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TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY
CENTRAL DYNAMIC SEQUENCE: PHASE OF CHALLENGE

(Part II)

ABSTRACT

This is the second of four articles on basic technical interventions in Dr. Davanloo's system of Intensive Short-Term Dynamic Psychotherapy (pressure, challenge, the entry of transference and head-on collision), based on the preceedings of a five-day immersion course presented by Dr. Davanloo. Part 2 focuses on the phase of challenge by in-depth analysis of the initial part of the trial therapy with a highly resistant patient suffering from life-long characterological disturbances as well as symptom disturbances, who shows a high degree of syntonicity, major resistance and tactical organization of the major resistance. The focus is further on the technical and metapsychological aspects of: rapid crystallization of the resistance in the transference and the elements of challenge.

Introduction

This is the second of four papers on technical interventions in Dr. Davanloo's System of IS-TDP. These papers are a summary of some of the proceedings of a five-day course presented by Dr. Davanloo to the Training Program of the German Society of Davanloo's Intensive Short-Term Dynamic Psychotherapy (June 17-21, 1998, Nuernberg, Germany). The highlights of this presentation where the Central Dynamic Sequence and the key tools of IS-TDP: pressure, challenge and head-on collision. In this course Dr. Davanloo also discussed intensively the concept of the transference in IS-TDP which differs profoundly from the concept of transference in traditional psychoanalysis.

Over the last thirty years Davanloo has developed his system of Intensive Short-Term Dynamic Psychotherapy (IS-TDP) which is based on extensive research using video-taped clinical material. IS-TPD is designed for the treatment of all neurotic disorders, symptom as well as character disorders. It is a most powerful technique in achieving multidimensional cognitive and emotional, conscious and unconscious intrapsychic structural changes.
The central dimension of this technique is to have the patient actually and directly experience the pathogenic dynamic forces within his unconscious which are responsible for the symptoms and character disturbances.

Recapitulation of the first part

Part I. summarized some of the basic principles of IS-TDP presented by Dr. Davanloo:
His metapsychology of discharge pattern of unconscious anxiety and the pathway of murderous rage, his psychodiagnostic spectrum of psychoneurotic disorders, his concept of unconscious therapeutic alliance, his concept of transference feelings, and, finally, his central dynamic sequence.
The paper focused on the phase of pressure with its specific functions (mobilization and intensification of transference feelings, mobilization of the resistance, crystallization of the resistance in the transference).
The technical interventions to exert pressure were illustrated by using some of the vignettes of clinical audiovisually- recorded cases presented in the course.
The importance of the phase of pressure with the central aim of the rapid development of the twin factors resistance and transference was outlined.
The focus of Part II will be on the phase of challenge. Again the principles will be illustrated by using segments of one of the clinical cases presented by Dr. Davanloo. All the concepts and technical interventions presented are those of Dr. Davanloo. All research data mentioned in these proceedings refers to Davanloo's audiovisually- recorded clinical research.

Technical Intervention of Challenge

With the extensive use of videotaped clinical material, Dr. Davanloo gave an in-depth presentation on the phases of challenge and pressure. He emphasized that challenge needs to be adapted to the particular type of the defense that the patient is using. These are various forms of challenge:

- making explicit,
- pointing out,
- countering,
- questioning,
- blocking a defense.

We can conceptualize challenge in a spectrum: mild, moderate, high, which then culminates in head-on collision.

All challenge has to be conveyed in an attitude of disrespect for the defense. When a large part of the patient is identified with his defenses, this part of him becomes angry and outraged for having them treated with disrespect, but underneath there is another part of the patient that begins to turn against the resistance, to appreciate profoundly the therapist's relentless determination to free him from their burden, and to sense the relief that he would feel if this could be accomplished. The therapist therefore sets up tension, not only between himself and the patient but also within the patient himself. This intrapsychic tension is between one part of the patient, the resistance, and another part, the unconscious therapeutic alliance. When the therapist challenges with precision and with the full use of the transference, this tension culminates in an intrapsychic crisis. The unconscious therapeutic alliance wins out in the end, and the breakthrough takes place.

Phase of Pressure and Challenge

Davanloo highlighted that the phase of pressure might contain passing moments of challenge. Systematic challenge cannot begin until the resistance has tangibly crystallized between therapist and the patient. This tangible crystallization is essential. The patient is not merely trying to avoid his painful feeling, but is specifically resisting the therapist's attempt to reach them in the interview. At this point the process enters to the phase of challenge, but continues with the application of pressure. One can generalize by saying that the phase of challenge contains elements of the phase of pressure.

