

Intensive Short-Term Dynamic Psychotherapy with Highly Resistant Depressed Patients: Part I—Restructuring Ego's Regressive Defenses

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This is the first part of a series of articles describing the technique of Intensive Short-Term Dynamic Psychotherapy in the treatment of patients suffering from depressive, functional and psychosomatic disorders. These patients suffer from a deep-seated inability to experience the Impulse/Feeling component of the triangle of conflict, mistaking various defensive manifestations for the impulse itself. If they are challenged too strongly their anxiety level is raised and the result is a serious exacerbation of their condition. However, by the use of carefully graded pressure and challenge it is possible to restructure the defensive mechanism, and it is now safe to use unremitting challenge in order to achieve a breakthrough into the unconscious. The article concludes with a clinical example of this phase of an interview with a chronically depressed patient.

Scholarship has discovered many aspects of unconscious mental processes. Throughout his life Freud was searching for better ways of achieving access to the unconscious. In "The Psychopathology of Everyday Life" he outlined many ways in which unconscious mental processes manifest themselves at a conscious level, such as jokes, slips of the tongue, parapraxes, daydreams and dreams; and he considered the interpretation of dreams as his most important contribution, referring to it as the royal road to the unconscious. One can say that Freud's constant search was for ways of overcoming the phenomenon of resistance, which was considered a very powerful force and which as we know is the inevitable consequence of the basic mechanism underlying neurosis, namely the repression of feelings and impulses because they are painful or unacceptable. In his struggle with this force Freud first employed hypnosis, and when he found this to be unsatisfactory he moved to the technique of suggestion in the waking state, which in turn he found exhausting and unreliable. He then realized that if the patient was simply asked to say whatever came into his mind, the repressed feelings, memories, and impulses would return in a disguised form; and if he translated the disguise he could gain inroads into the unconscious and bring the pathogenic forces into consciousness. This finally led him to the fundamental rule of free association and the development of the classical psychoanalytic technique as practiced today. Freud and generations of analysts have satisfied themselves that the only way to work with the powerful force of resistance is the technique of free association, which is followed first by the development, and then the analysis, of the

transference neurosis. This has finally been accepted as the only way to work with patients' resistances. Perhaps it never dawned on Freud and later generations of analysts that it might be possible to achieve a rapid major unlocking of the unconscious, making possible a direct view of the core neurotic structure responsible for all the patient's neurotic suffering. In my previous publication I have outlined what I consider to be my most important discovery and contribution, namely the technique of handling resistance and transference in such a way as to trigger the unlocking of the unconscious in a single interview. I have demonstrated that this is not an event that happens with a few—or even a dozen—patients, but that it can be achieved with every patient suffering from structural neurosis, with the sole exception of those with severe fragility of the ego. As a result of this discovery, during the course of more than twenty years I have developed a system of Short-Term-Dynamic Psychotherapy which is highly effective over the whole spectrum of structural neurosis. As I have described elsewhere, this begins with trial therapy in the initial interview, the most important aspect of which is the unlocking of the unconscious through the direct experience of transference feelings, leading to a direct view of the core neurotic structure. I consider this to be the true royal road to the unconscious. It must be obvious that this has profound implications for the future of psychoanalysis and all dynamic psychotherapies.

In summary, my standard technique for handling highly resistant patients is as follows:

Pressure toward the experience of repressed feelings, which leads to an intensification of resistance.

Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of resistance.

Systematic pressure and challenge to the transference-resistance leading to a further intensification of resistance.

Head-on collision with the transference-resistance. Creation of intrapsychic crisis with turning of the ego against its own defenses.

Direct experience of the complex transference feelings—the "triggering" mechanism.

Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious.

Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.

Major de-repression of current or recent past (C) and distant past (P) conflicts, leading to a direct view of the dynamic unconscious and multi-focal core neurotic structure.

I have outlined the details of handling the resistance, with the analysis of clinical examples, in a number of publications (see Davanloo, 1978, 1980, 1986a and b). As indicated above, this concept of unlocking the unconscious is not based on generalization from a few observations. It is based by now on large series of audiovisually recorded interviews by myself as well as by many clinicians trained by me in my technique. Almost all these patients were suffering from severe neurotic disturbances and major character pathology.

The standard technique as described above is used with the majority of highly

resistant patients, including those suffering from ego-syntonic characterological disorders, i.e. those in which the patient does not recognize certain character patterns as a problem, as long as these disorders are not complicated by any of the following conditions to be mentioned below. In these uncomplicated cases the therapist employs constant pressure toward the underlying feeling or impulse (e.g. "how do you experience your anger with me?"), and then steadily increases challenge to the defenses, and does not take the pressure off until the unlocking of the unconscious has taken place.

However, there are a number of conditions in which this technique has to be modified, namely clinical depression, chronic and characterological depression, functional disorder such as common migraines and irritable bowel syndrome and psychosomatic disorders.

Our extensive clinical data show that these patients suffer from a wide range of character pathology, which may be ego-syntonic or ego-dystonic. One of the major features of all these patients is a deep-rooted inability to distinguish between the corners of the triangle of conflict, particularly the *impulse* of rage and the *anxiety*. In both depressive and somatic patients the unconscious defense mechanism instantly internalizes the rage, with the result that they do not experience the repressed sadistic impulse, but instead experience an exacerbation of symptoms, which may or may not be accompanied by an increase of anxiety. In many depressive patients the impulses are homicidal, and when these impulses are internalized in this way the result is depression with suicide. Further, it seems that the explanation of psychomotor retardation is that is a defense mechanism designed to prevent the patient from acting on his impulses.

What I have systematically demonstrated is that with these depressive and somatic patients it is possible to bring about a total restructuring of the unconscious regressive defense responsible for their symptoms, and moreover that this is an essential step before proceeding to the complete unlocking of the unconscious. Trial therapy then becomes divided into two phases:

1) The phase of restructuring the ego's regressive defense mechanism by means of graduated pressure and challenge, and

2) The phase of unlocking the unconscious by means of intensified and unremitting pressure and challenge.

It is very important to state that if the therapist does not employ this two-stage technique, and instead maintains his pressure and challenge too strongly or too persistently, the result will be an intensification of depression or an exacerbation of somatic symptoms. If he does employ the two-stage technique, on the other hand, the result after a single trial therapy will be in the opposite direction, consisting of a marked lifting of depression or the complete disappearance of the functional disorder.

In the first part of this series of articles I will focus on the technique of restructuring the depressive defense mechanism.

The Technique of Restructuring the Depressive Defense Mechanism

If the therapist has any reason to suspect that the patient suffers from depression, he must create an early opportunity to explore its nature and history. If the depression turns out to be chronic or characterological, then he will institute the

restructuring technique. An entry into the patient's problems will usually be provided by some incident or situation involving current relationships which has been associated with an attack of depression. The therapist employs gentle pressure toward the patient's underlying feelings, followed by gentle challenge to the defenses, and will very soon confirm that the patient cannot differentiate between the corners of the triangle of conflict. Instead of describing the feeling or impulse, which almost always involves anger, the patient will describe anxiety or defense, and will quite often fail to understand that this is happening. The aggressive impulse is directly and instantly internalized so that it never reaches consciousness at all, but instead manifests itself as an increase in depression.

The therapist's aim is then, by graduated pressure and challenge, to bring the impulse gradually into consciousness, so that the depressive defense mechanism is undone. Moreover, since pressure and challenge invariably produce a rapid rise in transference feelings, the area in which this is accomplished is the transference. The patient's ego now becomes able both to experience the anger in the transference and to understand the mechanism by which it had formerly been avoided. The aggressive impulse is no longer instantly repressed, but passes the repressive barrier. Now the ego can clearly distinguish between impulse, anxiety, and defense—the three corners of the triangle of conflict—and the whole defensive system has been restructured.

This may of itself lead to a breakthrough and the unlocking of the unconscious, and if it does so, well and good. If it does not the therapist can then proceed to the second phase, the unlocking of the unconscious by means of unremitting pressure and challenge. This is possible because now the ego has the capacity to withstand the impact of the dynamic unconscious.

A description of the technique in further detail is as follows. As the therapist employs pressure and challenge he monitors signs of anxiety in the patient with the utmost vigilance. He is very careful never to arouse more anxiety than the patient's ego can bear. When necessary he can reduce the pressure in three main ways, (1) by turning back to enquiry, (2) by switching his pressure to another area, or (3) by asking the patient to describe the actual experience of anxiety. He can then return to pressure and challenge, this time increasing it from, say, "one plus" to "two plus," again monitoring the patient's response, and so on.

