CONTENTS

European Psychotherapy becomes the first european internet journal for psychotherapy

Dear Readers,
as we are publishing the second issue of European Psychotherapy, we can also notify you of a major innovation. European Psychotherapy becomes as well an internet journal for psychotherapy. The printed version will only be published once a year. However, the new articles will be currently available on the internet. This way the authors will have the possibility to be published within a very short time span (three months after handing in their articles). The journal will be made available to scientific libraries, free of charge, which guarantees a world-wide availability. Other subscribers can download the articles as pdf-files by paying their subscriber fees. Within the current european situation, this is the only true effective form of distribution and, at the same time, ensures the world-wide distribution of new scientific work.
As we will have two different subscriptions - the pure internet subscription and the additional complete subscription with the printed version - both former readers and prospective subscribers will have the best options for reading and collecting. Subscription fees stay the same for formers subscribers, therefore you will have your printed version to your availability as well as the internet version without having to pay more. You can also see the abstracts on the internet at www.cip-medien.com/psycheurop.htm
Only a few weeks after entry and reference by two reviewers, the complete article will be available as pdf-file. Date of publication will be the day of publishing on the internet. The pages will be numbered continously throughout a whole year. The division into single installments per year will be dropped.

The second issue is a subject issue which is, almost exclusively, dedicated to a very important psychoanalytically founded form of psychotherapy. The form of psychotherapy is presented almost completely in all important aspects. It is the Intensive Psychodynamic Short Term Therapy of Davanloo. The articles were written by his european collegues from Switzerland and Germany in cooperation with him. In that way they show the authorized representation of this therapy. For many years, psychoanalysis was lacking efficient short term therapies and creative variations of therapeutic procedures.
Therefore it seems quite significant to make new ways of psychoanalytical psychotherapy known.
The upcoming issues will again contain combined contributions depending on entry at the editor's office. They will contain original empirical works and reviews as well as essays regarding important and up-to-date themes.

Serge K.D. Sulz

Giuseppe Riva, Monica Bacchetta, Margherita Baruffi, Enrico Molinari

Virtual Reality Based Treatment of Body Image Disturbances in Anorexia and Bulimia Nervosa: Two Pilot Studies

ABSTRACT

In contrast to the great number of publications on body image in eating disorders, only a few papers have focused on the treatment of a disturbed body image. Generally, there are two different approaches to the treatment of body image disturbances that are actually used from leading researchers and clinicians: cognitive/behavioural and feminist methodologies. In this paper we tried to integrate these two methods within an immersive virtual environment, a new technology that allows the user to be immersed in a computer-generated virtual world.

Two pilot studies were carried out on female patients: 10 anorectic subjects were included in the first study and 14 bulimics in the second one.

At the end of the in-patient treatments, the patients of both samples modified significantly their bodily awareness. This change was associated to a reduction in problematic eating and social behaviors. However a controlled study, already planned, is needed to confirm the obtained results.

1. Introduction

It is well known that eating disordered patients are overly concerned with their physical body (Schlundt & Johnson, 1990). It is also known that for most patients, changing the body experience is the hardest part of their recovery (Rorty, Yager, & Rossotto, 1993). However, standard eating disorder programs provide less therapy, and have a smaller treatment effect, for body image compared with eating behavior (Rosen & Ramirez, 1998; Rosen, 1996). Moreover, few clinical trials with these patients have incorporated body image interventions and measurements (Cash & Grant, 1995; Rosen, 1996; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999).

Up to now, there are two different approaches to the treatment of body image disturbances that are actually used from leading researchers and clinicians: cognitive-behavioral and feminist methodologies (Thompson et al., 1999).

Cash is the leading figure in the development of cognitive-behavioral strategies for the treatment of body image in eating disorders (Cash, 1995; Cash, 1997). His eight-step approach is based on assessment, education, exposure and modification of body image. The therapy both identify and challenge appearance assumptions, and modify self-defeating body image behaviours. Moreover, the approach involves the development of body image enhancement activities used to support relapse prevention and maintenance of changes (Cash, 1995; Cash, 1997).

The feminist approach tries to help women to accept and celebrate the body they have (Bergner, Remer, & Whetsell, 1995; Dionne, Davis, Fox, & Gurevich, 1995). However, feminist therapy, generally, varies from traditional forms of therapy in number of ways. Feminists believe that traditional therapy perpetuates the central role of man in the form of the doctor-patient relationship (Wooley, 1995). So, this approach place the therapist and client in equitable roles. Moreover, feminist therapist usually includes more experiential techniques, such as guided imagery, movement exercises, and art and dance therapy (Wooley, 1995; Wooley & Wooley, 1985). Other experiential techniques include free-associative writing regarding a problematic body part, stage performance, or psychodrama (Kearney-Cooke & Striegel-Moore, 1994; Wooley, 1995).

In this paper we tried to integrate these two methods (cognitive-behavioural and feminist) within a virtual environment. A Such choice of would make it possible to use the psychophysiological effects provoked by the virtual experience on the body schema for therapeutical purposes (Riva, 1998a; Riva, 1998c).

Previous studies have suggested that Virtual Reality (VR) can be effective in clinical treatment (Hodges, Bolter, Mynatt, Ribarsky, & Van Teylingen, 1993; Hodges et al., 1995; Hodges, Rothbaum, Watson, Kessler, & Opdyke, 1996; North, North, & Coble, 1996; North, North, & Coble, 1997). One of the main advantages of a virtual environment (VE) for clinical psychologists is that it can be used in a medical facility, thus avoiding the need to venture into public situations. Infact, in most of the previous studies, VEs were used to simulate the real world.

However, it seems likely that VR can be more than a tool to provide exposure and desensitisation (Glantz, Durlach, Barnett, & Aviles, 1996). As noted by Glantz *et al.*, "VR technology may create enough capabilities to profoundly influence the shape of therapy" (Glantz, Durlach, Barnett, & Aviles, 1997, p. 92). Specifically, they expect that VR may enhance cognitive therapy.

In practically all VR systems the human operator's normal sensorimotor loops are altered by the presence of distortions, time delays and noise (Riva, 1997c). Such alterations that are introduced unintentionally and usually degrade performance, affect body perceptions, too. The somesthetic systems have a proprioceptive subsystem that senses the body's internal state, such the position of limbs and joints and the tension of the muscles and tendons. Mismatches between the signals from the proprioceptive system and the external signals of a virtual environment alter body perceptions and can cause discomfort or simulator sickness (Sadowsky & Massof, 1994). Perceptual distortions, leading to a few seconds of instability and a mild sense of confusion, were also observed in the period immediately following the virtual experience. Such effects, resulting from the reorganisational and reconstructive mechanisms necessary to adapt the subjects to the

qualitatively distorted world of VR, could be of great help during a therapy aimed at influencing the way the body is experienced (Riva & Melis, 1997), because they lead to a greater awareness of the perceptual and sensory/motorial processes associated with them. When a particular event or stimulus violates the information present in the body schema (as occurs during a virtual experience), the information itself becomes accessible at a conscious level (Baars, 1988). This facilitates a modification and, through the mediation of the self (which tries to integrate and maintain the consistency of the different representations of the body), also makes it possible to influence body image. In previous studies this approach was tested on non-clinical subjects (Riva, 1997a; Riva, 1998a; Riva, 1998c). The results indicated that the virtual experience induced in the subjects a significantly more realistic view of their body. The paper presents two preliminary clinical trials carried out on female patients: 10 anorectic subjects were included in the first study and 14 bulimics in the second one.

2. VEBIM 3 - Virtual Reality for Body Image Modification

In the reported studies we used the Virtual Environment for Body Image Modification - VEBIM 3. VEBIM 3 is an enhanced version of the original VEBIM virtual environments, previously used in two preliminary studies on non-clinical subjects (Riva, 1997a; Riva, 1998a).

2.1 The virtual reality system

VEBIM 3 is implemented on a Thunder 800/C virtual reality system by VRHealth of Milano-Italy. The Thunder 800/C is a Pentium III based immersive VR system (800mhz, 128 mega RAM, graphic engine: Matrox MGA 450, 32MB WRAM) including a head mounted display (HMD) subsystem.

2.2 The display system

VEBIM 3 uses as its display system the Glasstron head-mounted display (HMD) from Sony Inc. The Glasstron uses LCD technology (two active matrix colour LCD's) displaying 180000 pixels each. Sony has designed its Glasstron so that no optical adjustment at all is required, aside from tightening a two ratchet knobs to adjust for the size of the wearer's head. The motion tracking is provided by Intersense through its InterTrax 30 gyroscopic tracker (Azimuth: ±180 degrees; Elevation: ±80 degrees, Refresh rate: 256Hz, Latency time: 38ms ± 2).
The used HMD does not have a stereoscopic display. To compensate for the lack of binocular cues, we included perspective cues (light and shade, relative size, textural gradient, interposition and motion parallax) in the virtual environment (Dolecek, 1994).

2.3 The virtual environment

VEBIM 3 was developed by VRHealth, Milan-Italy, using VRT 5 from Superscape Ltd. (UK). The virtual environment is composed by different zones, each one individually used by the therapist during a session with the patient. The first session is used to assess any stimuli that could elicit abnormal eating behavior. Particularly the attention is focused on the patient's concerns about food, eating, shape and weight. This assessment is normally part of the Temptation Exposure with Response Prevention protocol (Schlundt & Johnson, 1990). The next four sessions are used to assess and modify:

- the symptoms of anxiety related to food exposure. This is done by integrating different cognitive-behavioral methods (see Table 1): Countering, Alternative Interpretation, Label Shifting, Deactivating the Illness Belief and Temptation Exposure with Response Prevention (Riva, 1998c; Schlundt & Johnson, 1990).
- the body experience of the subject. To do this the virtual environment integrated the therapeutic methods (see Table 1) used by Butter & Cash (Butters & Cash, 1987) and Wooley & Wooley (Wooley & Wooley, 1985). Specifically in VEBIM we used the virtual environment in the same way as guided imagery (Leuner, 1969) is used in the cognitive and visual/motorial approach. In all the sessions, the therapists followed the Socratic style: they used a series of questions, related to the contents of the virtual environment, to help clients synthesise information and reach conclusions on their own.

Session 1:

In this zone the subject becomes acquainted with the control device, the head mounted display and the recognition of collisions. To move into the next rooms subjects have to weigh themselves on a virtual balance. The balance is used for two functions:

- it is intended to be an inevitable obstacle for the user, who must focus her attention on this object, representing the importance of the "weight" dimension in the experiences to come thereafter;
- it can be used, if needed by the therapist, to display the initial weight of the subject, as acquired in the dialogue box at the beginning of BIVRS.

The next three rooms show a sitting-room, a dining-room and a study. Each of these rooms is furnished with typical items and contained different foods and drinks. These are used by the therapist to investigate any symptoms of anxiety related to food exposure in the patients and their concerns about food, eating, shape and weight. The data collected are used to plan the next sessions.

Session 2:

This zone is composed by different rooms showing a kitchen, a closet and a bedroom. Each of these rooms is furnished with typical items and contained different foods and drinks. When the

user decides to "eat" or "drink" something, all she/he has to do is to "touch" a specific item. In this way the food is "eaten" and the corresponding caloric intake is automatically recorded in a text file, which is used later to calculate the aggregate income of calories. At the end of the zone is located a second virtual balance. According to the "eaten" food and to the caloric intake inserted at the beginning of the session, the balance will show the new weight of the subject (in kilograms). As in the previous session, the therapist analyses the reactions elicited by food. Moreover, any dysfunctional belief and/or feeling is discussed with the patient according to the Label Shifting and Objective Counters methods. Finally, are analyzed and matched all the reactions induced by the view of the final balance.

Session 3:
This zone - the Body Image Virtual Reality Scale - BIVRS - is a three part virtual environments in which the user has to choose between 7 figures of different size which vary from underweight to overweight (Riva, 1997b; Riva, 1998b). Subjects are asked to choose the figures that they think to reflect their current and their ideal body sizes. The discrepancy between these two measures is an indication of their level of dissatisfaction. In the first two zones (one for real body and one for ideal body) the subject chooses between seven 2D images that are shown simultaneously. In the third zone the subject chooses between seven 3D rotating images. The 3D images can be changed using two arrow buttons located around the images.We decided to use both 2D and 3D images to improve the effectiveness of the scale. Even if existing body image scales use mainly 2D images, using 3D it is easier for the subject to perceive the discrepancies between the silhouettes, especially for specific body areas (breasts, stomach, hips and thighs).
Before and after the session, the patient is administered a battery of different paper-and-pencil tests: the Figure Rating Scale (Thompson & Altabe, 1991), the Contour Drawing Rating Scale (Thompson & Gray, 1995), the Breast/Chest Rating Scale (Thompson & Tantleff, 1992), the Body Satisfaction Scale (Riva & Molinari, 1998a), the Body Image Avoidance Questionnaire (Riva & Molinari, 1998b) and the Weight Efficacy Life-Stile Questionnaire (Clark, Abrams, Niaura, Eaton, & Rossi, 1991).

Session 4:
This zone is composed by a four-room working environment. The interaction with the virtual environment follows the same guidelines as Session 2. The main difference is the analysis of any link between the patient's job/working environment and the eating disturbance.

Session 5:
In the first room the patient is exposed to a series of panels textured with pictures of models, in the typical way of the advertising world. The images are used as stimuli to support a cognitive approach: the elicited feelings are analysed by the therapist according to the Label Shifting and Objective Counters methods. The feelings and their associated beliefs are identified, broken

down into their logical components, replaced with two or more descriptive words, and then critically analysed. In the next zone the patient finds a large mirror. Standing by it the subject can look at her real body, earlier digitised using an EPSON Photo PC camera. The vision of her own body usually elicits in the user strong feelings that can be matched using the Counterattacking and the Countering cognitive methods.
The mirror is also used, as indicated by Wooley and Wooley (1985), to instruct the user to imagine herself as different on several dimensions including size, race, and being larger or smaller in particular areas. The subject is also asked to imagine herself as younger, older, what they look and feel like before and after eating and social successes/failures. After the mirror, the patient finds a long corridor ending with a room containing five doors of different dimensions. The subject can move into the last room only by choosing the door corresponding exactly to his width and height.
Before start, and after the end of the session, the patient is administered the same battery of paper-and-pencil tests used in Session 3.
In the next paragraphs are presented two preliminary clinical trials showing the application of this method to anorectic and bulimic patients.

3. Two preliminary studies

3.1 Anorectic sample

3.11 Subjects

Subjects were consecutive patients seeking treatment for anorexia nervosa at the Eating Disorder Unit of the Istituto Auxologico Italiano, Verbania, Italy. The individuals included were 10 women (Mean weight: 43,83 ± 5,48 Kg.; mean height: 165 ± 4,59 cm; mean B.M.I.: 14,45 ± 3,5) between the ages of 18 and 45 years who met DSM IV (APA, 1994) criteria for anorexia nervosa for a minimum of 6 months as determined by an independent clinician on clinical interview. Individuals were excluded if they were acutely suicidal, medically ill or pregnant, had abused alcohol or drugs within the last year or had evidence of cardiac conduction disease. Before starting the trial, the nature of the treatment was explained to the patients and her written informed consent was obtained.
All the patients followed the same 4-week in-patient cognitive-behavioural eating disorders treatment.

3.12 Assessment

Subjects were assessed by one of three independent assessment clinicians who were not involved in the direct clinical care of any subject. They were two MA-level chartered psychologists and a PhD-level chartered psychotherapist. For the clinical interview they used a semistructured interview based on the Italian version of the Eating Disorders Examination (Fairburn & Cooper, 1993). All

the subjects were assessed at pre treatment and upon completion of the clinical trial.The following psychometric tests were administered at each assessment point:

- Italian version of the Minnesota Multiphasic Personality Inventory 2 - MMPI 2 (Butcher, 1990).
- Italian version of the Eating Disorders Inventory 2 - EDI 2 (Garner, 1995).
- Italian version (Riva & Molinari, 1998a) of the Body Satisfaction Scale - BSS (Slade, Dewey, Newton, Brodie, & Kiemle, 1990);
- Italian version (Riva & Molinari, 1998b) of the Body Image Avoidance Questionnaire - BIAQ (Rosen, Srebnik, Saltzberg, & Wendt, 1991);
- The Figure Rating Scale - FRS (Thompson & Altabe, 1991) a set of 9 male and female figures which vary in size from underweight to overweight.
- The Contour Drawing Rating Scale - CDRS (Thompson & Gray, 1995), a set of 9 male and female figures with precisely graduated increments between adjacent sizes.

In the last two tests subjects rate the figures based on the following instructional protocol (a) current size and (b) ideal size. The discrepancy between the ratings is called the self-ideal discrepancy score and is considered to represent the individual's dissatisfaction. The findings of Keeton, Cash, and Brown (1990), support the usefulness of the self-ideal discrepancy score in the assessment of body image, as it was shown to relate to other body-image indices and other clinically relevant measures. All the scales have good test-retest reliability (Rosen et al., 1991; Slade et al., 1990).

3.13 Treatment

During their stay the patients experienced five VEBIM sessions as delineated in Paragraph 2. After the subject entered in a virtual environment the therapist described the situation and encouraged him/her to associate to it in pictures instead of in words and to give a detailed description of his experience following the procedure described by Leuner (1969) and Kearney-Cooke (1989). Specifically we used the virtual environment in the same way as images in the well-known method of guided imagery (Leuner, 1969). It is in Leuner's belief that the imagery evokes intense latent feelings relevant to the patient's problems. This procedure was repeated for each of the five virtual environments experienced.

During the VR sessions the therapists also used the Socratic method (Vitousek, Watson, & Wilson, 1998). In this method, the therapist uses different questions to help patients synthesise information and to reach conclusions on their own. Usually, the therapist poses hypothetical, inverse, and third-person questions (Vitousek et al., 1998): for example, would the significance of body shape change if anorexic patient became stranded on a desert island? Would a patient swallow a magic potion that could remove her fear of normal weight? Would a bulimic client exchange her bingeing and purging for a 5- or 10-pound gain?

3.14 Statistical analysis

A power calculation was made to verify the opportunity to obtain statistically significant differences between the pre and post-treatment scores. Given the low statistical power, resulting from the small number of subjects, we decided to use the exact methods, a series of non-parametric statistical algorithms developed by the Harvard School of Public Health that enabled researchers to make reliable inferences when data are small, sparse, heavily tied or unbalanced (SPSS, 1995) The exact method used to compare the scores was the marginal homogeneity test (Agresti, 1990).

3.15 Outcome

Table 2 presents the means, and standard deviations for the body image scores obtained before and after the treatment. The marginal homogeneity test reported significant discrepancies in the BIAQ Eating Restraint and Real CDRS scores: both scores were lower after experiencing VEBIM. This reflects a general trend: all the mean BIAQ and BSS scores were lower after the therapy.
These results show that VEBIM was able to induce a more realistic perception of the real body in the subjects. This reflected also on eating behavior and motivation to change. In fact, patients reduced their eating control as showed by the reduction in the BIAQ Eating Restraint scale. No subjects experienced simulation sickness.

3.2 Bulimic sample

3.21 Subjects

Subjects were consecutive patients seeking treatment for bulimia nervosa at the Eating Disorder Unit of the Istituto Auxologico Italiano, Verbania, Italy. The individuals included were 14 women (Mean weight: 69,91 ±20,93 Kg.; mean height: 162 ±5,71 cm; mean B.M.I.: 26,63 ±8,46) between the ages of 18 and 45 years who met DSM IV (APA, 1994) criteria for bulimia nervosa for a minimum of 6 months as determined by an independent clinician on clinical interview. Individuals were excluded if they were acutely suicidal, medically ill or pregnant, had abused alcohol or drugs within the last year or had evidence of cardiac conduction disease. Before starting the trial, the nature of the treatment was explained to the patients and her written informed consent was obtained.
All the patients followed the same 4-week in-patient cognitive-behavioural eating disorders treatment.

3.22 Assessment

As in the previous study, subjects were assessed by one of three independent assessment clinicians who were not involved in the direct clinical care of any subject. The same psychometric tests were used.

3.23 Treatment

During their stay the patients experienced five VEBIM sessions as described in Paragraph 2.

3.24 Statistical analysis

As in the previous study, we used an exact method - the marginal homogeneity test -to compare the scores.

3.25 Outcome

Table 3 presents the means, and standard deviations for the body image scores obtained before and after the therapy by the bulimic sample. The marginal homogeneity test reported significant discrepancies in the BIAQ Grooming and Total scores, in the BSS Total, Torso and Limbs scores, and in the FRS Real score. Generally, all the BIAQ and BSS scores were lower after the therapy. These data indicate that the treatment reduced body dissatisfaction in the subjects, especially in both torso and limbs. This reflected also on the behavior of the subjects, less concerned about weight and body issues: patients reduced their weight control as showed by the reduction in the BIAQ Grooming scale. Also in the second sample no subjects experienced simulation sickness.

4. Discussion

Eating disorders are some of the most frustrating and recalcitrant forms of psychopathology. This is mostly owed to the strong resistance to change that characterises eating disorders patients.
As we have seen, a well suited approach for facing denial and resistance is the Socratic method (Vitousek et al., 1998). VR is well suited to this approach, because of its ability to immerse the patient in a lifelike situation that she/he is forced to face. Infact, the key characteristic of VR is the high level of control of the interaction with the environment without the constrains usually found in real life. VR is highly flexible and programmable. It enables the therapist to present a wide variety of controlled stimuli and to measure and monitor a wide variety of responses made by the user (Riva, 1998b). Both the synthetic environment itself and the manner in which this environment is modified by the user's responses can be tailored to the needs of each client and/or therapeutic application. Moreover, VR is highly immersive and can cause the participant to feel "present" in the virtual, instead of real, environment. It is also possible for the psychologist to follow the user into the synthesised world.
The advantages of a VR-based Socratic method are clear. It minimises distortion in self-report, since there is no script for conforming clients "to parrot" or oppositional clients to reject; a typical behavior of anorexic individuals. Moreover, it circumvents power struggles as the therapist can be invisible to the patient and thus presents no direct arguments to oppose. Finally, evidence is more convincing and conclusions better remembered because they are the patient's own. As noted by Miller & Rollnick (Miller & Rollnick, 1991) people are "more persuaded by what they hear themselves say than by what other people tell them" (p. 58). The analysis of the two preliminary clinical trials presented showed that VEBIM 3 could be an effective method for the

treatment of body image disturbances. The first interesting result is the lack of side effects and simulation sickness in our samples after the experience in the virtual environment, confirming the possibility of using VEBIM. This result, confirmed in both studies, is even more interesting given the sample used. Infact, females tend to be more susceptible to motion sickness than males (Griffin, 1990). The other obtained result is the significant modification induced by the treatment on the body image of the patients, always associated to a reduction in problematic eating and social behaviors.

Usually, body-image treatment involves a cognitive/behavioural or a feminist therapy that requires many sessions. The possibility of inducing a significant change in body image and its associated behaviors using a short term therapy can be useful to improve the efficacy of the existing approaches. As such, the procedure can be considered as a comprehensive treatment package to break through the "resistance" to treatment in clinical subjects (Vandereycken, 1990). Of course these results, even if very promising, are preliminary only. The cost of the VR system used in the study is about $10,000. This price, even if affordable for departments or hospitals, is still high for a single therapist, especially without a clear cost/benefit ratio. From a clinical view point the issues that we have to address in the future are:

- further testing of VEBIM 3. Even if the data obtained in the two pilot studies using VEBIM 3 are very promising, we have to test this approach in controlled studies. In particular the controlled studies will have both to compare the proposed method with the existing ones (cognitive/behavioural and feminist) and to verify the additional therapeutical effect eventually induced by VEBIM 3.
- a follow-up study to check how long the influence of the proposed approach lasts.

Acknowledgments

The present work was supported by the Commission of the European Communities (CEC), in particular by the IST programme (Project VEPSY Updated, IST-2000-25323 - http://www.psicologia.net).

Moreover, the authors have benefited from discussions on topics relevant to this chapter with many other colleagues. Their support and contributions cannot be overstated. These people include Eugenia Borgomainerio, Stefania Fontaneto, Stefano Marchi, Letizia Petroni, Silvia Rinaldi and Francesco Vincelli.

Table 1. Therapeutical methods integrated in VEBIM 2

Methods	Procedures
Socratic style	The therapist uses different questions, usually hypothetical, inverse, and third-person ones to help patients synthesise information and reach conclusions on their own.
Cognitive	**Countering:** Once a list of distorted perceptions and cognitions is developed, the process of countering these thoughts and beliefs begins. In countering, the patient is taught to recognise the error in thinking, and substitute more appropriate perceptions and interpretations. **Alternative Interpretation:** The patient learns to stop and consider other interpretations of a situation before proceeding to the decision-making stage. The patient develops a list of problem situations, evoked emotions, and interpretative beliefs. The therapist and patient discuss each interpretation and if possible identify the kind of objective data that would confirm one of them as correct. **Label Shifting:** The patient first tries to identify the kinds of negative words she uses to interpret situations in her life, such as bad, terrible, obese, inferior, and hateful. The situations in which these labels are used are then listed. The patient and therapist replace each emotional label with two or more descriptive words. **Deactivating the Illness Belief:** The therapist first helps the client list her beliefs concerning eating disorders. The extent to which the illness model influences each belief is identified. The therapist then teaches the client a cognitive/behavioural approach to interpreting maladaptive behaviour and shows how bingeing, purging, and dieting can be understood from this framework.
Behavioural	**Temptation Exposure with Response Prevention:** The rationale of temptation exposure with response prevention is to expose the individual to the environmental, cognitive, physiological, and affective stimuli that elicit abnormal behaviours and to prevent them from occurring. The TERP protocol is usually divided into three distinct phases: (1) comprehensive assessment of eliciting stimuli, (2) temptation exposure extinction sessions, and (3) temptation exposure sessions with training in alternative responses.
Visual motorial	**Awareness of the distortion:** The patients are instructed to develop an awareness of the distortion. This is approached by a number of techniques including the presentation of feedback regarding the patient's self-image. Videotape feedback is also usually used. Patients are videotaped engaging in a range of activities. **Modification of the body image:** The patients are instructed to imagine themselves as different in several aspects including size, race, and being larger or smaller in particular areas. They also are asked to imagine themselves as younger and older, and to imagine what they look and feel like before and after eating, as well as before and after academic-vocational and social successes and failures.

Table 2:
Mean BIAQ, BSS, CDRS and FRS scores before and after treatment (Anorectic Patients)

BIAQ	BEFORE TREATMENT	AFTER TREATMENT	p
Total score	27,1	22,7	-
Eating Restraint	6,8	4,1	,05
Clothing	8,4	7,4	-
Grooming/Weighing	5,1	3,9	-
Social Activities	6,8	7,3	-
BSS			
Total score	53,3	49,6	-
Head	19,8	16,4	-
Torso	15,5	15,6	-
Limbs	18	17,6	-
CDRS			
Real Body	2,5	1,8	,02
Ideal Body	2,9	2,9	-
Body Satisfaction Index	0,9	0,7	-
FRS			
Real Body	2,3	2	-
Ideal Body	2,6	2,6	-
Body Satisfaction Index	0,9	0,8	-

Table 3:
Mean BIAQ, BSS, CDRS and FRS scores before and after treatment (Bulimic patients)

BIAQ	BEFORE TREATMENT	AFTER TREATMENT	p
Total score	34,36	28,71	,026
Eating Restraint	6,00	5,57	-
Clothing	11,93	10,71	-
Grooming/Weighing	6,57	4,43	,009
Social Activities	9,86	8,00	-
BSS			
Total score	58,21	51,57	,012
Head	18,71	16,50	-
Torso	19,79	17,00	,026
Limbs	19,71	18,07	,023
CDRS			
Real Body	6,28	5,79	-
Ideal Body	3,43	3,29	-
Body Satisfaction Index	2,03	1,89	-
FRS			
Real Body	5,43	4,64	,005
Ideal Body	3,07	3,36	-
Body Satisfaction Index	1,88	1,36	,033

References

Agresti, A. (1990). Categorial data analysis. New York: John Wiley and Sons.

APA. (1994). Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC: APA.

Baars, B. J. (1988). A cognitive theory of consciousness. New York: Cambridge University Press.

Barham, P. T., & Mc Allister, D. F. (1991). A comparison of stereoscopic cursors for the interactive manipulation of B-splines. Paper presented at the Stereoscopic Display and Applications II.

Bergner, M., Remer, P., & Whetsell, C. (1995). Transforming women's body image: a feminist counseling approach. Women and Therapy, 4, 25-38.

Butcher, J. N. (1990). MMPI-2 in psychological treatment. New York: Oxford University Press.

Butters, J. W., & Cash, T. F. (1987). Cognitive-behavioral treatment of women's body image satisfaction: A controlled outcome-study. Journal of Consulting and Clinical Psychology, 55, 889-897.

Cash, T. F. (1995). What do you see when you look in the mirror? Helping yourself to a positive body image. New York: Bantam Books.

Cash, T. F. (1997). The body image workbook: an eight-step program for learning to like your looks. Oakland, CA: New Harbinger.

Cash, T. F., & Grant, J. R. (1995). The cognitive behavioral treatment of body-image disturbances in anorexia nervosa and bulimia nervosa. In V. Van Hasselt & M. Hersen (Eds.), Sourcebook of psychological treatment manuals for adults (pp. 567-614). New York: Plenum Press.

Clark, M. M., Abrams, D. B., Niaura, R. S., Eaton, C. A., & Rossi, J. S. (1991). Self-efficacy in weight management. Journal of Consulting and Clinical Psychology, 59(5), 739-744.

Dionne, M., Davis, C., Fox, J., & Gurevich, M. (1995). Feminist ideology as a predictor of body dissatisfaction in women. Sex Roles, 33, 277-287.

Dolecek, Q. E. (1994). Computer-generated stereoscopic displays. John Hopkins APL Technical Digest, 15, 137-142.

Fairburn, C. G., & Cooper, Z. (1993). The Eating Disorders Examination. In C. G. Fairburn & G. T. Wilson (Eds.), Binge eating: Nature, assessment, and treatment (pp. 317-360). New York: The Guilford Press.

Garner, D. M. (1995). EDI 2. Eating Disorders Inventory-2. Florence (Italy): Organizzazioni Speciali.

