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Chapter 6

**TRANSFERENCE NEUROSIS:
CONTRIBUTIONS OF HABIB DAVANLOO**

Alan R. Beeber, MD*

Professor Emeritus, Department of Psychiatry,
University of North Carolina, School of Medicine,
Chapel Hill, North Carolina, US

ABSTRACT

This chapter is an integration of several presentations I have given over the past several years on Davanloo's conceptualization of Transference Neurosis, from a metapsychological, clinical and technical point of view. The history of the development of the concept of Transference Neurosis is reviewed. Initially described by Freud as a "new edition of the old disease," it was the hallmark of psychoanalytic therapy. It had been a tenet of psychoanalysis that by working through the Transference Neurosis, via interpretation, neurosis could be cured.

Transference Neurosis is defined. Davanloo's most recent work is summarized. It is his view that Transference Neurosis is a morbid process that adds a new, destructive defensive system on top of the Original Neurosis. Davanloo states that when DISTDP is practiced in an optimum fashion there is no development of Transference Neurosis. However, not

* Corresponding author: Alan Beeber, M.D., Professor Emeritus of Psychiatry, University of North Carolina, School of Medicine, CB#7160, Chapel Hill, North Carolina, 27599-7160. E-mail: abeeber@med.unc.edu.

every treatment is optimum. Unconscious factors, including Transference Neurosis/Neuroses in the unconscious of the therapist, can complicate therapy.

Davanloo's broader sense of Transference Neurosis is explicated. Clinical indications of the presence of a Transference Neurosis are reviewed and specific clinical types are described. The negative effect of Transference Neurosis on access to the Original Neurosis in the Unconscious is reviewed. Lastly, Davanloo's method of removal of the Transference Neurosis is described, which relies heavily on his method of Multidimensional Unconscious Structural Change. Davanloo has pointed out the insidious nature of Transference Neurosis in the clinical situation and has shown that it is reversible.

The theoretical concepts presented in this chapter 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 more than fifty years 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. I wish to acknowledge the contribution that Dr. Davanloo has made to me personally and professionally, and to our field.

INTRODUCTION

In the previous chapter I presented the historical development and basic principles of Davanloo's Metapsychology of the Unconscious. Davanloo views the Fusion of Murderous Rage and Guilt, resulting from the traumatization of early attachment to parental figures, as "a pathogenic dynamic system in the unconscious" (Davanloo, 2009, 2010, 2011). He further observed that the age of the trauma and subsequent Fusion had major implications for psychotherapy. With patients for whom Fusion has taken place at age 4 or later, he has repeatedly shown that it is possible to access the core neurotic structure via the process of Total Removal of the Resistance in a single session (Davanloo 2001, 2005). He noted that for patients for whom Fusion takes place at age 3 or younger, there is far more complexity in the unconscious. Specifically, Total Removal of Resistance and direct access to the core neurotic structure of the Original Neurosis may not be possible in a

single session using the standard format of Davanloo's Intensive Short-Term Dynamic Psychotherapy (DISTDP) in those with early Fusion. What is necessary is a preliminary, more extensive process of Mobilization of the Unconscious and a focus on Multidimensional Unconscious Structural Change (MDUSC) before one can access the Original Neurosis directly and begin a traditional course of DISTDP (Davanloo, 2013, 2014). A further complexity arises with the presence of one or another form of Transference Neurosis in the Unconscious of the patient. Many psychotherapists are familiar with notion of a persistent, unresolved Transference Neurosis as a complication of previous therapies. However Davanloo has identified other important sources of Transference Neurosis which, when present, serve as a major obstacle to the breakdown of Fusion in the Unconscious. The presence of Transference Neurosis serves as a morbid defensive system that renders the Original Neurosis inaccessible. The identification, understanding and management of Transference Neurosis in DISTDP will be the major focus of this chapter.

CLASSIC PSYCHOANALYTIC VIEW

Transference

The foundation of any psychoanalytically oriented psychotherapy rests on the principles of Transference and Resistance. Transference can be defined as the phenomena of experiencing feelings, drives or fantasies towards a person in the present which are inappropriate to that person, and really apply to another person, usually from the person's past (Greenson, 1967). It often involves the repetition or displacement of reactions that originate with significant figures in early childhood (Freud, 1905, 1912, 1916-17). Though first observed by Freud in the psychoanalytic relationship, Transference can occur in any interpersonal relationship in current life. It often involves both "positive" and "negative" valence. When present in psychoanalysis and psychotherapy, Transference can be a vehicle for therapy or can function as a resistance to remembering (and experiencing) the past. Therapists must be prepared to be exposed to the powerful positive and negative feelings engendered in Transference phenomena (Chessick, 2002).

Countertransference

Therapists are not immune to experiencing Transference reactions. When Transference phenomena occur in the therapist during psychotherapy it is called Countertransference. Countertransference may be as a result of some specific issue in the patient that activates a reaction in therapist's unconscious (Racker, 1968). However, it may also result primarily from a specific unresolved conflict in the Unconscious of the therapist. Mostly, it is viewed as a phenomena contributed to jointly by the patient and therapist. When the therapist is aware of their Countertransference, it can be a useful tool for understanding the patient's Unconscious (Gabbard, 1999).