Pressure will be concerned at first with current relationships. (In the following pages these will be designated by the letter C, which term is used to include recent relationships though these may not necessarily be still current.) As the pressure mounts the patient's complex transference feelings (T) will be rapidly activated, and—as mentioned above—will almost always include anger. The therapist awaits his opportunity and now begins to exert pressure and challenge in this area (T). Once more, he is very careful to take the pressure off as soon as he observes that too much anxiety is being aroused. He increases the pressure gradually, as before, and it may be necessary to deal with other aspects of transference as well as anger, e.g. the patient's resistance against acknowledging positive feelings or allowing emotional closeness. Finally the impulse is experienced directly instead of being instantly internalized.

The restructuring process has now begun, but it is very important to state that it does not end there. It must be followed by a long phase of *consolidation*, in which every aspect of transference, whether already touched on or not, is systematically analyzed, over and over again, in a way that sometimes may seem repetitious.

Nevertheless, extensive clinical research data has shown that this repetition is absolutely necessary, in order to ensure that the patient both experiences the underlying feelings and understands the way in which they were formerly instantly internalized. Thus there is a considerable didactic element in this phase, and the therapist repeatedly draws the parallel, and points out the contrast, between the transference and current relationships (the T-C link). If all this is not done, what is inevitably observed is that the defenses reestablish themselves almost as inflexibly as before. If analysis of transference is done, on the other hand, the restructuring can finally be completed; and the therapist can now proceed to the full unlocking of the unconscious, if necessary by means of unremitting pressure and challenge.

The technique will now be illustrated by a clinical example.

The Case of the Woman with a Machine Gun

This was a single woman of 30. She suffered from characterological depression which had intensified into three major depressive episodes. Each of these had lasted from six months to a year, two in adolescence, and one had been severe enough for the patient to describe it as a nervous breakdown. In addition she suffered from the following: Chronic anxiety: which has permeated all aspects of her life. Severe disturbances in interpersonal relations, in which she was unable to allow herself emotional closeness and constantly took the role of victim, letting herself be used and abused.

Severe sexual difficulties: severe pain during intercourse and totally anorgasmic. A pattern of constant self-defeat and self-sabotage throughout her life. Self-directed aggression: on a number of occasions she had banged her hands against the wall to the point of severely bruising them. Long-life characterological problem, characterized by distancing, detachment, shifting from passivity and compliance to defiance, inability to assert herself.

Initial Contact

The session started with the therapist focusing on the circumstances of her referral. She said that she was self-referred, and then the therapist focused on the nature of her previous treatment. She said that she had been in psychotherapy with a psychologist on a once a week basis. She went to him for her depression, but he had focused on her sexual difficulties and her being anorgasmic. The following passage refers to the set-up in her previous treatment, which immediately reflects on aspects of her characterological problems.

TH: So you were separated from each other by a curtain?

PT: Yeah, yeah.

TH: And you said he would play music?

PT: Musical tape. I don't even remember what the tapes were, and he would just say just let yourself fantasize and tell me what are you thinking.

TH: Fantasize?

PT: Yeah, and tell me what you are thinking.

TH: Uh hmm. And you said there was also a curtain?

PT: He had me doing various exercises I guess.

TH: What do you mean guess?
PT: I was clothed, but I was touching myself.
TH: Touching yourself where?
PT: Well, sexually.
TH: You would masturbate yourself you mean?
PT: Yeah, but clothed, I . . .
TH: With clothes on?
PT: Yeah. (Laughs). It was you know, his idea, not mine.
TH: How did you masturbate with clothes on?
PT: Well it was more a question of fantasizing, he was saying. You know just like to touch.
TH: Touch your genital? But then fantasize?
PT: Yeah. But then just. . .
TH: And what was your fantasy?
PT: It was. . .it was more tied into the tapes and I can't remember what the tapes were. I found the whole thing silly.
TH: But now let us not call it silly. You went for the treatment.
PT: The treatment was focusing to help me to overcome my inhibition and I didn't get anywhere really.

What emerged is that she finally terminated the treatment with her therapist. She was very uncomfortable describing this experience.

One of the major components of a comprehensive trial therapy is transference and countertransference evaluation. The format in the majority of cases is that the therapist first obtains a phenomenological description of the patient's difficulties, which in turn is followed by transference/counter-transference evaluation. However, in patients such as this—especially where transference has been activated by previous therapy—transference/counter transference evaluation is done first, and this by itself gives important data regarding the patient's areas of disturbance and especially the area of her characterological problems.

At this point in the interview the therapist knows that the patient suffers from depression and sexual difficulties, and he makes the following inferences:

(1) that her depression is of the kind that calls for the technique just described, in which transference-countertransference evaluation is carried out first;

(2) that the situation that developed in her previous therapy, in which she passively complied with her therapist's choice of focus, and ended up by being exposed to humiliation, was itself an expression of characterological problems, one being an inability to assert herself and the other a tendency to enter into situations in which she is used and abused.

Focusing on Some Aspects of the Patient's Characterological Problem

TH: You go yourself on your own will but then the focus is on sexual problems which you have, okay?
PT: Uh hmm.
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.
TH: Let's not to call what it sounds. It looks like this: that you have gone for many major difficulties, most important of all your depression, but he decides to treat your sexual difficulties and you follow him without raising any question.
PT: Uh hmm.
TH: Are you a follower type? Do you have problems with assertiveness? Hmm?
PT: Yes, I don't follow, I back off. . .if I am having a confrontation with someone and one of us has to assert, and one of us has to follow, I will do neither, I will just back away.
TH: You mean you take flight.
PT: Yeah from the situation. . .rather than say no, this is not. . .
TH: So you are the type of person that you take flight.
PT: Yeah I am not assertive.
TH: Is this a problem for a young woman? I don't know, I am questioning you.
PT: Yeah.

The Transference Implication

So far the process has focused on some aspects of the patient's characterological problems, her inability to assert herself, her inability to say no, and particularly her tendency to take flight, as manifested in her previous treatment, and now the therapist brings into focus their implications for the present transference relationship.

TH: My concern here is this: are you going to follow me or are you going to. . .
PT: No, because I have been through that and I. . .I want to get the most that I can get out of this session.
TH: You have problems with assertiveness, either you don't assert yourself or you take flight from the scene.
PT: Right.
TH: Which is similar.
PT: Yes basically the same thing but uh. . .

What emerges is that her inability to assert herself is much more pronounced with men. "I will either go along or I will run away from the situation completely".

TH: Which is worse?
PT: Neither is worse, they are both bad.
TH: And you smile and say it is.
PT: Well running away is lonelier in the long run, but being too compliant is uh. . .uh. . .is not satisfying on any level, it may not be as lonely.
TH: So either you take flight from the scene or you bend over backwards to please the other person.
PT: Yeah, yeah.
TH: You have any hesitation about that?
PT: No, that is pretty much what I do.

TH: Are you saying that to agree with me?
PT: No, I'm . . . I'm . . . at the same time I'm learning the difference between running away and complying, uhh, I'm not. . .
TH: You see in every relationship you say you are either very passive, compliant or you take flight.
PT: Right.
TH: Now my question is this. How would that apply here? Is it going to be compliant in relation with me or are you going to take flight from here?
PT: No, I am not going to run out because I have made up my mind.
TH: That there would not be a flight.
PT: No. . . no. I won't do that. I want to work these things out.
TH: How about the other side, submissiveness and bending over backwards to please, how that would apply here with me?
PT: That would be something I have to fight, if I did not agree I would have to say it, but it will definitely demand an effort on my part cause on my part it is not something I would normally do.
TH: Uh hmm. So you see, to begin we have a problem in front of us which might interfere in what we want to do.
PT: Yeah, but it is a recognized problem, recognized by me.
TH: But this is an important issue, do you see what I mean?
PT: Yes, I do, but I don't think it is a major problem because now I recognize it, and therefore can just. . .
TH: Okay, hopefully then you would be able to exercise that as we go on.
PT: Yeah. I expect this to be hard work, I don't expect this to be easy.

In the foregoing passage we saw the extensive work that the therapist did on the transference. The therapist brought into focus the way in which two characterological problems, namely passivity or flight, might become an obstacle in the process of therapy. The patient's responses finally were very positive, and the therapist then proceeded to take the history of her depression.

The History and Nature of the Patient's Depression

She has had three major episodes of depression in her teenage years, one at 13 or 14 and the other at 18. Each lasted one year. The third depression she referred to as a nervous breakdown. Since then she has had frequent episodes of depression lasting from a few days to one or two weeks. The therapist made a careful assessment of the extent to which her major ego functions are affected during depression. While depressed she manages to continue with her job.

Then she talked about an episode of depression experienced three years ago which lasted three to four weeks. The therapist focused on the circumstances that triggered this off. She was living in a house which she shared with three other people, her brother Peter and his girlfriend Gina, and Gina's brother Tony. They had been living in the house for a year, and she described her relationship with her brother as strained and conflictual. The patient is 30 and her brother is one year younger.

