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Anxiety as an Indicator of Initial Transference Resistance and it's Handling in Intensive Short-Term Dynamic Psychotherapy

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The main focus of this article is the handling of initial resistance in the transference, that first of all can appear in the form of anxiety. The article is based on the trial therapy of a moderately resistant patient, who suffers from multiple symptom- and character disturbances.

Introduction

One of the principles in Davanloo's Intensive Short-Term Dynamic Psychotherapy is that the process is determined by the unconscious of the patient. This means, that the therapist has to pick up and work on what the unconscious of the patient brings to the forefront (Davanloo, 1980, 1984, 1985, 1986a). Theoretically this task is clear, but practically it can be complex: Is the position of the unconscious in the transference or in the C (this means an incident with a significant person in current life)? Is resistance at the front-line? Which kind of resistance? Does the therapist have to address it directly or to work on it in an indirect way? Or is anxiety dominating? Is it conscious or unconscious? Is anxiety in the therapeutically optimal range, is it to increase or to bring down? Or are impulse/feelings at the front-line? Are they strong enough to break through? etc. This task requests from the therapist a profound metapsychological knowledge as well as an attitude free of fixed ideas or planned interventions. And the therapist's own unconscious must not be overwhelmed by anxiety neither be locked up by character defenses.

In his writing and teaching on the metapsychological and technical principles of Intensive Short-Term Dynamic Psychotherapy, Davanloo demonstrates the correct assessment of the signals that the unconscious of the patient brings to the forefront, and the consequences for the therapeutic interventions. All the

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metapsychological concepts, that are used in this paper, are discovered and elaborated by Davanloo in the frame of his research.

Origins of Initial Anxiety

This article focuses on the trial therapy with a moderately resistant patient, who is anxious in the beginning of the interview. Anxiety in the beginning of a therapeutic session may basically originate in three different sources (Davanloo, 1986b, 1990, 1993)

(1) A dynamic force, this means a rise in the impulse/feelings, that mobilize unconscious anxiety. This is possible only with patients under psychoneurotic condition. The impulse/feelings can be related to a C-event prior to the session, for example an argument between the patient and his wife. Or it originates in the transference, for example a new activation of the patient's unconscious as a consequence of the preceding therapy session. If anxiety in the transference is mobilized in the beginning of the trial therapy, it bases on preexistent transference feelings, for example due to the duration of the therapist's waiting list.
(2) A structural pathology with low anxiety tolerance capacity (fragile character or borderline structure): If the patient is basically an anxious person, he will be anxious with the therapist as well as he is anxious in the supermarket or when going to bed. So anxiety in the therapeutic situation is not specific to this event and does not originate in a dynamic force.
(3) A real danger: If the patient, driving to the therapist's office, has by a hair's breadth avoided a car accident, he may come trembling and consciously anxious to the session.

In the following case example unconscious anxiety in the beginning of the trial therapy is related to a preexistent mobilization of "complex transference feelings" (Davanloo, 1986c, 1986d). They are due to the imminent emotional closeness with the therapist, that the patient senses necessary for a successful therapeutic process. The mobilization of complex transference feelings is initially at a low degree. Therefore the complex transference feelings are not perceptible by themselves. But they activate unconscious anxiety. Because this anxiety appears together with manifestations of a "resistance against emotional closeness" (Davanloo, 1986c, 1986d) the anxiety can be regarded as an indicator of this resistance and be handled as a part of it.

If the patient enters the trial therapy with anxiety and resistance in the transference, it is crucial to focus on these manifestations and to postpone the inquiry to a later phase of the interview. So the therapist has to fulfil a multiple task (Davanloo, 1989a, 1992a, 1993).

(1) To do his psychodiagnostic work. First of all, to exclude or detect a fragile character structure, which would require a modified technique (Davanloo, 1987a, 1987b, 1989d, 1989e).
(2) To determine if a more vertical or more oblique rise in the complex transference feelings is the procedure of choice. The better the anxiety tolerance capacity of the patient is, the more a steep mobilization of the complex transference feelings is indicated.
(3) To point out the patient's anxiety in the transference.
(4) To make the patient systematically acquainted with his character defenses in the transference. This brings the patient to recognize that the same mechanisms have deteriorated his life.

The patient is a 38-year-old self-employed dance-teacher. He is married and has two children. The inquiry, that is done mainly at the end of this trial therapy, will reveal that since the age of 20 the patient has been suffering from severe regressive crises with resignation, psychomotor paralysis, withdrawal, irritability, sleep-disturbances and loss of weight. The crises last up to several months and engender a considerable loss of income with the consequence of a very difficult financial situation of the family. Moreover the patient suffers from anxiety-attacks with low back pain, anesthesia of the face, thought-blockage and an irritable-bowel syndrome. During temper-tantrums the patient shouts and destroys things, for example the remote control of the television set. At the age of 20 he had stopped physical aggression towards persons, after having knocked down a provoking colleague and physically hurt him. In the military service the patient recently had to go to prison for a few days because of a refusal to use firearms. In his marriage the patient is emotionally and physically distant. Sexual life has more or less died. "I'm destroying my professional and private life," he says.

Excluding Structural Pathology

This is the very beginning of the trial therapy. The interview starts with a silence of a few seconds.

At the beginning of a session the therapist should not become active before he sees what the unconscious of the patient brings to the forefront. Otherwise he would iatrogenically falsify the therapeutic process.

