

The Major Mobilization of the Unconscious and the Total Removal of Resistance in Davanloo's Intensive Short-term Dynamic Psychotherapy

Part I: An Introduction

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Davanloo's Intensive Short-term Dynamic Psychotherapy has been the subject of various reviews. Davanloo has published extensively on his early work, but there have been no publications on his most recent work—most notably his Montreal Closed-circuit training program. This program focuses on his most recent discoveries and techniques and is a unique, videotaped supervisory program. It focuses on self-assessment and peer-assessment. It is also a unique format in which to review Davanloo's theoretical conceptions of resistance and the transference component of the resistance. This paper will review the early work of Davanloo as well as his most recent research findings. A case from the Montreal Closed-circuit training program will be reviewed in detail to highlight these findings.

KEYWORDS: Intensive Short-term Dynamic Psychotherapy; Davanloo, resistance, unconscious

THE HISTORY OF INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY (IS-TDP)

Freud regarded the removal of the resistance as the primary task of the psychoanalyst. Resistance, initially, was considered to be closely related to the concept of repression, and referred to a patient's inability to discuss, remember, or think about presumably clinically relevant experiences (Freud, 1904/1959). In many of Freud's early cases, treatment was completed after a short course of therapy. It could be surmised that such patients were highly responsive and presented with a circumscribed prob-

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lem. This is in stark contrast to many of the cases he treated towards the end of his career. Freud referred to the resistance of these patients as “the resistance of the repression” (p. 147).

Dealing with the resistance of these patients was challenging despite his having developed the techniques of free association and hypnosis. Freud noted that some patients tended to “cling to their disease.” He referred to another type of resistance, which he called the superego’s resistance. He wrote:

“The ‘unconscious sense of guilt’ represents the superego’s resistance. It is the most powerful factor and the one most dreaded by us.” (Freud, 1926/1959, p. 223).

He commented that analysis was difficult to end, and referred to “analysis interminable” (Freud, 1940/1959, p. 243). One may argue that a main shortcoming of psychoanalysis was the failure to adequately deal with the superego’s resistance. The punitive superego was seen to result in masochism and the therapeutic impasse of years of endless therapy.

Many therapists attempted to modify psychoanalytic technique to shorten its duration and to promote more robust clinical change. Franz Alexander (1946) concluded that there was a group of patients who, after a few sessions, obtained emotional insight and reported relief from their problems. This occurred after the therapist interpreted the patient’s defenses and pattern of functioning with individuals in the present as these related to the past. This emotional experience, in combination with interpretation of defenses and past/current relationships, lead to the notion that quicker results could be obtained by modifying the technique.

Following this, other therapists defined their own models of short-term dynamic psychotherapy. Malan (1975), Sifneos (1972), and Mann (1973) all developed their own models of short-term dynamic psychotherapy, each with their own specific criteria and treatment foci. Interestingly, each model requires either highly motivated patients or an avoidance of the patient’s characterological problem—for example, patients might be suitable if they have always been high functioning and have developed an acute symptom disturbance. However, the techniques are not applicable to highly resistant patients who present with ongoing characterological problems. Given the ubiquitous presentation of patients with high resistance in mental health centers around the world, there needed to be a solution.

The questions were raised: Can the patient’s resistance be addressed through a variety of psychotherapeutic interventions to the point where it breaks down completely and the patient experiences unconscious feelings

with ease and comfort? Would such a therapy provide long-lasting symptom resolution and characterological change?

Through the use of video technology at the Montreal General Hospital and the McGill University Health Centre, Dr. Habib Davanloo sought to answer these question (Davanloo, 1978).

THE TWIN FACTORS OF TRANSFERENCE AND RESISTANCE

Four decades ago, Dr. Davanloo developed a technique of steady and relentless therapist intervention. His technique brought the patient's resistance to the forefront, with the aim to eliminate it completely, thus allowing the patient to have a complete experience of unconscious feelings. Doing so Dr. Davanloo discovered the important interaction of resistance with transference feelings. He went on to refer to the "twin factors of transference and resistance," which became the central dimension of the technique (Davanloo, 1990).

