic Sequence

In the following account the abbreviations C, T, and P refer to the three corners of the triangle of person, Current (which includes recent past), Transference, and Past (i.e., distant past), respectively.

Phase (1): Exploring the Patient's Difficulties

Inquiry in the Area of C

The therapist opens with a question about the patient's complaints, e.g., "Can you tell me what seems to be the problem"? Patients in the left-hand half of the spectrum usually respond by describing some current difficulty, and as long as answers are freely and spontaneously given, the therapist continues with further clarification and history-taking.

Most patients in the right-hand half of the spectrum show resistance from the beginning and are unable to describe their difficulties. Below are examples;

The Man from Southampton

PT: I don't know, it's been a long time that I've been seeing doctors, and in all that time I don't know that I would be able to identify the problem . . .

Exploring his difficulties:

PT: I still feel somewhat guilty about it but . . .
TH: What is that you refer to as guilt when you say . . .?
PT: Well I have always felt that I should not be doing what I do.

The defense of vagueness, his tactical defenses to distance himself from his feeling in referring to his sexual life is clarified with some degree of challenge.

In cases such as this pressure begins at once.

Phase (2): Pressure, Leading to Increased Resistance

Among the many ways of exerting pressure the five most often used – like the major phases of the central dynamic sequence – themselves form a logical sequence, as follows:

(a) directing the patient toward significant areas that give him difficulty in his current life, or asking him to elaborate on areas already mentioned;
(b) asking him to be more specific, or asking for a specific example of a recent incident that has given him difficulty.

The interview then often crystallizes around such an incident and leads to the next three forms of pressure:

(c) focusing on feelings aroused by the incident;
(d) focusing on the actual experience of feelings;
(e) if anger is involved, focusing on impulses.

Even if they start by answering freely, most patients become resistant in response to any of the above interventions, because they sense consciously or unconsciously that painful or avoided areas are being approached.

Resistance may be defined as the use of defenses in the therapeutic situation, and therefore when an interview is being described the terms "resistance" and "defense" can often be used interchangeably. Resistance usually takes the form of a series of tactical defenses, of which there are a very large number, such as vagueness, intellectualization, obsessional rumination, diversionary tactics, defiance, etc.

The therapist may persist with his pressure, often reiterating his questions, for a considerable time, waiting until the resistance has crystallized unmistakably so that he can move on to clarification and challenge. In the

case of the Man from Southampton the patient was repeatedly pressed to be more specific or to give specific examples, but he was quite unable to do so. Only when this had become obvious did the therapist move on to Phase (3). With the German Architect the resistance was so clearly in evidence from the beginning that the therapist moved to Phase (3) almost at once.

Phase (3)

(a) Clarification and (b) challenge to the defenses in the area of C.

These two types of intervention overlap and need to be considered together, since almost all clarification contains an element of challenge, and most challenges contain an element of clarification. Their relation is of fundamental importance and is best introduced as follows:

Until the final breakthrough takes place there are always two opposite forces at work in the patient, with each of which a part of him is identified, though this is largely unconscious. The part that wishes to obtain relief is identified with his therapeutic alliance, while the part that wishes to avoid pain is identified with his resistance. Equally, whenever the therapist speaks, his remarks will lie at some point on a spectrum; at one end they are addressed to the part of the patient that is indentified with the therapeutic alliance, at the other end they are addressed to the part identified with the resistance, and in between they may be addressed – in various proportions – to a combination of the two.

In the third phase of the interview the therapist's aims are first, to speak to the therapeutic alliance, clarifying the nature of the defenses; and then to speak to the resistance, challenging each defense as it arises, which means calling it in question, casting doubt on it.

The following are three examples lying at different points on the spectrum of clarification, addressed to the therapeutic alliance, and challenge, addressed to the resistance.

The first example simply clarifies the fact of using defenses:

TH: *It's not clear how you felt. Do you see we are having difficulty seeing how you felt?* (The Case of the Corporate Lawyer)

In the next example the therapist specifies the nature of the defenses but introduces an element of challenge as well:

TH: (to the Man from Southampton) *Now could we clarify a few things, because I wonder if you notice you generalize issues or difficulties that you have? You generalize and somehow you remain vague. You see, for example, you say "sexual difficulties," or you say you feel "guilty," okay? These are all labels, they are vague, and we don't understand what really you mean by any of these issues. Do you notice that?*

This example consists mainly of clarification, but the therapist has also used words and phrases (such as "labels," "vague," "do you notice"?) which

call the defenses in question or cast doubt on them – which are two of the essential features of challenge. As long as clarification is present, it is legitimate to introduce an element of challenge at the same time.

