The Emergence of Psychodynamic Psychotherapy for Treatment Resistant Patients: Intensive Short-Term Dynamic Psychotherapy

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Abstract: Intensive short-term dynamic psychotherapy (ISTDP) was developed out of the need for relatively short psychodynamic psychotherapeutic treatment approaches to complex and resistant patient populations so common in public health systems. Based on extensive study of video recordings, Habib Davanloo discovered, and other researchers have validated, some important clinical ingredients that align the therapist with healthy aspects of the patient striving for resolution of chronic neurotic disorders and fragile character structure. In the case of character neurotic highly resistant patients, these approaches including "pressure," "clarification," "challenge to defenses," and "head on collision" can be used in a tailored and properly timed way to help the chronically suffering patient to overcome his or her own resistance and access core drivers of these pathologies. In this article the meta-psychological basis of ISTDP is reviewed and illustrated with an extended case vignette.

Keywords: short-term dynamic psychotherapy, emotion, unconscious, therapeutic alliance, somatization

In this article we will review the metapsychology, techniques, and empirical bases of interventions in intensive short-term dynamic psychotherapy. Readers who wish to see more detailed and elaborated discussion of these issues should refer to *Reaching Through Resistance: Advanced Psychotherapy Techniques* (Abbass, 2015).

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DEVELOPMENT OF SHORT-TERM PSYCHODYNAMIC METHODS FOR RESISTANT PATIENTS: ISTDP

Faced with long waitlists for public psychotherapy, a number of researchers developed short-term psychodynamic psychotherapy (STPP) models in the 1960s and '70s and showed they could be effective within a narrow range of patients (Davanloo, 1980). Such short treatments, typically defined as less than 40 treatment sessions, were developed independently by James Mann, David Malan, Peter Sifneos, and Habib Davanloo (Davanloo, 1980) but all found that the vast majority of patients referred for these early methods were not candidates (Malan, 2000). Davanloo, a trained psychoanalyst at McGill University, extended available STPP treatment methods by working with complex and resistant patient populations who were not candidates for existing STPP methods. Using treatment development methods now known as "deliberate practice" and "dismantling research" he studied video recordings, obtained patient feedback on recordings, and performed detailed process-based research over a period of many years. From this work he elucidated common psychodynamic pathways that led to sustained changes in both symptom and character disturbances in psychoneurotic and fragile patients. Based on Davanloo's early work and scope of application of his approach, David Malan reported that Davanloo's findings were a new frontier of psychodynamic therapy referring to his discoveries as the "most important development since the discovery of the unconscious" (Davanloo, 1980). The two collaborated over many years (Malan, 2000).

EMPIRICAL BASIS OF ISTDP FOR TREATMENT RESISTANT PATIENTS

There are now at least ten published outcome studies involving personality disordered and/or treatment resistant samples (Table 1). These include five cases series, four randomized controlled trials (RCTs) and one non-randomized controlled trial. Two of these were conducted in inpatient programs with a backbone of ISTDP delivered in group and individual sessions (Cornelissen, 2014, #148; Cornelissen & Roel, 2002; Solbakken & Abbass, 2014, 2015, 2016). A further RCT of treatment resistant depression is in process (Town, Clinicaltrial.gov NCT01141426). A meta-analysis of nine of these ISTDP based PD studies found the treatment to yield moderate to large effects that were sustained over follow-up (Town & Driessen, 2013). See Table 1.

Table 1. Studies of Treatment Resistant Samples treated with Intensive Short-term Dynamic Psychotherapy

Treatment Resistant Sample (Reference)	Number of Sessions	Number of Patients	Study Type (follow-up in months)	Within Group Effect Size: Post treatment*
Personality Disorder (Winston et al., 1994)	40	25	RCT (18)	0.84
Personality Disorder (Hellerstein et al., 1998)	29	25	RCT (6)	0.27
Personality Disorder (Callahan, 2000)	60	6	Case Series	4.92
Personality Disorder (Svartberg, Stiles, & Michael, 2004)	40	25	RCT (24)	1.76
Treatment Resistant Depression (Abbass, 2006)	13.6	10	Case Series (6)	2.16
Personality Disorder (Abbass, Sheldon, Gyra, & Kalpin, 2008)	27.7	27	RCT (24)	1.95
Refractory Mixed Diagnoses (Hajkowski & Buller, 2012)	8.6	23	Case Series	0.53
Psychiatric Inpatients (Abbass, Town, & Bernier, 2013)	9.0	33	Case Series	0.74
Refractory/Personality Disorders (Cornelissen, 2014; Cornelissen & Roel, 2002)	6 months	155	Case Series (12–120)	1.07
Mixed Treatment Resistant Samples (Solbakken & Abbass, 2014, 2015, 2016)	8 weeks	60	Controlled (14)	1.68
Numerical Means (unweighted)	**29.4**	**38.9**		**1.59**

Note. *Within Group Effect Size (Cohen's $d < 0.50$ is small, < 0.8 is medium, 0.8 or greater is large) on main self report outcome measure. RCT: randomized controlled trial.

META-PSYCHOLOGY

So what is it that Davanloo discovered and that Malan was referring to? Here we will review some of the core results of this extended, case-based research (Davanloo, 2005) of several hundred patients. In my own case-based research now over the past 25 years, I've come to the same conclusions as he did about pathogenic and therapeutic factors in working with complex and resistant patients (Abbass, 2002a, 2015; Abbass, Sheldon, et al., 2008). We are both concordant with the basic finding that psychodynamic therapy can be "uniquely effective" in these complex populations (Davanloo, 1990). Several of the aspects of this research have been corroborated by various groups of process researchers over the past 20 years (Abbass, Town, & Driessen, 2013).

Attachment and Attachment Trauma

Unprocessed complex feelings related to interrupted attachment are central emotional and psychodynamic drivers of neuroses and more severe character disorders. Such complex feelings including various degrees of thwarted loving feelings, grief, rage, and guilt about rage are activated by new attachments and threats to attachment rupture resulting in unconscious anxiety and unconscious defenses. When sexualized feelings are present they are heavily fused with murderous or primitive murderous rage and guilt. This process of transference can occur in both the patient and therapist upon attempting to form a new therapeutic bond, presenting both a risk and opportunity for this treatment team.

Unconscious Anxiety and Defenses

Three main pathways of unconscious anxiety include the striated (voluntary) muscle, smooth muscle, and cognitive perceptual disruption. Each of these correspond to categories of major resistances, or defenses against the experience of murderous rage and guilt, including isolation of affect, repression, and primitive defenses. Motor conversion is a mechanism whereby voluntary muscle is shut off under the mechanism of repression. Each of these patterns can be detected in clinical interviews allowing direct detection of processes of somatization (Abbass, Lovas, & Purdy, 2008).

Two Spectra of Resistance

Akin to Otto Kernberg's spectra, two spectra are defined, one with patients with fragile character structure of mild to severe degrees and one with patients without fragility. Patients with fragility experience the spectrum of primitive defenses and cognitive perceptual disruption when anxious while psychoneurotic patients do not do so under ordinary circumstances. Psychoneurotic patients go from low to moderate to high resistance with increasing early trauma and increasingly greater intensities of complex feelings and defenses. The spectrum of fragile patients goes from mild fragility to severe fragility with the difference being how high a rise in anxiety the patient can tolerate before being overwhelmed with cognitive perceptual disruption or primitive defenses. These two major groups are different in terms of trauma and attachment history, treatment duration, outcomes, and psychotherapy treatment process.

