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Chapter 8

PRESENCE OR ABSENCE OF TRANSFERENCE NEUROSIS

Irene Ostertag[1], MD,
and Atessa Firouz-Petermann[2], MA
[1]Specialist in internal medicine, psychotherapy, Nuremberg, Germany
[2]Sociologist and therapist, Geneva, Switzerland

Differential criteria in Davanloo's Intensive Short-Term Dynamic Psychotherapy used to determine the presence or absence of a Transference Neurosis based on the analysis of an interview conducted in a Closed Circuit Experiental Training Workshop setting in Montreal, Canada

ABSTRACT

In the first part of this article the authors will introduce Davanloo's Intensive Short-Term Dynamic Psychotherapy; they will present an overview of Davanloo's definition of Transference Neurosis[1] as well as his classification of 3 categories of patients:

[1] […] [transference neurosis] can best be described as a situation in which the patient has transferred all of his character resistance and underlying complex neurotic feelings onto the therapist while maintaining all these neurotic forces locked up within his unconscious (Davanloo 2009).

- Patients without Transference Neurosis TN (group 1),
- Patients with the Intergenerational Destructive Competitive form of Transference Neurosis IDCTN (group 2),
- Patients with IDCTN and TN developed during psychotherapy (group 3)[2].

In the second part of the article the authors will present and analyze the technique of Major Mobilization of the Unconscious and Total Removal of the Resistance through an audiovisually recorded, transcribed interview, which took place in a Closed Circuit Experiental Training CCT Workshop[3] setting.

Our analysis of the following interview will focus on the criteria used to determine whether a TN exists or not.

The criteria are:

- The status of the Conscious and Unconscious Therapeutic Alliance UTA
- The signs of anxiety
- The kind of defense mechanisms
- The extent to which the Transference Component of the Resistance TCR increases
- The extent to which the Neurobiological Pathways NBP of rage and guilt can be activated.

In this interview we find the following parameters as indicators for the absence of a TN:

- Anxiety is present in the form of tension of the striated muscles
- Absence of malignant defenses
- Freely accessible NBPs

[2] The first group consists of highly resistant patients with symptom and character disturbances. There has been a fusion of primitive murderous rage and guilt dating back to the age of 4 and after; there is no TN. Patients in the second group present a complex unconscious with fusion of murderous torturous and sadistic rage, sexuality and guilt dating back to birth or the first years of life with or without TN. The third group consists of patients with an IDCTN fused with a TN developed in the course of psychotherapy or in a professional setting.

[3] A Closed Circuit Live Interview is an interview which is embedded in an experiential training workshop with the following set-up: psychotherapists trained in IS-TDP and working with the technique meet during 5-6 consecutive days to conduct interviews. In these interviews, they are in the seat of the therapist or in that of the patient alternatively. There is ongoing supervisory work by Dr. Davanloo either at the end or in between interviews.

- Sufficient rise of the TCR
- Breakthrough of primitive but not sadistic or torturous Murderous Rage as evidenced by the absence of knife, axe or other equipment

To summarize: Though the patient was highly resistant, trauma occured after age 4.

No signs of TN were elicited in the process of the interview. Taken together TN can
be ruled out in this case.

In this article, the authors use capital letters to designate Davanloo's operative concepts.

An index of the concepts and their acronym, when there is one, is to be found at the end of this article.

INTRODUCTION

The metapsychology and the technique of Intensive Short-Term Dynamic Psychotherapy IS-TDP have been developed by Habib Davanloo MD, Professor Emeritus of psychiatry at McGill University in Montreal, Canada, for over more than 50 years, based on empirical research using video technology (Davanloo 2005).

The standard technique is effective for patients suffering from phobic, obsessional, depressive and panic disorders, posttraumatic stress disorders and somatization and - with some modifications - for patients with fragile character and structural pathology.

Concentrating on emotions in the Transference, the therapist mobilizes conscious and Unconscious Therapeutic Alliance (UTA), the Transference Component of the Resistance (TCR) (Davanloo, 2014), (formerly Complex Transference Feelings) unconscious anxiety and Resistance. Dealing actively with these dynamic forces, the therapist strengthens the patient's resources.

