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Chapter 5

**DAVANLOO'S NEW METAPSYCHOLOGY
OF THE UNCONSCIOUS: INTENSIVE SHORT-
TERM DYNAMIC PSYCHOTHERAPY,
MOBILIZATION OF THE UNCONSCIOUS AND
TOTAL REMOVAL OF RESISTANCE**

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ABSTRACT

This chapter addresses the development of the work of Habib Davanloo, M.D. from the early 1960's to the present. His focus has been both on shortening the length of psychoanalytic therapies and expanding the base of patients treatable with his techniques. He, like others at the time, initially worked with highly motivated patients with a single therapeutic focus. Over the decades his clinical and clinical research base expanded to include patients with the highest complexity in their unconscious structure and the highest unconscious resistance. This includes the full spectrum of neurotic and characterologic disturbances,

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fragile character structure and complex cases of persistent, unresolved Transference Neurosis. His current clinical work, clinical research and education of therapists have major implications for the future of dynamic psychotherapy. His metapsychology is presented with attention to the issues of unconscious feelings, manifestations of unconscious anxiety and his unique perspective on the unconscious defensive structure. His methods of Intensive Short-term Dynamic Psychotherapy (DISTDP) with “unlocking the unconscious,” Mobilization of the Unconscious, and Total Removal of Resistance are described. The evidence base for short-term dynamic and DISTDP is briefly reviewed. Lastly, the focus of Davanloo’s current work is introduced, namely his concentration on Transference Neurosis. This topic is discussed further in the next chapter.

INTRODUCTION

Habib Davanloo, MD, a pioneer in the field of short-term psychotherapy, began his work in the late 1950’s and early 1960’s in the psychoanalytic tradition. Trained in Boston, he was heavily influenced by his teachers Elizabeth Zetzel, Helene Deutsch and Eric Lindemann (Davanloo, 1980c, 2010). However, he rapidly became disillusioned with the increasingly long length of psychoanalysis. He noted Freud’s grappling with the issue of lengthy and interminable analyses which Freud believed in many cases emanated from an unconscious masochistic need to suffer and to prolong “illness,” as well as a self-punishing need to sabotage success in general and in psychotherapy.

Freud wrote “No stronger impression arises from the resistances during the work of analysis than of there being a force which is defending itself against every possible means of recovery and which is absolutely resolved to hold on to illness and suffering. One portion of this force has been recognized by us...as the sense of guilt and need for punishment, and has been localized by us in the ego’s relation to the super-ego” (Freud 1937, p. 242). However, Freud did not believe that the resistances of the super-ego alone explained the phenomena of masochism and the “negative therapeutic reaction and sense of guilt found in so many neurotics.” He postulated that a “death instinct” must be playing a role, and that “only by the concurrent or mutually opposing action of the two primal instincts- Eros and the death instinct-, never by one or the other alone, can we explain the rich multiplicity of the phenomena of life” (Freud, 1937, p. 243). In referring further, to the negative and destructive forces in the unconscious, which he believed emanated from both the super-ego resistances and the death instinct, he went on to say that “For the moment we must bow to the superiority of the forces against which our efforts come to

nothing” (Freud, 1937, p. 243). For a detailed discussion of Davanloo's view of “super-ego resistance” see Davanloo's papers on the “Clinical Manifestations of Super-ego Pathology” (Davanloo, 1990a,b).

Davanloo picked up where Freud left off. He began to experiment with short-term dynamic techniques in the 1960's. Like others at that time, notably Franz Alexander, Peter Sifneos, David Malan and James Mann, Davanloo initially restricted his short term approach to highly responsive patients with high motivation to change, low resistance and a comparatively simple or even single psychotherapeutic focus (Davanloo, 1975, 1976, 1977, 1978, 1980a,b). This initial work was anchored in psychoanalytic principles and heavily relied on interpretation as a therapeutic factor. However, Davanloo recognized that by utilizing such strict selection (and thereby exclusion) criteria he could only effectively treat a small percentage of patients who presented for treatment.

In the 1970's, not satisfied with “bowing” to the superior destructive forces in the unconscious, Davanloo began to focus on highly resistant patients with severe phobic and obsessional neuroses, and syntonic character pathology (Davanloo, 1979a) with the aim of increasing the range of patients who could be treated. By the use of audio-visual recording, he painstakingly reviewed his work and refined his interventions, culminating in the technique of “Total Removal of Resistance” in a single interview. With removal of resistance, the direct experience of transference feelings was mobilized and led to an immediate and clear view of the psychopathological dynamic forces in the patient's unconscious that were responsible for the symptom and characterological disturbances. This was the beginning of his technique of Intensive Short-Term Dynamic Psychotherapy (Davanloo, 1975, 1977, 1984). Based on patients' own description of this process he called this technique “Unlocking the Unconscious” (Davanloo, 1990e,f).

In the 1980's Davanloo further expanded the spectrum of patients who could be successfully treated with Intensive Short-term Dynamic Psychotherapy, to include those with depressive disorders, somatization and functional disorders, and panic disorder. Many of these cases have been published (Davanloo, 1978; 1979a; 1980a; 1990a,b, c, d, e, f, g, h). Continuing in the 80's and early 90's he focused on the application of the technique to a spectrum of patients with fragile and borderline character structure. Many of these cases were presented in a number of international symposia (Davanloo, 1993a,b, 1998).

In the later 1990s he refined his technique and interventions further, focusing on what he called the highly powerful method of “Mobilization of the Unconscious.” His focus was on the application of this method to extremely

resistant patients with the most the complex pathogenic unconscious. He further refined his technique of rapid mobilization of tactical and characterologic defenses (Davanloo, 2000d,e), “crystallization” of the resistance in the transference, rapid activation of the transference component of the resistance and the complex transference feelings, mobilization of the “Unconscious Therapeutic Alliance,” direct access to the psychopathological dynamic forces, and “Multidimensional Unconscious Structural Changes.” (Davanloo, 1998, 2013, 2014).