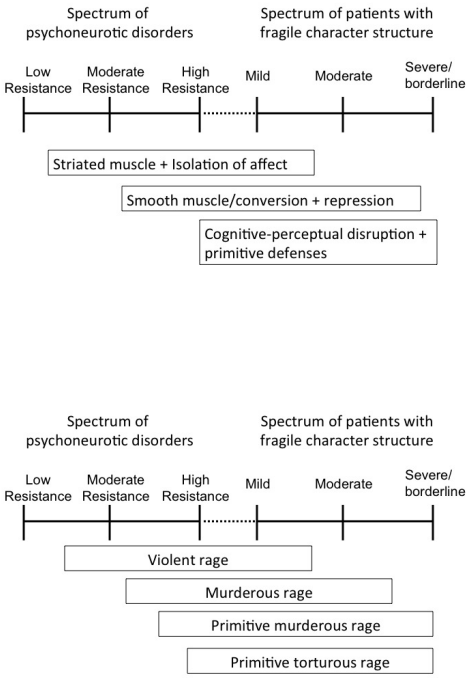
In highly resistant and fragile patients there are intense buried feelings and subsequent self-destructive tendencies with a heavy burden of guilt about rage toward attachment figures. In contrast, low resistant patients have only grief in the unconscious about unresolved loss and they do not have self-destructive tendencies: these patients are quite healthy and rare in clinical settings. In a private psychiatric practice, only 0.9% of 342 referred patients were low resistant while 47.6% were highly resistant and 24.5% were fragile (Abbass, 2002b). (See Figures 1a and 1b.)

Triple Factors

Davanloo's major discovery as it relates to resistant patients is that therapist efforts to engage, manage defenses, and focus on underlying feeling activates Complex Transference Feelings, Resistances, and the Unconscious Therapeutic Alliance. All three are mobilized in proportion to each other: in other words the road to the alliance is through the activation of and overcoming of resistance.

Complex Transference Feelings (CTF)

Efforts to attach therapeutically, understand the patient in depth, and to identify and experience underlying feelings and impulses results in



FIGURES 1a and 1b. Two spectra of patients.

an activation of complex feelings. These include positive feelings, rage, and guilt and these feelings activate the above noted, unprocessed, attachment feelings and subsequent unconscious anxiety and defenses.

Unconscious Therapeutic Alliance

The Unconscious Therapeutic Alliance or UTA is a term for the unconscious healing aspect of the person, which is inhibited or prevented from developing under unconscious anxiety and resistance (Davanloo, 1987). When activated it results in slips of the tongue, vivid memories, and imagery related to attachment and attachment rupture. Rather than an all or none phenomena, the UTA is on a spectrum from crisp communications of insight, to slips to linkages to the production of imagery.

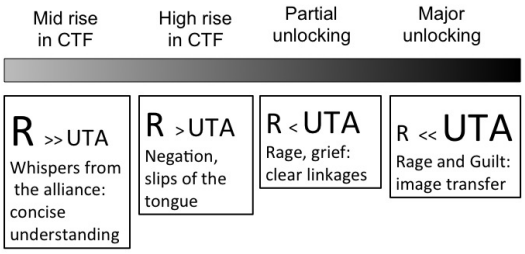


FIGURE 2. Spectrum of UTA and mobilization of the Unconscious.

Transference Component of Resistance

With this rise in anxiety, defenses tend to crystallize in the room creating a wall and barrier with the therapist: the patient moves from avoiding his or her feelings to avoiding the therapist. Beneath this barrier however lie the mobilized CTF and the UTA. (See Figure 2.)

Unlocking the Unconscious

When the CTF are experienced and the Resistance drops, the UTA takes a dominant position over the resistance giving the patient and therapist a direct access to underlying emotion-laden memories. This is considered to be a neurobiological event whereby emotion and memory centers are activated in concert with inhibitory and reflective brain centers: when the feelings are felt, the inhibitory centers are overpowered and reduced or stop operations allowing emotions and memories to be accessed (Gaillard, 2000).

With this process, a build-up of buried feelings and neurotic attachment with the therapist is prevented: the patient is freely able to move to difficult zones in the unconscious, experience feelings, and consolidate what is learned. The formation of transference neurosis is thus purposely avoided as it is considered to be an impediment to rapid moblization and working through of the unconscious content.

Unlocking is also on a spectrum from partial to major to extended. In partial unlocking, the primary experiences are some rage and grief and the patient brings linkages to attachment trauma related feelings: with

major and extended unlocking, rage, guilt about rage and grief are experienced and the imagery of the therapist or current figure transform to the person where the trauma-laden feelings originate.

Two research studies have now demonstrated the role of major unlocking of the unconscious and how it relates to diverse outcomes including symptom reduction, interpersonal problem improvement, improved work function, reduced psychiatric medications use, and reduced health care costs (Johansson, Town, & Abbass, 2014; Town, Abbass, & Bernier, 2013).

Timing and Types of Interventions

The key interventions of ISTDP include pressure, clarification, challenge, head on collision, facilitation of emotional experiences, and recapitulation.

Pressure is the summation of efforts to encourage healthy, active, engaged focus with the therapist on pathogenic defenses, and avoided unprocessed feelings. Examples of pressure may include detailed examination of key relationships, focus on identifying feelings, or focus on being emotionally present with the therapist. It is an encouragement of doing something positive, even though pressure is difficult to do. Pressure mobilizes the triple factors of complex transference feelings, resistance, and unconscious therapeutic alliance. Pressure is warranted whenever the process is emotionally detached, at *low rise in the CTF* and the patient is not engaged or is mired in defenses. Pressure stands as a common factor across most psychotherapy models where the focus is on encouraging positive relational and health-related behaviors.

Clarification and challenge to resistance is warranted when resistances crystallize in the therapy relationship beginning to form a wall or barrier in the process. We refer to this as the *mid rise in the CTF*. Defenses are clarified before challenging them so be sure the patient is never under attack, rather the pathogenic behaviors are under attack from both the patient and the therapist. Such work turns the patient against his defenses and renders them dystonic. This further mobilizes the triple factors. Without this work, the resistances block the therapeutic efforts of *pressure* to promote healthy actions and patterns of relating.

Head on collision is a global challenge to the summation of the resistance as it is crystallized in the transference coupled with high pressure to act against the resistance. It is a statement of reality that includes key elements tailored to the resistance of the moment. It typically includes efforts to deactivate the transference, undo the notion of the omnipo-

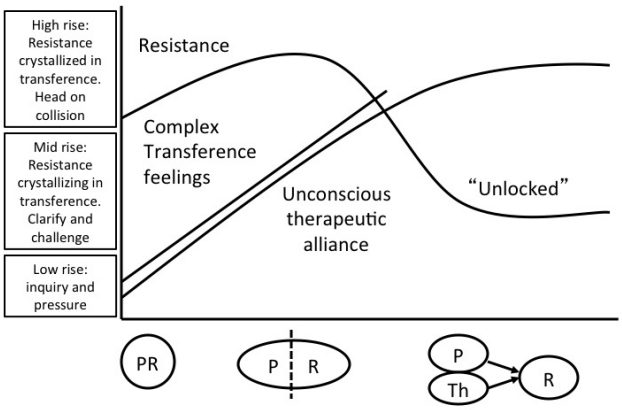


FIGURE 3. Unlocking the Unconscious.

tent therapist, undo defiance/ensure the patient's will, deactivate other resistances in the room, and high pressure/encouragement to the patient to do his or her best to override his or her defenses. There are different types of head on collisions and timing for these varies but major varieties of these are employed when the resistance is heavily crystallized in the transference at *high rise* in the CTF. (See Figure 3.)

