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Transference Neurosis Revisited: The Case of the Emotionally Frozen Woman With Help From Davanloo, Saint Paul and Dickens' Estella

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ABSTRACT

The most destructive psychological structures are made all that more lethal by their invisibility. This article explores one such structure, transference neurosis. Transference neurosis occurs when an individual is infected by the neurosis of another person, thus altering the normal defense patterns and causing a distortion in the unconscious. The therapeutic journey is charged with the task of addressing the primary injury as well as the foreign structure within the unconscious. The article will utilize the wisdom of Saint Paul, Charles Dickens, Sigmund Freud, Habib Davanloo and a case vignette in an effort to unmask and treat this destructive force.

KEYWORDS
Transference neurosis; psychotherapy; resilience; Davanloo; Dickens; Saint Paul

Introduction

The most destructive psychological structures are those that are hidden, buried deep within the unconscious. Fortified by the cloak of invisibility they possess the capacity to wreak havoc on the life of those individuals who are incarcerated by their presence. The focus of this article will be on one such structure, specifically transference neurosis. The article offers an comprehensive understanding of transference neurosis including how this term may have been conceived and experienced in historical narratives, suggests a way of conceptualizing and diagnosing the presence of transference neurosis in today's context, and offers an expanded understanding of a treatment method. In order to animate this journey into the unconscious the article with employ the personal reflections of an early Christian writer, Saint Paul, and examine Charles Dickens' character of Estella from *Great Expectations* (1861/1992). In particular, building on the work of Habib Davanloo, the article will shed light on the corrosive nature of transference neurosis and apply emerging theories to an actual treatment for a woman who suffered with transference neurosis. This clinical component is titled *The Case of the Emotional Frozen Woman*.

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Transference neurosis has undergone a significant process of redefinition in recent years. The term was first proposed by Sigmund Freud. At the time, the theory and how to name it were unique and innovative. Freud constructed innovative concepts by using language in a new way (Reed, 1994., p. 28). From 1905 when he first observed the phenomenon through to 1914 when he named it "transference neurosis," the theory was taking shape. In formulating the theory of transference neurosis Freud was wrestling with the issue of how to make use of the transferential feelings in the patient-therapist dyad. He saw the development of transference neurosis as a natural manifestation of the primary neurosis and, as such, therapeutically useful. This new form of the transference occurs as a part of the therapeutic relationship and culminates in the creation of a "special class of mental structures" (Freud, 1905b, p. 116). Freud (1914) notes, "we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by the 'transference-neurosis' of which he can be cured by the therapeutic work. The transference thus creates an intermediate region between illness and real life through which the transition from one to the other can be made" (p. 154). Thus, it was Freud's belief that patients could be cured of the original neurosis by working through the transference neurosis and properly interpreting the resulting insights (Beeber, 2016). Reed (1994) reaffirms Freud's insights, noting that the transference neurosis is actually "created in order to be annihilated" (p. 29).

But, what if the patient and therapist are unable to either work through or properly interpret the transference neurosis? In the post-Freudian period transference neurosis came under scrutiny. A building consensus developed among analysts that transference neurosis was not essential to successful analysis or training. A major concern among its critics was that the concept of transference neurosis was complex and its presence in the therapeutic relationship was challenging to detect (Beeber, 2016, p. 113).

It was these two issues – the possible inability to work through transference neurosis and the apparent nebulous nature of transference neurosis itself – that sparked Davanloo's interest in transference neurosis in 1976. His re-examination of transference neurosis is important because, as he began to notice, the presence of a foreign neurosis in the unconscious causes major disruptions within the life of the individual and in the therapeutic process itself. Having been trained in classical psychoanalysis, Davanloo was also concerned about the length of the therapeutic process for those patients who had been previously treated but who had not successfully worked through transference feelings they experienced with their therapist. Due to these unresolved feelings, the patients suffered with a new malignancy in their unconscious. Davanloo believed this new malignancy was due to transference neurosis and that it had more dire consequences for the patient that a failed attempt to work through their original transference feelings.

According to Beeber (2016), "(t)he presence of a persistent Transference Neurosis that has not been sufficiently worked through, leads to an impairment of the patient's original defensive structures. Providing an additional morbid defensive system. The Transference Neurosis renders the original normal defenses non-functional and renders the Original Neurosis of Fusion of Murderous Rage/Guilt/Sexuality inaccessible" (p. 116).

Davanloo disagrees with Freud's understanding that transference neurosis can serve as a useful development within the therapeutic relationship. For Freud the development of this artificial illness was "*the first sign of the mastery of the physician over the disease*"[1] (Reed, p. 29). The issue of mastery, specifically who has mastery, is a point of contention between Freud and Davanloo. As Hickey (2017) argues, "in Davanloo's technique, the transference neurosis develops only if the psychoneurotic illness has obtained mastery over the patient" (p. 20). Davanloo is unequivocal in his understanding that transference neurosis is a malignancy. It serves as an alien within the unconscious and thus compromises the patient's normal defenses and obscures the original neurosis.

In addition to intensifying the emotional distress, the transference neurosis colonizes its host in a way that makes its detection, diagnosis and treatment painstaking and, at times, almost impossible. Davanloo discovered that the complexity of uncovering and treating the transference neurosis is further compounded by the fact it can also occur outside the therapist-patient dyad. Beeber (2016) agrees with Davanloo and understands, "Transference Neurosis as a *transferred neurosis*, i.e., a neurosis transferred from one person's unconscious to another's, one sees the same process in many different relationships" (Beeber, p. 118).[2]

In summary, transference neurosis can be seen as an alien neurosis that fuses with the original neurosis. The individual's normal defenses no longer function. This has a major impact on the individual's character structures. Beeber points out that, "(t)he presence of Transference Neurosis leads to an extremely high degree of unconscious guilt, which in turn fuels destructiveness and masochism in the character. This can rise to a level of 'moral masochism' manifest by an addiction, so to speak, to perpetual suffering" (Beeber, p. 121). Thus, the therapeutic task is twofold; to work with the patient in the removal of this foreign structure and then turn our attention to the primary neurosis. It is the primary neurosis that opens the passageway by which the transference neurosis infiltrates the patient's unconscious.