PT: (Clinching his hands and pressing his lips)

This nonverbal communication of the patient is significant.

(1) His unconscious brings anxiety to the forefront. So it is crucial that the therapist picks this anxiety up and brings it to the focus.
(2) Anxiety goes into the striated muscles. This means that under the actual amount of mobilized feelings the patient doesn't show any signs of instant repression, psychosomatic condition, fragile or borderline structure. Of course this assessment must be confirmed by a stepwise introduction of "challenge and pressure" (Davanloo, 1986c, 1986d). Nevertheless, one should not underestimate the anxiety triggering factors at the beginning of the trial therapy.
 (a) The patient knows that he stands at the beginning of an interview that may last several hours.
 (b) He senses that he has to open in relationship with the therapist in order to bring the session to a successful result, and to prepare the ground for a psychotherapeutic treatment.
 (c) The therapist is avoiding any socializing. This would bring the anxiety down.
 (d) And the patient is exposed to an audiovisual setting.

Also during the course of a treatment, unconscious anxiety is often at the forefront in the first moments of the session. This is usually a consequence of the "unconscious therapeutic alliance" (Davanloo, 1987d), that wants to lead the

process to a new breakthrough of the complex transference feelings. If the therapist is busy with something else—for example switching on the videorecorder—he might miss initial anxiety and to focus on it. Character resistances would spread and the process would become prolonged.

TH: *What do you feel right now?*
PT: (taking a deep sigh, pressing his legs together, laughing) *Actually I'm quite tense.* (he is avoiding the eye-contact with the therapist) *I don't know . . . it is a feeling like . . . sitting in front of a judge or of a policeman.*

To go in the position of an accused is a resistance. But the therapist memorizes this information for the time being. Because it is the first encounter with the patient, he wants to know when the body sensations of the patient started. This will show to the therapist as well as to the patient, if the anxiety is due to the transference situation or to other anxiety provoking factors. And by determining the duration of the anxiety the therapist has another instrument to assess the anxiety tolerance capacity of the patient: The earlier anxiety appears and the later it disappears, the more the patient is in difficulties to deal with it, and the more he will need restructuring of his anxiety, before the "unlocking of the unconscious" becomes possible (Davanloo, 1988b, 1988c).

Determining the Origin of Unconsicous Anxiety

TH: *And when did this tension and this warmth start?*
PT: *In fact in front of the door. Before, I was restless all the day. I always forgot our appointment today. I always was doing something and realized, that in my planning of this day our appointment didn't exist. An then I remembered it again and verified in my agenda, that it was at 5:30 p.m. Then I was looking for the way to your office. I also was a quarter of an hour too early: I don't like to be late.*
TH: *So there was a restlessness during the day, you had to verify repeatedly our appointment, and the tension and warmth in your face started, when you were in front of the door of this practice?*
PT: *Ummmh hummmm.*

So it becomes clear, that anxiety has to do with the transference. The patient's comparison of the therapeutic situation with being in front of a judge or of a policeman indicates, that anxiety could have to do with exposing himself and letting the therapist get into his most private life.

This fear must be considered as a resistance against emotional closeness in the transference: An accused man is in a subordinate position and will hide as much as he can. The therapist now wants to verify that.

Resistance Against Emotional Closeness

TH: *And you are saying, that you sit here like in front of a judge?*
PT: (Moving intensely his thumbs and looking to the floor) *Yes, . . . like in front of an authority or someone who can effect something.*

TH: *So the question is, whether you want to transform me into a judge, and to take a subordinate position right from the beginning?*
PT: *No, not at all, that is a position I easily take when I get to know someone. So my position is initial retreat and the idea to have to submit.*

This is more profound communication of the patient, which indicates a very first rise in the unconscious therapeutic alliance. But it is also a moving away from the transference. This can be accepted as a C-reference for a few seconds. Then the therapist has to bring the focus back to the transference to maintain the rise in the complex transference feelings.

TH: *Is this a problem for you?*
PT: *Partially yes. It depends on the situation, it is more in private than in professional context. Yes, it is a problem.*

The question, if the patient considers his neurotic pattern as a problem, is an important pressure to the therapeutic alliance. It prevents, that the patient feels himself forced to give up a part of his character. This would mobilize defiance.

TH: *I also see, that there is a tension in your hands.*
PT: *Yes, it has arised now.*
TH: *So what do you account for your tension in your hands, in your shoulders, in your back, and this warmth in your face here in relationship with me?*
PT: (After keeping silent for a while, sighing and looking to the side) *It is . . . many things have been passing through my head in the last time, when I was alone, for myself it is quite easy, when I'm thinking about myself.*
TH: *But still we don't know, what you are accounting for this tension and this warmth. Obviously this has to do with your relationship here with me, OK?*

This vignette shows the following: After the therapist has brought the focus back to the transference, the patient is waiting, avoiding eye contact with the therapist and hesitating. He becomes completely vague and tries again to diversify to the C. But the therapist maintains the focus on the patient's anxiety in the transference. This activates further anxiety in the patient.

PT: (Sighing, clinching his hands, moving his knees up and down) *Yes, I contribute a function to you. You are not just some encounter for me. I have chosen you to get to my problems* (pause) *I have said yes, and so I really have to go for it. Now I really have to talk about and to reflect on what is happening in myself.*
TH: *Who says that you have to do it?*
PT: *Myself!* (tense, smiling) *I feel that it is absolutely necessary for me to do it.*

The question, if there is any pressure from outside to undertake a psychotherapy, has the function of weeding out as best as possible the ambivalence of this patient who has been carrying his character and symptom neurotic burden for many years and postponing further and further his decision to do something about it.