Transference Neurosis

It was Freud's view, that when the Transference was handled properly, Transference Neurosis developed. He viewed Transference Neurosis as "a new edition of the old disease" (Freud, 1916-17). The Original Neurosis, along with later variations, is "replaced" by a new neurosis in the Transference. It is characterized by intense transference feelings such that the analyst becomes the central focus of the patient's life. The analyst becomes an extremely important object relationship determined by projections of split off self and object representations (Chessick, 2007). In classical psychoanalysis, it has been the view that the Transference Neurosis, and thereby, the Original Neurosis, could be "cured" by working through via the process of (transference) interpretation (Greenson, 1965). The infantile neurosis is revived in the Transference but not in a one to one manner. It is influenced by events and relationships over the years before the analysis so as to involve what Chessick called a "layering" quality. It often has a shifting, dynamic quality, involves regression and repetition, and becomes a resistance itself in analysis. It is the working through of the Transference Neurosis by interpretation that differentiates classic psychoanalysis from other forms of treatment (Chessick, 2002, p. 88).

The classic analysts restricted their interventions to questions and interpretations. Anything else was considered a "parameter" (Eissler, 1953). The strict adherence to this role, viewed by many as a caricature of Freud's technique, served to maximize the formation of Transference Neurosis but had its limitations and complications. As Psychoanalysis evolved over the years, other therapeutic factors were emphasized including the "Corrective

Emotional Experience (Alexander, 1980),” the “Therapeutic Alliance” (Zetzel 1956), and the “Working Alliance” (Greenson, 1965). Though analytic candidates were initially required to have cases of Transference Neurosis for the certification of their training, many were said to have had difficulty finding such cases. It was felt, too, that analytic patients with primarily characterologic problems often didn’t develop Transference Neurosis. Chessick noted that frequently, even in formal psychoanalysis Transference Neurosis did not appear. Furthermore, when it did appear, it was “not always a reason to be jubilant.” He felt that patients with impaired defensive structures were not able to utilize the interpretation of Transference Neurosis to work through intrapsychic difficulties. Some Transference Neuroses did not respond to interpretation at all and bordered on “Transference Psychosis” (Chessick, 2002 pp. 87-89). Failure of the Transference Neurosis to resolve via interpretation, either because of the dynamics of the patient or as Davanloo maintains, from the lack of effectiveness of interpretation per se, can result in a persistent iatrogenic Transference Neurosis, therapeutic stalemate and interminable treatment. There developed a building consensus among analysts that Transference Neurosis was not necessary for successful analysis or training. Often difficult to identify, it became viewed more like a quantitatively intense Transference reaction. Brenner called Transference Neurosis a “tautology, the concept is an anachronism.” He felt that a transference manifestation was dynamically indistinguishable from a transference neurotic symptom and that to call it Transference Neurosis was to add a “word without meaning. Transference is enough. Nothing is gained by expanding the term to transference neurosis.” He called for abandonment of the term (Brenner, 1982). Cooper shared this view and called Transference Neurosis a “Concept Ready for Retirement” (Cooper, 1987).

CONTRIBUTIONS OF HABIB DAVANLOO

Historical Background

For a more detailed review of the development of Davanloo’s metapsychology and methods of psychotherapy see the preceding chapter (Beeber, 2016). Freud initially viewed the development of Transference Neurosis desirable in a successful psychoanalysis. However, he became concerned with the increasing length of psychoanalysis. Freud felt that the “unconscious sense of guilt” representing the “superego’s resistance” was the

“most powerful factor, and the one most dreaded by us” (Freud, 1926). He identified patients in whom there was a “force defending itself by every possible means against recovery and which is absolutely resolved to hold on to illness and suffering.” He attributed a portion of this force to the unconscious need for suffering and punishment emanating from what he termed the punitive superego. However he came to believe when looking at this “negative therapeutic reaction” and at masochism in the character, that, in contrast to the pleasure principle, there must also be at work in the unconscious, a destructive instinct “which we trace back to the original death instinct of living matter.” It was upon taking this view that Freud concluded, “For the moment we must bow to the superiority of the forces against which we see our efforts come to nothing. Even to exert a psychical influence on simple masochism is a severe tax upon our powers” (Freud, 1937). Davanloo noted Freud’s concerns but concluded that Freudian psychoanalysis bypassed the resistances of the superego, further lengthening the course of psychoanalysis. Some cases became interminable with persistent unresolved Transference Neurosis.

