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The Technique of Unlocking the Unconscious in Patients Suffering from Functional Disorders. Part I. Restructuring Ego's Defenses

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In many types of patients, especially those who are highly resistant and suffer from character neurosis and diffuse symptom disturbances, pressure and challenge can be used unremittingly. In patients with functional disorder, particularly when it is with chronic depression and episodes of major clinical depression, the unremitting technique can arouse too much anxiety and make the process both ineffective and, most importantly, can exacerbate the patient's functional disturbances. In such patients the therapist must use a carefully graded technique in which he temporarily takes the pressure off as soon as anxiety reaches a certain level, proceeding in a "spiral," and gradually restructuring the patient's defensive system. Once this has been achieved he can revert to a much more unremitting technique. In the present article this process is illustrated by means of the first part of the trial therapy with a patient suffering from both migraine and chronic depression with episodes of major clinical depression and severe masochistic character pathology.

Introduction

In my previous publications (Davanloo, 1987a, b, c; 1988), I discussed the nature of resistance, the resistance of repression, and superego resistance and outlined the clinical manifestations of superego resistance and the technical interventions necessary in handling such resistance. I further elaborated on the central dynamic sequence for unlocking the unconscious. The whole process is used in trial therapy, which is a comprehensive psychodiagnostic evaluation.

The central dynamic sequence can be summarized as follows:

(1) The phase of inquiry.
(2) The phase of pressure.
(3) The phase of clarification and challenge to patient's resistance with systematic attempt to acquaint the patient with his defenses that have paralyzed his functioning and turning the patient against his own defenses.
(4) The phase of transference resistance with head-on collision.

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(5) Creation of intrapsychic crisis with a high rise in the complex transference feeling with breakthrough of the complex transference feelings – the triggering mechanism for unlocking the unconscious and the direct view of the multifoci core neurotic structure.

(6) The phase of systematic analysis of transference and partial or major de-repression of the current or recent past (C) and distant past (P) conflicts.

(7) Return to further inquiry, to be followed by developmental history.

(8) The phase of direct access to the dynamic unconscious with the direct view of the multifoci core neurotic structure and its relation to the patient's symptoms and character disturbances.

This standard technique can be applied to the whole spectrum of structural neurosis no matter how resistant a patient might be; the therapist must employ unremitting pressure toward the underlying feelings or impulses, persistently increase challenge to the resistance, and not take the pressure off until the unlocking of the unconscious has taken place. However, there are a number of conditions (see Davanloo, 1987a, b) where this technique must be modified such as:

(a) Patients suffering from characterological depression with episodes of major clinical depression (Davanloo, 1987b).

(b) Highly resistant patients suffering from functional disorder such as common migraine headache with depression, irritable bowel syndrome, etc.

(c) Patients with panic disorder with or without fainting attacks.

(d) Certain psychosomatic disorders.

(e) Patients with fragile ego structure.

A general account of the technique that needs to be used with these types of patients is described in a previous two-part article (Davanloo, 1987a, b). The present two-part article illustrates in detail the technique of unlocking the unconscious in patients suffering from migraine and chronic depression and major character pathology.

In these patients the link between the underlying impulse of anger on the one hand, and the defenses of depression or somatization on the other, is very deeply unconscious. They are quite unable to experience the impulse of anger and describe instead one of the two other corners of the triangle of the conflict, namely defense or anxiety, while remaining quite unaware that this is what they are doing. This has the following important consequences:

(1) The use of unremitting pressure and challenge may cause, instead of a breakthrough, an increase in anxiety leading to an intensification of defenses and an exacerbation of the depressive and/or functional symptoms.

(2) Therefore the therapist (a) uses a carefully graded degree of pressure and challenge, (b) monitors the patient's anxiety level with vigilance, and (c) immediately takes the pressure off when he detects that the anxiety is exceeding a tolerable threshold.

(3) One of the most important ways of reducing pressure is to switch attention to another area, e.g., from transference relationships (T) to the current relationship (C).

(4) After an interval in which the therapist brings the level of anxiety to a manageable degree, he returns to pressure and challenge, now increasing it to a higher level. In this way he can proceed in a spiral, increasing the patient's ego adaptive capacity to tolerate a higher degree of anxiety and painful affect, gradually weakening the defensive system and bringing the impulse nearer to the surface so that it eventually reaches the point of partial breakthrough.

(5) Each time a partial breakthrough occurs, whether in the area of C or T, it is essential to make repeated analysis of the triangle of conflict, driving home the insight into the link between impulse, anxiety, and the defense. If this analysis of the triangle of conflict, particularly in the transference, is not done the defense inevitably re-establishes itself, and when the patient returns for a second interview the symptoms will be found to have recurred.

(6) This sequence may have to be repeated many times, but eventually the patient's defensive system is restructured; and now it is possible to use unremitting pressure and challenge in order to achieve a final breakthrough, and to proceed to the phase of direct access to the unconscious.

The special features of this graded technique are therefore as follows:

(1) Greater alternation between the areas of C and T

(2) Successive moments of partial breakthrough either in C or T.

(3) After each partial breakthrough, the introduction of a phase of consolidation of insight by analysis of the triangle of conflict in C and particularly in the transference, the link between the underlying impulses, anxiety and the defenses against them.

These features mean that the interview proceeds more obviously in a spiral rather than a smooth progression; but all of them represent differences of degree rather than kind, from the "unremitting" technique, since exactly the same forms of intervention are used in both types of interview. The differences of degree are in two opposite directions: Challenge and pressure are used and increased gradually while analysis of the triangle of conflict, the link between impulse, anxiety, and defense, is used more frequently and more emphatically.