Challenge and the Effect on Resistance and Unconscious Therapeutic Alliance

Davanloo pointed out that two opposite parts of the patient, namely resistance and the therapeutic alliance, are always both in operation, and the major task of the therapist is to tilt the balance in favour of the unconscious therapeutic alliance. Handling of the resistance and mobilization of the unconscious therapeutic alliance to a major extent depends on where the patient is located within the spectrum of psychoneurotic disorders. On the extreme left of the spectrum, the resistance that the therapist meets is of tactical nature. We don't see the presence of the major resistance, and there is absence of the murderous rage within the unconscious. But as we move towards the mid-line and particularly when we treat patients from the right side of the spectrum, the pathogenic organization of the unconscious is highly complex and we see the presence of murderous rage or primitive murderous rage. With these patients, systematic work on the phase of pressure and challenge must be done until finally we achieve major breakthrough into the unconscious and major mobilization of the unconscious therapeutic alliance. The descriptive term of major unlocking, metapsychologically conceptualized, is a major dominance of the major resistance by unconscious therapeutic alliance.

As the phase of challenge is the key intervention in Dr. Davanloo's IS-TDP, an intervention which is foreign to therapists trained in traditional psychoanalysis, it requires a great deal of exposition and discussion. It is best introduced by an example.
Dr. Davanloo presented clinical vignettes of a series of patients demonstrating challenge to the resistance, both in the transference as well as to the resistance outside of the transference.
Here we present one of these cases.

INQUIRY, PRESSURE AND CHALLENGE

The Case of the Board-Like Professor

All of these interviews come from a closed-circuit live interview setting. The patient first is interviewed by a psychiatrist-in-training for approximately one hour and a half, and after that the patient is interviewed by Dr. Davanloo himself, and all of the members in the training program view the interview in a second room, where it is transferred by videotechnology .

The patient was a married man in his fifties who suffered from characterological depression, chronic anxiety, somatization such as chest pain and muscle pain, disturbances of interpersonal relationships, major problems with intimacy and closeness and episodes of clinical depression. The interview started with the phase of inquiry and the therapist proceeded the session by asking him for the problems he wanted to get help for. He said that he had done a series of blood tests which were recommended by his family physician.

Phase of Inquiry

PT: Well, if I go to him (refers to his family physician) with my usual bag of complaints, ah, he sends me off for some tests and then ...
TH: Uh hmm.

He indicates that he has been seeing his family doctor for the past twenty- some years for a variety of somatic complaints such as "chest pain, dizziness, shortness of breath, stiff neck and pain in his muscles." He further emphasizes that his symptoms, "each of them is fatal", but his family physician tells him there is nothing wrong with him. He further indicates that his family doctor cannot find anything wrong.

Resistance in the Transference

The process immediately enters into the phase of resistance in the transference, which is mobilized by the fact that the supervisor had not been present to view the interview the patient had conducted with the psychiatrist-in-training. Now we return to the interview.

TH: What is that you want to get help for?
PT: Uhh ... did you see, were you (referring if the therapist was present while he was being interviewed)
TH: I have seen a few minutes, not really ...
PT: I see, so I really have to start all over again. Is that, is that it?
TH: Uhm, how do you feel about that?
PT: Well, it is ah ... sort of , ah ... well it just doesn't seem very efficient somehow, but ah ...
TH: So then the system is deficient.

The patient immediately is developing transference feelings for the therapist *("So I really have to start all over again. Is that?")* and his resistance is crystallizing in the transference, just at the beginning of the interview.
Because of this rapid progress to the crystallization of the resistance in the transference the phase of inquiry moves rapidly to the phase of pressure (*"How do you feel about that?"*), which then immediately moves to the phase of pressure and challenge. Any explanation or justification would not have any impact on the patient's resistance. Actually it would make it worse. The therapist's task is handling of the resistance in the transference. In this specific situation, the phase of inquiry is not possible. The patient's resistance is crystallized in the transference; the process moves to the phase of pressure (*"How do you feel about that?"*) and challenge (here by making explicit: *"So then the system is deficient."*). Now we return to the interview. The focus is on the deficiency of the system.

Pressure and challenge

PT: Well ... (laugh)
TH: You smile about that. You said that the system is deficient, because you have to repeat yourself.
PT: Maybe.
TH: "Maybe?" Now you move to the position of maybe (The patient is avoiding eye contact and actually looks at the opposite wall) and also you are avoiding my eyes, looking opposite direction.
PT: Yes, I suppose yes.