She referred to the year of living in this house as being "absolutely disastrous." She described her brother as easy-going and referred to his girlfriend Gina as a "self-admitted hypochondriac," suffering from massive anxiety attacks and always

complaining. Peter and Gina had been living together for some time. She described Gina's brother Tony as being highly manipulative, highly intelligent, and with a cruel streak liking to hurt people, to put them down. In view of this it is significant that she was interested in Tony sexually.

The focus is on her relationship with Tony. For some time she was chasing him, there was a lot of teasing, but there was no sex. She was pursuing him, but he was turning it into jokes. He did not want to have sex with her; he was involved with another girl. Tony finally broke off with his girlfriend, and the patient got the feeling that Tony was interested in her but wanted to take his time, so finally she stopped chasing him.

The Triangle of Conflict in Relation to a Recent Relationship (C)

PT: Uhh, well he finally broke off with his girlfriend, his signals were mixed. I got the feeling he was interested but wanted to take his time and not move too fast and then when he did make his move it was just to slap me in the face.
TH: Slap on your face.
PT: Yeah it was uh. . . I had stopped chasing him.
TH: Uh hmm.
PT: It was no longer fun, okay. And he commented on it, he says you're not coming up with the repartees anymore, and I said well the ball's in your court now. I'm not playing the game anymore.
TH: What do you mean balls?
PT: I was telling him that if you want to make the next move it's up to you, I'm not chasing you anymore. So he let a couple of days go by and then he. . .
TH: But when you say the ball is in your court are you saying. . .
PT: That's an expression I used.
TH: I know, but are you saying prior to that it was in your court?
PT: Yeah, I was doing all the chasing, okay, and uh which was very flattering to him and it was fun, it was good-natured for both of us but then I just stopped doing the chasing. I just stopped and he went oh, how come?
TH: So you told him that the ball was in his court and prior to that then the ball was in your court?
PT: Right.
TH: Which ball are you talking about?
PT: No, it is just a figure of speech. I am just saying that. . .
TH: Yeah, but maybe there is something about this figure of speech.
PT: I'm sorry?
TH: Maybe there is something in it when you say ball in your court and ball in his.
PT: It's a tennis expression, that's all. That's all it means to me.
TH: What does it mean to you?
PT: That it's now his turn to serve, it's his turn to make a move.
TH: And then?
PT: That's all. He did, he made a move, he approached me one evening when we were alone in the house, and uh we spent most of the evening building up slowly to go into bed together, and then when I turned around he was gone.

What emerged was that she had gone to the washroom to change into her nightgown, and when she came back into the living room Tony was not there. He had gone to his room, hiding under the blankets in his bed, and he told her that he had changed his mind, and the patient says she was very much humiliated. "The guy was weird."

Establishing Whether the Patient Requires the Restructuring Technique

This incident, which obviously might have been expected to arouse intense anger, gives the therapist the opportunity to establish whether (1) the patient is capable of truly experiencing her impulses; or whether (2) she can only experience the other two corners of the triangle of conflict, defense and anxiety, in which case he will have to use the restructuring technique with which this article is concerned. At the same time he undertakes the evaluation of another important issue, namely, whether or not she suffers from a tendency toward functional disorder as well as from depression. This would mean that part of her response to the above situation would be mediated through involuntary (smooth) muscle, resulting e.g. in irritable bowel syndrome, rather than voluntary (striated) muscle, expressing itself through such action as withdrawal, taking flight or tension in striated muscle. If involuntary muscle is involved, then the need for a carefully graduated technique is even greater than if she suffers from depression alone. This is the reason why in the following passage the therapist concentrates so strongly on the nature of her physical reaction.

The Triangle of Conflict in a Current Relationship (C) (Cont'd)

In the above passage the therapist for a few moments focused on the issue of the ball, but did not want to get entangled. He knows that this woman has suffered from major depressions, so he focuses on the triangle of conflict in relation to Tony, employing a certain amount of pressure and challenge, to see if her ego is able to differentiate between impulse and anxiety. The following passage indicates that at the unconscious level the impulse goes directly into the defense, and that what the patient experiences is anxiety expressed through voluntary muscle.

TH: And then how did you react to this situation?

PT: Iuhh...I got, uhh, very remote for a few days. I stopped talking to anybody.

TH: But how did you feel? "Remote" is a mechanism you use to deal with the feeling at that moment.

PT: Uh yeah, I was hurt, I was very...

TH: What was the way you experienced this hurt?

PT: By pulling away from the other three people.

TH: But that doesn't say how you felt.

PT: I felt hurt.

TH: How did you experience this physically?

PT: I was hurt.

TH: You say you are badly humiliated...Let's to see how you felt.

PT: I was humiliated and I was angry with him. Not, you know, blind angry, but I was angry. I mean it's...it's an anger.

TH: You mean you were angry with him?

PT: Yeah.

TH: How did you experience physically this anger?

PT: There was no physical reaction. I was just...I...

TH: You use a word to describe something that you say you don't know how...

PT: Well what other word is there besides angry?

TH: You see you say you are angry okay?

PT: Yeah.

TH: How did you physically experience this anger? When you are anxious, you have some tightness in your chest, you might get some butterflies in your...

PT: Yeah, I perspire.

TH: So you perspire; your voice might become shaky; your mouth might get dry; you have the physical manifestation of anxiety, but now...when you are in a rage or anger how physically you experience that?

PT: I was not enraged.

TH: So you were angry.

PT: Yeah.

In the above passage we saw the therapist focusing on the feeling, the lower corner of the triangle of conflict, but what she described was a defense "very remote for a few days, stopped talking to anybody." Under pressure, she finally said that she was angry. The therapist now explores whether she can really experience her anger.

TH: What was the physical reaction, how did you experience this anger physically?

PT: I was just angry, uhh. There was nothing really noticeable. I wasn't that angry. I was...I was humiliated.

TH: You were somewhat angry.

PT: Uh hmm. But not enough to have any physical reaction that I can remember...I don't remember having any kind of...I did not get the shakes, uh...

TH: You did not get the shakes. Let's to look to this. You were humiliated, and let us see how did you react to this humiliating situation?

PT: I went to bed, that is how I physically reacted.

TH: But that is flight.

The evaluator has clarified the defense in the triangle of conflict. I refer to this as a clarification of the defense as the patient is not experiencing the impulse, and the process is not in the domain of the unconscious.

PT: Yeah, I went to bed, but physically I didn't do anything.

TH: But how did you experience your anger? You said you were angry.

PT: Then I guess I didn't experience it.

TH: Here is a situation that Tony humiliates you and you don't have any reaction and you go to bed.

PT: Yeah I didn't even cry.

TH: But you say anger. What was it that you were experiencing which you label as anger?

PT: Well, I don't know what else to call it. I was angry but I did not break out in sweats. I really don't.

Reducing the Pressure by Returning to Enquiry in the Area of C

From the above passage it is clear that the patient's ego cannot differentiate between impulse, anxiety, and defense. In view of the fact that she has had major episodes of depression and has been chronically depressed, it is clear that the impulse is directly internalized, and the technique calls for restructuring the ego's defensive operation to undo the mechanism of depression.

As described above, an essential feature of this technique is that pressure and challenge should be carefully graduated, and therefore the therapist's first move is to reduce the pressure *for the moment* by returning to pure enquiry.

In reply to the question, "What happened then?" the patient said that she was "flabbergasted" and that it was "anti-climatic." For a few days she was very withdrawn. The therapist explored her state of mind during those few days and she said that she was confused and embarrassed and she spoke of "severe humiliation." Exploring the confusion, she said that she didn't know what was going on and she added "I really felt sorry for the jerk," thus clearly describing the depressive defense of turning anger into sorrow. She finally resigned herself to the idea that "it was not a big deal," now describing the defense of "sour grapes." "All I wanted from him was sex; I was not emotionally attracted to him at all." It became clear that she lets herself be abused by men, and that is her way if handling a conflictual situation is to walk out of it.

The therapist now returned to pressure and challenge at an increased level.

Return to Pressure and Challenge in Relation to C

TH: We are looking to your reaction.

PT: Physical reaction was virtually nil.

TH: You notice you put your fist like that. (One of her hands, which was hanging, changes to a fist)

PT: Yeah, I know.

TH: You smile now.

PT: I know. (laughs)

TH: You put one hand between your legs and the other hand like this and then you say physical reaction was nil.

PT: But it was.

TH: Do you notice that in a sense you are crippled to declare to yourself how you really feel? In the beginning you told me either you submit or you run away from the scene—flight.

PT: Yeah.

TH: So in a sense you are crippled either to assert yourself... .