This is the beginning of the trial therapy with this patient. It has become evident, that the initial anxiety in the transference is due to a resistance against emotional closeness. The therapist comes to this conclusion because of . . .

(1) . . . the information from the patient concerning a withdrawn and subordinate position as his usual feature of an initial contact, mainly, if it is on the private level.
(2) . . . the nonverbal communication in form of avoidance of the eye contact with the therapist, the smile (a cover-up) and the tension as repeated responses of the patient, when the focus is on the therapeutic relationship.

In the case of this patient, the resistance against emotional closeness is the forefront—as well as the central resistance from the beginning of the interview. Resistance against emotional closeness is a defense of every neurotic patient. This is the need to keep everybody out of one's innermost life, one's innermost thoughts and feelings, the need to prevent or destroy every warm, useful and long-lasting relationship. It can be more or less pronounced and is often covered by other resistances. The source is a double unconscious anxiety (Davanloo, 1992a, 1994).

(1) In the core of every child is a wish for a warm and close human bond. This desire can be traumatized by the attitude and behavior of the genetic figures or by external influences like forced separation, illness or death. In this case the child develops a primitive reactive sadism towards his genetic figures, which gets inseparably connected with his desire for emotional closeness. But simultaneously the child has tender feelings towards them, who not only provide frustration, but also positive experiences, and from whom the child depends in his existence. The result of this inner conflict between profound love and primitive murderous rage is an unconscious anxiety, that is related to emotional closeness. In his further life every offer for an emotional closeness from the environment reactivates the murdered bodies of his genetic figures (Davanloo, 1987c, 1988a).
(2) The other source of this anxiety is generated by the pain of the trauma by itself. The patient fears that this pain could repeat itself with every close relationship.

The other possible reasons for anxiety at the beginning of trial therapy are ruled out. So the therapist decides to prepare the ground for a "head-on collision with the resistance against emotional closeness in the transference" (Davanloo, 1986c, 1986d).

Making the Patient Acquainted with His Character Resistances in the Transference

PT: (Keeping silent)
TH: *May I point out something else to you?*

This is not a rhetoric question. At the beginning of the trial therapy, it is important to ask for the patient's cooperation to clarify his character resistances in the transference. It is a prevention against projection (the patient feeling himself under attack of the therapist) and resulting defiance.

PT: *Yes!*
TH: *The way how you are here in the relationship with me.*
PT: *Ummmhh humm.*
TH: *I notice how often you are silent and keep your thoughts for yourself.*
PT: (Pressing his lips together and clinching his knees) *Ummhh humm.*

TH: *And how often you are looking to the floor, avoiding my eyes.*
PT: *Ummh humm.*
TH: *And you let the time pass without allowing an exchange between you and me.*
TH: *It's important to examine this, do you agree . . .*
PT: *. . . yes . . .*
TH: *. . . what is happening between you and me?*

To stress the transference, using repeatedly expressions like "you and me", "here with me", "in our relationship," "you are avoiding my eyes" etc. is crucial to keep the focus clearly in the transference. If the therapist didn't do it again and again, the patient would move to the C-level of the triangle of persons—as we have seen above—to reduce his anxiety. Or a situation could be created, that the therapist thinks to focus on the transference, but the focus of the patient is in the C.

PT: *Yes.*
TH: *Or do you prefer to avoid it?*
PT: *Oh no, that is what I want to know at this moment, that I know for myself, if we get to our aim like that.*

A head-on collision can not be done out of the blue. Some preparation has to be done by making the patient acquainted with a part of his character resistances, which mobilizes further rise in the complex transference feelings. Otherwise the patient would not understand the therapist's intervention. In the following vignette the therapist moves to the head-on collision with the character resistances.

Head-on Collision with the Resistance Against Emotional Closeness

TH: *Let's look at what we can say until now. You are coming to me, apparently you have massive problems.*
PT: *Ummhh, humm.*
TH: *Or is this wrong?*

Minimization of neurotic misery is a common part of the superego resistance. Of course character-problems are easier to minimize than symptoms, but a lot of patients consider even a pile of symptom disorders as negligible, like multiple phobias, serious sexual difficulties, functional disorders or repetitive suicidal wishes, "because everybody has to carry his burden." The question, if the patient's problems are serious, is the way to undo the minimization.

PT: *I say, these are massive problems.*
TH: *Whatever your problems are, one of them is submissiveness.*
PT: *Ummhh, humm.*
TH: *Another problem is your incapacity to take decisions in personal matters and a third problem has to do with closeness.*
PT: *Ummhh, hummm.*
TH: *This is what you have mentioned to me until now.*
PT: *Ummmhhh, hummm.*

TH: *So I understand, that this is the task you give us, namely . . .*
PT: (Moving his whole body)
TH: *. . . to get to the core of your problems and to see together the engine of your problems. And to find together the first approach to resolve them with our mutual help. Is that correct?*
PT: *Ummhh, hummm.*
TH: *And we know, that you are here on your own will, or am I wrong?*
PT: (Smiling, a wave of tension passing through his face and chest) *Very voluntarily!*
TH: *Or has someone else, your wife or your mother, pushed you to come here?*
PT: *Oh no, rather the contrary.*
TH: *So you are here on your own will.*
PT: *Yes!*