The clinician applying the technique of unlocking the unconscious should take into consideration:

(a) These patients have easy access to major regressive defenses such as depression and somatization.

(b) Clinical research data show that in all such patients the sadistic impulses, guilt and grief-laden unconscious feelings, are of such high intensity as to produce disturbance when the breakthrough takes place. For that reason the technique of restructuring which I have described, a carefully graded technique is essential.

The following trial therapy illustrates the technique of unlocking the unconscious in patients suffering from migraine, chronic depression with episodes of major clinical depression, and major masochistic character pathology.

The Case of the Woman Used as a Go-Between

Enquiry (Phase 1)

The patient, a 48-year-old divorced woman, said she had applied for this particular form of therapy because she understood that there was "no transference and no dependency."

PT: I applied on my own because I have been looking for a kind of therapy which is short-term and what intrigued me about your approach is that there's no transference and no dependency.
TH: Uh hmm.
PT: Simply because I think that way, I'm suffering from migraine headaches since I was a child, and it . . .
TH: When you say since a child, how old?
PT: Umm, six.

She went on to say that she was Austrian, that her father was a Nazi sympathizer, and that she had suffered from migraine headaches—as often as 25 days in a month—since she was sent away from her parents for a period at the age of six. She then led the enquiry in the direction of psychodynamics by saying that her headaches, together with depression, seemed to occur after the break-up of a relationship with a man.

Further Enquiry

TH: You mean when there is a breakdown of a relationship following that you develop a severe migraine headache, and depression, both?
PT: Both, ah, I would relate the migraine headaches, I would say, maybe it's a depression, I don't know.
TH: But what you say is this. You get the headache plus depression after breakdown of a relationship.
PT: I have to admit I'm not sure what depression really entails.
TH: But you said that you get depressed, didn't you say that?
PT: Yes, you heard me say that I assume that I must be depressed first of all it's a loss, secondly it's a letdown.
TH: Yeah, but you say it is depression because it's a loss or do you experience something that you call depression?
PT: (She sighs.) *I should have read up on depression before.* (She laughs.)
TH: Could you tell me the state of mind that you are in when there is a breakdown?

Pressure Leading to Resistance (Phase 2)

The therapist began to exert pressure by asking for a specific example, in answer to which the patient mentioned the break-up of a relation with a man called Dick three years ago. However, she soon started to go into unnecessary detail about irrelevant matters, and the therapist began the preliminary clarification and challenge to her defenses.

Clarification and Challenge to the Resistance in the Area of C—Phase (3) of Central Dynamic Sequence

TH: Is it usually like this, that when you want to describe something you go round about the way? Are you usually like that or only here with me?
PT: Ah, in my private life I might be like this. On my job, I'm very much on the dot. (She laughs.)
TH: So here is more like your private life?
PT: Ja, because I'm dealing with my private self here.
TH: Uh hmm. So let's see first how you feel about your private self. You are smiling.

The patient now gives an answer which indicates that some of her neurosis is ego-syntonic. The therapist immediately begins the process of making her resistance ego-dystonic, with the aim of establishing a common aim with her therapeutic alliance.

PT: (She sighs.) *I like my private self.*
TH: Uh hmm. So let's see what are we going to do about that first. Because you say you come of your own will here.
PT: Uh hmm.
TH: And then you want to understand your problem, obviously we are here for that, isn't that?
PT: Ja, ja.

Clarification and Challenge to the Resistance in the Area of T

The therapist now both draws attention to the transference resistance and challenges it, continuing the process of trying to establish a common aim.

TH: But at the same time you don't want me to get to know you then.
PT: Oh yes I do.
TH: But you said that you like your private self.
PT: You're getting to know me right now as we . . .
TH: But you have a certain feeling about telling me about yourself?
PT: Why I'm here, I have a feeling . . .
TH: No, let's see, is it that you have difficulty to talk about yourself here with me?

PT: No. Yet I don't know what is really the real self. I have the feeling . . .
TH: No, let's not get to this because another tendency of you is labeling things. Hmm? Do you notice also you have a tendency to label yourself?
PT: No.
TH: Hmm?
PT: No, I'm learning that right now.
TH: Uh hmm. Do you notice that you label, you know that . . .
PT: No, I didn't notice.
TH: So, we were talking about this. That you are, you have difficulty to be specific, another difficulty also, you have a certain feeling about this interview and me knowing you. Now, you are holding back like that now.
PT: Maybe I don't understand you right.
TH: Now, you move to the position that you don't understand me right.
PT: I don't . . .

Here the therapist notices the patient's withdrawn posture and draws attention to this nonverbal manifestation of her resistance.

TH: Now you are holding back like that.
PT: Maybe I don't understand you right.
TH: Now you move to the position that you don't understand me right. Do you notice your posture right now?
PT: . . . I don't know whether this is the posture I assume when I am withdrawing into myself to search. I sometimes think I know myself and . . .
TH: But you see, again you are ruminating on the issue that you sometimes think you know yourself. That doesn't tell us anything.
PT: Could you give me an example of how I should express myself so that we get to the point quicker?
TH: Again that is vague, "to get to the point." Which point? You want to tell me a specific example of a situation that you become attached to a man and then that relationship ended.
PT: Uh hmm, uh hmm, uh hmm. Yes.
TH: But then what we see is this. You have to go all round about the way, and then you didn't tell me still, because what we wanted to know was what was Dick like? So could you tell me about Dick?

Return to Exploration, Pressure, and Challenge in C

The patient continues resistant.

PT: So, I met Dick.
TH: What type of person is he?
PT: (Silence) *Ah . . .* (She sighs a little.)