Dr. Davanloo has developed a set of specific emotion-focused interventions in the Transference. The work seeks and requires the commitment of the patient and his collaboration through the establishment of the UTA. The UTA emerges after the resistance to emotional closeness with the therapist has been overcome.

The focus is then brought on the physical experience of emotions.

The therapist monitors the activation of the NBP related to these emotions. As the TCR rises, so does the Resistance. The Resistance expresses itself

through the defensive array that has been contributing, throughout the patient's life, in keeping his avoided feelings repressed.

The therapist works on deactivating the defenses as they present themselves within the transference relationship.

The therapist's task is then to bring the patient to feel those repressed intense feelings, to direct them towards him (the therapist) and thus allow the patient to face them.

The Breakthrough into the Unconscious (Davanloo, 1990) leads to a specific traumatic experience loaded with mixed feelings (rage, guilt, grief and loving feelings) related to important figures of the past that can be, then, worked through with the therapist. This provides a direct insight into the psychopathological dynamic forces, responsible for the patient's symptoms and character disturbances, leading to a relief of the symptoms and to multidimensional structural unconscious changes in the patient.

There can be multiple repeated Breakthroughs into the Unconscious related to multiple layers of traumas at the core of the patient's neurotic suffering.

Davanloo's theorizations of Transference Neurosis, Transference as a concept and as a therapeutic tool fundamentally differ from the psychoanalytic perspective.

In the psychoanalytic treatment Transference is pivotal. The patient establishes a transference relationship with the therapist within which he unconsciously re-enacts the infantile conflict lying at the core of his neurotic suffering and psychopathology.

Theoretically, the dynamic forces having thus been uncovered and brought to the surface of the patient's psyche, within the Transference relationship, can be interpreted and worked through towards the resolution of the patient's inner conflicts.

Davanloo theorizes that "transference neurosis can best be described as a situation in which the patient has transferred all of his character resistance and underlying complex neurotic feelings onto the therapist while maintaining all these neurotic forces locked up within his unconscious. Once this state is reached, it is very difficult, if not impossible, to reach those dynamic forces responsible for the patient's neurotic suffering. The therapist becomes a figure of the patient's past, which gratifies his need, including all his destructive need, why should the patient give it up? Clearly the situation cements the neurosis rather than lifting it" (Davanloo 2009). TN builds on top of the original neurosis to protect it.

In IS-TDP treatment, TN is regarded as a twofold issue of major importance and by no means as a therapeutic tool (much less as the therapeutic tool of choice as in psychoanalytic treatment).

1. TN exists as a destructive entity against patient/therapist therapeutic alliance at the unconscious level. When transferring onto the therapist the patient re-enacts the elements of his original neurosis and, most importantly, the specific unconscious defensive organization and Resistance which will forbid the therapeutic alliance and block the way to the unconscious. The first and main hindering mechanism moving forth at that point is projective anxiety and resistance to closeness with the therapist.
2. When the presenting problem is not the original neurosis, but a transference problem derived from the original neurosis, the forces of the resistance of the guilt use TN, at an unconscious level, to protect the core neurosis. The therapist's efforts are thus misdirected towards the TN and the therapeutic process is misled.

With a TN wrapped around it, the original neurosis becomes very complex: it is sealed up and becomes invisible.

In IS-TDP the establishment of a TN is viewed as an attempt by the patient's unconscious to protect the original core neurosis in order to avoid complex feelings towards early attachment figures. These feelings are mobilized when the patient's unconscious perceives the possibility of emotional closeness with the therapist and becomes alarmed by the prospect.

The non-interpretive approach in IS-TDP involves bringing the volitional healthy part of the patient to turn against his own destructiveness by helping him become aware of the defensive barrier erected against closeness with the therapist and overcome it. This will allow the Transference TCR to rise and avoided feelings to come to the surface so that the patient can experience and work through them.

Dr. Davanloo's theorizing and conceptualization of IS-TDP is an on-going evolving process.

There are now 3 major categories of patients (whereas, previously, patients were scaled on a spectrum of neuroses).

1. The first group consists of highly resistant patients with symptom and character disturbances. Patients with multiple somatization and functional disorders, with fusion of primitive murderous rage and

guilt dating back to the age of 4 and after, for which IS-TDP is the therapy of choice. Dr. Davanloo's research results indicate that patients in this group do not develop TN.