PT: Hmm.

TH: Flight is another form of being crippled.

PT: Yeah.

TH: Is it or isn't it?

PT: Yeah.

TH: You agree because I say so or. . . ?

PT: No. I agree because it is true. . . 'cause one is not solving it.

TH: It is crippling for a woman of your age. How old are you?

PT: Thirty.

TH: Either you are not able to assert yourself, the person walks all over you, or the other way is to take flight from a situation, hmm?

PT: Uh hmm.

TH: So both of them are crippling for a young woman of your age, isn't that? Let's to see how you felt. You said you felt angry.

PT: No I didn't. I didn't.

In the previous passage of pressure and challenge the therapist had merely reiterated his questions about the patient's feelings, concentrating mainly on physical manifestations, and using no challenge stronger than simply pointing out the nature of her defenses ("remote is a mechanism. . ." "but that is flight"). In the above passage he has increased the pressure and challenge, e.g. repeatedly speaking to the patient how her ego is crippled and pointing out that her nonverbal signals belie her denial of feeling. He knows also that these challenges will have mobilized some degree of unconscious impulse in the transference. Nevertheless, the patient has finally used the defense of retraction, now completely denying her former clear statement of anger with Tony ("not blind anger, but I was angry"); and this serves as a warning that any immediate attempt to confront her with her anger, whether in the area of C or T, will arouse too much anxiety, and merely result in the impulses becoming immediately repressed and turning into depression. Therefore, once more he takes off the pressure by returning to enquiry, asking "What happened subsequently"?

Reducing the Pressure a Second Time by Returning to Enquiry in the Area of C

The patient now described another incident with Tony. Two weeks after the previous incident, Tony invited the patient's sister Linda to dinner and he and Linda slept together and had sex. She said that she was angry because Linda has her own apartment. "What's to stop them from going to her place?" Now the therapist is able to focus again on the triangle of conflict in relation to Tony, this time in a three-person situation. At this moment one can say that the unconscious therapeutic alliance is in operation; for, by bringing a second incident, she provides another opportunity to focus on how she experiences her feeling. Moreover this mobilization of the unconscious therapeutic alliance confirms that the therapist's move of reducing the pressure was correct, keeping the anxiety at just the right level.

PT: Why do it under my nose two weeks after he's kicked me in the face?

TH: Hmm.

PT: I thought that was more than just a little bit mean, that. . . that was really humiliating. . . that kept me awake all night.

TH: In a sense, that night Tony was having sex with your sister?

PT: Yeah, down the hall.

TH: And you were hearing the way that they had intercourse?

PT: I'm not curious about how other people make love, how other couples, you know, behave. That doesn't interest me.

TH: Uh hmm.

PT: But that. . .

TH: Night.

PT: Episode was more. . .more humiliating. I did not sleep all night.

TH: That was maximum. . .

PT: Yeah, that is the worst I've ever. . .I've ever experienced. Then I experienced the anger. I don't know if it was anxiety, but I. . .I didn't sleep.

All night she was awake, tossing and turning.

PT: I was just. . .I was ruminating, thinking about, you know, what. . .what was happening.

TH: What was happening? He's having sex with Linda.

PT: Yeah.

TH: Uh hmm.

PT: But figuratively speaking right under my nose. Uhhh he uh,. . .the crudeness of it. Not having sex, but doing it under those circumstances. . .

TH: Uh hmm.

PT: How he had manipulated me two weeks before.

TH: What was your reaction? So far what you said, you were mute for a few days.

PT: Yeah.

TH: And Linda your sister is having sex with Tony next to you.

PT: Yes, in a sense, yes.

TH: What was your reaction?

PT: Uhh aside from the lack of sleep I was uhh. . .I gotta think back because I. . .I haven't blanked it out otherwise I wouldn't remember any of it, but I. . .

Return to Challenge in the Area of C

The therapist now returns to challenge, stepping it up considerably.

TH: Do you notice you have tremendous difficulty to declare your negative feeling? You say you were devastated, humiliated.

PT: Yeah.

TH: But you have tremendous difficulty to declare. . .In a sense you are almost crippled here to tell me how you really felt.

PT: Well, I. . .I. . .

TH: I get the feeling, and you should not just agree, because we know that is a problem you have, what I say. . .

PT: Uh hmm.

TH: But I feel you are crippled to say how you really felt toward Tony who humiliates you in such a way.

PT: I find it difficult to verbalize it.

TH: But I am talking about how you feel.

PT: Yeah, but to say how I feel. You see if I say I'm angry. . .

TH: But you are crippled almost, here, here.

PT: Yeah.

TH: But "yeah" is not enough, and you smile as well.

PT: (laughs) It is because I recognize it. But uh. . .

TH: A woman at the age of 30 so paralyzed to talk about her emotions and feelings in such circumstances of the kind you describe.

PT: I don't know why, uh, I never. . .

TH: You are almost crippled here.

PT: Yes. . .

The therapist now directs his challenge to the therapeutic alliance, i.e., the patient's ego:

TH: Yes is not enough. Let's to see what you are going to do about it.

PT: But I don't know why.

TH: Here right now we are not looking at why you are crippled. We are looking that you are crippled, that you are paralyzed. First we have to identify that you are crippled and paralyzed.

PT: Okay (softly).

The words "crippled" and "paralyzed" are directed not only at the ego but also at the superego, which supplies the force responsible for the patient's paralysis. In the following intervention the challenge is directed first to the ego and then to the id:

TH: Then we have to see what you are going to do about it. You must have a lot of feeling about such a disastrous situation, at two levels. You must have a lot of feeling toward Tony. . .

PT: There is still a lot.

TH: Who humiliates you that way. And also Linda who is humiliating you, hmm?

PT: Yeah.

TH: But "yeah" is not enough. Let us see how you really feel.

PT: How I felt then or how I feel now towards them?

TH: Then or now, because obviously these are the ulcers of your life.

The above passage demonstrates some aspects of the process of restructuring the ego's defense mechanism. In the second incident the therapist has increased the challenge and the pressure on the patient's resistance, and it is important to note that the system of challenge and pressure is along the line of the structural concept of the psychic apparatus, namely, Id, Ego, Superego. Throughout the process it is absolutely clear that the evaluator is only challenging the patient's maladaptive defenses and not the patient herself. And this is of crucial importance in my technique. Throughout the challenge and pressure the responses are carefully monitored, and all the indications are that not only has there been no adverse effect, but that the patient's feelings are considerably nearer to the surface. The therapist takes this as his cue to switch his attention to the transference.

Challenge to Resistance in the Transference (T)

TH: What I'm bringing to your attention is that even when you want to talk about it you are taking a paralyzed, crippled position with me.

PT: Because I'm not accustomed to telling people how I really feel.

TH: And you prefer to call me "people" rather than me. Do you notice that?

PT: Yes, but . . .

TH: Let's not rationalize about that.

As the patient has problems with intimacy and closeness, the evaluator brings that into focus in the transference.

TH: You prefer to call me "people" rather than me. In a sense you say 'I don't want to share with you or to let you—that is me—to get close to my intimate thoughts and my intimate feelings'. This is what you are saying.

PT: Yes it is, yes it is, is what I'm saying.

TH: But then you put it in a vague term—"I am not accustomed to talking about these things with people".

PT: It's easier to say it that way.

TH: Let's see. Then a major problem is between you and me.

PT: No it could be anyone saying that.

TH: Doesn't make a difference. Right now it is me.

PT: Yes right now it's you, fine.

TH: And now we know you have two ways of dealing with every issue; you either submit or take flight, and both of them are crippling processes. Compliancy is crippling you as much as flight, okay?

PT: Yeah.

TH: So what you say is this; you don't want to share with me your intimate thoughts and feelings. . .

PT: It's not that I don't want to but it's difficult.

TH: Doesn't make a difference. But that is a major obstacle.

PT: Yes it is.

The therapist continues to increase the pressure.

TH: I'll tell you why it is a major obstacle. And I have a feeling you have a problem—again I emphasize, don't agree with what I say because you have a problem there. I have a feeling that you have a major problem with intimacy and closeness.

PT: Well I don't know how I'm supposed to correct it.

TH: We should identify it. Is it or isn't it?

PT: Yes.

TH: You are putting a wall?

PT: Yes. But I'm not putting one, it's already there. It's there when I walked in.

TH: Okay, is there, doesn't make a difference. Putting it consciously or putting unconsciously still is there.

PT: Still there.

TH: So there is a wall between you and me okay?

PT: Uh hmm.

TH: And this wall is like this; "that I would not want to have this stranger; I am not going to let this stranger get to my intimate thoughts and feelings." And it is very important we look to this process.

PT: Yeah, but even I don't know what they are.