In the third example there is yet another element:

TH: (To the German Architect) *Yeah, but you see this is very vague. 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 . . .*

Here, in addition to clarification there is a strong element of casting doubt on the defenses. It is essential to emphasize the following.

The rationale behind these interventions is that once the patient has been acquainted with his defenses, he will begin, so to speak, to see the sense of the therapist's challenges and turn against the defenses himself. Then, a situation which is potentially one of external conflict between patient and therapist is transferred to within the patient and becomes an internal conflict between his therapeutic alliance and his resistance. As the therapist heightens this internal tension, this will eventually lead to an intrapsychic crisis, which forms an essential step in the process of unlocking the unconscious. However, if the patient has not first been acquainted with his defenses, he will take the challenge as referring to himself, and then the conflict will remain external – his therapeutic alliance will turn, not against his defenses, but against the therapist. The result will be a misalliance, and the whole therapeutic process will be at an impasse.

In this connection I have carried out the following clinical experiment: Where a trainee or colleague has made the mistake of introducing challenge without sufficient clarification, I have interviewed the patient, shown him the videotape of the relevant passage, and asked him to describe his feelings. Invariably he has said that he failed to understand what the therapist was doing and felt himself to be under attack. When, on the other hand, challenge has been preceded by systematic clarification, the patient has clearly understood his resistances that have paralyzed his function have been challenged. Though he may have been angry at the time, his principal feelings now consist of warmth and appreciation.

Not all challenges are directed against the defenses. There is also a second kind of challenge which is directed toward the therapeutic alliance, aiming to mobilize it against the resistance. This is particularly important when the patient is strongly identified with his resistance, i.e., it is ego-syntonic to him, as in the following piece of dialogue:

PT: (the German Architect) *Yes, I know, but I am vague. I mean I'm very vague about . . .*

TH: *So the first question for us is, what are we going to do about the vagueness? Because as long as you are vague then we won't have a clear picture of what seems to be the problem . . . Our problem here is first to establish what seems to be the difficulty that you have. But if you want to be vague, then we wouldn't even understand what is the difficulty.*

Here the words "what are we going to do"? constitute the challenge to the therapeutic alliance, while the whole of the intervention is designed to begin the process of making the defenses more ego-dystonic.

The therapist may go on to point out explicitly that the defenses are a manifestation of self-destructiveness or self-sabotage, and he may use language such as that they are "a crippling force," or "the ulcers of your life." Some of his interventions may be identical with those used in the head-on collision in Phase (4), but the emphasis and the aims are different. In Phase (4) the aim is to mount a powerful assault on the resistance maintained by the superego. Here, on the other hand, his aims are twofold: to clarify his position in relation to the two opposing parts of the patient, and to begin the process of making the defenses ego-dystonic. The patient needs to be brought to see that his defenses have paralyzed his functioning throughout his life, and thus to understand at a deep level that the therapist's challenge to them is carried out in order to free him.

Once the therapist has driven this message home he can begin to increase the strength of his challenge against each defense as it arises, without the fear that he will create a misalliance.

There is no space to describe the many forms that such challenges may take, but the following are two examples, both taken from the interview with the Man from Southampton.

TH: Do you notice you want to leave things in a state of limbo? "You know," "I guess," "perhaps,"? Is it like that always?
PT: Because I don't remember distinctly . . .
TH: How is your memory usually?

The first example includes clarification, but the word "limbo" and the deliberate irony in the question, "Is it like that always?", are used to challenge the defenses and cast doubt on them. In the second example the question, "How is your memory usually"?, is itself challenging; and it is used to bring out that the patient has problems with his memory only over personal issues, so that his apparent loss of memory is a defense. Thus this intervention also includes clarification as well as challenge.

Finally, there are some challenges which do not include clarification, such as bringing the patient to commit himself to a decision, as in the following example also taken from the Man from Southampton. The subject at issue is the patient's sexual life:

TH: What was it like?
PT: For me it was exciting and I suppose it was more or less satisfactory.
TH: But you say "suppose."
PT: Well otherwise I would not have wanted to–
TH: Was it satisfactory or wasn't it?

To summarize, the aim of these challenges, directed against the defenses and toward the therapeutic alliance, is to turn the patient against his own

defenses. The ultimate aim is, by raising the tension between the two halves of him, to create an intrapsychic crisis. This process is continued in phase 4.