2. The second group is the intergenerational group of psychoneurotic disorders with or without additional transference neurosis. Patients in this group present a complex unconscious structure with fusion of murderous torturous and sadistic rage, sexuality and guilt, starting at birth or in the course of the first year of life. In this group there is an IDCTN passed down through the generations. Patients in this group respond well to the removal of the Resistance but the Resistance returns shortly. They need the technique of bringing about unconscious structural and intra-psychic change. Structural change means restructuring, in the adult patient, the neurobiological pathways and unconscious defensive organization corresponding to age 0 to 1 unto the neurobiological structure and defensive organization corresponding to age 4 and after. Mobilization alone is not enough to bring about this structural change: it must be followed by psychoanalytic investigation and treatment with multiple repeated breakthroughs into the unconscious.
3. The third group consists of cases with an IDCTN (Davanloo, 2015) which has become fused with TN in the course of psychoanalytic treatment or any other form of dynamic psychotherapy or in a professional setting.

This last comprises psychiatrists and therapists whose psychopathology has become fused with their patients', their supervisor's or their own therapist's psychopathology.

In the first group of disorders dating back from age 4 and after, the unconscious is not primitive, there are no tools of aggression or lethal weapons and the Murderous Rage is not torturous or sadistic when the patient visualizes the murder of the therapist and of the genetic figure. There is also no evidence of TN, as mentioned before.

For the second and third groups, with intergenerational or other forms of transference neurosis, accessing the core neurotic structure and reaching the actual experience of the Murderous Rage within the Transference with the therapist will require much higher levels of mobilization of the TCR, of the NBP of Guilt and the actual experience of guilt, of Murderous Rage and the actual experience of rage.

On what basis are these groups defined?

- The groups are scaled according to the patient's degree of resistance and the types of defenses used.
- The types of defenses are linked to the age of trauma, before or after age 4; age 4 is not meant as a set age limit: an infant aged 2 may be at a neurobiological developmental stage of a 4 year old and a 4 year old at the stage of a child aged two. It is to be regarded as a continuum.
- Nevertheless, age 4 more or less marks a qualitative change in the child's neurobiology, the pathways having become by then completely functional.
- The stage of neurobiological development of the child when trauma begins will determine the degree of impairment of the defensive organization of his unconscious. The health or impairment of the defensive organization of the unconscious can be measured through the degree of alertness and reactivity of its defense system, ranging from quick well-targeted tactical defenses to primitive projective, malignant defenses. The earlier the trauma, the higher the degree of impairment and the more primitive the defensive organization. An impaired defensive organization of the unconscious expresses itself through a sluggish system of projective and/or malignant defenses.

In the presentation and analysis of the following interview, where one therapist sits as patient and the other as therapist, the latter uses the Technique of Vertical Mobilization of the Unconscious.

The Technique of Vertical Mobilization of the Unconscious can be described as the therapist directly and simultaneously speaking to the patient on the conscious and unconscious levels, seeking the active collaboration of the volitional Conscious and the healthy Unconscious of the patient, to overcome the resistance to emotional closeness and the defenses the patient erects between himself and the therapist in an attempt to avoid his own true feelings.

In line with Davanloo's current research about TN, the criteria we shall be concentrating on, with regard equally to patient and therapist, are those indicating the presence or absence of TN.

The Interview

This interview is embedded in the Montreal Closed Circuit Experiential Training Workshop CCT with the following set-up: psychotherapists working

with IS-TDP either in private practices or in hospital settings meet during 5-6 consecutive days to conduct interviews, during which they occupy either the seat of the therapist or that of the patient.

The workshops are aimed at "cleaning" the unconscious of the therapists as well as supervising their work. The technique used here is the Technique of Vertical Mobilization of the Unconscious (Davanloo 2005) and of the NBPs of rage, guilt, grief and sexuality. There is, throughout the CCT workshops, ongoing supervisory work by Dr. Davanloo either at the end of the interviews or in between. The group members watch the live interviews and, through watching, are themselves mobilized by the process.

When the interview session is over and while it is being viewed by all the group members, including the interviewer and the interviewee, each interview undergoes extensive supervision and analysis by Dr. Davanloo.

This situation is therefore unique: a training workshop mobilizing the unconscious not only of the patient but also of the therapist and of all the other participants.