TH: Doesn't make a difference. But the wall is there. Now you say it is not intentional okay but still is there.

PT: Fine.

The patient is still highly resistant but she has shown no adverse reaction to the increased pressure, and the therapist therefore introduces the maximum challenge—the head-on collision with the resistance in the transference.

TH: But still is an obstacle. I'll tell you why it is an obstacle. Let's look at it. You and I are here together. The aim of this is that you and I, that we can establish what are the nature of your difficulties and problems that are paralyzing your life, okay. And then also to get to the core of your problem, to understand what is the engine to all these difficulties that you have. So this means if you put a wall, intentionally or nonintentionally, when the wall comes up between you and me we will not be able to understand the nature of your difficulties and we will not be able to get to the core of your difficulties, to the engine of all your problems.

PT: But I don't even. . .

TH: Then this process is doomed to fail. Up to the time the wall is there then the process is going to fail. Let me tell you what way it fails. Because up to the time you don't want me to get to your thoughts and feelings, again intentionally or non-intentionally then we would neither understand your problems nor get to the core of the problem. Then I would become useless to you on one hand. We depart from each other, okay, at some point today, we depart from each other. I say, okay I did my best to get to understand this woman's difficulties in life but then I failed. I can afford to fail because I cannot always be successful, but can you walk from this office and perpetuate your paralyzed life. Can you? Can you afford that?

PT: I didn't expect to walk out of here cured today. I mean I don't know. . . I don't know what to say.

TH: But do you see what I mean?

PT: Yes I. . . I. . .

TH: Right now we see there is a self-sabotaging pattern in you.

PT: Of course there's a wall there, if there wasn't. . .

TH: Yeah but first is what are we going to do about this wall?

PT: Today I don't know besides identify the fact that it's there.

TH: Yeah but you see again you want to postpone it which is another form of flight.

PT: No, I think it's called being realistic.

Challenge to the Non-Verbal Defenses in the Transference (T)

TH: Now what you say is I am unrealistic. Is it that? You see again you don't want to look to my eyes and say I am unrealistic.

PT: I don't know what you want from this. What I want. . .

TH: Now you see again you use "what I want from this." We are here to get you out of this crippled life. Of course you are the one to decide is it a crippled life or isn't it?

PT: Yes, it is.

TH: And it is sad that a woman of your age is running a life which is so paralyzed. One one hand you have your potentiality and on the other hand you have paralyzing forces within you.

(pause)

And you have tears also in your eyes and you avoid my eyes. Do you notice that you avoid my eyes?

PT: I don't like to cry (spoken softly).

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

PT: Embarrassed.

The above passage shows systematic work on the transference with the therapist assessing communications both to the patient's conscious and unconscious. There was a rise in the pitch of the patient's voice when she implied that the therapist was unrealistic. The therapist has no doubt that there is a rise in transference feeling, but he maintains his attention on the wall and distancing, and the patient starts to cry. It is of crucial importance at this moment to differentiate between the regressive defense of weepiness and genuine painful feelings which come from the unconscious. If it is a regressive defense it should be challenged, but if it is genuine sadness which comes from the unconscious it must have its link in the past. But there is a third phenomenon that he should take into consideration; that is, the emergence of sadness as the ego-syntonic characterological problems becomes ego-dystonic and the patient starts to realize that this maladaptive, ego-syntonic characterological problem has messed up a major part of her life. In my teaching on this subject, I always bring to the attention of the therapist that if you are not sure, don't move and challenge it as a regressive defense, and equally don't move to the idea that the breakthrough is taking place. Don't fall into the trap of the phenomenon which I have referred to as *mirage*. We take up the interview.

TH: How do you feel when you look at my eyes? (Patient is sniffing) . . . because you are avoiding me in a sense.

PT: I know I am.

TH: And I am repeatedly saying avoidance is another part of your problem. You are terrified of closeness with me.

PT: Yeah.

It is of importance to note that each time the therapist verbalizes the words intimacy or closeness, there is a rise in the patient's anxiety betrayed by frequent sighs, which confirms that in this particular patient intimacy and closeness must be a major conflictual issue. Obviously the truth is that in all character neurotics there is

some degree of conflict over intimacy and closeness, but in some this is much more intense, and this applies to this particular case. We don't want to conceptualize nor speculate about the reasons for this at this moment. We only look to the moment when we open the dynamic unconscious and have a direct view of the core neurotic structure.

TH: And that is what I'm saying, this is a major obstacle for a woman in life. Of course I am not the one to decide, you are the one to decide. In this. . .

PT: Well this is one of the reasons I came, yeah.

TH: Hmm?

PT: This is one of the reasons I came here.

TH: So you feel uncomfortable to look at my eyes?

PT: Yeah.

TH: But let's see how you feel when you look at my eyes?

Patient is highly charged, with frequent deep sighs.

PT: Uhh. . .

TH: Again you are still avoiding my eyes.

PT: I know!

TH: But you know is not enough.

PT: (sighs) It's uncomfortable. (sniffing)

TH: But let's to see how physically you feel when you look to my eyes?

PT: Physically no worse than when I don't look at them.

TH: You see I say how you feel physically. Makes you anxious when you look to my eyes?

PT: No uhhh. . .

TH: What? I'm questioning, how do you. . .

PT: I'm trying to tell you. I'm having trouble breathing. I'm having trouble talking. . .

TH: Right now you're. . .

PT: Yeah whether I look at you or not I'm having that trouble.

TH: You feel tightness in your chest you mean?

PT: No, just, uh, short of breath.

TH: Shortness of breath. And when you are anxious you get this way?

PT: Yes.

Reducing the Pressure by Exploring the Physical Experience of Anxiety (T)

There is a rise in the level of anxiety and there are frequent sighs. Here I want to point out an important technical issue: In patients with obsessive character structure and severe ego-syntonic character pathology, with no history of depression or functional disorder, if challenge and pressure on the transference resistance mobilizes anxiety, one should not divert the process by asking the patient to describe the physiological concomitant of the anxiety or how the patient experiences anxiety. On the contrary the technique calls for maintaining the challenge and pressure. But in

patients with depression or functional disorder one should definitely move to exploring how the patient experiences the anxiety, which brings anxiety down to a level that is manageable. Here we should note that we are still in the process of restructuring the patient's regressive defenses. We take up the interview where we left off.

TH: When you are anxious you get tightness in your chest. What part of the chest do you get this?

PT: I get shortness of breath.

TH: I know, but do you feel a pressure in the middle of the chest or do you feel like a tightness?

PT: No heavy. Not pressure, heavy.

TH: Heavy. Do you get any palpitations?

PT: No.

TH: Only pressure.

PT: Yeah.

TH: When you are very anxious?

PT: Yeah.

TH: Are you anxious right now?

PT: No, actually I feel better now than before I cried.

TH: Uh hmm. Did you feel anxious here with me?

PT: Yes I did.

TH: How do you feel right now?

PT: Uhh. . .

Further Challenge to the Transference Resistance (T)

For a very brief moment the evaluator has focused on the patient's anxiety in the transference. Now having checked that her anxiety has been reduced, he immediately moves back to challenging the transference resistance.

TH: Again your eyes are not with me.

PT: I know.

TH: A smile, hmm. (The patient laughs) A cover up.

PT: Yeah.

TH: You know, I feel that you are a woman of facade.

PT: I'm very good at that.

In this response the patient is making clear that her facade is ego-syntonic. The therapist's next intervention is designed to make it ego-dystonic.

TH: Yeah but when you say you are very good at that, that is the ulcer of your life. Do you see what I mean? You say you are very good at that but that is the most crippling factor—facade.

PT: Yeah.

The focus is on her facade and what emerges is that in her job she constantly keeps up the smile while inside she is agonized, and she says that this is a habit "which

is hard to break." The therapist clarifies with the patient the way she defends against her inner feeling by smiling. She says that when she is very nervous she ends up giggling, which indicates another form of facade. Then the focus is on the here and now as she has frequent sighs. She says that she feels anxious and her hands are sweaty, "I fidget." Then the therapist questions the patient from where her tears came a moment ago, and she says, "You wouldn't let me fake it anymore," "The realization that I would not be able to fake it." Then the focus is on the tears and weepiness and the clarification of this as a defense to sabotage the process. And further the session moves to her giggling and smiling and the clarification of this as a set of mechanisms to deal with her underlying anxiety. She adds that they have a releasing function. Then there is a recapitulation on the smile and giggling as a mechanism for dealing with the anxiety and at the same time releasing some of the built up tension. Crying and weepiness also have a releasing function, while at another level they are used as a mechanism for avoiding and sabotaging a confronting situation. Then there is a recapitulation on the mechanisms of passivity, submissiveness, weepiness, flight and the whole set of regressive defenses that she uses. Then the session focuses on the patient's self-sabotaging pattern, and there is a return to the transference.