He continued this work into the 2000’s primarily in the form of training workshops in North America and Europe, utilizing live closed circuit audio-visual observation and supervision. In 2007 he instituted the Montreal Training Workshops in Mobilization of the Unconscious (Davanloo, 2007-2016) to which I had the privilege of attending through 2014. Audio-visually recorded vignettes from this program have been presented in Montreal in the ongoing annual audio-visual symposia (Davanloo, 2007-2015). During this period Davanloo developed and refined his understanding of the role of “Fusion” of primitive murderous rage, unconscious guilt, and sexual feeling in the unconscious. It is this Fusion that is the “pathogenic destructive dynamic system in the unconscious.” Other terms he has employed for this destructive system are “Major Resistance,” the “Destructive Organization of the Unconscious,” the masochistic resistance of the superego (Davanloo 1990a,b), and the “Perpetrator of the Unconscious” (Davanloo, 2000a, 2001; Beeber, 1999a,b,c.). The rapid removal of this destructive force in the unconscious is the central task of the therapist in these techniques (Davanloo, 2011) and distinguishes Davanloo’s Intensive Short-term Dynamic Psychotherapy and Mobilization of the Unconscious from other techniques of short-term therapy.

For the past several years, Davanloo has placed major emphasis on the identification and removal of Transference Neurosis as a central factor complicating, if not preventing, the removal of the original fusion in the unconscious. This has been the focus of many of the training workshops since 2009. The programs of training in the Mobilization of the Unconscious, Multidimensional Unconscious Structural Change, and Transference Neurosis have been described in detail in numerous presentations at symposia under the direction of Davanloo, over the past several years (Davanloo, 2007-2016).

In this chapter I will present the basic principles that serve as a foundation of Davanloo’s metapsychology and psychotherapeutic techniques.

SPECTRUM OF PSYCHOPATHOLOGY

In his systematic work in the 70's and 80's he demonstrated that the technique of Davanloo's Intensive Short-term Dynamic Psychotherapy (DISTDP) could create multidimensional unconscious structural changes in a wide range of patients (Davanloo, 2000a). He initially described two broad groups of patients that were treatable with DISTDP, (1) a spectrum of psychoneurotic patients, and (2) a spectrum of patients with fragile character structure (Davanloo, 2005 pp.2650-2651). Patients with severely fragile character structure have an extremely low capacity to tolerate anxiety and painful affects. They easily become flooded with anxiety, with consequent disruption of cognitive and perceptual functions. They have access to primitive defenses such as projection, projective identification, and explosive discharge of affect and temper tantrums and are therefore usually excluded from short-term dynamic psychotherapies. Davanloo has shown that they *can* be treated with DISTDP, but that they cannot withstand the impact of their unconscious in a single interview. They require a phase, sometimes a quite extended phase, of multidimensional unconscious structural changes (MDUSC), raising the capacity to tolerate anxiety and painful feelings, and bringing changes to the defensive structure, before the patient can access their unconscious (Davanloo, 2005 p.2651). Davanloo has presented this important process of MDUSC in detail in recent symposia (Davanloo, 2012, 2013) and this topic requires much further discussion. The process of MDUSC underlies all of Davanloo's techniques and methods.

The "Spectrum of Psychoneurotic Disorders" represents the range of patients for whom Davanloo has demonstrated that access to the core neurotic structure can be achieved in a single session via the technique of "Total Removal of the Resistance." (Figure 1).

For a detailed discussion of the diagnostic spectrum see Davanloo's article on this topic (Davanloo, 2000a). Briefly on the left side of the spectrum patients are highly responsive, highly motivated and show low resistance. They have a high capacity to tolerate anxiety and painful affects. They have circumscribed problems, often only a single psychotherapeutic focus. There is an absence of early trauma and unconscious guilt, and the course of treatment is generally quite short. Davanloo reports treatment in a single session (Davanloo, 2000a). This type of patient is quite rare in the typical psychotherapeutic practice. On the mid-left of the spectrum patients have a moderate degree of resistance and symptoms are more diffuse. Character pathology is present to some degree but is often dystonic. Trauma is usually

present but generally occurs after the age of 4 or 5. There is unconscious violent rage and guilt- and grief-laden feelings in the unconscious in relation to early figures. As one moves further rightward, resistance is higher, symptom disturbances become more diffuse, and characterological disturbances become more diffuse, complex and generally syntonically. Masochistic character traits become manifest. Trauma occurs earlier, and is more intense. Unconscious rage takes on a murderous quality. Guilt and grief-laden unconscious feelings become more intense. On the far right side, resistance is at its highest, symptom and character disturbances are quite diffuse and complex; and there is a high degree of masochism present. Trauma is often early, (often in the first one to three years of life), and can be quite severe and repetitive. Unconscious rage has a primitive quality and often involves torturous feelings; sexualized feelings become fused with rage. Guilt and grief-laden feelings are extremely intense. This constellation of early trauma, pain of trauma, unconscious primitive torturous or murderous rage, intense guilt and grief-laden feelings and masochism in the character structure is what Davanloo termed “The Perpetrator of the Unconscious” (Davanloo, 1990a, 2001, p.28; Beeber, 1999a, b, c).

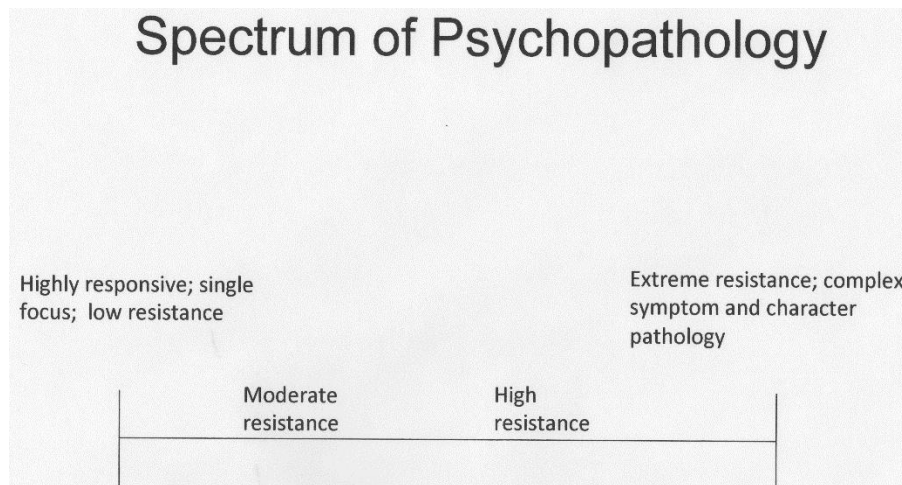


Figure 1. Spectrum of Psychoneurotic Disorders (adapted from Davanloo, 2000a. Used with permission of the author).

PSYCHOPATHOLOGICAL DYNAMIC FORCES

Based on his observations and systematic review of audio-visually recorded case series over the decades of his clinical research, Davanloo elicited and described the Psychopathological Dynamic Forces at work in human neurosis. They are represented schematically as a series of concentric layers in the Unconscious (Davanloo, 2000c, p. 102) (Figure 2).