Phase (4a) Challenge to the Transference Resistance (T)

As the inner tension between the two parts of the patient is progressively raised, it inevitably begins to manifest itself between patient and therapist in the form of conflicting transference feelings. The part of the patient that is identified with his defenses reacts with anger at having them challenged; while the part that is identified with the therapeutic alliance reacts with warmth and appreciation toward the therapist for his sustained efforts to help. In the great majority of patients both the negative and the positive transference feelings give rise to further resistance, the negative because the patient has conflict over his anger which has its unconscious link with unconscious repressed sadistic impulses in relation to the past, and the positive because in the past warmth and closeness have always ended in disappointment. The result is an intensification of resistance, which has now become a transference phenomenon.

During Phase (4) the therapist must monitor the signs of this with great care. They are more often nonverbal than verbal. Signs that the patient is defending himself against anger may consist of clenched fists, gripping the arms of the chair, becoming increasingly tense and passive, involuntary smiling, or sighing respiration; while the signs that he is defending himself against positive feeling and emotional closeness may come from the over-all atmosphere of distancing and also from the avoidance of eye contact. When the therapist senses that the tension has reached a sufficient pitch, he breaks in with a direct question, and he frequently follows this up by drawing attention to the nonverbal signals:

TH: (to the Man from Southampton) *How do you feel when I repeatedly bring to your attention this keeping things in a state of limbo?*
PT: I feel a little annoyance at it but then I realize that–
TH: But you say you feel annoyance with me and then at the same time you smile. You notice that, hmm?

The patient's reply to the initial question about his feelings was clearly defensive–as it almost invariably is with all patients–and there now follows a sequence of clarification, pressure, and challenge in the area of T similar to that already described for the area of C. However, there is one important difference, namely that the therapist no longer needs to be so careful and can increase his challenges more rapidly and to a higher level.

Here he must direct his pressure and challenge to the defenses both against anger and emotional closeness:

TH: (to the Man from Southampton) *And you frequently take a deep sigh, isn't that? You smile again. Now let's look to your annoyance. What is the way you experience this being annoyed?*

PT: I guess I swear to myself when you point out to me my behavior. I say, "Jesus Christ, again, and again and again."
TH: Now you are avoiding the issue of annoyance. You said you felt annoyed with me. What was the way you experienced that?
TH: (to the German Architect) *Now your eyes also avoid me.*
PT: Well, I mean I can't look at you all the time.
TH: Do you notice that you avoid my eyes?

Phase (4b) Head-on Collision with the Transference Resistance, Especially that Maintained by the Superego

Under this kind of pressure the resistance crystallizes more and more clearly in the transference, and in addition there may be signs that the defenses are becoming exhausted, which take the form of communications from the unconscious therapeutic alliance. Thus both parts of the patient are in evidence, and it is clear that the tension between the two is at a high level.

Now, using this situation as his cue, the therapist brings in his most powerful intervention, the head-on collision, which is designed to maximize the inner tension. The intervention has the following characteristics:

(a) it is essentially addressed to the therapeutic alliance, with the aim of mobilizing this against the resistance,
(b) the emphasis is almost always on the resistance in the transference,
(c) special emphasis is usually given to the patient's refusal to allow emotional closeness, and
(d) most important of all, it is largely intended to mobilize the therapeutic alliance against a form of resistance which so far has not been dealt with, namely that arising from the superego – the patient's need to defeat the therapeutic process in the interests of perpetuating his own suffering.

In its complete form the head-on collision usually spells the situation out starkly from first principles, and contains the following elements:

(a) emphasizing that the patient has a problem which causes him pain, and that he has come here of his own volition to solve it with the therapist's help;
(b) specifying the patient's defenses, particularly his emotional distancing in the transference, and pointing out that if he continues to use these defenses he will be defeating his own goal, perpetuating his own suffering, and making the therapist and the therapeutic process useless to him;
(c) pointing out the self-destructiveness in this and calling it in question;
(d) linking this with the patient's life and relationships outside.

In the case of the German Architect the therapist's interventions were as follows:

TH: Obviously you have some problem that so far we don't know anything about, okay? . . . But if you stay like this, vague, nonspecific and withholding as you are, then we will depart from each other . . . without getting to the core of your problem . . . Then I would be totally useless to you. Now, you have set a goal, obviously to come here to understand your problem . . . But then if I become useless to you and we don't get to the core of your problem, then you walk out of here carrying your own problem, whatever it is, with yourself . . . Then who is defeating? So obviously what is immediately coming into focus is that you have a self-defeating pattern. My question is, why does an intelligent person like you want to do that?