Glantz, K., Durlach, N. I., Barnett, R. C., & Aviles, W. A. (1996). Virtual reality (VR) for psychotherapy: From the physical to the social environment. Psychotherapy, 33(3), 464-473.

Glantz, K., Durlach, N. I., Barnett, R. C., & Aviles, W. A. (1997). Virtual reality (VR) and psychotherapy: Opportunities and challenges. Presence, Teleoperators, and Virtual Environments, 6(1), 87-105.

Griffin, M. J. (1990). Handbook of Human Vibration. London: Academic Press.

Hodges, L. F., Bolter, J., Mynatt, E., Ribarsky, W., & Van Teylingen, R. (1993). Virtual environments research at the Georgia Tech GVU Center. Presence, Teleoperators, and Virtual Environments (3), 234-243.

Hodges, L. F., Rothbaum, B. O., Kooper, R., Opdyke, D., Meyer, T., North, M., de Graaff, J. J., & Williford, J. (1995). Virtual environments for treating the fear of heights. IEEE Computer, 28(7), 27-34.

Hodges, L. F., Rothbaum, B. O., Watson, B., Kessler, G. D., & Opdyke, D. (1996). A Virtual Airplane for Fear of Flying Therapy. Paper presented at the Virtual Reality Annual International Symposium - VRAIS '96, Los Alamitos, CA.

Kearney-Cooke, A. (1989). Reclaiming the body: using guided imagery in the treatment of body image disturbances among bulimic women. In L. M. Hornyak & E. K. Baker (Eds.), Experiential therapies for eating disorders (pp. 11-33). New York: Guilford.

Kearney-Cooke, A., & Striegel-Moore, R. (1994). Treatment of childhood sexual abuse in anorexia nervosa and bulimia nervosa: A feminist psychodynamic approach. International Journal of Eating Disorders, 15, 305-319.

Keeton, W. P., Cash, T. F., & Brown, T. A. (1990). Body image or body images: comparative, multidimensional assessment among college students. Journal of Personality Assessment, 54, 213-230.

Leuner, H. (1969). Guided affective imagery: a method of intensive psychotherapy. American Journal of Psychotherapy, 23, 4-21.

Miller, W. R., & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press.

North, M. M., North, S. M., & Coble, J. R. (1996). Effectiveness of virtual environment desensitization in the treatment of agoraphobia. Presence, Teleoperators, and Virtual Environments, 5(3), 127-132.

North, M. M., North, S. M., & Coble, J. R. (1997). Virtual reality therapy for fear of flying. American Journal of Psychiatry, 154(1), 130.

Riva, G. (1997a). The virtual environment for body-image modification (VEBIM): Development and preliminary evaluation. Presence, Teleoperators, and Virtual Environments, 6(1), 106-117.

Riva, G. (1997b). Virtual reality as assessment tool in psychology. In G. Riva (Ed.), Virtual reality in neuro-psycho-physiology: Cognitive, clinical and methodological issues in assessment and rehabilitation (pp. 95-112). Amsterdam: IOS Press.

Riva, G. (Ed.). (1997c). Virtual reality in neuro-psycho-physiology: Cognitive, clinical and methodological issues in assessment and rehabilitation. Amsterdam: IOS Press.

Riva, G. (1998a). Modifications of body image induced by virtual reality. Perceptual and Motor Skills, 86, 163-170.

Riva, G. (1998b). Virtual reality in psychological assessment: The Body Image Virtual Reality Scale. CyberPsychology & Behavior, 1(1), 37-44.

Riva, G. (1998c). Virtual Reality vs. Virtual Body: The use of virtual environments in the treatment of body experience disturbances. CyberPsychology & Behavior, 1(2), 129-137.

Riva, G., & Melis, L. (1997). Virtual reality for the treatment of body image disturbances. In G. Riva (Ed.), Virtual reality in neuro-psycho-physiology: Cognitive, clinical and methodological issues in assessment and rehabilitation (pp. 95-111). Amsterdam: IOS Press.

Riva, G., & Molinari, E. (1998a). Factor structure of the Italian version of the Body Satisfaction Scale: A multisample analysis. Perceptual and Motor Skills, 86, 1083-1088.

Riva, G., & Molinari, E. (1998b). Replicated factor analysis of the Italian version of the Body Image Avoidance Questionnaire. Perceptual and Motor Skills, 86, 1071-1074.

Rorty, M., Yager, J., & Rossotto, E. (1993). Why and how do women recover from bulimia nervosa? The subjective appraisal of forty women recovered for a year or more. International Journal of Eating Disorders, 14, 249-260.

Rosen, C. J., & Ramirez, E. (1998). Comparison of eating disorders and body dysmorphic disorders on body image and psychological adjustment. Journal of Psychosomatic Research, 44(3/4), 441-449.

Rosen, J. C. (1996). Body image assessment and treatment in controlled studies of eating disorders. International Journal of Eating Disorders, 19, 341-343.

Rosen, J. C., Srebnik, D., Saltzberg, E., & Wendt, S. (1991). Development of a Body Image Questionnaire. Psychological Assessment, 1, 32-37.

Sadowsky, J., & Massof, R. W. (1994). Sensory engineering: the science of synthetic environments. John Hopkins APL Technical Digest, 15, 99-109.

Schlundt, D. G., & Johnson, W. G. (1990). Eating Disorders: assessment and treatment. Needham Heights, MA: Allyn and Bacon.

Slade, P. D., Dewey, M. E., Newton, T., Brodie, D., & Kiemle, G. (1990). Development of the Body Satisfaction Scale (BSS). Psychology and Health, 4, 213-226.

SPSS (1995). SPSS user manual: Exact tests. Chicago, IL: SPSS Inc.

Thompson, J. K., & Altabe, M. N. (1991). Psychometric qualities of the Figure Rating Scale. International Journal of Eating Disorders, 10, 615-619.

Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). Exacting beauty: Theory, assessment and treatment of body image disturbance. Washington DC: American Psychological Association.

Thompson, J. K., & Tantleff, S. (1992). Female and male rating of upper torso: actual, ideal and stereotypical conceptions. Journal of Social Behaviour and Personality, 7, 345-354.

Thompson, M. A., & Gray, J. J. (1995). Development and validation of a new body-image assessment scale. Journal of Personality Assessment,, 2, 258-269.

Vandereycken, W. (1990). The relevance of body-image disturbances for the treatment of bulimia. In M. M. Fichter (Ed.), Bulimia nervosa. Basic research, diagnosis and treatment (pp. 136-142). New York: Wiley.

Vitousek, K. B., Watson, S., & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. Clinical Psychology Review, 18(4), 391-420.

Wooley, S. C. (1995). Feminist influences on the treatment of eating disorders. In K. D. Brownell & C. G. Fairburn (Eds.), Eating disorders and obesity: a comprehensive handbook (pp. 294-298). New York: Guilford.

Wooley, S. C., & Wooley, O. W. (1985). Intensive out-patient and residential tratment for bulimia. In D. M. Garner & P. E. Garfinkel (Eds.), Handbook of psychotherapy for anorexia and bulimia (pp. 120-132). New York: Guilford Press.

Please send correspondence and printed drafts to:
Giuseppe RIVA, Ph.D., Istituto Auxologico Italiano
Applied Technology for Neuro-Psychology Lab., P.O. Box 1, 28900 Verbania , Italy
E-mail: auxo.psylab@auxologico.it
Tel: +39 - 0323 - 514278; Fax: +39 - 0323 - 587694

Bernardo Nardi & Giorgio Pannelli

A Tribute to Vittorio F. Guidano (1944-1999)

Vittorio Filippo Guidano, father of modern constructivist and post-rationalist cognitivism, prematurely died on August 31, 1999, in Buenos Aires, where he was holding a cycle of lectures at the local University. Born in Rome on August 4, 1944, he had both humanistic and medical formation. As neuropsychiatrist, he was in the staff of the Institute of Nervous and Mental Disorders of the University "La Sapienza" of Rome, were he began his experience in the field of behavioural and cognitive psychotherapy. Promoter in 1972 and first President of the Italian Society of Behavioural and Cognitive Therapy (SITCC), he developed a new post rationalist approach (systems and process-oriented), founding in 1997 the Institute of Post-Rationalist Psychology and Psycotherapy (IPRA).

He hold many professional trainings, in Europe, in North and in South America and he wrote innovative scientific contributes which are basic both for epistemology and clinical practice in modern cognitivism, as the followings: "*Cognitive Processes and Emotional Disorders*" (with G. Liotti, Guilford, New York, 1983), "*A constructivistic outline of cognitive processes*" (in: Reda M. and Mahoney M.J. Eds., "Cognitive Psychotherapies", Ballinger, Cambridge, Mass., 1984); "*A constructivistic foundation for cognitive therapy*" (in: Mahoney M.J. and Freeman A. Eds., "Cognition and Psychotherapy", Plenum Press, New York, 1985); "*The Self as a mediator of cognitive change in psychotherapy*" (in: Hartman L.H. and Blankstein K.P. Eds., "Perception of Self in Emotional Disorders and Psychotherapy", Plenum Press, New York, 1986); "*A systems, process-oriented approach to cognitive therapy*" (in: Dobson K.S. Ed., "Handbook of Cognitive-Behavioral Therapies", Guilford, New York, 1988); "*Affective change events in a cognitive therapy system approach*" (in: Safran J.D. and Greenberg L.S. Eds., "Emotion, Psychotherapy and Change", Guilford, New York, 1991); "*Constructivistic psychotherapy: A theoretical framework*" (in: Neimeyer R.A. and Mahoney M.J. Eds., "Constructivism in Psychotherapy", American Psychological Association, Washington, 1995); "*Self-observation in constructivistic psychotherapy*" (in: Neimeyer R.A. and Mahoney M.J. Eds., "Constructivism in Psychotherapy", American Psychological Association, Washington, 1995); "*A constructivistic outline of human knowing processes*" (in: Mahoney M.J. Ed., "Cognitive and Constructive Psychotherapies: Theory, Research and Practice", Springer, New York, 1995). His main works remain the two books "*Complexity of the Self*" (Guilford, New York, 1987) and "*The Self in Progress*" (Guilford, New York, 1991).

The Guidano's approach has pointed out importance of affective and emotional aspects for development of Self and has focused subjective manner of experience rearrangement, operating in experience/explanation interface, to identify basic aspects and processes that lead to knowledge

of Self and others. Continuous swinging from immediate experience and explanations of such an experience produces two levels of knowledge: "tacit" (emotional, scarcely defined and conscious) and "explicit" (rational and conscious). Individual development is characterized by a self-referring process of a more and more complex arrangement of continuous and heterogeneous flowing of external stimuli, perceived and elaborated as identity and knowledge of Self and world. Attachment patterns (concerning quality of parental expected response, intrusion, interference and control levels, and invested empathy), can produce, on one hand, early emotional control disorders, and, on the other hand, can compromise further evolution of attachment patterns during late infancy, preadolescence and adolescence, impairing affective style and ability of engaging valid couple friendships.

Observing that each person develops an own self-organization of personal meaning dimension based on attachment patterns, he developed the concept of "personal meaning organization" (P.M.O.). Such a definition refers to the specific assemblage processes for organization of a personal meaning dimension, by which one can maintain his/her own sense of personal uniqueness and historical continuity, also experiencing various changes along his/her life.

Therefore, in life cycle (which stability is kept by an "order through fluctuations" between balancing and unbalancing forces, developmental events can produce embarrassing, unstable and severe changes in self perception, which consequences depend on subjective competency in arranging internal affective-emotional and cognitive aspects in a new and coherent manner.

In Guidano's approach, any psychopathological disorder (neurotic or psychotic, with respect to one's flexibility, abstraction and self-integration abilities) reflects a perturbation of self-organization processes, essential for one's internal coherence maintenance, with arising of a critic phase resolved by getting a newer and more complex and adaptive equilibrium; any symptom, independently by its semeiological characteristics, must be referred to an alteration of internal balance and coherence.

Guidano's psychotherapeutical approach, performed by reframing subjective negativity themes, according to the personal meaning organization, can allow a more adaptive and viable reading of one's own experience over time. In such a way, during therapy, feelings of self-negativity, perceived as objective and unchanging aspects of Self, can be focused as subjective patterns in organizing experiences, giving them more adaptive directions.

The importance of Guidano's approach was recently discussed in several conferences, at the Congress that we organized on his figure and work at the University of Ancona on May 19 and at the 7th International Congress on Constructivism in Psychotherapy, hold in Genève on September 19-23, 2000.

Dr. Bernardo Nardi
Institute of Psychiatry, University of Ancona, Italy
Ospedale Regionale Umberto 1, Largo Cappelli 1, I-60121 Ancona
e-mail: ist.psichiatria@fastnet.it

Ilse Kryspin-Exner

Psychotherapy and Clinical Psychology in Austria

ABSTRACT

In Austria ten years ago two different laws cam into force adjusting the professions "Psychologist" and "Psychotherapist". The curricula are presented and settings of psychological counselling, psychological treatment and psychotherapy on this basis are discussed.

On the motorway approaches to Vienna there have been large posters in recent years, displayed at the entrances to the city and proclaiming "Vienna is different". Since Vienna is the capital of Austria, where the laws of the country are made, this is also true in terms of official regulations. In particular, we find it in the regulations governing psychotherapy and clinical psychology.

Two laws came into force in Austria on 1.1.1991. The first of these concerned the legal protection of the professional title of psychologist and the activities relating to the practice of the profession; the second concerned those of the psychotherapist.

This legislation laid down definite boundaries. Since the effective date, psychologists in clinical practice or the health service must have successfully completed a course of postgraduate training (Psychologists' Act – "Psychologengesetz"). The right to use the professional title of psychotherapist and to practise as such is limited to those who have completed the appropriate training leading to full official recognition (Psychotherapy Act – "Psychotherapiegesetz"). Many psychologists are also psychotherapists, meaning that they have completed both ways of training.

Significant features of the PSYCHOTHERAPY ACT are:

- The training concerned is not an "academic" one; it is not offered by universities, and is therefore subject to the regulations of the free market economy.
- Access to this training is open to individually qualified persons, who have either the final secondary school-leaving certificate (which entitles the holder to university entry) or its

equivalent. Access is also open to qualified members of certain professions ("Quellenberuf") such as health care workers, teachers, social workers, psychologists, members of the medical profession, etc. Individuals may also be admitted on the grounds of suitability by decision of the Federal Ministry for Social Security and Generations (former: Labour and Social Affairs) on the basis of a report by the Psychotherapy Advisory Committee declaring the individual qualified to take the course. This provision is known as the "Genieparagraph" ["genius" paragraph].

- The Psychotherapy Advisory Committee (Psychotherapiebeirat) referred to is the ultimate supervisory authority. It also maintains the list of qualified psychotherapists, the register of those who have duly completed the course of training and are thus qualified to carry out the independent practice of psychotherapy.

- The course of training is composed of two parts: a general course in psychotherapy (Propädeutikum) whose minimum length and content are defined in the Act, and a specialised psychotherapy course (Fachspezifikum) with various different specialist emphases. (There are currently 31 training establishments offering these particular courses, 17 concerning the specialisation.)

- The duration of the general training is approximately 6 semesters (exemption may be granted for elements of study covered in university-training – medicine, psychology, teacher training, etc.). A period of 4–6 years has to be allowed for the specialised training. The cost of training is approximately 100,000 DM.

Psychologists' Act:

According to Austrian law, the exercise of the profession of psychologist within the health service is "the investigation, interpretation, alteration and prediction of people's experience and behaviour by the use of scientific and psychological understanding and methods, through the acquisition of specialist skills" (Psychologists' Act, Section II, § 3 (1)). The professional title of clinical psychologist (Klinischer Psychologe), health psychologist (Gesundheitspsychologe), or both, may be obtained. A course of postgraduate training comprising at least 160 hours of theory, together with 1480 hours of psychosocial practical experience (equivalent to approximately one year of full-time work), are required. There is a further requirement of 120 hours of accompanied supervision. According to this Act, the practice of the profession of psychologist comprises:

- clinical psychological diagnosis
- the application of psychological treatment methods for the purposes of prevention, treatment

and rehabilitation in the case of individuals or groups, the provision of advice to legal entities, and teaching and research in the specified fields, and
- the development of measures and projects for the promotion of health.

The term "psychological treatment" in the Austrian Psychologists' Act consequently means the areas of therapeutic competence of the clinical psychologist and of the health service psychologist. The concept is not further defined in the text of the Act, there is no differentiation in terms of content, and it is not distinguished from psychological counselling or psychotherapy.

Diplomas of the Österreichische Ärztekammer (Austrian General Medical Council, ÖÄK) in psychosocial, psychosomatic and psychotherapeutic medicine

In 1989, the Austrian General Medical Council established a further training option for qualified and registered medical practitioners in the form of a series of diploma courses, with the aim of deepening the understanding of psychosocial and psychosomatic matters, and increasing physicians' use of psychotherapeutic treatments. The courses consisted of training in psychosocial medicine, training in psychosomatic medicine, and training in psychotherapeutic medicine, each designed to build on the previous course of training. This means that the ÖÄK Diploma in psychosocial medicine is the prerequisite for those wishing to take the Diploma in psychosomatic medicine. These two Diplomas are the prerequisite for the ÖÄK Diploma in psychotherapeutic medicine. The diploma course in psychosocial medicine has as its central theme a comprehensive understanding of medicine that takes account of the unity of body, mind and spirit and recognises the human being on the biological, psychological and social levels. The module on psychosomatic medicine sets out to convey a knowledge of various conceptual models of psychosomatic matters and how to apply them. It also aims to enable the physician to combine the insights of empathy with thinking on diagnostic and therapeutic aspects. The training in psychotherapeutic medicine aims to develop an all-embracing form of psychotherapeutic medicine not confined to any single "dogma", i.e. behavioral or analytic or cognitive or systemic, interactive a.s.o.

In order to embark on these courses, candidates need not only to have completed their medical training but to have taken up practice, the prerequisite for entry in the Medical Register. Only recently, a training in psychotherapy was made compulsory in the training of medical specialists in psychiatry.

What have been the consequences of this fragmentation of psychotherapy, and in particular of the separation of psychology and psychotherapy?

- A rude awakening for psychologists. They saw themselves deprived of an area of competence that had been part of their remit as psychologists and felt their existence to be under threat. Yet, viewed optimistically, it could represent a start to the creation of a new identity.
- Among psychologists, there is increasing interest in the subject of health. The health aspect is consequently better understood within the profession and this has an effect on the public (it also opens up, it is hoped, new career opportunities).
- Within psychotherapy, the incorporation of new specialisms has led to an increasing diversity of methods. Together with this has come the development of (provisional) criteria establishing scientific credentials and approach. These criteria should probably be seen as "work in progress".

Based on the Austrian experience, the following considerations appear to be important:

- A distinction must be made between the aspects of the regulations relating to social law and those relating to occupational law (and thus content). The act of wrenching apart this particular professional branch has blurred the allocation of areas of therapeutic competence: which treatment falls under psychology, and which under psychotherapy? What is the rightful place of specialist training for physicians? This can be seen particularly in examples of "neuropsychological rehabilitation" (following accident or stroke, for example), the care of the chronically sick (e.g. pain management and pre-operative preparation) and the care of relatives (e.g. in geriatric medicine).

  The current situation in Austria is that a partial refund of costs by the various social insurance schemes may be applied for by patients diagnosed as having a mental disorder (according to ICD classification). However, this is only applicable if the patient's care is in the hands of a psychotherapist (a different financial provision again applies to physicians with the ÖÄK Diplomas). These preconditions that decide the choice of psychotherapeutic or psychological treatment need to be discussed and re-thought. Similar re-thinking is required for the field of prevention and the understanding of clinical psychology and psychotherapy in relation to existential questions and response to life issues (such as marriage and partnership difficulties, redundancy, problems at school, etc.)

- Another matter that frequently gives rise to discussion concerns the issue of (psycho)therapy that transcends the various individual methods. Whereas the training provided for by the General Medical Council rests mainly on an eclectic approach, entry in the register of psychotherapists – as described above – rests on a training in a specific discipline. The individual's entry is in the first instance as a psychotherapist, and goes on to state the area in which the specialised training was completed. Psychologists on the other hand increasingly speak of "psychological therapy". This is mainly structured around psychological models (development psychology, social psychology, cognitive psychology, motivational psychology, neuropsychology and theories on problem-solving, coping strategies, stress-management, etc.)

- Last but not least, many Austrian psychologists and psychotherapists are concerned about the "Europeanisation" of this training sector. The first step, in view of the specific situation in Austria, would be to analyse the position of psychotherapy and psychology at the postgraduate level in Europe – to what extent does the right to practise in various professional areas in the different European countries depend on this? What sort of mutual recognition exists in this right to practise? (see "MAPS-C", Pal & Kryspin-Exner, 2001)

Bibliography

Grawe, K. (1998) Psychologische Therapie, Göttingen (Hogrefe)

Kierein, M., Pritz, A. & Sonneck, G. (1991) Psychologen-Gesetz, Psychotherapie-Gesetz: Kurzkommentar, Vienna (Orac)

Kryspin-Exner, I. (1994) Einladung zur psychologischen Behandlung. Verhaltensmodifikation, Verhaltenstherapie, Verhaltensmedizin, Gesundheitspsychologie, Berlin (Quintessenz)

Kryspin-Exner, I., Lueger-Schuster, B. & Weber, G. (Eds.) (1998) Klinische Psychologie und Gesundheitspsychologie. Postgraduale Aus- und Weiterbildung, Vienna (WUV-Universitätsverlag)

Pal, K. & Kryspin-Exner, I. (2001). Postgraduale Ausbildung in Klinischer Psychologie und Psychotherapie in Europa: MAPS-C, ein Sokrates/Erasmus-Projekt der Universitäten Wien, Athen, Dublin, Koblenz-Landau und Luxemburg. Psychologie in Österreich 1-2: 73-75

Slunecko, Th. (1996) Wissenschaftstheorie und Psychotherapie. Ein konstruktiv-realistischer Dialog (Cognitive science: 7), Vienna (WUV-Universitätsverlag)

Stumm, G., Deimann, P., Jandl-Jager, E. & Weber, G. (1995) Psychotherapie Beratung, Supervision, Klinische Psychologie, Ausbildung in Österreich, Vienna (Falter)

Univ.-Prof. Dr. Ilse Kryspin-Exner
Institut für Psychologie der Universität Wien
1010 Wien, Universitätsstraße 7
Tel.: 0043-1-4277478-90
e-mail: Ilse.Kryspin-Exner@univie.ac.at

Habib Davanloo

Intensive Short-Term Dynamic Psychotherapy Extended Major Direct Acess to the Unconscious

ABSTRACT

In this article, the author gives an overview of his technique of Intensive Short-Term Dynamic Psychotherapy, and describes in detail the technique of extended major direct access to the unconscious.

My systematic research for nearly forty years, using videotechnology as a research tool, combined with a number of discoveries, have enabled me to apply a scientific method to the understanding of the unconscious mind. I have been able to revise the whole metapsychology of the unconscious, a scientific psychology based upon empirical evidence - not theory or intuition. This work has resulted in the development of two highly powerful psychotherapeutic techniques: first, Intensive Short-Term Dynamic Psychotherapy; and, second, a new method of Psychoanalysis for the systematic exploration and investigation of the unconscious; which have the power to resolve the highly complex pathogenic organization of the unconscious of highly resistant patients who suffer from diffuse symptom and character disturbances.

The systematic work of the 80's concerned itself with the application of the technique with patients suffering from phobic, obsessional, depressive, functional, somatization and panic disorders; and this work clearly demonstrated that the technique is highly effective in the above disorders (Davanloo 1987b,c, 1989 c,d, Zaiden 1979). Then I concerned myself with the application of the technique to patients with fragile character as well as those suffering from psychosomatic conditions. and that research clearly showed that the technique, with some modification, can successfully be applied to patients with structural pathology, and those with psychosomatic disorders. The work of the 80's and 90's resulted in major refinements of the technical interventions in Intensive Short-Term Dynamic Psychotherapy, as well as the development of a very powerful new method of Psychoanalysis with the aim of systematic investigation and exploration into the unconscious. This work shows that both techniques have the power to bring multidimensional structural character changes, particularly in extremely resistant patients with the most pathogenic unconscious. The truth of this statement has been demonstrated unequivocally, the work has

been presented at a large number of audiovisual symposia and training courses and programs to professional audiences, both in North America and in Europe for the past twenty-five years (Davanloo 1975, 1976a,b, 1977, 1978, 1980b, 1984b, 1985, 1999a,b).

The technique of rapid and direct access to the unconscious will be discussed in great detail in this article. I have already both presented and published the technique of the direct access to the unconscious, which we may call the "Unlocking of the Unconscious" (Davanloo 1975, 1976a,b, 1980a, 1984a, 1988b,c, 1990). This provides a unique opportunity for both patient and therapist to have a direct view of the psychopathological dynamic forces responsible for the patient's symptoms and character disturbances (Davanloo 1975, 1976a,b, 1977, 1978, 1980a, 1990). One of the most important early findings is that the degree of unlocking of the unconscious is precisely in proportion to the degree that the patient is experiencing the transference feelings (Davanloo 1980b, 1981, 1988b,c, 1992). One of the very early discoveries that I made had to do with the direct management of the resistance and the direct access to the unconscious, and the interrelation between major resistance and what I call "unconscious therapeutic alliance" (Davanloo 1975, 1976a,b, 1980b, 1985, 1987a). This series of early observations indicated that the first breakthrough into the unconscious is the first dominance of the unconscious therapeutic alliance over the resistance, and partial and major unlockings of the unconscious are partial and major dominance of the resistance by the unconscious therapeutic alliance (Davanloo 1988b,c, 1989a,b). This led to further research in the area of the technique of mobilization of unconscious therapeutic alliance over the forces of the resistance.

The earliest observation and the discovery of the direct handling of the major resistance and the direct rapid access to the unconscious is the presence of the murderous rage and guilt-laden unconscious feeling in the resistant patient. There I established a clear correlation between the intensity of the murderous rage/guilt-laden unconscious feeling and the degree of the resistance. In the highly resistant group of patients, direct access to the unconscious showed the presence of a high degree of primitive murderous rage/intense guilt-laden unconscious feeling toward one or both parents and/or siblings. In this research, I clearly demonstrated that in patients who are highly responsive to dynamic psychotherapy with circumscribed problem and single psychotherapeutic focus, there was virtual absence of the murderous rage within their unconscious. They had a healthy relationship with both parents as well as with their siblings, with a virtual absence of major resistance. The resistance was primarily of a tactical nature (Davanloo 1977,1983,1995a, 1996a,b).

Before I present the technique of direct access to the unconscious, I will outline briefly two major spectra of patients who can successfully be treated with Intensive Short-Term Dynamic Psychotherapy, namely: Spectrum of Psychoneurotic Disturbances; and Spectrum of Patients with Fragile Character Structure.

Spectrum of Psychoneurotic Disorders

Based on the clinical research data, we can classify the spectrum of the psychoneurotic disorders into five major groups (Davanloo 1982,1986a,b,c, 1995a). This spectrum is based on the degree of the resistance.

1) **Patients on the Extreme Left on the Spectrum**

   These patients were the focus of my earliest research. They are patients who are highly responsive to psychotherapeutic intervention, some of them suffering from mild obsessional neurosis of recent onset, others suffering from mild phobic disorders or other forms of neurotic disorders. We can summarize briefly the main features of all patients on the extreme left:

   • highly responsive to psychotherapeutic intervention
   • circumscribed problem
   • single psychotherapeutic focus
   • no major resistance whatsoever, the only resistance being of a tactical nature
   • absence of unconscious murderous rage and guilt in relation to early figures.

   What we have seen in a number of research, both in North America as well as in Europe, is that the number of patients from the extreme left are indeed very few, and in some major psychotherapeutic centers quite rare.

2) **Mid-Left Side on the Spectrum**

   This second major group shows a moderate degree of the resistance, and the main features of this group can be summarized briefly as follows:

   • moderate degree of the resistance; presence of major resistance
   • diffuse symptom disturbances
   • some degree of characterological disturbances
   • a definite presence of unconscious violent rage and guilt-laden unconscious feeling, as well as grief, in relation to the early figures, such as parents, siblings, etc.

3) **Mid-Spectrum**

   We can briefly summarize the characteristics of this third major group:

   • the presence of high degree of resistance; presence of major resistance as well as the tactical organization of the major resistance
   • they suffer from diffuse symptoms as well as character disturbances
   • presence of unconscious murderous rage and guilt feeling in relation to early figures, such as parents, siblings, etc.
   • in many of them there is fusion of sexuality and murderous rage
   • the core pathology is complicated.

4) **Mid-Right Side on the Spectrum**

   These patients are highly resistant and suffer from life-long psychoneurotic disturbances. The following is a brief summary highlighting their characteristics:

   • very high degree of the resistance

- diffuse symptom and character disturbances; life-long character neurosis
- the core pathology is highly complicated
- direct major access to the unconscious shows the presence of an unconscious primitive murderous rage, guilt- and grief-laden unconscious feelings toward parents, siblings, and others in their early life orbit, which I call the Perpetrator of the Unconscious
- sexualized feelings, when present, are deeply fused with the primitive murderous rage.

5) **Extreme Right Side on the Spectrum**

We can summarize briefly the following as the main features of this group:

- extreme degree of the resistance
- symptom and major character disturbances
- high degree of masochistic character traits
- highly complicated core pathology
- direct and extended unlocking of the unconscious shows the presence of highly primitive unconscious torturous murderous rage and intense guilt and grief, multidimensional in relation to the early figure(s)
- sexualized feelings, when present, are deeply fused with the unconscious primitive murderous rage.

Structure of the Pathogenic Organization of the Unconscious

Obviously, space does not permit us to cover this subject in a short article as such. I would like in a few lines to highlight my findings in the spectrum of the resistant patients. We can summarize by stating the following: the presence of trauma, covert or overt, or a series of traumatic experiences; attachment, bond, traumatization, the major pain of trauma; primitive murderous rage, intense guilt-, grief-laden unconscious feeling; character resistance and resistance against emotional closeness. A metapsychological analysis of the structure of the pathogenic organization of the unconscious responsible for the patient's symptoms and character disturbances is what I have called "the perpetrator of the unconscious," and will be the subject of a series of future publications (Davanloo 1977, 1987d,e, 1988a, 1994c, 1995b,c).