THE UNCONSCIOUS THERAPEUTIC ALLIANCE

In IS-TDP the twin factors of transference and resistance are central. Dr. Davanloo also discovered a third important dimension that he referred to as the Unconscious Therapeutic Alliance or UTA. The UTA is seen as the therapist's ally in the process—that force, created by patient and therapist, which seeks to create positive change in the patient's life (Davanloo, 2001a).

Just as the patient's resistance seeks to defeats the process, the UTA becomes the therapist's ally, and it seeks to enables the patient to experience the most painful and repressed unconscious emotions. In Dr. Davanloo's technique, the mobilization of the UTA against the forces of the resistance is made possible. As the UTA gradually strengthens—and as the resistance proportionally weakens—it commands the process. The resistance is subsequently rendered useless and direct access to the unconscious becomes possible (Davanloo, 1995).

THE TRANSFERENCE COMPONENT OF THE RESISTANCE

Dr. Davanloo further refined his discoveries in the last decade. He discovered an important fourth variable called the transference component of the resistance (TCR). The TCR refers to the patient's degree of resistance, and the transference component in it. This transference component of the resistance (TCR) is a critical therapeutic parameter and must be monitored constantly to ensure that unlocking of the unconscious

occurs. Dr. Davanloo discussed the importance of the TCR in Closed-circuit training programs (Davanloo, 2009-2013).

The therapist seeks out the resistance of the patient, and through a series of interventions (outlined below in the Central Dynamic Sequence [CDS]), intensifies the TCR. As the interview progresses, the UTA strengthens, and when it dominates the resistance, the first breakthrough in to the unconscious occurs. The degree of dominance of the UTA (partial, major, extended major, extended multiple major) reflects the degree of the unlocking (Davanloo, 2001b). The degree of unlocking also reflects the degree to which the transference feelings were experienced.

Resistance is primarily tactical in nature (Davanloo, 1996). The more highly resistant the patient, the more intense the patient's unconscious feelings of murderous rage and guilt. In highly resistant patients, there is often a high degree of primitive murderous rage and intense guilt-laden feelings towards one or both parents and/or siblings. In patients who are more responsive and exhibit low resistance there is often a single, circumscribed psychotherapeutic focus and an absence of murderous rage in the unconscious.

THE SPECTRUM OF PSYCHONEUROTIC DISORDERS

In 2005 Dr. Davanloo outlined the "spectrum of psychoneurotic disorders;" on the extreme left of the spectrum are patients who are highly responsive, have a single psychotherapeutic focus, and hold a circumscribed problem (for example a mild phobic or obsessional neurosis). At mid-spectrum are patients who are highly resistant, have diffuse character and neurotic disturbances, and possess murderous rage and guilt in relation to early figures. In many of these patients, there is complicated core pathology and a fusion of sexuality with murderous rage. On the extreme right of the spectrum are patients who have an extreme degree of resistance, severe symptom and character disturbances, and highly complicated core pathology. In addition they have highly primitive, tortuous unconscious murderous rage, and intense guilt and grief-laden feelings. They have a high degree of masochistic character traits and sexualized feelings, when present, are deeply fused with the unconscious primitive murderous rage.

THE SPECTRUM OF STRUCTURAL PATHOLOGY

Patients may have a fragile character structure. These patients are referred to as having "structural pathology." Character fragility lies on the spectrum and can be referred to as mild, moderate, or severe (Davanloo,

2005). As a group, these patients are unable to withstand the impact of their unconscious during the first interview. They do not have the full capacity to tolerate anxiety and painful feelings, and they also have a longstanding access to primitive defenses, including splitting and projection (Greene, 1996).

The therapist might identify fragility when the patient experiences cognitive/perceptual disruption during the phases of the interview. Disruption could consist of dissociating, drifting, and hallucinating. In mild fragility there would be infrequent cognitive/perceptual disruption—usually only when the most painful areas are explored. Severe fragility would consist of more frequent cognitive/perceptual disruption occurring independent of the interview's content—for example, in patients who present to the interview with severe character disturbance and hallucinations. Moderate fragility lies somewhere in between. In moderate fragility, a patient might have cognitive/perceptual disruption even when relatively neutral content is explored in greater depth or for greater specificity. (Davanloo, 2005).

