

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

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Summary

This is the second of a two part-series on Davanloo's intensive short-term dynamic psychotherapy (IS-TDP). In the first part, the theoretical foundations for Davanloo's metapsychology of the unconscious were reviewed. In the past five years Davanloo has focused his teaching on a live, Closed Circuit interviewing programme. The format of this programme, the Montreal Closed Circuit training programme, was also discussed and an interview from this programme was reviewed. This second article continues with this interview, exploring it in depth. Special consideration is given to the application of multidimensional unconscious structural changes as a means of creating intrapsychic changes.

Davanloo / psychotherapy / intensive / short-term

This is the second article of a two-part series on Davanloo's intensive short-term dynamic psychotherapy (IS-TDP). In the first article [1], the basic principles of Davanloo's metapsychology of the unconscious were reviewed. In addition, the basic tenets of Davanloo's Montreal Closed Circuit training programme were discussed. A case from this programme was presented and important vignettes were highlighted to illustrate Davanloo's most current research findings.

What follows are further vignettes from the interview. The patient is a professional therapist who is a participant in the Closed Circuit training programme. In the first vignette, she had an experience of rage towards the therapist. What follows is the passage of rage and guilt.

Vignette II: The experience of the neurobiological pathway of murderous rage in the transference and the passage of guilt

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PT: I have a knife. And I go in your nose. Pound your head. Pound it. Pound your head. Into the ground. I smash your head into the ground. I put my foot in your face.

TH: And then? And then? What do you see there? Who do you see there?

PT: My father.

TH: Father? Let it go.

PT: I love you.

TH: Let it go.

PT: I love you. I love you.

TH: Let it go.

PT: I love you. I love you.

TH: Let it go.

PT: I love you. I love you. I love you, Dad. I'm sorry, I love you and I'm sorry.

TH: What do you see there?

PT: I see my father.

TH: What colour are the eyes?

PT: Very light blue.

TH: You see those blue eyes. Let it go, you have a lot of feeling.

PT: I love you. I love you. I love you, Dad. I love you, Dad. I'm sorry. I love you, Dad. I'm sorry. You know how much I love

you, I'm sorry. Don't leave me. Don't leave me. Don't let her drive a wedge between us. Don't let her do it. Don't let her do it. I'm sorry. I'm sorry.

TH: How old is he? In this?

PT: He has darker hair so I think he would be in his forties.

TH: Hair is dark.

PT: But there is some grey.

TH: How do you look at him?

PT: He's peaceful and happy and content and relaxed.

PT: He loves me.

Evaluation

The murderous rage and guilt towards the patient's father are of supreme importance. The above passage of guilt is very important. The patient is able to comfortably and completely experience her guilt in relation to this important genetic figure.

In the patient's prior course of therapy she developed a transference neurosis towards her therapist. As a result, the patient did not have an appropriate focus of therapy. In a misguided effort to directly access the unconscious, that therapist pursued multiple major unlockings focused on the father. Subsequent Closed Circuit evaluation showed that this was the wrong focus.

At the heart of the patient's pathogenic organization of her unconscious was a conflicted but loving relationship with her mother. When the patient was a young adolescent, the mother turned her against her father whom she previously had a loving and affectionate relationship with. Because of the past therapy and transference neurosis, the patient has a massive build-up of guilt. The guilt towards her mother was largely unexamined in that first course of therapy, whereas the guilt towards her father was in many senses exaggerated and embellished. The patient colluded with the therapist in creating an "avalanche" in the unconscious, but the true core neurotic structure lay unexamined and un-pursued. This added to the massive reservoir of guilt in the unconscious and fuelled, rather than treated, the patient's ongoing symptom and character disturbances.

We must examine the conditions that create the atmosphere for such a smooth passage of murderous rage and guilt in the above vignette.

Many patients can present at this moment of therapy with projective anxiety. Projective anxiety can take on a variety of different forms. On one hand, the patient may have unconscious anxiety that they will actually murder the therapist. The patient may also have unconscious anxiety that the therapist will murder them (double projective anxiety). In some patients, the therapist may assume the role of a past genetic figure. In this case, the patient may see the therapist as her grandmother, the "queen bee", who constantly hovers in the background of all of her human relationships and interactions. She will be reviewed further below.

In this vignette, the therapist employs the technique of total removal of projective anxiety. Because of the highly mobilized milieu of the Closed Circuit training programme, very few interventions are needed. Throughout the programme, participants are exposed to a number of therapeutic interventions that mobilize the unconscious. Head-on collision is employed on and on. Participants come to understand that there is no room for malignant character defences. There is no sense of omnipotence. If they want to learn this technique and engage in the total removal of resistance and major mobilization of their unconscious, then the responsibility lies with them. In this sense, projective anxiety is removed as a result of both group and individual processes and interactions. As a result, direct access to the unconscious and complete experience of the neurobiological pathway of murderous rage and guilt becomes not only possible, but comfortable.