It is necessary to emphasize that the CCT is a training setting and by no means designed for therapy.

We shall here examine in what way and to what extent a TN is:

- Interfering with or allowing the establishment of the UTA between patient and therapist, thus blocking or facilitating the unlocking of the patient's unconscious.
- Hindering or allowing the application of proper pressure by the therapist towards the mobilization and rise of the TCR aimed at bringing the patient's resistance into the Transference in the form of defenses.

The important parameters that are being monitored throughout the interview are:

- The conscious therapeutic alliance
- The partnership between the therapist and the patient
- The signs of anxiety
- The UTA
- The extent to which the TCR rises
- The kind of defense mechanisms showing up
- The extent to which the NBPs of rage and guilt can be activated.

The Interviewer is a 56 year lady therapist thereafter referred to as Therapist (TH).

The Interviewee is a 58 year old lady therapist thereafter referred to as Patient (P).

Both are members of the CCT Group.

They were not previously acquainted, professionally or otherwise.

This is their first interview together.

To begin with, the therapist points out that this is their first meeting and that the purpose of the interview is to understand the patient's difficulties and get to the engine of her problems.

What becomes immediately clear is the patient's high level of motivation to work with the therapist.

The therapist exerts Pressure on the feelings and on the Transference Component of the Resistance TCR.

TH: How do you feel right now?
P: I am anxious. My mouth is dry.
TH: You are anxious. And how do you feel in relation with me?
P: Anxious.
TH: So you are anxious.

The therapist acknowledges the anxiety.
The patient takes a sigh.
Anxiety shows up in the tensing of the striated muscles.

TH: And what do you feel towards me besides anxiety?

The Pressure on the TCR continues.

P: Anxiety is going up.
TH: You are anxious. What else do you feel?

The therapist exerts Pressure towards the transference feelings.
The patient remains silent.
The therapist takes this as a sign of resistance against emotional closeness.

TH: You are silent. Do you allow yourself to get involved here with me?

The therapist calls on the resistance against emotional closeness. In addressing the destructive force of distancing the therapist talks to the UTA and to the Resistance; the therapeutic alliance becomes more powerful.

TH: So first let us look at what you are going to do against the distancing and the barrier? The distancing is destructive here. But if you are determined to work here with me what are you going to do against the distancing?

P: I have mental flashes of me attacking you... But I don´t feel the feeling. I don't want to let you in.

TH: So still there is a destructive need in you to hold back, to put up this barrier between us. Wherever this need is coming from… This is destructive. And we still don´t know how you feel towards me. How do you feel towards me?

The therapist applies further Pressure to feelings in the Transference. The patient answers truthfully, no sign of projective anxiety ("I don't want to let you in"). The only defense so far is anxiety defending against emotional closeness.

P: I only feel anxiety.

TH: And what else do you feel besides anxiety?

The patient takes a sigh.

Psychodiagnostically anxiety is channeled in the striated muscles, which is a sure sign that the patient's capacity to tolerate anxiety is good. This in turn means that the therapist can safely go on applying Pressure.

TH: And you took a sigh. You are anxious. What else do you feel?

P: Still I feel anxious, but some anger is building up.

TH: So let's see how you feel towards me?

The NBP of Rage is beginning to build up as, in parallel, the mobilization of the NBP of anxiety decreases.

Therefore further pressure is applied to Transference Feelings.

The therapist is looking to increase the TCR.

P: Anger is going up and down.

The patient describes the physical sensation of the movement of anger (up and down in the abdomen and thorax) but still the therapist's assessment is that the TCR is not as yet high enough and exerts further Pressure on the Transference Feelings.

So far, what can be determined with some degree of certainty is that the patient has a sound unconscious defensive system, she is not trying to avoid the therapist except for the distancing and the patient's comment "I don't want to let you in" is an indication that there is no projective anxiety.

She does not use malignant or regressive defenses such as defying the therapist or becoming weepy.

There is a good conscious therapeutic collaboration on both sides but not yet enough Unconscious Therapeutic Alliance UTA. The patient is willing to work, she answers the therapist's promptings without evasiveness, which in turn allows the therapist to exert maximum Pressure and not be lured into irrelevant directions.

TH: So still there is a destructive need in you to hold back. And we still don't know how you feel towards me. How do you feel towards me?