Application of the Technique to Patients with Structural Pathology

Here we might consider three major groups of patients, some with mild to moderate degree of fragility and others with severe fragile character structure. One of the major features of this group of patients is the fact that they cannot withstand the impact of their unconscious during the first interview. This group of patients does not have the capacity to experience and tolerate anxiety and painful feelings; they have life-long access to a spectrum of primitive defenses. I will here mention a few: temper tantrums; explosive discharge of the affect; poor impulse control; projection; double and multiple projective identification; the phenomenon of drifting; drowsiness; dissociation; and disruption of their cognitive and perceptual function with hallucinatory experiences. My research

here clearly demonstrates that patients with fragile character structure can be successfully treated with Intensive Short-Term Dynamic Psychotherapy. The technique requires certain modifications: in the first phase, the therapist must aim at bringing about sufficient psychic integration and multidimensional unconscious structural changes before he undertakes a direct access to the murderous rage, which in all these patients is highly primitive, and, in many cases, is primitive murderous torturous rage. The application of the technique to this group of patients was the subject of six intensive training courses in North America, and I have already presented five immersion training programs on the treatment of the fragile character structure in Switzerland, Germany, and Italy in the past six or seven years (Davanloo 1993, 1994c, 1995d, 1996c, 1997a,b, 1998a,b,c). The following disorders can be successfully treated with the technique, and here I enumerate them briefly, based on the evolution and application of the technique:

- phobic and obsessional neurosis
- severe obsessional neurosis
- obsessive-compulsive disorders
- somatization disorders
- panic disorders in patients with obsessive, as well as those with fragile, character structure
- functional disorders, such as irritable bowel syndrome, migraine headaches, etc.
- depressive disorder
- suicidal patients with a history of major clinical depression
- suicidal patients with character disturbances
- the whole spectrum of psychoneurotic disorders
- patients with structural pathology such as fragile character (some modification)
- patients with psychosomatic disorders (certain modifications of the technique).

The Spectrum of the Technique of Direct Access to the Unconscious

If we present the analysis of our research data, there are four major techniques:

1) Partial unlocking of the unconscious which is partial dominance of unconscious therapeutic alliance against the forces of the resistance
2) Major unlocking of the unconscious which is the major dominance of unconscious therapeutic alliance
3) Extended major unlocking of the unconscious. Here we have a major mobilization of the unconscious therapeutic alliance, and the forces of the resistance are weakened to a great extent
4) Extended multiple major unlocking of the unconscious where we have maximum mobilization of the unconscious therapeutic alliance.

Partial and major unlocking are very much practiced in Intensive Short-Term Dynamic Psychotherapy, but extended mobilization of the unconscious therapeutic alliance or optimum mobilization of unconscious therapeutic alliance against the forces of the resistance is very much practiced in the new form of Psychoanalysis.

Central Dynamic Sequence in the Process of Direct Access to the Unconscious; Mobilization of the Unconscious Therapeutic Alliance Against the Forces of the Resistance

The central dynamic sequence consists of:

1) Phase of Inquiry
2) Phase of Pressure
3) Phase of Challenge
4) Transference Resistance
5) Partial or Major direct access to the unconscious
6) Analysis of the Transference
7) Dynamic Exploration into the unconscious.

Here I briefly highlight the central dynamic sequence and I refer the reader to the four-part article written by my German colleagues in this journal.

Phase of Inquiry:

Exploring the patient's difficulty; patient's ability to respond. Technically, inquiry should move rapidly to dynamic inquiry.

Phase of Pressure:

One of the basic principles in both techniques is exerting pressure; the therapist attempts to reach the patient's feelings directly via resistance and the transference, increasing the pressure toward the avoided feeling with the aim of bringing resistance and the transference into the open. The therapist must exert pressure with the major aim of rapid development of the twin factors of the resistance and the transference feelings. The major aim of exerting pressure can be summarized as follows: tilting the patient's character defenses in the transference; mobilization and intensification of the resistance; to create some degree of crystallization of the resistance in the transference; and rapid development of the twin factors of the resistance and the transference feelings.

Phase of Challenge:

Challenge is the key intervention in the whole technique, and it lies on a spectrum from relatively mild at one end to exceedingly powerful at the other, culminating in the head-on collision. One of the essential ingredients of the therapist's attitude in this technique is that, while maintaining the greatest sympathy and respect for the patient, he has neither sympathy nor respect for the patient's resistances, and conveys an atmosphere of considerable disrespect for the resistance. As a large part of the patient is identified with his defenses, this part of him becomes angry at having them treated with such disrespect; but, underneath, there is another part of him that begins to turn against them. This sets up tension between one part of the patient: the resistance, and another part: the therapeutic alliance. Until a major breakthrough has been achieved, the two opposite parts of the patient, the resistance and the therapeutic alliance, are always both in operation at the same time, and the the rapist's task is to tilt the balance between these two

opposing forces in favour of the therapeutic alliance. In the first breakthrough, we see a major change from the dominance of the resistance to the dominance of the unconscious therapeutic alliance, and in major breakthrough we have a major mobilization and dominance of the unconscious therapeutic alliance against the resistance. In an extended repeated major unlocking, which is the subject of this article, we have an optimum mobilization of unconscious therapeutic alliance and, correspondingly, a major weakening of the resistance. For more detail on the phase of challenge, the reader is referred to the article in this journal by my colleagues.

Transference Resistance:

Crystallization of the resistance in the transference; head-on collision with the transference resistance; to bring the patient face-to-face with the self-destructiveness of his resistance; mobilization of unconscious therapeutic alliance against the resistance; and to loosen the patient's psychic system and make possible direct access to the unconscious.

This is then followed by the phase of direct access to the unconscious which, as I have already indicated, can be partial, major, extended major, or extended multiple major. It is always extremely important that, after the direct access to the unconscious, at the completion of the passage of the guilt and the grief, the therapist moves to a systematic analysis of the transference and to the phase of consolidation.

EXTENDED MAJOR DIRECT ACCESS TO THE UNCONSCIOUS

This format is most often used in highly or extremely resistant patients. The trial therapy consists of three parts which can be conducted on the same day, with an interval of fifteen to twenty minutes between each part. But these three parts can also be conducted on three consecutive days. The total duration of the three-part interview in either format averages four to five hours.

These patients do not respond to the phase of inquiry, and the process rapidly moves to the phase of pressure. The phase of pressure plays an important part, and aims at the rapid crystallization of the patient's character defenses in the transference, and extensive mobilization of transference feelings, with extensive mobilization of the transference component of the resistance. The therapist now systematically challenges the patient's character defenses, and every tactical defense which is mobilized is rapidly challenged. Finally, the therapist meets a major resistance in the transference, and now he applies his most powerful technique of head-on collision with the major resistance in the transference, with the aim of mounting a direct challenge to all the forces maintaining the resistance and self-destructiveness; and systematic weakening of the major resistance, as well as all of the tactical defenses entrenched in the major resistance. This finally results in a major breakthrough into the unconscious with the passage of the primitive murderous rage in the transference and its neurobiological and somatic pathway.

The Process of Extended Major Unlocking can be summarized as follows:

1) Passage of the primitive murderous rage in the transference, with its somatic pathway and actual experience of the primitive murderous rage. This is immediately followed by:

2) Emergence of Sadness, indicating that the guilt- and grief-laden unconscious feelings are mobilized;
3) The patient attentively looks at the murdered damaged body of the therapist, then:
4) There is transfer of the murdered body of the therapist to the murdered body of the biological figure of the early life orbit of the patient - mother, father, sibling, etc.. It is important to note that in this mental imagery, the murdered body of the therapist appears exactly as the murdered body of the mother, father, or brother, in terms of the colour of the hair, eyes, in every respect. This visual imagery is extremely intense. The patient is, for example, seeing the dead body of the mother with blond hair and blue eyes. The dead body of the therapist is no longer there. This is then followed by:
5) Major breakthrough of intense guilt-laden unconscious feeling, a very painful experience which involves the neck and upper part of the chest. The duration of the passage of the guilt averages eight to twelve minutes in the first extended major unlocking. This is then followed by:
6) Passage of the grief-laden unconscious feeling, which is then followed by intense positive feeling;
7) Now, both the patient and the therapist have a first direct view of the psychobiological dynamic forces responsible for the patient's symptom and character disturbances.

Major unlocking is the standard technique used in Intensive Short-Term Dynamic Psychotherapy. Extended major unlocking of the unconscious and extended major mobilization of unconscious therapeutic alliance can also be used in Intensive Short-Term Dynamic Psychotherapy, but is used most often in the new form of Psychoanalysis. Here I will attempt to do an in-depth analysis of the process of an interview with a patient from the mid-right of the spectrum of psychoneurotic character neurosis, highlighting some of the important technical and metapsychological issues in achieving a rapid and direct access to the pathogenic organization of the unconscious.

The Case of the Man with Crushing Chest Pain

At the time of the initial interview, the patient was in his thirties, and suffered from arthralgia of many years duration, frequent episodes of crushing chest pain, severe panic attacks, diffuse characterological problems, disturbances of the interpersonal relationships, a major problem with intimacy and closeness, and disturbed relationships with his three children. He had been treated by a number of internists and had had long periods of physiotherapy. He had been very reluctant to see a psychiatrist, which was a source of tension between himself and his wife, who insisted that he should search for psychological help. He had been defiant and stubborn about it. The circumstance that brought him to this interview was a major crushing chest pain. While driving his car, he had a crushing chest pain and an attack of panic. He had to pull the car to the side of the road, and an ambulance had to take him to the coronary intensive care unit with a tentative diagnosis of a heart attack. He was admitted for twenty-four hours. A full investigation,

which included a serial EKG, showed no physical findings. He was discharged and referred to the therapist. A brief intake evaluation indicated that he suffered from a wide range of disturbances, the most important being panic disorder with blurring visual disturbances, crushing chest pain simulating a heart attack, double knee arthralgia of a functional origin, disturbances of interpersonal relationships, in his job as well as with his family, major problem with intimacy and closeness, masochistic character traits, self-defeating and self-sabotaging patterns which permeated many aspects of his life. He suffered from somatization disorder in the early part of his life.

Now we will focus on the interview with this patient.

Initial Contact

He enters into the interview visibly anxious, and the therapist focuses on the anxiety to see if it has transference implications.
TH: How do you feel right now? I notice you 're anxious.
PT: I am anxious.
TH: You took another sigh.

A very brief exploration into the physiological concomitant of the anxiety is made which indicates that the discharge pattern of the anxiety is exclusively in the striated muscle, clenching of the hands, and sighing respiration indicating tension in the intercostal muscle. The therapist concludes that there is no sign of the fragility.

Now we return to the interview.
TH: What do you account for your anxiety?
PT: Well, I, I was trying to analyze, trying to see why I am...
TH: What is there to analyze? What do you account for your anxiety?

Phase of Pressure

The main factors that influence the course of an interview are the degree of resistance and the extent of the transference component of the resistance. The technical interventions that I have introduced to exert pressure aim at the rapid development of the twin factors of resistance and the transference feelings. Based on that principle, the therapist maintains a structured interview: probing questions focusing on the patient's feeling underlying the anxiety in the transference.
Now we return to the interview.
PT: I, I ... the only thing I can see is, is, uh, I presume, presume it is ... coming here.
TH: You presume? Why presume, either is or isn 't?
PT: Yes, it definitely is. Yes.
TH: So then why you don't want to be specific?

With a tone which contains reluctance, he says "Okay, it is not. Okay maybe."
TH: Why you say 'Okay'?
PT: Uh, I guess my wording is not correct, uh.
TH: Now you take the position that your wording is not correct.
As I have emphasized, the phase of pressure might have passing moments of challenge, but systematic challenge should only begin when the resistance is well crystallized in the transference. In other words, the therapist should aim via the phase of pressure to mobilize and intensify the transference component of the resistance (Davanloo 1995a,b,c). This is particularly important if the therapist is aiming at major mobilization and dominance of the unconscious therapeutic alliance against the forces of the resistance.
PT: Hm hmm.
TH: You don't want to directly address it at me, that the anxiety has to do with seeing me.
PT: Yes, it's, it's, it is, it ...
TH: Unless you want to say it has to do with the hospital.
PT: No, no.
TH: So has to do with seeing me?
PT: Yes, yes, hm hmm.

Exerting Pressure:
Pressure toward the Underlying Feeling
TH: So could we look to see how you feel about seeing me?
PT: Well, I. I don't feel uncomfortable in the sense that I, I...
TH: 'I don 't feel uncomfortable' doesn 't say how you feel.
PT: Uh ah...see I, I ...

Further Rise in the Anxiety:
Further Pressure toward the Underlying Feeling
TH: How do you feel about seeing me?
PT: Well I don't... see I don't have a...
TH: Still we don't know how you feel about seeing me.
PT: Hmmmm, maybe I'm not ...
TH: How do you feel about seeing me, because obviously it makes you very anxious.
PT: Yes. it does.
TH: So then you must have a certain feeling besides anxiety about seeing me.
PT: Uhhhhh ... feeling in the sense that uh ...
TH: 'Feeling in the sense' doesn't say how you feel towards me.
PT: Well, it's, it's a negative feeling uh I don't know ah, ah to ...
TH: You mean you feel negative about seeing me?
PT: Yes. yes.

TH: Negative refers to what?
PT: Not anger, no, no uh...
TH: But negative refers to what feeling?
PT: In, in a, in a sense I don't look forward to come because ...
TH: Now you want to qualify.
PT: Hm hmm.
TH: You don't look forward to come here, hmm.
PT: Yes and no.

The process remains on the phase of pressure. He uses the tactical defense of negation. On the one hand, he talks about negative and anger, but immediately he also negates it. The therapist maintains the process by exerting further pressure and further mobilization of the transference feelings. Now the patient moves to another tactical defense, "yes and no." We return to the interview.

PT: Because I, I see it from two points of view.
TH: What two points?
PT: One that it, it will be good for me but on the other hand ...
TH: So in a sense part of you wants to come here and to do something about your paralysing life, your misery, but another part of you says, look, let's to carry the misery and the paralysed life?
PT: Hm hmm.
TH: Hmm?
PT: Yes.
TH: Okay, so a part of you wants to maintain a paralytic life full of misery and suffering but a part of you says something good might come of it, which might result in your freedom and putting an end to your misery. The point that we have here to begin with is this part that wants to continue the suffering.

The focus of the session is on his ambivalence, a part of him; the destructive organization of the resistance searching for the perpetuation of his suffering, and the fact that for years he has procrastinated about doing something for his suffering, and the reason that he has come to the interview was a crushing chest pain which had a similarity to a heart attack. Then the therapist moves to exert further pressure:

TH: Now, let's to see what you are going to do about that part that doesn't want to?
PT: What am I going to do about it?
TH: Hm hmm.
PT: Ah... Well I wish to cooperate, ah express what I feel but uhh...

Pressure and Challenge

In the following passage, the therapist uses both pressure and challenge, mobilization of the patient's will, emphasizing the destructive component of the resistance which demands perpetuation of suffering: the masochistic component of the character. For the sake of brevity, the dialogue has been shortened and paraphrased in places, but nothing important has been omitted.

.....

TH: But it is very important, a part of you wants to perpetuate, a part of you wants to maintain the suffering but a part of you is fed up with the suffering and wants to change.

PT: Yes I understand.

TH: But understanding is not enough. To do something about it is the task, unless you don't want to do something about it?

PT: No, I definitely do, yes.

Return to the Phase of Pressure

Now the process moves to the anxiety in the transference and pressure toward the feeling in the transference. Throughout the process, he avoids the eyes of the therapist and looks at a different direction, and the therapist brings this to the focus.

TH: Well, let's to see how you feel.

PT: Well, I feel uh ...

TH: You avoid my eyes, particularly when you want to say how you feel. Do you notice you are constantly avoiding me?

Pressure and Challenge

Head-On Collision with the Resistance Against Emotional Closeness

Every person who has been traumatized, particularly in the very early phase of their life, almost all patients on the right side of the spectrum, have major problems with intimacy and closeness. Focusing on and working through of this resistance, technically, is always in the transference. As the process goes on, this resistance becomes crystallized in the transference, and the therapist has a unique opportunity, first to make the patient acquainted with the nature of the resistance, then to apply the technique of pressure and challenge or head-on collision with this resistance. Having said that, I want to point out that there are patients for whom this resistance, in a powerful way, manifests itself in the forefront of the major resistance, and pressure, challenge and head-on collision can be applied in the very early part of the interview. In this patient, the resistance against emotional closeness manifested itself from the beginning of the interview, but the therapist waited that it becomes further intensified in the transference. In the following passage, he brings this into focus:

TH: Do you notice, you avoid my eyes and you are constantly avoiding. Another issue with you and me has to do with this problem which is a major problem for you - the problem of intimacy and closeness hmm that you want to constantly put a barrier between you and me. The barrier we see; you cannot look to my eyes and directly tell me how you feel. There is a need in you to put a wall between yourself and me, there is a need in you to put a barrier between yourself and me, there is a need in you not to let me to get to your intimate thoughts, intimate feelings, there is a need in you to keep me on the other side of the wall and not wanting me to get to your intimate thoughts and feelings. So, then to begin with, this barrier, this wall is another destructive force, because up to the time there is a need in you to distance yourself and put a wall between yourself and me, then the process is doomed to defeat, is doomed to fail.

PT: Hm, hmm. (sighing)

TH: Then, to begin with, we have an impasse between you and me. The impasse is the wall, is the barrier. And this impasse is going to cripple this process as well and the question is this: what are you going to do about this one also ?

PT: Well, I, I wanna make a conscious effort to, to, to, to not have this.

TH: Then let's to see what are you going to do. You keep avoiding my eyes.

In the above passage, the therapist applied the technique of head-on collision with this resistance. His major technical interventions consisted of: pointing out to the patient the nature of the resistance; emphasizing its effect on the patient's life; challenging the destructive aspect of the resistance, self-defeat and self-sabotage; and then the therapist introduced pressure and challenge "Let's to see what are you going to do?"

Pressure, challenge and head-on collision to the resistance against emotional closeness mobilizes anxiety and further intensification of the transference component of the resistance. Metapsychologically, it mobilizes and activates the centre of the core neurotic organization which is well defended by the major resistance, namely, attachment, bonding, traumatization of the bond, the pain of the trauma, murderous rage and guilt- and grief-laden unconscious feelings. Now the therapist moves to the anxiety and exerts pressure towards the transference feelings. We return to the interview.

Further Pressure

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

PT: I feel uncomfortable and anxious.

TH: What else do you feel besides anxiety?

PT: Just that, I don't know, whether I am not really in touch with my feelings uh ...

TH: Do you notice the way you hold your hands, you hold them on your crutch like this?

PT: Yes ... I feel defensive.

The hands are clenched, and the movement of the two thumbs against each other indicates anxiety in the form of tension in the striated muscles of the hands, the supinators and pronators of the forearms, and his sighing respiration also indicates anxiety in the form of tension in the intercostal and subdiaphragmatic muscles. All of the signalling systems indicate ongoing mobilization and intensification of the transference feelings, and the direct experience of the transference feelings is the goal towards which the therapist is working. It is this that finally would lead to the direct access to the central and pathogenic organization of the unconscious.

Further Pressure toward the Feelings

PT: I don 't feel anything else, maybe anger, I, I'm not sure uhh.

TH: Again, do you notice, you avoid me when you want to say anger and you don't want to be direct 'Maybe'? The issue is are you angry or aren't you angry? ... Again you look away from me as soon as it becomes the issue of anger.

PT: Cause for me it's difficult to, to ...

TH: Now, you want to move and take the position 'It is difficult.'

PT: Yes .... I see.

TH: ... and obviously you are both anxious and angry, and both of them they are interconnected. The anxiety part you experience, but the anger part is only a thought.

The focus of the session is on anxiety and anger in the transference, and the therapist on two occasions emphasizes "You shouldn't agree with what I say, but you are here to examine it, unless you don't want to," to which the patient responds affirmatively. (Deactivation of the transference as well as of defiance and stubbornness).

Pressure towards the Actual Experience of Anger in the Transference

TH: How do you experience this anger towards me, physically? This is important, when you 're tense, your muscles become tense; which indicates to you you are anxious, okay - and it is very important for you to examine this, not to agree.

PT: Hm, hmm.

TH: When you are angry, how do you physically experience the anger, actual physical experience of the anger?

.....

The focus of the process is on the actual experience of anger in the transference. All character neurotics have an inability to differentiate between anxiety and anger, and this is in the service of the resistance. The task of the process is that the patient can actually physically get in touch with the experience of anger. By virtue of the fact that anger itself is a tactical defense against violent rage, murderous rage, or primitive murderous rage, alarms the major resistance and its tactical organization. The major therapeutic task is the ongoing crystallization of the tactical defenses and aiming at the breakdown of the major resistance.

Pressure and Challenge to the Major Resistance

TH: How do you physically experience this anger?
PT: Other than the nervousness, anxiety, nervousness.
TH: But under the anxiety is the anger.
PT: Well.
TH: But how do you physically experience it?
PT: Uhhh, well I feel defensive uhh...
TH: Yeah, but that is a mechanism of dealing with anger. Anger gives rise to the anxiety, you become tense and then all the other hmm?
PT: Hmm.
TH: But that is a mechanism, but what is the way you actually and physically experience the anger? Now, you look puzzled.
PT: Yes, because I, I ... Other than what I feel I don't feel any ...
.....
PT: How do I feel? I feel uh helpless.
TH: That very well we know that you take a paralysed position.
.....
TH: You want to move away from how actually and physically you experience your anger and use a set of defenses, a set of mechanisms, detachment, being withdrawn. Right now you have become very slow and actually you are taking a board-like position.
.....

During this phase, there is mobilization of a wide range of tactical defenses; some of them are of a tactical nature, some of them are tactical defenses well-entrenched into the major resistance; and the task of the therapist is to apply challenge and pressure and render them ineffective. Throughout this phase, the therapist must be very specific and should keep in mind that the patient has clearly identified with these defenses for many years of his life. They are syntonic characterological defenses.

PT: But I don't understand where I, I'm ...
TH: You move towards this 'I don't understand.' Now the question is this, do you want to do something about it or do you want to keep it the rest of your life?

Throughout the early part of the interview, the patient's voice was low. Now, for the first time, there is a rise in the voice. We return to the interview.

PT: No. I definitely wanna do something about it. But ...
TH: But you are not doing anything about it.
PT: All I am doing is suppressing ...
TH: Suppressing what?
PT: My anger ... I don't know how to experience it.
.....

TH: You say you suppress it, there must be something you suppress. So how do you experience that something that you suppress? As if this is totally alien. You are puzzled as if you don't know what anger is.

PT: Oh yes I know what anger is.

What emerges is that with his wife and his children, he alternates between regressive, explosive discharge of the affect - thrashing, screaming, yelling, major temper tantrum or total withdrawal, detachment, not talking with them for days. The therapist makes systematic clarification, and makes the patient well acquainted with the regressive defense of explosive discharge and its defensive function, as well as with the defense mechanisms of withdrawal and detachment.

During this process, there is further increase in the level of anxiety with frequent deep sighs, which are reflected upon, further intensification of the patient's characterological defenses and increase in the patient's level of the resistance.

TH: Again you want to move toward this position 'I don't know,' explanation. This is the make-up of your character. They are the golden fabric of your character, and definitely you want to treat them as a golden fabric, you don't want to give it up. Either you move to because, explanation, rumination, intellectualized rumination or you move to sarcasm, stubbornness, procrastination or defiance.

.....

Further Challenge and Pressure

What we have is the intensification of the resistance in the transference, the high level of anxiety in the form of tension in the striated muscles, and intensification of the transference component of the resistance. This indicates that the breakthrough is going to be imminent. The major task of the therapist in this process is a very short form of a head-on collision with the aim to deactivate the transference, which in turn deactivates the defiance; reemphasizing the therapeutic task; pressure to the unconscious therapeutic alliance. Major interlocking chain of head-on collision is not indicated as it might trigger off grief-laden unconscious feeling which means bypassing the unconscious murderous rage and guilt. The actual experience of the murderous rage and guilt is the key and central task which cannot be compromised. The therapist's task is the activation of the somatic pathway of the murderous rage or primitive murderous rage. At this time of the process, the major goal of the therapist is major mobilization and intensification of the transference feelings which finally creates a major and extended unlocking of the unconscious.

Now what follows is the declaration of being terrified of his rage "Might erupt like a volcano," and the therapist points out "You are terrified that it might erupt toward me." He responds "Towards anybody." The therapist, once more, focuses on the somatic pathway of his rage. He points to his lower abdomen and says "It is like a fireball, it's like heat moving." There is further pressure for the actual experience of the somatic pathway and he points to his chest that the fireball is now in the mid-part of the chest. He takes a deep sigh. He wants to diversify and elaborate on an incident when he was fuming with rage. The diversification is immediately blocked, and challenge and pressure to further experience the somatic pathway continue.

Further Challenge

TH: You love the crutch, you love to use the crutch, and if your life goes like this you will be on the crutch unless you do something about it. This crutch has many components: your voice is low, your hand is in a paralytic position, there is a major buildup of rage inside you but then you are more and more tense because you are terrified that it erupts on me.

PT: I am terrified (deep sigh).

TH: You are terrified to let it go.

PT: (Deep sigh)

TH: And you took a sigh, you are terrified to let it go. You prefer to be civilized rather than honest with your feelings.

PT: I'm, I'm confused. (Tactical defense)

TH: Let's not to get to confusion. Let's to see how you experience this rage toward me.

The process indicates a high mobilization of the transference feelings. The somatic pathway has been activated and is located in the upper chest. The frequent sighs indicate that the buildup of the transference feelings is close to breakthrough.

TH: You know the story of Dr. Jekyll and Mr. Hyde.

PT: Hm hmm.

TH: It was the transformation of an intellectualized man to a homicidal man.

There is a sudden change in his voice which indicates the absence of tension in the vocal cords, and, with a strong tone, he declares that he is not going to his grave in a crippled fashion: "I don't want to live on the crutch anymore." (While he has his two hands in a fist-like position). The therapist again goes to the Dr. Jekyll and Mr. Hyde.

TH: Now, if that takes place, if you put all these destructive defenses aside, and if you put all these paralysing defenses aside and get in touch with the rage that is within you, how would you be like?

Passage of the Primitive Murderous Rage in the Transference

In the following passage, we see a major change which is extremely important. There is no tension in the vocal cords, and total absence of anxiety. The facial expression is one of vicious rage, there is a passage of a primitive murderous rage in the transference.

TH: Let's to see, if you go berserk here what it would be like. If you go berserk what would it be like?

PT: I would start hitting, punching and ... screaming.

TH: How would you go on me? With what power?

PT: Well, I would punch very hard, uh.

He is moving his two hands which here now become fists. Again, it should be emphasized that there is a total absence of anxiety. He is sitting in his chair and, in a vicious way, is demonstrating how hard he would punch and attack the therapist. We return to the interview.

TH: How hard?

PT: As hard as I could. (By moving his fists he shows how hard). My fist would go through ... I would hit so hard (indicating the face and the chest), on your head, your chest or ... and then right and left.

TH: And if you go further berserk, how would you attack me?

PT: I would kick and punch. (Patient is sitting in his chair and shows with his leg how he would kick and with his fists how he would punch). Kick with my feet, my left foot, my right foot.

TH: How hard you would kick?

PT: I would kick with all my might, uhh ... I would kick very hard.

TH: If you go further berserk?

PT: I would kick, and kick with other foot.

TH: Where?

PT: Anywhere, chest, abdomen. I keep kicking, ah.

TH: And how would you go further?

PT: I'm trying to see, I'm trying to picture. I'd probably keep kicking you here within the chest and the abdomen.

TH: In the chest and abdomen, and then I am where? In my chair or on the floor?

PT: You are lying on the ground, uh.

TH: And then where else you would attack now? If you let this vicious animal in yourself loose.

PT: I, I would punch you on the face (Holding his hand in a fist-like position), uh ... after I stop kicking you I would hit you in the face.

TH: Kick face?

PT: Keep punching you in the face.

TH: Hm hmm, and then where else would you damage further?

PT: I can't see anything else, other than ... if there was a piece of block or something, I would pick it up and smash it.

TH: Piece of block?

PT: A block of cement or something and ... I would smash it on you until there was nothing left.

TH: Until I am squashed?

PT: Squashed and there is nothing.

The above passage demonstrates the passage of the murderous rage which, as we see, is primitive. The following should be emphasized: total absence of anxiety; absence of any resistance, any form of a defense; throughout, the patient is in his chair, actually experiencing his murderous rage; and unconscious therapeutic alliance has taken a major-dominant position in relation to resistance. At this point, the therapist should very carefully monitor for the unconscious signaling system, which comes from the unconscious therapeutic alliance, that the passage has come to

an end. The most important is the emergence of sadness, and, at this point of the interview, the patient is sad. Now we return to the interview where we had left.

TH: And then? Still there is rage there?
PT: Sadness.
There is a definite emergence of sadness which indicates that both guilt- and grief-laden unconscious feelings have been mobilized but remain within the unconscious. The following passage shows some of the technical and metapsychological considerations which are essential in conducting this technique. We return to the interview where we had left.

TH: Hm hmm, and how do I look? If you carefully examine my body, where do I look? My eyes are looking at you, or the ceiling or where? The rage is gone, now you look at my mutilated body which is squashed, where my eyes are looking? (Patient is very quiet and sad, looking to the floor, where the mutilated body is located).
PT: I have difficulty seeing the face and the eyes.
TH: What colour are the eyes, my eyes? What colour?
PT: I don't know. I have trouble seeing them. (His voice is low, talks very quietly, totally absorbed in this process, there is no anxiety and no traces of resistance).
TH: What colour is it?
(Pause)
PT: Green, green eyes.
TH: Green eyes and the hair?
PT: (Pause, silence)
TH: And the hair?
PT: Brownish, light brown.
TH: Light brown and the eyes are green, hmm? The eyes are green? You say the eyes are green. What is the colour of my eyes in actuality? (For a split second he looks up to see the colour of the eyes of the therapist).
PT: Dark, very dark.
TH: But that one is green.
PT: Yes.
TH: Hm hmm. Then who are you seeing there? Green eyes, brown hair?
PT: Trouble seeing.
(There is a silence. He is very quiet, sad, looking to the image of the murdered body with green eyes and brown hair).