The crack in the unconscious: the passageway for the transference neurosis

Neurosis is born when a trauma or series of traumatic events ruptures the bond of love and affection between a child and their mother, father, siblings

and/or family members. The damaged bond produces a degree of sadism within the unconscious as the child attempts to manage the hostile feelings toward the objects to whom the child is attached. This sadism then fuses with the resulting guilt that arises from the unconscious and deeply repressed feelings of rage. The normal defenses that assist a person navigate through life are turned against the self. The sadism now has masochistic features, essentially pitting the self against the self. Sadism, masochism and guilt replace love, empathy and attachment. This destructive organization floods the individual's unconscious and conscious life. Without the resources of a healthy defensive system the person is subject to malignant character choices, thus exacerbating the destructiveness that has become the hallmark of their internal and external world.

In a therapeutic process not contaminated by transference neurosis, the therapist and patient can work together as a team in addressing the genesis of the original neurosis. A thematic arch exists between the patient's destructive symptoms and the nature of the trauma. Stated simply, the pieces fit together. With the removal of the original neurosis the patient's unconscious need for sadism, masochism and guilt is replaced by empathy, freedom and relational generosity. Characterologically, the defenses no longer work against the interests of the individual. However, should the person encounter a therapist or an environment that is unconsciously – and in some cases consciously – malignant, an external neurosis can enter the person through the crack that was created by the original neurosis. In such cases, direct and clear movement by the patient and the therapist into the unconscious is made extremely difficult by the presence of this alien psychological structure. In the therapeutic relationship, the expected defenses are not functioning (Beeber, 2016, p. 122), and malignant character structures such as projection, projective identification, defiance and a need to prolong the suffering are operational. The patient also experiences a high degree of anxiety. Cherrick (2002) correctly notes, that "the transference neurosis itself becomes involved in a resistance to treatment" (p. 88). He also suggests that this neurosis "revives the infantile neurosis" (p. 87). This may be true to the extent that the transference neurosis calls upon the patterns of regression and repetition associated with the infantile neurosis in order to perpetuate the patient's suffering. It is the contention of this article that while the infantile neurosis contributes to the creation of a crack in the unconscious, the transference neurosis possesses its own agency. Both Beeber (2016) and Cherrick (2002) point out that the presence of transference neurosis makes treatment difficult. The major difficulty is found in the non-linear therapeutic narrative. Or to state it clear, the pieces do not fit. In an effort to defend itself, the transference neurosis compromises a patient's ability to understand or connect with their behaviour, either in or out of therapy. This massive disconnect replaces the

patient's natural defensive structures and, in so doing, severely weakens their will and capacity to achieve the desired outcome.

Saint Paul, evil and transference neurosis: "I do not understand my actions"

The massive disconnect that indicates the presence of transference neurosis is not a new phenomenon. At the height of his writing, in his letter to the Church in Rome, Saint Paul states "I do not understand my own actions. For I do not do what I want, but I do the very thing I hate" (Romans 7:15). A few verses later he pushes further into the nature of this inner conflict, "I can will what is right, but I cannot do it. For I do not do the good I want, but the evil I do not want is what I do. Now if I do what I do not want, it is no longer I that do it, but sin that dwells within me" (Romans 7:18b – 20). In these biblical verses, the writings of Saint Paul bring into focus a series of psychospiritual insights mirroring those of transference neurosis. The author adeptly captures a crippling dimension of an internal force over which he has no control. Of particular concern is the way that this inertia cuts him off from his ability to do good while propelling him to do what is not good. This loss of freedom bewilders him. In concluding his thoughts, Saint Paul places responsibility for his state on the presence of some kind of "sin" within himself. He acknowledges that there is something wrong, but he is not sure how this internal agent works or what to do about it. He does recognize that it is destructive.

It may be that Saint Paul was wrestling with his own guilt at having followed the law while a zealous persecutor of early Christians prior to his conversion. Since he makes reference to the tenth commandment "thou shalt not covet" at the outset of this pericope, it could also be argued that he is reflecting on the power of that particular bodily sin in his own life, some sort of moral evil and how he is helpless in its presence.[3] Regardless, as is the case with what today we have come to understand as transference neurosis, Saint Paul is describing an internal structure, one that is malignant, destructive, and over which he has no apparent control. He is aware of the challenges in navigating, or even fully understanding, this force that has overtaken him.

In today's world of psychotherapy, the malignancy that plagued Saint Paul would likely be recognized as a transference neurosis. In the world of Saint Paul, such a malignancy was understood in terms of a force of "evil," something possessing a "sinful" quality. Terms such as evil and sin may appear to be too theological or judgemental for inclusion in a discourse about transference neurosis. However, given that transference neurosis is a destructive force that colonizes the unconscious of another so as to render the individual helpless, then this destructive force can be understood even in today's world

as essentially "evil" by cultures and religions that accept the presence of evil in the world. Christian pastoral theologian, Pamela Cooper-White typifies this message when she picks up on Paul's articulated struggles in Romans 7 stating that: "No pastoral theology, founded in the care of suffering human beings, can ignore the problems of sin and evil" (Cooper-White, 2007, p. 40).