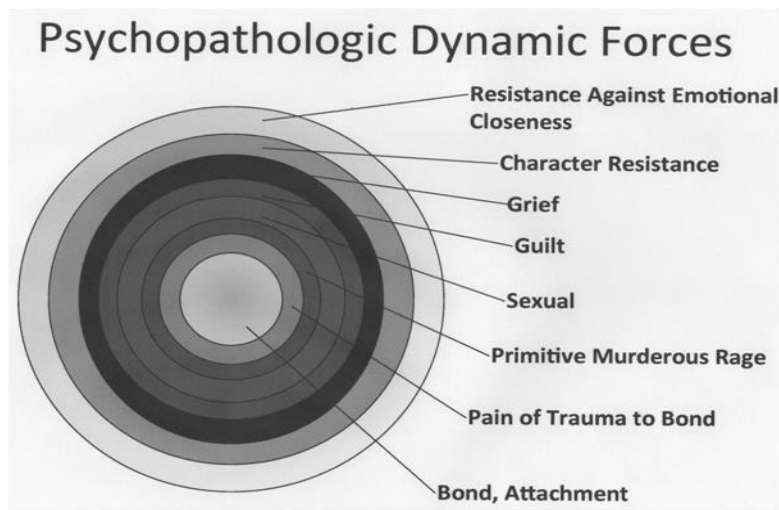


Figure 2. Psychopathologic Dynamic Forces (adapted from Davanloo, 2000c, p. 102. Used with permission of the author).

At the center of these forces is the bond and attachment to the early parental figures. For patients on the right side of the spectrum this bond is traumatized and the trauma is experienced as extremely painful. In reaction to the trauma and pain of trauma, is rage directed at the attachment figure. This rage is qualitatively and quantitatively in proportion to the trauma. While constitutional factors may play a role, generally the more intense and repetitive the trauma, the more intense is the reactive rage. As one moves rightward on the spectrum of psychoneurotic disturbance the rage takes on a murderous, primitive murderous, and primitive torturous/murderous quality. Unconscious guilt results in reaction to the rage (that has been directed at the attachment figure who has been loved as well) and it too, is in proportion to the intensity of the trauma and rage. This unconscious guilt is a highly pathogenic system which is the dynamic engine to the need for self-sabotage and self-punishment,

i.e., masochism in the character. As the rage may have a murderous quality, there is also grief-laden unconscious feeling in reaction to the loss (murder) of the early parental figure. Actual early losses may also give further rise to Grief-laden unconscious feelings.

These unconscious feelings are not experienced separately and remain in a “fused” state in the unconscious, defended against by the development of characterologic defenses (character resistances). In addition, Davanloo uniquely observed and described a specific constellation of character defenses whose aim is to defend against reactivating the early attachment and traumatic painful feelings by fending off closeness and intimacy in current interpersonal relationships. He identified these defenses in many of his early cases, notably the “German Architect” (Davanloo, 1990i, p.14), the “Machine Gun Woman”(Davanloo, 1990c, pp. 62,64,68,74; 1990b, pp. 209,214, 218.) and the “Woman Who Bruised Her Thigh” (Davanloo, 1990e, p. 119). In the “Case of the Corporate Lawyer” he called this constellation of defenses “Resistance Against Emotional Closeness” (Davanloo, 1990f, pp.132, 134-136,156).

Unconscious Guilt plays the central role in Davanloo’s understanding of the Psychopathological Dynamic Forces. He uses the terms “Major Resistance” and “Resistance of Guilt” synonymously, both of which are present in patients in the middle and on the ride side of the diagnostic spectrum. In his earlier work, he described the effects of unconscious Guilt as “clinical manifestations of Superego Pathology (Davanloo, 1990a,b).” He later, in referring to the entire constellation of attachment/trauma, abandonment in the early phase of life/murderous rage/intense guilt- and grief-laden unconscious feeling/masochism in the character, coined the term “Perpetrator of the Unconscious.” (Davanloo, 2000a, p.4).

More recently he has adopted the term “Fusion” to describe this dynamic constellation in the unconscious. The Major Resistance of Guilt does not allow the pain of the trauma, the reactive rage and sexualized feeling to be experienced as separate feelings. Instead these feelings are bound together in the unconscious - as if they were set in concrete and are inaccessible (Represented schematically in Figure 3).

He called the “Fusion of Guilt and Primitive Murderous Rage” (as well as the other feelings) “a pathogenic destructive dynamic system in the unconscious (Davanloo, 2009, 2010, 2011). A major task of the therapist is “the rapid removal of this destructive system” (Davanloo, 2009, 2010, 2011). It is only through removal of Fusion, that the dynamic forces of the Original Neurosis become accessible. He went on further to state that the age of the trauma was critical and that patients traumatized at an early age, for whom

fusion takes place at age 3 or earlier have far more complexity in their unconscious, than those for whom the trauma and fusion takes place at age 4 or older. This complexity arising from early fusion requires a more extensive process of Mobilization of the Unconscious and of Multidimensional Unconscious Structural Change before a more traditional course of DISTDP can be initiated. In contrast, patients whose fusion takes place at age 4 or later can be treated in a much more straightforward fashion with DISTDP (Davanloo, 2013, 2014). The complexities of Multidimensional Unconscious Structural Change go beyond the scope of this introductory chapter and require much further discussion.

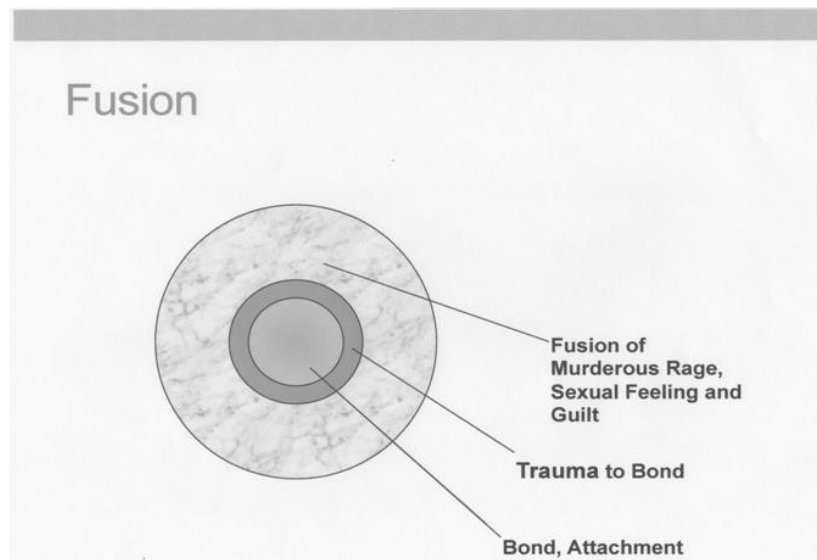


Figure 3. Fusion of Primitive Murderous Rage and Guilt (adapted from Davanloo, 2009. Used with permission of the author).