Vignette III: The phase of psychic integration and the incorporation of multidimensional unconscious structural changes

TH: How big was the knife?

PT: Was there a knife? I can't remember. There was a knife in your nose.

TH: What do you remember?

PT: I just remember pounding.

TH: What do you remember?

PT: My memory was that there was a knife in your nose and I pounded.

PT: It was very powerful and I took you and pounded you in the floor.

TH: What do you do with the knife?

PT: What comes to mind is that it goes up the rectum. He was penetrated in life. He was a subordinate to my mother and grandmother.

TH: So both of them dominated your father? Who else besides the two?

PT: I added to it. I aligned with my mother and grandmother. But less so than my sisters.

TH: All throughout your life?

PT: Mostly since my teens.

TH: Do you have a memory?

PT: I had an affectionate relationship with him and then I gradually grew apart from him. We had less hugs and kisses.

TH: Why are you not sure? You're not one hundred percent about being in alignment to torture your father? Why are you vague about it?

PT: I didn't realize I was being vague.

TH: This torture of your father and alignment with your mother and grandmother is very important. What did your father do for a living?

PT: He was a fireman and then an electrician and then a fireman.

TH: So his last job was a fireman. He did physical work.

PT: He worked at the airport. There weren't a lot of fires. It was not that strenuous.

TH: You have a memory that your mother and grandmother abused him?

PT: If you consider neglect abuse, yes.

TH: You have memories?

TH: How would you say his relationship is like with your mother?

PT: It's very bad. I've never seen them be affectionate.

TH: How was he with your mother?

PT: My memory is that my mother was critical of him.

TH: Could you tell me about your memory of him being scolded?

PT: Once he tried to do some cleaning after he had had a few drinks. She would yell at him and be explosive. "What are you doing? Why are you using that? You've made a mess."

TH: You have a specific memory? That she was openly critical that he was no good. Do you have a specific memory?

PT: I do have a memory.

Evaluation

In the above vignette, we see the therapist engaging in the process of multidimensional unconscious structural changes (MUSC). Junior therapists often focus heavily on MUSC during the phase of psychic integration following

the unlocking of the unconscious and the breakthrough of murderous rage and guilt. Ideally, however, MUSC should be employed throughout the interview regardless of which phase of the central dynamic sequence (CDS) the therapist is employing.

Incorporating MUSC into the interview is important for all patients. It is especially important in patients who have had transference neuroses. Davanloo views the transference neurosis as a completely malignant force that must be avoided at all costs. The consequences of an untreated transference neurosis are widespread and lethal. If this patient's transference neurosis is not "cleaned up", then the patient will remain destructive in life and her family (husband and children) will be the first to suffer the ramifications of this destructiveness.

It is clear that this patient has a reservoir of guilt in relation to her father. Ironically, this guilt was intensified because it was not fully and accurately evacuated in her prior course of therapy. This guilt is the engine to many of her disturbances and manifests as a massive inhibitory force in her life. She perceives herself as less intelligent than other therapists around her. She has difficulty with her husband and feels sexually inhibited in this relationship. She repeats the patterns of her mother, father and grandmother who, because of their own neuroses, were part a lost generation. This is a very painful reality for the patient.

Employing MUSC is essential at this stage of therapy. We see that the patient is a victim of being turned against her father. Davanloo has spoken extensively of "the syndrome of the mother turning the son against the father" [2-4]. These terms can be gender neutral and can refer to any configuration of a parent or grandparent turning a child against the other parent. At some point in this patient's development, she was turned against her father by her mother and grandmother. The father was subsequently deprived of loving and affectionate relationships with his four children.

This highly destructive pattern is not immediately obvious to the patient, despite her mobilized unconscious. Unless these destructive forces are highlighted repeatedly, the patient will continue to be destructive. In order to change, she needs to be made aware of what needs to

change. Otherwise, without this emphasis, the destructiveness will continue and be passed on to the next generation. Dr Davanloo refers to this as the “intergenerational transmission of psychopathology” [2-4].

Vignette III also demonstrates the inverse relationship between guilt and memory. The patient cannot remember some of the details of the passage of murderous rage. She cannot remember that she attacked the therapist with a knife. In this sense, she relates to the therapist as though she is an elderly woman with dementia when in fact she is a highly efficient therapist with a very busy practice.