Trained in the classic psychoanalytic tradition, Davanloo became troubled by this ever-increasing length of psychoanalysis. He presented his initial attempts at shortening the course of therapy most prominently in his first three international symposia on short-term dynamic psychotherapy (Davanloo, 1975, 1976, 1977). He characterized his technique as emphasizing the importance of the therapeutic alliance generated by a dynamic interaction between the patient and the therapist. His technique employed active utilization of the transference relationship, with active interpretation of transference resistance and the active avoidance of a transference neurosis. He observed, based on more than a hundred early cases, that core neurosis could be de-repressed and experienced deeply in the first few sessions. Further, by bringing insight into the relationship between impulse-feeling/anxiety/defense and transference/current life/past one could achieve rapid and permanent changes in symptom disturbances and characterological difficulties (Davanloo, 1980).

While Freud bypassed the resistances of the “hostile superego,” others in the field of short-term dynamic psychotherapy avoided superego resistance by the application of selection criteria that excluded such patients. Patients were typically selected for having a circumscribed focus to their difficulties, high motivation, positive response to interpretation and absence of superego resistance (Sifneos, 1980, Marmor, 1980, Malan, 1980). In contrast, Davanloo sought to increase the range of patients suitable for short-term dynamic psychotherapy.

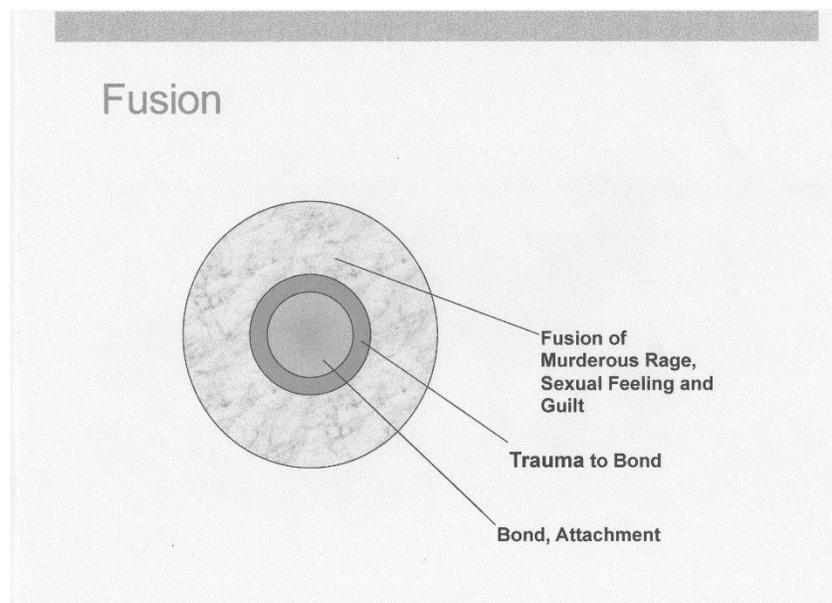
The majority of patients seen in his clinic and practice were more complex than those patients typically selected by his colleagues for short-term therapies. They often had multifocal symptom disturbances, complexity in their character structure often of a syntonic nature, and masochistic self-defeating character traits. Davanloo noted that this group of patients evidenced resistances of the “superego.” He elaborated the dynamics of superego pathology in great detail using audio-visually recorded sessions from a series of cases (Davanloo, 1990a,b) He later developed the concept of “Perpetrator of the Unconscious” to describe this destructive dynamic system (Davanloo, 2000a,b). A review traces Davanloo’s development of this concept and his technique to address it (Beeber, 1999a,b,c).

Undaunted by Freud’s pessimism, he sought to develop an approach that didn’t rely on “slow demolition” via interpretation. Through the extensive use of audiovisual recording of his sessions with this wider range of patients he painstakingly developed his techniques of “the Central Dynamic Sequence,” (Davanloo, 2001, 2005) “Mobilization of the Unconscious” (Davanloo, 2007-2015), “De-Fusion of Primitive Murderous Rage, Guilt and Sexuality” (Davanloo, 2009), and “Total Removal of Resistance” (Davanloo, 2007-2015, 2010-2014). With total removal of resistance and the mobilization of the triple factors of the Transference Component of the Resistance, the Complex Transference Feelings, and the Unconscious Therapeutic Alliance, direct experience of all of the mixed feelings in relation to the key psychogenetic figure(s) become accessible in a single session. This provides a direct view of the psychopathological dynamic forces in the unconscious, which can now be integrated by the patient. From there, the processes of “Psychoanalytic Investigation” and “Multidimensional Unconscious Structural Change” proceed (Davanloo, 2010, 2011, 2012 2013, 2014). By virtue of the development of his techniques, Davanloo has been able to successfully apply his method to the very group of patients that have been bypassed by both psychoanalysis and other short-term techniques.