TRIANGLE OF PERSONS AND TRIANGLE OF CONFLICT: HISTORICAL PERSPECTIVE

The constellation of intense, conflictual feelings described above remains fused in the Unconscious as a result of the Major Resistance. When issues in current life and current relationships reverberate emotionally with these feelings from the past, unconscious anxiety is mobilized. Anxiety in turn

mobilizes characterologic defenses, which may or may not be adequate to manage the anxiety. If not, more malignant character defenses may be mobilized or the person may become symptomatic with anxiety and its concomitants. These basic principles of Impulse/Anxiety/Defense and the relationship of Current Life/ Past/ Therapeutic Relationship (Transference) are cornerstones of most psychodynamic theory (Fenichel, 1945; Greenson, 1967).

These concepts have been represented schematically by a number of analytic theorists. Menninger coined the term "Triangle of Insight" (Menninger 1958). He felt that the insight necessary for successful psychoanalysis rested on the recognition of the relationship of the past, current life and the analytic situation.

"In the proper sense of the word and in the useful sense for psychoanalytic technique, insight is the simultaneous identification of the characteristic behavior pattern in all three situations, together with an understanding of why they were and are used as they were and are." (Menninger, 1958, p. 148).

Ezriel, (1959,1992) writing about the role of transference in psychoanalysis and in group therapies also described the triangular relationship of the past, present life and the transference relationship. He noted that the patient is "consciously or unconsciously attempting, to establish with me in that session one kind of relationship which he requires ("required" relationship) in order to avoid another (the "avoided" relationship), because he believes that this second relationship would inevitably lead to a third, the "calamitous" relationship." He felt that by interpreting these three elements in the "here and now" of the analytic situation or therapy group, "reality testing" was induced which would lead to symptom reduction and character change (Ezriel's notion of the so called "mutative interpretation").

In both these systems interpretation is the central therapeutic intervention. The therapist notes and points out over the course of therapy the patterns of issues in (1) current relationships; (2) the transference patterns of behavior; and (3) relationships in the past, primarily with family members. Links are drawn between Transference, Current and Past.

In the mid-70's Davanloo presented his pioneering work, along with Malan, Sifneos, Marmor and others, in the form of the First and Second International Symposia and Workshops on Short-Term Dynamic Psychotherapy (Davanloo, 1975,1976). As a result of the success of these two symposia, Davanloo set up the Third International Symposia and Workshops in 1977 and founded the Institute of Short-Term Dynamic Psychotherapy at Montreal General Hospital and McGill University (Davanloo, 1977, 1980a p. ix). It was at these symposia that he presented his method of Short-Term

Dynamic Psychotherapy accompanied by audio-visually recorded actual sessions with patients. His book, *Short-Term Dynamic Psychotherapy* grew out of these symposia (Davanloo, 1980a). It was here that he published his method (Davanloo, 1980b), which at this point in time still relied on the use of interpretation. His method is elaborated in other publications of his at that time as well (Davanloo, 1978; 1979b).

In this early phase of his work Davanloo's method focused on understanding and clarifying for the patient the relationship of Impulses and Feelings (I/F), Anxiety (A) and Defense (D) in the Past (P), the Current Life of the patient (C) and in the Transference (T) (Davanloo 1980a p.52, pp.81-82). He, like others at the time, believed that it was the interpretation of the T-C-P link, accompanied by insight into the relationship of Impulse/Feeling to Anxiety to Defense that were the main psychotherapeutic factors (Davanloo 1980a p.91). I include this process of interpretation of I/F-A-D and the T-C-P link for its historical place in the development of Davanloo's Metapsychology of the Unconscious. He later came to the conclusion that that interpretation was ineffective as a major therapeutic factor and abandoned interpretation entirely as a therapeutic technique. By virtue of his systematic review of his audio-visual recordings he came to see the serious limitations of the process of interpretation. This motivated him to refine his interventions and develop his further understanding of the metapsychology of the unconscious. His current focus on his techniques of Mobilization of the Unconscious and Total Removal of Resistance and Multidimensional Unconscious Structural Change (Davanloo, 2007-2015) go far beyond interpretation of the psychoanalytic triangles.

BEYOND THE TRIANGLE OF CONFLICT

Davanloo took the basic analytic concepts of the relationship of impulse/feelings to anxiety and defense –the triangle of conflict- much further. He noted that neurotic patients have great difficulty distinguishing feeling from anxiety from defense. He also observed that there was much confusion among psychotherapists as well about what constituted a feeling or a defense, and what distinguished one feeling from another. This is especially true of the painful affect-laden feelings of guilt and grief. As a result of his systematic clinical research with a wide variety of patients, Davanloo observed and described straightforward guidelines for distinguishing impulse/feeling from anxiety and defense, based on their psychophysiological concomitants.

PSYCHOPHYSIOLOGICAL CONCOMITANTS OF FEELINGS

On Davanloo's view "feelings" have psychophysiological concomitants. "I feel angry" may be merely a statement of thought, a purely cognitive experience with no physiological concomitant, and may therefore serve a defensive function. He called this type of resistance a "tactical defense" (Davanloo 2000d,e). Only if one were to focus on *how* the person actually *experiences* the "anger" can one tell if this is a true feeling or merely a defense. Taking the feelings one at a time, Davanloo describes clear physiologic concomitants as the basis for each.

Rage, murderous rage, and torturous murderous rage all involve the mobilization of a specific system, which Davanloo calls the Neurobiological or Somatic Pathway (NBP) of Murderous Rage. Patients describe this experience as a force of energy, often hot, like a "fireball" or "volcano" that starts in the pelvis or lower abdomen, then moves upward into the chest, where it moves up and down for a brief period of time, and then moves up towards the head. It then feels as if it were moving into the arms, to the hands, accompanied by the impulse to grab the other person. (Davanloo, 2001 p.40). This *internal* experience, which is not associated with *external* acting on the rage, stands in contrast to "explosive discharge of affect," a defense mechanism associated with activity such as yelling or punching walls in the form of a temper tantrum. This latter explosive discharge is considered a regressive defense against the *actual experience* of unconscious murderous rage (Davanloo, 2005 p.2652). Hence, rageful feeling is here distinguished from angry thought and regressive defense.