In the case of the Corporate Lawyer there was greater emphasis on the refusal to allow emotional closeness:

TH: So then you want to keep me behind a wall. And as long as you keep me, behind a wall . . .
PT: You can't help me.
TH: Then I would be useless to you . . . Now why an intelligent person like you goes to the whole trouble to come but at the same time wants to defeat the purpose of this . . .
PT: There's no ration . . .
TH: Why do you want to sabotage this and why do you want to make me useless to yourself?
PT: I don't want to sabotage it.
TH: But obviously it is there.

In the case of the Man from Southampton this phase of the interview developed as follows:

The patient's strongly worded remark reported above, "Jesus Christ, again and again . . . ," was one of the indications that his defenses were beginning to become exhausted. The therapist took this as his cue to begin the head-on collision.

TH: So if you continue to be vague and keep things in a 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? Why do you want to do that? Because obviously it is very evident that you put a barrier between yourself and other people. Is that barrier between you and me?

In many cases the head-on collision may have to be continued for a considerable time, and may need to be followed by further work on the defenses, before the first breakthrough occurs. In the case of the Man from Southampton, however, the breakthrough began almost immediately, though the therapist continued with the head-on collision in order to complete the process.

Phase (5) Intrapsychic Crisis, the Direct Experience of Transference Feelings, and the First Breakthrough

Most frequently the principal manifestation of intrapsychic crisis is that the patient is faced with a feeling which so far has been completely hidden, namely his grief and remorse about all the wasted opportunities and destroyed relationships brought about by his self-destructive defenses. This is usually expressed in tears. Of course he wishes to conceal his grief from the therapist, as well as his anger and warmth, which leads to further resistance. The therapist must now bring all these complex feelings into the open. Highly condensed, this happened with the Man from Southampton as follows:

In response to the intervention above the patient put his head in his hands and began to cry.

TH: How do you feel right now?
PT: (Recovering from his bout of crying) *What you've told me made me feel angry for sure.*
TH: What was it like when you felt angry with me?

Suddenly the patient switched to his grief, behind which there lay a great deal of warmth, but the therapist continued the head-on collision in order to free all the feelings completely:

PT: . . . I got very upset just now because what you were saying indicated that there is no good in your sitting there and talking to me like this unless we can get something out of it.
TH: But that is one of the major problems that we should focus on. Because you are putting a barrier between yourself and me, you are hiding behind a wall. And as long as there is this wall, then obviously we cannot get to the core of your problem. So the question is, what are we going to do about this wall? Because I assume this is the problem in any other relationship. Have you ever had a person in your life that you felt you wanted . . .
PT: A person with whom there was no barrier at all? No.
TH: So this is a lifelong problem, hmm? (The patient looks away). *Do you notice that when you become tearful you avoid me? You avoid both the eye contact as well as not looking at me. Why? Because you are talking about closeness, hmm?*

The patient begins to sob without restraint.

Discussion of the Process of Unlocking the Unconscious

The Therapist's Interventions in Phases (3) to (5)

In these three phases, it is important to note the need for a profound understanding of the forces both within the patient and between patient and therapist. This understanding leads to specific interventions designed to manipulate each of these forces, with the aim of bringing about an intrapsychic crisis and achieving a breakthrough into the unconscious.

In the cases described above, the therapist's interventions in Phase (3) included the following:

(a) Clarification of the defenses in the area of C ("I wonder if you notice you generalize . . ."?). This has the aim of making sure that it is the defenses and not the patient himself that is being challenged.
(b) Challenge directed against the defenses in the area of C—calling them in question ("These are all labels, they remain vague . . ."), and casting doubt on them. (". . . so far you are ruminating in a vague fashion"). This has the aim of undermining the patient's identification with his resistance.
(c) Challenge directed toward the therapeutic alliance (". . . what are we going to do about this vagueness? Because as long as you are vague . . ."). This has the aim of making ego-syntonic defenses ego-dystonic and mobilizing the therapeutic alliance against them.

In Phases (4) and (5) the therapist's interventions included the following:

(a) Pressure toward the experience of transference feelings ("How do you feel when I bring to your attention this keeping things in a state of limbo"? "What is the way you experience being annoyed"?).
(b) Drawing attention to nonverbal signals indicating tension in the transference ("You frequently take a deep sigh"). This informs the patient's unconscious that it is betraying its rising conflict, heightens the tension, and brings the underlying feelings nearer to consciousness.
(c) Challenging and thus weakening the resistance to experiencing negative transference feelings ("Now you are avoiding the issue of annoyance").
(d) Drawing attention to nonverbal or verbal signs indicating avoidance of emotional closeness in the transference ("Do you notice that you avoid my eyes"? "You want to keep me behind a wall.") This constitutes a challenge to the resistance against experiencing positive transference feelings.
(e) The head-on collision with the resistance of the superego in the transference ("If you stay vague and withholding, I will be totally useless to you . . . What is coming into focus is that you have a self-defeating pattern"). This weakens the superego resistance, mobilizes the therapeutic alliance against it, and activates the patient's grief about his own self-destructiveness.