Facilitating the somatic experience of the CTF is done when the patient is nearly in contact with the visceral, motoric, and cognitive aspects of the feelings. If the first feeling is a loving feeling then this is experienced somatically as warmth, an urge to embrace, and a softness with tendency to smile. Rage is typically experienced with increasing sensation of heat sometimes of volcanic intensity. Accompanying this heat is an urge to grab, bite, strike, or do some other form of violence: when this is felt the tension of anxiety drops and the person is free to move. Guilt about the rage is experienced with pain and constriction in the upper chest, intense painful feeling, flowing tears looking at the damaged image of a loved one after the passage of rage for example. Grief is experienced as a softer painful feeling without the physical pain and constriction and the cognitive set relates to loss.

Recapitulation is the interpretive equivalent in ISTDP and is reserved for after a rise in feelings or passage of feelings. It includes linkages of the past to present people, and linkages of feelings to anxiety to defenses. It includes a review of the complexity of the feelings and the source of the feelings. It includes other detailed ingredients and factors observed through the mobilization phase. This recapping is very important to bring both symptom reduction and psychic changes in

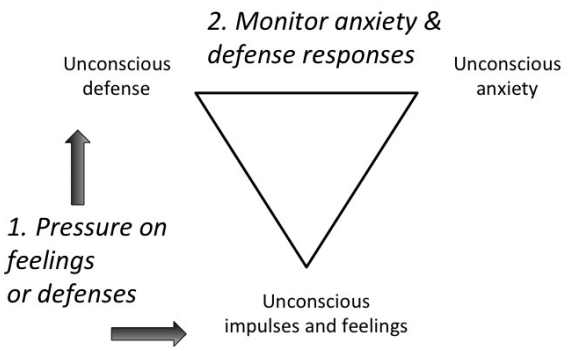


FIGURE 4. Psychodiagnosis.

multiple dimensions including anxiety discharge pathways, defense, and self-reflective capacity.

INITIATING THE TREATMENT PROCESS

The ISTDP process includes (1) addressing barriers to engagement, (2) finding the therapeutic front of the system, (3) psychodiagnosis, and (4) monitoring five parameters.

Barriers to engagement include things like no awareness of an internal problem, lack of willingness to look inward, or fixed suicidal ideation. Each of these require direct management before the unconscious can be safely mobilized.

There are four main types of therapeutic front each of which is handled differently. These include, feelings ready to break through, unconscious anxiety, defenses crystallized in the room, or an absence of any signals. If feelings are ready to break through it is best to facilitate this experience. If unconscious anxiety is too high it is brought down by recap or focusing on body cues to increase self-reflection and isolation of affect. If anxiety is in striated muscle then apply pressure to underlying feeling. If there are no signals then the therapist should search for the resistances that are keeping the process flat and explore or pressure in that direction (Abbass, 2015, Chapter 7).

Psychodiagnostic assessment: In order to determine a patient's placement along these spectra, a psychodiagnostic process is used to activate

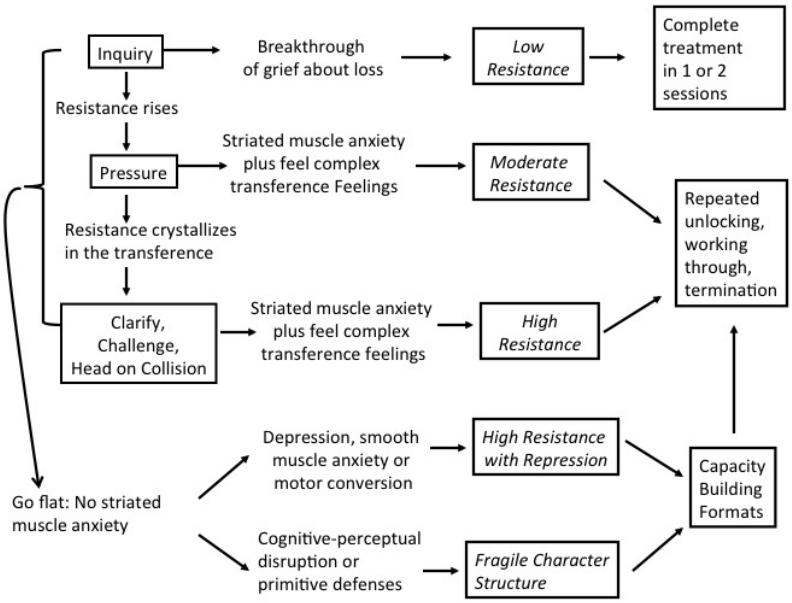


FIGURE 5. Psychodiagnostic and treatment algorithm.

unconscious complex feelings through pressure directed on avoided emotions and defenses that are being used in the office. This process mobilizes the triple factors of Resistance, CTF, and UTA in resistant patients. In low and moderate resistant patients, this alone leads to breakthrough to the unconscious. In moderate to highly resistant patients, this brings a rise in resistances in the office visible with walling off, detachment, and active avoidance while at the same time an increase in self-reflection and curiosity. Patients with repression will experience a flattening effect with loss of muscle tone and signals of smooth muscle anxiety, muscle weakness, or depressiveness at some level of rise in feelings. Finally patients with fragile character structure will experience a loss of striated muscle tone and have cognitive perceptual disruption and/or projection or projective identification at some level of increased intensity of feelings (see Figure 4).

The end result of this process is a roadmap or pathway outlining what is required to either build capacity or break through the resistances and activate the UTA (see Figure 5).

ISTDP WITH A HIGHLY RESISTANT PATIENT

Here we will review the assessment, treatment method, first breakthrough to the unconscious, and later major unlocking with a highly resistant patient.

Case History

The patient is a 66-year-old married accountant with chronic depression with past suicidal plan, somatic problems of choking sensation, functional chest pain, and emotional detachment. He had inadequate responses to both supportive psychotherapy and medications. Following inquiry into the problem areas, pressure to a specific example allows us to understand how his symptoms formed when he was removed from some contracted accounting work. In this vignette, the pressure is to identify feelings that preceded his depression. He was sitting with hands clenched and some striated muscle tension.

Th: So how did you feel toward the man who terminated your contract? [*Pressure to identify feelings.*]

Pt: Well, I felt sorry for him. [*Intellectual answer, denial of any anger.*]

Th: How did you feel toward the guy about terminating you though? [*Pressure to identify feelings.*]

Pt: I felt sorry for him.

Th: How did you feel toward him? [*Pressure to identify feelings.*]

Pt: Towards him? (Clenching his hands.)

Th: Yeah.

Pt: Felt sorry for him; he's having a terrible time. [*Intellectualizing, rationalizing.*]

Th: But how did you feel about him cutting you off in the middle of the contract? [*Countering tactical defenses, pressure to feelings.*]

Pt: Yeah. (Takes a big sigh.)

Th: Let's see how you feel toward him about that. [*Pressure to identify feelings.*]

Pt: I had no bad feelings toward him. [*Denial.*]

Th: But how do you feel toward him about the action of cutting you off in the contract? [*Pressure to identify feelings.*]

Pt: (Takes a big sigh.) I was ambivalent really. [*Tactical defense: cover words.*]

Th: But what feelings do you have because you say you got tired and depressed around then right? [*Linking to his problems, pressure to feelings.*]

Pt: Yeah.

Th: When you look back now, how do you feel toward him? [*Pressure to identify feelings.*]

Pt: (Takes a big sigh, and breaks eye contact.)