Further Pressure is applied to Feelings in the Transference.

P: I only feel anxiety.
TH: And what else do you feel besides anxiety?

The patient takes a sigh.

Psychodiagnostically anxiety is being channeled as tension in the striated muscles.

TH: And you took a sigh. You are anxious. What else do you feel?
P: Still I feel anxious, but some anger is building up.
TH: So let's see how you feel towards me?

Further Pressure is applied to Transference Feelings.

P: Anger is going up and down.

The patient shows with her hands an up and down movement in front of her body.

Here the therapist does a Head-on Collision HOC with the Resistance and the destructiveness of the Resistance.

TH: And still you are anxious. And still there is a barrier between us. There is a part of you that wants to work here with me. And there is another part of you that wants to distance itself from me and put a barrier between us. And then the work will be useless to you and I will be useless to you.

The therapist points out the barrier and its destructiveness.

TH: You are a capable woman. You are here to work. Now my question is this: do you really want to work with me?

The patient nods.

This intervention of reminding the patient of her abilities boosts the UTA. The therapist talks to the patient on a cognitive and emotional level, simultaneously on a conscious and unconscious level.

"Do you really want to work with me?" is a Rhetorical Question addressed to the unconscious of the patient.

TH: You are a capable woman. How old are you?

P: Uhh… How old am I? 58.

TH: You are an intelligent capable woman. You are not an anxious woman, but you are making yourself anxious.

This comment about self-inflicted anxiety brings the patient's attention to her unconscious use of anxiety as a defense.

From that moment on, the position of the patient changes and the unconscious of the patient bonds with the therapist in the UTA.

Now the defense changes into a tactical defense against anger: the patient avoids eye contact with the therapist.

P: I would like to push you.

TH: How do you really experience the anger physically?

TH: You are looking away. You are avoiding my eyes.

The therapist now labels the tactical defense.

There are no signs of regressive (e.g., no weepiness) or malignant defenses (e.g., no defiance), which is another indicator of the sound

unconscious defensive structure of the patient and therefore of the absence of IDCTN in the life of the patient.

HOC with the force of the resistance

TH: Still you are anxious and controlling - a 58 years old woman who wants to work here with me. Do you want to go to this destructive system of controlling and withholding? Still you keep to this crippled position and to being the slave to the master. And you hold back this upsurge of rage towards me.

The therapist calls on the Resistance of the patient against emotional closeness which will not allow the therapist to examine the deeper feelings and impulses.

The UTA shows up in the strong emotional interaction, in the defenses (mainly tactical ones) and in the increasing striated anxiety.

TH: But how do you physically experience this anger towards me?

The therapist repeats Pressure towards the experience of anger in the Transference.

P: I can feel the anger. I can feel it in my arms.

TH: I can see this rage in your eyes. How do you experience it?

The patient shows, with a movement of the hands, that the rage is moving up from the abdomen to the chest. There is a shift from anxiety and distancing to the physical experience of anger.

The relatively short time elapsed between anxiety to anger, the ease with which the therapist acknowledges the patient's anxiety without being stopped by it, the way the therapist keeps a high level of Pressure towards the actual experience of the feelings beyond the anxiety, is an indicator of the absence of TN and of the high build-up of the conscious and UTA. The therapist is not afraid of applying Pressure towards the actual experience of anger and the patient is moving on to the actual experience of anger.

TH: If you don't minimize. How do you physically experience this rage towards me?

The therapist maintains the Pressure towards the actual experience of anger in the Transference.

P: I kick you in the stomach... I smash your head against the wall.

The anxiety has decreased allowing the mobilization of the NBP of Primitive Murderous Rage.

Here occurs the de-fusion of the Primitive Murderous Rage and the Guilt which is the central element in IS-TDP: the forces of the Resistance are the forces of the Guilt.

In the therapeutic setting, Transference Resistance can be compared to a task force of defenses set in motion by the unconscious defensive organization in an attempt to push away the therapist whose questioning threatens to bring to the surface unacceptable and guilt-laden feelings.

When structured and healthy, the unconscious defensive organization mobilizes a set of swift and efficient tactical defenses.