Davanloo’s Expanded View of Transference Neurosis

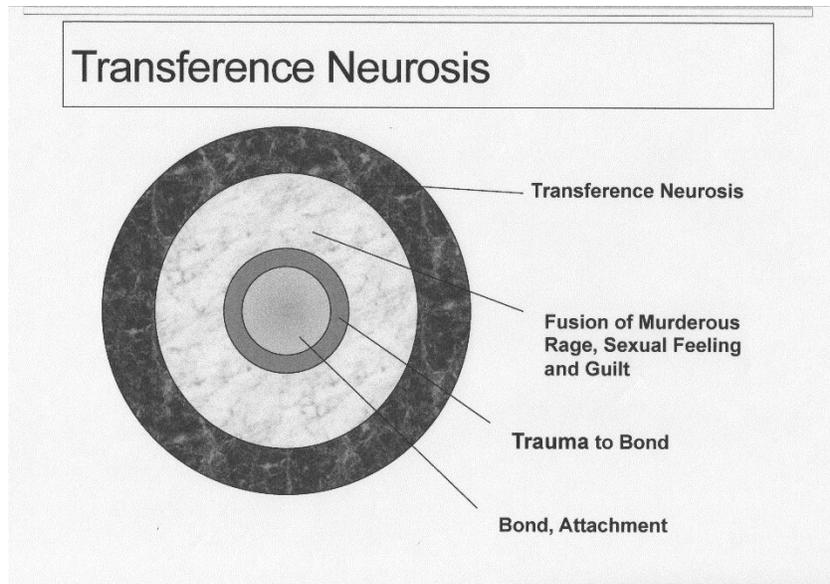
All of these observations are Davanloo’s, not mine. I have had the privilege to be supervised and trained by Davanloo beginning in 1991 and continuing to the present. Most of what I present below comes from unpublished work of Davanloo’s, generously shared with us in his Training Workshops (Davanloo, 2007-2015) and International Symposia (Davanloo,

2007-2015) where I have had the honor of being invited to present from 2007 to 2015. I am deeply indebted to him for his generous sharing of his unique observations and his synthesis of the metapsychology of the unconscious and for giving me permission to use material from the workshops and symposia in this publication. Davanloo's clinical research concerning Transference Neurosis began in 1976 and continues to the present. He has observed many cases of patients who suffer from a Transference Neurosis in relationship to a previous therapist, many of which have been presented in his supervisory training programs [I refer here only to those programs to which I had the privilege of attending (Davanloo, 1991-1993, 1997-2005) but other training programs share the same experience]. The presence of a persistent Transference Neurosis that has not been sufficiently worked through, leads to an impairment of the patient's original defensive structure. Providing an additional morbid defensive system, the Transference Neurosis renders the original normal defenses non functional and renders the Original Neurosis and Fusion of Murderous Rage/Guilt/Sexuality inaccessible. The Original Fusion and the effect of Transference Neurosis are represented schematically in Figures 1 and 2.



Adapted from Davanloo, 2009. Used with permission of the author.

Figure 1. Fusion of Primitive Murderous Rage and Guilt.



Adapted from Davanloo, 2007-2015. Used with permission of the author.

Figure 2. Transference Neurosis.

These are cases of what might be considered formal Transference Neurosis - that is Transference Neurosis developed in the course of therapy. However, Davanloo has offered a unique conceptualization of Transference Neurosis that goes far beyond the idea of the formal Transference Neurosis. He noted that Transference Neurosis was not limited to the patient therapist relationship. Just as Transference and Counter Transference can occur in any relationship, so too can Transference Neurosis, should the quality and quantity of the mutual Transference reactions achieve the necessary intensity. This will be elaborated further.

In the mid-1990's Davanloo introduced a format of therapy called "Major Extended Mobilization of the Unconscious." He used this powerful technique for professionals who were in training in his techniques, in a the form of a block of three full days duration set 1-3 months apart (Davanloo, 2005). He also has, over the years, conducted a number of training workshops for groups of professionals studying his techniques. One such group, instituted in 2007, is the Montreal Closed-Circuit Experiential Training Workshops in the Mobilization of the Unconscious and DISTDP. This program continues to the present (Davanloo, 2007-2016). I am most fortunate to have had the privilege of participating in this program from 2007 through 2014. The purpose of the

experiential training is the learning of the technique of Mobilization of the Unconscious. The main focus is the identification of unconscious resistances in the trainee. The group typically consists of 8-12 professionals, meeting six to eight hours a day for four to six days. The program consists of a mixture of didactic review of metapsychology with heavy emphasis on the use of audiovisual-recorded material from Davanloo's teaching and research library and of interviews from previous workshops. Members of the workshop also conduct live Closed Circuit observed and recorded interviews of each other, one person in the "patient" role and the other in the "therapist" role. Through this process of the use live, observed and recorded sessions, of interviews conducted by Dr. Davanloo as well, and of extensive review of recorded material it has been possible for members of the program to come face to face with the role resistance in their own unconscious plays in their work. They are then in a position to begin to bring changes in their unconscious in multiple dimensions. What became obvious in the workshops was that Transference Neurosis was playing a major role in complicating the unconscious defensive system of many of the participants. This led to an emphasis being placed on Transference Neurosis. Presentations from this program have been delivered at Davanloo's symposia in Montreal from 2007 to the present. Transference Neurosis is currently a central focus of these annual Audio-Visual Symposia on the Mobilization of the Unconscious (Davanloo, 2000-2015).

