

Multidimensional unconscious structural changes in Davanloo's intensive short-term dynamic psychotherapy. Part I

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Summary

Davanloo's intensive short-term dynamic psychotherapy is a brief dynamic therapy that focuses on transference feelings and resistance. By doing so, therapist and patient can work together to enable the patient to have a full experience of unconscious feelings – namely rage, grief and guilt. However, this experience of unconscious feelings is not the only therapeutic factor. In addition, the therapist must expertly apply multidimensional unconscious structural changes. Doing so allows the patient to make conscious sense of unconscious experiences. This article focuses on the Montreal Closed Circuit training programme, which is a new teaching format for Davanloo. A case will be presented which will highlight the application of multidimensional unconscious structural changes in a highly resistant patient.

Davanloo / psychotherapy / intensive / short-term

Over the past 40 years, Dr Habib Davanloo has developed a method of intensive short-term dynamic psychotherapy (IS-TDP), which has been highly effective in treating resistant psychoneurotic disorders [1]. By using audiovisual recording, Davanloo has been able to research his technique and has provided comprehensive teaching to those attempting to learn it.

Dr Davanloo has made many discoveries about the human unconscious. These discoveries are based on empirical evidence, not theory or intuition, and form the basis of his metapsychology of the unconscious [2]. His work of the early 1980s focused mainly on patients with phobic, obsessional, panic, depressive, functional disorders [3-6]. Following this, Davanloo began to focus on treating patients with psychosomatic conditions and fragile character pathology. He was able to demonstrate that these patients could be treated successfully with some

modifications of the IS-TDP technique [7, 8]. In IS-TDP, “direct access to the unconscious”, and to all of the pathogenic dynamic forces that contribute to the patients' symptoms and character disturbances, is possible [9]. The technique of rapid and direct access to the unconscious will be demonstrated in a case presentation in this two-article series. Davanloo has presented extensively on his technique of “unlocking the unconscious” [10-18], which allows the patient a direct and affective experience of the pathological dynamic forces that maintain any symptom and character disturbances [10-12].

The twin factors of transference feelings and resistance

One of Dr Davanloo's important early discoveries was that the degree to which the unconscious could be unlocked was directly proportional to the degree of transference feelings that the patient experienced. Another important early discovery was that direct access to the uncon-

scious was influenced not only by transference feelings but also by the interaction between the patient's resistance and the unconscious therapeutic alliance [10, 11].

The unconscious therapeutic alliance

Just as the patient's resistance seeks to defeat the process, the unconscious therapeutic alliance (UTA) becomes the therapist's ally and seeks to enable the patient to experience the most painful and repressed unconscious emotions. In Davanloo's technique, the mobilization of this very powerful force against the forces of the resistance is made possible [19, 20]. As the UTA gradually strengthens, and as the resistance proportionally weakens, the UTA assumes command of the process. The resistance is subsequently rendered useless and direct access to the unconscious becomes possible [20].

Davanloo has shown that dominance of the UTA and direct access to the unconscious is made possible by expertly seeking out and handling the resistance of the patient. In general, the more highly resistant the patient, the more intense are their 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 [2]. In more responsive and low-resistance patients, there is often a single, circumscribed psychotherapeutic focus and an absence of murderous rage in the unconscious. Resistance is primarily tactical in nature [21, 22].

The spectrum of psychoneurotic disorders

Davanloo has carefully outlined the "spectrum of psychoneurotic disorders" [21]. On the extreme left of the spectrum are patients who are highly responsive, have a single psychotherapeutic focus and a circumscribed problem (e.g. a mild phobic or obsessional neurosis). In the mid-spectrum are patients who are highly resistant, have diffuse character and neurotic disturbances, and have murderous rage and guilt in relation to early figures. In many of these pa-

tients, there is complicated core pathology and a fusion of sexuality with murderous rage. Finally, 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.

Spectrum of fragile character structure

In addition to the spectrum of psychoneurotic disorders, there is also a spectrum of patients with fragile character structure. These patients are also referred to as having "structural pathology". Character fragility lies on a spectrum and can be referred to as mild, moderate or severe [2]. As a group, these patients are unable to withstand the impact of their unconscious during the first interview. They do not have the capacity to tolerate anxiety and painful feelings and also have a long-standing access to primitive defences. The therapist might identify fragility during an interview, when the patient experiences cognitive/perceptual disruption during the phases of central dynamic sequence (CDS), which will be explained below. This can consist of dissociation, drifting and the experience of hallucinations. Davanloo has successfully treated such patients with modifications of his technique: most notably by engaging in extensive multidimensional unconscious structural changes before having the patient experience the full depth of their murderous rage (which is often highly primitive and tortuous) and guilt. The treatment of patients with fragile character structure has been the subject of many past international symposia [23-25].