In the case of an impaired unconscious there are no tactical defenses to be mobilized, they don't exist, and the Resistance of the Guilt will bring forth a barrage of malignant defenses such as stubbornness, defiance, sarcasm, etc.

The technique of bringing the feelings and impulse within the Transference with the therapist by way of Pressure on the TCR is the protective safeguard, the safety net that will allow the patient to experience his repressed feelings and impulses.

The Pressure the therapist exerts on the TCR is aimed at bringing about the de-fusion of the Murderous Rage and the Guilt. This is achieved by safely bringing to the surface the unconscious murderous impulse the patient has repressed all his life towards his genetic figure, and redirecting it towards the therapist, into the safety of the Transference and the therapeutic alliance.

When de-fusion takes place, the anxiety, as the first defensive move on the part of the unconscious defensive system, decreases and disappears thus clearing the NBP for the passage of the Murderous Rage

TH: So you smash my head, go on, go on.
P: And I kick you with my leg.
TH: With which leg?
P: With the right leg.
P: I kick you on your back. Then I smash your head to the ground.

The passage of Murderous Rage continues, the image is the therapist lying on the floor.

TH: So you smash my head against the floor. Go on! If you don't control anything! Don't stop!

P: Then I keep kicking your head… Your head is destroyed. Your neck is broken. Then I keep kicking you all over the room.

The murder is weaponless, neither torturous nor sadistic. The patient uses her own limbs to murder the therapist. This indicates that the trauma in the patient's life took place when the unconscious defensive system was already structured, at around age 4 and after. This, in turn, points to an absence of IDCTN in which case trauma would have begun at birth or during the first year of life, impairing the unconscious defensive system.

The passage of heavy Murderous Rage towards the therapist continues and then the visual imagery of the therapist turns into the visual imagery of the mother.

P: There is no blood. I kick you on your back. No bone remains whole. You are loose like a puppet. And I kick and kick.

TH: You have brutally murdered me. I am now lying on the floor. And then? Look at my eyes. Keep looking to my eyes. To whom do the eyes belong?

P: They are big black eyes. It is my mother. Oh no! There are tears in her eyes, she is crying!

The patient covers her face with her hands. There is heavy sobbing. The passage of Murderous Rage is over; there is no more fusion of the murderous feelings and the guilt-laden feelings.

In this passage, two events of great importance occur:

The first one is that the NBPs correctly operate in relation to one another: after having murdered the therapist, the patient is racked with a sudden and overwhelming upsurge of Guilt. The mobilizer of the Guilt is the visual imagery of the mother. The actual physical experience of the Murderous Rage clears the NBP for the subsequent passage of Guilt. And before that, the passage of Murderous Rage becomes possible when the NBP of anxiety had been cleared for the subsequent passage of Murderous Rage.

The second important event is that the NBP of Guilt is activated through the channel of the eyes. The eye contact with the visual imagery of the

murdered therapist activates the transition to the visual imagery of the genetic figure and some movement in the eyes of the murdered body clearly increases the Guilt, in this case the patient sees tears in her mother's eyes.

TH: It is your mother! Don't stop, don´t stop. You have a lot of painful feelings.

P: (Loud sobbing)

TH: Let the feelings come. There is another wave of feeling.

P: They are big black eyes. It is my mother.

TH: Look at the eyes of mother, you have another painful wave. Don't fight your feelings. You owe it to yourself.

P: (Heavy waves of sobbing)

TH: Perhaps it is good to get closer to mother, don´t be distant.

The heavy extensive passage of guilt-laden feelings continues.

P: I am stroking her black hair... I should have done that long ago... I needed her so badly.

Continuation of grief and guilt-laden feelings and sadness about all that has been missed in the past.

P: I would tell her, I love her.

TH: How would you say that?

P: Mummy, I love you so much.

There are more painful waves of feelings.

P: I am so sorry. I want to be close. No, actually I want to be a child again; I want to be in her arms. It is too late now, she is dead, and it is all gone.

The process enters the phase of analysis and recapitulation. The patient has seen the image of her mother at the age of approximately 40, which was 46 years ago when she, herself, was 11-12 years old. The patient is not able at that moment to calculate correctly. Memories come back about having missed her so much.

P: I needed her so badly and I didn't want to feel the need …When I was sent to boarding school, at around the age of 5-6, I needed her and she wasn't

there for me. So from then on I never let her close to me again. I didn't want to feel the need of her.