Return to Challenge in the Transference—The Need to Defeat (T)

TH: As we have seen so far there is a need in you to sabotage.

PT: Yes, I do.

TH: That you set a goal for yourself and you defeat that goal.

PT: Yeah.

TH: But the question is this. How that applies here with me? Still you are distancing yourself. So if you put the wall it means defeat, and then we depart from each other this process would be a failure like your life.

PT: Yes.

TH: Maybe you want to defeat this by your distancing and add a new addition to your past.

PT: I know that on a short term basis it would be a lot easier to walk away from this, but I also know that on a long term basis I must not.

TH: But you see what I'm saying is this; if you walk out of here defeated. . . If this process defeats then you might go and carry a crippled life to your grave. My question is this: why should you do that?

PT: No I. . .

TH: You have along way ahead of you. Why should you set the stage for. . .

PT: I shouldn't, that's why I'm here. That's why I'm here because I don't want that.

TH: So then we should keep that in mind.

PT: Yes.

TH: That defeat means perpetuating the crippling life to your grave and you are young and you have many years ahead of you. This is very important we monitor it.

PT: Yeah.

TH: Your need to defeat. I cannot be an exception to this rule.
PT: No. No you're not.

Focusing on the Patient's Feeling in the Transference (T)

TH: How do you feel right now?
PT: A lot more scared.
TH: Uh hum.
PT: A lot more scared.
TH: Scared.
PT: Scared yeah. You know it's one thing to tell you that this is going to be a lot of hard work, and it's another to realize exactly how much.
TH: And then the barrier and the wall between you and me, hmm.
PT: I don't know if it's gone, uhh.

Return to Resistance in the Transference (T)

TH: We can see your eyes constantly avoid me still. You prefer actually to interact with the all than with me.
(Patient laughs)
TH: You can laugh, but there's a truth in it.
PT: Well, yeah, walls are easier to deal with, yeah.
TH: So let's see what we are going to do about that because you don't want to be in interaction with me, you want to interact with the wall.
PT: No what I want is to get out of this rut.
TH: Okay but the major issue. . .
PT: The problem is the wall.
TH: Immediately the major obstacle between you and me is this need in you to erect a massive wall.
TH: Yeah.
TH: Then I would be on the other side of the wall and you are on this side of the wall. And I don't know what has happened in your life in the past. . .

Further Systematic Challenge to the Resistance in the Transference (T)

TH: . . .that you are terrified of intimacy and closeness. But whatever has happened in your life that you decided to set up this massive wall, this massive wall between you and I is going to cripple the process that we are aiming at, as it has done outside of here. But outside is not the issue right now. The issue is what are we going to do about you and I and the massive wall you put between you and me?
PT: Well I've got to get rid of it, but I don't know how.

TH: You move to the helpless position.
PT: No I. . . I really.
TH: You see when you say I don't know how, that is the helpless position.
PT: Okay so it's the helpless position. I don't know how!
TH: But the helpless position wouldn't help us. And you have developed a pattern of moving to the helpless crippled position and obviously weepiness is another way of. . .
PT: I find it. . . I find it a great release.
TH: I know, but still is a crutch.
PT: Yeah, okay, fine.
TH: You see you say 'okay,' fine' but that. . .
PT: I find it to be a release and. . .
TH: I know but still is a crutch. Still is a crutch.

As we see, the therapist has returned to the patient's resistances. There is a systematic challenge and pressure to the patient's tactical defenses including weepiness. Her communication that she is more scared was handled as a regressive maneuver to put the therapist off. The therapist is now putting further pressure which brings about weepiness and anxiety.

TH: So we know your anxiety and your weepiness. . .
PT: Uh, fear and uh. . .
TH: Anxiety and weepiness we have seen. What else besides fear?
PT: Some anger.

Admitting to Anger in the Transference

The question for the therapist at this moment is this: Is the anger itself a regressive defense or is it a true impulse? Is it from the lower corner of the triangle of conflict or is it from the upper left corner? We take up the interview where we were left.

TH: You felt some anger?
PT: Yeah uhhh. . .
TH: Do you notice when you want to say "some anger" your hand is like this?
PT: Yeah, I'm very nervous.
TH: You see when you want to declare to me you were angry with me you don't want to look into my eyes and directly tell me that during this process you had anger towards me. Do you notice that?
PT: Yeah.
TH: Again you prefer to tell to the wall that you had anger towards me rather than to tell me. Why? Why when you want to declare you were angry with me you had to look to the wall or look somewhere else and avoid my eyes? Not to look at my eyes and tell me that you were irritated or angry with me.

As I mentioned earlier, these patients have a major difficulty in distinguishing between impulse and anxiety. Restructuring the regressive defenses of the ego

requires that the impulse must actually be experienced by the patient in the transference situation, which means that the defense mechanism of instant repression of the aggressive impulse is no longer in operation. At this moment the patient is declaring anger. Those interested in learning and practicing this technique should not only have a precise knowledge of the anatomy of the psychic apparatus, they should also have a clear knowledge of the physiology of psychic processes. Here the work of Cannon on the Fight-Flight reaction is of importance. At this very moment she declares anger in the transference, and if we monitor it carefully her level of anxiety is much less. Her body movements have changed; she moves her hands, and there is some rise in her voice. The tension in her jaw is no longer there. From all this we have an indication that there is a good possibility that the true unconscious impulses and feelings are breaking through. The therapist continues to clarify the triangle of conflict.

TH: You said you felt angry with me.

PT: Yes.

TH: But it is very important for you to examine it. During the moment that you felt angry with me, was there also anxiety?

PT: Yes there was.

TH: Okay, so on one hand there is anger, on the other hand is the anxiety. Do you think there is a link between the anger and the anxiety? That whenever you get. . .

Breakthrough of the Impulse in the Transference (T:) The T-C Link

The therapist increases the pressure by asking how she experiences her anger, and she says, "anger is anger." The therapist points out that it is still not clear how she physically experiences her anger toward him. Further he brings to her attention the incident with Tony (T-C link) when she also said she was angry, but what she actually experienced was first anxiety and then detachment, and she ended up in her room banging her two hands against the wall until they were badly bruised, which was followed by her being depressed for some weeks. The patient raised her voice and said, "This is different."

TH: In what way is it different?

PT: I am telling you that I am angry.

(Rise in voice)

TH: If you put it out in terms of thoughts and ideas, what would you want to do to me?

(The patient raises both her clenched hands at the therapist. Her voice is loud.)

PT: I would grab your lapels and shake you badly.

TH: What further would you want to do to me in terms of thoughts and ideas?

PT: I would grab you and shake you badly.

TH: Then what would happen to me?

PT: (A loud voice with frequent sighs) You would be on the floor.

TH: So you throw me on the floor. What else? Would you damage me?

PT: No. (Increased level of anxiety. She is now sitting on the chair in a more controlled position.) I don't want to damage.

What we have seen is the breakthrough of the impulse through the repressive barrier. For this short period the defense mechanism responsible for her depression was undone, which means that her aggressive impulses were no longer instantly internalized and she actually experienced the difference between the impulse and anxiety. This is of crucial importance. Unless this takes place the therapist should not under any circumstances move on to a major unremitting challenge to the patient's resistance. This differentiation in the triangle of conflict is a prerequisite to the phase of major challenge. Extensive accumulated clinical data both with currently depressed patients and patients with life-long depression show the following: that if the therapist does not reconstruct the ego's regressive defense mechanism and proceeds to major challenge, the result is that the patient becomes more depressed, the ego becomes flooded with anxiety, and the process becomes paralyzed.

The Phase of Consolidation by Systematic Analysis of the Transference Understanding of the Depressive Defense and the Contrast Between T and C

The patient has now actually experienced the impulse in the T, which the therapist now links with the incident with Tony (C). She can clearly see the difference. He drives this lesson home, making absolutely sure that she understands the difference.

TH: In terms of experiencing anger, you actually experienced it with me?

PT: Yes.

TH: It is very important that we look and examine the process that took place here with me. You experienced some degree of anger in relation to me, which was to the level of grabbing me and shaking me and throwing me on the floor.

PT: Uh hmm.

TH: But if we go back to the incident with Tony, what differences do you see?

PT: It was very different. That was more anxiety and tension. With you my head is

very clear, but with him I was very confused. . .

TH: But we should look at this carefully. There, there was rage that somehow you did not experience and you set up a set of mechanisms against the rage. Then you became anxious, remote, detached and subsequently became depressed. Do you see what I mean?

PT: Yeah.

TH: But these are mechanisms you use to defend against your negative impulses as well as other feelings that so far we don't know.

PT: I can see it clearly.