Pressure in this case is mobilizing complex feelings, unconscious anxiety in striated muscle, intellectualized defenses and a tendency to detach in the transference. Now the process is at mid rise in the transference and now is the time to start to clarify this resistance (see Figure 4).

Th: What do you feel though? You see "sorry for him" is a thought in your mind. It's an idea. [*Clarification of feelings versus thought.*] How do you feel toward him when he cut you out of the contract? [*Pressure to identify feelings.*]

Pt: I never really had any feelings. [*Denial, sigh.*]

Th: Did you notice you just took a big sigh? [*Pressure to notice unconscious anxiety.*]

Pt: Yeah.

Th: There is tension in your body. It's anxiety. But how do you feel underneath all that? Your wish is there that we get a good grasp of why is this happening to you, right? [*Pressure to will.*] I mean you get depressed, you get anxious, and you get shut down. [*Linking feelings to his problems.*]

Pt: Yeah.

Th: But what's happening inside you? Do you want us to look into that? [*Pressure to will.*]

Pt: Well, it would be nice to know…

Th: Okay, so let's see how you felt toward that guy. [*Pressure to identify feelings.*]

Pt: I don't think I have any feelings toward him.

Th: No, but you get depressed and anxious. What happens to how you feel toward him? How do you feel toward the guy when he cuts you off? [*Pressure to identify feelings.*]

Pt: Well, I guess I was frustrated. [*Tactical defenses: indefinite terms, past tense and minimization.*]

Th: You're not sure if you were. [*Blocking of the defense.*]

Pt: No, I'm not.

Th: You say you guess and you're frustrated, but…[*Blocking of tactical defenses.*]

Pt: I don't recollect having any feelings toward him!

Th: How do you feel when you look back on the picture now? How did you feel toward him when you got the notice he was cutting you off? [*Pressure to identify feelings.*]

Pt: (Big sigh and further avoiding eye contact and slowing down.)

At this point the resistances he uses against feelings are becoming resistances against engagement with me. Clarification and challenge to the resistances in the transference are now necessary. Challenge is increased as resistance increases. You will see that clarification is used as needed to be clear about what is being challenged so the patient is absolutely clear that the challenge is toward his defenses and not his self.

Th: What's happening here in the room while we're talking about this because you seem to be slowing down a lot? Did you notice you're slowing down a lot? You're slowing down and you have tension here when we talk, right? [*Clarification of resistance in the transference.*]

Pt: Yeah.

Th: Yeah, but what feelings do you have here with me when we talk because you get slowed down here with me and tense. [*Pressure coupled with clarification.*] How do you feel here with me if you don't slow down or go away? [*Pressure and challenge.*]

Pt: Well I feel a sense of hopelessness not being able to come up with the answers. [*Intellectual answer.*]

Th: How do you feel about the question? [*Pressure to identify feelings.*]

Pt: Well, it is a good question.

Th: What emotions do you have inside, because you get slowed down. [*Pressure to identify feelings and clarification of defense.*]

Pt: Yeah.

Th: Well how do you feel toward me? Back there with those guys, you don't feel the anger, you get slowed down and hopeless and anxious and tense, okay? [*Linking current–transference relationships.*]

Pt: Yeah.

Th: You don't feel any of that anger about what they were doing. You get slowed down, right? Now here with me you're getting tense and slowed down. [*Clarification of defense.*] But, how do you feel here with me? [*Pressure to identify feelings.*] I'm asking you a hard question. This is a hard question for you, but how do you feel about it? [*Pressure to identify feelings.*]

Pt: Well maybe I don't understand what feelings are. [*Whisper from the unconscious therapeutic alliance.*]

Th: Well that's one thing we're seeing, but how do you feel about me asking how you feel? [*Pressure to identify feelings.*]

Pt: Well I feel we're probably getting to the root of the problem. [*Communication from the unconscious therapeutic alliance.*]

Th: Uh-huh, so what emotions are stirred up when we work together here to figure this out because you get tensed up, slowed down, and hopeless thoughts? [*Pressure to identify feelings.*]

Pt: I can feel the tension building now. [*Ruminating, detaching plus increased self-reflection.*]

With continued pressure and clarification the patient is increasingly detaching in the room, avoiding eye contact, slowing down, and ruminating to himself. The resistance is crystallizing in the transference.

Th: Now how do you feel here with me? There's a positive feeling because we're working hard and we're doing something. But how do you feel because you are slowing down, and slowing down blocks the feelings. Am I right? [*Clarification and pressure.*] And I think you're measuring everything in your mind, too, censoring yourself. Do you get what I mean? [*Clarification.*] You're filtering everything, am I right? [*Clarification.*]

Pt: Right.

Th: Okay, now if you don't filter yourself, how do you feel? [*Challenge and pressure.*]

This segment illustrates a head-on collision at high rise in the transference built to turn the patient against his own resistance and make a first breakthrough to the unconscious.

Pt: (Sitting tense with hands firmly clasped, eyes fully avoiding mine.)

Th: How do you feel emotionally here with me if you don't avoid me? [*Pressure and challenge.*] And your hands are like that too by the way. [*Clarification and challenge.*] They're closed up, and you're closing yourself. How do you feel if you don't shut down? [*Pressure and challenge.*]

Pt: Well I'm going to have to learn how to open up, aren't I? [*Somewhat sarcastic and passive comment.*]

Th: Well, let's see what we can do about it at this point because part of you shuts you down and the rest of you is trying to open up. [*Head-on collision: emphasizing conflict between alliance and resistance.*]

Pt: Right.

Th: But what can we do about that so you don't shut down anymore [*Head-on collision: pressure and challenge.*] because shutting down would paralyze you, depress you, make you anxious and then shut you off. [*Head-on collision: consequences of resistance.*] Let's see what we can do about that shut-

down system that you have. What are we going to do about it? [*Head-on collision: pressure to alliance.*]

Pt: Well, that shut down system has been around for years, perhaps 64 years [*Whisper from the unconscious therapeutic alliance.*]

Th: Sixty-four or so? How much has that been hurting you? [*Head-on collision: consequences of the resistance.*]

Pt: I never realized it until you pointed it out, but I think you're right.

Th: How much has it hurt you? You don't let people get close to you. [*Head-on collision: consequences of resistance*.]

Pt: I've been told that.

Th: But here with me there's part of you that wants to put up a wall that keeps me out and then I can't get in to help you, right? [*Head-on collision: consequences of resistance against emotional closeness.*] It keeps me out. Do you follow me? Part of you puts up a wall… [*Head-on collision: nature of the resistance.*]

Pt: Yeah.

Th: That limits what I can do, and that defeats what you're trying to do here with me. [*Head-on collision: undoing the notion of omnipotent therapist, deactivating defiance, emphasizing the destructiveness of the resistance.*] What are we going to do, because part of you wants to sabotage what you're trying to do with me here, to defeat it? [*Head-on collision: emphasizing the partnership and resistance of the guilt.*] To hurt your effort…

Pt: So what causes that? [*Unconscious therapeutic alliance.*]

Th: And hurt what you're trying to do here with me, and we don't know why you would want to do something against yourself. [*Head-on collision: destructiveness of resistance, limits of the therapist.*] What can we do about this because otherwise the risk is that you would hurt yourself; you wouldn't get the best for yourself. Part of you would defeat what you're trying to do with me. [*Head-on collision: consequence of defeat if the resistance stays.*] So what are we going to do? [*Head-on collision: pressure to partnership.*]

Pt: So why does that happen? [*Unconscious therapeutic alliance.*]

Th: What can we do about it right now? [*Head-on collision: pressure to battle his own resistance.*]

Pt: I don't know.