TH: You see again your hesitation.
PT: What type of person . . .
TH: How would you describe him as a person?
PT: He's rather dynamic.
TH: But that doesn't say anything, he's dynamic, dynamic what?

Under further pressure and challenge the patient said that Dick had been extremely generous and attentive and had pursued her in a way that she had never been pursued before. Their sexual relation had started within four weeks and had been very intense. She also said that he was a very ugly man, that all her previous relationships had been with very good-looking men, and that she had said to herself, "Why not try an ugly one"?

Return to Challenge to the Resistance in T, with Special Reference to Nonverbal Indications

Pressure on the details of their sexual relationship produced a flirtatious attempt at diversionary tactics, which the therapist aborted in such a way that she did not try again.

TH: What was specific sexually? . . . Do you notice that when you want to talk about this you are looking over there?
PT: Because I'm searching for the right word.
TH: But maybe at the same time there is a way of avoiding me.
PT: You look a little bit like Dick. (She laughs.)
TH: Uh hmm. You smile and say I look like Dick. And you also said Dick is ugly, hmm? And you are smiling now. (She laughs.)
PT: You look better than him.
TH: Now you take a sarcastic position, do you notice?
PT: I look to the side but I also lean forward.
TH: Yeah, but let's see. On one hand you are taking a sarcastic position with me.
PT: Sarcastic?
TH: Uh hmm. And also you are bending over like that. Embryonic position. And your hands. Do you notice that also?
PT: What's with my hands?
TH: Clenched like this . . .
PT: It's loose . . . Ah . . .
TH: Now you are becoming slow as well. So, you said Dick was like me, but you didn't finish that.
PT: It's the eyes. (She laughs lightly.)
TH: What about the eyes?
PT: Similar eyes. Well, we had a very . . . there was closeness.
TH: Yeah, but you moved away from the sexual relationship.

Return to Enquiry, Pressure, and Challenge in C

The patient gives a crucial piece of information.

PT: That is what we experienced in our sexual togetherness, a real intense closeness. And I did not know that Dick at that time had had another relationship for seven years.

She had discovered this by chance two months after she had started sexual relations with Dick. The other woman, Maria, worked in Dick's office. Dick had opted for the patient after she had given him an ultimatum, "either Maria or me."

When she is asked to describe her feelings about Maria within this triangular situation she immediately goes into resistance, stronger than before, indicating that a very sensitive area is being touched.

Pressure and Challenge in Relation to C

TH: How did you feel toward Maria? (The patient takes a deep sigh.) *You took a sigh now.*
PT: Sometimes I was angry, not I . . .
TH: You mean you felt angry with Maria?
PT: Sometimes in the beginning I was angry when ah he made a decision . . . he made a decision for me and he said he . . .
TH: And how did you feel that he dropped Maria for you, because she was around seven years with him, and you were two months, hmm?
PT: I didn't feel too good about it.
TH: Yeah, but you see that is just a sentence, "I didn't feel too good about it." That doesn't say how you feel.
PT: I did not feel guilty.
TH: But that still doesn't say how you felt. "I did not feel guilty" is a sentence again. Do you notice, I question you how you felt but then you use sentences to describe your feeling?
PT: I don't remember how I really felt.
TH: No. How is your memory usually?
PT: Very good.
TH: So, your memory is very good, so how come when it comes to your feeling for Maria who is dropped by Dick, suddenly your memory collapses? Now you look puzzled.
PT: Ja, because I try to put myself into that time.
TH: Do you notice how helpless you become when I question how you felt towards Maria being dropped by Dick after your demand?
PT: (Silence).

The patient starts to cry, and with tears the patient said that it was the first time in her life that she had started fighting for herself. She continued highly resistant, at first using generalities to describe her feelings—"confused," "hurt"—and then falling back on an inability to describe anything. The therapist now concentrates on clarification and challenge to the resistance in the transference.

Clarification and Challenge to the Resistance in T

TH: You see how much difficulty you have to be in touch with your feelings?
PT: Ja.
TH: Because you yourself say you have a lot of feeling about it.
PT: Ja.
TH: But at the same time you don't want me to know about this feeling.
PT: I would love you to know because I want to know too.
TH: I know, but there is some obstacle here between you and me. Do you notice that? Do you see that there is some kind of distancing between you and me, hmm?
PT: Ja.

Clarification and Challenge to Resistances against Emotional Closeness in Transference

TH: I have a feeling that in a sense you are distancing yourself from me and you don't want me to get close to you in a sense. You see, a sort of a wall, a kind of wall that you put between yourself and me. Do you notice that?
PT: You don't put it there consciously.
TH: Doesn't make difference, consciously or unconsciously. But, still we have to look to . . . Is there a wall between you and me? Is there a need in you th distance yourself from me?
PT: I think the wall is not between you and me; the wall is between me and me, that's why I'm here. There's a wall.
TH: Yeah, but that doesn't help us you are here. We have to see what we are going to do about the wall first.
PT: Ja.
TH: Hmm? Because you are holding back from me . . .
PT: (She sighs.) *Yes, I'm looking at you now.* (She laughs.)

Return to Challenge to Resistance in C, Partial Breakthrough

After systematic challenge to patient's resistance she described how Maria had created "incredible scenes" at the office, which Dick seems to have deliberately provoked.

PT: And Dick always came back and told me how he provoked her by telling her about me.

Finally the crucial detail emerged, which the patient had concealed hitherto, revealing Dick's pathological manipulation of triangular situations.

PT: And then he said, "Oh, I'm going on a three-week vacation," and I said, "That's good. That will do you a lot of good." And he told me

he wouldn't go alone. And I said, "What"? And he said, "We have planned this, Maria and I, and we are going to do it. We have a lot of talking to do."