The corresponding complexity of the patient's feelings will be considered under the next heading.

Discussion of the Process of Unlocking the Unconscious (cont'd)
The Patient's Emerging Feelings

As described above, the whole aim of these interventions has been to bring about an intrapsychic crisis, which leads to the direct experience of extremely complex feelings, principally in the transference. The Man from Southampton showed very clearly almost all the different kinds of feelings that may be aroused:

The simplest feeling was anger caused by the therapist's repeated challenge to his resistance, as represented by his strongly worded remark, "I guess I swear to myself, 'Jesus Christ, again and again and again'."

However, side by side with this the patient made the following remark, which was loaded with grief: "I got very upset just now because what you were saying indicated that there is no good in your talking to me like this unless we can get something out of it."

This requires considerable analysis:

First, one root of his grief lay outside the transference: the recognition of the way in which his self-destructiveness had spoiled his life over many years.

Second, the very fact of sharing his grief with the therapist indicated something highly positive in the transference, namely the ability to abandon his withdrawn position and allow emotional closeness.

Third, there lay behind this another highly positive transference feeling, which was a warm appreciation of the therapist's determination not to give in to his resistances. In a later part of the interview he said, "There is one big difference from my previous therapist, and that's an interest in my welfare . . . Nobody has talked to me the way you do about identifying the problem."

Finally, both the anger and the grief led directly into the distant past. In Phase (5) it was easy to bring out that his anger with the therapist had roots in his unexpressed anger with his father, who used to oblige him to be specific. And in Phase (8) it became clear that the reason why he was so deeply touched by the therapist's concern for him lay in his longing for a good relation with his father, which—as he now remembered—he had once known but had later lost.

It is a mass of conflicting feelings like this that the intrapsychic crisis brings to the surface, at least potentially, in every patient suffering from character pathology and much more so in those suffering from severe character pathology.

The fact that these complex feelings, mainly in the transference, are so clearly related to the distant past makes the following—universally found—observation less surprising: the patient's experience of them constitutes the triggering mechanism which will eventually lead to unlocking the whole of his unconscious.

However, the word "eventually" is important, because although a major unlocking has taken place this is only the first stage, and there is still much resistance hidden beneath the surface. This is of two kinds. The first is unresolved transference resistance arising from aspects of past relationships not yet touched on, which will be dealt with in Phase (6) by interpretation, with the use of the two triangles. The second is nontransference resistance arising from the reluctance to face painful feelings, which is dealt with in Phase (8), much more easily, by minimal pressure and challenge.

Thus the unlocking of the unconscious occurs in stages: First, the intrapsychic crisis as described above; then the dissolution of residual transference resistance by interpretation in Phase (6); and finally the sweeping aside of minor resistance against facing painful feelings in Phase (8). Nevertheless the most important of these is the first, because without it any attempt to reach the unconscious quickly by traditional interpretative methods is bound to fail.

Phase (6 & 7) Systematic Analysis of Transference, Inquiry, Completing Dynamic Phenomenological Approach to Patient's Psychopathology, and Developmental History

The immediate result of the intrapsychic crisis is a major drop in tension and a considerable shift within the patient, so that for the time being the therapeutic alliance gains the ascendancy. This has important consequences: (a) areas outside the transference can now be explored in a much more meaningful way, (b) interpretation, which so far has hardly featured in the interview at all, now becomes effective. After systematic analysis of the transference and two triangles then the therapist may begin by completing the psychiatric enquiry—an essential step in all initial interviews—and, provided nothing untoward has emerged, he will then go on to explore the patient's current life and relationships. The exploration of the past where the patient's neurosis originated needs to be carried out in the most dynamic way possible, which can only be done after the residual transference resistance has been analyzed and dissolved. In many cases, information about the past emerges spontaneously, so that the therapist can include this in his interpretations as well, thus completing the triangle of person.

The therapist makes use of the material that emerges to give interpretations based on the two triangles, the triangle of conflict (defense, anxiety, and underlying feeling or impulse) and the triangle of person (current, transference, past). He emphasizes the different ways in which the patient has defended himself against his underlying feelings and impulses; and above all he draws the parallel between the use of these defenses in other relationships, and their use in the transference in the service of resistance.