The question if his mother has pushed him to go into treatment has a specific reason. The mother of the patient has been in treatment with the therapist for 8 months. When the patient applied for psychotherapy and revealed his identity as his mother's son, the therapist hesitated for a moment. But the patient declared on the telephone, that his relationship with his mother had very much improved since the beginning of her therapy. And he had come to the conclusion, that in psychotherapy a patient doesn't ally with the therapist against his family, but against his difficulties! What the patient says is true. There may be exceptions, but in general there is no contraindication to treat simultaneously several members of the same family, provided the work is done in a correct fashion. In the case of this patient his mother didn't push him to undergo psychotherapy. But she was relieved, when he took this decision, because she painfully has been observing many years his self-sabotage and the distance he kept in relationship with her.

Inadequate constraint in the childhood is a usual part of human neurosis. It creates defiance, submissiveness, incapacity to take decisions, suggestibility, etc. By asking the patient if he is here on his own will, the therapist clarifies the patient's own decision to do something about his suffering. It is one of the steps to prevent the emergence of a transference neurosis. Transference neurosis means, that the patient establishes the whole spectrum of his neurosis in the relationship with the therapist. And he can not overcome this attitude at the end of the session. Thus the patient perceives the therapist more and more as a repetition of his genetic figures, who for example know better than himself, what he has to do or not to do. This is a therapeutic impasse and characterizes many interminable psychotherapies. The nonverbal response of this patient to the question of the will is a response from the unconscious, that there are problems in this field.

TH: *Let's look at the way you are here with me. You are very ambivalent; one part wants to undertake something, another part is paralyzed.*

If the therapist had said to the patient: "You don't want to do something about your problems, you prefer to procrastinate," he would have omitted the healthy core of the patient, that is striving to stop the suffering. So the patient might perceive the therapist as blaming, which prevents a rise in the complex transference feelings and could contribute to a therapeutical misalliance. After one or two unlockings of the unconscious, the situation will be different. Even if the therapist only challenges the procrastinating part, the patient knows that the therapist doesn't fight the patient himself, but his maladaptive system. This is a consequence of the established unconscious therapeutic alliance.

TH: *And then we see something else: You are erecting a kind of a wall between you and me.*
PT: *Umm . . hmmm . . .*
TH: *You have a big need to reflect on your own and to keep silent. You have a need to avoid my eyes and to look somewhere else; to the carpet or the wall.*
PT: (Moving his head, clinching his cheeks and lips): *umhhh hummm.*
TH: *You have a need to be paralyzed, to wait and to let the time run.*
PT: (He keeps silent and after a moment, he presses his lips together. His whole mimic becomes petrified)

Even though the patient doesn't express one word, his unconscious clearly answers to the therapist's interventions on the nonverbal level.

TH: *And let's look at how you are sitting right now here with me; you formally paralyze your body, you are paralyzing your arms which are resting like that between your legs.*
PT: (Looking to his hands and nodding)
TH: *Your face is completely emotionless, you are paralyzing your legs, you are paralyzing yourself, you are paralyzing your language.*
PT: *Yes!* (looking to the floor)
TH: *And with all these mechanisms you erect a wall between yourself and me.*
PT: *Yes.*
TH: (After a pause): *Obviously you have a need to keep me out of your innermost feelings and to keep me out of your innermost thoughts. As long as this wall is here, this is a safe method to prevent an emotional exchange . . .*
PT: (Taking a deep sigh and moving his whole body from one side of the chair to the other).
TH: *. . . and an emotional closeness between you and me.*

This nonverbal response is by far the most important of this head-on collision until now. It is a confirmation from the unconscious of the patient, that the resistance against emotional closeness is at the forefront.

To declare the wall between the patient and the therapist as a "safe method to prevent an emotional closeness" contains quite a pressure. By not disqualifying this resistance, but siding with it and clearly demonstrating its consequences, the therapist leaves the decision to maintain or destroy the wall entirely to the patient (Davanloo, 1986d, 1987a, 1991, 1994).

TH: *I don't know if this is also a problem in your everyday life—a while ago you made a corresponding remark—but definitely you are hindering yourself completely here in the relationship between you and me. Because it is our task to look together to the core of your problems.*
PT: (Moving in his chair) *I think I hinder myself massively also elsewhere. That is a description of myself I know. I have a poker-face and nothing appears in it, whatever one says to me. It's a feeling of being just here, but not present. I think that I encounter a lot of people in this way.*

This is a profound communication of the patient as a sign of a rise in the complex transference feelings and the unconscious therapeutic alliance.