TH: So, now he is dropping you and going back with Maria. And how did you feel about that?
PT: I felt really shitty.
TH: But that doesn't say anything . . .
PT: (She sighs.)
TH: You are dumped and disposed like that, how you felt?
PT: Dumped.
TH: Yeah, but that doesn't say how you felt. What type of the feeling that generated in you?
PT: I froze.
TH: Uh hmm. You mean, actually, you felt numb.
PT: Ja.
TH: Where did you feel numb?
PT: My whole body.
TH: Your whole body? You mean become like paralyzed.
PT: Not paralyzed, numb.

Further Pressure and Challenge in Relation to C

The therapist puts pressure on the feeling, the lower corner of the triangle of conflict. What emerges is one tactical defense after another. "I froze," "I felt numb," "I felt rejected," "I felt empty," (she becomes weepy), "I just became very active," "Can I report another incident?," and so on. The therapist responded with sustained pressure and challenge, and the nonverbal indications of tension steadily increased.

Challenge to Tactical Defenses

PT: (She sighs.) (Silence) (She cries.) *I don't know what I really feel.*
TH: Now you are becoming weepy now, right now. I question you how you felt for being disposed like that, then is not clear how you felt.
PT: It isn't clear how I feel, otherwise I would say it. (Continues crying)
TH: Now you become weepy instead of looking to see what else you felt for being disposed like that. What was your reaction?

PT: (She sighs.) (She sniffs.) *At the same time, there were so many other things happening in my life . . .* (She remains weepy.)
TH: No, let's not get to the other things happening to your life, let's focus on this.

Partial Breakthrough

Sustained pressure and challenge to the patient's resistance bring about a partial breakthrough.

PT: I really felt, I, I, I wanted to have it out with him.
TH: Yeah, but that's a sentence. "I felt . . ."
PT: I felt like hitting him.
TH: So, you felt anger inside you?
PT: Ja, ja, ja.
TH: Uh hmm. Could you describe the way you experienced this anger inside? Do you notice your posture here? (She sighs.) *There is a clenching . . .*
PT: Uh hmm, uh hmm.
TH: You said that you wanted to hit him.
PT: I, ja.
TH: That means anger, hmm. So, let's see how you experienced your anger.
PT: Well, I cried a lot. I screamed a lot.

PT: I don't know how to express it in words.
TH: No, we don't want words, we want to see physically how you experience the anger. Was it that you wanted to lash out?
PT: It was like this (She makes an angry gesture.) *. . . Ja.*
TH: Now, if you had let yourself go and be honest with yourself in terms of thoughts and ideas, how would you lash out?
PT: I would have knocked his front teeth out (She laughs.)

PT: To go up to him and take him by his tie.
TH: With what hand?
PT: This hand, and just slap him.
TH: Uh hmm, uh hmm. And then . . . (She laughs.) *You are smiling again.*
PT: Ja because (She sniffs.) *. . .*
TH: Do you see how much difficulty you have to talk about anger?

PT: Slapping him.
TH: And then, until . . .
PT: Taking a bucket of shit and pouring it right on top of him . . . and letting it drain all down . . . and sending him out into the street.

Insight into the Link between Impulse and Defense

The therapist now begins the process of acquainting the patient with this link by repeated questioning, which itself requires challenge, but eventually an important and unexpected answer emerges.

TH: What did you do with this impulse within yourself?
PT: I remained civilized.
TH: You mean by "civilized" you become limp?
PT: No.
TH: Paralyzed?
PT: No.

TH: What was the way you dealt with it?
PT: I think, I really . . .
TH: You think?
PT: I think I didn't deal with it.
TH: What was the way you handled this rage, internal anger?
PT: I handled it by rationalizing it. I handled it by hitting the bed with a tennis racket.
TH: Uh hmm. And who really you wanted to hit with a tennis racket?
PT: (She sighs.) *All the male figures in my life* (She becomes sad and very choked up.)
TH: All the male figures, hmm? Includes who?
PT: (She is crying.) *My father, my brother, my . . .*

We saw a partial breakthrough, the negative impulse partially has been experienced as well as a major breakthrough into her grief laden unconscious feeling. Now the therapist returns to resistance in the transference.

Return to Challenge to Resistance in T

TH: And where do I stand there?
PT: (She sniffs and sighs.) *Sorry, you're not included.*
TH: Why am I an exception.
PT: (She sighs.) *I feel no dependency on you.*
TH: Now, just a moment. Why am I excluded, you say all male? So that means that still I am on the other side of the wall, hmm? Are you saying that?
PT: Ja.

Challenge to Resistance against Emotional Closeness in Transference

TH: . . . that here in your relationship with me you are on the other side of the wall and I am on this side of the wall, hmm?
PT: (She takes a deep sigh and sniffs.)
TH: Isn't that? Hmm? . . . Could we look into that?
PT: I think that difference between difference is between people.
TH: That is rationalization, I mean, that is intellectual issue. But my question is this, am I on the other side of the wall?
PT: Ja.
TH: Is there a wall between you and me or not?
PT: In this sense there is a wall.
TH: Now what are you going to do about this wall?
PT: I wouldn't know how to take you into the circle of people in my past.
TH: Uh hmm. Are you saying you don't have any feeling here with me?
PT: (She sighs.) *I feel comfortable with you. Uh, I'm not scared.* (She laughs.)

In the above passage the therapist again exerted some degree of challenge and pressure to the patient's resistances against emotional closeness which immediately mobilized anxiety in the form of tension in her striated muscle, particularly in the intercostal muscle with frequent deep sighs. All evidence indicates that the patient has a major conflict in relation to emotional closeness.