Technically and metapsychologically, it is extremely important to take the following into consideration:

- There is absolute silence and no activity on the part of the resistance.
- There is a major mobilization of the unconscious therapeutic alliance.

- The murdered mutilated body of the therapist has been transferred to a person who has green eyes and brown hair.
- The person with the green eyes and the brown hair has not as yet been identified. The therapist must wait for a short moment until the green eyes become identified, then the patient is in a direct relation with his biological figure. Then, in a split second, there would be a heavy passage of the guilt-laden unconscious feeling.

We return to the interview where we had left.

PT: Well. I se .... I se ... I see my brother.

TH: Hm, hmm. It's a portrait of your brother with the light brown hair and the green eyes. So he's dead and murdered in a vicious way, hmm? And what do you do? And you are loaded with a major wave of painful feeling and you have full capacity to experience it.

Major Passage of Waves of Guilt-Laden Unconscious Feeling

There is a heavy passage of guilt-laden feeling with major waves of painful feeling. The patient is crying and sobbing.

TH: You have a major wave of painful feeling.

(Patient continues sobbing)

TH: Do you touch him?

PT: Yes.

TH: Where?

PT: (sobbing) I hug him.

TH: You have tremendous painful feeling.

(Patient sobbing heavily)

PT: I'm gonna miss you.

(Choke-laden voice, heavy sobbing which involves pharyngeal, laryngeal and upper thorax and it comes in waves. When it comes, it has high amplitude and his voice becomes choked).

The therapist's interventions are very minimal, only certain brief communication both to intensify the passage of the guilt and also to indicate that he is present, as the patient is heavily absorbed in this extremely painful intrapsychic process. There are further waves of passage of unconscious guilt. Now we take up the interview.

TH: What does he tell you before he dies eternally?

(Again there is another major wave of sobbing with heavy breaths which lasts for a few minutes).

TH: Does he say anything to you?

PT: No, I don't see anything, I don't hear anything right now.

(Patient continues deep sobbing. With a very choked voice not clear - he is talking to his brother).

PT: Why were you so mean? (Choked voice). Why were you so mean to me? (Heavy crying).

(Patient deep breathing and sniffing)

(Patient continues crying heavily)
(Sob-laden voice).

With a sob-laden voice, he continues, and the process enters into passage of the grief-laden unconscious feeling. It is important to note that both guilt and grief must actually be experienced. Guilt is far more painful, comes in waves with high amplitude and involves the whole upper respiratory area. Grief is far less painful and does not involve the upper part of the chest. It comes in waves, but the amplitude of its waves is far less than guilt.

The patient is in direct relation with his brother, and says:
PT: I feel like I am in nowhere. I feel (sniffling) ... so alone.
TH: With his death and murder.
PT: Feel like I'm all by myself. (choked voice, sobbing)

A Major Communication from Unconscious Therapeutic Alliance

There was rivalry with the brother. He became the black sheep and the brother became "Golden Boy." But, now that the brother is murdered, he is left alone with nobody. The communication from the unconscious therapeutic alliance is that unconsciously he is the murderer of both parents. Now we return to the interview.

TH: You mean after he is murdered, then you are alone by yourself.
PT: (Further sobbing)
TH: Then what do you do with his dead body?
PT: (Sobbing) I hold him.
TH: How do you hold the dead body?
PT: (High choked voice) I hold him tightly ... the chest and then the head on my chest and shoulder ... I see myself lying on the ground holding him (Sobbing)... tight.
TH: Do you say something to him before ... as your eternal goodbye to him, his dead body?
PT: (Sobs, very choked voice) I love you, I love you Peter.
TH: Hm hmm. So you hold him tight and you say to him as your eternal goodbye I love you Peter.
PT: (Cries heavily) I feel like my brother's not part of my life anymore. (Sob-laden voice)
TH: You said that you would lay down and hold him.
PT: In my vision I see him... I see him lying in a casket, doesn't look good, his face is white (Sobbing). He's dressed up in a blue suit. (Further sobbing) (Then he sees his brother being buried next to this grandmother, who was fond of him) (Continues sobbing)
TH: And what would be your eternal goodbye when the casket is being lowered? What would be your last goodbye to Peter?
(Patient cries heavily)
PT: I love you Peter. (Crying heavily)

TH: And what else would you say to him as your eternal, final...
PT: I will miss you. (Crying heavily, but more softly)

The above passage can be summarized as follows:

1) We saw the direct breakthrough into the unconscious and the passage of the primitive murderous rage in the transference
2) The emergence of sadness as an indicator that the guilt- and grief-laden unconscious feelings have been mobilized
3) A total absence of anxiety and no activity on the part of the resistance
4) Major mobilization of the unconscious therapeutic alliance; a major dominance of the unconscious therapeutic alliance over the forces of the resistance which is major unlocking of the unconscious
5) The visual imagery of the murdered body of the therapist being transferred to the visual imagery of the murdered body of the brother, and now the patient is in direct relation with his brother and his primitive murderous rage toward him
6) As we saw, instantly when the transfer took place, there was a heavy passage, actual experience of the guilt feeling which then follows with the passage of grief, his love for his brother at one level and his primitive murderous rage at another level
7) This was then followed by mourning the death of his brother, and he said "I feel like I am in nowhere," "Feel like I'm all by myself," which is a communication from unconscious therapeutic alliance that he has unconscious murderous rage toward his father as well as toward his mother.

Now, we return to the interview. The therapist waits for a moment to see that all of the waves of painful feeling have been consciously experienced. Then he moves to the phase of recapitulation and analysis of the transference and of the process.

Analysis of the Transference and the Phase of Consolidation

Recapitulation and analysis of the transference is an important part of the process and, at the end of each session, the therapist recapitulates the process, and it is extremely important in patients who suffer from major symptom disturbances. For example, in this man, in addition to characterological problems, he suffers from severe panic attacks, crushing chest pains, double arthralgia of the knees. Our systematic research in this area shows that if analysis of the transference and the phase of consolidation is done systematically, it would remove the symptom disturbances within one to three, maximum five, psychotherapy sessions. In this particular case, the phase of consolidation is rather extensive. For the sake of brevity, I will only highlight aspects of this process.

TH: You see, when we met you had anxiety and it is very important to recapitulate and examine what took place between you and me. When you came you had anxiety.

PT: Yes.

TH: And then the focus was on your anxiety, and shortly after that you had anger towards me.

PT: Hmm.

TH: Then you were using a set of mechanisms to defend against the very deeply buried feelings. One mechanism to deal with this rage and anger was anxiety which was in the form of tension in the muscles of your hands, arms, chest, do you see what I mean ?

PT: Yes.

TH: Another mechanism was becoming detached, remote and building up a barrier between yourself and me.

PT: Hmm.

TH: There was anger and rage, anxiety was one of the mechanisms, but you used another set of defenses such as detachment, withdrawal, distancing, intellectualizing, intellectualized rumination, going for the cause. There was a range of other defenses such as procrastination, stubbornness, defiance, which obviously are in relation to others, but they came into operation in relation to me ... What we saw was under the anger there was primitive murderous rage, but it's important that we keep in mind that under the anger, under the anxiety and anger there was a primitive murderous rage.

PT: Hm hmm.

TH: You see, at the very deep unconscious level is the murderous rage, the primitive murderous rage.

PT: Yes, I can see that.

TH: Then as soon as the focus is on anger, this gives rise to the signal of anxiety, because underneath the anger is violent rage and under that there is a primitive rage, which has been buried in you for years of your life.

PT: Hm hmm.

TH: Then as you saw there was a passage of this primitive murderous rage, the block of cement, the major attack on the head, the major attack on the chest and you well remember that I became transferred to your brother who is the person you really have the rage for.

In this analysis of the process, the therapist emphasizes heavily the experience of the guilt and reemphasizes the unconscious murderous feeling toward his brother and the intense guilt and his need for punishment and suffering. Then the patient said that he had a disturbed relation with his brother and there have been many occasions he experienced a fuming rage inside, but he keeps it in and takes a totally mute, detached position. He describes an incident that he had gone to help his father to put up a window, he had done half of the work when his brother came to visit, found major fault in the patient's work and took over the job. The patient experienced a fuming rage "I became almost paralysed." What further emerges is that the brother was the golden boy of the family, he was the star in the eyes of the father and the mother, and there were other incidences where the patient was physically beaten by his brother who was much stronger.

Then he breaks into another wave of grief-laden feeling, the wish that he would have had a brother-to-brother relationship.

TH: So at one level there is love for him, there is love, that you wished that you had a brother-to-brother relationship which is gone with the wind, you see? So there is a love but at another level, which is very important that you get in touch with the full range of it and which you saw, is a primitive murderous rage which had been reactivated due to the fact, as you said, he was the golden boy both in the eyes of your mother as well as your father, and you were the black sheep of the system.

PT: Yes. I see that clearly.

TH: So, then it goes to the early phase of your life, this primitive murderous rage toward your brother which is sitting within your unconscious and is locked there. But also is important to see that you have a lot of other feelings. We saw the tremendous guilt, grief, love and so on and so on.

PT: Yes.

Projective Identification and Symptom Formation

Another major function of the phase of consolidation is analysis of the mechanism of projective identification and symptom formation which again is extremely important in patients with character and symptom disturbances. Again, space does not allow the part of the interview which focuses on this. The therapist must clearly recapitulate the manner in which he murdered his brother. In this particular case, the way the primitive murderous rage was acted out is a block of cement crushing the chest of his brother and his own crushing chest pain; in the early part of the passage, he attacked the body, the chest and the abdomen, stomping with his legs and feet, both left and right, with destruction of the body; and the fact that for years he has been suffering from chronic double arthralgia of the knees which, at times becomes severe, and prevents him from going bicycling with his children. He ends up sitting on the steps of his home watching his children and his wife going bicycling and participating in other sporting activities.

Return to the Phase of Inquiry

Now the therapist moves to a systematic approach to the phase of inquiry and dynamic inquiry, exploring the patient's areas of disturbances, medical and social history, as well as the current family dynamics.

Exploring his recurrent episodes of chest pain - which at times are intense and he has to see his family physician. The worst one was the crushing chest pain which, as mentioned earlier, was so bad and resulted in his admission to the coronary care unit.

Exploring his chronic double arthralgia of the knee - indicates that he has had it for many years, at times mildly, but there are times that it becomes severe. He has been treated by an

internist. When pain is severe, he receives physiotherapy which helps him to some extent.

Exploring episodes of panic - which at times are very intense. He is chronically an anxious person, with episodes of panic, always associated with blurring of vision.

In addition, he has episodes of intense headache, with pressure on the top of his head.

Exploring episodes of depression - he has had a number of clinical depressions, each of them being treated by his family physician with medication.

Exploring his relation with his wife - it is problematic, alternates from episodes of regressive behaviour - explosive discharge of affect, screaming, yelling - to withdrawal, detachment, and not talking to her for days.

Exploring his relationship with his three sons - with them, he is punitive, putting them down and always critical. His children are defiant, stubborn, perform poorly in school, which resulted in the family seeing a school counsellor to help the children not to fail in their exams. The counsellor recommended treatment which the patient did not follow up on.

Exploring his work - he works hard, always afraid that he might get fired. There is a definite pattern of self-defeat and self-sabotage and, as a result, he has never received a promotion.

As already mentioned, he has diffuse characterological problems and major problem with intimacy and closeness.

Closing Part One of the Interview

At this point, the therapist recapitulates and points out the therapuetic task by indicating: "We have only touched the top of the iceberg," and invites the patient's willingness to continue the session. The patient's response is positive. Then he was seen for the second part of the interview.

SECOND PART OF THE TRIAL THERAPY

Anxiety in the Transference: Phase of Pressure

He came into the second part of the interview with anxiety in the transference and the process immediately moved to the phase of pressure.

TH: How do you feel right now? What do you account for your anxiety?
PT: (Clears throat) Well ...
TH: You took a deep sigh.
PT: Yeah, cause I was thinking when I was young ...

He resorts to the defense mechanism of diversification, which is blocked, and the therapist moves to pressure to the underlying feeling. He says he is afraid of failure and has anxiety about

his performance. The process immediately moves to pressure and challenge; further mobilization and intensification of the transference feelings.

Phase of Pressure and Challenge

There is mobilization of the major resistance and the therapist systematically applies challenge and pressure with repeated short-range head-on collision with the resistance and deactivation of the transference. This results in major intensification of the transference component of the resistance. Finally, he declares anger and rage in the transference. Systematic pressure for the actual experience of the rage finally leads to the breakthrough of the murderous rage in the transference.

As the phase of pressure, challenge and head-on collision is very much similar to the first part of the interview, this is omitted for the sake of brevity, and we take up the interview where the therapist exerts pressure for the actual experience of rage in the transference.

TH: How would the violence on me be like, and you are looking somewhere else?
PT: Because I am trying to see.
TH: If you protrait yourself as a violent person here with me, how it would be? How would the attack be like ?

All of the indicators point out that the neurobiological and somatic pathway of the murderous rage is well activated and he is actually experiencing his murderous rage in the transference.

Passage of the Primitive Murderous Rage in the Transference

TH: How would that be like?
PT: Well, I would punch. (He is sitting in his chair, his hands are upward in a punching position, there is no anxiety and with the movement of the hands he demonstrates how he would act on the murderous rage toward the therapist).
TH: Punch where?
PT: In the chest, in the stomach and then the face; both sides of the face, and I would just keep punching and punching and punching.
TH: And which side of my face would be the target more? Left, right or what?
PT: I don't think I would make a difference, it would be, be the same.
TH: But how would you. I mean ...
PT: One side and then the other side ... any part of the head really uh ... hitting in the face.
TH: And then if you let this vicious rage out further, in terms of this thought, where else would you attack besides the face?
PT: Ah. Oh. I'd probably kick uh ... kick with my feet, kick with my feet ... kick your abdomen and in, in the chest.

TH: If you let this vicious rage out, how would you ... how the attack on the abdomen would be?
PT: I could just see myself standing beside and then with one leg ... (thumping sound)
TH: Beside me or beside who?
PT: Besides you, standing and pushing and banging and ... (thumping sound)
TH: Right or left?
PT: Banging with my right leg ... in the abdomen.
TH: Abdomen, upper or lower?
PT: (Pointing to lower abdomen) ... Well I would kick hard enough to, to, to crush, to put my foot almost to the ground.
TH: So in a sense it would pass my abdomen.
PT: Would go right through, if it, if it was capable, it would go right through you.
(Thumping sound)

It is extremely important to note that in the whole process he is actually experiencing his vicious rage, and again the somatic and neurobiological pathway of the murderous rage is well activated. Further, we see again the mechanism of projective identification and symptom formation, namely, murdering with his legs and his double arthralgia.

Now we return to the interview where we were left.
PT: Visually I see it crushed.
TH: And if you let this rage unleash further?
PT: Kick every part of your body (thumping sound). In the, in the arms and in the legs and in the head.
TH: And if you further unleash this rage on me?
PT: I would just keep kicking and kicking ... every part that was in front of me, I ... whether it be the head or the abdomen or the chest or the leg or the arm. Just keep kicking.
TH: And if you had lost total control over your rage, what else would you do?
PT: I just see me kicking you, kicking. You would be lying in front of me... (Forcefully stomping his leg) crushed, then I am kicking inside the genital and my foot would enter your body and your genital would be totally destroyed and I have made a hole in your body.

He is enraged, and with his foot he shows how he would penetrate the cavity that he has created in the genital area of the therapist. It is important to note that on the research scale, both the degree of primitiveness of the murderous rage, as well as the intensity of his violent rage, are much higher than in the first part of the interview.
Now we return to the interview where we had left.
TH: And then if you go further?
PT: I just can see myself banging on the chest, banging and banging on your chest. Then I would grab my fist and smash it on your face, on your nose like this.

TH: Hm hmm.
PT: And then punch from the side and finally terminate your life passing a stick through the chest.
Again, we see the mechanism of projective identification and symptom formation, namely, his crushing chest pain and the symptoms related to his head.

Return to the interview.
TH: So I'm murdered and then my eyes are looking at you or where? Do you see my eyes? When you look to my dead body, my abdomen is totally demolished, mutilated, my genital is mutilated, there is a cavity there, your foot has gone into the cavity, my face is severely damaged ... It is very important you look and keep looking at my eyes.
PT: I see ... (Patient whispers) I have trouble seeing the face.

Emergence of Sadness

The emergence of sadness indicates the end of the passage of the murderous rage. The therapist is asking the patient to keep looking at the eyes of the murdered body of the therapist, waiting for the unconscious therapeutic alliance to identify who is being murdered. The therapist is waiting for a phenomenon of transfer. The emergence of the sadness also indicates that the guilt and the grief have been mobilized and are going to breakthrough as soon as the transfer takes place.

Now we return to the interview.
TH: If you carefully examine my face and my eyes.
(The patient is very sad. He is looking to the floor where the murder has taken place and there is a major wave of painful feeling which wants to surface).

Unconscious Murderous Feeling Toward the Mother

Passage of the Guilt-Laden Unconscious Feeling

TH: There is a major wave of painful feeling, why you don't want to get in touch with the full range ...
PT: (Heavy wave of sobbing) I see my mother's face. I see my mother's eyes. (Heavy passage of the second wave of guilt) (Whimpering sound, heavily sobbing)
TH: You have another major wave of painful feeling.
PT: (Heavy sobbing)
TH: What colour are her eyes?
PT: Brown.
TH: Brown eyes?
PT: Brown eyes.
TH: How about her hair?

PT: Brown, dark brown.
TH: At what age do you see her? Present age or younger age?
PT: No, younger age. Somewhere around forty. (Another wave of sobbing) I visually see her screaming at me.
TH: What way?
PT: I have been bad (choked voice, crying). What I visually am seeing right now is me being a little boy and I spilled ink on an encyclopedia ... on a new expensive set of books my parents bought.
TH: What age?
PT: Very young, I was so scared ... terrified that my mother would see that and... and my father would beat me. So I told my brother never to show them the book.
TH: You called your brother?
PT: He was there when it happened.
TH: But you were terrified?
PT: Ohh.
TH: ... that she finds out.
PT: Scared, (another major wave of sobbing, painful feeling)
TH: So you were terrified, hmm?
PT: I was so scared (High-pitched voice, continues with heavy sobbing) she was a forbidding figure. (Another wave of sobbing)
TH: Hmm.
PT: Every time it was parent and teacher's night at the school I used to hate it so much. (Patient is crying) My mother always went to school cause the teachers wanted to see her (further wave of sobbing). She would then have to go to see my brother's teachers. Ohh she'd be so mean when she came home. (Another wave of sobbing)
TH: And your mother's manner was what?
PT: Hitting me, physically ... may be not as much as my father (sobbing). She always ...(sobs)... why couldn't I be like my brother.

Some Early Memories of his Life with his Parents and his Brother

Aspects of Family Dynamics

What further emerges is that both parents constantly compared him with his brother, that he was the golden star and the patient was the black sheep. During the interview, he says he is hearing her voice "He is much smarter," "He never gets into any problem," "He did not break things," "I could never do anything right."

The focus is on the patient's grief-laden unconscious feeling and he talked of being humiliated. Then he said, "I usually see myself, my parents making me stand in the corner when we had

visitors." About his brother he says, "He was the favourite of both my mother and father." Then he says that he has another visual image that he was hiding under a bed, and his mother was swinging the broomstick at him underneath the bed. This is followed by another wave of heavy crying. He comes with memories of his mother having a vicious temper, and his way was always to hide under the bed "trying to get away from her."

The focus of the session is on the family dynamics in the early years of his life. Father was physically brutal, and he would frequently punish the patient with a stick or a strap. Mother also physically punished as well, with a broom, but at the same time would prepare the ground for the punishment by father. Then the punishment by the father would start. The target of the punishment would be the head or the legs.

Recapitulation and Analysis of the Transference

After the passage of the painful feelings, the waves of painful feelings, the therapist then moves to the phase of consolidation, analysis of the transference and recapitulation. As space does not allow the fall verbatim analysis of the transference and the phase of consolidation, I will present only the passage which follows where we had left the interview.

TH: How do you feel right now?

PT: Tired a bit.

TH: How is your anxiety?

PT: I don't have any anxiety.

TH: There is no anxiety?

PT: No, I feel relaxed.

TH: Uh huh. Now if we look and it is very important at this moment that we can recapitulate and examine this process as we saw. When we met you were anxious again.

PT: Yes.

TH: And you indicated that your anxiety had to do with me, had to do with the issue that you might fail in relation with me, and you talked about the performance.

PT: Hm hmmm.

TH: So that is one; the anxiety if you will be able to perform and so forth. And it is very striking when you look at it; it is similar to the anxiety that you had always with your mother, hmm, that if you will be able to perform or if she would be satisfied with your performance, hmm?

PT: Yes.

TH: And we can see that you have always had the fear of whether your mother would approve, be satisfied with your performance or she would become punitive, humiliating and punishing, hmm?

PT: Hm hmm

TH: But it's also important to take again another look when we met, then I told you that you have a major problem with intimacy and closeness. Now we are getting to understand why you have this major need to defend yourself against intimacy and closeness. And I pointed

out to you that you don't want me to get to your intimate thoughts; intimate life and intimate feelings, hmm, that you erect a wall between yourself and me, that you don't want me to get to your intimate life, to your intimate feelings. And now, at this point of the interview, we can have some understanding, we don't have time to go into the detail at this time, the explanation is after these experiences that you are talking about, that your mother was punitive, your father was physically brutal, you had to escape under the bed, attacked with the broom, strapped, being humiliated in front of the others. So, as if in a sense at one level you have decided that you would not let anybody get close to you, hmm, but something has to explain because ...

At this point of the phase of consolidation, the patient said that in the early years he was searching for bonding with his brother, which was not possible. He ended up to develop a close relation with his grandmother who was living in the same house. The therapist acknowledges and points out "That is important, we can explore it in due time, but at this point it is important that we focus on the process as we went through it." The therapist briefly outlines the therapeutic task and brings this part of the interview to closure.

PART THREE OF THE INTERVIEW

Anxiety in the Transference: Return to the Phase of Pressure

The patient entered to the interview with the return of the resistance in the transference, anxiety in the transference, and the therapist immediately focuses on the anxiety. It is important to note, and this is an empirical clinical research, that after the first breakthrough and mobilization of the unconscious, the subsequent interviews during the first and second phases of the treatment, the patient enters into every session with anxiety which always has a transference implication. We see this in the standard technique in which the patient is seen in weekly intervals. We also, with no exception, see it in the extended and repeated major unlocking of the unconscious. The therapist's task is to focus on the anxiety and the dynamic forces underlying the anxiety. Now we return to the beginning of this interview.

TH: I notice you are anxious.
PT: There is something about you ... may be the session that makes me anxious.
TH: You took a deep sigh ... and you are fidgeting.
PT: Being uncomfortable uh ...
TH: You said something about me but at the same time you said something about the session, which one?
PT: Obviously it is you.

In the above passage, the patient uses a tactical defense, wants to move away from the transference to the session. This tactical defense is challenged and called upon. The patient responded: "Obviously it is you." Now the process enters into the phase of pressure.

Phase of Pressure

TH: So let's to see how you feel toward me?

.....

The patient has entered to this interview with the return of the major resistance, and the therapist systematically applies the phase of pressure and challenge with the aim of mobilization and intensification of the resistance in the transference. There is further mobilization of the transference component of the resistance. Now, the phase of pressure and challenge alternates with repeated head-on collision to the resistance in the transference combined with deactivation of the transference. There is anger and rage in the transference with pressure for the actual experience of the anger and, finally, there is mobilization and activation of the somatic pathway of the primitive murderous rage and its breakthrough in the transference. It is important to note that the duration of this phase in the third part of the interview is quite a bit shorter than in the first two parts. As the technical and metapsychological aspects of this process is to a large extent similar to Part I, this part of the process is omitted, and we return to the interview where there is the passage of the murderous rage in the transference.

Passage of Primitive Murderous Rage in the Transference

Unconscious Murderous Feeling Toward the Father

TH: If you give up this paralysed position and let this rage out on me, what the attack on me would be like? If you let it loose? What it would be like? If the vicious animal is put out?

PT: Well, punch you in the chest.

TH: What force, the force of the punch?

PT: My fist would have infinite strength ... (It is important to note: absence of anxiety; facial expression of vicious anger; firmly sitting in the chair but in forward position; both hands are in the fist position and he is actually experiencing his rage). A heavy punch... with two hands punching the face, head, again punching the face and the head like this.

TH: And then?

PT: ... grab you by the shirt and smash you against the wall. (Patient is sitting in the chair, the two hands are in the forward grabbing position and he viciously says I will smash you against the wall)

His posture, tone of voice, and all of his nonverbal communications are indicative of a tremendous violent rage that he is experiencing, and he is totally absorbed in the process.

TH: What way?

PT: Push you against the wall ... probably break the wall ... if I hit you and crush you on the door, it'd go through the door.
TH: And then?
PT: Crush you again on the wall ... and then the other wall ... back and forth.
TH: And then?
PT: Throw you on the floor.
TH: And then?
PT: Start kicking you and stomp on you ... kicking you, keep kicking you. (Thumping sound - patient hitting the floor with his foot) Up and down, smashing with my foot. (Further stomping his foot)
TH: And then?
PT: On the chest... kicking you heavily in the chest and the legs.
TH: And if you unleash further?
PT: Further kicking on the chest ... step on your hands, (thumping noise) break your arms (thumping).
TH: And then?
PT: Break your feet.

In the above passage, we saw the breakthrough of a vicious murderous rage which is primitive. We still do not know who is the actual target of this primitive rage. The process clearly demonstrates, again, the mechanism of projective identification and symptom formation: his double arthralgia, crushing chest pain, and symptoms related to his head.

Major Unlocking of the Unconscious

Emergence of Sadness: which indicates the passage of the murderous rage has come to an end; guilt-and grief-laden unconscious feelings are mobilized and the major entry into the unconscious is taking place. Now we return to the interview.

TH: The rage is gone now?
PT: Hm hmm.
TH: And what is my position? My eyes look at you?
PT: (Sniffling and very sad)
TH: As you look at my eyes, what is the colour of my eyes?
PT: Green.
TH: And the colour of the hair?
PT: Light brown, light brown.
TH: Light brown, hm hmm. It's green eyes with light brown hair and these pair of eyes are looking at you or avoiding to look at you?

The patient is heavily absorbed, looking to the floor and to the identity of the person who has been murdered so primitively.

Passage of the Major Wave of Guilt-Laden Unconscious Feeling

PT: (Continues to be sad, then there is a sudden wave of a major guilt-laden feeling) My father. (He is sobbing, very choked voice)

TH: How old is he?

PT: He's forty ... I don't know exactly. (Patient continues looking to the floor, totally absorbed in this process)

TH: Your father is mutilated, the head is totally damaged, the chest is totally crushed, arms and legs are broken, when you approach his dead body, what communication you get from his eyes? ... There is a major wave of feeling in you and you want to experience it as fully as you can, the full impact of this major wave.

PT: (A second major wave of painful feeling is passing, heavy sobbing)

TH: Hmm.

PT: I hold him in my arms ... I bend down and then hold him in my arms (heavy sobbing, choked voice), hold him around his chest with both arms and put my head on his shoulder. (Another major wave)

TH: How his eyes look?

PT: (Pause) His eyes are just staring.

TH: Staring, does he say anything before he says goodbye to life? ... His eternal goodbye to life or he dies in silence?

PT: He is very dead.

TH: Does he say anything in his last struggle with life and death?

PT: He asks me to take care of my mother. (Heavy sobbing)

TH: How did he put it to you ?

PT: She's ... have her move in with you.

In a very painful state, he talks about his father telling him "Joseph ... Joseph ... take care of your mother ... hmmm?" In a very choked voice he says:

PT: I have mixed feelings ... (pause) I don't know whether to say I will or I won't. (Patient continues sobbing)

TH: What do you want to say?

PT: I wanna say yes (heavy crying), but I am not sure ... that I'll take care of my mother. (Crying)

TH: But it must be very painful because his request to you as he dies is to take care of your mother, you want to say yes, but a part of you has a lot of mixed feelings.

PT: Yeah (whispers).

TH: Hmm.

PT: (Choked voice) I think that it would not be good for my family (referring to his wife and three children).

TH: I know, in terms of your feelings, to say yes to your father about this would not be honest

because that is not the way you feel about it at this point in time. But at the same time you are afraid that she might have a negative impact on the family.

PT: Yes.

Emergence of Another Wave of Painful Feeling

TH: You said that you have his head and chest in your arms. How you say your final goodbye?

PT: (Continuous heavy sobbing) I tell him ... (sobs)... that I'm gonna miss you.

TH: How would you verbalize it to him before he ... closes his eyes forever.

PT: (Continues sobbing heavily) I love you dad (sob-laden voice) ... I love you Dad, I hold him and I hug him.

TH: Hmm.

PT: I hold ... (sobs) ... and I hug him and I talk to him.

TH: You talk to him? What would you say further?

PT: (Heaving breaths, sniffling, then heavy sobbing) He never wanted to play with me.

TH: Hm.

PT: He didn 't wanna play with me. (Pause, with intermittent sobbing and sniffling)

TH: So must be a lot of painful feeling about the wish that you could have played with him. Or he had spent time with you, hmm.

PT: We spent time together but we never really had quality, quality time together (continues crying).

Further Grief-Laden Unconscious Feeling

In an intensely sad and painful state, he continues and talks about not having had time alone with his father who was not physically affectionate.

PT: I don't remember much.

TH: Because it is very important, you said that before he ... I mean in his last struggle with life you will hold him and hug him.

PT: (Heavy sobbing)

TH: So as if in death only you could feel close to him and hold him and hug him, hmm?

PT: (Further sobbing)

TH: Not alive? You see what I mean? That in death you were holding him and hugging him, but not when he was alive.

PT: (Emotion-laden voice) I remember when I was a little boy I used to ... not often, but I used to hug my father, kiss him on both cheeks. Then, as I got older, I did not hug him anymore and now, when I kiss him hello or goodbye, I don't feel anything.

Then the focus is on the burial and the funeral.

TH: He is going to be buried in a mutilated way, hmm?

PT: Visually I see him dead but I don't see him mutilated in the coffin. I see him normal, skinny face, very thin face.