Th: But ultimately you have to break through this. [*Head-on collision: undoing notion of omnipotent therapist, deactivating passive compliance.*]

Pt: I appreciate that.

Th: But what can we do? Because if you keep a wall with me, we won't break through it. [*Head-on collision: consequence of resistances.*] Because part of you still wants to avoid me so you detach. You cover up with me. [*Head-on collision: highlighting the specific defenses.*]

Pt: But I, I feel I've been pretty open with you.

Th: But besides words, though, part of you wants to detach from the emotions that you have here with me. [*Head-on collision: emotional wall and barrier.*]

Pt: That's the result of many years of practice. [*Unconscious therapeutic alliance.*]

Th: I wonder how do you feel about that. Because how many years have you kept yourself from your own true emotions…from being your *self*.

Pt: (Tears well in his eyes.) Well, I'm saying it's been 62 years; that's my first reaction. Sixty-two years and sure it's damaged me probably more than I realize. [*Unconscious therapeutic alliance.*] And maybe you know as a result of the cancer (seven years prior), I knew something was wrong, but I didn't know how to deal with it. I knew something wasn't right, and I was frustrated with "hey, life is short. I've got to get through this." But I didn't know what it was and didn't know how to get through it.

Th: Part of you didn't want to go to the end detached. You didn't want to go through your life as not a feeling person.

Pt: Right.

Th: You didn't want to die that way.

Pt: [*More tears, palpable painful feeling and patient is much more open and relaxed.*]

This vignette illustrates a first breakthrough of grief about the destructiveness of the resistance. This breakthrough is a direct response to heavy pressure to reach the person stuck under the resistance and challenge to help him battle his own defenses. Head-on collision was also required to enable this breakthrough and to turn him against his defenses. This is typical of early process work with highly resistant patients and it renders the defenses dystonic.

Later in Trial Therapy: Partial Unlocking

This passage of grief mobilized further anxiety and resistances crystallized heavily in the transference. This called for mounting pressure, challenge, and head-on collision to bring the UTA back into a dominant position.

Pt: [*Sitting in a laid back posture, with hands clenched and full eye avoidance, detached.*]

Th: But the problem is what are we going to do about this detachment and this wall and barrier you're putting up here with me right now? [*Head-on collision: problem of the wall, pressure, and challenge.*]

Pt: I don't see the wall.

Th: But right now, it's very specific: it's like that. [*Therapist points to his laid back posture which is a nonverbal defense.*] You're totally closed up, tense, smiling, and avoiding me. [*Head-on collision: nature of resistance.*] You're totally avoiding me and covering up. Now here's the issue: part of you (unconscious therapeutic alliance) wants to get to the bottom of this. And part of you (resistance) wants to put this wall and sabotage and defeat yourself and keep the problems inside and not let me get in to help you out. [*Head-on collision: effects of the resistance.*] But then I'm limited. Right? I'm limited, but then I'd have to say I could only do what I could do. And then I would have to say I failed. But then I can afford to fail because I can't always get there. Because sometimes I can't get through; we can't get through. [*Head-on collision: undoing notion of omnipotence.*] But one question is "can you afford to carry this any longer?" Do you want to carry this any longer, this wall, this detachment, this sabotaging of yourself like that? [*Head-on collision: appeal to the unconscious therapeutic alliance.*] Why do you want to have it like that? [*Head-on collision: pressure to unconscious therapeutic alliance.*]

Pt: I don't see…

Th: Take a look here. [*Head-on collision: pointing to his nonverbal defense.*] You're totally closed up here with me. You're disconnected from how you feel here. You're anxious and tense and you're avoiding me and we still don't know how you feel here with me. [*Head-on collision: clarification of the state of resistance, high pressure.*]

Pt: [*Ruminating to himself, still detaching.*]

Th: See, you're thinking, but how do you feel? Your mind is blotting the whole thing out, but how do you feel if you don't do that? [*Pressure and challenge.*] See you're avoiding me. More specifically you're avoiding my eyes. [*Pointing out detachment, pressure.*]

Pt: I am now because I'm thinking about…

Th: Yeah, but most of the time you avoid me and you're slowed down and closed up.

You put a wall up between you and me, but let's see what are we going to do about that. [*Head on collision: nature of resistance, pressure to task and partnership.*] What are we going to do about the wall here between you and me and maybe part of you says "he can ask all day but I'm not going to tell him how I actually feel, I've kept it 62 years; I'll keep it the next 30 years or whatever there is." [*Head-on collision: high pressure.*]

Pt: But I'm not doing that consciously. [*Unconscious therapeutic alliance.*]

Th: Consciously or unconsciously doesn't matter. It's happening, and only you can control it. [*Head-on collision: deactivating the transference, pressure.*]

But let's see what are we going to do about this because so far it wants to sabotage.

Pt: But then I... [*Beginning to ruminate.*]

Th: But now you want to explain, but if you don't... [*Blocking rumination.*] You're explaining why you want to keep a wall; part of you wants to keep it.

Pt: If I don't see the wall, how can I defeat it? [*Bouncing back and more active, but still leaning back.*]

Th: Yeah, but so far this wall is still here. Your smile is part of the wall. [*Challenge to nonverbal defense.*]

Pt: I don't see the wall. [*Active moving, gesturing and appears irritated.*]

Th: Closed up is part of the wall and holding yourself like that is part of the wall. [*Pointing out his leaning back posture: challenge to nonverbal defense.*]

Pt: But if I don't see the wall how do I get rid of it. [*Slaps hands down on legs.*]

Th: But now you're saying "if I don't see the wall."

Pt: Well I don't. I feel I'm being quite open with you. [*Smiling and defended.*]

Th: Yeah, but your smile is here right now. But what do you feel here with me right now underneath that? You're covered up, but how do you feel toward me? [*Pressure to identify feelings.*]

Pt: I told you, I feel fine! [*His voice is obviously revealing irritation.*]

Th: But how else do you feel toward me? Your voice doesn't sound "fine." Your voice is probably the true feeling. How do you feel toward me there? [*Pressure to declare feelings.*]

Somatic Pathway of Rage: Partial Unlocking

The patient finally sits forward and engages eye contact. He is giving up his defenses and allowing the impulse to break-through.

Th: I think you'd be crippled to say you're frustrated, and you would close up and sabotage and become hopeless and anxious and put up a wall and barricade and cripple yourself and shut down rather than to say how you actually feel. [*Head-on collision: crippling effect of resistances, deactivating defiance, high pressure and challenge.*]

Pt: But I don't feel frustrated! [*Unconscious therapeutic alliance: negation. Moves arms in a very active thrusting motion: tension has dropped and somatic pathway of rage is activated.*]

Th: How do you feel right there? You say you don't feel frustrated. But, how do you feel right there inside your body? [*Pressure to identify feelings.*]

Pt: Well the moment I said it, I felt frustrated!

Th: But how do you know, you felt aggressive for a split, for a flash of a second there, you know you felt like aggressive, I'm talking, if you level with yourself about it, there was an aggressive wave of something in you.

Pt: It was there for a split second.

Th: You get so that immediately you shut it down though. Did you see how quick you did that? You totally shut off the system. You disconnect from it that quick: you get detached, you get tense and then something happened to shut you down. [*Recapitulation.*]

Pt: But I know the anger was going at me.

It is important to note that through this entire segment there is no anxiety, no eye avoidance, and the patient heavily engaged with the therapist: the resistance has ceased operating and the UTA is taking a dominant position. Notice as well there is no role of challenge at this point because resistance is overcome. This is where the real history emerges and verbal content is highly relevant: emotional content is accessible and easily interpretable. This process occurred at the 40-minute mark of this trial therapy interview.