Guilt is experienced as a wave of deeply painful feeling starting in the chest and involving the upper airway, bronchi, pharynx and larynx. It is experienced in sharp waves of high intensity and may be associated with gasping or sharp, painful sobbing. In contrast, Grief-laden feelings are also painful waves in the chest and but involve the lower airway. The upper airway and pharynx are generally not involved. Waves are smoother and of lower amplitude. Sobbing is also smoother and the entire feeling is less painful than the pain of Guilt (Davanloo, 2001 pp.44-45). In contrast, weepiness, (often having a whining quality), is a regressive defense against murderous rage and, like explosive discharge, acts like the opening of a valve on a pressure cooker to reduce the buildup of unconscious anxiety that had been mobilized by the rage. The person is unlikely to be able to identify the origin of the tears and not associate it with any particular painful memory or particular issue.

However, if the person is then asked what it is that they are experiencing they describe anxiety (Davanloo, 1990c, p.64-67).

Sexual feeling has obvious physiologic concomitants as well. In women there is tumescence of the nipples and clitoris as well as lubrication of the vagina. In men there is erection of the penis. (Davanloo 1990j, 1991, 1993a,b). Without these physiologic concomitants of "feelings" being present one is likely dealing with tactical defenses despite the fact that the patient uses the word "feeling." This simple sounding principle is not widely understood. It is extremely important to note that when there is Fusion in the unconscious, the person has great difficulty being in touch with his/her "feelings." It is only when Fusion is removed, that unconscious "feeling" can actually be experienced fully and consciously (Davanloo, 2005 p.2647, 2009-2014).

DISCHARGE PATTERN OF UNCONSCIOUS ANXIETY

Another of Davanloo's unique and elegant observations involves the psychophysiological discharge pattern of unconscious anxiety. He noted that for some patients, unconscious anxiety is primarily manifested in the form of tension in the voluntary (striated musculature. The voluntary muscles provide a huge reservoir for anxiety and thus these patients show a relatively high capacity to tolerate anxiety (and the underlying unconscious feelings) (Davanloo, 1990j, 1991, 1993a, 2005, p.2637). In the initial interview with these patients, Davanloo observed the progression of the mobilization of unconscious anxiety in the striated muscle system. He noted that anxiety in the form of muscle tension is often initially seen as tension in the hands, thumbs and fingers. As it increases in intensity it involves the pronator and supinator muscles of the forearm, leading to a squeezing movement of the hands. Tension increases up the arms to the neck, with tension in the sternocleidomastoids, and muscles of the jaw. Higher anxiety creates tension in the intercostal and sub diaphragmatic muscles leading to tightness in the chest wall and sighing respirations. (Davanloo, 2005, p.2642). Some patients however, have very little access to striated muscle tension when anxious. Instead anxiety is channeled primarily into the autonomic nervous system (smooth muscle). In this situation, capacity to tolerate anxiety is much lower and patients become symptomatic with autonomic manifestations such as sweating, rapid heart and shallow breathing, queasy stomach, nausea, vomiting, abdominal cramping, diarrhea, or bronchospasm and experience muscular weakness rather than tension. (Davanloo, 2005, p.2642). The third

group of patients also lacks access to the striated muscle discharge pattern of anxiety. Instead anxiety is channeled into the cognitive and perceptual system. These patients have an extremely low capacity to tolerate anxiety. They easily become flooded with anxiety and develop cognitive and perceptual disturbances such as drifting of their thoughts, light-headedness, visual blurring, disrupted thoughts, fainting, and even micro psychotic symptoms such as brief periods of auditory illusions or hallucinations, and mild paranoid ideas. (Davanloo, 1993a,b). These observations have major significance for the application of Davanloo's technique of mobilizing the unconscious. Patients with access to striated muscle tension have the capacity to withstand the feelings in their unconscious and the anxiety it activates; and one can access the unconscious in a single session (Davanloo, 2001.) For patients with predominantly autonomic discharge, a more graded and step-wise approach is necessary. This can be done in one extended session or in a few sessions, until such time as structural change has been accomplished in the discharge pattern from the autonomic system to striated muscle tension. (Davanloo, 1990g,h; Whittemore 1998). For patients with primarily cognitive and perceptual discharge of anxiety, a period of several sessions (sometimes in the range of 10-20 sessions or more) is necessary to bring unconscious structural change at the dimensions of (1) increased capacity to tolerate anxiety, (2) discharge into striated musculature, (3) increased capacity to tolerate rage, (4) increased capacity to tolerate painful feelings, (5) changes in the defensive organization from more primitive defenses (for example projection and projective identification) to more obsessional defenses. Once these multidimensional unconscious structural changes have been accomplished, the patient can now withstand the impact of his/her unconscious (Davanloo, 2005, p.2642, 1993a,b). It is extremely important in the first phase of the initial interview to determine the degree of the patient's anxiety and its discharge pattern as well as the patient's capacity to tolerate anxiety (Davanloo, 1990j, 1991, 1993a,b).

UNCONSCIOUS DEFENSIVE SYSTEM

Davanloo observed, in a wide range of patients, a complex defensive system, which needs to be recognized and understood by any practitioner hoping to treat the full spectrum of patients with DISTDP or any other dynamic technique for that matter. Each patient's defensive structure is unique and most be actively and rapidly detected and mobilized if one wants to achieve "Total Removal of Resistance" in a single or even a few sessions.

Most dynamic therapists are familiar with characterologic defenses. Many have been elucidated by Wilhelm Reich (1933/1980). Very few therapists are familiar, however, with what Davanloo refers to as “Tactical Defenses” (Davanloo, 2000d,e). These defenses are unconscious maneuvers on the part of the patient to reduce anxiety and avoid uncomfortable feelings. The person’s responses seem to answer a question from the therapist or seem to provide a fruitful direction for the interview but are actually tactics geared towards managing anxiety and blocking the further mobilization of feelings. Typical tactical defenses in the early phase of the interview include: diverting to the past, generalizing, using a word of lower intensity to cover the intensity of a feeling and minimization. These defenses may be used alone or in combination. A brief example will suffice. When asked how he feels towards the therapist, the patient, sitting forward, hands tightly clasped, scowling, responds, “I guess maybe I felt a little bit irritated,” a quintuple tactical defense against a negative feeling. One can apply pressure to the underlying feeling by blocking the tactical defense with specific targeted interventions. For example, at the beginning of the first interview a patient is asked what are the difficulties he’s experiencing for which he wants help. The patient replies, “Well my father died when I was a 5 years old.” While this is likely important, it does not really answer the therapists’ question. Viewing this response as a the tactical defense of diverting to the distant past, the therapist responds, “Oh, I see. We can get to that. But what are the current difficulties you are having, that you decided to come now for my help.” This intervention blocks the defense of diverting. The patient clasps his hands together, looks away from the therapist and responds, “I was abusing alcohol until two years ago...” to which the therapist replies, “So what are the current difficulties...” The patient now shifts in the chair, puts his hands on top of his head, sighs deeply and says “I suffer from anxiety.” More anxiety is mobilized by the intervention in the form of increasing striated muscle tension and new tactical defense is mobilized. This increase in striated muscle tension confirms the therapist’s view that he/she is encountering tactical defense and is a green light to increase the pressure on the defensive system. The ability to recognize tactical defenses and respond accordingly is an essential feature of Davanloo’s techniques (Davanloo, 2000d,e).