Return to Triangle of Conflict in C–Consolidation of Insight

TH: Uh hmm. Now let's go back to this. This is very important you look at it . . . With Dick obviously there was anger in you . . . We see it in terms of the necktie and the slapping . . . And then there was the racket-banging on the bed . . . These are all related to your rage, hmm? But the way you dealt with it, it is important to look at it . . . Is it to say that the numbness, helplessness, passivity, paralyzed position that you take is a defensive way of dealing with the rage? Do you see what I mean?
PT: I think this is . . . (She sighs.)
TH: No, this is important to look at it. You see, if you look to this situation, it is a triangle in which you and Dick develop an intense relationship, okay? . . . But then your ultimatum was that either you or Maria . . . and then he plays about with it . . . and then suddenly you realize that he and Maria are going to go on vacation, okay? . . . Now this mobilizes an anger in you. This mobilizes a rage in you and then at that moment you feel physically numb, okay? . . . You become weepy, you become sad, hmm? . . . And then you don't want to eat. Now the question is this. Is this sadness, the weepiness, the numbness, a defense against the rage?
PT: Ja.
TH: You say ja because I say so or . . .
PT: No, it is. I started to get angry only about two years ago. I really physically felt that I turned all green . . .

The therapist brushes aside this tactical use of the defense of "fancifulness," and concentrates on the experience of anger and the instantaneous operation of the depressive mechanism. Our extensive clinical research data, has shown that repeated analysis of transference as well as analysis of triangle of conflict in C is of extreme importance, to bring insight over and over again. If this is not done there is no lasting effect and the depressive mechanism reasserts itself on the next occasion. The following passage illustrates the importance of this technical intervention. As will be seen, the end product is an important breakthrough.

TH: I know, but do you think that in a split second you experience the anger . . .
PT: Uh hmm.
TH: . . . in a split second . . .
PT: Uh hmm.

TH: . . . what you experience is not the anger. In a split second . . .
PT: It's not the anger . . .
TH: . . . you experience, look at this. This is very important you look at this.
PT: Uh hmm.
TH: That in a split second you don't experience the anger, what you experience is depression.
PT: Ja.
TH: . . . is weepiness . . .
PT: Uh hmm.
TH: . . . is numbness, as a defense against anger?
PT: Ja.
TH: Do you see that there is or no?
PT: Yes, yes, I see that.
TH: Uh hmm.
PT: It is numbness. It is a freezing numbness.
TH: Uh hmm.
PT: And then there . . . it takes quite some time and then comes weepiness.
TH: Weepiness. First is . . .
PT: Numbness.
TH: Then is weepiness. And then when does the migraine come?
PT: Ah, after that.
TH: The migraine comes after that?
PT: Ja.
TH: And the depression.
PT: (She sniffs.) *I assume it goes all along . . .*
TH: But you think that there is that depression, and these symptoms that you develop are a defensive way of dealing with this . . .
PT: With anger.
TH: Anger?
PT: Ja.
TH: Have you previously thought about it or . . . ?
PT: Yes, I've, I started to think about that . . .

Breakthrough in C

Now suddenly in response to the therapist's pressure she reveals that she experienced anger to a considerable degree and is terrified of it:

PT: And I'm, I, I'm afraid of, of, my anger as it came out lately.
TH: Hm, hmm, uh hmm. You mean, afraid that you might lose control over . . .
PT: That I, I might lose control.
TH: And is very important to look at it. If you lose control over your anger, let it go, what would you be like?
PT: I've . . . it would feel like losing my senses.
TH: But, could you portray yourself if you go berserk?

PT: I would be very physical.
TH: What would you be like?
PT: I would hit, I would . . .
TH: Could you describe?
PT: Yes. I had an anger outbreak during the Christmas holidays . . .

There is a major change in her posture from a very bent position to a more upright position; with frequent sighs and very animatedly she described the following: Every year she and many other neighbors from similar backgrounds celebrate a traditional Christmas Eve at the patient's house. It is understood that afterwards her two teenage sons will help with the cleaning up. Her son Paul, age 14, with whom she has been having trouble for some time returned home late in the afternoon and this mobilized a major rage in her in relation to Paul. The focus of the session is on the triangle of conflict in relation to Paul. Now we take up the interview.

PT: When Paul came, I mean I started throwing things already. The whole house . . .
TH: What was the way you experienced this rage?
PT: (She sighs.) *It's so, it's physically, it really takes over.*
TH: Uh hmm.
PT: And he came in and I grabbed him and I threw him across the, the (she sniffs), *the living room. His glasses were flying and I'm losing my . . .*

During the interview she shows with her hands how she grabbed Paul and how she threw him across the room. There is a sudden breakthrough of the guilt-laden feeling. She becomes very sad, crying. We take up the interview.

TH: So, you must be really in a rage then? You took him like what? From the shoulder, you mean?
PT: Ja. Like this and I threw him across the living room.
TH: With the head, you mean?
PT: No, sideways.
TH: Uh hmm.
PT: And, and, then I had also chairs in the kitchen on the table and I blew them off the table.
TH: Uh hmm.
PT: (She sniffs.) *And then I realized where I was and I grabbed my coat and I said, "I'm leaving."*
TH: So, you must be really in a rage then. You took him like what? From the shoulder, you mean?
PT: Ja. Like this, and I threw him across the living room. And, and, then I had also chairs in the kitchen on the table and I threw them off the table.
TH: Uh hmm.
PT: (She sniffs.) *And then I realized where I was and I grabbed my coat*

and I said, "I'm leaving." All the chairs went off the table and all of a sudden it just clicked. I said, "Brother, I'm getting out of control here," and I grabbed my coat and I left.

TH: I see. So you were in such a rage and then the rage was directed at Paul.

PT: Ja.