Dr. Davanloo successfully treated patients with fragility using modifications of the technique: most notably by engaging in extensive structural changes before having the patient experience the full depth of the murderous rage.

To summarize, the therapist attempts to acquaint the patient with the symptoms (for example, hallucinations) by relating to the defences, anxiety, and impulses. Hence, the therapist uses the “triangle of conflict” discussed by Ezriel (1952). The therapist also focuses on and inquires about the transference feelings, and relates these feelings to current, as well as important past, figures from the patient's life. This “triangle of person” was first discussed by Menninger (1958). Following this, the therapist more systematically attempts to use the *central dynamic sequence* (as outlined below) to access unconscious material.

Other authors have used the modified technique in patients with fragility. For example, Abbass (2008) performed a randomized controlled trial on patients—many of whom were fragile—diagnosed with DSM-IV personality disorders. He found improvements in all primary outcome indices. However, the small sample size in the study raised doubts about the generalizability of the findings and further studies were recommended. The authors claimed that there was “high treatment adherence and fidelity;” however, given the precision of the technique and the lack of a manualized approach to IS-TDP, treatment fidelity should be questioned in each and every study.

THE CENTRAL DYNAMIC SEQUENCE

The central dynamic is integral to intensive short-term dynamic psychotherapy. The aim of the “*central dynamic sequence*” (CDS) is to seek out the resistance of the patient through means of active therapist intervention. The goal is to rapidly remove the resistance so that the patient can experience all unconscious feelings at the nucleus of his/her character and symptom disturbances.

The CDS consists of the phases—*inquiry, pressure, challenge, transference resistance, direct access to the unconscious, systematic analysis of the transference, and dynamic exploration into the unconscious*. Although these concepts are extremely well explained in past scholarly articles (see Gottwick et al., 2001), a brief review of some of these steps follows. All of the steps may not be performed in the same order in each interview and some steps may be omitted in some interviews. At any rate, the goal of the CDS is to increase the TCR as rapidly as possible.

The therapist begins the interview with the phase of *inquiry* in which the therapist asks the patient about the disturbances for which s/he is seeking help. The therapist assesses the patient’s ability to respond, and the process becomes dynamic in nature. In this sense, the process moves quickly in to the realm of dynamic inquiry.

The phase of *pressure* usually follows. Essentially, this phase refers to the therapist’s focus on a variety of elements for illumination. The therapist may engage in repeated attempts at clarifying details (*pressure to specificity*) or the nature of feelings (*pressure to feelings, which may be in the transference*). The major aim of the phase of *pressure* is to develop the twin factors of resistance and transference feelings and to tilt the patient’s character defenses in the transference. This leads to some degree of an increase in the transference component of the resistance (TCR).

The phase of *challenge* is next. Challenge is defined as a direct and persistent communication to the patient, usually about the patient’s resistance as it operates in the session. It is different from previous interventions because of its directness, assertiveness and the timing at which is applied—only after the resistance has crystallized in the transference. While the therapist wants to maintain an atmosphere of complete respect and empathy for the patient, the therapist must also convey a considerable amount of disrespect for the patient’s resistance.

If challenge is applied prematurely, before the resistance has crystallized in the transference, then there is a danger of misalliance between patient and therapist. This is to be avoided at all costs. On one hand the

patient becomes angry about this, as the resistance is often entirely ego syntonic, but on the other hand the patient has intense warm feelings about another human being attempting closeness. With this closeness, comes the therapist's complete intolerance for the destructive defenses and resistance, which has maintained the patient's suffering throughout the years. Challenge lies on a spectrum. There can be mild challenge, such as calling on a patient's defence.

Throughout the past four decades, Dr. Davanloo has expanded and refined this phase considerably—namely by focusing less on pure challenge and focusing more on the *head-on-collision*, which also lies on this spectrum. The *head-on collision* is perhaps the most powerful technical intervention. It is a complete blockade against all of the forces that maintain the patient's resistance (Gottwick & Orbes, 2001). With this intervention, there is crystallization of the resistance in the transference.