During this phase there are, again, passages of Guilt and loving feelings.

Then the session is brought to closure. It lasted 25 minutes.

As mentioned before, the establishment of trauma at age of 5-6 is important in that it shows the type of neurosis the patient has developed: no TN, no malignant defenses, no projective anxiety, willingness to work and a great fear of emotional closeness with anxiety as the main defense against emotional closeness.

We are dealing here with the original neurosis.

Also as mentioned before, the weaponless murder points to the fact that trauma took place after the age of 4: she uses her body strength, hands, arms, feet, legs, to murder the therapist.

One could hypothesize that this shows the state of the patient's body strength and development of the NBPs at the age the trauma happened.

The visual imagery could be tapping into the stream of a child's unconscious aged 5-6, who is, at that point, strong and powerful enough to feel she can murder without enhancing her strength with lethal weapons.

CONCLUSION

The interview lasted around 25 minutes.

It started with the phase of Pressure: Pressure towards the experience of feelings in the Transference and Pressure to the Resistance especially the resistance against emotional closeness. Then there were Head-on Collisions HOC with the Transference Resistance, the therapist directly addressing the resistance and pointing out how this resistance is a destroyer of relationships, leading to a rise in the TCR and to the mobilization of the UTA.

During this phase there has been no interpretation or analysis whatsoever. With the total removal of the resistance the patient has been able to experience the NBPs of the Primitive Murderous Rage, which is in relation to her mother and dates back to almost 50 years, followed by guilt and grief and loving feelings.

There was a Total Removal of the Resistance, leading to a major Breakthrough. The analysis showed the biographical background.

As we have seen, the parameters which are indicators for the absence of TN in the patient under these special circumstances can be summarized as follows:

- Anxiety shows in the form of striated anxiety, tension of the striated muscles.
- There are no signs for malignant defenses.
- The NBPs are freely accessible.
- The TCR can develop.
- The Breakthrough is primitive but not sadistic or torturous, there is no use of knife or axe or other lethal equipment.

ACKNOWLEDGMENTS

In this article the authors have used a set of concepts and technical interventions such as Pressure, Breakthrough (previously Unlocking of the Unconscious), Transference Component of the Resistance TCR (previously Complex Transference Feelings), Unconscious Therapeutic Alliance UTA, and Neurobiological Pathways of Rage and Guilt (NBPs of R and G), Head-on Collision (HOC). All of these concepts and interventions come from Dr. Davanloo's published and unpublished work.

Additionally the authors have made references to metapsychological conceptualizations from Dr. Davanloo's live teachings.

We want to thank Dr. Davanloo for his teaching and intensive supervisory work.

INDEX OF KEY CONCEPTS AND ANCRONYMS

- Breakthrough into the Unconscious (formerly Unlocking the Unconscious)
- CCT Closed Circuit Experiential Training Workshop
- De-fusion of the Murderous Rage and the Guilt
- Transference Feeling, Feelings in the Transference
- Guilt
- HOC Head-on Collision with the Resistance

- IDCTN Intergenerational Destructive Competitive form of Transference Neurosis
- IS-TDP Davanloo´s Intensive Short-Term Dynamic Psychotherapy
- Major Mobilization of the Unconscious
- Neurobiological Pathways
- Primitive Murderous Rage, Murderous Rage
- R Resistance
- Resistance against emotional closeness
- Resistance of the Guilt
- Rhetorical Question
- TCR Transference Component of the Resistance (formerly Complex Transference Feelings)
- Total Removal of the Resistance
- TN Transference Neurosis
- T Transference
- Transference Resistance, Resistance
- UTA Unconscious Therapeutic Alliance
- Vertical Mobilization of the Unconscious

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Curriculum vitae

Dr. med Irene Margarete Ostertag
Fachärztin für Innere Medizin, Psychotherapie
Fürther Str. 62
90429 Nürnberg
Tel. 0049(0)911267400

1958 Born in Heidelberg

1964-1977 School Education in Heidelberg and Ulm

1977-1984 Medical School in Ulm, Tübigen and Vienna

1984 M.D. and License to Practice Medicine

1984-1985 Assistant at the Department of Oncology at the University of Ulm

1985-1993 Assistant and Senior Physician at the Municipal Hospital of Nuremberg, continuus education in Internal Medicine with a specialization in oncology