Another of Davanloo’s unique contributions is his observation of a specific set of characterologic defenses that are geared towards defending against intimacy and closeness – what he calls “Resistance Against Emotional Closeness.” By avoiding and resisting closeness, one tries to prevent activation of the feelings that are at the core of the neurosis, namely attachment, bond,

love, trauma, pain of trauma, and the reactive rage and guilt associated with the trauma. Resistance Against Emotional Closeness takes many forms and is a major emphasis in all of Davanloo's techniques. It is through recognition and systematic work on this constellation of defenses in the Transference that Davanloo achieves the mobilization of the unconscious necessary for access to the psychopathological destructive dynamic forces (Davanloo, 2005 pp. 2637-2638).

Yet another contribution is Davanloo's recognition of the importance of the mobilization of the Transference Component of the Resistance. Any resistant patient enters the interview in a divided state. Though the patient wants the therapist's help, they also want to reduce anxiety and at the same time avoid rageful and painful feelings. Initially the patient employs their typical characterologic defenses but as the therapist keeps up the pressure by blocking the defenses the defenses "tilt" towards the therapist. That is, the more the therapist blocks the avoiding, the harder the patient tries to distance and keep the therapist out of their intimate thoughts and intimate feelings. This occurs at the same time the patient recognizes that they need and want the therapist's help. Not just resisting anyone now, the patient is actively resisting the efforts of the therapist to help them despite the patient's wish to cooperate and collaborate with the therapist. This creates an intrapsychic tension within the patient, between the resistance and the transference and activates what Davanloo terms the Transference Component of the Resistance (TCR) and concomitant Complex Transference Feelings (CTF). It is the very mobilization of the TCR and the CTF that leads to an intrapsychic crisis, and ultimately to access to the core neurotic structure (Davanloo, 2005 p.2630; 2007-15).

Still other defenses are in the category of regressive defenses such as weepiness or explosive discharge of affect, which are attempts to reduce anxiety, and defend against the experience of (murderous) rage. They should not be confused with the actual experience of rage (Davanloo, 1987/1990c, pp.64-67; 2005 p. 2652).

Lastly is the category of what Davanloo refers to as malignant character defenses, such as projection, projective identification, defiance (often "wrapped in a bouquet of seeming compliance"), oppositional character traits, and accusation, to name a few (Davanloo, 2007-15). This last category of defense often indicates impairment in the defensive system, which is characteristic of those with Fusion in the first three years of life.

MOBILIZATION OF THE UNCONSCIOUS

Mobilization of the Unconscious refers to both an overarching aim and principle of Davanloo's techniques, and to a specific teaching and learning process Davanloo uses in a specific form of workshop for the training of DISTDP therapists. In the first sense, Mobilization of the Unconscious is the process by which the therapist activates the patient's unconscious in an attempt to bring all of the Psychopathological Dynamic Forces to consciousness so that they are available to the patient and therapist to be worked through via the processes of Psychoanalytic Investigation and Multidimensional Unconscious Structural Change (Davanloo, 2010, 2011, 2014). These latter therapeutic techniques, Psychoanalytic Investigation and Multidimensional Unconscious Structural Change require much more extensive elaboration than can be addressed in this overview.

Briefly, Mobilization of the Unconscious is accomplished by Davanloo's techniques of the application of the Central Dynamic Sequence and Total Removal of the Resistance (described below). The process depends heavily on the twin factors of the Transference Feeling and the Transference Component of the Resistance. As the resistant patient is both trying to cooperate with the therapist and defeat the therapist at the same time, it is through the application of the Central Dynamic Sequence that the therapist rapidly achieves mobilization of the tactical organization of the patient's resistance as well as their characterological defenses. Through the process of relentlessly trying to liberate the patient from the destructive forces in their unconscious and at the same time not being put off by the patient's efforts to delay and defeat the process, there is activation of intense Complex Transference Feeling (CTF). The patient experiences positive feelings and a sense of gratitude towards the therapist for the relentless efforts to help the patient. At the same the patient experiences negative, rageful feelings towards the therapist for not allowing their usual defenses to work. As characterological and tactical defenses fail to thwart the therapist, the resistance redoubles its efforts and becomes tilted in the direction of therapist. The patient is not merely defending and distancing as they do in every relationship, but is now resisting and distancing the therapist, despite it being against their best interests. This leads to crystallization of resistance in the transference and activation of the Transference Component of the Resistance (TCR) (Davanloo, 2005 pp.2630-31). It is at this point that Davanloo brings his most powerful intervention, the Head-On-Collision with the Resistance into operation. Following application of the technique of Head-On-Collision with the Destructive Organization of

the Resistance there is de-fusion of the primitive murderous rage and guilt with direct experience of the transference feeling in the here and now of the interview. As a result of the de-fusion, there is mobilization of the Neurobiological Pathway of the Murderous Rage in the Transference. This is accompanied by the mobilization of a new force in the Unconscious, namely the Unconscious Therapeutic Alliance (UTA). A hallmark of “Mobilization” is now achieved, namely the predominance of affective responses over cognitive responses, and the predominance of the UTA over the forces of the Resistance. There is can now be direct access to the psychopathological dynamic forces heretofore having been repressed in the unconscious. The unconscious is now said to be “Unlocked” (Davanloo, 2001 pp.30-46; 2005 pp.2630-2631, 2636-2641).

TECHNIQUE OF TOTAL REMOVAL OF RESISTANCE

Akin to Mobilization is Davanloo’s technique of Total Removal of Resistance, which will be briefly reviewed. Patients on the right side of the spectrum are highly resistant and yet access to the core neurotic structure is possible in a single interview. Davanloo has presented this process in many international symposia since the 1970’s. A detailed description of the process is found his article “Intensive Short-Term Dynamic Psychotherapy: Extended Major Direct Access to the Unconscious” (Davanloo, 2001). Typically, the interview progresses through a series of phases, which he called the Central Dynamic Sequence (Davanloo, 1990e p. 101; 2001 pp.30-32).