What Davanloo noted, in his clinical work and in his training workshops, was that the phenomena of transferring a neurosis from one person to another was not unique to the psychoanalytic relationship. Transference is a two way street in any close relationship. If one then takes the view that Transference Neurosis as a *transferred neurosis*, i.e., a neurosis transferred from one person's unconscious to another's, one sees the same process in many different relationships. He noted that when transference phenomena were qualitatively and quantitatively sufficient, they had the same impact on the defensive structure of the patient, as would a formal Transference Neurosis in the therapeutic setting. He has presented numerous audio-video recorded sessions with patients and with members of the training workshops demonstrating the many variations that Transference Neurosis could take. For example, one may see transference phenomena with a spouse or with a child. In this situation, the husband relates to his wife as if she is his mother, or the wife relates to the husband as if he is her father or mother, for that matter. When the transfer of neurosis involves one's children, the parent relates to the child as if they were their own parent (or grandparent). As with the unresolved formal Transference Neurosis, Fusion of murderous rage/guilt/sexual feeling originating in one

person's unconscious can be transferred to the unconscious of the other person, resulting in a new Fusion and new neurosis on top of the Original Neurosis. The defensive system becomes impaired and direct access to the Original Neurosis and Fusion is not possible.

The Closed-Circuit workshop, given its intensity, is a laboratory for the study of these phenomena. With the use of audio-visually recorded and observed interviews in the training workshops Davanloo has elucidated the most common types of Transference Neurosis. Each type will be taken in turn (Davanloo, 2007-2016, 2007-2015).

1. Unresolved Transference Neurosis from Prior Therapy

In a DISTDP practice one often encounters patients who have had prior therapy, (either ISTDP or therapy of another type). In many cases the patient has formed an intense transference to the previous therapist, which was insufficiently worked through. This Transference Neurosis is often of a dependent nature. Even if the prior therapy was ISTDP, which strives to avoid Transference Neurosis, major technical errors on the part of the therapist may have prevented sufficient rise in the Transference Component of the Resistance and the Complex Transference Feelings to protect the process from development of Transference Neurosis. Unconscious issues in the previous therapist often play an important role. Conflicted relationships with one or both parents, with grandparents or with siblings may unconsciously contribute to the therapist manipulating the transference by introducing issues from their own unconscious. This is especially prominent if Fusion in the therapist's unconscious occurs in very early life (age 3 or younger). In its most exaggerated form, the therapist bulldozes the patient by telling the patient what to focus on rather than following the lead of the Unconscious Therapeutic Alliance. The therapist may have access to malignant defenses, defending against their own unconscious guilt by acting out. In its worst form the therapist may actually have psychopathic traits. In this situation the process may resemble brainwashing. The presence of a history of multiple therapists may compound all of these issues (Davanloo, 2007-2016, 2007-2015).

2. Result of Professional Work

In Davanloo's training workshops, the aim is to identify and work through unconscious resistances that impede one's psychotherapeutic work. A common defensive structure encountered is the presence of Transference Neurosis as a result of one's professional work, such as an extremely busy practice with highly complex patients. Oftentimes, the workshop member may

have a DISTDP practice of up to 10 hours a week while also being in full time employment with difficult patients, such as in a forensic setting with psychopathic patients; or in a clinic or hospital setting with borderline patients and patients suffering from psychotic disorders. With insufficient time for reflection, rest or relaxation, there is little opportunity to process one's own unconscious reactions. Issues in the patients' unconscious are transferred to or activate certain issues in the therapist's unconscious. In each instance, a seemingly minor problem festers and in a year's time becomes a major issue in the unconscious of the therapist (Davanloo, 2007-2016, 2007-2015).

3. Occurring in Professional Relationships

Another form of Transference Neurosis seen in the training workshops is a Transference Neurosis that occurs in professional relationships. A colleague or coworker becomes a transference figure. Issues in the unconscious of the workshop member are projected and transferred to the colleague or vice versa. The colleague now assumes a position that is psychologically larger than life. This person may be idealized, or devalued and despised. With respect to a primary supervisor, or training director the situation commonly seen is one of identification and idealization. If the supervisor themselves has certain unconscious issues in relation to their own family, or has psychopathic traits, these issues can be projected onto the trainee. In the context of the trainee identifying with and idealizing the supervisor, a Transference Neurosis can ensue. What happens in this situation is that a new Fused Neurosis occurs on top of the Original Fusion (Davanloo, 2007-2016, 2007-2015).