TH: But another issue you might want to look at are the incidents in which you end up badly damaging your hand. Do you think the way you deal with your rage is to instantly turn it against yourself, taking it out on your hands?

PT: Uh hmm. I can see the difference between what I have been calling anger and what I felt here.

TH: Okay.

Further Analysis of the Transference: Exploring the Positive Feelings (T)

After the analysis of the triangle of conflict in the transference and its link with C, the further analysis of the transference is of crucial importance. It completes the restructuring of the patient's ego defense mechanism. In addition, we should not forget that patients with life-long depression have some degree of impoverishment of ego functions and the libidinal energy is at a low level. This process of analysis of the transference serves the purpose of fueling the ego for the final journey. Extensive clinical data show that beneath the repressed sadistic impulses—the “butchery houses”—that are found in these patients, there lie extensive grief-laden layers of painful feelings which are equally profound. Our journey to the dynamic unconscious requires the ego to have the capacity to withstand the impact of a major outpouring of these sadistic impulses and painful feelings, and we have to equip the ego before we start the second phase of the journey. The restructuring of the ego's defense mechanism, which includes the systematic analysis of the transference, is a preparation for this journey to the unconscious.

So far, with this patient, the therapist has brought into focus both the whole set of defense mechanisms against negative impulses and her problem over intimacy and closeness. He now pursues the positive feelings directly, immediately arousing further anxiety and resistance.

TH: Okay. But then you said that you would not go further than that. Do you think that between this also maybe there is some positive feeling toward me? (Pause) In a sense you didn't want to leave me damaged?

PT: Hmm. Yes. . .uhh (the patient is anxious).

TH: When I talk about the positive. . . You see when I talk about the positive feeling you get paralyzed as well.

PT: I get squirmy, yeah.

TH: Uh hmm. How you felt when I said there might have been also positive feelings toward me?

PT: I wanted to deny it right away.

TH: Positive feelings?

PT: There was.

TH: You always talk about the past. There was a positive feeling.

PT: (Laughs). No.

TH: A smile. But obviously you have a conflict about the issue about the positive feeling as well. Because as soon as I used the words “a positive feeling” toward me, that mobilizes as well anxiety in you. Isn't it that? You see as also I talk about the positive feeling you freeze, hmm?

PT: Yeah.

(Patient sighs)

TH: You saw the deep sigh?

TH: Hmm? Hmm?

PT: I don't know what to say.

TH: But it is very important you examine it because when I say you have problems with intimacy and closeness, there is also the problem with the positive as well as the negative.

Return to Negative Impulses and Further Analysis of the Mechanism of Depression

TH: You see, you said that the side that has to do with the negative is dead. Obviously it is not dead. It is defended against by a variety of mechanisms.

PT: Uh hmm.

TH: Do you see what I mean? That the rage and the murder—all the aggressive impulses within you, they are not dead, they are defended.

PT: Yeah.

TH: There are a set of mechanisms you use in dealing with all these negatives and rage and the murderous impulses there. One of the mechanisms you use in depression which is very crucial because when you get depressed you turn it against yourself, and then you become a crippled person. Because you know, you have experienced what it is like when you are depressed.

PT: Yes.

TH: You see. Then life is no good, life is gloomy and you know, the thoughts are gloomy, the world is no good and you have the feeling that it would be better to be dead.

PT: Yeah.

TH: You see. So you have experience first hand. You have had firsthand experience of what it is like to be depressed. So one way of dealing with this massive rage is turning it against the self and getting depressed and weepy. Another mechanism of it, that you use is becoming defiant.

PT: Hmm.

TH: You distance yourself, withdrawal, detachment okay. Locking yourself up in the room. Another mechanism is to use a regressive pattern of dealing with it. Namely banging against the wall, yelling and this and that. You see a wide range of mechanisms that you use. Another mechanism is the level of anxiety that comes in a split second. To the level that you don't even experience the anger. You see? Okay. But if you look awhile ago, when your hand went. . . like that, you experienced the negative impulse. It's different from anxiety.

PT: Yes.

TH: Is different isn't it?

PT: Yes.

TH: But anxiety also comes immediately. Okay?

PT: Yeah.

Return to Analysis of the Transference in Terms of Closeness (T)

TH: But what I want to say is this; the same is a serious conflict about intimacy and closeness and the positive. I don't know what has happened in your life that you have developed all these sets of mechanisms to deal with it. Okay, that is a different issue that we have to look at, but there is something. Because as soon as I say is there a positive feeling toward me?—then we see.

PT: Yeah.

TH: You become uptight and your anxiety. . .

PT: Yeah.

TH: Have you ever considered these issues?

PT: No not. . .uh. . .

Return to Driving Home the Understanding of the Triangle of Conflict

The therapist focuses on the patient's feelings at the present moment, and she says she is somewhat more relaxed.

PT: I do feel now that I know the difference between. . .

TH: Between the. . .?

PT: Anger and anxiety. I thought I was experiencing anger.

TH: Now that you know the difference it is better.

PT: Well, yes. . .I didn't even realize I was feeling it.

TH: Okay.

PT: So it came and went.

TH: It is very important.

PT: Yeah.

TH: So let's take a piece and examine that piece.

PT: Yeah.

TH: For the first time you actually experienced that anger, to whatever extent it was, you actually experienced it and now you are equipped with a different knowledge about yourself. That is different from anxiety.

PT: Anxiety, right.

TH: You see? Anger and rage are different emotions than anxiety, and anger immediately mobilizes anxiety. Depression is a mechanism of dealing with this internal rage okay. Now we persisted and worked hard together and finally you experienced it, okay? So now you are better equipped than if you had not experienced it. I'll tell you why. Because then you would have left me, gone with some feelings that you have repressed within yourself without experiencing it. But the fact that you experienced it, you have a better knowledge of yourself.

PT: Yes.

TH: It is not only a cognitive knowledge, it is an experienced knowledge.

PT: No. . .yes, I see.

Further Focus on the Positive Feelings (T)

TH: But I am sure you only got a glimpse of it. But if you can get in touch with the deeper parts it would make a big difference. Now let's look at the positive feelings. How do you feel toward me?

PT: Uhh. . .

TH: At this moment.

PT: Friendlier than I did ten minutes ago.

TH: But you see again you have difficulty to look to my eyes and say you have positive feelings towards me. What happens when you say that you have positive feeling?

PT: Physically?

TH: Uh hmm.

PT: Sort of blocks up. . .mobilizes anxiety. . .more fear of vulnerability.

TH: And obviously vulnerability refers to intimacy and closeness.

PT: Yeah.

Exploring Interpersonal Relations (C)

TH: You see because I'm sure in all your interpersonal relationships, particularly—I don't know, you can correct me because you know your life better than I do. Maybe you put a massive wall and barrier in relationship with them. Is that the case?

PT: Yes, definitely, uh I can't recall a single satisfying relationship with anyone, with a man either emotionally, or. . .

TH: So in a sense all men are on the other side of the wall?

PT: Yeah, it's like there's half the population doesn't really exist.

TH: You are relating that the man is on the other side of the wall. hmm? That there is a serious conflict about the intimacy and closeness. From where it roots we don't know yet.

PT: No.

The restructuring of the depressive defense is now completed.

The therapist explores the patient's reactions to previous contacts and then brings the interview to an end.

**Closing the First Part of the Initial Interview
Exploring the Patient's Reaction to the First Independent Evaluator**

TH: How did you feel toward him?

PT: I felt much less anxious, physically more at ease.

TH: Uh hmm. What else?

PT: He didn't challenge me. . .was different

TH: Then you would prefer to see him. . .

PT: No. I'd rather be challenged because I would get somewhere with it. . .I don't want to brag, but I could put the wall up higher and stronger and leave it there with him.

TH: Uh hmm. What you say, with him you put a massive wall.

PT: Yeah.

TH: But this massive wall has crippled your life. More wall means maintaining the crippled life, which further means carrying your suffering to the end of your life.

PT: Yes.

TH: Which one do you prefer?

PT: I would rather work with you. . .well this is what I am saying because I feel that I'd have to go through much more painful feelings with you. But I'd get more done.

TH: How did you feel when he asked you to see me?

PT: I knew I was going to see two persons today. I had no idea how the tests would be done, but I knew I was going to see more than one person. I didn't know what I'd be seeing.

Exploring the Patient's Experience with Her Previous Therapist

PT: That was a very bad experience. It was a bad choice.

(She said she had gone because of depression, but the therapy had focused on her sexual difficulties, her being anorgasmic and experiencing extensive pain during penetration so she ends up avoiding sex, which was there and still is there.)