It is essential for the patient to experience the aggressive impulse to the maximum degree in this process.

TH: Was there in your mind the thought at that moment on a split second that you might do something disastrous to Paul?

PT: Ja.

Further Analysis of the Triangle of the Conflict in C

It is again important to further analyze the triangle of the conflict, the impulse, the anxiety, and the defense against the impulse, and further to determine if the negative impulse has murderous quality.

TH: Is very important you look at it.

PT: Ja.

TH: Not because I say so.

PT: Ja, I . . .

TH: Did the thought, did you have a passing thought . . . ?

PT: I sometimes think I could kill them.

TH: Uh hmm. So, the passing thought came to your mind that you might kill him.

PT: Sure.

TH: And then you defended yourself against this impulse by walking out, hmm?

PT: Hmm.

TH: If you said to yourself this passing thought to kill him, how would you, in your thoughts?

PT: (She has frequent deep sighs.)

The patient again becomes very sad and cries and what emerges is the impulse to strangle Paul which is then linked with Dick.

TH: Obviously it must be very disturbing to you that . . . (She starts crying.) *. . . You see, how would you, I mean the instrument you might kill Paul, with a knife or with what?*

PT: No, no, no strangling, but it's not . . .

TH: The method is strangling. And Dick is on similar format in the different ways, hmm?

PT: Ja.

The focus of the session is on the impulse to strangle her son, the massive rage within herself and the defense mechanism of walking out to protect

Paul against her massive rage. What happened is that she almost ran two miles through the city and ended up in a shopping plaza and went to a movie. A crucial piece of information emerged, namely that she did not get depressed nor did she have a migraine headache. Then she went on to say that she had two other disturbing episodes with Paul, one of which occurred as follows: She and Paul had arranged to go to an exhibition after he returned from school. But that afternoon she received a phone call from the principal saying that Paul had not been in school for five days. Questioning now revealed that during the telephone call she had been completely calm, but that a migraine headache with vomiting had set in immediately afterwards.

PT: Ja.

TH: And then you had a migraine immediately?

PT: The migraine right away started, I threw up, and I was just incapable of functioning.

TH: You mean vomiting?

PT: Ja.

TH: What else when you got the call? Is very important to see what in a split second took place first before the migraine.

PT: I, I was totally calm during the call. At the moment the action is complete, the migraine starts.

TH: Now, you were, you say on the phone you were calm . . .

PT: Ja.

TH: . . . but then the migraine started. Is very important to see was that in a split second on the phone . . .

PT: No.

TH: . . . any other feeling within you?

PT: While I'm on the phone, it's o.k., and then it is like . . . then the, the vomit, vomiting . . .

Analysis of the Triangle of Conflict in the Area of C

After the breakthrough of the waves of painful feelings she once more became relaxed, and now the therapist proceeds again to drive home insight into the link between impulse and the defense in relation to Paul. The following passage illustrates this important process, including the necessary repetitiousness very clearly.

TH: Now let's look at this. You are calm, then you have the migraine headache.

PT: Uh hmm.

TH: In the other one, the Christmas incident, your rage is out, you are pushing Paul against the wall, you are pushing all the chairs, you are in a massive rage, you walk through the city, but you don't have the migraine headache. It is very important that you look at this too . . . in that incident of Christmas there is very explosive rage, but then you don't get the headache.

PT: Uh hmm.

TH: But the second one you are calm, but you have severe migraine headache with vomiting. Do you think that there might be a link between massive rage and the migraine headache?
PT: Oh, certainly.
TH: Because in that incident your massive rage is out, you don't have the headache. The second one you are calm—that means the massive rage is not experienced consciously, but what you develop is a severe migraine headache with vomiting. Do you notice that?
PT: Ja, then I had the rage at night when Paul came home, and I hit him.
TH: What way did you hit him?
PT: I slapped him, just like this . . .
TH: Did you have a headache that night?
PT: The headache then disappeared.

Return to Pressure toward Impulses in the Area of C

The therapist now sets about exploring the possibility of death wishes toward Paul.

TH: So, in a sense, Paul is like a pain in the neck in some form?
PT: Oh, he is (she is choked up). *He, he is both. He is very . . .* (She sighs.) *In some way, yes, and on the other way he is a very lovely boy.*
TH: And what happens if this pain in the neck disappears in your life? What would happen to you?
PT: I would be very happy.
TH: I mean, you would be happy if he disappears in your life?
PT: (She sighs.) *It's hard to say about one's kid.*
TH: How would you feel if you heard that he had dropped dead?
PT: (She cries.) *That would make me very sad.*
TH: Why? Why should you feel sad if he is a pain in the neck?
PT: I love him too. (She is crying.)
TH: Have you had thoughts that something might happen to him?
PT: (She sighs.) . . . *I am afraid that something might happen to him.*

Further Pressure

Further pressure brought out that she had had quite specific ideas of Paul being "run over by a car," with blood all around him. She had not thought further, but in answer to the question of where the blood was coming from, she said "I'm developing that right now," and went on to say that it was coming not from his head but from his chest. The therapist asked if there was something special about the chest, to which she said, "He has a very big heart."

PT: Be run over by a car.
TH: You get thoughts that he might be run over by a car?
PT: Ja.

TH: And what do you picture him when he is run over by a car?
PT: (She has frequent deep sighs, is very choked up.) *That, that he would be dead.*
TH: But, how do you picture him dead? In terms of thoughts.

Breakthrough of Painful Feelings, and She Begins to Cry

PT: There would be a lot of blood . . . all around him. (She has another deep sigh.) *I never thought that far.* (Another deep sigh) *It wouldn't come out of his head . . . his chest, maybe.*
TH: Uh hmm. His chest, hmm? Why chest?
PT: (Sobbing) *He is a kid with a very big heart.*
TH: Uh hmm. So then you have a lot of mixed feelings about Paul . . . hmm?