Briefly, the phases of the interview consist of:

- (1) Inquiry
- (2) Pressure
- (3) Challenge
- (4) Transference Resistance
 - a. Crystallization of the resistance in the transference, the transference component of the resistance
 - b. Head on collision with the resistance in the transference, its destructive role and with Resistance Against Emotional Closeness
 - c. Mobilization of the Unconscious Therapeutic Alliance against the forces of the resistance
 - d. Creation of an intrapsychic crisis, loosening of the psychic system
- (5) Direct Access to the Unconscious

- (6) Analysis of the Process (Analysis of the Transference) and Consolidation
- (7) Psychoanalytic Investigation – a dynamic exploration of the unconscious
- (8) Recapitulation, Consolidation and Psychotherapeutic Planning

Essentially, the initial process is one of establishing the psychodynamic diagnosis – i.e., where the patient lies on the psychodiagnostic spectrum. If the patient evidences an intact defensive system with a robust tactical defensive organization, discharge of anxiety in the form of striated muscle tension with a relatively high capacity to tolerate anxiety and no indication of fragility in the character, direct access to the unconscious is indicated. One then can apply the technique of Total Removal of Resistance via application of the Central Dynamic Sequence. The aim of the Phase of Pressure is to mobilize the tactical system of defense and the complex transference feeling (Davanloo, 2000f). As this is accomplished, the unconscious of the patient becomes alarmed and the characterologic and tactical defenses now tilt in the dimension of the therapist to defend against the rising Transference Feelings (CTF). With further pressure, there is now “crystallization” of the resistance in the transference. At this point the therapist can begin to apply passing and then systematic challenge to the resistances in the transference, with further pressure, which gives further rise to the Transference Component of the Resistance (TCR) (Davanloo, 2000g). By challenging the destructiveness of the resistances, pointing out that the defenses have been paralyzing and crippling for the patient, the therapist turns the patient against the resistance, showing no respect for the defenses that have been damaging the patient's life. At the same time the therapist shows the highest respect for the patient, highlighting that the patient has the capacity to change and does not deserve to lead a life of self-sabotage and self-punishment. In part the patient is identified with their defenses and becomes angry with the therapist for not allowing the defenses to work. At the same time the patient recognizes the self-damaging and self-defeating aspects of the resistances and is highly appreciative of the therapists relentless efforts to help free them from this internal perpetrator of destruction. This intrapsychic conflict of mixed feelings leads to further mobilization of the triple factors of Complex Transference Feeling, the Transference Component of the Resistance and the Unconscious Therapeutic Alliance (UTA). The process continues in the phase of Transference Resistance culminating in the application of Davanloo's most powerful intervention, namely the Head on Collision (HOC) with the Resistance

Against Emotional Closeness and with the Destructive Organization of the Resistance (Davanloo, 2000h). By definition, the Head on Collision entails the total blockade of all the forces of the resistance. Consisting of a possible 16 or 17 elements, various components of the Head on Collision may be assembled to form specific interventions in specific situations. As a result of its application, Transference Feeling intensifies greatly and there is a state of palpable tension between the Resistance and the Unconscious Therapeutic Alliance. The patient is exquisitely aware that though they want their utmost, to collaborate and cooperate with the therapist, they are also heavily resisting the therapist's efforts to get to their most intimate thoughts and feelings and to help free the patient from the destructive "master" of unconscious guilt to which they has been a "slave." This creates a major intrapsychic crisis and loosens the whole psychic system as it reverberates with the core of the psychopathological dynamic forces. There is now further activation of the Neurobiological Pathway of Murderous Rage (fusion age 4 or later) or Sadistic Primitive Murderous Rage (fusion age 3 or earlier) (Davanloo, 2007-2014b, 2011, 2012, 2013, 2014.). Patients have described this process as "breaking through" or "unlocking the unconscious." At this point in the interview, there is dominance of the Unconscious Therapeutic Alliance and total removal of resistance. Unconscious anxiety drops and the patient is brought face to face with his/her unconscious. Typically the patient has visual imagery of the murdered body of the therapist and a feeling of sadness begins to emerge. In the process of looking at the body and describing the damage to the therapist, the patient is asked to focus on the visual image of the eyes of the dead body and to describe the expression, communication from the eyes and most importantly the eye color. If the Unconscious Therapeutic Alliance has been sufficiently mobilized what transpires is that the imagery of the therapist's eyes become visually transferred to the eyes of an early figure in the patient's life – usually a parent. At this point the Neurobiological Pathway of Guilt becomes mobilized with the experience of waves of extremely painful Guilt-laden feeling typically lasting from upwards of 8 minutes. This is followed by the experience of positive loving feelings for the parent. Waves of Grief-laden feelings are experienced for the (unconscious) murder of the loved one, for loss of the bond as a result of early trauma, for the murderous feeling and for the lost years in their relationship (Davanloo, 2001, pp.59-62). This then leads to the phase of Analysis of the Process with recapitulation of the session and a Phase of Consolidation (Davanloo, 2001, pp.30, 46,54), followed by a phase of extensive dynamic, psychoanalytic investigation of the patients early years and relationships to the key figures in early life. This exploration is often

accompanied by additional breakthroughs of feeling in relation to these figures from the past. There is a major focus here on creating multidimensional unconscious structural changes in the dimensions of anxiety, defense, feeling and memory. The initial session usually ends with a phase of further recapitulation, consolidation, and psychotherapeutic planning (Davanloo, 2001, p. 64).

COURSE OF DISTDP

Generally, the full Spectrum of Psychoneurotic Disorders and the Spectrum of Fragility can be treated with one or another variation of DISTDP. As noted earlier, patients with fragility in their character with an extremely low capacity to tolerate anxiety and painful affects are typically excluded from other forms of short-term dynamic therapy. However, utilizing Davanloo's method of an extensive phase (5-20 sessions duration) of Multidimensional Unconscious Structural Change many of these patients can be then treated with a variation of DISTDP. A full course of treatment can be upwards of 60-80 sessions for patients with fragile character structure though symptomatic improvement can be achieved within the first 20 sessions (Davanloo, 2000a, p.4; 1993a,b; 2005, pp.2650-2651). This obviously is not "short-term" therapy in its usual sense but certainly a much shorter course than that of typical psychodynamic psychotherapy.