The central dynamic sequence

The CDS consists of the following phases: inquiry, pressure, challenge, transference resistance direct access to the unconscious, systematic analysis of the transference, and dynamic exploration into the unconscious. These concepts are well explained elsewhere [26-29].

Phase 1: enquiry

To summarize, the therapist begins the interview with the phase of enquiry – the therapist enquires about the disturbances the patient is seeking help for. They assess the patient's ability to respond and the process becomes dynamic in nature. In this sense, the process moves quickly into the realm of dynamic enquiry. The phase of pressure usually follows. Essentially, this phase refers to the therapist's focus on a variety of elements. The therapist may ask for 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 defences in the transference. This leads to some degree of an increase in the transference component of the resistance (TCR), the importance of which will be explained below.

Phase 2: challenge

The phase of challenge is next. Throughout the past four decades, Davanloo has expanded and refined this phase considerably. While the therapist wants to maintain an atmosphere of complete respect and empathy for the patient, they must also convey a considerable amount of disrespect for the patient's resistance. On one hand, the patient becomes angry about this as the resistance is often entirely egosyntonic. 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 defences 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. However, in the past two decades, Davanloo has refined the phase of challenge considerably and has focused much more heavily on the technique of head-on collision, which also lies on this spectrum.

The head-on collision is perhaps the most powerful technical intervention in all of the CDS. It is a complete blockade against all of the forces that

maintain the patient's resistance [28]. This intervention is applied when there is crystallization of the resistance in the transference. Through the use of head-on collision, 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 in this phase, but they should ideally be implemented throughout the entire interview process.

The discharge patterns of unconscious anxiety

In the early phases of the interview, the therapist must constantly monitor the discharge pattern of anxiety as it closely relates to the patient's resistance. Some patients have a clear pattern of striated muscle discharge of anxiety, thereby making it easier for the therapist to visualize the anxiety and focus therapeutic interventions accordingly [29]. These patients have tension in the thumbs which eventually involves the entire hand. It then moves to the muscles of the forearm, shoulders and neck. It culminates in tension in the intercostal muscles, which results in the patient having sighing respirations.

Other patients may have a different discharge pattern (e.g. smooth muscle), making the process more challenging. They may complain of diarrhoea, bronchospasm or headache. The task of the therapist is to raise the threshold for tolerance of the anxiety and to eventually convert the discharge pattern to striated muscle.

The third discharge pattern is in the perceptual and cognitive field. These patients often have fragile character structure and cannot withstand the impact of their unconscious during the first interview. Their capacity to tolerate anxiety is low. They require a modified technique, which first creates structural changes before attempting an unlocking of the unconscious.

The transference component of the resistance

The therapist must use the phases of the CDS (not all steps are used in all interviews and sometimes they are used in a different order) to tilt the patient's character resistances in the transference. This leads to the crystallization of the resistance in the transference, a phenomenon which Davanloo has referred to as the transference component of the resistance (TCR) [30, 34]. By ensuring an extremely high rise of the TCR, the therapist can aim for a major mobilization of the unconscious. With this major mobilization, the therapist aims to completely remove the resistance, to completely drain all guilt and to have direct access into the unconscious. In what is comparable to a "fact finding" mission, the therapist and patient collaborate during the phases of psychic integration and multidimensional structural changes. In these phases, patient and therapist become pilot and co-pilot and work together to understand the pathogenic core of the patient's unconscious.

This is the first of two articles which will illustrate the above metapsychological and technical principles. In order to achieve this, we will focus on a case of a patient interviewed in the Montreal Closed Circuit training programme.

Montreal Closed Circuit training programme

The Montreal Closed Circuit training programme is run by Dr Davanloo and has been in operation since 2008. Usually, 10-20 therapists gather for 3-5 training blocks per year. Each block consists of 5-6 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 videotaped and witnessed live. Often, the session DVD is then viewed repeatedly. Davanloo watches the entire process and gives formative feedback. Sometimes, he interviews the patient himself. The feedback occurs both live and in real time – if the interview is stagnating or at an impasse – and retrospectively – through the viewing of DVDs.