Psychiatric History

Having made this important progress on impulses in the area of C the therapist turned his attention to the psychiatric enquiry. The important features that emerged were that the patient suffered from attacks of reactive depression, the worst of which lasted two years, and in two of which she had made a suicidal attempt with tranquilizers. One of these attempts was many years ago and followed an abortion in which she almost died, together with the break-up of the relation with the man involved. After taking the tablets she had been unconscious for 48 hours and was only discovered by chance by a friend who had a key to her flat. The second occasion was eight years ago and was precipitated by her husband telling her he wanted a divorce. She had taken valium and a whole bottle of liquur. She said that on both occasions she had really wanted to die. She has also had thoughts of opening a vein in the bath. During her attacks of depression she sleeps more rather than less.

Throughout this enquiry the patient showed evidence of being considerably more relaxed and willing to communicate. For instance, on one occasion she addressed the therapist by name, and on another she spontaneously opened up the problem of making wrong choices in relationships, saying that people were deceived by her facade. She emphasized the strain of her current situation, trying to hold down a job and keep two children without support. In addition, she has just learned that her landlord wants to sell the house in which she has lived for 12 years. She is very attached to this house.

She has had three periods of psychotherapy, one from a marriage counselor at the time of her divorce, and two from a psychologist to help her with Paul's behavior problems.

Analysis of the Transference, Return to Pressure on the Impulses Together with Driving Home Insight, Further Insight in the Area of "T"

The therapist asked how she felt about the interview so far, to which she said she felt good, adding spontaneously that she would have a hard time

getting angry with him. However, pressure now brought out that there had been a number of occasions on which she had felt angry with him.

TH: Was there any time that you had anger toward me?
PT: At times when I felt I expressed myself to the best I could, and you said, "you are not saying it right," my feeling was "then bloody well help me."
TH: In a split moment you felt anger toward me?
PT: Ja. Physically I could have taken you by your neck.

T–C Link

The therapist explored the similarity to her impulses against Paul.

TH: Again, around the neck?
PT: No, like someone shaking someone . . .

PT: It is anger.
TH: But, do you see in a sense we see in all these situations there is this anger that mobilizes . . .
PT: Sure.
TH: . . . and we know that the defenses you use against the anger, hmm?
PT: Ja. It's . . .
TH: I mean today what we learn is the way you, there is this rage inside you . . . But then also the defenses you use against this anger . . . And we learn also the link between that and depression and migraines and so forth.
PT: Ja.
TH: Now, uh, then obviously what you said is that for those moments also, you had that flashes, or that moment, you know, came in relation with me, hmm?
PT: Ja.
TH: But, now, if I had not brought that into the focus at this moment, would you had declared that you were angry with me?
PT: I wouldn't even have thought about it.
TH: So, you would have walked out.
PT: Ja.
TH: Uh hmm.
PT: I would not have thought about it that there was . . .
TH: Uh hmm.
PT: . . . the anger here between you and me.

Here, again, the therapist reemphasized the various mechanisms she employed to avoid her negative impulses, linking it again with two of her major disturbances, namely depression and migraines. As we saw, she admitted that if he had not drawn attention to her anger she would not even have thought of it. The therapist prepared to bring the first part of the trial therapy to a

close. The patient said she was feeling relieved and that she did not want to stop.

PT: I don't want to stop.
TH: Uh hmm . . . . uh hmm . . .
PT: It's like you look for the beginning in a ball of thread . . .
TH: Uh hmm, uh hmm.
PT: . . . and I don't want to let it go.
TH: How about we meet again in a few days?

Recapitulation and Discussion

A crucial and universal phenomenon, whatever the kind of patient being interviewed, is that each time pressure and challenge are applied there is a rise in complex transference feelings. With patients for whom an unremitting, steadily progressive technique is appropriate, the complex transference feeling can be raised rapidly until it is at such a level that the transference feelings are ready to break through. With patients of the kind described here, however, this procedure would result in a level of anxiety high enough to produce a breakdown of communication. What is needed, on the contrary, is that after each period of pressure and challenge the transference feelings must be brought into the open. The effect produced is relief, and the level of anxiety never becomes intolerable.

The other important aspect of technique that is illustrated by this interview is the necessity – with patients in whom the impulses are so deeply repressed – for driving home again and again insight into the defensive mechanism by which the sadistic impulse is converted into depression or functional disturbances. The process of acquainting the patient with this mechanism is begun as soon as the underlying impulse has come near enough to the surface to enter consciousness, and the resulting insight represents an essential factor in preventing the same defense from reasserting itself in the future.

The sequence of events in this interview may be summarized as follows.

(1) Enquiry and Pressure in the Area of C

After an initial phase of enquiry, the therapist employed one of the mildest forms of pressure in the area of C, namely asking for a specific example of a situation that had led to depression and migraine headaches. The patient showed immediate resistance, going into unnecessary detail about irrelevant matters.

(2) Drawing Attention to the Transference (T)

The therapist challenged this, which led to a remark by the patient indicating that some of her neurosis was ego-syntonic, which the therapist challenged in its turn. The therapist now drew attention to the transference,

saying "You have a certain feeling about this interview and me knowing you," and followed this by drawing attention to her hands, an indication of rising anger in the area of T.

(3) Challenge to Resistance in the Area of T

He now returned to pressure in the area of C, meeting further resistance. This produced some overt transference resistance, which took the form of a flirtatious comparison between the therapist's appearance and that of her man friend, Dick. The therapist first challenged this, and then drew attention to her hands, an indication of rising anger in the area of T.