TH: How is he dressed up?
PT: Visually, what I see, bluish, bluish-gray jacket (patient is sobbing), I hold him ... I hold his hand, his hand. (Sniffling)
TH: With which hand you hold?
PT: I hold his right hand with my right hand.
TH: In this last moment, what would you say?
PT: I'd tell him I'm gonna miss him. (Choked voice, sniffling)
TH: Where is he going to be buried?
PT: (sobbing heavily) Beside my grandmother.

In the above passage, we see intensification and systematic passage of the painful feeling and, in particular, grief-laden, while in the early part of the breakthrough, the passage was heavily on guilt-laden feelings.
Then the process of the interview enters the phase of consolidation, analysis of the transference and of the process which, because of the shortage of space here, is totally omitted. After the completion of the phase of consolidation, he spontaneously talked about his grandmother from the father's side, and at this point the pathological mourning becomes converted to a process of acute mourning.
In all the forms of direct access to the unconscious - be it partial, major or extended major -all pathological mourning becomes converted to a process of acute mourning. In this case, we see the acute mourning phase.

Mourning the Death of the Grandmother

The grandmother lived with the family until she died. She was always sick. There was a division in the family: father, mother and brother in one camp, and the patient, who became the favourite of the grandmother. Mother and father were very hostile towards the grandmother, with constant exchange of hostility; and, in the interview, the patient, in an intensely sad state, said:
"Actually, they tortured her to death." The process of the session now moves to mourning the death of the grandmother.

Emergence of Painful Feelings and Memories of his Life with his Grandmother

As I have already mentioned, in all life-long character neurosis, when there is a pathological mourning, as a result of the mobilization of the unconscious, they become converted to an acute mourning process. Now we return to the interview. The patient avoided the funeral of the grandmother, and has never gone to visit her grave. At this point in the interview, there are intermittently heavy waves of painful feelings and sobbing.

PT: She taught me ... (heavy breaths, sobs) ... my first prayer ... I remember ... (voice breaks) ... I don't remember any more the prayer, just the first few words. (Very choked up) She taught me three prayers, two I remember.
TH: How old you were?
PT: Five or six ... we used to say our prayers together before going to bed. They are pleasant memories, but also sad (choked voice), sad that she was tortured and died in suffering.

He talks further about his grandmother, "She was battered by her (referring to his mother)," "My father was reinforcing the abusive behaviour of my mother." He further says that his grandmother had a tough time. In the earliest phase, she used to fight back. But as she became very sick, she could not fight back any more. "She died in a very traumatic way." The patient often wished that he could have defended his grandmother. "I always saw her as a crippled person, or a weak person, not able to do anything."
The focus is on his idea of his father and his mother being buried next to the grandmother.

PT: I don't know if they would wanna be buried together (heavily choked voice). They were always fighting. There was always exchange of hostility between my grandmother and my mother ... always.
TH: Hmm.
PT: (Sniffling) Always.
TH: Hmm. Where is your grandmother buried?
PT: I think, she's buried near our house.

In a painful choked and sniffling voice, he says that he has not visited her grave.

TH: Hm hmm. You mean that you want to visit and you don't?
PT: I find it too difficult, too painful ... too painful to visit her grave. (Sob-filled voice)
TH: Hmm.
PT: To visit my grandmother.
TH: Because it is going to mobilize a lot of feeling ... painful issues?
PT: Hmm. I'm so sad when I think about her. Brings memories ... very disturbing memories. (Patient crying heavily) Good memories (Sobbing) Hurts because it is only memories (crying as he says this) ... but also there are memories ... that she was tortured by my mother.
TH: Hmm.
PT: My mother was so mean to her and (sobbing), and my grandmother wouldn 't defend herself.
Then he talked about his grandmother as his refuge, and about how he had replaced his mother with his grandmother. He became attached to his grandmother, but the relationship was an ambivalent one, as the grandmother, who was his protector, herself was the subject of constant

attack and humiliation. The focus is on his ambivalent feelings for the grandmother, and he said: "She was helpless to defend herself," "We were both treated the same way." The focus of the session is now on the process of mourning: a piecemeal review about his life with his grandmother, the way she died and, finally, her death and the fact that he totally avoided being present (Lindemann 1979).

The whole passage of the process of mourning the death of the grandmother is omitted, as it is beyond the scope of this article. At this point, as his painful feelings subside, the process enters into a comprehensive phase of consolidation and analysis of the process of the three parts of this interview, broadcasting the important task ahead; and assessing the patient's willingness to get to an in-depth exploration and investigation of his unconscious. At the end of such an interview, the unconscious therapeutic alliance is very much mobilized; we see a weakening of the major resistance; the patient's willingness for the future work is extremely high, and the therapist sets up the psychotherapeutic contract.

RECAPITULATION

It is important to recapitulate the major technical interventions and the process of this three-part initial interview, presented in this article. The process can be summarized as follows:

1) The interview started with the phase of pressure (the phase of inquiry and dynamic inquiry became the focus of the session at the end of Part I of the interview). The therapist exerted pressure to the underlying feeling which led to a rise in the transference and further anxiety; the therapist maintained his focus on pressure, and the patient's resistance became well crystallized in the transference; this was followed by systematic challenge to the patient's character defenses, concomitantly making him acquainted with these defenses.
2) From the psychodiagnostic point of view, the therapist came to the conclusion that the patient suffers from character neurosis with no fragility whatsoever, and the discharge pattern of the unconscious anxiety is exclusively in the form of tension in the striated muscles; and decided that a rapid direct access to the unconscious is the procedure of choice.
3) The process continued with the systematic application of challenge and pressure and, as the resistance against emotional closeness became well crystallized in the transference, the therapist applied head-on collision with the resistance, and continued with challenge and pressure; there is mobilization of anger in the transference. Then the process moved to:
4) Systematic challenge and pressure to the major resistance; pressure for the actual experience of anger in the transference; activation and mobilization of the neurobiological and somatic pathway of the primitive murderous rage; there is weakening of the major resistance and major mobilization of the unconscious therapeutic alliance against the forces of the resistance. This was followed by:

5) Passage of the primitive murderous rage in the transference; crushing of the chest, the head, and the murdered body of the therapist is on the floor. This was followed by:
6) Visual imagery - the visual portrait of the murdered, mutilated body of the therapist now becomes transferred to the portrait and visual imagery of the murdered body of the brother, with the green eyes of the brother looking at him. The transfer was instantly followed by:
7) The passage of guilt-laden unconscious feeling which is very intense, and after three to four minutes, the passage of grief-laden unconscious feeling and extremely painful feelings for the wish he could have had a positive relationship with his brother, and the emergence of his love, "I'm gonna miss you," and then:
8) A major communication from unconscious therapeutic alliance, which indicated that he must unconsciously be a criminal in relation to his parents, which is computerized by the therapist for future reference.
9) It is extremely important to emphasize that there is absolutely no anxiety, no tension in the striated muscles and no activity on the part of the resistance - major or tactical - from the moment of passage of the primitive murderous rage to the end of the interview.
10) The therapist immediately moved to the phase of consolidation, analysis of the transference, emphasizing the mechanism of projective identification and symptom formation. Then:
11) The therapist returned to the phase of inquiry and dynamic inquiry, exploring the patient's episodes of depression which are being treated by his family physician; and his chronic arthralgia, with episodes of exacerbation necessitating physiotherapy and treatment by an internist. The therapist then explored other areas of disturbances, as well as the current family dynamics.
12) In Part II of this initial interview, he came with anxiety in the transference and a return of the major resistance, and the process immediately moved to the phase of pressure, pressure and challenge, and repeated short-range head-on collision. He declared anger and rage in the transference. This was followed by:
13) Pressure for the actual experience of the rage, and, finally, activation of the somatic and neurobiological pathway of the murderous rage, then:
14) Passage of the murderous rage in the transference, then:
15) Transfer of the portrait and visual imagery of the murdered body of the therapist to the visual imagery of the murdered body of the mother, the brown eyes of the mother looking at him. Instantly, as the transfer took place, there was:
16) Major passage of unconscious guilt-laden feelings in relation to the murdered body of the mother which was then followed by grief-laden feelings, which were then followed by some of his earliest memories of his life with his parents and his brother, and some aspects of the family dynamics came into focus. The therapist then moved to the phase of analysis of the transference and of the process, explored how he felt, and the patient declared himself somewhat tired, but with no anxiety, and relaxed. Now, we summarize the process of the third part of the interview.
17) He returned with anxiety in the transference and a return of the major resistance. The

process immediately moved to the phase of pressure, anxiety in the transference, and pressure from the underlying feeling; systematic challenge and pressure with head-on collision, head-on collision with the resistance against the emotional closeness; anger and rage in the transference; pressure for the actual experience of anger, and activation of the neurobiological pathway of the primitive murderous rage, and then:

18) Passage of primitive murderous rage in the transference, visual imagery of the murdered body of the therapist on the floor, which then became transferred to the visual imagery and portrait of the father mutilated, looking at him with his green eyes and light brown hair. Then, instantly, with the transfer, followed by:
19) Passage of the major waves of guilt-laden feeling and then grief-laden feeling, and this was followed by the phase of consolidation and analysis of the transference. Then he introduced;
20) The death of his grandmother and there was the conversion of the pathological mourning to acute grief and passages of highly intense painml feelings; memories of his early life with his grandmother who was heavily used and abused by his parents. Then:
21) The session moved to a major recapitulation, analysis of the process and, once more, analysis of the mechanism of projective identification and symptom formation; the interconnection between the psychopathological dynamic forces within his unconscious and his symptom and character disturbances, and then setting up the psychotherapeutic contract, which was with this particular patient on an hourly, once-a-week basis.

SUMMARY, CONCLUSION AND GENERAL OVERVIEW

In this article, I have presented the technique of Intensive Short-Term Dynamic Psychotherapy and briefly highlighted a new method of Psychoanalysis. What I have presented can be summarized as follows:

1) The technique has proven highly effective in the treatment of phobic, obsessional, panic, somatization, functional and depressive disorders; on the whole spectrum of psychoneurotic character neurosis and, with some modification, is effective in certain kinds of psychosomatic disorders. Again with some modification, it is highly effective in the treatment of patients with fragile character structure.
2) Then I presented briefly the spectrum of resistance with particular emphasis on patients with psychoneurotic disorders; and I summarized briefly five major groups of patients on the spectrum, and indicated that at the extreme left are highly responsive patients with circumscribed problem, single psychotherapeutic focus, and virtual absence of unconscious murderous rage of guilt; and further indicated that this group of patients is very rare. Then I presented the extreme right on the spectrum and briefly summarized that these patients present a very high degree of the resistance, major symptom and character disturbances, with a highly complex core pathology; and emphasized the presence of a highly primitive unconscious murderous rage/intense guilt and grief, multidimensional in relation to the early

figure(s); between the extreme left and the extreme right there are various degrees of resistance, and that the unconscious of all resistant patients contains highly primitive unconscious murderous rage/intense guilt and grief.

3) Then I briefly presented the spectrum of the technique of direct access to the unconscious; partial, major, extended major and extended multiple major; and pointed out that the partial and major unlocking of the unconscious are most often used in Intensive Short-Term Dynamic Psychotherapy, and extended major mobilization of the unconscious, with maximum mobilization of unconscious therapeutic alliance, is practiced in the new form of Psychoanalysis.
4) Then I very briefly outlined the dynamic sequence in the process of direct access to the unconscious and mobilization of unconscious therapeutic alliance over the resistance: the phases of inquiry; pressure; challenge; transference resistance; direct access to the unconscious; and systematic analysis of the transference, were briefly outlined; and I referred the reader to the four-part article by my German colleagues in this journal.
5) I emphasized a spectrum of mobilization of unconscious therapeutic alliance against the forces of the resistance. Mobilization of the unconscious therapeutic alliance is of central importance in both techniques, but the difference is one of degree. Optimization of the unconscious therapeutic alliance, which I call "Dreaming While Awake," is the central feature of the new method of Psychoanalysis.
6) I emphasized the rapid mobilization of the triple factors of resistance, transference and unconscious therapeutic alliance. Again, this applies to both IS-TDP and the new method of Psychoanalysis, but there are quantitative and qualitative differences in the degree and rapidity of the mobilization.
7) As much as space permits in an article, there was an in-depth analysis of an extended major unlocking of the unconscious of a patient from the mid-right of the spectrum, with three major breakthroughs into the unconscious, demonstrating the technique of extended major direct access to the unconscious, which is often used in the new method of Psychoanalysis, but may also be used in Intensive Short-Term Dynamic Psychotherapy.
8) Spectrum of the Resistance and Duration of Trial Therapy : The duration of a comprehensive initial interview/trial therapy varies from ninety minutes to three and one half hours, and in some patients it might even extend from four to five hours. For patients on the extreme left of the spectrum, the initial interview lasts fifty minutes. Here, we obviously cannot talk about unlocking, there is no major resistance and no murderous rage within the unconscious. But, on the mid-left on the spectrum, there is the presence of the murderous rage/intense guilt; and there is resistance of moderate degree; and the duration of the trial therapy averages ninety minutes. On the right side of the spectrum - high degree of the resistance and major resistance - the duration increases from two to three and one half hours. It may be conducted in a single interview, or in two parts within twenty-four hours, but should not exceed a one week interval.

9) Psychotherapeutic Contract: In the standard technique of Intensive Short-Term Dynamic Psychotherapy, the psychotherapeutic contract can be presented after direct access to the unconscious (partial or major unlocking) at the end of the comprehensive initial interview which, as mentioned before, can last anywhere from one and one half hours to three and one half hours, based on the degree of the resistance. After direct access and direct view of the psychopathological dynamic forces responsible for the patient's symptom and character disturbances, the therapist sets up the therapeutic contract which consists of one hour per week.
10) Spectrum of the Resistance and Duration of the Course of Treatment: In patients on the extreme left on the spectrum, therapy lasts from one to five psychotherapy sessions. On mid-left of the spectrum of the resistance, it lasts between ten to fifteen psychotherapy sessions, and, on the right side of the spectrum, between twenty-five and thirty-five sessions. The upper limit of the treatment is forty sessions.
11) A total avoidance of the development of any trace of transference neurosis is central in this technique, which starts from the first session and continues throughout the process. By virtue of the fact that management of the resistance is direct - no free association technique - and strict avoidance of the transference neurosis with rapid mobilization of the unconscious and rapid and maximum mobilization of the unconscious therapeutic alliance, the technique is radically different from Freudian, neo-Freudian, Jungian or any other form of psychoanalysis.
12) Outcome: In terms of outcome, this requires the total removal of symptom and character disturbances, and this must be achieved during the course of the therapy, and by termination there should be a total resolution of the core pathology: a total resolution of the psychopathological dynamic forces responsible for the patient's disturbances.
13) Psychotherapeutic Setting: Briefly, in every centre, institute, and department of Psychiatry of major teaching hospitals, as well as in the consultation room of private practitioners, the interview is conducted face-to-face with a microphone between the therapist and the patient. The interview room is equipped with audiovisual recording and the whole process - from the initial interview, course of treatment, outcome and follow-up - is audiovisually-recorded for scientific research and teaching, with the aim of the development of a scientific psychology of the unconscious mind, a scientific psychology to explain psychological phenomena in neuroscientific and neurobiological terms.
14) Teaching and Supervision: Closed-Circuit Live Interview: This is an integral and important aspect of teaching and research. It is central to the training program where the patient is interviewed by well-trained supervisors, while members of the training program are observing the interview; or the trainee is interviewing the patient, and the process of the interview is supervised by the supervisor in the presence of the members of the training program. There are a number of variations in the format of closed-circuit, which is beyond the scope of this article; and from the beginning of my research, I considered it a vital artery in teaching and research of the science of psychodynamics. Without it, scientific research would not be possible.

The process of supervision of the trainee, in addition to didactic presentation in terms of summary of the case and of the process, is done on the audiovisually-recorded interview. The process of ongoing video supervision is usually done in a small group setting, which consists of six to ten trainees. Obviously, such a powerful and effective technique as I am describing here requires systematic training on the technical and metapsychological roots of the technique in general, as well as on the more major revisions of the metapsychology of the unconscious: the new psychology of the unconscious mind.

The data in this area shows that, without question, the technique is absolutely transferable. To cite a few examples, on the European scene, there are the Swiss Associates, the German Society, the Dutch Association, and the Italian Institute for Intensive Short-Term Dynamic Psychotherapy - all with a sizeable faculty that has been trained directly by myself. Over the past number of years, they have set up their own training programs, providing training to other psychiatrists and psychotherapists in their own country in this technique. A similar trend exists in North America, and there are even major teaching medical centres that provide comprehensive training in this technique to the residency training program. The directors and supervisors were directly trained by myself and over the past number of years, they have been training others. This evolutionary trend, and the feedback from those in training in many centres, indicates that the technique is indeed transferable.

References

Davanloo, H. (1975) Proceedings of the First International Symposium and Workshop on Short-Term Dynamic Psychotherapy, Montreal, Canada. March.

Davanloo, H. (1976a) Proceedings of the Second International Symposium and Workshop on Short-Term Dynamic Psychotherapy, Montreal, Canada. March-April.

Davanloo, H. (1976b) Proceedings of the Audiovisual Symposium on Short-Term Dynamic Psychotherapy. Tenth World Congress of Psychotherapy, Paris, France. July.

Davanloo, H. (1977) Proceedings of the Third International Congress on Short-Term Dynamic Psychotherapy, Century Plaza, Los Angeles, California. November.

Davanloo, H. (1978) Basic principles and techniques in short-term dynamic psychotherapy. New York: Spectrum.

Davanloo, H. (1980a) Short-term dynamic psychotherapy. New York: Jason Aronson.

Davanloo, H. (1980b) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the 133rd Annual Meeting of the American Psychiatric Association, San Francisco, California. May.

Davanloo, H. (1981) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the 134th Annual Meeting of the American Psychiatric Association, New Orleans, Louisiana. May.

Davanloo, H. (1982) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy with Resistant Patients presented at the 135th Annual Meeting of the American Psychiatric Association, Toronto, Canada. May.

Davanloo, H. (1983) Proceedings of the First Summer Institute on Intensive Short-Term Dynamic Psychotherapy. Wintergreen, Virginia. July.

Davanloo, H. (1984a) Short-term dynamic psychotherapy. In Comprehensive textbook of psychiatry (4th ed.. Chap.29.11), H. Kaplan and B. Sadock, (Eds.). Baltimore, MD: William & Wilkins.

Davanloo, H. (1984b) Proceedings of the Second Summer Audiovisual Immersion Course on Intensive Short-Term Dynamic Psychotherapy. New York City, New York. July.

Davanloo, H. (1985) Proceedings of the First Audiovisual Symposium on Intensive Short-Term Dynamic Psychotherapy sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Pfafers, Switzerland. June.

Davanloo, H. (1986a) Intensive short-term dynamic psychotherapy with highly resistant patients. I. Handling resistance. International Journal of Short-Term Psychotherapy, 1(2), 107-133.

Davanloo, H. (1986b) Intensive short-term dynamic psychotherapy with highly resistant patients. II. The course of an interview after the initial breakthrough. International Journal of Short-Term Psychotherapy, 1(4), 239-255.

Davanloo, H. (1986c) Proceedings of the Second European Audiovisual Symposium and Workshop on Intensive Short-Term Dynamic Psychotherapy sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Bad Ragaz, Switzerland. June.

Davanloo, H. (1987a) Unconscious therapeutic alliance. In Frontiers of Dynamic Psychotherapy, P. Buirski (Ed.). New York: Mazel and Brunner, Chapter 5, 64-88.

Davanloo, H. (1987b) Intensive short-term dynamic psychotherapy with highly resistant depressed patients. Part I. Restructuring ego's regressive defenses. International Journal of Short-Term Psychotherapy, 2(2), 99-132.

Davanloo, H. (1987c) Intensive short-term dynamic psychotherapy with highly resistant depressed patients. Part II. Royal road to the dynamic unconscious. International Journal of Short-Term Psychotherapy, 2(3), 167-185.

Davanloo, H. (1987d) Clinical manifestations of superego pathology. International Journal of Short-Term Psychotherapy, 2(4), 225-254.

Davanloo, H. (1987e) Proceedings of the Fifth Annual Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Intensive Short-Term Dynamic Psychotherapy. Killington, Vermont. August.

Davanloo, H. (1988a) Clinical manifestations of superego pathology. Part II. The resistance of the superego and the liberation of the paralyzed ego. International Journal of Short-Term Psychotherapy, 3(1), 1-24.

Davanloo, H. (1988b) The technique of unlocking of the unconscious. Part I. International Journal of Short-Term Psychotherapy, 3(2), 99-121.

Davanloo, H. (1988c) The technique of unlocking of the unconscious. Part II. Partial unlocking of the unconscious. International Journal of Short-Term Psychotherapy, 3(2), 123-159.

Davanloo, H. (1989a) Central dynamic sequence in the unlocking of the unconscious and comprehensive trial therapy. Part I. Major unlocking. International Journal of Short-Term Psychotherapy, 4(1), 1-33.

Davanloo, H. (1989b) Central dynamic sequence in the major unlocking of the unconscious and comprehensive trial therapy. Part II. The course of trial therapy after the initial breakthrough. International Journal of Short-Term Psychotherapy, 4(1), 35-66.

Davanloo, H. (1989c) The technique of unlocking the unconscious in patients suffering from functional disorder. Part I. Restructuring ego's defenses. International Journal of Short-Term Psychotherapy, 4(2), 93-116.

Davanloo, H. (1989d) The technique of unlocking the unconscious in patients suffering from functional disorders. Part II. Direct view of the dynamic unconscious. International Journal of Short-Term Psychotherapy, 4(2), 117-148.

Davanloo, H. (1990) Unlocking the unconscious. Chichester, England. John Wiley & Sons.

Davanloo, H. (1992) Proceedings of the Eighth European Audiovisual Immersion Course on Technical and Metapsychological Roots of Intensive Short-Term Dynamic Psychotherapy sponsored by the Swiss Institute for Intensive Short-Term Dynamic Psychotherapy. Glion-sur-Montreux, Switzerland. October.

Davanloo, H. (1993) Proceedings of the Eleventh Annual Audiovisual Exploration of the Unconscious: Technical a. Metapsychol. Roots of Davanloo's Psychoanalytic Technique. Fragile Character Structure. Killington, Vermont. July.

Davanloo, H. (1994a) Proceedings of the Twelfth European Audiovisual Symposium and Workshop on Technique and Metapsychological Roots of Dr. Davanloo's Intensive Short-Term Dynamic Psychotherapy, sponsored by the Dutch Associates for Short-Term Dynamic Psychotherapy. Amsterdam, The Netherlands. April.

Davanloo, H. (1994b) Proceedings of the Audiovisual Course on Intensive Short-Term Dynamic Psychotherapy presented at the Sesquicentennial Annual Meeting of the American Psychiatric Association. Philadelphia, Pennsylvania. May.

Davanloo, H. (1994c) Proceedings of the Audiovisual Immersion Course: Fundamentals of the Metapsychology of the Unconscious in Davanloo's Psychoanalytic Technique. Bad Ragaz, Switzerland. June.

Davanloo, H. (1995a) Intensive short-term dynamic psychotherapy: Spectrum of psychoneurotic disorders. International Journal of Short-Term Psychotherapy. 10(3,4), 121-155.

Davanloo, H. (1995b) Intensive short-term dynamic psychotherapy: Technique of partial and major unlocking of the unconscious with a highly resistant patient. Part I. Partial unlocking of the unconscious. International Journal of Short-Term Psychotherapy. 10(3,4), 157-181.

Davanloo, H. (1995c) Intensive short-term dynamic psychotherapy: Major unlocking of the unconscious. Part II. The course of the trial therapy after partial unlocking. International Journal of Short-Term Psychotherapy. 10(3,4), 183-230.

Davanloo, H. (1995d) Proceedings of the Audiovisual Immersion Course on the Metapsychological Conceptualization of Character Resistance, Transference, Guilt and Unconscious Therapeutic Alliance in Davanloo's Psychoanalytic Technique. Bad Ragaz, Switzerland. December.

Davanloo, H. (1996a) Management of tactical defenses in intensive short-term dynamic psychotherapy. Part I. Overview, tactical defenses of cover words and indirect speech. International Journal of Short-Term Psychotherapy. 11(3), 129-152.

Davanloo, H. (1996b) Management of tactical defenses in intensive short-term dynamic psychotherapy. Part II. Spectrum of tactical defenses. International Journal of Short-Term Psychotherapy. 11(3), 153-199.

Davanloo, H. (1996c) Proceedings of the Audiovisual Immersion Course on the Metapsychological Conceptualization of Character Resistance, Transference, Guilt, and Unconscious Therapeutic Alliance in Davanloo's Psychoanalytic Technique. Bad Ragaz, Switzerland. December.

Davanloo, H. (1997a) Proceedings of the Fifteenth Annual European Audiovisual Symposium on Davanloo's Psychoanalytic Technique, sponsored by the Italian Institute for Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of the University of Florence. Florence, Italy. March.

Davanloo, H. (1997b) Proceedings of the Immersion Course on the Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique; Patient with Fragile Character Structure. Hotel Bristol Conference Centre. Bad Ragaz, Switzerland. December.

Davanloo, H. (1998a) Proceedings of the Sixteenth Annual European Audiovisual Symposium on Davanloo's Psychoanalytic Technique, sponsored by the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of Friedrich-Alexander University. Erlangen, Germany. March.

Davanloo, H. (1998b) Proceedings "Audiovisual Exploration of the New Metapsychology of the Unconscious; Technical and Metapsychological Roots of Davanloo's Intensive Short-Term Dynamic Psychotherapy" presented at the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy. Nürnberg, Germany. June.

Davanloo, H. (1998c) Proceedings of the Seventeenth Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique. Technique and Metapsychology of the Process of Working Through: Fragile Character Structure. Montreal, Canada. November.

Davanloo, H. (1999a) Proceedings of the Audiovisual Immersion Course: Audiovisual Exploration of the Metapsychology of the Unconscious in Davanloo's Psychoanalytic System, sponsored by the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy and the Department of Psychiatry of the University of Erlangen-Nürnberg. Erlangen, Germany. March.

Davanloo, H. (1999b) Proceedings of the Nineteenth Audiovisual Exploration of the Unconscious: Technical and Metapsychological Roots of Davanloo's Psychoanalytic Technique. Montreal, Canada. August.

Lindemann, E. (1979) Beyond Grief. New York. Jason Aronson.

Zaiden, J. (1979) Proceedings of Audiovisual Symposium on Basic Principles of the Technique of Short-Term Dynamic Psychotherapy of Patients Suffering from Obsessional and Phobic Neurosis presented by H. Davanloo, M.D., Sheraton Hotel, New York, New York. March.

Habib Davanloo, M.D.
Professor of Psychiatry
McGill University
The Montreal General Hospital
1650 Ave Cedar, Montreal, Quebec
H3G 1A4 (514) 937-6011

Gerda Gottwik, Irene Ostertag, Martha Weiss

TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY

CENTRAL DYNAMIC SEQUENCE: PHASE OF PRESSURE

(Part I)

ABSTRACT

This is the first of four articles on basic technical interventions in Dr. Danvanloo's system of Intensive Short-Term Dynamic Psychotherapy (pressure, challenge, the entry of transference and head-on collision), based on the proceedings of a five-day immersion course presented by Dr. Davanloo. This article gives an introduction to his conceptualisation of the metapsychology of the unconscious (new concept of transference and unconscious therapeutic alliance; discharge pattern of unconscious anxiety; neurobiological pathway of the murderous rage and guilt; the direct access to the unconscious dynamic forces, responsible for the patients disturbenaces). Then this article elaborates on the Dr. Davanloo's psychotherapeutic technique, introducing the Central Dynamic Sequence and focusing on a set of technical interventions, designed to exert pressure (Phase of Pressure), by presenting audiovisually recorded vignettes of sessions with different patients, elaborating on the nature of the technical interventions and their major aim, namly bringing rise in the complex transference feelings.

Introduction and overview

This is the first 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). These articles are based on the proceedings of a five-day immersion course presented by Dr. Davanloo at the training program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany. The clinical vignettes come from Dr. Davanloo's Research Library, and they represent a small sample of the audiovisually-recorded clinical vignettes in this course. Research data mentioned in this proceedings is Dr.

Davanloo's audiovisually-recorded clinical research, and all the metapsychological concepts and technical interventions presented are those of Dr. Davanloo.
Dr. Davanloo gave an in-depth presentation of the Central Dynamic Sequence based on the technical and metapsychological roots of his system of Intensive Short-Term Dynamic Psychotherapy (IS-TDP). The goal was to give a much deeper knowledge of how the unconscious is functioning and how one can work with the unconscious in order to approach the psychopathological dynamic forces responsible for the patient's symptom- and character disturbances, that is how to achieve the breakthrough into the unconscious and the unlocking of the unconscious.
Based on his work of more than thirty years with the dynamic unconscious - with extensive use of videotechnology - Dr. Davanloo has developed a new conceptualization of the metapsychology of the unconscious, that is, the way it is and the way it operates. Further he has developed a set of powerful technical interventions such as pressure, challenge and head-on collision on the one hand, and the various phases of the Central Dynamic Sequence on the other.
He emphasized that clinicians must become familiar with his new concept of transference and unconscious therapeutic alliance. They must observe with utmost vigilance all the parameters, which indicate that the rise of complex transference feelings has become a major factor between the patient and the therapist in the interview. It is the rise in transference feelings, that gives rise to the unconscious therapeutic alliance and it is the unconscious therapeutic alliance which in connection with the technical interventions among the phases of the Central Dynamic Sequence guides the whole process of the unlocking of the unconscious.