In general, the larger the reservoir of unconscious guilt, the more impaired is the patient’s memory for the historical details of her life. The sooner the guilt is removed, the sooner the patient will get her full memory back.

Vignette IV: The second major unlocking of the unconscious

TH: And what was your reaction?

PT: If I felt anything, I never stood up for him. But as you say that, I’m sure I feel angry. I feel a rage building. Towards her.

TH: Right now, you take a sigh.

PT: It’s building again.

TH: So you want to experience it? Is it rage?

PT: It’s a violent, murderous rage. I stab you in the eye. I would choke you repeatedly. And I squeeze tight, as tight as I can. And I bang you against the floor. Why? Why do you have to do this?

TH: And still you have rage towards your mother?

PT: Why? (Massive passage of guilt)

TH: How do you feel right now?

PT: I love you. I love you, Mum.

TH: What do you see?

PT: I see my mother as a very young girl and she just lost her father and she is so alone. She would do anything to get him back.

PT: I tortured her in life.

TH: She talked to you about her father?

PT: She has. There have been times.

TH: What did she say?

PT: She loved her father. He was very kind and warm and loving.

TH: Could you describe the way she portrayed him?

PT: He was the life of the party. He was kind and warm and loving and affectionate.

TH: And when you say this - you mean your mother really turned against him [AQ5. Meaning the patient’s father? Suggest replace with ‘[your father]’] because her father died on her?

PT: Her recollection is that he was a very loving man.

TH: She destroyed the relationship with your father?

PT: Under the power of my grandmother.

TH: You murder your father. Your murder your mother. Do you see the dead body?

PT: I see it as a flash and then I see a living body.

TH: Out of here also?

PT: I’m not sure what you mean?

TH: Your mother has an affectionate bond with her father but she destroyed it with your father. What do you make of that?

PT: It goes to show you how destructive she is.

Evaluation

Following this interview, further historical data emerged about the patient’s mother and grandmother. This occurred in the group discussion that transpired between Dr Davanloo and the other participants.

The patient’s mother lost her father early in life. He was an affectionate and loving man. This occurred during the Great Depression and the grandmother subsequently struggled with poverty as a single mother to two young children. Given the economic reality of this situation, she became dependent on her own mother and father to help her raise her children. To some degree, she was loaded with murderous rage and guilt towards her first husband and this fateful event in her life. The only way she can deal with this traumatic event is to become massively controlling. Hence, she adopts the persona of the “queen bee”. She exerts massive control on the people in her life and this serves only to drive them further away. She cannot tolerate a close bond with another affectionate and loving man, so she married her second husband who was explosive.

The patient, through the mechanism of intergenerational transmission of psychopathology, has been raised by a damaged system. To remedy her guilt, she seeks out more guilt by developing a transference neurosis with her previous therapist. There is a need to bring about uncon-

scious structural changes so that she can be fully acquainted with these destructive forces.

In this phase of her therapy, there are repeated breakthroughs into her unconscious with repeated passages of guilt. This must occur until such a time that there are sufficient unconscious structural changes. In actuality, the patient's resistance has undergone some structural changes and there is an emergence of an early unconscious therapeutic alliance (UTA). However, the resistance still dominates the UTA, whereas for the process to proceed, the UTA needs to build and dominate the resistance. Davanloo has referred to this early UTA as a "young, dynamic system" [2]. Given that the patient lives outside Canada, it would be ideal for her to have block therapy sessions at least once per month. Otherwise, this young, dynamic UTA will die and further attempts at therapy will be analogous to starting from scratch.

CONCLUSIONS

The above is the fourth in a series of interviews from a Closed Circuit training programme offered by Dr Habib Davanloo of Montreal. We can see that the patient, as a result of her participation in the programme, arrives at the interview in a mobilized state. Very few interventions are needed for her to fully experience the neurobiological pathway of murderous rage and guilt.

What is needed, however, is the timely and accurate application of the process of multi-dimensional unconscious structural changes. The phase of MUSC runs parallel to the central dynamic sequence, which consists of a series of stages employed to allow the patient and therapist direct access to the unconscious. Throughout each and every stage of the CDS, the therapist should attempt to apply MUSC.

Previously, some authors have argued that the only goal of IS-TDP was to gain direct access to the patient's unconscious and evacuate the reservoir of unconscious guilt. It is clear that such a reductionist approach is not only short-sighted, but dangerous as well. Without the careful and thoughtful application of MUSC throughout all phases of the interview, the patient cannot achieve an understanding of their resistanc-

es, their destructiveness and their capacity for change in life.

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