Th: Who else?

Pt: Maybe my father. [*UTA: linkage.*]

Th: Was he on your mind?

Pt: Yeah.

Th: What was there about you and him, about the anger in you and him.

Pt: Well the fact that he had cancer at 60 and I had cancer at 60.

Th: Uh huh.

Pt: That was in my mind, no question about that.

Th: That, you got (inherited) something from him?

Pt: Yeah. But I don't really recollect getting angry. [*UTA: negation.*]

Th: Yes.

Pt: But the anger was certainly there. I'm not sure who I directed it at [*UTA: negation*]. I suspect I directed it at me. [*UTA: deep insight.*]

Th: Yeah but you see that's what you would have done but was there some anger with your father somehow. What happened with you and your father?

Pt: Um, we weren't what you call close.

Th: He wasn't close with you?

Pt: No.

Th: So, he was a detached man too.

Pt: Yeah.

Th: He wasn't affectionate?

Pt: No, and all the first 11 years I was home and then when I was ten I was sent away to boarding school.

Th: So you were sent to boarding school.

Pt: Yeah. Oh, it was about three months at a time, and he was always working. He was a salesman so he was always working. We very rarely did anything together.

Th: Uh huh.

Pt: So that may have something to do with it but I'm not sure.

Th: I mean you wanted something with him? You wanted at some point to have something with him? [*Underscoring his craving of attachment with the father.*]

Pt: Later on in life I certainly did. Yeah but then the relationship that I had with my son is terrible too. [*UTA: understanding transference. Intergenerational transmission of trauma.*]

Th: It's kind of the same way?

Pt: Yeah.

Th: So you have trouble getting close to your son and your father had trouble getting close to you.

Pt: Yeah. [*Sniffles, grief coupled with deep insight.*]

The trial therapy proceeds with medical, psychiatric, and personal histories. The findings of the interview regarding the two triangles and underlying feelings are reviewed. The treatment plan to identify and process defended feelings while overriding resistances is underscored and a plan to proceed is agreed to.

Subsequent sessions include increasingly intense mobilizations of underlying CTF with strengthening of the UTA: partial unlockings of the unconscious proceeding to major or extended unlockings of the unconscious. The difference between these is the degree to which the resistance is broken through and the UTA is in a dominant position. Partial unlocking results in linkages to the unconscious content while major or extended unlocking results in a transfer of images from the therapist to the past person with greater passage of guilt (Davanloo, 2001).

Later Session Major Unlocking

In the sixth session the patient arrives tense and anxious with a choking sensation and constriction of his voice. He was at high-rise in the transference and required pressure and challenge to mobilize the CTF and UTA because a heavy zone of complex feelings in his unconscious had become mobilized.

Th: How do you feel? [*Pressure to feelings.*]

Pt: My whole body's going tense.

Th: Now how do you feel here toward me if you don't put a wall between you and me? If you don't put a wall between you and me, if you don't avoid me, how do you feel with me here? [*Pressure to feelings and challenge to resistance.*]

Pt: I feel stuck. [*Resistance.*]

Th: How do you feel toward me? [*Pressure to feelings.*]

Pt: Well I want to tell you something but I don't know what it is I want to tell you. [*UTA and Resistance.*]

Th: What is it in the category of? The positive feelings or in the rage feelings; what's on the top? [*Pressure to feelings.*]

Pt: Well, I feel like kicking you in the groin.

Th: You mean there's a rage in your leg?

Pt: Yeah, and I want to punch you in your gut.

The patient is sitting with clenched hands and choked voice suggesting that the unconscious anxiety is still present in his body. This means that the somatic pathway of rage is not yet being experienced. Rather the feelings are being somatized and resistance is dominating.

Th: But how do you experience the feeling of it first without choking or crippling of your body?

Pt: It's tightening everything up.

Th: Yeah but let's see first how do you experience the rage that gives you energy in your arm and leg. How does that rage feel as it surges through you? [*Pressure to feelings and challenge to resistance.*]

Pt: It feels like I got to kick and punch you. [*Sitting with limp arms, choked voice, and lack of movement.*]

Th: But how do you know you've got energy? Your arms look paralyzed to me. Do you see, there's rage in you but your arms look dead. [*Clarifying resistance.*]

Pt: Yeah.

Th: And you're straining yourself almost to hold it in.

Pt: Yeah.

Th: If you don't grip and cripple, if you just let yourself feel the volcano as it surges through you, how does that volcano feel in your body? [*Pressure to experience the rage and challenge to resistance.*]

Pt: Oh it just…

Th: Tell me how you feel that volcano in your shoulders, your arms. [*Pressure to experience the rage.*]

Pt: Very tight. [*Anxiety.*]

Th: Without them going dead though. [*Challenge.*]

Pt: It's stuck here (points to shoulders).

Th: This is why I'm saying. It's vital that you experience this whole thing; the pathway going up. Let it be. [*Pressure to experience the rage and challenge to resistance.*]

Pt: But it gets stuck in my throat and can't get out. [*Voice is constricted with anxiety.*]

Th: Let it move up more. How do you experience this rage as it passes up your body? [*Pressure to experience the rage.*]

Pt: Well it's like something that's strangling me. [*Whisper from the UTA. Revealing the impulse to come.*]

Th: Where do you feel strangled? On your neck?

Pt: Yeah, it's stuck there. I can't get it out. [*Choked voice, straining.*]

Th: Now how do you experience this rage here toward me if you don't detach from me at all right now. [*Pressure to experience the rage and challenge.*]

Pt: Well it's…

Th: If you don't detach from me at all. It's vital. [*Challenge.*]

Pt: Well it feels like something pushing out and I can't get it out (points to chest).

Th: Yeah but how does that feel if it comes up? [*Pressure to experience the rage.*]

Pt: It won't come out.

Th: Yeah but how does it feel if you let it be up and don't cripple it down.

Pt: I can't. I can't get it out. It's stuck (points to neck).

Here we see the herculean battle between the forces of resistance, alliance, and the complex transference feelings. Thousands of case studies show that if he can win this battle and experience these complex feelings that the anxiety will drop, the resistance will drop, and the UTA will become dominant leading to direct access to the underlying pathogenic forces. This is the process of unlocking the unconscious in highly resistant patients.

Th: Yeah but if you don't cripple it, let it be up. Let it be up right now and don't cripple it in your throat. If you let it just be through your neck. Let it move up. [*High challenge with pressure to experience the rage.*]

Pt: It won't come out.

Th: Yeah, but right now there's energy in your chest right?

Pt: It's up in here (points to throat).

Th: What about your shoulders? Do they have power or no?

Pt: It's just stuck in here (throat).

Th: What about your arms though?

Pt: My arms are weak. [*Conversion.*]

At this point I move to recap and review the process to bolster the alliance versus the resistance. Repression in the form of conversion, is also present and the process calls for recapping to increase isolation of affect: this process of building reflective capacity moves the anxiety to striated muscle and away from conversion (Abbass, 2015, Chapter 15, #147). He did not have repression at his baseline in function but due to the mobilization of a primitive zone of his unconscious in this session, more primitive defenses were activated (see Figures 1a and 1b). A limited amount of recapping to bring back isolation of affect is required.

Th: So you just saw what happened; the rage moves up, then tightening comes, the pain and then weakness comes.

Pt: Yeah.

Th: And you get constricted here in your neck.

Pt: Yeah.

Th: It's like the blockade is there in your neck.