During the whole process the therapist keeps his eye on the important parameters such as:
- unconscious anxiety
- rise in transference feelings
- resistance and all its tactical organization
- unconscious therapeutic alliance
- reactive murderous or reactive primitive murderous rage
- guilt and grief-laden unconscious feelings

The Discharge Pattern of Unconscious Anxiety

Davanloo emphasized the need for clinicians to have a good knowledge of the discharge pattern of the unconscious anxiety. Throughout the whole process, unconscious anxiety shows up as a signal from the dynamic unconscious giving the therapist a clue as to whether and how the patient's unconscious is responding to each intervention. He presented his systematic research on the discharge pattern of unconscious anxiety:
The first is unconscious anxiety channeling itself in the form of tension in the striated muscles. This starts from the muscles in the thumbs, then goes in the muscles of the hand. If there is further increase of unconscious anxiety it moves to the supinator and pronator namely into the

muscles of the forearm. If it increases further, then it goes to the muscles of the arms and shoulders and to the sternocleidomastoid muscles, creating stiffness in the neck. Then it travels to the intercostal muscles, in which case the patient starts to have a deep, sighing respiration. He now has tension in the intercostal and sub-diaphragmatic muscles. If it increases further he may have tics in the muscles of the face, tics around the preorbital muscles, perioral tics as "rabbit" movements and, finally, anxiety goes into the muscles of the legs. This is the pathway for the unconscious anxiety when it channels itself as tension in the striated muscles. Patients belonging to this group have very high capacity to experience and tolerate anxiety, and therefore a high capacity to withstand the impact of their unconscious.

The second discharge pattern of unconscious anxiety is to the smooth muscles, as in the GI-tract or the lungs. The patients may react with diarrhea or bronchospasm. With these patients, the task of the therapist is to raise the threshold for toleration of the anxiety and so to convert the discharge pattern of the anxiety from the smooth muscles to the striated muscles.
The third pathway for the unconscious anxiety is in the perceptual and cognitive field. These are patients with fragile character structure. They suffer from psychoneurotic disturbances, but when anxiety is mobilized in these patients - in the transference or out of the transference - a sudden disruption may be created. This group of patients has a very low tolerance to withstand or experience anxiety. Any mobilization of unconscious anxiety creates disruption of the cognitive and perceptual processes (for example, blurring of vision or buzzing in the ears). They move easily to dissociation and splitting, or even to hallucinatory experiences. A direct move into the unconscious with this group of patients is not possible. For these patients, it is necessary to modify the technique of unlocking the unconscious to first create structural changes.

The Neurobiological Pathway of the Murderous Rage

Davanloo then presented on his discovery of the neurobiological pathway of the murderous rage, primitive murderous rage or primitive murderous and torturous rage, which starts from the solar plexus in the pelvis. The patients refer to it as having a hot feeling, that moves to the lower and upper abdominal zone. Some patients describe this as feeling like a "vulcano" or a "fireball" or a "force" or an "energy".
If you mobilize more rage, then it goes up to the chest, branches of it going to the head, moving up and down for a while. Finally, the murderous rage does not go to the head, but to the shoulders, arms and hands, and they want to grab. If the murderous rage reaches this zone and comes to the arms or legs, the patient is actually experiencing this murderous or torturous rage "as if he is doing it" without actually acting on his impulses. When the murderous rage passes to the conscious zone, unconscious anxiety is not there any more. Intense painful feelings of guilt and grief follow the rage, taking a somewhat different neurobiological pathway.
Dr. Davanloo emphasizes again and again, that only the actual and physical experience of the murderous rage, guilt and grief-laden unconscious feelings can create multidimensional

unconscious structural changes. In no way this would be possible on the cognitive level, but only on the gut level, that is, the patient's feelings must be materialized.

The Spectrum of Psychoneurotic Disturbances

He then outlined his spectrum of psychoneurotic disturbances where on the extreme left are patients who are highly motivated, highly responsive, with a single psychotherapeutic focus and with an absence of unconscious murderous rage. Moving to the other extreme, patients on the extreme right side of the spectrum have life-long character neurosis, highly complex core pathology, with the presence of a major trauma, the pain of the trauma and reactive unconscious murderous rage, primitive murderous rage, or primitive murderous and torturous rage and intense guilt- and grief-laden unconscious feelings. Thus they have and use the major resistance with all its tactical organization to bury, cement or even to seal off these unacceptable, disturbing and most painful unconscious feelings, that is, the ugly "truth of their unconscious". IS-TDP can be applied to the whole spectrum of psychoneurotic disturbances, no matter the degree of resistance.

Various Degrees of Unlocking the Unconscious

Dr. Davanloo's four major techniques of unlocking the unconscious: partial, major, extended major, and extended multiple major unlocking were then presented and he highlighted that the degree of unlocking the unconscious correlates with the degree that the patient has actually experienced the transference feelings, and with the degree of the dominance of the unconscious therapeutic alliance over the forces of the resistance.

Unconscious Therapeutic Alliance and Complex Transference Feelings

Davanloo's concept of unconscious therapeutic alliance was then presented and it was emphasized that it is activated as a force against the forces of the patient's resistance by the proper application of the technical interventions of pressure, challenge, head-on collision. The resulting rise in transference, intensification and ultimate crystallization of the resistance in the transference and the mobilization of the unconscious therapeutic alliance sets the stage for the development of an intrapsychic crisis, which he defines as an intense tension and battle between the forces of the resistance and the forces of the unconscious therapeutic alliance with the final dominance of the unconscious therapeutic alliance over the resistance. The first dominance of the unconscious therapeutic alliance over the forces of the resistance is called "the first breakthrough".

Central Dynamic Sequence

He then outlined the Dynamic Sequence in the unlocking of the unconscious which consists of:

- Phase I. Inquiry into the patient's difficulties rapidly moving to dynamic inquiry
- Phase II. Pressure leading to rise in transference and intensification of the resistance

- Phase III. Challenging the resistance , leading to heavy crystallization of the patient's character defenses in the transference and the transference resistance
- Phase IV. Mounting the challenge to the transference resistance and head-on-collision with the transference resistance
- Phase V. Intrapsychic crisis leading to rapid breakdown of the major resistance and direct access to the unconscious
- Phase VI. Systematic analysis of the transference
- Phase VII. Further dynamic inquiry , exploring the medical, social and developmental history, and it was emphasized, that theses phases can be seen as a framework which the therapist can use as a guide, and that they tend to overlap and proceed in a spiral rather than a straightforward line.

Phase of Pressure

Here we summarize aspects of Dr. Davanloo's presentation on the phase of pressure. A number of patients were shown to demonstrate some of the important principles of exerting pressure. The therapist steadily increases pressure with the major aim to mobilize the triple factors: transference, resistance and unconscious therapeutic alliance . The main factors influencing the course of an interview are the degree of resistance and the transference component of the resistance. When we exert pressure in a proper way all the character defenses will be crystallized in the transference.

Dr. Davanloo presented a set of technical interventions that he designed to exert pressure and indicated, that these interventions tend to overlap.

The clinician's task is to pursue his inquiry to turn it to a dynamic inquiry, then exert pressure towards the avoided feeling and then toward the defense. The pressure must be sufficient in the preparatory phase, which includes the phases I through IV for sufficient mobilization of complex transference feelings so that the breakthrough in the unconscious can be achieved. This requires that the therapist holds tightly on the phase of pressure.

Major Aim of the Phase of Pressure

The aim of the phase of pressure is to mobilize some parameters which are important in the whole process :

a) Mobilization and build-up of unconscious anxiety in the transference. As a result of pressure anxiety comes up as the first signal from the unconscious. For the therapist, unconscious anxiety is a guide throughout the whole process;
b) Mobilization and intensification of complex transference feelings;
c) Mobilization and intensification of the resistance;
d) Crystallization of some degree of the resistance in the transference. That means tilting and shifting all the character defenses in direction to the therapist;

e) The rise in the transference feelings eventually leads to the rise of the unconscious therapeutic alliance.

When we exert pressure towards the avoided feeling in the transference with the 'simple' question: "How do You feel right now towards me besides your anxiety?", this brings the unconscious anxiety into direct connection with all the forces of the buried feelings which are hidden behind the anxiety. If the therapist remains tightly on the phase of pressure, sooner or later there will be a constant rise in the complex transference feelings. From the very beginning of the interview, it is his task to create a dynamic and vivid process, that is, to move to the psychopathological dynamic forces into the patient's unconscious.

Technical Interventions to Exert Pressure

We should keep in mind that pressure and challenge are not entirely separate. Some pressure clearly contains an element of challenge:

- Structured interview
- Inquiry and dynamic inquiry
- Asking patient to be more specific, asking for a specific example and framing
- Probing questions
- Directing the interview toward significant areas; asking for further information in these areas
- Focusing on feelings in these areas
- Focusing on the actual experience of feelings
- Focusing on the impulse
- Clarifying remarks
- Confronting comments consisting of pointing out some issues which are entirely true but which the patient does not wish to look at
- Repeating a question to block diversionary tactics
- Focusing on fantasies
- Introducing an anxiety-laden area
- Directing the patient's attention to the use of certain words
- Making explicit what the patient has implied but is avoiding
- Underlining patient's disturbing feelings
- Confronting comments on the patient's transference behaviour
- Directing patient's attention to non-verbal cues
- Blocking in the form of non responding
- Directing the interview toward a specific area where the patient has difficulty

These interventions of pressure make clear, that pressure is not only pressure to the avoided feeling. At any time, pressure must be very specific, as the whole system of intervention and

response is not like a "Procrustean bed", i.e. to have the same menu for every patient and at any given moment. The therapist's interventions must be in tune with the patient's unconscious. It is necessary to modify and adapt the interventions in dependence to the patient's responses in order to achieve a successful and satisfying process. This requires, on the side of the therapist, to not only have a vivid interest in the patient's life and suffering, but, also, to learn step by step in an exact way a technique and a method on the one hand, and to acquire deep knowledge of the metapsychology of the human unconscious on the other, as well as the ability to pick up the patient's unconscious clues at any given moment.

Usually the therapist opens with the question - "Can you tell me what seems to be the problem?" As the patient responds, the therapist senses areas that are likely to be significant and directs the patient's attention to them. He might question the patient "Can you tell me more about that?" or "Could we look into that?" and the patient might respond and speak of some general situation that gives him difficulty. Then the therapist proceeds by asking for a specific example and focuses on the feeling "How did you feel in that situation?" and the patient responds "I felt such and such". The therapist focuses on the actual experience of the feeling "How did you experience your warm feeling?" or "How did you actually experience your anger?"

At any point in the above sequence, the patient's unconscious begins to sense that the therapist is searching for the very feeling which he has been trying to avoid for years of his life, and that the therapist will not stop until he finds it. This is the beginning of first tilting and shifting of anxiety and resistance into the transference and, eventually, crystallization of the resistance in the transference. (The third of these articles will elaborate on when to move to the transference). Here, we will condense and summarize a few of the clinical vignettes presented by Dr. Davanloo to further highlight the phase of pressure.

Patient 1
Phase of pressure when a patient is entering the interview with a series of defenses

Many patients make their resistance clear from the first moment that they speak. Dr. Davanloo presented a vignette from an interview with a male patient. The question of the therapist was "what seems to be the problem that you want to get help for?" "My problem is not knowing how to deal with the problem." This was the most revealing statement and in that clinical vignette there was a series of defenses of vagueness and evasiveness in the early part of the interview and , shortly, this resistance became resistance in the transference and we saw the crystallization of the resistance in the transference. Then the process entered into the phase of challenge.

Patient 2
Phase of pressure when a patient is entering the interview with anxiety in the transference

This patient entered the interview room with anxiety in the transference. The therapist opened the session by "How do you feel right now?"; the patient indicated anxiety; then the focus was on the patient's feeling in the transference; the process rapidly entered into the phase of pressure to the underlying feeling and then to resistance in the transference; which was then followed by the phase of challenge to the resistance in the transference.

Patient 3
Phase of pressure when the patient focuses on feelings

Then Dr. Davanloo presented a female patient in her thirties. In reply to the opening question the patient almost immediately speaks of her feelings.

TH: Could you tell me what seems to be the problem?
PT: Well, one of the main difficulties is that I feel angry a lot of the time. I feel tremendously angry towards my family, towards my parents and ah I also feel angry toward many other things and it doesn't ...

The therapist exerts pressure by blocking this attempt of moving away from people.

TH: Things?
PT: You know, things that happen or people but this anger comes up a lot. It surfaces very easily.

Exerting Pressure: Asking for a Specific Example.

TH: Could you give me a specific example where anger comes up?
PT: Well I can give you an example of when I visit my parents. For some reason I try to, like, speak to my mother. She's always very nice and everything, but she somehow just evokes this anger in me and I just remember all kinds of the things from my childhood.

The therapist has asked for a specific example of a situation, that arouses anger. The patient has partly responded, in the sense that she has specifically mentioned her mother; but she has gone on to speak only in general terms and now wants to diversify into the past, avoiding the therapist's question. While the data about the past is immensely important, moving to the past at this time, however, is diversification and is being used to avoid the true impact of her feeling in this recent situation. In fact, the patient's unconscious resistance is setting up a subtle trap, offering something of great dynamic significance in order to deceive the therapist into following her away from the

central issue, which consists of the details of the recent incident and what the patient felt in it. Dr. Davanloo points out a fundamental principle which can be summarized as follows: If the therapist asks a specific question, then he should accept nothing but an answer to his question; if the patient answers something else, no matter how significant it may appear to be, it should be regarded as resistance. At this point, the therapist exerts pressure to this resistance by simply repeating the question.

TH: Could you give me a specific example in the current, most recent time?
PT: The most recent one, uh, I just spoke to her last week and she ... my mother loves to pickle, and she said to me, "I'm not pickling very many things because I don't have any jars," and I said to her, "Well, you can go and buy jars," and she said "No, we don't buy jars, I don't have any jars," and I immediately became very angry and started fighting with her because ... what it symbolizes for me is that when we were young they neglected us, they never wanted to pay for anything.
TH: But you see, you haven't yet described that incidence. You move to ...
PT: Right. Okay, so she said, "I don't have any jars" and I said "Well you can buy jars, they sell jars in the stores," and she said, "No."

The therapist exerts pressure toward the feeling.

TH: So this mobilized anger in you?
PT: All of a sudden, I became so angry towards her and I just became very agitated and nervous and I wanted to ...

In the above passage, the patient is using the defense of moving away from the disturbing feeling of anger into the less disturbing feeling of anxiety. The therapist exerts pressure by blocking this and moving to the anger, by exerting pressure towards the experience of the anger.

TH: What was the way you experienced your anger?
PT. I just became very agitated and nervous and I wanted to ...
TH: But what was the way you experienced your anger towards your mother?
PT. It is hard to explain. I just ...
TH: But you said you were in such anger, how did you experience this anger toward your mother?

In the above passage, the patient again wants to move away from anger to anxiety, and the therapist exerts pressure by focusing on the experience of anger. This, obviously, is mobilizing feelings in the transference, feelings toward the therapist for refusing to go along with her defenses, manifesting itself by a smile which is a signal that heightened dynamic interaction is beginning to occur.

Now the therapist exerts further pressure to the transference simply by adressing the smile.

TH. You smile also.

Return to pressure to anger in the specific situation

TH: You said that the discussion was around pickling and the jars and you were in such anger with your mother.
PT: Yes, a hatred towards her when she told me that.
TH: But how did you experience the anger?

Anger is a tactical defense against rage and murderous rage and the patient's unconscious becomes alarmed at the therapist relentless insistence on the experience of anger. Now, she immediately retreats, going back to describing anxiety.

PT: I felt very agitated inside.

Further pressure

TH: What do you mean by agitated inside?
PT: Nervous, I started to get nervous and agitated.
TH: You felt nervous?
PT: I wanted to hit her, I wanted to scream at her, I started fighting with her immediately as soon as she said that.

Then the patient tries to move to generalization, which the therapist blocks. As now the resistance has become resistance in the transference, the process can move to the phase of challenge.

Patient 4 (The Case of the Man with the Chewing Gum) Phase of pressure when the patient has masochistic character traits with transference implications

Dr. Davanloo emphasized one of the interventions used in the phase of pressure consisting of making confronting comments: pointing out some issues which are entirely true, but which the patient does not wish to look at. For example, making confronting comments about the patient's secondary gains in his symptoms. The patient's response always contains a strong transference component and intensification of the resistance.

This man, at the time of the initial interview, was twenty-nine years old, married and suffered from a chronic state of anxiety, panic attacks, wide range of functional and somatization disorders, phobic disorder and diffuse characterological problems. His severe anxiety would become intensified when he was away from home, or when he was left by his boss to cope with his work.

During the phase of dynamic inquiry, it became clear that he is highly dependent on his wife and that he uses the regressive secondary gain expressed by his symptoms in the form of trying to make his wife and his boss stay with him. The therapist exerted pressure with a number of confronting comments:

TH: So in your job you have to have your boss around in order of function. Otherwise, you become anxious and panicky. And in your personal life, you cannot function without your wife. She is even the one who has to cut your hair. What do you think about this?
PT: I don't have any thoughts. What can one do when one has all these symptoms? (Silence)

There is increase in his anxiety in the form of tension and becoming immobile and silent, and the rate of his smoking has increased. For the therapist, this is the clue that pressure has given rise to the transference feelings and has intensified the transference component of the resistance. Now, he puts pressure on the patient's feelings in the transference.

TH: How do you feel right now? Have you noticed that you have become much more slow and passive?
PT: (smiling) No, I don't think so.
TH: Still you haven't said how you feel when I point out to you that without your boss and your wife you are helpless.
PT: Yeah ... mm, hmm. One doesn't like to be told that one is so dependent.

.....

PT: Yeah, I was annoyed ... because the idea was that I was like a child.

Now, the process enters into the phase of challenge, pressure and challenge and head-on collision with the resistance, which is soon crystallized in the transference.

Patient 5 (The Case of the Man with the Celiac Disease) This is an example for the principle of applying pressure, challenge and head-on collision in a spiral way with a patient with a moderate degree of resistance

The therapist entered into the interview questioning the patient "Could you tell me what seems to be the nature of your difficulties that you want to get help for it?" He responds well to the phase of inquiry and indicates that he suffers from chronic anxiety which has become intensified since his present girlfriend has been pressing him to live together and talks about marriage. He suffers from episodes of depression, feeling of inferiority, insecurity, major problem in the interpersonal relationships, has no friends. He has suffered from gastrointestinal disturbances in his early and adolescent years, diagnosed as Celiac Disease. He is in his early thirties and works

as a teacher. He complains of being self-conscious about the size of his physique. He has problem in relationships with women. With women who are not intellectual, but are rather passive and compliant he feels comfortable but ends up by becoming bored and the relationship ends up terminated. With women who are warm, intellectual and assertive he experiences anxiety. His anxiety becomes much worse if the woman is also controlling. All of his relationships with women have ended up in disappointment. The only relationship that lasted three years was with Ms. L., who was extremely passive and intellectually inferior. The sexual relationship was good, but Ms. L. changed and pressured him for marriage. He felt trapped, with a high level of anxiety and the relationship was terminated. The issues of commitment and marriage end the relationships.
The phase of inquiry rapidly moves to the phase of pressure with the entry of the transference. The therapist exerts pressure by making a comment, pointing out the issue of the passive-compliant women towards which he gravitates. While this comment is entirely true, at the same time the patient does not wish to look at. As a result, there is a rise in the transference and some degree of crystallization of resistance between the patient and the therapist. The following passage demonstrates aspects of the phase of pressure:

TH: How do you feel here when I focus on this issue off follower, passive-compliant type of women, or something like that? How do you feel toward me?
PT: Uhmm (Deep sigh) ... Well, as you've already seen, it is an awkward subject for me because I don't like to think of myself that way.

Here the deep sigh is the unconscious response to the therapist's intervention. The rise in transference feelings is mobilizing unconscious anxiety which here is channelling itself in the striated intercostal muscles.

Further Pressure toward his Feelings in the Transference

TH: How do you feel when I focus on that issue?
PT: Well, you saw I felt rather defensive.
TH: But how do you feel? I am talking about feeling towards me.
PT: I, I felt ahh ... I felt a little angry
TH: A little angry?
PT: Well I wasn't jumping up and down and yelling, but I felt angry.

Pressure toward the Experience of Anger in the Transference

TH: What was the way you, experienced the anger?
PT: That you were trying to fit me into a category that I vigorously resist being fitted into.
(The focus of the session remains on the anger in the transference and the way he defended by dismissing the therapist).

PT: Well, I did not express that I was angry, but I just denied what you were saying.
TH: Because my feeling was from the moment that I told you, and brought the issue to the focus, you became more ... moved to the position of censoring yourself. Do you notice that?
PT: (Rise in anxiety, deep sighing respiration) I hadn't noticed that I started doing it, particularly then. Uhhm. I will censor myself pretty easily under a lot of situations.

In the above passage, the therapist turns to pressure to resistance by commenting the patient's needs to censor, which in a sense implies the need to exert control in the transference. Taking into consideration that this character trait of the need to control is disturbing to him mobilizes further rise in the complex transference feelings and he himself declares that one of his character traits is censoring himself under a lot of situations, which has transference implication. Now the therapist brings the transference into focus.

TH: Do you think you are doing that here with me? Repeating certain patterns which are disturbing to you, need to control here with me?

The patient clearly declares that his need to control is in the transference but is also in other relationships and that he does not like this character trait but he cannot help it.

Mobilization and Intensification of Resistance in the Transference; Head-on Collision with the Resistance

TH: Repeating certain patterns which are disturbing to you and then you are the one, you had told to yourself how long further you are going to go and to repeat this pattern that you have, okay. You are the one who has decided ... and I again would assume that you have decided to come here on your own decision. Is it true or not? Is it that you come here because you want or Dr. whoever refers you wants you to come here? Or is it that you come here ...
PT: No, because I want to come here, because I'm ...
TH: Okay, so then you have set up a goal for yourself to come here and the goal is to get to the core of your problem, okay?
PT: Yeah.
TH: Now, if you censor yourself and if you control, and if you be evasive and if you put a wall between yourself and I then we are not getting to the core of the problem, okay. Now, if we do not get to the core of the problem then you go and you continue your suffering.
PT: True.
TH: Now my question is this: why an intelligent person like you sets up a goal for himself to come here to get to the core of the problem, but at the same time puts a goal to defeat? Because let's to face with it, if you exercise control and if you censor yourself and if you, put a wall between yourself and I, then at the end of this session we are not going to get anywhere. But who suffers from it?

PT: (deep sighing)
TH: So why you want to do that?

The above passage shows a specific composite form of head-on collision which has two goals:
- Direct challenge to the character defense of the need to control, which has its roots far back in the early life of the patient.
- Further intensification of the rise in transference feeling and making the patient acquainted with the therapeutic task.

The major ingredients of the above head-on collision can be summarized as follows:
1. Bringing into focus the nature of the resistance
2. Establishing a parallel between self-defeating and self-sabotaging pattern both in the transference and out of the transference
3. Emphasizing the patient's will; that it is his determination to seek help
4. Emphasizing the therapeutic task and the patient's goal
5. Emphasizing the destructive organization of the resistance
6. Pointing out self-sabotaging and self-destructive aspects of the resistance
7. Pressure to the therapeutic alliance
8. Deactivation of the transference

(For further elaboration on head-on collision, one should refer to part IV of these articles).

The following passage shows the impact of the head-on collision, a clear rise in the therapeutic alliance. The process has shifted to a partnership between the patient and the therapist.
Now we continue with the interview where we had left off:

PT: Well, two things, two comments, first of all I don't think I'm doing it as much as you say that I'm doing it. Secondly, it is because I am uncomfortable and anxious. Since yesterday, I have been quite anxious and last night, uh ... about this session. I was ... I had ... (frequent sighs as he speaks) considered it ... I had expected it would be something of a, of a, of a difficult and ah I would have hoped that there would be some kind of time to psyche myself up for it, and ah also that it would be later in the day because I am a night person.
TH: Hm hmm.
PT: And ah, when I was told yesterday about the appointment at 8:00 a.m. I felt quite shocked cause I felt that I would be defenseless at that hour of the morning. And then I thought to myself that this is stupid, you ought to be defenseless because uh, things will come out better if you are, but that didn't make me feel any better.
TH: Hm hmm. But you see this is what really goes with, what I told you.
PT: Yes, it does.
TH: You were talking about defense. In other words, if you come later on or in the evening you are going to put all of the defenses in operation, hmm?

PT: Yeah, that is true.
TH: But now, when the defenses get into the operation who is defeated?
PT: Well, I think you are perfectly right.
TH: Hmm.
PT: You're right.

Further Inquiry

He has always been self-conscious about his body and has felt inferior in his relationships with both men and women. He was terrified to approach women and often had feeling that they were laughing at him: "I was skinny, unathletic; felt very inferior." Then he talked about a girl that he met at the age of twenty. He was desperately in love with her and was very passive and compliant. She became the leader and he the follower. She got bored with him and dropped him. He got depressed "I was devastated, cried all the time, it was a disaster." He further said "It was the most painful thing."

About his relationships with men, he said that he always ends up being the follower, which mobilizes anger in him and he ends the relationship "I cut off the relationship," and the result is he doesn't have any friends. As a teacher, he does a good job, but always has a preoccupation with whether his performance is as good as that of other teachers.

The focus is then on his feeling of inferiority "feeling of nothing," which is widespread in all of his relationships.

Entry of the Transference

TH: How do you find this in your relationship with me? How do you see that?
PT: Uhmmm (Pause).
TH: Because we know in every relationship if you are in control of that relationship you feel comfortable. And if you don't then you move away.
PT. Well, I don't think, I mean I don't think I'm in control but it is a professional relationship, and I find ...
TH: But that is intellectual.
PT. But this is generally true, I find that ... gonna lead to something else. I find that in dealing with things and people, I know that, I know that, that, eventually if, if I am going to get any benefit from this treatment, this cannot go on. I mean I can't deal with it in this way, but I, I find that, uhm dealing with, things in a professional way, that is dealing with organization and so forth I'm actually much more comfortable than dealing with, individuals on a person-to-person level, because the rules are set down.

Some Degree of Challenge and Some Elements of Head-on Collision with Resistance against the Emotional Closeness

TH: You see because we are talking about putting a wall around yourself in relationship with me.

PT: Yeah.

TH: Hmm?

PT: Yes.

TH: Now is this going to be a barrier in exploring and pursuing to get to the core of the problem? Is this going to be a barrier? Because obviously we know that this is there in every relationship. And the, the question is this: is this going to be an exception here or what?

PT: Yeah, good point.

(Pause)

TH: Because what you say is if you put a barrier between yourself and the other then you feel comfortable, but if that barrier breaks down ...

PT: Yeah.

TH: ... then you start ...

PT: Yeah, yeah, yeah. Uhmmm ... well you want an honest answer it, it may be a problem uhmmm ... but you know you pointed it out and I guess I will just have to uh .. Make whatever kind of effort I can make, uh not to let that happen.

TH: Because you see one of the things that I am struck by is that in a sense you have had this problem - which is of many years duration, is not really anything new ...

PT: Yeah.

TH: ... and is a long-life problem that you have.

PT: That's right.

TH: And then somehow you have let it go and you have not ah, got ... if I understand it correctly no help for it.

What emerges is that he has been in long-term psychoanalytic psychotherapy "for a long time," "It did not root it out and I put up a considerable barrier."

Return to Dynamic Inquiry and the Search for the Major Resistance.

His father had a series of heart attacks when the patient was five. He worked at a university, was a detached and withdrawn person who was not athletic. The patient further describes him as a small, weak man and that he always compared him to the father of others. In spite of that, in the first few years of life he had a close relationship with him and enjoyed mechanical work. During the early phase of his life, the patient suffered from GI tract problems, which was diagnosed as Celiac Disease. His mother gave up all other interests and devoted herself to the patient and became overprotective. His relationship with his mother became closer at the age of five, after

his father's first heart attack. He describes his mother as aggressive, domineering and "Sexually aggressive". She was sexually active before she met his father.

Upon focusing on his mother, there is major mobilization of the major resistance and anger toward the therapist. The process now enters to the second phase of pressure; pressure for the actual experience of anger in the transference until the final breakthrough and passage of the primitive murderous rage.

Recapitulation of Five Patients shown in the First Part of the Immersion Course

All vignettes were shown to demonstrate the application of some of the various forms of pressure in the initial contact with various patients.

Patient 1 entered with the sentence "My problem is not knowing how to deal with the problem" revealing a series of defenses. Pressure soon was turning the resistances to resistances in the transference.

Patient 2 entered with anxiety in the transference. By picking up the anxiety the process rapidly was moving to feelings and resistance in the transference.

Patient 3 replied to the opening question almost immediately by speaking of her feelings. The therapist exerted pressure by blocking the patient's attempts to diversify from the avoided feelings.

Patient 4 came with a variety of problems including characterological problems leading to highly dependent relationships and secondary gain of his symptoms. Since these character traits of the patient had serious transference implications the phase of pressure started with confronting comments on this issue. The therapist pointed out some issues which were entirely true, but the patient did not wish to look at.

Patient 5 responded well initially in the inquiry. The process began with the phase of inquiry until the patient showed the first signs of a rise in the transference. Here the phase of pressure included other elements, which followed one after another in a spiral way: the phase of pressure leading to resistance in the transference, a head-on collision with the resistance in the transference was followed by a continuation of the inquiry, pressure and challenge, and after a head-on collision with the resistance against emotional closeness there was the continuation of the inquiry again with elements of pressure which was leading to a mobilization of major resistance and anger in the transference. Pressure and the actual experience of the anger in the transference was leading directly to a major breakthrough.

Summary

The main aim of the phase of pressure is, as we have seen, the mobilization of the avoided feelings in the transference. This intensifies and mobilizes all the character defenses of the patient in the dimension of the transference which sets the stage for the application of the phase

of challenge. In order to achieve the desired crystallization of all the patient's feelings and resistances in the transference, the therapist must constantly remain and glue onto the phase of pressure and later pressure and challenge, until the rise in the transference feelings is sufficiently high for the breakthrough to take place. Very often, the patient and also the therapist want to diversify from the transference out of the transference because of the anxiety of both of them. But the credibility and guarantee of the process depends on the rise in transference feelings and the transference component of the resistance. We will see in the following articles, how the application of the two other technical interventions (challenge and head-on-collision) will influence the unconscious therapeutic alliance and also the process of breakthrough into the unconscious.

Acknowledgements

This article is based on the proceedings of a five-day immersion course presented by Dr. Davanloo at the training program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, in Nuernberg, Germany.

Author's Note

Please address reprint request to: German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy e.V., c/o Dr. med. Gerda Gottwik, Wackenroderstr.11, 90491 Nürnberg, Germany

Gerda Gottwik, Ursula Sporer, Friedrich Tressel-Savelli

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.

Acknowledgements

This article is based on the proceedings of a five-day Immersion Course presented by Dr. Davanloo at the training Program of the German Society for Davanloo's Intensive Short- Term Dynamic Psychotherapy, June 17-21,1998, in Nürnberg, Germany.