TH: *And who is the person who comes away empty handed?*
PT: (Clinching his hands): *That's me!*
TH: *So let's look at this problem here between you and me. If you maintain this position of the distant, paralyzed, ambivalent man . . .*
PT: (Interrupting the therapist): *We even wouldn't have to start. I could go right away.*
TH: *So if you maintain the position of the man, who doesn't want to have a closeness with me on the level of your thoughts and feelings, we wouldn't have any chance to fulfill the task you give to the two of us.*
PT: *Ummhhh hummm . . . Ha- Yes!*
TH: *So this evening would become a failure for you. And I would become a useless person to you. So at the end, when you leave me, you would say to yourself: "he is another person in my life whom I didn't let come close to me and thus is useless to me."*
PT: *Yes.*
TH: (After a pause): *If you keep me out of your innermost thoughts and feelings and if you maintain this wall between you and me, you are here to fail.*
PT: (Moving in his chair, rubbing his face, smiling, looking to the floor): *Yes!*

The unconscious needs time to respond, that's why the therapist has to wait a moment after each intervention. This slow-motion procedure is necessary in the early phase of the trial therapy, when the patient is not yet acquainted with his defenses. The duration between each remark of the therapist and the response of the patient's unconscious corresponds to the necessary time the intervention needs to weaken the resistance. It lasts longer, if the character-armour is thick and syntonic. If the therapist does not wait for the unconscious responses of the patient, he operates in the dark. And the patient does not follow the process, perceiving himself as bombarded, confused, reacting with all sorts of negative mechanisms like passivity or defiance.

TH: *But why do you want to sabotage yourself, why are you looking for the failure, not only here with me, but also elsewhere, but right now here with me? How a young, differentiated man wants to fail whilst another part is searching for something constructive?*

This last intervention is a new pressure to the unconscious therapeutic alliance.

TH: *So you switch off your thoughts and look to the carpet, is it that you want to tell me?*
PT: (Keeping quiet)
TH: *Now for example, you are sitting here stiff and quiet. I ask you something, you don't bat an eye-lid. You are sitting petrified here with me.*
PT: *I even don't breath.* (Deep sighing)
TH: *Your look is to the carpet, like this you are sabotaging yourself.* (Pause) *I don't know if you want to see it, I cannot help you if you are quietly staring at the carpet.*

PT: (Laughing breathing deeply, moving intensely in his chair, then pushing his sleeves back, turning his hands into supination and looking into my eyes): *Oh yes, I understand, that doesn't help at all when I'm sitting here like a block—it's like a bad farce!*
TH: *Now the question is, how you want to decide. You have two possibilities: one is to do something about your wall here between you and me . . .*
PT: *Ummhh humm*
TH: *. . . that you do something against your paralysis and your hindering an emotional closeness here between you and me. This would mean to let me into your personal life, to take a decision against your paralysis, to take a decision against your self-sabotage. Do you understand what I mean by self-sabotage?*
PT: *Yes!*
TH: *Setting a goal and fighting it simultaneously.*
PT: *Yes.*
TH: *And your decision could be to give up your self-sabotage. And I think that this would be our task.*
PT: (Clinching his hands, smiling, moving back and forth in his chair)
TH: *So, this would be one option. If you choose it, we have a good chance to get to the core of your problems this evening . . .*
PT: (Rubbing his hands, making fists) *Uummhh humm.*
TH: *. . . and to fulfill the task you have given to us.* (Pause) *And then you have the other option: you can maintain this wall between you and me, you can keep me out of your inner life, you can target the failure, if you wish it, and then this is OK as well. Because in this moment you do it consciously as an adult, intelligent man, who knows, what he is doing.*
PT: (Very tense and attentive) *Yes!*
TH: *You also may say to yourself, that you don't want to resolve your problems—whatever they are . . .*
PT: (Rubbing his palms)
TH: *. . . that you want to carry them further throughout your life and that you want to keep me out—this is your free decision.*
PT: *Ummhh humm.*
TH: *I don't know why you should do it . . .*
PT: (He is becoming more and more vital, rubbing firmly his cheek, interrupting the therapist, and the therapist senses an upgrading irritation in the patient.) *I don't know it neither!*
TH: *. . . but it is your life, it is your trial therapy at this evening, that should decide in which direction you want to go and if I can be useful to you or not.*
PT: (Chewing, pressing his hands together)
TH: *It is your future! Now we first want to see how you are going to decide about the wall between you and me.*

Rise in the Complex Transference Feelings

The head-on collision ends by putting once more pressure to the dominating resistance of this patient, the resistance against emotional closeness. The frequent and multiple striated muscle responses of the patient indicate a good rise in the

complex transference feelings and a conversion of the character resistances into transference resistance. The defensive system becomes more and more exhausted, the aggressive impulse is near to break through in the transference, the unlocking of the unconscious becomes possible.

Davanloo has discovered an elaborated, that the key to the unlocking of the unconscious is the rise in the complex transference feelings (Davanloo, 1980, 1984, 1986a, 1989b, 1989c). This rise is the result of the therapist's and the patient's common efforts to identify and undo the patients character resistances. In this last vignette, we can see all the signs of a rise in the complex transference feelings (Davanloo, 1987d, 1990, 1993).

(1) An increase of the unconscious anxiety as a response to the interventions of the therapist. This build-up is the main feature of a rise in the complex transference feelings. But it must be considered only in the context with the other signals.
(2) An intensification of the existing character resistances and the emergence of new character defenses in the transference. The engine to this mobilization of the character resistances is the increase of the unconscious anxiety. Finally the character resistances become transference resistances. This means that the whole defensive organization of the patient now becomes directed against the increasing complex transference feelings.
(3) A build-up in the unconscious therapeutic alliance between the patient and the therapist. This means the partnership between the unconscious healthy core of the patient and the unconscious of the therapist in the battle against the patient's self-sabotaging part. The patient's verbal communications become more significant and profound. And the therapist perceives an inner emotional vibration with the arising feelings of the patient as well as a kind of additional guidelines in doing the appropriate interventions.
(4) A rise in the patient's vitality and a first glow of transference feelings, mostly an aggressive impulse.