The therapist aims to further amplify this crystallization to mobilize the UTA against the forces of the resistance and to loosen the psychic system so that direct access to the unconscious is possible. Direct access to the unconscious can be partial, major, extended major and extended, multiple major as above. Following the unlocking of the unconscious, it is very important that there be systematic analysis of the transference. Often, the therapist incorporates *multidimensional unconscious structural changes* (MUSC) into this phase. Multidimensional unconscious structural changes refer to the ongoing integration of the patient's unconscious experience with his/her conscious understanding. The therapist uses both the *triangles of person* (Menninger, 1958), and *conflict* (Ezriel, 1952) to ensure that the patient has a robust understanding of the dynamic forces that have left him/her crippled in life. Ideally, MUSC should be implemented throughout the entire interview process.

To illustrate the above principles, a case will be presented and reviewed in considerable detail.

MONTREAL CLOSED-CIRCUIT TRAINING PROGRAM

The patient in the case history presented was interviewed in the Closed-circuit training program with Dr. Davanloo in Montreal. This program, in operation since 2008, usually consists of 10 to 20 therapists from all over the world who gather for three to five training blocks per year. Each block consists of five to six days of intensive, immersion training. The therapists assume different roles at different times. Often one therapist (the interviewer) has a session with another therapist (the interviewee). The session is both watched live and videotaped. Often the taped

session is then viewed repeatedly. Dr. Davanloo watches the entire process and gives formative feedback. This feedback occurs live—if the interview is stagnating or at an impasse—and retrospectively—through the viewing of DVDs.

The objectives of this program are twofold. One reason is to provide the participants with timely and focused feedback on Dr. Davanloo's therapeutic techniques. The second is to identify, and hopefully remove, any unconscious blocks a therapist may have since these may prevent the therapist in correctly applying this very precise and powerful technique. While this program is intended as a training program (not a therapeutic program) it can be uniquely beneficial for all of the participants.

CASE PRESENTATION

The patient was a 55-year-old female therapist who presents for evaluation in the Closed-circuit training program with Dr. Davanloo. Her demographic details are camouflaged to preserve anonymity. She lives in Europe and has four children. She has had lifelong character disturbances, which include rigidity, stubbornness, and resistance against emotional closeness. She has also suffered from lifelong migraines and has had the more recent onset of insomnia. There were no malignant character defenses and there was an absence of structural character pathology.

She presented at the mid-right side of the spectrum of psychoneurotic disorders. Her genetic figures include her mother and father, to whom she was closely attached. She described a loving relationship with both of them. Her father was often passive and submissive to her mother, who she describes as the more dominant one in the marriage. But everyone in the family was completely submissive to the maternal grandmother. She was the "Queen Bee" of the family and was seen by all as the ultimate ruler and authority.

The patient had a prior course of therapy consisting of approximately seventeen blocks of IS-TDP over the span of three years (2004 to 2007). This treatment was provided by a private therapist and did not occur in the context of the Closed-circuit training program. It concluded approximately two years before the patient entered the Closed-circuit training program in 2009. During this treatment (the 2004-2007 therapy), she developed a transference neurosis towards the therapist which consisted of idealization and sexualized feelings. While the private therapy had been videotaped, there was no supervision from Dr. Davanloo or any other therapist. The patient herself, had training in IS-TDP, and was able to identify that her feelings were consistent with a transference neurosis.

The focus of the earlier therapy had been the patient's father. Subsequent closed-circuit evaluation of the patient revealed that this was not the core neurotic disturbance. Throughout this previous therapy, the transference component of the resistance (TCR) was too low to result in a major mobilization. As a result, an unlocking of feelings towards the patient's mother and grandmother did not occur to any extent. The mother and grandmother later proved to be the focus of the original neurosis of the patient as illustrated in the vignette below.

CLINICAL VIGNETTES

What follows are vignettes from the patient's first interview with Dr. Davanloo in the Closed-circuit training program. This interview occurred five years after the termination of her treatment with a private therapist. An attempt will be made to highlight how each intervention demonstrates the various phases of the central dynamic sequence.