In the case of the Man from Southampton this phase of the interview unfolded as follows:

(a) The therapist began with psychiatric enquiry. Here the patient revealed the mobilization of his therapeutic alliance by spontaneously making some deep interpretations about his own behavior, in particular that some accidents that he had had were an expression of suicidal impulses.
(b) Since in one of these accidents the patient's wife narrowly escaped

being killed, the therapist made an interpretation of murderous feelings toward her.

(c) The therapist gave a superego interpretation, that the patient had a self-sabotaging, self-punishing pattern. The patient fervently agreed, confirming this with a further spontaneous interpretation of his own behavior.

(d) In connection with enquiry about previous psychotherapy, the above-mentioned strongly positive feelings for the therapist emerged: "There's one big difference with you and that's an interest in my welfare."

(e) As the patient said this he was once more overcome with grief, and he then spontaneously contrasted the therapist's concern with the fact that when he got upset his father used to ridicule him, i.e., he gave his own TP interpretation, linking two corners of the triangle of person.

(f) This enabled the therapist to give major interpretation of the resistance, making use of the two corners of the triangle of conflict and two of the triangle of person; that the patient's detached and withdrawn attitude in the early part of the interview was his way of dealing with anger, and that this was the same pattern as he had used with his father, i.e., linking defense with underlying feeling and past with transference.

(g) This led to a further experience of anger in the transference, more direct and intense than before: "Now I realize that I would like to say, 'For Christ's sake leave me alone. Don't keep asking me these questions'."

Finally the therapist linked the patient's avoidance of eye contact in the interview with the same reaction to the father (another TP interpretation).

During this phase the patient twice openly expressed strong feelings for the therapist—on the first occasion positive and on the second negative—both kinds of feeling being linked with the father. These moments gave evidence of the second stage of unlocking the unconscious, which was a direct result of the analysis of the residual transference resistance.

In this connection it is also important to emphasize the presence, side by side with anger, of the patient's warm appreciation of the therapist's approach. This was only made possible by the preliminary systematic clarification of the defenses, which enabled the patient to realize at a deep level that it was his resistance and not he himself that was under challenge.

The analysis of residual transference resistance and the phase of inquiry was now completed, and the therapist could embark on the final phase of the central dynamic sequence.

Phase (8) Direct View of the Multifoci Core Neurotic Structure

The therapist now undertakes a systematic exploration of the past, often starting with purely factual enquiry—"Where do you come from"?, "How old are your parents"?, and learning about the family situation in the patient's upbringing. Then, once sufficient evidence has accumulated, he begins to make his enquiry much more dynamic, exploring genetically structured conflicts and patient's core pathology.

Major Unlocking versus Partial Unlocking of the Unconscious

If the protocol has called for the major unlocking of the unconscious during the phase of (6) and (8) there is no return of the resistance. Exploration of the multifoci core neurotic structure and the emergence of the guilt-laden eroticized feelings, guilt, and grief-laden unconscious feelings in relation to the people in the past is without any return of the resistance. But if the research protocol calls for the partial unlocking of the unconscious such as the Case of the German Architect, the Man from Southampton, and the Corporate Lawyer, then during the phase of (6) and (8) resistance is not over and will almost always return when painful areas are approached, but now it can be penetrated much more easily, e.g., by simply repeating a question, and in many cases the transference no longer needs to be mentioned at all. The therapist aims to bring the patient's most painful feelings to the surface and to enable him to experience them directly. This is possible in proportion to the degree to which there has been direct experience of complex feelings in the transference. Where transference experience has been intense there will be major breakthrough; where it has been only partial the breakthrough will not be so complete, but it will still be highly significant. In either case this represents the third stage of unlocking the unconscious, leading to a direct view of the patient's multifoci core neurotic structure.

With the man from Southampton (partial unlocking of the unconscious) the major features that emerged were as below. It is worth noting that throughout this phase the transference was not mentioned at all.

The patient somehow became the outsider in his own home. Of the five children, a sister was preferred by the father, and his brother one year younger became the favorite of the whole family. Nevertheless, the patient gave evidence that there had been a time when he felt close to his father. Resistance returned as the therapist tried to bring this into the open, but now it was quite easily swept aside, which led to a fresh memory:

PT: 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: (Using the defense of evasiveness) *it was just a path across the field.*
TH: . . . So you looked forward to your father.
PT: Yes I did, and I ran down to meet him and fell down the stairs and knocked myself out and had to be taken to hospital. I've just remembered that.