In the above passage we see how pressure to the patient's feeling and challenge to his resistance leads to further crystallization and intensification of the resistance: There is a smile and avoidance of eye contact, looking to the opposite wall. The therapist now refers to both the verbal and the nonverbal signs of the resistance. On the one hand, he is pointing out to the patient that he is verbally avoiding his feelings toward the therapist (*"Maybe? Now you move to the position of maybe."*). And additionally he calls up the defenses of smiling and avoiding eye contact. Thus, the therapist makes it visible to the patient that he is using defense mechanisms, and starts to

make him acquainted with them. Moreover, this is a powerful message to the patient's unconscious that every single trace of the resistance is immediately noticed by the therapist and brought to the surface. The result is a further rise in the transference feelings of the patient.

Metapsychology of the Process

These transference feelings are complex: one side of the patient, which is heavily identified with his defenses and wants to avoid his buried aggressive and painful feelings, becomes even more angry with the therapist. But the other side of the patient, craving for a free life, starts to develop appreciation because he senses that the therapist would not allow the resistance to push him out of his way and that he is not loosing even a single minute. And that is quite a difference to the course of the life of the patient who, under the influence of his super-ego pathology, is suffering and, unconsciously, procrastinating his multiple problems more than twenty years! This appreciation deep inside the patient is becoming the driving force of another factor crucial for the success of any psychotherapy: the unconscious therapeutic alliance.

So, by carefully using pressure and challenge, the therapist sets the stage for a growing intrapsychic tension between the resistance and the unconscious therapeutic alliance. At the same time, the tension in the relationship between the therapist and the patient is growing, too: The patient's feelings are crystallizing more and more in the transference, and the transference component of his resistance intensifies.

Return to Pressure and Challenge

TH: So the system is deficient?
PT: Well , it doesn't seem like the way I would do it.
TH: So it is not the way you would like it to be.
PT: Yeah.

Further Pressure

TH: So then let's see how you feel about the deficient system and the system that is not the way you would like it to be?

The defenses of the patient up to now in the fore- front are the tactical ones of indirect speech, vagueness and rumination which are challenged by the therapist again by making explicit (*"So it is not the way you like it to be?"*).

Then the therapist returns to pressure to the patient's feeling. It is central that, even if the therapist challenges the defenses of the patient, there is always a need to exert pressure too (*"How do you feel?"*). The patient starts to realize that these defenses are obstacles and prevent him from access to his inner feeling. Thus he clearly can differentiate that the challenge is not aimed at himself but purely at his defensive system.

We return to the interview:

Further Challenge

TH: Again do you see, your eyes are somewhere else? Your eyes are somewhere else?
PT: Sure.
TH: Sure what?
PT: I do realize.
TH: You are avoiding me in a sense.
PT: Well, well I am.
TH: Let's not to get to "well," you are avoiding my eyes or aren't you?
PT: It's when I'm thinking.
TH: Thinking - you are avoiding my eyes. Are you or aren't you? Now your hand also is clinched like that.
PT: Well what am I supposed to do with it?

The therapist is challenging the nonverbal defenses which is followed by further rise in the transference feelings and further rise of the transference component of the resistance. Avoiding of eye contact and the smile that the therapist is calling up are defense mechanisms belonging to the resistance against emotional closeness (RAEC), which has a wide range of mechanisms serving as a blockade to the experience of the most painful feelings of the pathogenic core trauma. Every human being who has suffered a severe trauma developes RAEC to a certain degree, to bury the pain and to avoid a new traumatization by preventing intimacy and emotional closeness.

The patient now activates more tactical defenses of vagueness, rumination and indirect speech (*"Sure"*, *"Well"*, *"I do realize"*, *"I'm thinking"*). The therapist is using another form of challenge, fitting to the defense: countering. Here it takes the form of asking the patient for a direct answer (*"Sure what?"*, *"Let's not go to well. Are you avoiding my eyes or aren't you?"*). Countering also may take the form of asking the patient for an explicit statement or to make a decision, as we shall see later.
Additionally, because of the rapid rise in the transference, the patient is activating new defense mechanisms, diversification, which is a tactical one and defiance (*"Well what am I supposed to do with it?"*). The patient's answer, on the one hand, is tactically diversifying from the subject of his feelings, and on the other hand, it is also a sarcastic remark. It is important to know that patients with a long history of characterological disturbances and a complex core pathology have an easy access to malignant defenses such as defiance and sarcasm, with the unconscious aim to avoid emotional closeness.