Evil can be dissected from a variety of perspectives.[4] Theologian Susan Nelson argues that evil comes into view with the "knowledge that suffering and violence are real and threaten not only life and health but also any sense of meaning, order and blessings" (Nelson, 2003, p. 399). At its core, evil cuts the person off from their essential nature. As with a transference neurosis, we become strangers to ourselves and others. In her exploration of "radical suffering," Nelson (2003) notes that the one wounded by the sin of others can "see themselves as sinful and thus deserving of punishment" (p. 403). In evil there is no symmetry, logic, pattern or moral code. Those who see themselves this way, at times unconsciously, perpetrate harmful acts that increase suffering. In his work on moral evil, Thomas White (2015) observes that the perpetrators of such acts look like us. They do not resemble monsters. They do however inflict "cruelties, such as emotional abuse but sometimes physical, as well as humiliating, bullying, and dominating others, typically in the school, workplace, and in the home, such behavior usually being gratuitous in nature" (p. 491). These actions possess no "remorse or empathy for the well-being of others" (p. 491). In the absence of guilt, there can be no moral compass, no capacity to access remorse let alone empathy.

Transference neurosis can be understood in terms of radical suffering in that those experiencing a transference neurosis can come to "see themselves as sinful and thus deserving of punishment" (p. 403). Both transference neurosis and radical suffering can annihilate a person's access to meaning and, in so doing, contribute to the experience of evil. In a further manifestation of their radical nature, both conditions leave the sufferer in the position of believing that they deserve such misery.

Transference neurosis: the case of Dickens' Estella

As we have seen in the writings of Saint Paul, the phenomenon of what today is understood as transference neurosis is not a new concept within human history. Charles Dickens captured the full measure of transference neurosis in the character of Estella in his novel, *Great Expectations* (Dickens, 1861/1992). To illustrate Davanloo's expansion of transference neurosis, as well as Nelson and White's analysis of radical and moral evil, let's turn our attention to the character of Estella. Her history and character exemplify the development of transference neurosis and the radical suffering that emanates from it.

Journalist Serena Davis (2012) describes Estella as "one of Charles Dickens's most destructive creations." Davis goes on to write that Dickens'

Estella, is “a merciless little viper whose ability to spread discord in a man’s heart is breathtaking: she can crush them under the heel of just one of her pretty satin shoes.” The transformation of the character Estella from an infant into a “destructive creation” demonstrates how transference neurosis is transmitted and its consequences on the life of the one it inhabits, and the lives touched by that life.

Estella is adopted at the age of two or three by the novel’s primary female protagonist, the wealthy Miss Havisham. Davanloo suggests “that the earlier the disruption occurs, the more damaged the patient becomes” (Hickey, 2017, p. 18). The transition from her birth mother to Miss Havisham during a critical phase of attachment forms the second of at least two traumas in Estella’s early life. The first trauma occurred as a product of the violent familial environment into which she was born. Hickey notes that, “(i)f the patient is damaged early in life, say at age one or two years old, then the healthy development of the neurobiological pathway is interrupted” (p. 18). Dickens does not make reference to Estella’s infancy with her birth mother, Molly, but the portrait he draws of Molly is one built on capriciousness, destructiveness and anger. Molly is accused of killing a woman out of jealousy and turns to the lawyer, Mr. Jagger, for help. Prior to her trial, Molly gives Estella to Mr. Jagger for safe keeping in the event that she is convicted. Mr. Jagger has another client, Miss Havisham. Mr. Jagger arranges to have Miss Havisham adopt Estella. In the end, Molly is acquitted but spends the rest of her life in physical and emotional debt to Mr. Jagger. Out of this trauma-filled turbulence Estella is passed from her deeply disturbed parents to the emotionally scarred Miss Havisham. Much like Molly, Miss Havisham is a woman with a socially unacceptable past. Theresa Atchison (2015) argues that Dickens could not make direct reference to the traumas in Miss Havisham’s early life, so “instead he uses her lack to footwear and torn stocking to signify her disgraced status (p. 466). While she is wealthy, she is also ostracized by the judgmentalism that was rampant in the time of Dickens. Miss Havisham had been jilted at the altar on her wedding day. While this abandonment is not the most significant trauma in her life, it exacerbates the earlier unresolved traumas associated with the rejection of her family and English society. Atchison states that Miss Havisham “was not merely jilted at the altar, but she was discarded in a sullied state, necessitating her withdrawal from society to Satis House. She exists in a liminal space sans time because she is an undesirable that society does not wish to acknowledge” (p. 467).

In the narrative, Miss Havisham remains in her wedding dress. The clocks in Satis House – her residence – remain fixed at the time of the ill-fated marriage. Misery and suffering have encased Miss Havisham. With the adoption of Estella her rage against society in general and men in particular

found a single diabolic foil, Estella. Miss Havisham pours her neurotic rage into the fragile unconscious of Estella. Estella is raised to be Miss Havisham's weapon of vengeance.

Dickens scholar Maria Ioannou (2012) notes the consensus among critics concerning the damaging effect Miss Havisham has had on Estella. Ioannou goes on to suggest that "Estella is Miss Havisham's creature, and a study of how the self may be molded by others so as to vicariously fulfil their desires" (p. 144– 145). Miss Havisham is the product of her own story of betrayal, first at the hands of her family and then at the hands of the men in her life. Her rage eventually extends to all men and the revenge she enacts is to fashion a creature who will be loved and adored by many suitors but will be incapable to returning such love. Miss Havisham states, "I adopted her to be loved. I bred her and educated her to be loved. I developed her into what she is, that she might be loved" (GE, p. 261). Speaking of the state of her own heart Estella says, "I have no softness there, no – sympathy – sentiment – nonsense" (GE, p. 259). The creature fashioned by Miss Havisham will crush the hearts of men. The first and most prolonged act of emotional torture is the one that she inflicts on the novel's primary character Pip. When Pip – as a young man – declares his love for Estella she replies:

> *"'It seems,' said Estella, very calmly, 'that there are sentiments, fancies – I don't know how to call them – which I am not able to comprehend. When you say you love me, I know what you mean, as a form of words; but nothing more. You address nothing to my breast, you touch nothing there. I don't care for what you say at all. I have tried to warn you of this; now, have I not?'"* (GE, p. 376).