Vignette I: Recapitulation of the Task and the Phase of Dynamic Inquiry

Habib Davanloo [HD]: OK, We follow the principles that the best way to approach some issues is that we explore and honestly experience our feeling as we progress. You accept that principle? And you are on that principle.

PT: OK

HD: This issue with your father is very much linked with your mother and grandmother. But now, what type of the person is your grandmother? How would you describe her?

PT: She was very stubborn. She wanted things her own way. She was the Queen Bee of the family. She called the shots. But she was very devoted. She was two people. She was very loving with the kids and grandkids, and that was her life. At the same time, she was very stubborn and could be very explosive. Definitely with my step-grandfather, the man she married after my grandfather died.

HD: You have memories of your grandmother?

PT: Oh, yeah

HD: What type of the memory? Could you give a name to her second marriage?

PT: What's his name? Grappy

HD: Means what?

HD: Means grandfather

PT: (Laughs)

HD: Very nice way. Because I always hear Grandpa, they write to me. But I never hear Grappy. What type of the person was he?

HD: He was someone who, when he drank, he was very explosive. Once he threw a bucket of water at her.

HD: Grappy was explosive? How old were you?

PT: Five—six—seven

HD: So you remember him . . . Could you describe him physically?

PT: He wore very, very thick glasses. He was always dressed up. He wore a hat and a suit and a tie.

HD: He was from where?

PT: Outside of the city . . . He was from a small town.

HD: He was a local person from the region? How old was your grandmother when Grappy came in the picture?

PT: She must have been in her late thirties or forties.

HD: Grappy was thirty or forty?

PT: They both were probably in their thirties and forties. When she married him she was in her thirties or forties and so was he.

Evaluation of Vignette I

The therapist began the interview with the focus on honesty. He was aware that this patient may have preferred to let “sleeping dogs lie,” and the initial communication to the unconscious was that such an approach would be futile for the jointly agreed upon task. This communication also highlighted that the process would center on what is in the unconscious and would be devoid of intellectualization.

The therapist then proceeded to ask for details surrounding the early genetic figures in the nucleus of the patient’s unconscious. He identified the grandmother and her husband from her second marriage. By asking for details about their ages and where they were from, the therapist engaged in the phase of pressure—particularly pressure for more specificity. This increased transference feelings in the patient.

The patient was able to discuss the two sides of the grandmother in a very clear and precise fashion. The grandmother was stubborn and the “Queen Bee” of the family. She did not want anyone else in the family to get close to each other because this would be very threatening to her. There is precision in this communication and the patient was in command of herself. In the following vignette this leads to unconscious anxiety, most notably discharged through striated muscle tension and sighing respirations.

It is important to note that the therapist constantly monitors the patient for signs of unconscious anxiety, as the timing and application of various

steps in the CDS depends on the patient's response. Generally, the presence of unconscious anxiety (as signalled by sighing respirations), indicates that the therapist can continue to apply the CDS in a sequential fashion. The task then moves on to the search for resistance and the building of a high rise in TCR.

It should be noted that the phase of multidimensional unconscious structural changes (MUSC) begins at the onset of the interview. By inquiring about the important early genetic figures in rich detail, the therapist lays the foundation for the phase of psychoanalytic investigation into the unconscious, which occurs after the breakthrough of guilt.

Vignette II: The Rise in the Transference Component of the Resistance

HD: Your memory is that your grandmother was explosive. Could you describe an instant that she used to be explosive? You took a sigh.

PT: I am trying to pick one instance. It would usually revolve around him drinking and getting drunk . . . and she would get angry and yell and scream.

HD: You took a sigh. What she was like when she was explosive?

PT: It's hard to remember it, but I know it happened so many times. One memory doesn't jump out.

HD: What do you account for that . . . your memory suddenly collapses?

PT: (sigh)

HD: How do you feel right now?

PT: I'm feeling a bit anxious.

HD: What is that?

PT: I feel some tension in my abdomen.

HD: What do you account for that?

PT: I wish I could remember more. I feel anxious that I can't remember more.

HD: Do you think you have some resistance of the issue about the feeling you have about your grandmother?

PT: I think so.

HD: What do you mean I think so?

PT: I have resistance. I don't want to see my grandmother as a loving woman.