4. Intergenerational Transference Neurosis

The Intergenerational Transmission of Transference Neurosis is the most common form of Transference Neurosis seen in the training workshops (Davanloo, 2007-2016). As mentioned repeatedly, Neurosis, which in Davanloo's metapsychology is a result of Fusion of Murderous Rage, Guilt and Sexuality in the Unconscious, can be transferred from one person to another in any close relationship. Transfer to family members is extremely common. It is often seen in marital relationships with one partner or the other projecting issues from their unconscious originating with a parent and transferring the neurotic constellation to the spouse. This process can span generations as well. Intergenerational Transference Neurosis often begins in the earliest days of life, with Fusion taking place typically by age 3 or earlier. The infant is a sponge for the incorporation, introjection and identification of feelings originating with parents and grandparents. The young, undeveloped

defensive system is characterized by projection, projective identification and idealization. Projective anxiety is heavy. In this context, the infant can't distinguish its own feelings from those of the other. Anxiety is at the level of fear of destroying the other or of being destroyed. The parent or grandparent can easily transfer his or her own neurosis to the infant. A common dynamic in operation in this setting involves destructive competitiveness in one generation being transferred to another generation. A typical example involves a parent, having issues of competition with one of their parents or siblings for the love and affection of the other parent. This competitiveness takes on a destructive dimension (murderous rage fused with guilt), not just to best the other but also to destroy the other. This destructive competitiveness can then be transferred to one's spouse. The spouse is then related to as if they are a figure from the past. Then the infant or child is brought into the arena and becomes the repository for the destructive competitiveness. From early life the child is turned against one parent by the other. An example of this complex situation involves a mother who has been turned against her siblings by her father or mother. She marries and ultimately transfers this destructive competitiveness to her spouse. She then turns her son against his father as a transfer of the neurosis originating in the previous generation. This can be compounded further if the marital relationship ends in divorce, death or even suicide. The child via this intergenerational transfer of neurosis has been turned against an innocent person, his father. This then leads to the development of an extremely high degree of unconscious guilt, which in turn fuels further destructiveness (often self-destructiveness) and masochism in the character (Davanloo, 2007-2016, 2007-2015).

5. Combined Intergenerational Transference Neurosis Plus Transference Neurosis from Previous Therapy

It is not uncommon to see a combined form of Transference Neurosis. The person who is the repository of Intergenerational Transference Neurosis experiences an especially heavy load of unconscious guilt. This leads to the need to perpetuate oneself suffering through maintaining the Transference Neurosis. With ever increasing self-destructiveness, there is further susceptibility to and searching for additional new Transference Neuroses. If one enters into therapy there is an exceedingly strong need to sabotage the therapy and develop another Transference Neurosis. Now there are two new Fusions on top of the Original Fusion (Davanloo, 2007-2016, 2007-2015).

SUSCEPTIBILITY TO TRANSFERENCE NEUROSIS

In his audio-visual recorded case series research Davanloo has identified several factors that contribute to one's susceptibility to develop Transference Neurosis. This applies equally to the clinical situation and to the professional setting. The presence of early and extensive trauma to the affectionate bond to parents is an important and frequent risk factor. When fusion occurs before the age of four, especially at age one or two, the defensive system is not yet fully developed. Defenses consist mainly of projection, introjection and projective identification. Obsessional defenses are not yet well formed. When this early Fusion is coupled with Intergenerational Transmission of Neurosis from a parent or grandparent, the young child is under the impact of extremely heavy unconscious guilt. Further susceptibility arises if one or more of the figures in early life have tendencies to act out or have psychopathic traits. The masochistic need to suffer and be punished becomes very high. The need to repetitively sabotage and punish the self becomes deeply entrenched in the character and manifests itself into adulthood. Often when such a person attempts to obtain help or psychotherapy they do so in a self-sabotaging and self-damaging way. It is not uncommon for them to gravitate to therapists who themselves suffer from early Fusion and Intergenerational Transference Neurosis and who may even have psychopathic traits. Early Fusion in the patient coupled with early Fusion in the therapist (projected onto the patient) is a recipe for Transference Neurosis (Davanloo, 2007-2016, 2007-2015).

INDICATIONS OF THE PRESENCE OF TRANSFERENCE NEUROSIS

In the psychotherapeutic setting, one notes that "normal," expected character defenses are not operating. Obsessional defenses are absent and are replaced by a set of malignant character defenses, most often projection, projective identification and compliance/defiance. One frequently sees the presence of oppositional and psychopathic character traits. With this impairment in the defensive organization, "normal" defenses are not working and there is an associated high level of unconscious anxiety, mainly in the form of projective anxiety. This is accompanied by a relatively lower capacity to tolerate anxiety manifested by the person being flooded with anxiety in certain interpersonal situations, most notably in the Transference relationship.

In the DISTDP setting, when one attempts the process of “Mobilization” or “Total Removal of the Resistance” one rapidly notices that efforts to mobilize the Transference Component of the Resistance fall into difficulty in the presence of Transference Neurosis. This occurs despite otherwise adequate technical knowledge and skill. At this point the therapist should become suspicious of the presence of Transference Neurosis.

This issue is especially prominent in the Closed-Circuit Audio-Visual observation and supervision in Davanloo’s training workshops. The inability to obtain the expected mobilization of Transference Component of the Resistance can implicate a Transference Neurosis in either the interviewee or the interviewer. In this setting, when the interviewer, in the “therapist” role, has a Transference Neurosis, they often have great difficulty applying Davanloo’s most powerful intervention, the Head-On-Collision with the Destructive Organization of the Resistance. Despite specific supervision to apply the Head on Collision and despite adequate knowledge and skill the interviewer either bypasses the Head-On-Collision completely, or applies it in such a way as to water down or undo its effectiveness, thereby avoiding mobilizing their own unconscious. Difficulty applying the Head-On-Collision is a strong indicator of Transference Neurosis on the part of the interviewer (Davanloo, 2007-2016, 2007-2015).