Pip and Estella have been positively associated with each other since childhood. Her incapacity to experience affection, even for a life-long friend, highlights the devastating power of a transference neurosis. Estella's inability to allow anyone to become close to her is not restricted to Pip. She also lacks the capacity to hold affection for her adopted mother. When Miss Havisham questions Estella about her obvious indifference to her, Estella can only rely with the language she has learned from her tutor.

> *"Estella looked at her with perfect composure, and again looked down at the fire. Her graceful figure and her beautiful face expressed a self-possessed indifference to the wild heat of the other, that was almost cruel.*
>
> *'You stock and stone!' exclaimed Miss Havisham. 'You cold, cold heart!'*
>
> *'What?' said Estella, preserving her attitude of indifference as she leaned against the great chimney-piece and only moving her eyes; 'do you reproach me for being cold? You?'*
>
> *'Are you not?' was the fierce retort.*
>
> *'You should know,' said Estella. 'I am what you have made me. Take all the praise, take all the blame; take all the success, take all the failure, take me'" (GE, p. 322)*

There is a sadistic rage that lurks in Estella's unconscious. The question is, however, whose sadism is it? In this case, the of the sadism stems directly from the unconscious of Miss Havisham, but some of it does belong exclusively to Estella. In Estella's case, the sadism is fused with a high degree of masochism and guilt. Her masochism is evident in two particular relationships for two diametrically opposite reasons. Much like Saint Paul, Estella is subject to the evil or destructive forces within her, even when the good is self-evident. She is completely incapable of having affection for the one person who adores her, Pip. Estella's masochistic self-destruction does not end with her inability to choose good. She decides to marry Pip's long-time rival Bentley Drummle. With the marriage to Drummle, who is physically and emotionally abusive, Estella's misery is only intensified. Pip notes that he "*had heard of her (Estella) as leading a most unhappy life, and as being separated from her husband who had used her with great cruelty and who had become quite renowned as a compound of pride, brutality and meanness" (GE, p. 495)*[5]

Dickens takes the character Estella to the ultimate irony of existence as a person living with transference neurosis. Estella now becomes a person driven to a life of suffering and privation. She was raised to torture men and, in the end, finds herself married to a man who tortures her. In the novel, her character structure, the one developed under the tutelage of Miss Havisham, locks her in a state of captivity from which she sees no escape.

The case of the emotionally Frozen Woman

A transference neurosis takes the unconscious structures of one person and bleeds them into the unconscious of a vulnerable recipient. In the case examined thus far, transference neurosis leaves Estella emotionally frozen. Estella's original neurosis, the one formed as a product of her turbulent infancy is buried under the power of the transference neurosis. The question now is how can someone with a history such as Estella's overcome the presence of transference neurosis? This article will now turn to the Case of the Emotionally Frozen Woman. Themes of torture, privation and helpless fatalism that are alluded to by Saint Paul and exemplified in the life of Dickens' Estella permeate the Case of the Emotionally Frozen Woman.

Jane is a thirty-six-year-old woman who entered therapy for the purpose of addressing her "tendency to freeze in the presence of forceful people, particularly men." She notes that she is not close to her four-year-old son and that her marriage lacks both emotional and sexual intimacy. She has had several affairs with men twice her age, all of whom were married. A professional woman, with two university degrees and a successful business, Jane presents herself as a competent woman but feels that there is "something deep inside" that seems to undermine her

confidence. She states, “I always second guess myself, so much so that I become immobilized. It is like I am frozen somehow.” Similar to Saint Paul, Jane says that she does things she does not want to do and is unable to do the things she knows that she should do. Also, like Saint Paul she refers to a “contamination” that constantly informs her self-identity. Jane cannot explain why she engages in sexual activity outside her marriage, except to say that she “does not like it.” Jane describes the liaisons as “dangerous,” but is unable to elaborate. She states, “I make like I am being seduced, but I am doing the seducing.” She expresses a desire to look at the destructive forces that appear to have control of her life. In response to her yearning for substantial change the therapist suggests the use of Intensive Short-Term Dynamic Psychotherapy (ISTDP.) The patient agrees, and the therapeutic journey moves into an exploration of the patient’s unconscious.[6]

The patient enters the second session with a high degree of anxiety. Davanloo (2000) notes that the first psychodiagnostic task is for the therapist “to determine the discharge pattern of the unconscious anxiety as soon as he introduces the pressure” (p. 44). Discharge patterns fall into three categories. In patients with minor character disturbances, anxiety moves into striated muscles. This is visible in the patient’s hands and forearms. Gottwick, Ostertag, et al (2001), notes that patients “belonging to this category have a high capacity to experience and tolerate anxiety and therefore a high capacity to withstand the impact of their unconscious” (p. 73). Such patients respond well to one or two psychotherapeutic sessions.

In patients who exhibit a high degree of resistance and who display diffuse character and neurotic symptoms, the anxiety moves into the patient’s smooth muscles such as the GI-tack and the lungs. Such patients “may complain of diarrhoea, bronchospasm, or headache” (Hickey, 2017, p. 10). These patients have a complex core pathology. In other words, the trauma to the attachment bond occurs early in the life of the patient. Dickens’ Estella fits into this category. The rupture to her unconscious occurred prior to the time of her adoption by Miss Havisham or between her birth and the age of three . Such patients are flooded with unconscious primitive murderous rage. Guilt and grief dominate the world of their unconscious. According to Hickey (2017) the task of the therapist “is to raise the threshold for the tolerance of anxiety and to eventually convert the discharge pattern to striated muscles” (p. 10).

The third pathway is one in which the anxiety disrupts the patient’s perceptual and cognitive fields. These patients have major character disturbances typified by the presence of “highly primitive unconscious with torturous murderous rage and intense guilt and grief, multidimensional in relation to early generic figures” (Bilski-Piotrowski, 2011, p. 53). The patient may also experience sexualized feelings that are fused with the murderous rage and

guilt. Such individuals tend to be both sadistic and masochistic. The use of sexuality as a weapon for Miss Havisham and Estella would indicate that both Dickens characters could well be suffering from a complex character disorder.