Pt: Yeah.

Th: Okay, but at first it moved up and you had something in your legs too at one point.

Pt: Yeah my legs are all weak. [*Conversion.*]

Th: But, they wanted to kick though, right?

Pt: Yeah, but right now they're all weak.

Th: Okay, but let's see. First it moves up and then it moved down, right?

Pt: Yeah.

Th: Okay, but let's see at this point. Don't let it go on your neck. Don't let it throttle. Don't let it cripple. Don't let it weaken you. Don't let it put you down any which way. Don't let it put anger on you. Don't let yourself block it. This is what I'm saying. [*Recap and pressure and challenge on all resistances.*]

Pt: I understand (partial sigh and hands are clenching).

With this brief recap, striated muscle anxiety and isolation of affect are reactivated and we can resume pressure and challenge.

Th: So let's see how do you feel here toward me, right now, if you don't do anything to let a wall be between you and me. Don't let anything be a wall between you and these feelings. Don't cripple you. How do you feel here toward me? [*Pressure and challenge.*]

Pt: [*Staring through the therapist, detaching.*]

Th: See if you don't stare through. You're staring at me but it's almost through me. [*Clarifying the resistances against emotional closeness.*]

Pt: Yeah.

Th: See your eyes are not engaged to me. See if you let yourself be here with me. You've been in there on your own with these things for this many years and we know that you don't want to carry it on your own like that anymore. [*Head-on collision with all the forces of resistance, resistances against emotional closeness. Reaching through to the person stuck beneath.*]

Pt: Yeah.

Th: But what are we going to do? You have to be with me to feel anything about me. [*Pressure and element of head-on collision.*]

Pt: But it gets stuck.

Th: Yeah, but if you let yourself be here with me. [*Pressure and challenge.*]

Pt: Yeah.

Th: But you're still avoiding being here with me. The first thing is don't avoid me. [*Pressure and challenge.*]

Pt: I don't know (helpless).

Th: But if you don't go helpless and don't avoid me or go passive. If you want to…do you want to… [*Pressure and challenge.*]

Pt: Yeah.

Th: Well let's see what you're going to do about it because it's your wall and you're the only one that can remove it. I can't. [*Head-on collision, deactivating defiance and the notion of omnipotent therapist*.]

Th: How does that rage feel here toward me right now, without crippled, without avoiding me. [*Pressure to experience the rage and challenge.*]

Pt: It feels like I'm going to attack you.

With this work he is becoming more engaged, sitting forward and trying to experience his feelings. At the same time his arms continue to lack power. The therapist's job here is to provide pressure and challenge to help the feelings override the repressive mechanism and other defenses. Words alone are not enough: we are looking for the markers of somatic experience of the rage.

Th: How do you feel the rage in your body to attack? Your body's so dead right now you couldn't attack anything (referring to residual conversion in arms).

Pt: Yeah, yeah I wanted to attack you.

Th: Now how do you know you feel that though if you don't cripple you? [*Pressure and challenge*.]

Pt: Just because.

Th: How do you know you have some arms, because they look dead to me.

Pt: Just the whole body wants to go at you. (Moves arms in expressive gesture and voice is becoming firmer.)

Th: How do you know you've got a rage in your body right there without going crippled. [*Pressure and challenge.*]

Pt: It's just something that says I've got to jump at you. (Hands lunge forward, voice is firm now, tension has dropped.)

Th: Uh huh, where is that at in your body?

Pt: It's coming out of here (points to stomach).

Th: And where is it moving to?

Pt: It's just, just, I could jump at you. (Hands move in expressive fashion toward therapist.)

Th: But how do you know you feel though if you don't go dead. [*Pressure and challenge*.]

Pt: It's just…

Th: How do you experience this rage through your body if you don't go dead in the arms. [*Pressure and challenge*.]

Pt: It's pushing my whole body toward you. It feels as though I can jump. My body is saying "jump on him." (Thrusts forward in expressive fashion.)

Th: How do you know you've got power up in your upper body if you don't cripple your arms?

Pt: Well my upper body feels quite strong right now (arms are up).

Th: Well let's see how you experience the whole strength of it though, without any crippled. [*Pressure and challenge*.]

Pt: Well, I jumped and my knee's buried into your gut. (Very firm voice, good body tone, highly engaged.)

Th: You mean you want to attack with the legs first?

Pt: Yeah, right in my knees. My knees are pressing down on your gut there.

Th: My stomach.

Pt: Very forcefully, yeah.

Th: How's the tension all in here right now—is it still there or is it less? (Checking for removal of subjective tension.)

Pt: No, there's no tension there now. (Somatic pathway of rage has overtaken the anxiety.)

Th: And then what?

Pt: Pushing down on your stomach.

Th: And then what happens to my stomach?

Pt: Well, you're gasping for breath.

Th: I can't breathe you mean.

Pt: Well, you're gasping. You're still breathing but I'm pressing down even harder. I'm beginning to squeeze.

Th: To squeeze my stomach, you mean. And then what?

Pt: It feels pretty good. [*Good feeling attached to the murderous impulse*.]

Th: It feels good to crush into the chest and stomach.

Pt: Yeah.

Th: And then what?

Pt: And then it's giving in, there's no resistance at all.

Th: You're right through it you mean?

Pt: I'm pushing it quite flat.

Th: The stomach's right flat.

Pt: Yeah and you're just staring up at me, your mouth's wide open and you're just staring at me.

Th: Staring up at you.

Pt: You're not breathing anymore and I'm pushing hard down on your gut.

Th: And then what? What happens?

Pt: I've now gone for your throat.

Th: You mean I'm not breathing any more, now to go for my throat. You must have some strength in your arms.

Pt: In my hands. [*Moves in gripping fashion with strong arms: no conversion*.]

Th: You must have power to do that.

Pt: My hands have gone for your throat. They've gone for your throat and they're squeezing it.

Markers of Somatic Pathway of Rage

Note at this point his choking sensation and weakness in his voice have entirely ceased. Now the rage is being experienced to strangle the throat and destroy the voice box of someone else similar to what he had been doing to himself under the resistance.

Th: Squeezing it and then what?

Pt: They're squeezing it and squeezing it and then you're gone. [*UTA: the image is transferring to an attachment figure and the therapist is gone.*]

Th: I'm gone.

Pt: You're gone, but the gut is flattened out and it seems to be oozing out now.

Th: The guts are going out somehow.

Pt: Yeah, I've squashed them and they're oozing out. It's all a hell of a mess. (Face looks disgusted with this image.)

Th: What do you see?

Pt: Red stuff and purple stuff and black stuff and there's all sorts of tubes and globs of flesh.

Th: So it's burst open.

Pt: Yeah. It's a mess.

Th: How do the face and eyes look when you see it?

Pt: Oh, it goes purple.

Th: Face is all purple you mean?

Pt: Yeah, yeah.

Th: What about the eyes as they look right at you, you said.

Pt: They're brown (therapist's eye color).

Th: What do you see there?

Pt: I see a lot of pain.

Th: Pain in the eyes, uh huh.

Pt: And now they're…they're changing color (looks surprised at what is happening).

Th: They're changing color?

Pt: Yeah, they're going from brown to blue and they seem to be pleading for something.

Th: They're blue and pleading you mean?

Pt: They're just pleading for something.

Th: Whose eyes are you looking at there with the blue, who's that?

Pt: They seem to be blue.

Th: Uh huh.

Pt: And my hands are releasing and they're all sore, my wrists and my knees.