The patient went on to describe, with tears, how his father used to punish him physically with a strap. Further enquiry then suggested strongly

that a major source of conflict lay in the relation with the brother, with whom the patient used to fight constantly. He said that his father bought them boxing gloves and told them that if they were going to fight they should fight properly. He described an occasion on which, fighting in this way, his brother knocked him backwards into a china cabinet. The dialogue then proceeded as follows, with resistance returning and once more being easily penetrated:

TH: How did you feel when he knocked you down? Did you feel that you wanted to get at him?
PT: I don't know. I suppose I did . . . I don't remember how I felt.

The therapist reminded him that during quarrels with his wife he had had the wish that he could kill her:

TH: . . . Was there the wish that you could do that to your brother?
PT: I'm sure there was. Yes, because on one occasion I remember fighting with him in the field . . . and I did a terrible thing when he walked away. I took a stone from the ground and threw it at him and hit him on the back of the head.
TH: If you didn't have a brother what would have happened?
PT: Well, I would not have had a rival in the family, would I?

Further exploration led to another fresh memory, this time involving the triangular relation between the patient and his father and mother. The father became angry with the mother and called her a pig, and the patient stood in front of his mother and raised his fist, wanting to attack his father, who said he would disown him as his son. The relation with the father eventually became so bad that the patient had to leave home.

Toward the end of the interview the therapist dealt with the patient's feelings about his father's death, taking him in detail through the last time he had seen his father alive. It became clear that behind the anger there was much buried grief. Once more there was resistance, and once more this was quite easily penetrated. The final part of this passage was as follows:

TH: What do you remember about the funeral.
PT: I didn't attend the funeral. I didn't have the money to travel to England.
TH: Was that the only factor or was it less painful for you?
PT: I don't remember considering whether I should or should not go.
TH: But this is not you, is it? I mean you are a sensitive person, aren't you? You were wishing for the father that you didn't have, and you were very much touched when he was incapacitated . . . So do you think that a part of you wanted to go but a part didn't want to face that dead body? Where is he buried?

At this point the patient became overwhelmed by grief.

The above account illustrates very clearly the contrast from the beginning of the interview, where the patient could hardly describe his problems, let alone any feelings. Now, on the other hand, the degree to which his whole psychic system had been loosened became entirely apparent. Resistance was minimal, and in each area that was explored intense buried feelings emerged from his unconscious.

The End of the Interview

The final phase is followed by a relatively brief period, in which the therapist enquires how the patient feels now, explores motivation for continued therapy, and sums up some of the issues that have been discovered, before bringing the interview to a close.

Cases in Which Phases (1) to (3) are By-passed

Some patients enter the interview room betraying obvious transference feelings from the beginning, in which case the therapist by-passes phases (1) to (3) and returns to phase (1) at a later point. There is not enough space to describe this in detail. Here I will briefly outline *The Case of the Woman who Frequently Bruised her Thigh.* She suffered from characterological problems, major problems in human relationships, inability to allow herself intimacy and closeness and a life-long patern of self-defeat and self-sabotage. She entered the interview room visibly nervous. The therapist focused first on her anxiety.

TH: How do you feel right now?
PT: I feel very nervous and anxious.

The physiological concomitant of the anxiety were explored and she indicated that she had trouble with breathing, tightness in her chest, she sighed frequently, fidgeting, these were reflected on.

PT: Well I know it was to do with coming here this morning.
TH: And what were the thoughts in your mind about coming here? (Patient sighs deeply)
PT: I feel that I'm going to sort of expose myself, you know?

Immediately the process is shifting to the triangle of the conflict in the transference bringing into focus one of her major problems which has to do with intimacy and closeness.

TH: The idea is you are going to expose yourself which means in a sense you are going to come here and we are going to get to your intimate thoughts . . . intimate feelings, huh? That is the idea huh?
PT: Yes.
TH: So you have to let me into your intimate thoughts and intimate feelings, huh? And that mobilizes anxiety in you?
PT: Yes, and I'm afraid of what you will see.

The focus of the session is on the conflict over intimacy and its transference implication and the patient has deep sighs.

TH: You took another sigh as soon as I said intimate thoughts and feelings.
PT: Well, I know, this is part of my difficulty that I have trouble getting, allowing a man to get close to me.
TH: You say one of the problems you have is letting a man get to your intimate thoughts and feelings and close to you. Are you saying that you put up a barrier . . .
PT: Yes, I don't trust men.

The above passage shows that the process has by-passed phases (1) and (2) and is on phase (3) to (4). Clarification of her defenses and her tactical defenses such as "I don't trust men" and the therapist moves to further clarification of her defenses in the area of T drawing attention to her nonverbal and verbal signs indicating avoidance of emotional closeness in the transference.