In the Case of the Emotionally Frozen Woman, the discharge patterns were mixed. There was movement within her intercostal muscles but there were also perception disruptions indicating the presence of a complex disturbance. Rather than moving directly into the unconscious the therapist – in consultation with the patient – decided that the best route forward would include a restructuring of the unconscious. Rudimentary restructuring begins by making the patient consciously familiar with the presence of disruptive features in the session.

Th: I notice the degree of anxiety here. What do you think accounts for the anxiety?
Pt: (After a time of silence.) I think you are angry with me.

Such a statement indicates the presence of projective anxiety. Projective anxiety can take a number of forms. The patient can be concerned that he or she may attack the therapist, or that the therapist may attack them. The projection has transference implications and in all likelihood the therapist has come to represent a generic figure in the patient's unconscious. In the interest of further psycho-diagnosis and with a focus on restructuring of the unconscious, the session continues with an ongoing exploration of the anxiety.

Th: You say that I am angry with you, can you say more about this?
Pt: Well, you're yelling at me.
Th: Yelling?
Pt: Yes.
Th: In what way was I yelling?
Pt: (silence) It felt like yelling.

Jane is projecting her anxiety onto the therapist. The complex structure within her unconscious possesses an auditory component where she experiences the therapist as loud and aggressive. The therapist makes her aware that the anxiety is distorting her reality. As a psychotherapeutic discipline ISTDP constantly monitors the *transference component of the resistance* (TCR). The therapist monitors the TCR during this phase of treatment. In reconstruction, the therapist brings the patient to a conscious awareness of her defenses. To move directly toward the primitive feelings within the TCR would overwhelm the patient.

Th: This anxiety wants to push me away and make me useless to you.

Pt: (Nods and remains silent.)
Th: The silence too is destructive.
Pt: (Looks away, remains silent.)
Th: Can you say more about how you experience this anxiety here with me?
Pt: I keep thinking that you will attack me.
Th: What form would this attack take?
Pt: (Silence)
Th: Silence is a part of this destructive organization that wants to cripple your life. The anxiety tells you that I would attack you, how would I attack you?
Pt: (Silence) You would ripe off my clothes.
Th: Would I continue to attack you?
Pt: (nods)
Th: How would the attack go?
Pt: (nods) You would grab me and hold me down.

Davanloo (2005) believes that love and attachment to early genetic figures is a critical part of human development. However, when attachment to the genetic figures is disrupted, particularly by prolonged abuse, then a fusion takes place in the unconscious. In Jane's case her rage is fused with her sexuality. Hickey(2017) notes that the earlier the fusion occurs, "the more damaged the patient is and the more complicated the entry into the pathogenic core of the unconscious will be" (p. 59). Indeed, over the next fifteen sessions the therapist and patient work together at the process of restructuring her unconscious.[7] Throughout these sessions the volume of the anxiety slowly decreases as Jane becomes familiar with her destructive pattern. During the therapeutic journey, it is apparent that Jane has a high degree of projective anxiety. In response to the projective anxiety, the therapist applies a very limited head-on-collision and then brings the interview back to the feelings in the transference. Keeping the sessions within the therapeutic parameters of the transference provides optimal safety for both the therapist and the patient. Working directly with the transference component of the resistance gives the sessions a present reality and avoids the use of external narratives such as blaming or distorting reality to mask deeper truths.

By session sixteen Jane's anxiety is less debilitating. She is now consciously familiar with the many of the structures that have debilitated her life. The therapist asks if Jane feels ready to excavate the unconscious forces that fuel her destructiveness. Jane agrees. Davanloo (1990) employs a series of steps that the therapist can use in order to access the unconscious. He refers to these series of steps as the *Central Dynamic Sequence* (CDS) (p. 101). The CDS consists of six phases. During the first phase, the *Phase of Inquiry*, the therapist explores the patient's stated difficulties. In the Case of Emotionally

Frozen Woman, the phase of inquiry was included in the process of reconstructing her unconscious.

In the second phase, the *Phase of Pressure*, the therapist inquires about the patient's feelings with a focus on the actual experience of feeling. It is at this point in the process that the therapist and the patient turn their attention to those issues that the patient's unconscious is concertedly trying to avoid. This focus on the patient is experienced as pressure, which mobilizes complex transference feelings and intensifies the resistance. Gottwik, Ostertag, et al. (2001) note that during this phase there is a crystallization of "some degree of resistance in the transference. That means tilting and shifting all the character defenses in direction to the therapist" (p. 75).

The third phase within the CDS is the *Phase of Challenge*. The concept of "challenge" stems from the degree to which the therapist remains vigilantly attentive to the patient's distress, continually seeking clarification. During this phase, the patient, in this case Jane, experiences an intensification of their resistances while at the same time developing an alliance with the therapist. This alliance is a major feature of Davanloo's overall theoretical base and is referred to as the Unconscious Therapeutic Alliance (UTA). During this phase the primary aim of the therapist is to amplify the tension between the resistance in the transference and the UTA. This brings about a loosening in "the psychic system so that direct access to the unconscious is possible" (Hickey, 2017, p. 10). This phase – indeed the entire therapeutic relationship – is built around a principle Davanloo (2001) considers to be essential, specifically the therapist's attitude in "maintaining greatest sympathy and respect for the patient, he has neither sympathy nor respect for the patient's resistances and conveys an atmosphere of considerable disrespect for the resistance" (p. 30).

During the phase of challenge, it is important to observe the mounting tension within the therapeutic relationship as the "patient is not merely trying to avoid his painful feelings, but is specifically resisting the therapist's attempt to reach them in the interview" (Gottwik, Sporder, et al., 2001, p. 91). The dynamic energy between the patient and the therapist mounts. The patient, who strongly identifies with his defenses wants to avoid "buried aggressive and painful feelings and becomes even more angry with the therapist" (p. 94). Equally, at a deeply unconscious level, the patient begins to feel an appreciation for the therapist who refuses to capitulate to the forces of the resistance. This shift in the therapeutic relationship ushers in the fourth phase, or the *Phase of Transference Resistance*. During this phase, the patient is brought "face-to-face with the self-destructiveness of his resistances" (Davanloo, 2000, p. 39). The resistances are undeniably active in the therapeutic relationship. Given this reality, the therapist invites the patient to turn against the forces of the resistance.