HD: But I asked you for an instance when she was in rage, and you don't remember it. You became very defensive with me. How do you feel here with me? Look at this. Look at the way you are with me. You are evasive with me.

PT: I feel like I am going dead.

HD: You are not dead. You are resisting.

PT: OK

HD: You are a mother. You have a major responsibility ahead of you. You want to deal with it?

PT: I do.

HD: Let's see how you feel here towards me. You have a major anger.

PT: It's building.

HD: It's not building. It's there.

PT: It's there, and my fists are tight.

Evaluation of Vignette II

In an attempt to further build the TCR, the therapist continues asking for details surrounding the patient's grandparents. The patient struggles with finding a specific example and the therapist points out that the patient's memory collapses. The therapist is pointing out the truth—that the patient cannot remember important details about an important genetic figure. Furthermore, the memories of this important figure are likely to cause the patient tremendous pain.

As a result, the patient has unconscious resistance to the therapist's relentless pursuit of these details. The patient has feelings towards the past figure (grandmother) and the transference figure (therapist). These feelings include both tremendous rage—with an associated unconscious murderous impulse—and tremendous positive feelings. These feelings lead to the unconscious anxiety as manifested by the sighing.

These interventions, then, causes a dramatic increase in the TCR. There is no reason to explain the patient's memory collapsing, except as a phenomenon under the command of the resistance. Even though the inquiry had hitherto referred to the patient's family of origin, the therapist had been working heavily in the transference. By pushing for pressure to specificity, the therapist communicated to the therapist's unconscious that there was no room for error or evasiveness. This had a profound effect on the patient and on the unconscious therapeutic alliance (UTA). While the patient was resistant to experiencing pain, she knew, on some level, that such an experience would be liberating for her. The patient was profoundly grateful that the therapist did not accept her resistance; that he was willing to pursue relentlessly the feelings which she defended against. The patient said "I feel like I am going dead," which was a joint communication from both the resistance and the UTA. The patient

signaled to the therapist that deadness came as the murderous impulse began to surface.

As the therapist said earlier on, the process must be governed by the principle of honesty. The patient had accepted this and knew that she must face the truth. Dr. Davanloo refers to the “ugly truth” of the unconscious (Davanloo, 2012). As the TCR increased, the patient experienced anxiety, and had a high capacity both to experience and tolerate anxiety. As the various steps of the CDS were applied, the patient did not drift, dissociate, or hallucinate. Rather, she exhibited an ongoing, striated muscle response (sighing respirations, wringing of the hands). These are the hallmarks of the physiological concomitants of anxiety, which indicate that she can withstand the impact of her unconscious in a single interview. As the TCR got even higher, the neurobiological pathway of murderous rage came into operation and the patient experienced a violent, primitive impulse towards the therapist.

Vignette III: The Major Mobilization of the Unconscious, the Removal of Resistance and the Passage of Guilt

HD: How do you experience this rage?

PT: I have a knife—I start attacking.

HD: But that doesn't show how the rage goes.

(At this point, the patient has the full activation and experience of the neurobiological pathway of murderous rage: She physically gestures as though she has a knife in her hand and is slashing the therapist.)

HD: Don't close your eyes. Don't move too much. That's not how you hold a knife.

PT: Down and down (repeatedly).

HD: Go on. Go on. Let's see how systematically you go. Go on. Go on. Go on.

(Here the patient has a massive passage of guilt. She is extremely tearful.)

HD: Look to my eyes.

PT: I see my grandmother and mother together.

HD: Could you describe my eyes?

PT: They are green/blue. Why did I do this to her? Why? How could I do this?

HD: Look to my murdered body. You said my eyes were green . . . face with the feeling. Face with your feeling.

PT: I love you. I love you so much.

HD: You are talking to whom?

PT: My grandmother

HD: How does she look at you?

PT: She loves me too. I love you.

HD: How badly the body is damaged?

PT: There's blood. I have carved. There is a big incision down her head and down her neck and her abdomen is filled with blood. I'm so sorry. I'm so sorry. I love you.