The objectives of this programme are twofold. One is to provide the participants with timely

and focused feedback on 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 from correctly applying this very precise and powerful technique, it is important to identify these blocks and remove them when possible. While intended as a training, not a therapeutic programme, it can be uniquely beneficial for all of the participants.

In this case presentation, the focus will be on the application of multidimensional unconscious structural changes (MUSC) throughout the therapeutic process.

Case presentation

The patient is a 55-year-old female therapist who presents for evaluation in the Closed Circuit training programme. Her demographic details will be camouflaged for anonymity. She 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 a more recent onset of insomnia. There are no malignant character defences and there is an absence of structural character pathology.

She presents 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 describes a loving relationship with both of them. Her father was often passive and submissive to her mother whom 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's grandmother was one of 13 children growing up in economic hardship in a rural village. She worked hard, had little autonomy in life and developed a neurosis in which she became extremely controlling. Further details about her emerge in this interview.

The patient had a prior course of therapy consisting of approximately 17 blocks of IS-TDP over the span of 3 years. This treatment was provided by a private therapist and did not occur

in the context of the Closed Circuit training program. It concluded approximately 2 years before the patient entered the programme. During this previous treatment, 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.

It should be noted that Davanloo does not allow for the development of the transference neurosis in his technique. Freud argued that the transference neurosis develops "when the treatment has obtained mastery over the patient" [35]. However, in Davanloo's technique, the transference neurosis develops only if the psychoneurotic illness has obtained mastery over the patient. The transference neurosis is felt to be a highly destructive manifestation of the resistance and is to be avoided at all costs during the course of therapy.

The focus of the previous therapy had been the patient's father. Subsequent Closed Circuit evaluation revealed that this was not the core neurotic disturbance in the patient. Throughout the previous therapy, the TCR was too low to bring about 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.

In the first session of the Closed Circuit training programme, the patient had a massive passage of murderous rage towards the therapist, an impulse to sadistically torture and murder him, and finally, a massive passage of guilt as she looked into his eyes and saw the green eyes of her grandmother. In the second session, she had a similar experience of murderous rage and guilt towards the grandmother. In the third session, she had a murderous impulse towards her mother. What followed was an intense passage of guilt towards this woman.

What follows is the fourth interview in the series. There will be a special focus on the use of MUSC as a means of solidifying the therapeutic task, acquainting the patient with her resistance

and highlighting the possibility for change. Finally, the interview raises a number of important concepts which reflect Dr Davanloo's present-day understanding of the metapsychology of the unconscious.

Vignette I: The therapeutic task and the phase of dynamic enquiry

TH: OK, Dr, thanks for coming. In spite of that we have a lot of data. But some of the things need to be more explicit. How do you feel now?

PT: I feel anxious. Before you came in I felt anxiety.

TH: How do you account for that anxiety?

PT: I feel there is a rage building in me.

TH: So you feel the rage?

PT: I do.

TH: You are still on the principle of honesty?

PT: I am.

TH: Complete honesty? Let's see how you experience the rage.

Evaluation

It is important to note that this is the patient's fourth session in the Closed Circuit setting. As such, she has gained some degree of familiarity with the experience of the neurobiological pathways of anxiety, rage and guilt. She presents with anxiety about meeting the therapist again. On brief exploration, she acknowledges that the anxiety is explained by the murderous rage she feels towards the therapist. In this case, the therapist does not pursue the steps of the CDS in a sequential manner as there is no need to do so. He simply puts pressure on the patient to experience the neurobiological pathway of the murderous rage in the transference and the impulse to murder the therapist. The rather immediate nature of this patient's experience of murderous rage reflects the Closed Circuit training programme in general and several important dynamics therein.

Participants attend the training block for 5-6 days. From day 1, there is an atmosphere of complete and total immersion in the technique. Patient vignettes are shown by means of audio-visual recordings as well as live interviews. In-

tense scrutiny of the interviews follows, again, by means of in-depth review of the audiovisual recordings. What results is a unique and highly “mobilized” group process. Participants experience group cohesion as they see one another experience their unconscious emotions in a highly mobilized state. It is not uncommon for many participants to have extended multiple major unlockings of the unconscious.

In the second article in this series, further vignettes from the interview will be presented. The concept of MUSC will be further explored. Important dynamics of the Montreal Closed Circuit training will be discussed and these will highlight Davanloo’s most current findings.

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