Termination of the First Part of the Initial Interview

TH: You know, let me describe to you. The purpose of this interview is to determine what would be the best way to work on your problems. Now we have really not finished this and the time is running out and we have not finished. I was wondering. . .we need another similar session. Probably it might take another two hours or what before we decide what would be the best treatment for you.

PT: Okay.

TH: Now is it acceptable to you to come back next Monday?

PT: Uhh. . .

TH: We could meet at 8:30 and hopefully finish by 10:30.

PT: Uh hmm. Yes. Yeah.

TH: Is it okay, then, for you to come back next week?

PT: Definitely it is okay with me, yes.

Conclusion

Here it is worth while to recapitulate the main issues with which this article has been concerned, and also to summarize the course of the interview that was used in illustration. In my standard technique for handling highly resistant patients, pressure and challenge to the resistance are steadily increased and are not relaxed until the patient directly experiences the complex transference feeling, and "triggering" mechanism for the unlocking of the unconscious comes into operation. This technique is appropriate for the majority of patients suffering diffuse psychoneurotic disturbances with mild to severe degree of character pathology. However, when the following conditions are present the technique requires quantitative modification. These are depressive disorders, characterological depression, patients with chronic depression with episodes of clinical depression, patients suffering from functional disorder and finally patients with psychosomatic disorders. Such patients suffer from a deep-rooted inability to distinguish between the corners of the triangle of conflict. If they are challenged too relentlessly, the only result is an intensification of their defenses, which means a serious exacerbation of the original condition. In this observation there lies a major warning of all therapists seeking to learn the practice of ISTDP.

The Restructuring Technique

Extensive clinical investigation has shown me that his problem can be overcome by *graduated pressure and challenge* in the following way. The therapist starts by exerting gentle pressure toward the avoided feelings, followed by limited challenge, monitoring the patient's responses with the utmost vigilance. As soon as he senses that the threshold of tolerable anxiety is about to be exceeded, he immediately reduces the pressure, which he can do in three ways: (1) by returning to pure enquiry, (2) by shifting from one area to another, e.g., from transference (T) to current (C) or vice versa, or (3) by asking the patient to describe the experience of anxiety, particularly its physical manifestations. After a while he returns to pressure and challenge, now to some degree increasing them above their formal level. Because the defensive mechanism has begun to be loosened by the previous period of challenge, without an intolerable increase in anxiety, the patient's ego is now able to approach the pressure before the tolerable threshold of anxiety begins to be exceeded. By means of this stepwise process, the impulse can finally be brought fully into consciousness with complete safety. Now the therapist drives home *insight* into the original defense mechanism, and repeatedly points out the difference between the present experience and the defensive manifestations that the patient had formerly mistaken for anger. The final result is that the patient's ego is enabled to experience and tolerate the impulse in a way that reduces anxiety instead of increasing it.

Although during this process the therapist has usually alternated between the transference and current relationships, it is inevitably in the transference that the first true experience of impulse/feeling must take place. The next step is for the therapist to enter a phase of *consolidation*, and systematic analysis of the transference in which he uses a much more interpretative technique to resolve every aspect of transference that is still contributing to residual resistance. Now the defensive mechanism has been completely and permanently *restructured*, and the therapist can

proceed to use the standard technique of unremitting pressure and challenge that is used with neuroses and character disorders uncomplicated by the above-mentioned conditions.

The Course of the Interview

Enquiry soon revealed that the patient had suffered from recurrent episodes of depression since her teenage years. This made it clear that she came into the category of *chronic depression*, and the inference was that almost certainly it would be necessary to use the *restructuring technique* with which this article is concerned.

The therapist then concentrated on the precipitating factor for a recent attack of depression, which consisted of an incident in which she had been severely humiliated by a man. The natural reaction to this incident would have been extreme anger; but when the patient was asked to describe her feelings, though she did use the word "anger," it became absolutely clear that she had suffered no experience of anger whatsoever—"I don't remember having any kind of physical reaction. . . I went to bed, that is how I physically reacted. . . Then I guess I didn't experience it." This description of a defensive move ("I went to bed") as her only way of describing anger is typical. It makes clear that she is quite unable to distinguish between the corners of the triangle of conflict, and thus it completely confirms the inference that the restructuring technique will be necessary.

The therapist now employed the technique of challenge alternating with a reduction in pressure, in the following stages:

(1) Limited Pressure: When the patient made the remarks quoted above, the therapist exerted no more pressure than simply reiterating questions about her experience of anger, and pointing out the nature of her defensive moves ("But that is flight, not anger").

(2) Reduction of Pressure: He then took the pressure off by returning to pure enquiry, eliciting further details of the precipitating incident.

(3) Challenge: He now began to use a considerable degree of challenge, pointing out her non-verbal indications of hidden anger, and using such words as "crippled" to describe her inability to experience her feelings. Yet this only resulted in a blank wall, with the patient finally retracting her former statement of anger completely (TH: "You said you felt angry." PT: "No, I didn't. I didn't.").

(4) Reduction of Pressure: He therefore returned once more to pure enquiry with the question, "What happened subsequently?"

(5) Continued Resistance: This led to her describing a second incident with the same man, which had added insult to injury, and should have resulted in even greater rage than before. This time she again mentioned anger, but then quickly turned it into "anxiety," and ended by having difficulty in recalling anything that she had felt at all.

(6) Increased Challenge: Again the therapist returned to challenging the resistance, and then directing his remarks toward the therapeutic alliance with the repeated rhetorical question, "What are you going to do about it?"

(7) Transference: He then switched to the transference resistance, challenging her unwillingness to allow him into her intimate thoughts and feelings.

(8) Head-on Collision: Although she remained highly resistant she showed no adverse reaction, and he therefore introduced the maximum challenge in the form of the "head-on collision," forcefully pointing out the self-destructive consequences of maintaining her resistant position.

(9) Sadness and the Defense against It: This produced two reactions. First, she became intensely sad as she began to realize the way in which her difficulties had ruined her life; and second, she did her best to conceal this from the therapist and not to share it with him.

(10) Further Challenge: He therefore repeatedly challenged her defense against allowing herself to become emotionally close to him, with particular reference to non-verbal indications of this such as avoiding eye contact.

(11) Increased Anxiety: As a result there was a considerable rise in anxiety and its physical manifestations, which included shortness of breath and difficulty in speaking.

(12) Reduction of Pressure: Taking this as his cue that anxiety was rising to a dangerous level, the therapist immediately reduced the pressure once more, this time by means of the devise of asking her to describe her physical experience of anxiety.

(13) Return to Challenge: Within a short while the patient said she felt better, and the therapist returned to challenging the transference resistance, emphasizing in particular the self-defeating nature of the barrier that she was putting up between them.

(14) Breakthrough of the Impulse: Under pressure she finally experienced the impulse (anger) in transference, and under further pressure she described with raised voice how she would like to grab the therapist by the lapels and throw him on the floor.

(15) Insight: This had a major freeing effect. She said that her head felt clear, and that her present feelings were quite different from those that she had experienced in the incident which had precipitated her depression. The therapist drove home the lesson in order to give her insight, and she finally put it into the clearest possible words: "Now I can see the difference between what I have been calling anger and what I felt here."

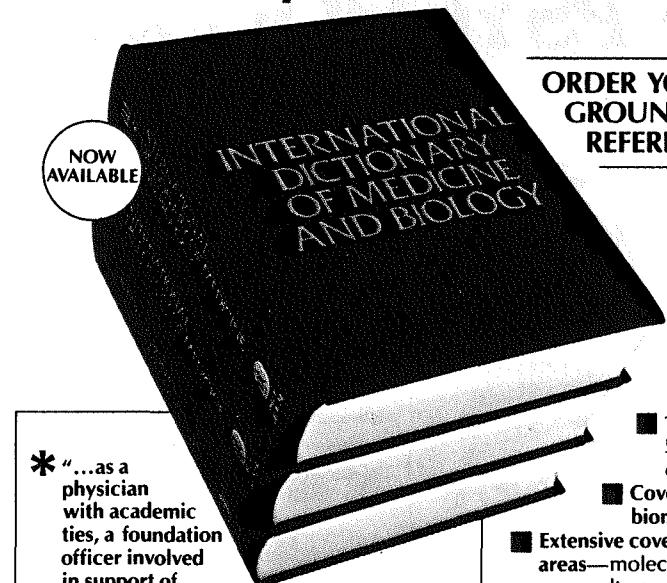
This complex phase was followed by the *phase of consolidation*, consisting of further analysis of the transference resistance, with particular reference to her wish to protect the therapist from her anger and her defense against the positive feelings that this implied. Now at last the phase of restructuring was completed and the therapist could make a further appointment, knowing that when resistance returned next time he would be able to return to his standard technique, keeping up his challenge without remission until the major unlocking of the unconscious could be achieved.

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