(4) Challenge to Resistance in the Area of C

This produced an increase in communication, as the patient revealed one of the features of her psychopathology. Acting on this indication that the unconscious therapeutic alliance was being mobilized, the therapist stepped up his pressure in the area of C, for the first time asking the patient to describe her feelings. There was then stronger resistance, met by stronger challenge (PT: "I didn't feel too good about it." TH: "But that is just a sentence." PT: "I don't remember how I felt." TH: "How is your memory usually"? and so on). The patient now began to employ the defense of weepiness, followed by withdrawal into a state of inability to describe anything.

(5) Challenge to Resistance in the Area of T

The therapist clarified and challenged the transference aspects of this ("Do you notice that there is some kind of distancing between you and me"?), and continued with further challenge to resistance in the area of T.

(6) Challenge to Resistance in the Area of C; Partial Breakthrough

He then returned to the area of C, and the patient told of the crucial incident in which Dick announced that he was going on vacation with Maria. Again the therapist pressed for the patient's feelings, which resulted in major resistance, which took the form of a series of defenses. Now the ground had been sufficiently prepared by the previous work, responded with sustained pressure and challenge, accompanied by drawing attention to the nonverbal communication of the rise of the impulse, moving the hands upward, a decline in the level of tension in the striated muscle of the hand and forearm. This eventually led to a partial breakthrough of rage in the area of C—the fantasy of "taking a bucket of shit and pouring it on top of him . . ."

(7) Driving Home Insight

Having reached partially this impulse, the therapist for the first time drove home insight into the link between impulse and defense. This led to a

major communication from the unconscious therapeutic alliance: TH: "And who did you really want to hit with the tennis racket?" PT: "All the male figures of my life."

(8) Challenge to Resistance in the Area of T

The therapist immediately returned to the area of T: "And where do I stand there"? The ensuing renewed resistance was clarified and challenged: "Is there a wall between you and me? . . . What are you going to do about this wall"? This resulted in an important communication about the reduction in anxiety: "I feel comfortable with you. I'm not scared."

(9) Driving Home Insight

The therapist now embarked on a passage of consolidation of insight into the link between her impulse of rage and all the defenses so far manifested—"In a split second you don't experience the anger, what you experience is depression . . . weepiness . . . numbness . . . migraine."

(10) Breakthrough in the Area of C

Whereas the previous breakthrough in the area of C had been only partial, the breakthrough that now occurred was total. The patient described an uncontrollable attack of rage against her son Paul. There was a clear nonverbal communication indicating that the breakthrough of the impulse had taken place. There was a rise in her voice, she changed her position from bent to sitting straight forward, thrashed her hands around, and demonstrated the way she pushed Paul. This followed by an emergence of sadness with the breakthrough of the guilt-laden unconscious feeling and there was a major wave of painful feeling when she said, "he would be dead."

(11) Driving Home Insight

It emerged that this outburst was not followed by migraine and the therapist therefore drove home insight into migraine as a way of dealing with her rage.

(12) Exploring Murderous Impulses in the Area of C

Then the therapist explored the possibility that the patient had death wishes toward Paul, which was confirmed.

(13) Exploring Impulses in the Area of T

The therapist first took the psychiatric and medical history (medical and neurological investigation had been done—all negative—and she was diagnosed as suffering from common migraine headaches), and then in the final passage of the first part of the trial therapy the therapist explored anger in

the area of T. She was able to admit that she had had the impulse to take him by the neck and shake him.

(14) Driving Home Insight

Now once more the therapist consolidated insight into her mechanisms for avoiding anger. When he prepared to bring the first part of the trial therapy to a close she said that she didn't want to stop—"It's like looking for the beginning in a ball of thread and I don't want to let it go."

Thus a very carefully graded technique, proceeding in a spiral alternating between the areas of C and T, and repeatedly driving home insight into the link between impulse and defense, resulted in a major but controlled breakthrough, and there was both relief and a marked increase in unconscious therapeutic alliance. Now the patient is ready for the second part of the trial therapy and the completion of this comprehensive psychodiagnostic evaluation.

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The Technique of Unlocking the Unconscious in Patients Suffering from Functional Disorders. Part II. Direct View of the Dynamic Unconscious

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Part I described the first part of the trial therapy with a patient suffering from both migraine and chronic depression. In such patients, unremitting pressure and challenge are absolutely contraindicated, and the therapist must take the pressure off as soon as anxiety reaches a certain level, only re-applying it when the level of anxiety has reached a tolerable level. In this way he proceeds in a spiral, gradually restructuring the patient's defensive system. Once this has been achieved the therapist can revert to a more unremitting technique. The present article describes this latter phase. The second part of the trial therapy of the same patient is presented to demonstrate the technique of unlocking the unconscious. The article concludes with a discussion of two further important aspects of the technique, namely: (1) the therapist's use of nonverbal communication, and (2) the handling of pathology of the superego.

Recapitulation

In Part I of the present article I made clear that in patients suffering from chronic or characterological depression and or functional disorders, the underlying impulses—usually sadistic—are very intense and deeply unconscious, and any attempt to bring them to the surface too quickly arouses intolerable anxiety and results in an immediate breakdown of communication and a later exacerbation of symptoms. For this reason, a technique of sustained, unremitting pressure and challenge is contraindicated. The technique that must be used has the following characteristics:

Beginning with carefully graded pressure and challenge, usually in the area of the patient's current life (C).

Acute awareness that all pressure and challenge produce a rise in transference feelings (T), which are inevitably loaded with anxiety.

Therefore, vigilant monitoring of nonverbal signs both of transference and of anxiety.

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