With the simultaneous rise in the resistance component of the transference and the UTA, the therapist moves to a *head-on-collision (HOC) with the resistance*. The HOC is one of the most significant contributions that Davanloo makes to our understanding of the unconscious.[8] A feature of the HOC is that it creates a total blockade of the various defenses that maintain the resistances. This is done by systematically pointing out the forces that fortify the patient's destructiveness and perpetual desire for self-sabotage. The HOC places the UTA in direct opposition to the forces of the resistance. In the Case of the Emotionally Frozen Woman, as the dynamic energy builds, it is now up to Jane whether she wishes to grab her freedom or to remain incarcerated by the unconscious structures that have crippled her life.

Th: You are a young woman, with great potential, and yet you remain a slave to these forces that cripple your life.
Pt: I don't have any potential.
Th: Your potential is a cold hard fact. You are accomplished in life and you want to deny your own potentiality? These forces in you are very destructive.
Pt: I don't like it when you say that about me, your words are meaningless.
Th: You hold a very responsible position in life. You are an intelligent woman. Yet this destructiveness in you is dismissing me. This is very destructive.[9]

The therapist now moves directly to an exploration of feelings in the transference.

Th: How do you feel here toward me?
Pt: Nothing.
Th: You dismiss me, and you say that you are feeling nothing. So, your destructiveness is alive and well in our relationship. How do you feel toward me?
Pt: I suppose you want me to say angry.
Th: This is about your freedom. So, you let's see how you actually feel toward me.
Pt: Pissed off.
Th: You experience anger here with me.
Pt: Sort of.
Th: Either you experience anger, or you don't. How do you feel toward me?
Pt: You are making me angry.
Th: You are sort of angry with me or I am making you angry, but you refuse to experience your own anger toward me. Minimization or blaming maintains the wall between you and me. Let's see what you are going to do about this wall, this separation? How do you feel toward me?

Pt: (Sigh. The patient tightens her jaw and closes her fists.)

At this point it is evident that the neurobiological and somatic pathways of the murderous rage are active within the therapeutic relationship. The key is for Jane to experience them at the highest possible level of intensity. The full experience of the repressed feelings will bring her close to the zone of her difficulties in the unconscious. The therapeutic process now moves to the fifth phase of the CDS, *Direct Access to the Unconscious and a Major Unlocking of the Unconscious*. During this period of treatment, Davanloo (2000) suggests that the therapist and patient enter into a series of head-on collisions that result in a "high rise in the transference feeling" (p. 40) as well as "optimum mobilization of the unconscious therapeutic alliance" (p. 40). Jane is about to experience her primitive murderous rage in the transference.

Th: How do you experience this rage within you? And don't deny the truth of your own unconscious. Honesty is the only option. You either want to be a free woman or a destructive woman.
Pt: (Looks fiercely at the therapist.)
Th: Sitting in silence is only another manifestation of this destructiveness. Let's see what the destructiveness would do if you directed it at me. What have you done that you should torture yourself? If you were to bring this full torturous feeling toward me in thought or idea, with full intensity, what would you do?
Pt: I would stab you.

The neurobiological pathways of murderous rage are engaged, but the patient's voice lacks intensity. The therapist applies a further HOC with the resistance.

Th: How much rage is there in you? Fifty percent, eighty percent?
Pt: Seventy!
Th: Seventy is only seventy, why settle for seventy when you can have full liberation. You remain cut off from your power.
Pt: I would lash into you, and lash and lash. Into your chest.
Th: Go on.
Pt: Into your stomach.
Th: Go on.
Pt: Into your legs, your thighs, your genitals.
Th: And go on.
Pt. I would cut them off.
Th: My genitals.
Pt: Yes, I would cut them off and stuff them in your mouth.
Th: And then?
Pt:

I would shove and shove. (The patient appears to have ripped off the genitals and actively pushed them down the throat of the genetic figure, represented by the transference with the therapist. Immediately following the shoving action, the patient settles. The patient is breathing heavily but calmly and is staring at the floor.)

The therapist and the patient now explore the portrait of murdered genetic figure. The anxiety and rage have passed. Jane appears relaxed. She is staring at the floor.

Th: You slashed my chest, my abdomen and my thighs, then you cut off my genitals and shoved then down my throat. What is the condition of my body?
Pt: A mess.
Th: Am I dead?
Pt: Yes, I think so.
Th: As I look up at you, what is the colour of the eyes.
Pt: I don't know, I can't see the eyes.
Th: Take your time. What colour do you see?
Pt: Green.
Th: Who has green eyes?
Pt: (Massive tears begin to fall from the eyes of the patient. The passage of painful guilt laden feelings is difficult for Jane.)
Th: Just feel the waves of feeling, don't talk, just feel.
Pt: (Jane encounters three more painful passages of feeling.)

Davanloo (2000) notes that at this point the patient experiences the emergence of grief-laden feelings as she looks at the murdered and mutilated body of the therapist. The unconscious now "transfers the murdered body of the therapist to the murdered body of the genetic figure" (p. 40). "(T)he murdered body of the therapist appears exactly as the murdered body of the mother, father or brother – in terms of color of the hair and eyes – in every respect. The patient is seeing, for example, the dead body of the mother with blond hair and blue eyes. The body of the therapist is not there anymore" (p. 40). This shift often gives rise to guilt-laden feelings. Guilt is the emotion that patient's most struggle to avoid.

At this point, Jane has not yet fully made the transfer of images.

Th: Jane, who has the green eyes?
Pt: Elliot.