Authors' Note

Please address reprint request to: The German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy e.V., c/o Dr. med. Gerda Gottwik, Wackenroderstr. 11, 90491 Nürnberg, Germany

Gerda Gottwik, Ingrid Orbes

TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY
HEAD-ON COLLISION WITH THE RESISTANCE

(Part III)

ABSTRACT

This is the third 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), bases on the proceedings of a five-day immersion course presented by Dr. Davanloo. Part 3 focuses on Dr. Davanloo's new concept of the transference, by analysing a series of clinical interviews (strect avoidance of the transference neurosis, unconscious therapeutic alliance, twin factors of the transference and resistance). Serveral clinical vignettes were presented to elaborate on the way how transference enters the process.

Introduction

The authors in this article summarize the proceedings of a five-day course on the technical and metapsychological roots of Dr. Davanloo's technique, presented to the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany.

Davanloo, in over thirty years of audiovisually-recorded clinical research with more than 1,000 patients, developed his powerful system of IS-TDP to access and work through the unconscious dynamic forces responsible for neurotic disorders. Key is the rapid access to the neurotic core in a single interview. Davanloo has divided the process of the trial therapy into various phases, the

Central Dynamic Sequence, which contains a set of technical interventions: pressure, pressure and challenge, culminating in head-on collision.
The other three articles of this series summarized Dr. Davanloo's presentation on pressure (Gottwik, Ostertag, Weiss), pressure and challenge (Gottwik, Sporer, Tressel), entry of transference (Gottwik, Kettner-Werkmeister, Wagner).
The focal point of this paper lies on head-on collision. To illustrate, the paper contains transcripts of video vignettes of three of the patients presented by Dr. Davanloo.

Head-on collision with the resistance

In this section of the course, Dr. Davanloo focused on the technique of head-on collision, and presented twelve different forms of head-on collision to highlight the application of the technique. Some head-on collisions are used when there is major resistance in the transference, with the aim of direct access to the unconscious, while others may aim at loosening the psychic system, mobilizing the patient's unconscious, and making the patient acquainted with their syntonic character defenses, and, at the same time, creating further mobilization of the transference feelings.
Head-on collision essentially addresses the therapeutic alliance and is directed against the self-destructiveness inherent in the patient's conscious or unconscious refusal to abandon his resistance. It aims both to mount a direct assault on all the forces maintaining the self-destructiveness, and, at the same time, to mobilize the patient's unconscious therapeutic alliance against the destructive forces of the resistance.
Head-on collision contains a number of technical interventions, and it can be the most complex of all of the therapist's interventions.
Here, we summarize the major aims of head-on collision, as was presented to the Program.

Aims of Head-On Collision with Resistance

Head-on collision is always used within the setting of resistance in the transference, or when the patient's character resistance, as the result of pressure or pressure and challenge, has been crystallized in the transference. It may take various forms. One is the interlocking chain of head-on collisions, which is the most complex of all the therapist's interventions.

Head-On Collision aims:

1. At total blockade against all defenses maintaining the forces of resistance,
2. To mount a direct assault on all the forces maintaining self-destructiveness, self-defeat, and self-sabotage,
3. To intensify the rise in transference feelings,
4. At mobilization of the therapeutic alliance against the resistance; to tilt the balance between the two forces in favor of the therapeutic alliance,

5. To create a state of high tension between resistance and therapeutic alliance in the transference; the act of challenging the resistance, combined with the conveyed lack of respect for them, creates an extremely complex state within the patient - one in which he both wishes to cling to his resistance even more strongly, and, at the same time, begins to turn against them, deeply appreciative of the therapist's relentless determination to help him. This is what is meant by the tension between resistance and therapeutic alliance. When the process has created tension between the resistance and therapeutic alliance in the transference, it calls for some form of head-on collision with the aim to mobilizes therapeutic alliance against resistance.
6. To bring the patient face to face with his self-destructiveness with such a communication as "good-bye," "doomed," and "misery" to both shock him out of the syntonic part of his resistance and challenge his therapeutic alliance to make a supreme effort,
7. In many cases, the head-on collision results in major communication about the nature of the resistance,
8. The aim is to loosen the patient's psychic system in such a way as to make the unconscious more accessible.
9. In the interlocking chain of head-on collision the aim is to loosen or mobilize the patient's psychic system and make a partial unlocking of the unconscious possible.

In the following passage, we present three of the clinical vignettes, presented at the course which illustrate three different forms of head-on collision. The vignettes come from Dr. Davanloo's research library. All of the metapsychological concepts and technical interventions presented are those of Dr. Davanloo. All research data mentioned in this proceeding refers to Davanloo's audiovisually-recorded clinical research.

Patient 1

The first case is a man who described himself as having been "naive" in not noticing the signs that his wife was having an affair. This involved the defense of denial, since the truth was that he had unconsciously turned a blind eye to the signs because they caused him too much anxiety.

TH: Let's not get into this ... because if you put it in terms of being "naive" then we are going to dismiss some of the very essential issues.

The first intervention "Let's not get into this"; is challenge by blocking the defense of denial. By addition "If you put ... issues", this intervention turns into head-on collision. This addresses the therapeutic alliance. It emphasizes the consequences of maintaining the defense, and is aimed at mobilizing the therapeutic alliance against the resistance. In addition, the therapist's intervention is designed to make the resistance unacceptable. Thus, the therapist's intervention is a simple form of head-on collision. Although the therapist does not directly say that the result would be self-destructive, definitely this is implied. The therapist is communicating that if the patient uses

this particular form of the defense, then the therapeutic process would be at an impasse. Usually in head-on collision, the communication with the therapeutic alliance about the self-destructiveness is very explicit.

The Major Technical Interventions of Head-on Collision

The following are some of the main technical interventions used in the head-on collision. For the sake of brevity, we have summarized it, but the therapist must take into consideration that there is a wide range of head-on collisions; from short form, composite form; composite extensive form, and interlocking form of head-on collision. These forms have specific indications.

1. To specify and point out the nature of the resistance. The therapist must emphasize the nature of the defenses that the patient is using. For example: "If you maintain a defiant, passive position;" "As long as you are going to rationalize, intellectualize, ruminate, and being vague ..."
2. To point out and emphasize the problem and its effect on the patient's life. When the patient is deeply involved in his resistance, he tends to fight to maintain his resistance and lose sight of the fact that he has a problem which causes him pain. So the therapist begins by reminding him of this fact, but in forceful terms, like: "major problem" "misery and suffering", "agony." The aim is to maximize the impact of this technical intervention.
3. To challenge the self-destructive aspect of the resistance. This can be explicitly introduced with a rhetorical question: "Is there an element of self-defeat and self-sabotage? Why do you put a goal for yourself to come here of your own volution, so that together we can get to the core of your problem, but, at the same time, you want to make it a failure, which obviously means perpetuating your own suffering."
4. To point out and emphasize the self-sabotage and self-defeating component of the resistance and its masochistic component: "And there will be self-defeat in it, isn't that so? Now my question is this, why should you of your own will come here to see if we can get to the bottom of your problem, and, yet, at the same time, another part of you wants to defeat the goal you have set for yourself and wants to perpetuate your own misery?"
5. To establish a parallel between self-defeating and self-sabotaging pattern in the transference and in other relationships: "And throughout your life, people have been useless to you, a self-defeating, self-sabotaging pattern which right now is in operation with me".
6. To point out and emphasize the patient's will, that the patient is the prime mover in seeking help: "You have come here on your own will seeking help for your suffering."
7. To emphasize the partnership between the patient and the therapist: „You and I are here together to find the core of your misery."
8. To point out the therapeutic task and emphasize the therapeutic task: „Then we will not get to the core of your problems. Our task is to understand your problems and get to the engine ."
9. To deactivate the development of transference pattern: "As long as you take a passive, defiant position, then this process is doomed to fail, but who is the failure? It's your decision, you said

you want to get free, then we must look at this. When you will do this, good, when you won't, good, too. You have the right to be defiant, but you also go to misery." (He must see clearly, that he is his own architect of his life.)

10. To challenge the dependent transference pattern, the need to use the therapist as a crutch. "Now you again move to the crippled position. What will you do against this. At the moment you are using me as a crutch."
11. To challenge the self-destructiveness in the transference resistance: "Let's look to your relationship with me", "Then, I will be useless to you, why should you want to make me useless to you?"
12. To challenge the resistance against emotional closeness. "There is a wall between us. When you don't want me to get to your intimate thoughts, then why you are here?"

As mentioned above, there are many types of head-on collision each of them with a specific indication and composed of a smaller or larger number of these interventions. The sequence, emphasis and repetition of the given interventions depends on the response of the patient's unconscious (signals of anxiety and/or appearance of new resistances). Because head-on collision is, by its nature, addressing the unconscious, the therapist, while colliding head-on does not allow any dialogue with the patient.

Patient 2
The Man with the Baseball Bat

The pseudonym of this man in his early thirties is based on some of his fantasies which were of great violence. The patient entered into the interview with anxiety, giving evidence of an immediate transference. The phase of inquiry rapidly moved to the phase of pressure and challenge, and under challenge he became openly defiant "I refuse to answer you when you ask that question." After further pressure, there was a fleeting moment in which there was sudden upsurge from his unconscious therapeutic alliance: "I am looking to punish and I don't know how to do it." Shortly after which the therapist introduced head-on collision.

TH: Now, let's look at it, obviously you, have a major problem and this problem is a source of misery a suffering for you. I don't know, you have to decide is it or isn't it?

In the above passage, we see two components of head-on collision: emphasizing the problem and its effect on the patient's life; then addressing the patient's autonomy to decide whether it is a problem for him or not, so that the responsibility remains with him.

PT: Yes.

TH: And I assume you have come here of your own will, and you have a goal, otherwise you wouldn't be here?

In the above passage, the therapist points out that the patient is the prime mover in seeking help (addressing the patient's autonomy and free will in the decision to seek help), and emphasizes the patient's goal (pressure to conscious therapeutic alliance, as well as message to unconscious therapeutic alliance).

PT: That is right, many goals.

TH: One of the major tasks that we have ahead of us, hopefully, is that you and I with the help of each other will explore and understand where you stand in life, what your problems are and where the core of your problem lies.

In the above passage, the therapist emphasizes the partnership and the therapeutic task. Spelling out the therapeutic task "to explore and understand what your problems are and where the core of your problems lies" is another powerful technical intervention in Davanloo's IS-TDP. Although it sounds simple, it has a very complex effect on the therapeutic alliance.

PT: Exact.

TH: Okay, and the fact is that the problem is yours. If there is suffering it is yours and if there is happiness it is yours, if there is success and the failure, again it is going to be yours, okay? But if you maintain a defiant, passive, cutoff position what will happen here?

Again the therapist is repeating that the responsibility is with the patient, adding the nature of resistance and the destructiveness of maintaining the resistance, and at the same time undoing the omnipotence.

PT: Nothing.

TH: In a while when this session finishes and we say good-bye to each other and you go away and carry on the miserable life that you have ... because as long as you take a passive, cut-off or defiant position you will not be able to reach the goal you have set for yourself. We will not be able to understand the core of your problem and the process is doomed to fail.

In the above passage, the therapist is pointing out again the nature of resistance, the destructive component of the resistance, emphasizing the therapeutic task and the consequences of maintaining the resistance.

TH: There will be self-defeat in it, isn't that so? Now my question is this, why should you of your own will come here to see if we can get to the bottom of your problem, and yet at the same time another part of you wants to defeat the aim you have set for yourself, and wants to perpetuate your own misery.

The self-destructive component of the resistance is now introduced explicitly with the rhetorical question, and again the therapist is addressing the patient's will and the therapeutic task and then he is challenging this destructive mechanism. Also this passage contains the technique of making the two sides within the patient explicit: the resistance and the unconscious therapeutic alliance. This is starting to put the battle where it belongs: within the patient (eventually leading

to the intrapsychic crisis of phase 5 of the central dynamic sequence). This is a very strong measure of undoing defiance in the form of "battle of will" between therapist and patient.

PT: I know.

TH: Then I will be useless to you.

The therapist is pointing out the self-destructiveness in the transference resistance.

PT: Yes. (Now the patient is becoming increasingly sad)

TH: Why should you want to make me useless to you.

The therapist is challenging the self-destructiveness in the transference resistance. As an indicator of rise in the unconscious therapeutic alliance, the patient makes the following communication:

PT: I don't want you to be useless to me.

TH: And throughout your life, many people have been useless to you. (Pause)

TH: But you see, what is immediately coming into focus is that you have a self-defeating and self-sabotaging pattern which right now is in operation with me.

In the above passage, the therapist is challenging the self-sabotaging and self-defeating pattern in the transference relationship, and establishing a parallel with outside relationships.

PT: Yes, I have.

TH: Let's look at this self-defeating pattern, if this process continues like this we will fail to understand where the core of your problem lies, and let's face it. I can afford to fail - obviously I cannot always be successful - but the fundamental question for you is can you afford to fail?

Again, he is pointing out and emphasizing the consequences of maintaining the resistance and deactivating the transference and undoing the omnipotence.

PT: That is right.

TH: Then what are we going to do about it?

PT: Overcome it.

TH: So let's see how we are going to overcome it ... and I have a feeling that you are putting a massive wall between yourself and me.

Patient 3

Here we focus on another patient who was presented in the program. It shows how the dynamic inquiry crystallizes the resistance in the transference by exerting pressure, and how the application of the phase of pressure and challenge prepares the ground for head-on collision which totally blocks the resistance. This allows a rapid breakthrough into the unconscious.

The Scottish Strangler

When he came into treatment, he was in his forties and worked as a salesman. The evaluator does not know anything about the patient.

Phase of Inquiry

TH: Do you want to tell me what is the nature of the difficulty you want to get help for it?
PT: Yeah ... My inability to form a long-term relationship with a woman.
TH: Only with women?
PT: I have problem with men too, but more pronounced with women.

Further dynamic inquiry indicates that he has problems in interpersonal relationships with both men and women, but becomes more pronounced with women.

PT: Well, all my life, you know, I have never been with, one partner for very long and the... ahh ... with my second wife, there was a major problem.

What emerges is that he has had many extramarital affairs with a number of women, and both of his marriages have ended up in divorce.

TH: You mean both?
PT: Two marriages, yeah.
TH: And now you are divorced?
PT: I am divorced, yeah.

Further Inquiry

TH: Divorced, how long ago?
PT: Eight years.
TH: So you have been eight years divorced.
PT: Yes.
TH: I see. So one problem is with, women and your tendency of having frequent relationships ?
PT: Yes.
TH: Any other problem besides an inability to develop any long-lasting relationship?

Further inquiry indicates that he suffers from episodes of depression. He also suffers from a chronic state of anxiety, particularly in his job. Exploration into the physiological concomitant of his anxiety indicates that the discharge pattern is heavily at the striated muscles, particularly the muscles of the hands, of the forearms and the intercostal.

Anxiety in the Transference: Phase of Pressure

He is becoming increasingly anxious during the interview, which definitely has a transference implication, and the therapist focuses on the anxiety and exerts pressure.

TH: Are you anxious? I notice you took a deep sigh. Do you feel anxious right now?
PT: Yeah. (He takes another sigh,)
TH: You took another sigh here.
PT: Yes.
TH: Are you aware here, you had a few times a deep sigh?
PT: No (sighs).
TH: As if you have to catch your breath. Are you aware?
PT: Yeah, when you when you point it out, yeah, but ah ...
TH: You are not conscious of this?
PT: No. It's, it's sort of... normal, you, know, for me to do that. I guess, you know, so I don't notice it (sighs).
TH: Yeah, but the issue is not is it normal or abnormal. You have a deep sigh but you say you are not aware of it.
PT: No, when ... only when you point it out, ah

Dynamic Inquiry; Pressure

The therapist now explores directly the family dynamics, and the patient indicates that his anxiety increases with his children, particularly with his younger daughter, Joan. With her, he has episodes of violent rage, with explosive discharge of the affect and blow-ups. The therapist exerts pressure by asking for a recent incident. A few weeks prior to the interview, he lost control, which resulted in a physical attack on her. It seems that this incident has been a major factor for him to search for help, as there was the possibility that he could have damaged her physically.

Then the therapist focused on his current girlfriend. There are many episodes where he gets into rage towards his girlfriend and handles it by walking out. Further dynamic inquiry indicates that he suffers from explosive discharge of the affect which is specific with women and which has been a problem for all of his life. Focusing on his first marriage, this was at the age of twenty, he states that the relationship deteriorated immediately after the marriage. His wife would have episodes of explosive discharge. She was highly volatile, stormy and on occasions would throw the plate of food on him. There were many episodes where he got physically violent with her.

This dynamic inquiry with exerting pressure intensifies the patient's resistance in the transference. He becomes detached, totally non-communicative and silent. The therapist focuses on the patient's feeling in the transference.

Resistance in the Transference

Focusing on the patient's feelings in the transference is leading to increasing resistance in the transference (silence), followed by pressure to resistance in the transference.

TH: How do you feel talking about these issues with me? I feel as if you are not with me.
PT: Oh, I'm trying to, you know ...
TH: You are not here with me.
PT: Oh no, no I'm ...
TH: Are we together here, or are you somewhere else?
PT: No ahh, we're together here, I'm ...
TH: You see, you are detached from me and suddenly you have become non-communicative?.
PT: Well, uhhh.
TH: You know, what passes through my mind is if I don't tell him anything, or question him anything, what would happen here between us? Do you know what I mean?
PT: Yeah.
TH: If I don't question him, that is ...
PT: Meaning me?
TH: Yeah.
PT: Okay, yeah, yeah.
TH: Then what would happen here?
PT: Nothing, probably.
TH: You mean you wouldn't say anything, huh?
PT: No.
TH: Then we would have silence between each other, huh?
PT: Yeah, yeah.

In the above passage, the therapist is exerting pressure by pointing out the nature of the resistance which is in the transference. The patient goes along and confirms that nothing would happen and that silence would prevail. The pressure against the resistance in transference mobilizes more anxiety, as we can see, when the patient continues to have more sighs. The process indicates the presence of the resistance against emotional closeness which has been mobilized during the phase of dynamic inquiry and pressure in relation to his daughter, first wife and current girlfriend.

The computerized data from the early part of this interview point out the following:

- a man suffering from life long character neurosis;
- moderate to high degree of the resistance; presence of resistance against the emotional closeness and moderate degree of syntonicity in his character;
- major regressive defenses, such as explosive discharge of the affect, which is a major defense against homicidal feeling as well as suicide which alternates with a high level of anxiety and flight from the situation.

The therapist's decision is to accomplish the task in two phases in a single interview: partial breakthrough into the unconscious to be followed immediately by a major breakthrough into the unconscious.

Head-On Collision with the Resistance Against Emotional Closeness: First Partial Direct Access to the Unconscious

The therapist cannot make a patient acquainted with this resistance unless it manifests itself in the transference. In the early part of the interview, the patient had indicated that he has problems in relationships with both men and women, but more pronounced with women. Later on, the therapist moved to a dynamic inquiry into his intimate life with his first wife as well as into his current relation with his girlfriend, which led to the mobilization of the resistance in the transference. Now, the therapist moves to the head-on collision with this resistance.

Pointing Out the Nature of the Resistance

TH: Do you have problem with closeness, because I feel you keep a detached position with me. This is the way I feel, you can tell me how you feel. You are detached from me and you are not involved with me and that there is a barrier between you and me. You know what I mean by barrier?

PT: There is a barrier, there is a barrier, yes.

It is important to note that the therapist must be very specific: "closeness," "wall" "not involved," "barrier", and "detached." As we saw, he immediately used another component of the head-on collision, namely, deactivation of the transference, when he said to the patient: "This is the way I feel, you can tell me how you feel." If the transference is coloured by any genetic figure, the patient ends up getting into battle with the therapist, the same person he wants help from.

Continuation of the Head-On Collision

TH: And there is a wall between you and me, you know what I mean?

PT: Yeah, yeah.

TH: The wall and barrier?

PT: Hm, hmm.

TH: And you don't want me to get to know you, and you don't want me to get to your intimate thoughts, to your intimate feelings.

PT: I...

TH: This is the way I feel.

PT: Yeah, I, 1 can understand your feeling that way too uhh I feel that uh I have got things to hide.

TH: Hm hmm. But that is very important for us to examine it.

PT: Yeah, I know.

Each time the therapist repeats it: "You don't want me to get to your intimate thoughts, you don't want me to get to your intimate feelings," this mobilizes the center of the nuclear structure, which mobilizes anxiety in the transference. The repetition of pointing out the nature of resistance is extremely important when one works with the head-on collision against the emotional closeness,

because it is deeply rooted in the center of the pathogenic zone of the unconscious, namely the bond, the attachment, the trauma, the murderous rage, the guilt and the grief.

Now we return to the interview.

TH: Because you, for whatever reason - I don't know what it is that makes you to be like this, but that is not important at this moment - for some reason you have a need to erect a wall between yourself and me and not to let me to get into your intimate thoughts and not to let me into your intimate feelings.

This repetition of the nature of the resistance against emotional closeness is of paramount importance in the mobilization of the centre of the nuclear structure. The therapist further points out that the transference should be clearly spelled out: "You and me."

TH: And now, this is very important for you and me to examine, because if this wall continues and this barrier between you and me continues, then at the end of this session I would be useless to you, because our aim here, our aim is to understand your difficulties at one level, at another level also is to get to the engine that creates all your difficulties, Okay?

PT: Hm hmm.

TH: So now up to the time there is a wall, and up to the time there is a barrier, up to the time you don't want me to get into your intimate thoughts and feelings, then by the end of this session I, would become useless to you, it would be a failure.

PT: Hmm.

TH: Then, when we depart from each other, I would say, okay I did my best, I failed, but <u>you</u> have to go to perpetuate your suffering. Still you are young and you have many years ahead of you, why you have to let it go to waste? Now if you go on, if you go from here at the end of this session and I be useless to you, then you have to perpetuate your suffering and this suffering you carry to your grave the balance of your life. Why you want to do that?

PT: I don't want to do it. I mean that is why I am here.

TH: I know, but being here is not enough. The fundamental issue is the wall, the barrier, and if this wall continues, means perpetuation of your suffering.

The following will highlight step by step the components of head-on collision in the above passage:

- Elaborating and pointing out the nature of the resistance
- Emphasizing the problems
- Therapeutic task and emphasizing the patient's goal
- Pointing out the self-destructive element of the resistance
- Bringing into focus the consequences if he maintains the resistance
- The destructive aspect of the resistance, therapeutic failure and the self-defeating and self-sabotaging components of the failure
- Undoing the omnipotence

- Pointing out the perpetrator of the unconscious
- Pressure to the unconscious therapeutic alliance

First Breakthrough

As we saw, the therapist has applied a composite form of head-on collision - which results in a specific response – namely, the first breakthrough. When the first breakthrough takes place, there is the first dominance of the resistance by the unconscious therapeutic alliance. The patient becomes increasingly sad and tearful which indicates breakthrough is imminent.

We return to the interview.

PT: I have been doing it all my life.

TH: Right now, your eyes are wet, something is ...

PT: Hm hmm.

TH: Which indicates that there are certain feelings in you, but in a sense maybe you don't want to share that with me as well. Maybe part of you says who is this stranger that you let ... you know what I mean by the stranger?

PT: Well I feel close to tears now.

TH: And you are fighting it. You don't want to experience the full impact of it. Why you want to perpetuate the suffering?

The therapist puts pressure to the unconscious therapeutic alliance against the perpetrator of the unconscious.

PT: I do not, that is why I am here. (He has become further sad and tearful)

TH: Because, from the little bit I get, your life is frying pan to fire.

PT: Yeah, from one disaster to another. The only thing that has changed, there is no children this time at least uh ...

TH: Yeah, but still I'm talking about you and you in life. You are right now agonized with a lot of painful feelings and you don't want to experience it, you hold yourself. You don't want to let it go, and you avoid my eyes as well.

PT: Hm.

TH: The tears are there, your sadness is there, and your are determined not to fully experience it. (He is becoming more tearful and also avoids the therapist's eyes)

You see, when you become more tearful, you avoid my eyes. When tears come, you avoid my eyes.

PT: I feel frightened. End of the vignette.

In a sad and tearful state, he talks about the way life has gone for him from one disaster to another, like a pressure cooker. In a sad way, he talked about his daughter, Joan, and his other children, repeating the life of the past. Then in a sad, tearful state, he talks about his mother,

memories of her being attentive but, at the same time, highly controlling, demanding, and everything had to be her way. She often had explosive tempers and would become volatile, was both physically and psychologically abusive. Father was passive, ineffective who stayed away and later on resorted to heavy drinking.

The therapist, after the first and partial direct access to the unconscious, then moves to the phase of dynamic inquiry until he meets the major resistance. Then he moves to the phase of pressure and challenge to the major resistance; major mobilization of the transference resistance, and, again head-on collision with a major direct breakthrough into the unconscious, and major mobilization of unconscious therapeutic alliance against the resistance.

Summary

(1) This is the fourth of a series of four articles on technical interventions of IS-TDP. These papers are based on proceedings of a five day course on the technical and metapsychological roots of Dr. Davanloo's technique presented to the Training Program of the German Society of Davanloo's IS-TDP, June 17-21, 1998, in Nürnberg, Germany. Dr. Davanloo elaborated on his "new metapsychology" and technique by presenting vignettes of the audiovisually recorded therapies of many different patients. Each article focuses on one technical element of IS-TDP, but also contains elements of the whole concept of Dr. Davanloo's new metapsychology of the unconscious.

(2) The first article focuses on the phase of pressure with its specific functions of mobilization and intensification of transference feelings, mobilization of the resistance and crystallization of the resistance in the transference, presenting five clinical cases.

(3) The second paper highlights the phase of pressure and challenge, presenting one clinical case. This phase aims at further crystallization of the patient's characterological defenses in the transference, making the patient well acquainted with ego-syntonic defenses, further mobilization of the transference feelings, and intensification of the transference component of the resistance.

(4) The subject of the third article is the "entry of the transference", to elaborate the central importance of the transference in Davanloo's IS-TDP; and seven of the cases presented at the course were discussed.

(5) This fourth article summarizes some of the essentials, the indications, various forms, the aims and the ingredients of head-on collision, illustrated with transcripts of video vignettes of three patients presented in the course.

(6) Head-on collision is the most powerful form of challenge, mobilizing the patient's unconscious therapeutic alliance against the destructive forces of the resistance. It is always used within the setting of resistance in transference.

(7) There are different indications for head-on collision. In moderately resistant patients when the phase of pressure, pressure and challenge, have resulted in the crystallization of major resistance in transference the major head-on collision is applied to get a direct access to the unconscious. In highly resistant patients, particularly in those with syntonic character defenses, head-on collision aims at loosening their psychic system.

(8) Depending on the indications and the type of unlocking the therapist is aiming for, there are various forms of head-on collision: specific, complex, composite or interlocking chain of head-on collision.

(9) Each head-on collision is essentially aiming at the whole system of the patient's unconscious forces:
- blockade of defenses
- assault of all forces maintaining self-destructiveness
- intensification of the rise in transference feelings
- mobilization of conscious and unconscious therapeutic alliance
- creating the state of intrapsychic crisis
- facing the patient with the syntonic part of his resistance
- loosening the psychic system

(10) Transcripts of three patients illustrate specific and composite types of head-on collision.

Acknowledgements

The authors in this article summarize a segment of the proceeding of a five-day course on the technical and metapsychological roots of Dr. Davanloo's technique, presented to the Training Program of the German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, 1998, Nürnberg, Germany.

Authors' Note

Please address reprint request to: The German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy e.V., c/o Dr. med. Gerda Gottwik, Wackenroderstr. 11, 90491 Nürnberg, Germany

Gerda Gottwik, Ingrid Kettner-Werkmeister, Gerhild Wagner

TECHNICAL AND METAPSYCHOLOGICAL ROOTS OF DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY

THE ENTRY OF THE TRANSFERENCE

(Part IV)

ABSTRACT

This is the fourth 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), bases on the proceedings of a five-day immersion course presented by Dr. Davanloo. Part 4 focuses on the head-on collision (technical element of the Cetral Dynamic Sequence) as the most powerful form of challenge, mobilizing the patient's unconscious therapeutic alliance against the destructive forces of the resistance. To illustrate various forms and indications of head-on collisions clinical vignettes from three different patients were selected.

Introduction

This paper is based on proceedings of a five day immersion 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).

In this section of the program, with extensive use of audiovisual clinical material, the major focus of Dr. Davanloo's presentation was on direct access to the unconscious; he emphasized the specificity of the intervention with the specificity of the response; he further emphasized the twin factors of the transference and resistance. In this article, we focus on and summarize his presentation on the subject of the entry of the transference.

"Transference" in Intensive Psychodynamic Psychotherapy

Davanloo began by emphasizing that his conceptualization and technical approach to „transference" in IS-TDP differs radically from transference neurosis in classical psychoanalysis. Based on Davanloo's extensive clinical research using video technology transference neurosis can best be described as a situation, in which the patient has transferred all of his character resistances and underlying complex neurotic feelings on to the therapist, while maintaining all these neurotic forces deeply locked within his unconscious. Once this state has materialized itself, it is very hard to reach the dynamic forces responsible for the neurotic suffering. The therapist has become a parental figure, gratifying the patient's needs. Why should the patient give it up? Clearly, this situation cements the neurosis rather than lifting it.

He therefore concluded that the therapist has to do everything to prevent the development of a transference neurosis from the first encounter with the patient, onward. To start with, he has to maintain a firm and clear position of neutrality. Taking neurotic suffering and the power of neurotic forces seriously leads to the consequence of assuming an active attitude against the patient's need to repeat his destructive pattern in his relationship with the therapist. Neutrality can not equal passivity. In this attitude in working with the patient, he makes sure that he takes and sticks to a clear, firm and neutral position. Whenever indicated, or even as a preventive measure, he spells out his position of being a therapist to the patient. Davanloo described the technique of undoing transference and undoing defiance. The last of this series of papers expands on examples of this technique during head-on collision.