Medically Unexplained Symptoms Now Explained

As noted this patient had presented with unexplained arthralgias, knees pain, weakness, choking panic attacks, chest pain, and loss of voice. These are a direct product of unprocessed rage and guilt. At this moment the guilt is manifesting as pain in the attack weapons: his hands and knees.

Th: And your knees too.

Pt: My knees and below my knees are all sore.

Th: Who did you just murder here in a vicious fashion?

Pt: It looks like my son. Yeah, he's laughing now.

Th: But his stomach is all smashed open?

Pt: Yeah and now he's laughing. He's there just laughing.

Th: He's not dead you mean?

Pt: No.

UTA Operations

We teach to always trust the UTA. With the passage of the CTF, the UTA is now in a dominant position. The UTA brought the son in a live happy memory side by side with the mutilated image of the dead son. The reason for this appears to be the fact he had been estranged from his son and could not recall nice times with his son: in this situation it may be difficult to access guilt about the rage due to a mechanism of splitting so common at the deeper zones of the unconscious. With this loving memory and image, guilt about the rage can be experienced and bring healing of this longstanding ulcer inside himself.

Pt: His eyes are all sparkling there and he's got a smile on his face and he's laughing and smiling at me.

Th: You mean he's like humiliating you?

Pt: No I don't think it's humiliation. It's just a nice, happy smile.

Th: So you mean he's not laughing at you, he's laughing.

UTA: Compliance is Not Possible

With the UTA in a dominant position, destructive defenses including passive compliance cannot operate: the resistance is quiet. As we see here, my hypothesis that the son is laughing at him is not correct. The patient, with UTA in charge, corrects me.

Pt: Yeah, he seems happy.

Th: He's not murdered? Who is this body that you just mutilated and ripped his stomach open and then strangled to death?

Pt: I'm seeing my son there now and he's happy.

Th: So you're seeing two pictures you mean?

Pt: Yeah.

Th: Ok, so you have one dead and one is alive and smiling.

Pt: Yeah.

Th: Now how do you feel when you see him dead, murdered and strangled like that.

Pt: Oh terrible (tears in eyes, looking guilty).

Th: How do you feel when you murdered him like that when you see the murdered body out there, when you remember the smiling times and then

he's murdered? [*Keeping the two images together. Note process is going slowly here.*]

Pt: I feel terrible. Yeah, he's smiling and now he's put his arms around me.

I'm moving toward the smiling one and I'm not sure what to do about the dead one, he's just lying there; it's all just a mess.

Th: What would you do if you did this to your son right now, remembering the times when there were smiles? What would you do with this dead body of your son? [*Keeping the love side by side with the rage to facilitate guilt. Process moving slower than text can illustrate.*]

Pt: Well I'd pick it up.

Th: You'd pick him up.

Pt: Yeah and I'd hold him.

Th: You'd hold him in your arms.

Pt: Yeah.

Th: What did you say to him?

Pt: I just tell him I am so, so sorry.

Th: There's a very painful feeling in you right now.

Pt: [*Weeping with the passage of guilt.*]

This set of complex feelings had been triggered with his son throughout the son's life leading to defensive reactions and hostilities toward the son as a means to repress the feelings and harm himself and generate guilt secondary to hurting his own son. The feelings became linked to the intense complex feelings of rage, guilt, and craving of attachment with his own father.

The result of this session is immediate: a new relationship emerges with his son. This is from three weeks later where he arrived looking well, with no further signs of depression and happy to describe some changes.

Pt: My son and I are doing well! (Smiling widely.) We're talking to each other. We're sharing with each other. We're not screaming at each other. We're not shouting at each other. We're having a good debate but it's not an argument, if you know what I mean

Th: Uh huh, uh huh.

Pt: That hasn't happened in many, many, many, many years.

Th: Uh huh. How do you feel about that?

Pt: Oh it's just great! It's not exactly where I'd like it to be but it's moving in that direction.

In the 18th treatment session he arrived with tension and strong feelings rising toward the therapist. With pressure and challenge he experienced a similar primitive rage activating his knees to destroy the chest and abdomen. When he was watching the body it became the image of his father on the sports field where his father had left him off at boarding school as a child. The exact impulse was toward the father and mobilized painful feelings of guilt and even love for the father who was also cut off from his own father. At the time of being dumped at the boarding school he developed severe skin problems, was bullied by peers, and developed depression with suicidal ideation.

A further breakthrough led to complex feelings with his long estranged brother. This, when they were both near the age of 70, led to a joyous reunion with the brother who lived on the opposite side of the globe: this began an ongoing bond with the brother and his family. Love and understanding had replaced hatred and disdain for both his son and brother. Though his father was now long deceased, he mentally reunited with him and made his peace with the father.

Complex feelings were also experienced toward his wife of many years resulting in an emergence of loving feelings. In one session he had a passage of a warm, loving feeling and an urge to embrace the therapist: upon looking in his arms the image became the loving face of his wife with a breakthrough of grief. Beyond symptomatic relief, this was perhaps the most important change he experienced: the ability to enjoy the remaining years with his most loved one.

In 8-year follow-up after a 25-session treatment course, this patient was vital at age 77, active in charity work and physically robust. These are standard outcomes when this type of process goes well with highly resistant individuals who have endured early attachment trauma. The person beneath this resistance with all his buried love and creativity can indeed become liberated, even in later stages of life with a relatively short but intense treatment course.

INTERGENERATIONAL TRANSMISSION OF TRAUMA

In seeing the massive and buried primitive rage and guilt about the rage toward his father you can see how near to impossible it would be for this man to develop a loving bond with his own son. In the same way as these heavy feelings and secondary resistances were activated with the therapist, the same were mobilized with his son resulting in

repression of heavy guilt-laden rage toward his own boy. This led to defenses of distancing, punishing the son, and other defenses that badly damaged the bond with his son. The destruction of the trauma with his own father would inevitably be transferred onto the son.

CHALLENGES TO THE THERAPIST

And the same is the case of transference with the therapist. If these transferred feelings are not experienced they result in repression of another load of rage and guilt toward the therapist increasing his psychic burden of guilt and need to self-destruct. For these reasons this treatment model insists that no trace of transference neurosis be allowed to develop: as soon as the patient is capable the complex feelings toward the therapist are brought to experience as in this treatment frame they are considered the gateway to the dynamic unconscious.

Moreover, this same work will tend to mobilize intense, deep zones of feeling in the therapist if he has not experienced these feelings up to that point in time. If the therapist does not allow himself to feel the feelings he may end up with a burden of increased guilt and neurosis transferred to his patients. On the other hand if he can persist and reach toward the person beneath the resistance, he may be able to experience his own unprocessed feelings, for example about his own father or son in this case. In this case a double unlocking of the unconscious may take place for a double therapeutic effect in both treatment team members (Chapter 6 in Kenny, 2014).

CONCLUSION

Psychodynamic therapy is well positioned to activate feelings connected to relational trauma, help overcome complex resistances to attachment, and enable the processing of these pathogenic feelings resulting in a new way of relating to oneself and others. The technical interventions of a high degree of engagement, reaching through to the person beneath the resistance with pressure and challenge and enabling the somatic experience and processing of feeling can effectively unlock the repressed unconscious feelings giving direct access to these forces. In this way it is possible to liberate the character neurotic patient stuck

in jail for crimes he never committed. Various types of research now support this approach for those character neurotic patients with personality disorders and other refractory patients including those with treatment refractory somatic, anxiety, and mood disorders. The use of video self and peer review to detail technical intervention and somatic responses is an invaluable instrument to study one's own cases toward optimizing the pace and depth of emotion access and processing in the psychodynamic frame.

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