The rise in the complex transference feelings is also the central factor which makes the process safe. It activates the character resistances and thus enables the patient to recognize them. It prevents the process as far as possible from undesirable resistances like malignant defenses (defiance, sarcasm, provocativeness, etc.), regressive defenses (weepiness, position of the "poor little me" etc.) primitive defenses (projection, projective identification, etc.) and mushrooming of the resistances (simultaneous and widespread emergence of a large number of resistances). Even with suicidal or fragile patients a rise in the complex transference feelings is the best safeguard of the process, but the therapist has to dose the rise corresponding to the reduced anxiety tolerance capacity of these patients.

Further Challenge and Pressure to the Character Resistances

PT: *My feeling is: I don't succeed in this short time to destroy this wall, it is much too strong.*
TH: *So you are pleading for maintaining it. Is this correct?*
PT: (Energetically, first with supinated hands, then with fists) *No, really not, but you say: Pull down this wall! And I have never really tried it. I feel it requires so much to make it possible.*

TH: *Do I say that you are forced to destroy this wall?*
PT: *No! You just say what in my opinion has to happen. But I thought, that I can go on much smoother with myself, I can take much more time. But I think, I have waited already for a long time!*
TH: *So for how long do you want to keep waiting?*
PT: *This is precisely the question! I don't want to wait any longer and now somebody* (addressing himself to the therapist) *is standing here saying: Now! Not tomorrow, neither in half an hour, but now!*
TH: *But let's look at it. You also have the right to wait.*
PT: *True, but I'm waiting already so endlessly long with myself.*
TH: *So the question is: Why should you do something about your problems that you are carrying for so many years?*
PT: *Because I have the feeling to destroy everything around myself. My relationship with my wife and my children—with the children it's a bit less dramatic—and I'm going to fail in my profession. My profession has a very high significance to me, it's much more than just a job. And everything is going more and more in a wrong direction. I need more and more energy to keep everything going on.*

The patient's declaration of being too weak to demolish the wall and his need to postpone this task can be regarded as a resistance against his therapeutic will. The therapist manages this ambivalence by siding with it. Instead of trying to convince the patient—which would be counterproductive and end in a power struggle—the therapist repeatedly questions the necessity to overcome the problems now. The result of this intervention is the patient's description of his neurotic misery and a rise in his will to overcome the life-long procrastination. This response indicates also a further rise in the unconscious therapeutic alliance between the patient's healthy part and the therapist.

After this operation on the ambivalence of the patient, the therapist goes back to the central resistance, the resistance against emotional closeness.

TH: *So let's see, what you are now going to do about your wall between you and me, and with the part in you, that doesn't want to change and prefers to sabotage yourself.*
PT: *Mmm* (Then becoming silent, motionless and staring at the wall)
TH: *Staring there* (pointing at the wall) *and keeping silent, is this your option?*
PT: (Sighing, tense, lifting helplessly his arms and turning his head away from the therapist). *No, it is just . . . empty in my head, like a black-out, I could look like a fish* (opens his mouth).
TH: *Do you think that we have a chance to fulfil our task, if you are here as a fish or with an empty head?*
PT: *No, just not!*

The "empty head" and the "black-out" positions are again tactical defenses and not signs of a cognitive disruption, regarding the open channel of unconscious anxiety to the striated muscle system.

TH: *So, let's see what you are going to do about your fish-position and your "empty head" and your paralysis and your avoiding me, and if you prefer to maintain this position or not.*

PT: (Smiling, moving, looking to the carpet) *Can I change it so easily?*
TH: *You are an adult man. It's your life, it is your decision, what you are going to do. You can also leave it as it is.*
PT: *Hmm.*
TH: *And you are staring away from me, and your face is petrified and you keep silent. You don't want me to get into your innermost world. Also now you are avoiding my eyes.*
PT: (Smiling, sighing repeatedly)
TH: *And you repeatedly sigh. But you keep me out of your inner life. You don't want me to find an emotional closeness with you and to fight together with your problems. You say, that you want to do something about your wall between you and me, but simultaneously you are reinforcing it.*
PT: *I don't know where to operate.*
TH: *That's helplessness.*
PT: *Yes.*
TH: *Do you prefer to be helpless?*
PT: *No, I want to become active and to do really something against all, what I'm doing here. It is completely crazy!* (the patient is heaving himself a little up in his chair) *I cannot breath anymore, I have a dry mouth, I don't know how to move anymore.*
TH: *That's your anxiety!*
PT: *And you don't do anything to me at all!*

This last remark clearly indicates that the patient doesn't feel himself aggressed by the therapist and that his anxiety and paralyzing defenses must have another origin. The transference situation is characterized by a strong conscious and unconscious therapeutic alliance between the therapist and the patient's healthy core against his neurotic part. The crisis is not between the therapist and the patient, but is between the two parts of the patient. This is a result of the therapist's targeting on the main resistances: the resistance against emotional closeness and the ambivalence (Davanloo, 1988b, 1988c).