The therapist handles the resistance by blocking.

We return to the interview.

TH: Let's not get to what you are supposed to do. You can talk with the wall, isn't that?
PT: I ...
TH: No, you can talk with the wall.
PT: I'm ...
TH: I assume that you are here to do something about it. But if you want to talk with the wall there is nothing we can do about it. The system is deficient and you don't like the way the system is. How you feel about this deficient system that you dislike?
PT: (sighing)
TH: You took a sigh now. (Pause) And your hand now is like that.
PT: I, I'm having difficulty seeing ...
TH: Now that is rumination "I have difficulty".
PT: I don't ...
TH: And you smile,- I don't know, is it ...
PT: I don't see where, where we're going.
TH: Let's not get to where we are going. You say the system is deficient and the system is not the way you like, how you feel about it? About this deficient system.
TH: And how you feel that you have to repeat yourself? How do you feel about it?
PT: Uhh well ...
TH: You must have a certain feeling.
PT: Uh, irritated.

In the above passage, we see again the application of the phase of pressure and challenge with the aim of: further crystallization of the patient's characterological defenses in the transference; making the patient acquainted with these defenses which he has heavily identified with. The patient is absolutely not conscious about his diversification and rumination, nor does he look at these mechanisms as destructive components in his life. By challenging the resistance in a manner of disrespect, the therapist is loosening the patient's psychic system. The patient starts to become aware of his defenses, and he himself is beginning to look at them with disrespect and to turn against them.

Challenge in the above passage first consists of blocking the patient's diversification (*"Let's not go to what you are supposed to do."*), and countering (*"You can talk with the wall, isn't that?"*). Later on, the therapist is again blocking the patient's diversification (*"Let's not go to where we are going....how do you feel about it, the deficient system?"*). Blocking means brushing aside the defense and is especially used to stop diversification and to keep the patient in touch with the subject he is avoiding.

As a result of further mobilization of the transference feeling and intensification of the transference component of the resistance, the patient finally declares irritation towards the therapist. It is

necessary to keep in mind that irritation itself is a tactical defense against anger, and anger is, by itself, a tactical defense against murderous rage, and so on. Here, the therapist could challenge the tactical defense, but by virtue of the fact that the patient's characterological defenses are heavily syntonic, it is far better to exert pressure, for example, exert pressure for the actual experience of irritation or for the actual experience of anger. Here, by using pressure toward the actual experience, this mobilizes more tactical defenses and provides the opportunity to make the patient acquainted with these defenses. Now we return to the interview where we had left off.

TH: So you feel irritated with the system which is deficient and it is not the way you would like it to be.

PT: Yes.

TH: Now irritated at who? Now you see you look down there still.

PT: Well at you I guess.

TH: That is "guess." Are you irritated with me or aren't you irritated with me? First to establish that. Your eyes are again changing its pattern - closing actually. (Tension in periorbital and eyelid muscles)

PT: I don't ...

TH: Now you see the way you are sitting there? Board-like position, immobile. Now you said you are irritated with me. (Pause) Are you irritated with me or aren't you?

In the above passage, we saw the phase of pressure and challenge which is followed by further rise in complex transference feelings. Because these complex feelings consists of repressed, unacceptable, aggressive and very painful feelings, their rise mobilizes anxiety in the patient which is manifesting itself in the transference.

With this patient, the discharge pattern of the anxiety exclusively is in the form of tension in the striated muscles, which starts with the muscles of the hands and forearms manifesting itself by clinching; then moves up to the muscles of the neck, the sternocleidoid muscle, which creates stiffness of the neck; the muscles of the face in the form of tic. Tension in the muscles of the eyelid and periorbital muscles, creating closure of the eyes; tension in the muscles of the lip, creating rabbit-like movement; then tension in the intercostal muscle which manifests itself by deep sighing respiration; tension in the muscles of the legs. When the tension is highly mobilized, it creates a picture which we might call "board-like" and the patient becomes slow and even immobile. This discharge pattern of the anxiety, with tension exclusively in the striated muscles, is an indicator to the therapist that in this patient there is no trace of fragility and that vertical unlocking of the unconscious is indicated. (Please keep in mind that with patients who suffer from fragility or functional disorder or somatization, vertical unlocking is contraindicated. In such cases a modification of the technique is required.)