Some patients enter the interview room in a state of transference resistance. This can be illustrated by the following case. Because of the research protocol he was on the waiting list for a period of six months and entered into the interview explicitly referring to his frustration and declared that he was annoyed.

PT: I was annoyed quite frankly.
TH: You mean you were annoyed, that is past or you are annoyed?

The process is focused on the patient's tactical defenses and the triangle of conflict in the transference. He says "annoyed" which refers to the lower part of the triangle of the conflict. He uses tactical defenses, puts the annoyance in terms of the past and also does not indicate at whom he was annoyed.

Clarification and Challenge to the Defenses in the Transference

TH: So what you say is this, you were annoyed but you are not annoyed anymore.

Focusing on how he experienced his annoyance:

PT: Well I said to myself, you know to me it doesn't make sense.
TH: But that is a sentence.

Challenge to the patient's resistance in transference Phase (4)

PT: Well in my mind I said you know stupid, bloody doctors.

His defenses are clarified, challenged and his use of a sentence to describe a feeling is challenged and further it was pointed out.

TH: But then also you made it plural—doctors (Patient has a deep sigh)
TH: Who is stupid and bloody? . . .
PT: Well I guess it was directed at you.
TH: You say guess. It was directed at me?

In this case the central dynamic sequence started with phase (4) namely transference resistance. The major intervention consisted of systematic challenge to the patient's resistances against experience of the impulse in the transference.

Summary and Conclusion

The Central Dynamic Sequence-Recapitulation

In the first part of this two-part article I have outlined the process of the unlocking of the unconscious and indicated that the whole process can be divided into a series of phases each consisting of a particular type of intervention with its corresponding response and this whole process I have called the "Central Dynamic Sequence." The following is an account of the complete sequence as used in patients with moderate to high levels of resistance. The therapist opens with pure enquiry exploring the patient's difficulties: Phase (1), but very soon begins to exert pressure: Phase (2), directing the patient toward significant areas, asking for specific examples, enquiring about the experience of feelings. This inevitably leads to resistance, which takes the form of a series of tactical defenses. The therapist waits until the resistance has crystallized unmistakably and then begins first to clarify the defenses and then to challenge the defenses Phases (3a and 3b).

Clarification is an essential step before challenge, because the patient must be enabled to understand that it is his resistance and not himself that is under challenge. Challenge may be directed against the defenses, calling them in question and casting doubt on them, or toward the therapeutic alliance, urging it to make a supreme effort to overcome them. In either case the aim is to increase the intrapsychic tension between these two opposing forces, with each of which a part of the patient is identified.
The inevitable result is a rapid rise in transference feelings, usually negative on the surface and positive underneath. Both kinds of feeling lead to a further increase in resistance, which has now become a transference phenomenon.

The therapist carefully monitors the signs of this, most of which are nonverbal, and when the tension has reached a sufficient level he breaks in with the question, "How do you feel right now"? [the beginning of Phase (4)].

The patient's answers to this direct question about his feelings are invariably resistant, and there now begins a phase of pressure, clarification, and challenge, to the resistance both against experiencing anger, and against allowing emotional closeness, in the transference [Phase (4a)]. The therapist

draws attention to nonverbal signs of increasing tension and emotional distancing.

There now often emerge signs that the defenses are beginning to become exhausted, which take the form of communications from the unconscious therapeutic alliance. Using these as his cue, the therapist introduces the head-on collision, which consists of a challenge directed toward the therapeutic alliance, with the aim of mobilizing it against the self-destructive resistance of the superego in the transference [Phase (4b)].

The result is an intrapsychic crisis [Phase (5)], the triggering mechanism which makes possible all the stages of the unlocking of the unconscious. In the first stage of the unlocking, which occurs now, the resistance breaks down and the patient is brought to the direct experience of feelings of great complexity, which include negative and positive transference feelings, and grief both about losses due to his own self-destructiveness, and about earlier losses which were not under his own control. All these feelings have roots in the distant past, and the result is a loosening of the patient's whole psychic system. The immediate effect is a great drop in tension, and what follows is the first unlocking of the unconscious and the direct view of the multifoci core neurotic structure. The therapist now moves to the systematic analysis of the two triangles. The process is now actively in the interpretative phase. The analysis of the transference is important in removing residual transference resistance. The therapist now embarks on enquiry completing dynamic phenomenological approach to the patient's psychopathology Phase (7). The trial therapy then enters Phase (8) which usually starts by the therapist undertaking a systematic exploration of the past. This phase provides both patient and therapist with a direct view of the patient's multifoci core neurotic structure.

In the second part of this article the whole process will be illustrated by means of a complete trial therapy.

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