EFFECTS OF TRANSFERENCE NEUROSIIS ON THE CHARACTER

All of the forms of Transference Neurosis enumerated above have profound effects on the character structure. As mentioned, the presence of Transference Neurosis leads to an extremely high degree of unconscious guilt, which in turns fuels destructiveness and masochism in the character. This can rise to the level of “moral masochism” manifested by an addiction, so to speak, to perpetual suffering. The normal defensive system is impaired and gives way to malignant character defenses. These defenses are inadequate in daily life and the person becomes flooded with anxiety, often of a projective quality. They become symptomatic with anxiety often with an autonomic discharge pattern. Lastly, there is significant impairment of memory, most importantly affecting memory involving close relationships with figures in the past (Davanloo, 2007-2016, 2007-2015). For professionals, the presence of one form or another of Transference Neurosis in their unconscious has serious

consequences. It can be a major obstacle in their work. What is more, they are susceptible to passing on the Transference Neurosis to those they set out to help.

DAVANLOO'S TECHNIQUE OF TOTAL REMOVAL OF TRANSFERENCE NEUROSIS

The standard format of DISTDP involves the utilization of Davanloo's Central Dynamic Sequence. For a detailed discussion see the previous chapter (Beeber, 2016). Briefly, the application of pressure leads to tilting characterologic defenses in the dimension of the transference. With the addition first of passing challenge, and then systematic challenge added to the pressure, resistance becomes crystallized in the transference, which leads to mobilization of the Transference Component of the Resistance. Head-on-collision with the Transference Resistance sets the stage for the actual experience of the Complex Transference Feeling, the triggering mechanism that de-fuses unconscious murderous rage from unconscious guilt (and sexual feelings). The Unconscious Therapeutic Alliance is concomitantly mobilized and all the mixed feelings in relation to the psychogenetic figure are experienced. There then is a direct view of the core neurotic structure, the Original Neurosis. The presence of Transference Neurosis, in one form or another, either alone or in combination, serves as a new Fusion on top of the Original Fusion. It becomes very difficult, if not impossible, to get sufficient mobilization of the Transference Component of the Resistance to break down the Fusion. It is critical to be able to recognize the presence of Transference Neurosis in this situation. Once the presence of Transference Neurosis is established, a modification of the Central Dynamic Sequence is necessary. The process shifts to inquiry into the relationship with the Transference Neurosis figure (e.g., professional colleague, previous therapist, training supervisor). As the exploration continues feelings in relationship to that person are mobilized. This in turn mobilizes anxiety and defense. Pressure to the avoided feelings towards that person is applied, often coupled with Head-On-Collision which leads to the beginning of the mobilization of the Neurobiological Pathway of Murderous Rage. When the person begins to show signs of experiencing the rage, one then shifts the process to the Transference. This is a crucial intervention and the optimum timing is critical. Davanloo has shown in many cases that if one keeps the focus here with the Transference Neurosis figure,

that even with heavy experience of the Murderous Rage, with activation of the Neurobiological pathway, the transfer of visual imagery to the genetic figure often does not take place, and guilt is then not experienced. The person may feel that the rage is “justified,” no connection to the Original Neurosis is obtained and the Original Fusion remains. However, if at that critical moment of activation of the Neurobiological Pathway of Murderous Rage the therapist or interviewer shifts the process, the focus on the Transference serves to mobilize the Unconscious further. At this point, one says something along the lines of: “This may be difficult for you to do but if you take all those feelings towards “X” and you direct them at me, in your thoughts and ideas- not actually do it; but in your ideas, how would you unleash those feelings at me? ... How viciously? If you totally unleashed further...” Typically what ensues is the temporary break down of Fusion. The actual experience of the Neurobiological Pathway of the Primitive Murderous Rage is heavily experienced in the here and now. The person sees a vivid image of the dead body of the therapist/interviewer. The damage is seen in full detail. With focus on the eyes of the murdered therapist/interviewer the visual image is transferred to the visual image of a figure from the person’s early life—someone who is dynamically linked to the Transference Neurosis. Intense Guilt-laden Unconscious feelings are mobilized and experienced. This passage of the Guilt-laden feelings may last for from five to ten minutes or more, followed by the experience of positive and Grief-laden feelings in relation to the psychogenetic figure. This then affords a direct connection of the early figure to the Transference Neurosis figure. A phase of repetitive analysis of the process further consolidates the connection to the Transference Neurosis. A formal Transference Neurosis can be worked through sufficiently to allow access to the Original Fusion, in a series of several (2-6) sessions.