He further emphasized the need for the therapist to take a firm and active approach in structuring the process by spelling out the therapeutic task in the general form of: "We are here together to explore, to understand what your problems are, and to get to the engine of your problems". Most patients are lay people in terms of psychotherapy. At the beginning of the treatment, they can not know, what psychotherapy can offer to them. Even if a person is psychologically minded and introspective, his neurosis itself and inherent defense mechanisms (especially the defense of externalization), prevent him from being able to see his psychic problems clearly, and from being in touch with their unconscious feelings maintaining the symptoms and character problems.
Even the goal of the therapy is spelled out explicitly in the form of freedom: freedom from the need to suffer, freedom to live a life in full possession of one's potential, and to live a life in peace. Especially patients who were traumatized early in their lives, and who grew up in a traumatic environment, have not much hope for leading a peaceful life, nor have they a sense of their potential. They need the therapist as a guide who knows there is a "peak of the mountain", not just "dark and dirty ditches", and who knows the patient has the capacity to reach the peak, and who knows the techniques of mountain climbing - although he does need the patient's activity in exploring his individual "ditches" and in finding his individual "mountain peak"; and in finding out together what are the factors inhibiting the patient in climbing. This attitude of knowing

that there is freedom and that the patient can reach it mobilizes a lively force within the patient, which is inherent in any human being but is often deeply buried. In the therapeutic situation, Davanloo calls this the unconscious therapeutic alliance.

Based on the fact that the patient has come to seek help, it can be assumed that his neurotic system is giving him more suffering than gratification, and that he wants freedom from neurotic patterns, at least part of him. In order to avoid transference neurosis, it is very important to spell out to him the two sides in the patient to him from time to time, and spell out that the patient is the one to choose which of his two sides he wants to follow. In this intervention, the therapist has to make sure within himself that he thoroughly stands behind, giving the patient the freedom of choice, that he is clear of any dependency or need for success with the patient. The intervention in the form of "your life is yours, misery is yours and happiness is yours, failure and success, clinging to neurotic suffering and freedom is yours", with the addition of "I am here to help you on your road to a free person, I would rather be successful, but my life does not depend on your success" is very helpful, clearing the relationship of any trace of transference neurosis. This intervention is forcing the patient to acknowledge his wish for health from time to time and is strengthening his unconscious therapeutic alliance.

While in IS-TDP the therapist does everything to prevent transference neurosis, Davanloo found that the mobilization of complex transference feelings and mobilization of transference resistances is the unrenouncable key to the unconscious pathological dynamic forces responsible for neurotic symptoms and for maintaining neurotic suffering, and the key for change.
The previous articles elaborated on the phase of pressure and the ways in which pressure and pressure and challenge is stirring up the repressed complex transference feelings. Since the old feelings in neurosis are often murderous feelings and /or very painful feelings of traumatization of the bond and attachment, a great deal of anxiety is also stirred up. The art (and the difficulty in learning the technique) is to mobilize sufficiently to get the dynamic process going, but not more than the patient (or the therapist in his state of learning) can tolerate.
The present article will deal with the moment the situation is "ripe" for taking up the transference with the patient.

Central Dynamic Sequence

Davanloo continued his presentation on the Central Dynamic Sequence, by emphasizing that each phase is a direct consequence of the one before; pressure from the therapist mobilizes resistance in the patient; resistance leads to challenge by the therapist; now challenge results in the mobilization of transference feelings and further increase in resistance; resistance rapidly acquires a transference quality, transference component of the resistance is mobilized. The therapist in turn responds by challenge to the transference resistance; the process eventually leads itself to the patient's direct experience of transference feelings.

The phases of the Central Dynamic Sequence form an interconnecting sequence. On that basis, it is artificial to single out any one phase and describe it as being more important than the others, but it is definitely true that the direct experience of the transference feelings is the goal towards which the therapist is working, and it is this that will lead to the unlocking of the unconscious. On that basis, transference must be regarded as the central and the key issue, and the therapist must watch vigilantly for indications that the transference is becoming a factor in the interview. He pointed out that the indications that the transference is becoming a major issue in the interview often may be subtle and indirect, but it is important that the therapist takes note of them and acts upon them. He emphasized that the therapist should watch for the following:

a) Partial breakthrough of the underlying feeling
b) An intensification of the resistance
c) Signals of increasing tension together with the indication that it is the transference that is involved.

Indications that Transference is Becoming an Issue

Here, we briefly summarize some of the signals as indicators of the entry of the transference:

a) A partial breakthrough leading to some remark by the patient which has a direct or indirect bearing on the transference,
b) Crystallization of a relationship with the therapist, which almost always contains both defensive and expressive components, with the defensive predominating and often showing a clear parallel with other relationships out of the transference,
c) Signal from the discharge pattern of the anxiety in the form of tension in the striated muscle, clenching of the fist, taking a deep sigh or gripping the arm of the chair,
d) Involuntary smile,
e) Avoidance of the eye, etc.

Then he presented a series of vignettes of twelve different patients to elaborate on the subject of the entry of the transference and the search for the resistance. Here, we summarize a few of these cases.

Case 1: The Case of the Salesman

The vignette of this case that he presented is representative of a patient on the extreme left of the spectrum of psychoneurotic disorders, who are highly responsive and can be treated in a single interview. During the phase of inquiry into the past, the therapist questions the patient as to whether his younger brother had become their mother's favorite. This mobilizes some resistance; the therapist, sensing that this was a crucial area, used challenging phrases by making explicit in order to crystallize and highlight the resistance:

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

This mobilized a series of tactical defenses: passive-compliance, rumination, rationalization and vagueness.

PT: Yeah, okay ... I guess he was then, but...

.....

PT: He was the favorite because he was the youngest ... possibly right.

Each of these defenses was challenged, and then the patient made an open statement of his resistance:

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

Transference resistance is crystallized. The therapist challenged the vagueness „I guess" and the need to rationalize "because he was the youngest". This leads immediately to crystallization of resistance in relationship with the therapist in form of open defiance. This means that he now behaves with the therapist in just the same way as he behaves with his parents.

Now, the therapist opens up the transference immediately:

TH: Now, let us look to your relationship here with me. You prefer to hang things in the middle of nowhere, okay?

(Entry of transference by addressing transference).

The therapist returned to the same issue on two subsequent occasions; and finally the following passage occurred which entirely confirmed the therapist's original perception.

TH:... was there any time that you felt resentful towards me?

(asking for transference feelings)

PT: Yeah, sure, you can sense it when I don't answer you. I go all around the issue. The issue is resentment, not that I dislike you ...

The patient is reacting with positive response, making himself the connection between his feeling of resentment and defenses.

Indication for the Entry of the Transference from the Parallel with the Relation Outside of the Transference

Here, he presented a few vignettes from the following case.

Case 2: The Case of the Chess Player

In the early part of the interview, the therapist explored a situation between the patient and his supervisor, and mobilization of hostility in the patient from his feeling of being in the power of the

supervisors and not himself being in control. As soon as the therapist mentioned this, there was intensification of the patient's intellectualization, obsessional defenses. This mobilization indicated that this was an anxiety-laden area.

In this case, the dynamic inquiry was soon leading to a specific situation (patient not being in control of the situation of his life, which mobilized hostility, defiance and obsessional defenses) The therapist is applying challenge by framing.

TH: So then we see in all these situations that you are describing, when you are not in control then that mobilizes anger and anxiety in you, and the mechanism with which you deal with it is already clear.

(challenge by making explicit).

PT: I would say that certainly applies to a lot of my interpersonal relationships.

Positive response of patient followed by entry of transference by drawing the parallel between specific situation and transference situation: "How does this apply here with me?"

TH: If we focus on the issue of control, how does this apply here with me?

PT: I think that is something very much understood ... that you are in the position ...

TH: Now you are going into the intellectual issue. I am talking in terms of your feeling.

Another positive response by the patient enables the therapist to focus directly on transference feelings.

PT: Yeah, okay, I'm just trying to get in touch with that. The more that I am able to find out where you are coming from, which really comes down to being able to trust you, the less it is an issue for me.

The therapist exerted further pressure which brought out the underlying transference feelings and his major problem with intimacy and closeness. It brought into the open his resentment towards the therapist's "professionalism" perceived by him as lack of warmth. This eventually led to his feeling about a detached, emotionally non-involved father, and further to his murderous rage towards his mother who was ineffective and always sick.

Now, we will summarize another patient presented which again highlights indication for the entry of the transference from the parallel with outside of the transference relationship.

Case 3: The Case of the Machine Gun Woman

The initial contact started with the phase of inquiry and dynamic inquiry. A woman in her thirties suffered from disturbances in the interpersonal relationships, episodes of depression, two major clinical depressions, sexual problem, being anorgastic; major problem with intimacy and closeness. During this very early phase of the interview, the therapist also focused on her earlier treatment which indicated that she had passively complied with her therapist and ended up being exposed

to humiliation. This was, by itself, an expression of her characterological problems, such as her inability to assert herself, and the tendency to enter into situations in which she was used and abused. In the following passage, the therapist focuses on some aspects of the patient's characterological problems.

TH: You go yourself on your own will, but then the focus is on sexual problem which you have okay?

PT: Uh hmm.

TH: But you say 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.

The therapist points out a situation to the patient where she reacts in a compliant way. She can recognize her pathologic behavior. With further and increasing pressure by the therapist, the patient eventually has a positive response: she even brings in a second character resistance, withdrawal.

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.

The therapist brings into focus the transference implication, particularly, her tendency to take flight as manifested in her previous treatment.

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.

The patient, again, responds positively by bringing in herself the parallel to her previous treatment. Especially in view of previous treatment, the therapist has to make sure that the character resistance is thoroughly worked through.

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.
This is a first signal of transference anxiety.
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.

The patient is more and more capable of understanding the defense mechanism which implies that transference feelings are rising steadily and constantly.
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?
(Picking up on transference by questioning on character resistance in the transference).
PT: No, I'm ... I'm ... at the same time I'm learning the difference between running away and complying, uhh, I'm not ...
(positive response)
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?
(Entry of transference by questioning character resistance in the transference).

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, of 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.

Still, the therapist maintains his focus on her character resistance even longer. The patient further mobilizes her forces against her defenses which is the result of a further rise in the transference. Now, the therapist brings in an even stronger emphasis on the transference in the following form, followed by a positive response.

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.

Joining forces together with the therapist and going for the battle against her defenses is the result of high transference , mobilizing unconscious therapeutic alliance.

In the above passage, we saw intensive work on the transference, and emphasized two of her characterological problems, namely, passivity or flight might become an obstacle in the interview. The patient finally responded very positively, and the therapist then proceeds to the phase of inquiry and dynamic inquiry.

ENTRY OF THE TRANSFERENCE: CRYSTALLIZATION OF THE TRANSFERENCE RESISTANCE

Case 4: The Case of the Man with the Chewing Gum

One of the ways the therapist could exert pressure is by pointing out some issues which are entirely true, but which the patient does not wish to look at. There was the analysis of the early part of the interview of a man in his twenties, a blue collar worker who suffered from a wide range of disturbances, both symptom and characterological. He suffered from panic attacks, chronic anxiety, phobic symptomatology, somatization, dizziness and characterological problems such as compliance, passivity, dependency and others. In the very first few years of his life, he suffered from a number of physical illnesses which resulted in his hospitalization, and when he was brought home, his mother, grandmother and aunt would rock him on a three-shift basis.

The first part of the interview focused mainly on inquiry, to which he was responsive, and what emerged was that the regressive secondary gain expressed by these disturbances was very prominent. The therapist brings this into focus. This mobilizes anxiety in the transference and mobilizes resistance. Now, we will see a few passages from the early part of the interview:

TH: Then you run to your mother.
PT: Hm hmm ...
TH: To protect you.
PT: Yeah.
TH: How long that sickness went while your mother, aunt and your grandmother were shifting and then rocking you.

The therapist, continuing his dynamic inquiry, kept focusing on an area the patient did not want to look at. This intervention mobilized anxiety in the transference, which immediately turned to resistance in the transference: the patient became detached, slow with avoidance of the therapist.

PT: I don't know, must have been uh ... well I don't uh ... (a deep sigh) know. It couldn't have been more ah, than a year, because ah ...
TH: Again your mother comes to your protection.
PT: Yeah, in a sense sure.

The therapist was exerting pressure by making explicit. The patient responded positively: "Yeah, in a sense sure," and by increasing his transference resistance (becoming more slow, with a low voice and becoming silent). These are all indications that the therapist needs to bring the transference to the open.

TH: How do you feel right now? Have you noticed that you have become much more slow and passive ?
PT: (smiling) No, I don't think so.
(Entry of transference by asking for transference feeling and by questioning and at the same time spelling out transference resistance)

Exerting Pressure Toward the Transference Feeling

The therapist has pointed out the parallel between the past and the present: that, in the past, he was rocked on a three-shift basis by his mother, grandmother and aunt; and that in his current life, without his boss and his wife, he is helpless.
PT: Yeah ... mm hmm, one doesn't like to be told that one is so dependent.

After further pressure and challenge, he becomes more resistant and there is both anger and anxiety in the transference. He moves to his pocket, takes out a piece of chewing gum and starts to chew it (major resistance in the transference). Then the technical intervention that the therapist applies is head-on collision with the transference resistance which leads to the breakthrough into the unconscious.

INDICATION OF THE TRANSFERENCE FROM PARALLEL WITH RELATIONSHIPS OUTSIDE OF THE TRANSFERENCE

Case 5: The Case of Hyperventilating Woman

The case of a young woman suffering from chronic anxiety, attacks of hyperventilation, disturbances of the interpersonal relationships, letting herself to be used and abused, and masochistic component in her character. During the phase of inquiry, it became evident that the first attack of hyperventilation started after a telephone conversation with her sister. This is followed by the phase of pressure and challenge toward her feeling, and then she admits that the conversation had made her angry.

Then, the therapist exerts pressure toward the experience of anger.
TH: Could you tell me how you experienced this anger?
PT: ... Cried.
As she spoke, she became tearful and began trying to control her tears in the interview. The therapist saw the obvious parallel between the transference and the relationship outside of the transference, namely, her sister and her mother, which, in a sense, was a communication about the transference.

TH: So you are holding onto your feeling right now, hmm? How did you feel when I repeatedly say "you guess so, " you don't commit yourself."
(Entry of transference by addressing transference resistance, "holding onto your feeling", immediately followed by pressure for transference feelings).

She finally admitted first to her irritation towards the therapist, and then to her anger toward the therapist.
It should be emphasized that here irritation by itself is a tactical defense against anger, and anger is a tactical defense against violent murderous rage. In this particular patient, it was demonstrated that, in the third psychotherapy session, she had come into the interview with a very vivid dream of her mother in the white dress in the entrance of the bedroom and wanting to murder her with a large knife. Patient woke up sweating and terrified. The following week, she reported another vivid dream in which with that large knife she murdered her mother, with blood all over the place. The focus of the subsequent sessions was on her unconscious murderous feelings towards her mother who was a demanding and controlling woman. She had terminated the relationship with the patient's father, and, subsequently, entered into a number of other relationships with other men with disturbed behaviour.
The technique used in the initial interview was a partial unlocking of the unconscious, with clear dominance of the unconscious therapeutic alliance against resistance.

INDICATION OF THE TRANSFERENCE: PARALLEL WITH OUTSIDE RELATIONSHIPS

Case 6: The Case of the Praying Mantis

Then he presented the initial part of the interview with a young woman. The major focus of his presentation had to do with the twin factors of transference and resistance. This young woman's pseudonym arises from intense elaborated fantasies of murdering men at the neck section of the vertebral column during sexual intercourse. She complained of chronic anxiety, disturbances of the interpersonal relationships, major problem with intimacy and closeness, severe phobic symptoms involving medical procedures, such as injection, and sexual penetration. The major reason for the referral was an acute vaginitis, and she was refusing gynecological examination and when she accepted to undergo an examination, the speculum could not be introduced.
The early part of the interview focused on inquiry, dynamic inquiry, and it became clear that her phobic symptoms dated back to her childhood. The result had been that, for years, her pediatrician had difficulty to examine her "turning the office upside down," and her mother had to describe her symptoms to the pediatrician and receive instructions over the telephone about how to treat her.

Here, we summarize a few vignettes to highlight the entry of the transference.
TH: Then you were stubborn in a way?
PT: Very, I still am.
Admitting to be stubborn is quite an achievement for a person.
TH: Was it only with the doctor or were you stubborn with the others?
PT: I was quite stubborn as a child.

One could expect that confirming this statement of her stubbornness should be accompanied by a rise in anxiety in transference, but it is of significance to note that throughout the whole of the early part of the interview, the patient used the defense of "La Belle Indifference," talking in a cheerful way about even the most distressing subjects. She even spoke in the same way about her masturbation.

PT: I have had orgasm from masturbating ever since I can remember, and I have been masturbating ever since I can remember.
The therapist went on to ask about the details , receiving an initial reply which was the epitome of "La Belle Indifference":
TH: What are the fantasies you have during masturbation and how do you do it?
PT: I just sort of grab my crutch with my hand.
TH: And then what type of fantasies do you have?
(The patient smiles in a coy fashion)

PT: I just really don't want to go into it. They embarrass me very much. Can we skip that one?

Now, for the first time, her cheerful chatting is changing to an embarrassed smile. She has a first subtle weakening of her resistance to any feelings. Now, we might say that the patient's smile is simply an expression of her embarrassment at being asked such an intimate question. But, it is an indication of mobilization of a major resistance in the transference; she is now embarking on the same kind of stubborn, defiant pattern she has described in other relationships, so that there is a definite parallel between these and the transference. The therapist now moves to a specific technical intervention:

TH: You said that you have always been a stubborn person, hmm, and that you always get your way. And this has been a pattern in both your current life and in the past with you pediatrician as a child and currently with your gynecologist.

PT: I don't know if I get my way always. Not anymore certainly. When I was a child I got my way always.

TH: Yeah. But you said that when you see a doctor you manage to get your own way.

PT: No ... I mean ... I have to submit to them eventually. I will go through a bit of trying to talk them out of it in order to stall.

TH: Finally you give in?

PT: Finally I give in.

The specific technical intervention consists of making explicit and putting emphasis on her stubborn behavior in her current and past life, again and again, until the patient starts backing off. This implies that, at least unconsciously, she can admit to the self-sabotaging aspect of her character resistance.

TH: And do you think that might be here with me?

(Entry of transference by questioning character resistance of stubbornness in the transference)

PT: Well ... I am not going to go into these fantasies.

TH: You are smiling.

PT: Maybe if I talk to you a second or a third time I might be willing to, but on the first meeting, No, I won't. Now maybe that is stubbornness.

Now, she behaves in the same way as with her gynecologist or other doctors. Her smile is a cover- up for rise in feelings. This indicates that her character resistance is softening, a sign of a rise in complex transference feelings.

Dr. Davanloo pointed out that all his cases that he has labeled "Praying Mantis" show a similar pattern. When the therapist wants to break through into the unconscious, they put a major resistance in the transference. The detail of the structure of the sexual fantasy is essential to make the first entry possible. He further pointed out that the therapist must be extremely careful not to allow himself to be drawn into a battle of wills. Then, he demonstrated a specific form of

head-on collision in handling such a transference resistance, and we saw a clear breakthrough into the pathogenic organization of the unconscious.

THE INDICATION OF THE TRANSFERENCE FROM PARALLEL WITH OUTSIDE RELATIONSHIPS

Case 7: The Case of Masochist Physician and the Big Eyes

Then he presented and analyzed a woman in her thirties who suffered from major characterological problems, passivity, compliance, self-depreciation, need to let herself to be used and abused, disturbance in the interpersonal relationships, specifically in her private life, sexual problems, episodes of clinical depression and a chronic state of anxiety. Her first marriage was to a man who was very disturbed, and she was badly abused and had intense dislike for him. She became pregnant before the marriage, she described herself as "scared to death" of her mother, and finally she had a baby who died at birth. She passively complied with the doctors who discouraged her from going to the funeral.

When the therapy started, she was married for a second time to a man who was highly controlling and domineering, and referred to herself as a masochistic partner. It also became clear that there was intensification of her character patterns in situations that would mobilize anger in her. During the interview, she showed a similar pattern of passivity, detachment, compliance, vagueness and self-depreciation, and the therapist, at first without mentioning the transference, brought this into the open.

TH: Did You feel that you wanted to see the baby?
PT: I don't remember. I think ... yeah, I wanted to see ...
TH: Did you?
PT: No. They didn't want me to see the baby.
TH: Why didn't they want you to?
PT: I don't know.
TH: I am not sure that you don't know, or is it that in a sense you ...
PT: You see ... I don't believe you know, I was so dumb... I just don't think ...

Instead of getting in contact with her angry feelings about this painful situation, she depreciates herself by declaring herself dumb. The patient, so far, has no awareness of this defensive character mechanism.

TH: Let me clarify one thing here. Have you noticed that during this period of time whenever we are getting into some of the important issues you say either it is "absurd," or "I don't remember," or "I don't know" and now you say you were "dumb"? Have you noticed that whenever we approach any of these painful issues you become very vague?

The therapist spells out the character defensive mechanisms to the patient in a very thorough and specific way.
PT: I notice I become vague, and I think it is because I don't remember that well.
This is a positive response , patient is starting to become aware.
PT: Well ... I asked if I could go and they said No. I didn't argue the point.
Why should an adult woman ask for a permission to go? Passivity and dependence are part of her masochistic character.
TH: If you wanted to go, what held you back?
PT: I was passive.
(Positive response)

Now the therapist opens up the transference by drawing the parallel between the outside resistance and resistance in the transference.

TH: This is something we should look into. You have your passivity in many situations, your passivity with your husband, your brother, and from the little we know it was the same with your mother, how about here with me?
PT: Probably passive.
TH: Are you passive or not?
PT: I would say I am even more passive.
Expressing to be „even more passive" is very honest.

After some further work, the therapist can proceed to transference feelings. He finally brought out that the patient had been angry with him when he focused on issues that she wanted to avoid, and that, just as in other relationships, her passivity was a way of dealing with her anger. It is important to highlight in the outline of this proceeding that Dr. Davanloo heavily emphasized again that anger is a tactical defense against the murderous rage; and the task for the direct access to the unconscious is the breakthrough of the primitive murderous rage and guilt in the transference which then becomes transferred to one, two, or more of the genetic figures. In this patient, the major column of the murderous rage is toward the mother, as well as toward the father. Equally important is the younger brother and the making of the perpetrator of her unconscious consists of this primitive murderous rage, and the guilt and the grief at the multidimensional level. She had an equally disturbed relationship with her father who went completely blind when the patient was young.

After a number of breakthroughs into her unconscious, when unconscious therapeutic alliance took a major dominance in relation to the major resistance, she had visual imagery of huge eyes around herself. Further, those huge eyes which she would see while driving would move over the windshield of the car, and also go under the car. Then, the process of working through focused

on the earliest trauma, her attachment, trauma, pain of trauma, primitive murderous rage, guilt and grief. Then, the focus was on the mutative law of the trauma under the dynamic system of the perpetrator of the unconscious.

Summary and Conclusion

This paper summarized Dr. Davanloo's presentation on the entry of the transference. As with other technical interventions in his system of IS-TDP, Dr. Davanloo, by his extensive research, has defined the exact moment when entry of transference is indicated. The phases of the central dynamic sequence have to be properly applied to prepare for the entry of transference. This paper emphasized:

1. Davanloo's conceptualization and technical approach to transference differs radically from that in classical psychoanalysis;
2. The direct experience of the transference feelings is the goal towards which the therapist is working, as it will lead to the unlocking of the unconscious;
3. The transference must be regarded as the central and key issue, and the therapist must watch vigilantly for indications that it is becoming an issue in the interview, and act upon them.

Several clinical vignettes were presented to elaborate on the subject of the entry of the transference, and to demonstrate various indications that transference is becoming an issue.

Case 1 is a patient of the extreme left side of Davanloo's spectrum of neurosis. The entry of the transference was by addressing the feelings of the patient towards the therapist directly. He was capable of responding to it immediately. The patient himself was able to make the connection between his defense of retreat and his resentment. In Case 4, the entry of transference also was by crystallization of transference feelings. This was evident when he became more slow with a low voice during the dynamic inquiry. But, in contrast to the salesman, he needed further pressure towards his transference feelings until he became aware "one does not like to be told that one is so dependent."

In case 2,3,5,6 and 7, the entry of transference was made by drawing a parallel of relationships out of the transference, and the relationship in the transference.
Finally, Dr. Davanloo emphasized the need for the therapist to monitor the process carefully. While he applies the phases of inquiry, pressure and challenge, he has to pay attention to signs from the unconscious. He has to be well acquainted with the signaling system of the unconscious to recognize the rise in the transference and the manifestation of the intensification of the patient's resistance in the transference. He must constantly adjust the impact of his specific technical intervention to the patient's unconscious. During his research studies and scrutiny, during more than thirty years, Dr. Davanloo evaluated thoroughly the patient's reactions to specific interventions

by videotape. Thus, he was able to give us a good knowledge of the metapsychology of the unconscious, based on research data and not on theory. It is obvious that a good knowledge of this metapsychology of the unconscious is required to master such a powerful technique. It requires systematic training to grasp all these subtle signs from the unconscious.

Acknowledgements

This paper is based on proceedings of a five-day immersion course presented by Dr. Davanloo to the Training Program of The German Society of Davanloo's Intensive Short-Term Dynamic Psychotherapy, June 17-21, Nürnberg, Germany.

Authors' Note

Please address reprint request to: The German Society for Davanloo's Intensive Short-Term Dynamic Psychotherapy e.V., c/o Dr. med. Gerda Gottwik, Wackenroderstr. 11, 90491 Nürnberg, Germany

Eckart Daser

Boothe, B. und Heigl-Evers, A. (1999) Psychoanalyse der frühen weiblichen Entwicklung. Reinhardt, München

In a continuation of the discussion of triangular models in psychoanalysis, the authors present the first developmental theory that is consistently triadic. For this reason, much of the book's focus is on formation of the concepts. The book outlines not only categories of prototypical enactments in the child's interpersonal developmental constellations, such as "embeddedness, positioning, and control" (125ff.) but also translates concepts of one-person psychology into dramaturgical concepts. "Triadic constellations," for example, take the place of oral, anal, phallic, and Oedipal phases and include "mediation," "exodus," "the self making its mark," and "inclusion and exclusion" (167). This dramaturgical interpretation of the phases now also accommodates phenomena that did not fit the classical concept of drives. For example, it now becomes evident why at the transition from "the self making its mark" – formerly the transition from phallic to Oedipal phase – the ideal of narcissistic perfection gives way to a willingness towards relationships characterized by mutual recognition and mutual esteem.

A dramaturgical interpretation of the phenomena leads to a view of the primary drives and primary communicating of the child as tension-filled mediation (105). Put another way, the classical concept of drive is complemented by a theory of interaction and dialogue, so that experiences such as "being meant" ("Gemeintsein") (89, 317) or "love…, or to be existentially moved by another" (279) can be accounted for systematically. A central category of enactment is "mediation" (34), a triadic constellation (194) that in a setting for at least three positions (167) creates "specific boundaries and connections" (128). This process, at the very best, can develop out of "creative ensemble acting" (172, 177), in that those involved can take on others' contributions and make them their own.

The background of these concepts - not made explicit by the authors themselves - lies in a dialectic whereby participants create a new world (a dramaturgical creation), in that they affect each other just as they allow themselves to be moved and changed by the other. In this process, the "you are the one we mean" ("Du bist gemeint") can be seen as an appeal to "test the validity of self-representation" (90), and "love…, or to be existentially moved by the other" is the willingness to take the "path of self-knowledge" (90) for the sake of the other. In such a process, not only do conflicts develop (and are perhaps resolved), but also ways of interacting take form that become binding to those involved. In this way, conflict dynamics, the development of social behavior, and

the formation of values all originate from the same dramaturgical dialectic. With this, a theory of dramaturgical dialectics, based on the material offered by the authors, could fulfill their demand for a psychoanalytic model that is "morally, socially, and psychologically" coherent (90).
Triadic scenes are in effect from very early on, even as early as the "primal scene at the breast" (180ff.). Behind the harmony of this scene, as part of the dramatic structure, there is also the fantasy of an ideal, female relationship that excludes the male, as well as its frightening correlate, the wish of the male to destroy this relationship or to place it under his control. The father can not be conveyed as a friendly representative of the non-mother world if the young girl's access to the world (exodus/separation) and thus her creative energy remain inhibited. The ideal of the female-maternal unity is called into question at the latest, however, at the awakening of genital sexuality. This also the young girl wishes initially to share with her mother (276ff.), but mother does not respond in the same manner. The young girl puts this down to the fact of her inadequate equipment, and she now turns to the father, only to find that he desires mother more than her. This defeat can no longer be explained by phallic inadequacy. The orientation towards the narcissistic ideal of perfection thus does not get her anywhere. Oedipal love demands confrontation with the relationship, but it is from this relationship that the young girl is excluded. What is crucial is how the young girl responds to this crisis. Will she flee back to childish dependency and develop passive, reproachful submissiveness? Or will she use her indignation over being excluded to form the boundaries of self and to reflect upon her own resources as the basis of her ability to love? Here the authors emphasize the necessity that self-consciousness develop not on the basis of affirmation by authority figures, but rather grow out of determined reflection upon the self.

This appeal for determined self-consciousness appears to be the authors' personal position, as it does not follow from the systematic aims of the book, the conceptual explication of enactment phenomena. It is a position that invites critique, and it is not shy, for it is has political meaning. Like the election slogan "Have the courage to trust your own mind!" that sought to loosen authoritarian bonds, the authors exhort fellow women to "Have the courage to trust in your own strength!" They fear that today's common accusations against the patriarchy serve to affirm women's traditional, passive role instead of emancipation if they are not based upon active engagement on women's part.
As it abstains from the use of the artificial language of psychoanalysis, the books is accessible to all interested readers. This is particularly fortunate, because a thorough examination of the interactive sphere requires interdisciplinary efforts. The authors themselves have based their theses on analysis of the most various scenes: the therapy setting, fairy tales, literature, the fine arts, and even everyday scenes from Hollywood. There are a number of impressive digressions, including a discussion of irony (115f), neo-Nazism (128f), and female beauty (185). Not the least due to its precise as well as personal and vivid language, the book benefits all attentive readers.

Dr. phil. Eckard Daser, Facharzt für Psychotherapeutische Medizin, Psychoanalyse
Hebelstr. 2, Konstanz