TH: *And now, do you just want to complain about your misery here with me?*
PT: (Animated, very tense, looking away from the therapist) *No, neither! It is . . .*
TH: (Interrupting the patient) *And why do you tell this to the floor?*
PT: (Keeping silent, clinching his lips)
TH: *Now again your self-sabotage in form of silence and petrification. We see now nicely the triumph of your self-sabotage: A slight vitality is growing up in you—as you have described before: A bit of light—and immediately you go back to the jail. Again you are sitting here like a mummy!*
PT: *Mmmhh.*
TH: *Or, as you have called it before: Like a fish.*
PT: *Mmmhh.*
TH: *Psychotherapy for fishes?*
PT: (Very tense, moving his trunk fore and backwards, making a fist, smiling)
TH: *And you are grinning at your chair!*
PT: *For a few seconds I have been enraged!*

TH: *With whom?*
PT: (After a hesitation) *I just could hit out!*

Breakthrough of the Complex Transference Feelings

This is the first emergence of a conscious aggressive impulse in the transference. Putting it in the past ("I have been enraged") is a tactical defense. It is spontaneously undone by the patient ("I just could hit out!"). Omitting the target of the aggression (the therapist) is another tactical defense, that will be undone by the therapist. During the process of working through—that is always done after the breakthrough of the complex transference feelings and the unlocking of the unconscious—the patient will declare, that his aggressive impulse towards the therapist climaxed, when the therapist for the fourth time challenged the avoidance of eye contact. This has a metapsychological implication, because looking away from the therapist is a central part of the resistance against emotional closeness. We go back to the interview.

PT: *It is a rage, that really emerges from inside.*
(The patient is moving his left hand from his belly upside. His right hand is in supination, and the tension in his muscles has considerably dropped.)

TH: *From inside up?*

PT: *Yes, really. From inside upwards.*

TH: *And where do you feel this rage?*

PT: (Moving each hand towards the shoulder and the arm of the other side) *In my whole body, mostly in my arms.*

TH: *You can feel this rage in your whole body, predominantly in your arms?*

PT: (Moving his hands in an outward direction, then making fists) *Yes, in an outward direction like this.*
TH: *And you are making fists.*

The breakthrough of the aggressive impulse manifests itself by a drop of tension in the striated muscles, a decrease in the character resistances as well as an emergence of anger and vitality. The hands of the patient are no longer paralyzed, but powerful and moving to supination (or a middle position between supination and pronation). The voice becomes assertive and the trunk of the patient is in a more upright or forward position. A breakthrough of the impulse is preceded by a sufficient rise in the complex transference feelings and followed by a transition of the aggressive impulse into guilt (Davanloo, 1988b, 1992a, 1993).

This is the first time in his life, that the patient is in contact with his aggressive impulse. The breakthrough of the aggressive impulse is never a spectacular event. Of course there are individual and cultural variations. But it is crucial to understand, that dramatic reactions like screaming, banging the fists on the table or standing up are never physiological concomitants of an aggressive impulse. The

same is true for this patient's knocking down a colleague in his adolescence and his throwing the remote control of the television set through the living room whilst in an argument with his wife. All these reactions are—provided that the person has a neurotic structure—regressive defenses with the function of tension release. Because the engine for human neurosis is not acted-out destructiveness in childhood. It is the little child's horrifying inner experience of an outsized physical strength and the fantasy of brutally attacking his genetic figures, whom the child simultaneously loves profoundly and is dependent on. This experience will be reactivated in the therapy during the breakthrough of the impulse and the subsequent unlocking of the unconscious.

The decisive change, which makes the breakthrough of the impulse possible, happens on the anxiety level of the triangle of conflict. As a result of the rise in the complex transference feelings, not only unconscious anxiety increases, but also the patient's capacity to tolerate this anxiety. More and more the patient becomes able to withstand the impact of his complex transference feelings, which are emerging from the unconscious towards the pre-conscious and the conscious zone. For this reason finally unconscious anxiety drops. Consequently also the resistances, which were nourished by the anxiety, become exhausted. This is a victory of the patient and his unconscious therapeutic alliance with the therapist against the forces of the neurosis.

TH: *If in that moment—not in reality, but in terms of thoughts and ideas— . . .*
PT: *Yes.*
TH: *. . . if you had attacked me, what would you have done to me, if you really had hit?*
PT: (Again with some tension in his muscles) *I would have hit you probably with my fist.*
TH: *With which one?*
PT: *With my right one* (showing his right fist, which is firm since a while).
TH: *Are you a right-hander?*
PT: *No, a left-hander.*

Then the patient declares, that nevertheless his right side is the stronger one.

TH: *So you would have hit me with your stronger fist?*
PT: *Yes.*
TH: *Can you show, how you would have raised your arm?*
PT: (Sitting on the edge of his chair, with his trunk in a forward position, showing, how he prepares himself for the beat).
TH: *Like this?*
PT: *Yes!*
TH: *And with how much energy would you have hit me, if you had brought out all what you converted before into a crippled, avoiding and anxious position . . .*
PT: (Interrupting the therapist) *I feel, that the result would be a hole.*
TH: *Where?*
PT: *In your body, if I had hit you.*
TH: *And where would you have hit me?*
PT: *On your chest.*
TH: *So strong, that the result would be a hole in my chest?*

PT: *Yes.*
TH: *That is a mighty punch.*
PT: *Yes.*

The technique of letting the patient show the physical preparation for his attack is adequate mainly in the first breakthroughs. The aim is to decrease as best as possible the remaining anxiety of the patient, that he might attack the therapist in reality. This will ease up the entire breakthrough of the aggressive impulse as well as the breakthrough of guilt. Nevertheless—as I have outlined before—a patient, who experiences his aggressive impulse, always keeps sitting on his chair, avoiding loud noises or wild movements. And the more the therapy advances, the less the patient will have his body moving during the breakthroughs. On the other hand, if a patient shows spectacular reactions, this is a way to prevent the breakthrough of the primitive murderous impulse (Davanloo, 1992a, 1992b).