Jane experiences an onslaught of guilt-laden feelings. The therapist and patient now have access to a portion of the psychopathological dynamics within Jane's unconscious. Working as a team, the therapist and patient shift into the sixth phase of the CDS; *Dynamic Exploration*. Davanloo (2001) states

that it is "extremely important that, after the direct access to the unconscious, at the completion of the passage of the guilt and grief, the therapist moves to a systematic analysis of the transference and to the phase of consolidation"[10] (p. 31)

Th: Elliot, who is Elliot?
Pt: (Passage of painful, guilt laden-feelings.) My uncle.
Th: As you look into the eyes of your uncle, what is your final communication to him?
Pt: Why? (A further wave of complex feelings.)

During the phase of dynamic exploration Jane reviews her relationship with Elliot. Elliot is Jane's mother's brother. The families were close, both relationally and geographically. Jane grew up is a small farming village. She spent her childhood with Elliot's daughter, her cousin Jillian who she describes as being "like a sister." They had frequent sleepovers, and the families were "extremely close." The relationship with her uncle was always "affectionate." As a child Jane said that she was closer to Elliot than she was to her own father. At about the time Jane entered puberty, or about the age of eleven, she and Elliot began a sexual relationship that lasted until she was fifteen. The relationship ended when Jane was sent to the city to finish high school. According to Jane, she was "hanging with a tough crowd, doing a lot of drugs" and her parents sent her to live with a maternal aunt who lived in the city.

Over the next several sessions there is a resurgence of Jane's primitive and anxiety laden resistances. Her malignant anxiety returns. The therapist and patient continue the process of reconstructing the unconscious for the purpose of mounting another movement into the unconscious. Jane is now familiar with her patterns of self-sabotage, that include elements of masochism and sadism. The masochism appears to be fused to her unrelenting conviction that she is the perpetrator of sexual deviance in her family. Jane believes that as an eleven-year-old, she seduced her uncle. Jane has several more unlockings, and in each case the genetic figure is Elliot. She remains firm in the belief that he was the "innocent one."

Again, as does Saint Paul, Jane continues to do the things that she does not want to do and is unable to do those things that she would like to do. She believes that there is no good in her. In fact, she understands herself to be "contaminated" and believes she deserves to be used and abused by others. Like Dickens' Estella, Jane is an attractive woman who is also emotionally frozen. She uses her sexuality as a way of punishing or hurting men. She resists emotional closeness, believing that if people truly got to know her they would see "what a sick person I am." The therapist is aware that there is a major impairment in Jane's unconscious defensive organization. The impairment is due to the presence of a transference neurosis. Beeber (2016) points out that the presence of transference neurosis is easily detectable

"when one attempts the process of 'Mobilization' or 'Total Removal of the Resistance' and one rapidly notices that efforts to mobilize the Transference Component of the Resistance fall into difficulty in the presence of Transference Neurosis" (p. 123).

In session twenty-five, Jane experiences a breakthrough of massive primitive torturous and murderous rage in a manner similar to session seventeen. As in the previous breakthrough, Jane uses a knife to rip into the chest and abdomen of the therapist. However, at this point Jane begins to viciously attack the genitals and anus of a female. Immediately following the passage of the murderous rage, Jane finds herself staring into the eyes of her mother.

Th: This is your mother?
Pt: Uhm, (nods)
Th: These are her eyes?
Pt: (nods)
Th: What is the expression on her face?
Pt: Satisfaction.
Th: Satisfaction?
Pt: (nods)
Th: What is your communication to your mother?
Pt: Why? (Staring at the floor, with no apparent passage of feeling.)

While a great deal of work has been done on the multidimensional unconscious structural changes, Jane's unconscious continues to lack fluidity. A further HOC with the forces of the resistance is applied.

Th: You mutilated your mother. What is the condition of her body?
Pt: It is bloody.
Th: What is your position in relation to the dead body of your mother?
Pt: I am standing over her.
Th: How do you feel toward your mother? Is there more rage in you?
Pt: I think so.
Th: Then why would you not put it out? You have kept these feelings in for a long time. What next would you do?
Pt: More stabbing. (Jane brings her hands down on the image of her mother.)

Jane stares at the portrait of her mother. Large tears begin to form in her eyes. The tears drip onto her lap.

Th: Feel as much as you can. These are major feelings, they will come like a wave. What is your communication to your mother?
Pt: (With fists and teeth clenched) I hate you. I hate you. (Followed by a major passage of painful feeling.)

The patient reveals that she has felt like a "motherless child" throughout her entire life. Her mother was "beautiful but cold." "She would love me as long as I was pretty." Jane also reported that her mother would often sleep with her. When she was three her relationship with her mother took on an erotic dimension. Jane reports, "It was fondling bum mostly. I think there may have been other things, but I don't remember. She said that I had a cute ass. What mother says that to her daughter?" This statement prompts Jane to once again attack the portrait of the mother.

Th: And now what is the condition of the body.
Pt: Bent and broken, twisted, bloody.
Th: And the expression on your mother's face?
Pt: Sad … confused.
Th: What do you want to communicate to your mother?
Pt: Mummy … (Jane experiences a major passage of guilt-laden feeling.)

Jane now examines a gentle portrait of her mother. Anxiety and anger are no longer present. She sees her mother as a little girl who "had no chance." Jane describes the childhood of her mother. Her grandfather was the "unofficial mayor" of their village. He was chief of the volunteer fire department and a justice of the peace. But according to Jane, he had a "darker side." While Jane's mother did not speak about a history of sexual abuse, Jane is certain that the grandfather perpetrated systematic physical and emotional abuse on his children, including her mother and Elliot.

Jane had a massive passage of guilt-laden feeling when she realized that her mother sent her to the city to "save me." This appeared to be a new revelation to Jane. During this phase of systematic analysis and consolidation, Jane remembers that her mother was not permitted to go to university even though she was offered a scholarship because the grandfather did not believe that, "women should go to university. Yet he wrote reference letters for other girls who wanted to go to university."