Patients with access to autonomic discharge or with characterologic depression, dysthymia or other depressive disorders not currently in the throes of a major depressive episode can be treated with DISTDP but require a more gradual access to their unconscious. One may or may not be able to access the core neurotic structure in a single interview. It may be necessary to have 2 or 3 interviews of a graded process. For patients with a low capacity to tolerate anxiety the emphasis is on bringing structural change to the discharge pattern of anxiety from the autonomic system to the striated muscle system. This is accomplished by systematically raising and lowering anxiety; and by fluidly moving between focus on current life and on the transference, following the lead of the patient's unconscious communications. In this way, capacity to tolerate anxiety is gradually increased as evidenced by increasing channeling of anxiety into the striated muscle system. Concomitantly, capacity to tolerate feelings is increased and communications become more meaningful. For depressed patients, the connection between feeling, anxiety and defense is not in operation. Feeling is instantly repressed into depressive symptoms and

collapse. What is required here is bringing change in the defensive structure from instant repression of feeling into depressive symptoms to more obsessional defenses and to a striated muscle tension discharge pattern of anxiety, again with a graded technique. (Davanloo, 1990c,d,g,h; Whittemore, 1996). Following this brief, graded preparatory phase, these patients can enter into a course of DISTDP.

The majority of patients on the Spectrum of Psychoneurotic Disorders, who are highly resistant but have access to striated muscle discharge of anxiety, an intact defensive system and fusion of murderous rage and guilt occurring at age 4 or later, are candidates for the standard technique of DISTDP of 16-40 weekly sessions of an hour to an hour and a half duration (Davanloo, 1984, p.1466, 2005, p.2650, 2011). Patients with fusion at age 3 or earlier have complexities in their unconscious, which require a phase of Mobilization of the Unconscious, Multidimensional Unconscious Structural Changes and Psychoanalytic Investigation prior to commencing standard DISTDP. This can be a relatively straightforward process or a quite complex and lengthy one, depending on the specifics of the case. (Davanloo, 2010, 2011). Additional complications arise with the presence of one variety or another of unresolved Transference Neurosis from previous psychotherapies; in relational to other important figures in one's early family constellation (especially including intergenerational issues); or from relationships in one's professional life (Davanloo, 2009, 2010, 2011, 2012, 2013, 2014). Transference Neurosis in its various forms has been a major focus of Davanloo's training program and a detailed discussion will appear in the next chapter of this book.

EVIDENCE BASE FOR DAVANLOO'S METAPSYCHOLOGY AND ISTDP

Since 1975 Davanloo has presented his audio-visually recorded sessions with patients at annual conferences and courses. He has a large library of cases and case series representing the entire Spectrum of Psychoneurotic Disorders and of Fragility. Most of these cases also have outcome evaluation data. He reports in one case series, that of 617 consecutive general psychiatric patients presenting to the outpatient department at Montreal General Hospital, 28 percent were candidates for DISTDP. Of those 172 patients, 143 had successful outcomes. In a second series, with refinement of the technique to

include patients with panic, somatization and functional disorders, the proportion suitable for DISTDP rose to 35 percent. Once he developed the technique to address fragility in the character, the proportion of patients suitable for DISTD rose to 52 percent (Davanloo, 2005, p. 2650).

Others have conducted and published over 25 outcome studies of ISTDP in one form or another. In many reviews and meta-analyses, studies of ISTDP were mixed with studies involving other short-term dynamic psychotherapies. A Cochrane review of ISTDP (Abbas et al, 2006), a meta-analysis of 21 outcome studies (Abbas et al, 2012), and reviews and meta-analyses for short-term dynamic psychotherapies (including ISTDP) for personality disorders (Town, 2011), depression (Driessen, 2010) and somatic disorders (Abbas, 2009) all conclude that ISTDP appears to be an effective treatment for this broad spectrum of patients.

CONCLUSION

I have attempted to provide a historical perspective and overview of Davanloo's pioneering work in short-term dynamic psychotherapy. The development of Davanloo's metapsychology was summarized. The spectrum of patients treatable with Davanloo's techniques was reviewed. The unconscious engine of psychoneurosis in Davanloo's metapsychology, namely the Psychopathological Dynamic Forces was highlighted. The role of unconscious Guilt and of Fusion in the Unconscious, the major destructive dynamic system at the nuclear structure of neurosis was discussed. In Davanloo's view, it is this destructive Fusion that is the source of masochism in the character and forms the major resistance to be reckoned with in psychotherapy. Trained in the psychoanalytic model Davanloo's early work utilized interpretation, especially of the link between current life, the past and the transference – the so-called T-C-P link. However, Davanloo has gone far beyond this model, based on his empiric observations and findings. His unique observations of the Neurobiological Pathways of Unconscious Anxiety, Murderous Rage, Guilt, Grief and Memory were presented. His techniques of Mobilization of the Unconscious, Total Removal of the Resistance and his Central Dynamic Sequence were briefly presented. Via the use of his techniques, Davanloo has been able to elucidate the complexity of the Unconscious and at the same time show the applicability of his techniques to a wider group of patients and complex clinical situations. The setting and duration of the types of DISTDP for particular patients, including certain

complexities and complicating factors, was summarized and a brief review of the evidence base was provided.

ACKNOWLEDGMENT

Each of these topics is quite complex. A more detailed discussion goes far beyond the scope of this introduction. My aim was to clarify and outline the work to be done in further elaborating these important concepts. It has been a privilege to be able to participate in so many of the rich training activities that Dr. Davanloo has provided my colleagues and me. I hope this paper acts as an impetus for us all to share with our professional colleagues Dr. Davanloo's generous teaching. I am tremendously grateful to Dr. Davanloo for the contribution he has made to my life, both professionally and personally. I have been most fortunate to have Dr. Davanloo as a mentor and colleague for these past 25 years.

The theoretical concepts presented in these chapters including the terminology such as Mobilization of the Unconscious, Transference Component of the Resistance, Complex Transference Feeling, Unconscious Therapeutic Alliance, Central Dynamic Sequence, Perpetrator of the Unconscious, Fusion of Primitive Murderous Rage with Guilt and Sexuality, Intergenerational Destructive Competitive Transference Neurosis, Uplifting the Transference Neurosis, Unlocking the Unconscious, and others, are not mine. They were developed by Dr. Davanloo over the more than five decades of his systematic clinical research. My aim has been to integrate these concepts for my colleagues and to solidify my own understanding of them in the process. The work of Multidimensional Unconscious Structural Change is ongoing.

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