However the presence of the Intergenerational Destructive Competitive Transference Neurosis is another matter. Davanloo reports that the analysis of his data from the training workshops indicates that with those who have an Intergenerational Destructive Competitive form of Transference Neurosis, after the Breakthrough into the Unconscious, and De-fusion, there is a return of the resistance in the next session (Davanloo, 2015). The presence of the Intergenerational Transference Neurosis has impaired the person’s defensive system. Restructuring of the defensive system from malignant character defenses to a “normal” defensive system is necessary. Projective anxiety is high. The Neurobiological Pathway of Primitive Murderous Rage is not fully accessed. As a result the pathway of the connection via the eyes from the Transference to the genetic figure does not operate sufficiently, visual imagery

is impaired, memory is impaired, and the experience of guilt is not of sufficient intensity to permanently remove the Transference Neurosis.

What is needed in these situations is the systematic application on the process of Multidimensional Unconscious Structural Change (Davanloo, 2012, 2013). Immediately after the breakthrough has taken place, systematic analysis of the projective anxiety, the malignant defenses, and their effect on the experience of the Neurobiological Pathways needs to take place. As the capacity to tolerate anxiety is increased, and projective anxiety is diminished and ultimately eliminated, malignant character defenses give way to more obsessional defenses. Memory, often of a multisensory type (visual imagery, smells, tastes and sensations from the past) dramatically improves. Working through requires repetitive breakthroughs. The therapists/interviewers need to be fluid in their technique, shifting focus in synchrony with the Unconscious Therapeutic Alliance. This is a difficult art to master and is impeded by the presence of Fusion in the therapist's/interviewer's unconscious. The therapist needs to be skilled in the utilization of what Davanloo calls the projective technique. This involves selecting a focus based on signals from the Unconscious Therapeutic Alliance, which is highly conflictual for the person, is avoided and heavily mobilizes the Transference Component of the Resistance. One might pick up on an issue from a previous session and utilize it to apply pressure to the avoided feeling by the use of fantasy. This can apply to aggressive feelings, positive feelings or feelings of a sexual nature. Pressure to the avoided feeling, coupled with Head-On-Collision, mobilizes unconscious resistance further. The avoided feeling, Transference Component of the Resistance, and the Complex Transference Feeling are now well mobilized. In a sense, the process is similar to that used to mobilize feeling towards the Transference Neurosis figure. For further discussion of Davanloo's method of treatment for Transference Neurosis see the recent publications of Hickey (2015,2015a).

With repeated breakthroughs, the intensity of the actual experience of the Neurobiological Pathway of the Primitive Murderous Rage increases until it is experienced at an optimum level. This is associated with a concomitant increase in the intensity of the experience of Guilt-laden feelings, which hastens the draining of the Pathogenic Reservoir of Unconscious Guilt. Throughout the process an emphasis is placed on the role that guilt plays in perpetuating suffering through maintaining the Transference Neurosis. Guilt is especially heavy in the Intergenerational Transference Neurosis because what is often the case is that an "innocent," loved person has become the target of one's murderous rage. This high level of guilt fuels the self-destructiveness

and addiction to suffering and leads to susceptibility to or even seeking out further Transference Neuroses. If left untouched, the destructive organization of the resistance fueled by and fueling the Transference Neurosis, in a vicious cycle, maintains an impaired defensive system and can even lead to psychopathic traits. However, when the process of Multidimensional Unconscious Structural Change has been successful (often requiring a dozen or more sessions), access to the Original Neurosis via the standard technique of DISTDP is now possible (Davanloo, 2007-2016, 2007-2015).

CONCLUSION

Davanloo was a pioneer in developing several techniques to shorten the course of psychoanalytic therapies. He also developed a powerful teaching and learning format in the form of Closed-Circuit Audio-visual training. He adapted the closed-circuit training to a structure in the form of experiential workshops designed to address unconscious resistance on the part of the therapist – resistances that served as obstacles to one's work. This interest intersected with his interest in preventing and eliminating Transference Neurosis. In his clinical work and training workshops he has elucidated several types of Transference Neurosis. He considers Transference Neurosis to be a morbid process in psychotherapy and when present adds a destructive system on top of an already destructive, self-damaging masochistic character structure in a person suffering from early trauma and fusion, often combined with an intergenerational transfer of neurosis. In the training workshops he has devised variations in the therapeutic process and has applied it to the training setting to address the various forms of Transference Neurosis. His work in this endeavor is ongoing and he continues to present his results in his Audio-Visual symposia. He has repeatedly demonstrated that Transference Neurosis, though complex and difficult, can be a reversible process. I wish to acknowledge my heartfelt gratitude to Dr. Davanloo for allowing me to participate in this process with him over these past two and a half decades. All of the ideas, concepts and principles presented in this chapter are his discoveries. He has generously shared them over the years and encouraged me to synthesize them for others and for myself by presenting at his annual symposia and by writing this chapter. What is clear to me at this point, is that rather than a term ready for abandonment or retirement, Transference Neurosis is a destructive force that needs to be reckoned with for successful psychotherapy and for human growth. Fortunately, Davanloo has alerted us to the role it plays in our most

difficult cases and in ourselves and has pointed the way for us towards reversing and resolving this destructive process.

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