It is extremely important to note that shortly before the passage of murderous rage, or primitive murderous rage, tension and anxiety totally disappear and the patient becomes animated and

quite vibrant, and anxiety and tension are now replaced by the somatic pathway of the murderous or primitive murderous rage.

The way the therapist is here challenging the resistance again is by making explicit and countering. Countering this time takes the form of asking the patient for a decision (*"Are you irritated with me or aren't you irritated with me ? First to establish that."*).

We return to the interview.

TH: So now you say you guess you are irritated with me. So let's first deal with the "guess" part of it. Do you feel irritated or don't you feel irritated?

PT: Yes..

TH: You feel irritated. And how do you experience your irritation toward me?
Now your head does like this. And you say you are irritated with me. How do you physically experience this irritation?

PT: Uh huh.

TH: Now let's to see how you experience it physically? We know your hand is in the clinching state, like that. Your body is totally immobile.

PT: I sit like this many hours of the day.

TH: That doesn't make a difference. It's rumination that "I sit like this." Right now you say you are irritated with me and my question is this, how do you physically experience your irritation and your hand is clinching and your body is immobile.

PT: Well if you can ...

TH: Do you notice that you become like drowsy? Your eyes are closing up.
Now let's to see how you physically experience the irritation with me. You took another sigh.

PT: I've given you the best answer I can.

The therapist relentlessly is further challenging the tactical defenses of the patient, which aims at more mobilization of transference feelings and its twin factor, the resistance. At the same time, he helps the patient to become aware of and acquainted with these formerly unconscious and syntonic defense mechanisms. By looking this way on the process, it becomes understandable that the activation of all the specific defense mechanisms of the patient is welcomed. Because this creates a unique opportunity for both, patient and therapist, to learn about his defensive system, to loosen it and to turn his will against it, which means activation of the conscious and unconscious therapeutic alliance.

When the patient declares his irritation in the transference, the therapist exerts pressure for the actual experience of this irritation, and, at the same time, continues to challenge the resistance with heavy emphasis on the nonverbal component. The patient's attention is directed to his body and the physical experience of his feelings. Further mobilization of the transference feelings, anxiety in the transference and resistance takes place.

We return to the interview.

Challenge to the Resistance

PT: Defiant, I suppose in some ...
TH:Again "suppose".
PT: I know that ...
TH: You have difficulty to commit yourself: suppose, maybe, perhaps, guess, and you took another deep sigh and your eyes are closing up again ... So one way is avoiding me by looking somewhere else, the other one looking at me but closing your eyes and you have a smile, I don't know it's a sarcastic smile or what?
PT: Maybe.
TH: Again "Maybe." Are you aware of your facial movements?
(In addition to closure of the eyes, as a result of tension in the periorbital muscle, there is a special movement of the lips which we can call it "rabbit-like" chewing movements, and a tic in the muscles of the chest, all indicators that there has been rise in the anxiety in the form of tension in the striated muscles.)

The patient then declares anger in the transference. The process then moves to pressure for the actual experience of the anger, mobilization of further tactical defenses and challenge to the tactical defenses.
In the above passage of the interview, we again see challenge to the patient's resistance, aimed to further mobilization and intensification of the transference component of the resistance. The therapist is challenging the defenses by pointing out to the patient the nature of the defense (*"Again suppose"*, *"You have difficulty to commit yourself "*,*"suppose"*, *"maybe"*, *"perhaps"*, *"guess" ",.....So one way is avoiding me by looking somewhere else, the other one looking at me but closing your eyes." "Again maybe."*). The way the therapist is challenging the defenses is with an attitude of disrespect for the resistance. The patient has identified with his defenses to a large part and even thinks of them with appreciation as a "goldmine" in his life. When he sees them treated with disrespect, the syntonicity is beginning to convert to dystonicity. The patient instead starts to identify with the therapist's position of looking with disrespect at his defenses, and mobilizes his will to say good-bye to them. More, this attitude of disrespect encourages the patient in an idea totally new to him: that he might actually have the potentiality to overcome the burden of his defense mechanisms. And he is changing his position and looking down on the resistance as something that can be dismissed.

The Case of the Board-Like Professor: Summary and Completion

In summary, this passage from the initial interview of the "Board-Like Professor" shows the application of the phase of pressure and challenge to a highly resistant patient suffering from life-

long characterological disturbances as well as symptom disturbances, who shows a high degree of syntonicity, major resistance and tactical organization of the major resistance. He came into the interview in a state of resistance in the transference, and the process rapidly moved from pressure to pressure and challenge, with the aim to further mobilize and intensify the transference component of the resistance. Challenge to the patient's resistance, and pressure to his feelings mobilized more anxiety and further intensification of the resistance, which was then again followed by further pressure and challenge.