TH: *And at this moment your rage towards me would be out? If you carefully examine it, neither adding nor omitting something?*
PT: *I see a person in front of me, whom I'm hitting. And to beat her just once is not sufficient.*

The patient for the first time describes "a person" and no longer the therapist in front of him. This is the beginning of the therapist's transfer into a genetic figure.

TH: *What would you have done, if you had let out all the beast, without any anxiety?*
PT: *It's necessary to strangle.*
TH: *Can you demonstrate, how?*
PT: (Letting a very small space between his hands) *Like this.*
TH: *So narrow is the space between your hands?*
PT: *I have to sever, to close totally.*
TH: *So, this is decapitation, is that correct?*
PT: *Yes.*

The patient describes, that in comparison with the strength in his hands, the neck of the victim is weak. Then the patient sees the murdered person as a younger man and identifies him as his father in the patient's childhood. In relationship with his father the patient experiences guilt and grief. Spontaneously the patient reports, that his father prevented every emotional (be it tender or aggressive) interaction with the patient, avoiding the eye-contact, taking a distant and paralyzed position.

After the analysis of the transference and a working through process of the triangles of conflict and persons, the trial therapy with the patient leads to another breakthrough of the aggressive impulse in the transference in the form of killing the therapist with the fists. Then the therapist becomes the mother. What emerges as the reason for the primitive murderous rage towards her is the mother's attitude of not saying what she expected from the children, of not acknowledging when they tried to do something for her, of doing everything by her own in a hurt, withdrawn and reproachful way. And behind the reactive sadistic impulse

appears the profound wish of the patient for a mutual forgiving between him and his mother.

Psychodiagnostic Considerations

One could be prone to diagnose the patient's crises as depressions. But this would be wrong, if one considers, that in the trial therapy the patient has not showed any access to instant repression. Instant repression is a condition *sine qua non* for a depression. Of course, the defensive pattern of a patient can change corresponding to his actual vitality and the cruelty of the sadistic layer which wants to emerge. But nevertheless, one would expect, that a patient with major clinical depressions would also in the interval show some signs of instant repression. And this has therapeutic consequences: The treatment of a patient with a repressive defense organization requires a much more restructuring technique than of a patient who is more on the isolation-side of the defensive spectrum. This is an example for the psychodiagnostic importance of trial therapy in IS-TDP, in contrast to a purely phenomenological assessment, that is not based on the transference (Davanloo, 1987a, 1987b, 1989c, 1989e).

Summary

(1) This article bases entirely on the metapsychological concepts and the technical interventions that are discovered and elaborated by Dr Davanloo in the frame of his research on Intensive Short-Term Dynamic Psychotherapy.
(2) This paper focuses on the handling of initial resistance against emotional closeness in the transference. The very first indicator of this resistance is—in the described case example—unconscious anxiety. The article bases on vignettes from a trial therapy with a male patient in his thirties who suffers from multiple symptom and character disturbances.
(3) The way to the unlocking of the unconscious bases—among other things—on the correct assessment of the patient's actual position within the triangles of conflict and person.
(4) The simultaneous tasks of the therapist at the beginning of the interview are to do a psychodiagnostic evaluation as well as to make the patient stepwise acquainted with the character defenses that paralyze his functioning.
(5) After this preparatory work, the therapist moves to a head-on collision with the resistance against emotional closeness. The result is a considerable rise in the complex transference feelings with a simultaneous increase in the unconscious therapeutic alliance.
(6) Further challenge and pressure to the resistance in the transference lead to a breakthrough of primitive murderous rage in the transference.
(7) The concepts of resistance against emotional closeness, anxiety in the transference and unconscious therapeutic alliance are briefly highlighted.
(8) The central key on the way of the unlocking of the unconscious is the rise in the complex transference feelings. This rise is also a preventive factor against the emergence of undesirable resistances.

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Paving the Royal Road: An Overview of Conceptual and Technical Features in the Graded Format of Davanloo's Intensive Short-Term Dynamic Psychotherapy

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This paper attempts to provide an overview of a variation of Davanloo's Intensive Short-Term Dynamic Psychotherapy known as the Graded Format. This format is the appropriate choice for therapists who wish to treat particular diagnostic groups such as depressive disorders, functional disorders, panic disorder, certain psychosomatic conditions, syntonic character pathology, patients with low capacity to tolerate anxiety and those with mild to moderate degrees of fragility. A summary of key conceptual and technical aspects of the Graded Technique is provided along with some clinical vignettes, followed by a brief overview of why some therapists fail to apply this method, the consequences of such failure and the method's overall advantages.

Introduction

When discussing Davanloo's Intensive Short-Term Dynamic Psychotherapy (IS-TDP), a great deal of emphasis is typically placed on the unlocking phase of the method. This emphasis is certainly warranted in that it is through the unlocking process that the true nature and etiology of an individual's psychopathology can be illuminated and treated. However, an incompletely understood and/or neglected aspect of IS-TDP is the phase of the technique known as the "bringing of multidimensional structural changes" (Davanloo 1987b,c, 1994–95). The model of IS-TDP best suited for carrying out the task of rendering these

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