HD: Obviously you are loaded with the primitive murderous rage. Look, you have to face the truth of your unconscious. You say you love her but at the same time you have murderous feelings. You see the two sides? A part of you wants to destroy her but another part of you loves her. But you have to face the two sides of the ugly truth of your unconscious. You have to face it.

PT: I have to face it.

HD: One part of you wants to torture her even worse than this. Another part wants to love her. This is the ugly truth of your unconscious. If you want to examine it we can examine it.

PT: I want to.

HD: There is a massive primitiveness, and it is extremely important you examine . . . this.

PT: Yes, there is.

HD: You carefully want to examine it? If you want to put an end to it, and I put emphasis on if, if you want to put an end to the suffering . . .

Evaluation of Vignette III

As a result of the very high rise in the TCR, this patient's unconscious became highly mobilized. The result was full activation of the neurobiological pathway of rage. The patient experienced a high degree of primitive, murderous, torturous rage, and had the impulse to sadistically murder the therapist. She was able to physically experience this unconscious impulse to murder the therapist without actually acting upon it. Upon unleashing this rage and unconsciously completing the murder of the therapist, the patient looked to the eyes of the therapist. Fundamental in this technique is the transfer of the visual imagery of the therapist to the visual imagery of the genetic figure. As the UTA dominated the resistance, the patient saw the green/blue eyes of her mother and grandmother. Upon further examination, she saw most clearly the green eyes of the grandmother. What followed was a rich portrait of how the grandmother looked in life. This portrait is critical to the technique, and offers a significant message from the

unconscious of the patient. The therapist must carefully explore it, as the communication is often rich in detail and is not contaminated by resistance.

An intensely painful wave of feeling followed, and the patient experienced this as an agonizing constriction of the upper muscles of the chest and larynx. The feeling came in waves along with massive guilt associated with the unconscious murder of her grandmother. But as the therapist then pointed out, there was also massive love associated with this primitive murder. As the patient said "I love you, I love you so much, I am so sorry", the therapist pointed out the reality of the two sides of the grandmother in the patient's unconscious. On one side, the patient loved the grandmother and had a very affectionate bond with her. On the other side, the patient had a violent, sadistic longing to kill her in a tortuous way.

Because of the tremendous love, there was also tremendous guilt. And it is this heavy layer of guilt that fueled the "perpetrator of the unconscious" (Davanloo, 2005) in this patient. Such guilt has built up for decades and has resulted in the characterological and symptom disturbances the patient has experienced her entire life. What complicates the matter is the presence of a transference neurosis in this patient. The transference neurosis is a crippling force in her life and will be the subject of the next article in this series.

CONCLUSION

This article highlights the *central dynamic sequence* of Davanloo's IS-TDP and gives a case vignette which illustrates the major mobilization of the unconscious. The therapist begins the interview with the emphasis on honesty. While the patient is honest, she also prefers to "let sleeping dogs lie." This intervention alone tilts the resistance in the transference and serves to create a foundation for a high rise in the TCR.

As the therapist applies pressure for specificity surrounding the details of the patient's genetic figures, the patient's resistance crystallizes in the transference. While the therapist does not formally apply pressure for feelings in the transference, the transference feelings build regardless. The therapist's focus on the figures of the patient's past creates tremendous feeling in the patient. On one hand, she is appreciative that the therapist wishes to explore these damaged people whom she intensely loved. On the other hand, this exploration will be extremely painful for her. The therapist will point out the "ugly truth" of the past. This mobilizes the patient's unconscious rage towards him.

It is important to note the very unique surroundings and context of the Closed-circuit training program. Ten to 20 therapists are immersed in a program that consists of witnessing and participating in numerous live interviews. In addition, each interview is recorded and sometimes watched repeatedly. These acts create a highly charged atmosphere, in which most participants become rapidly mobilized. Such an atmosphere allows for the interview discussed in this paper, but this interview could never be performed in an initial meeting in an unsupervised private practice setting.

This article highlighted the use of the CDS and the steps needed to create a high TCR. The high TCR is essential in facilitating the major mobilization of the unconscious and the removal of the resistance. In the next article in this series, these concepts (with further vignettes from this case) will be explored. In addition, there will be a special focus on the role of transference neurosis and how this crippling and damaging entity must be avoided at all costs.

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