Now, the therapist applies a form of head-on collision which aims at further mobilization of the transference feelings, and making him more acquainted with his characterological defenses and front line defenses, which then is followed by a special form of head-on collision with the resistance against the emotional closeness. In order to achieve major unlocking, the process should remain on the transference until we have the passage of the primitive murderous rage in the transference and major mobilization of the unconscious therapeutic alliance against the resistance. In this specific case, the primitive murderous rage of the patient is directed toward both father and mother, but far heavier toward his mother.

In closure, it was pointed out that the actual experience of all feelings, primitive murderous rage, guilt and grief, is essential in bringing about structural character changes. The patient had a very conflictual relationship with his mother: he constantly moved to stubbornness and defiance with her, punishing her. She had an episode of major clinical depression and had received a series of electroconvulsive treatments. In the early phase of his treatment, under major mobilization of unconscious therapeutic alliance in the session with the therapist the patient had visual imagery of his mother receiving electroconvulsive treatments, and, in the session, the patient himself had a sudden seizure-like movement and the passage of the guilt.

Summary and Conclusion

This second part of a four-part report of Dr. Davanloo's presentation of a five-day course can be summarized as follows.

(1) Based on over thirty years of clinical research using videotechnology, Dr. Davanloo developed a highly refined psychoanalytic technique and his new Metapsychology of the Unconscious. The central dimension of this technique is to have the patient actually and directly experience the pathogenic dynamic forces within his unconscious, which are responsible for the symptoms and character disturbances.

(2) Summarizing part 1 of this four-part report, the phase of pressure with its specific functions (mobilization and intensification of transference feelings, mobilization of the resistance, crystallization of the resistance in the transference) are recapitulated.

(3) In Part II, the focus then moves onto the phase of challenge. It has to be emphasized that systematic challenge to the resistance cannot be applied until the resistance is well crystallized in the transference. Challenge to the resistance is always combined with pressure.

(4) The elements of challenge are: making explicit, pointing out, countering, questioning, blocking a defense. The range of challenge is from mild to moderate and high, culminating in head-on collision.

(5) Dr. Davanloo presented clinical vignettes of a series of patients demonstrating challenge to the resistance, both in the transference as well as to the resistance outside of the transference. The early phase of the trial therapy with the Case of the Board-Like Professor is presented and analyzed to further highlight the application of the phase of challenge and pressure and challenge:

   (a) The interview started with the phase of inquiry leading to rapid crystallization of the resistance in the transference.

   (b) The therapist rapidly moves to phase of pressure and challenge: pressure towards the patient's feelings in the transference, and challenge of the resistance (tactical defenses: generalization, diversification; transference component of the resistance: avoidance of the eyes). The aims are: further crystallization of the patient's characterological defenses in the transference, making the patient acquainted with the defenses which he has heavily identified with, further mobilization of the transference feelings and intensification of the transference component of the resistance.

   (c) Then the patient declares irritation towards the therapist. Pressure now moves toward the experience of the irritation, mobilizing syntonic defenses which are then further challenged to make the patient acquainted with them (nonverbal defenses; tactical defenses: vagueness, rumination, indirect speech; resistance against emotional closeness).

   (d) During the interview, tension begins to show up in the hands and forearms (clinching), then moves to muscles of the neck (stiffness) and the face (closing eyes, tic, rabbit-like movements), intercostal muscles (deep sighing respiration) and the muscles of the legs. The highly mobilized tension creates the picture of the "board-like" position of the patient, even becoming slow and immobile.

   (e) As the research protocol calls for a major unlocking, the therapist chooses the direct access to the unconscious with this highly resistant patient, remaining in the transference until the passage of murderous rage takes place in the transference, indicating the first clear dominance of the unconscious therapeutic alliance over the resistance.

   (f) In this specific case, the primitive murderous rage was directed toward both father and mother, followed by the passage of guilt.

   (g) In closure, it is pointed out that the actual experience of all feelings, primitive murderous rage, guilt and grief is essential in bringing about structural character changes.

In the third and fourth part of this report, some of Dr. Davanloo's presentation on another component of the central dynamic sequence will be summarized: the entry of the transference and the head-on collision.

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