Consolidation and conclusion

Over a nineteen-month period Jane's treatment consisted of forty-eight, 90 minutes sessions. Such a lengthy course of therapy could hardly be described as "short-term"; however, 19 months within a life dedicated to torture and destruction is a relatively minor period. Jane entered into treatment because she was doing things that she felt were destructive, but over which she felt helpless. She "froze" in the presence of powerful men, who she would later identify as being "like grandad." And she replayed "seductive scenarios" in which she was in complete command, actions that only fed her guilt and sense of "contamination."

Early in treatment it became evident that the patient's defensive structures were defective in a number of ways. She was a slave to anxiety, an anxiety she

directed toward the therapist in the form of a crippling projective identification. Her defenses were working against her, causing her to freeze and contributing to the erection of an emotional wall between her and her son. Jane was also engaging in sexual activities that were both masochistic and sadist. The heavy layers of guilt completely dominated her identity as one who was "contaminated." These various layers of neurotically oriented symptoms indicated to the therapist that Jane's unconscious required a multidimensional reconstruction.

Transference neurosis entered her unconscious from two directions. The first was through the unconscious of Elliot. Rather than mentoring and nurturing Jane, Uncle Elliot's neurotic complexities moved into a crack in her unconscious. His helplessness and sadism infiltrated the unconscious of his young niece. The first therapeutic task became that of lifting the transference neurosis. The therapist had no idea that Elliot existed or the role that he played in Jane's unconscious until he surfaced as a result of the first major breakthrough into Jane's unconscious during the seventeen therapeutic session. His presence in her unconscious served to cement her belief that she was "contaminated," that she was not capable of emotional or physical closeness and that in fact she deserved her "frozen state." This belief was fueled by a deep reservoir of guilt trapped in her unconscious.

The second transference neurosis entered Jane's unconscious through the Intergenerational Transmission of Transference Neurosis. Intergenerational transference neurosis begins in the early phases of an infant's life. Beeber (2016) notes that the "infant is a sponge for the incorporation, introjection and identification of feelings originating with parents and grandparents" (p. 120).[11] The lifting of the transference neurosis associated with Elliot allowed the therapist and patient to have access to the primary neurotic structure, the one associated with Jane's mother.

Over time through therapy Jane came to see her mother as an injured woman, one for whom she could have empathy and closeness. She also began to see the generations of damage within her family. Jane now came to understand why she had done the things that she did not want to do and failed to do those things that give her life meaning, purpose and fulfilment, and why she had felt helpless and hopeless. At a core level, Jane had believed herself to be unlovable. Like Dickens' Estella, her response to her own distress had been to use her erotic energy as an instrument of torture, a torture with both masochistic and sadistic elements.

The use of Davanloo's Central Dynamic Sequence, with emphasis on the transference component of the resistance, enabled the patient and the therapist to see the crystallization of the patient's disturbances within the therapeutic relationship. Together, the patient and the therapist rebuilt the patient's unconscious, enabling her to withstand direct access to it. In moving into the unconscious, the first major transference came into view. Such a revelation was only possible by remaining focused on the

feelings in the transference. All subsequent breakthroughs followed the same route. The dead or mutilated portrait of the therapist became the body of Elliot, Jane's mother, father, maternal grandfather, maternal grandmother and sister.

Jane diligently excavated her unconscious. With the elimination of each layer of suffering Jane felt physically "lighter." Her relationship with her mother, father, husband, and son all improved significantly. She had compassion for the generations who went before her. Anxiety, fear and projection were no longer the hallmarks of her life.

Notes

1. The italics appear in the original text.
2. The italics appear in the original text.
3. Robert Jewett, *Romans* (2007) provides a comprehensive review of the various factors that may have contributed to Paul's struggles.
4. Nelson's five models of evil appear in "Facing Evil's Many Faces: Five Paradigms for Understanding Evil" in *Interpretations, 57, no 4*, Oct. 2003. They include: A Moral View; Radical Suffering; The Ambiguous Creation; Eschatological Imagination; Redemptive Suffering. It is a succinct and emotionally honest article.
5. Dickens writes two endings to the novel *Great Expectations*. This excerpt is contained in the first ending … Both endings conclude with a degree of rapprochement between Pip and Estella.
6. The patient agreed that the therapist could use the video and transcripts for the purposes of education and research. Some minor changes have been made in order to insure confidentiality.
7. Each session lasts for 90 minutes. The process of restricting is painstaking. The focus is on bringing the patient to a conscious awareness of the destructiveness and how her defenses are not serving her therapeutic goal.
8. The HOC accomplishes three things: "First, it puts responsibility firmly where it belongs, that is on the patient himself. Second, it is a confrontation directed at the conscious therapeutic alliance, with the implication that unless the patient makes a supreme effort to be honest he cannot be helped. And third, it contains a crucial message to the patient's unconscious, an implied interpretation of destructive impulses both in the transference and directed by the patient toward himself" (Davanloo, 1990, p. 7).
9. This is an excerpt from the seventeenth session. It was this exchange in which the presence of a transference neurosis first became evident. The patient reacted to the therapist's statement of fact. Essentially, the transference neurosis was attacking the UTA. In patients without a transference neurosis, underscoring the patient's potential as well as the patient's destructiveness would increase the UTA.
10. The underlined section appears in the original text.
11. Beeber notes that Davanloo, during his Closed Circuit Workshops (2007 – 2016), listed five categories of transference neurosis: 1. Classically, from therapy; 2. Professional Work; 3. Professional Relationships; 4. Intergenerational Transference Neurosis; 5. A combination of previous therapy and Intergenerational Transference Neurosis. (Beeber, 2016, p. 119– 121). Catherine Hickey's *Understanding Davanloo's Intensive Short-Term Dynamic Psychotherapy* (2017) follows the treatment of one patient who suffers with the fifth category listed by Beeber.

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