1993 Exam as specialist in Internal Medicine

1989-1993 Continuous training in Psychodynamic Psychotherapy at the Institute of Psychotherapy (Nürnberger Weiterbildungskreis für Psychotherapie) affiliated to the clinic of Psychosomatic Medicine and Psychotherapy of the Municipal Hospital of Nuremberg

Since 1993 Registerd Doctor and Practitioner for General Medicine, Internal Medicine and Psychotherapy in Nuremberg

Since 1996 Member of the German Society of Davanloo's Intensive Short-term Dynamic Psychotherapy

Since 1996 Training with Dr. Davanloo in Switzerland, Germany and Canada

Since 2006 Supervisor and teacher in Psychodynamic Psychotherapy

Since 2007 Instructor of IS-TDP Training Program in Nuremberg

Since 2012 Participation in Workshops with supervision by Dr. Davanloo in Montreal

Since 2012 Leader of Balint Groups by approval of the German Balint Federation and of the Medical Association of the State of Bavaria

Since 2015 President of the German Society of Davanloo's Internsive Short-term Dynamic Psychotherapy

Curriculum vitae

Atessa, Firouz Petermann
President of D-ISTDP Swiss Institute for H. Davanloo's Technique of Total Removal of the Resistance, Major Mobilization of the Unconscious and ISTDP

E-mail: atessafirouz@yahoo.fr

Date of birth: March 5th 1956
Place of birth: Rome, Italy
Nationality: Swiss and Iranian
Marital status: Married, two children (1988 and 1990)

Professional address
CCPP Cabinet Consultation Psychologie and Psychothérapie
8, Place de Grenus
CH-1201 Geneva, Switzerland
Prof. Phone: +41 22 731 72 73

Home address
5, Chemin des Lucioles
CH-1234 Vessy, Switzerland
Private phone: + 41 22 784 21 79
Cell phone: +41 76 379 77 63

Schooling and university
1982-1988
University of Geneva, Switzerland
1974-1975
University of Florida, Gainesville, Fla. US
1962-1973
Boarding school, primary and secondary: Collège Beau-Soleil CH-1884 Villars-sur-Ollon
(Vaud) Switzerland

Diplomas and degrees
2004 Physical Trainer diploma FISAF International

2001 Squash Instructor diploma with Jeunesse et Sports Suisse Squash, OFSPO Swiss

Federal Office for Sports

2001 Master Specialist's degree in Sophrologie Caycédienne, social prophylaxis section

and sports section, Geneva, Switzerland and Principality of Andorra with Dr. Psych.

Alfonso Caycedo

1988 Master's degree in Sociology, University of Geneva, Switzerland

1973 French baccalaureat option philosophy

Current studies and continuing education

2014-on CCT Closed Circuit Training with Dr. Psych. H.Davanloo Montreal, Canada

Supervisors in Switzerland: Dr. Psych. M. Fournier and Dr. Psych. R. Bandettini

2014 ASTRAG Association pour le travail Groupal thérapeutique et social – Association

for socially therapeutical group work with Dr. psych. G. Galli-Carminati, Geneva,

Switzerland.

2013-on ISTDP Intensive Short-Term Dynamic Psychotherapy studies

***Professional experienc*e**

In the field of therapeutic work

Working languages: French, English, Persian, Dari Afghani

2015-on President for D-ISTDP Swiss Institute for H. Davanloo's Technique of Total

Removal of the Resistance, Major Mobilization of the Unconscious and ISTDP

2012-on Geneva, Switzerland

Private practice: 8, Place de grenus, CH-1201 GE

ISTDP Intensive Short-term Dynamic Psychotherapy (supervised)

Supportive therapy

Sophrology

Sophrology sports mental training

Analytical individual psychodrama in group setting and individually
EMDR Eye Movement Desensitization and Reprocessing
Volunteer therapeutical work with Asylum seekers in Switzerland

2008-2010 Téhéran, Iran
Private practice of Dr. M-V Sahami, Child psychiatrist DPM, MRCPsych, DM
Supportive therapy, Individual psychodrama, sophrology
Work with traumas associated with war conditions, forced migration issues associated
with war, rural-urban adjustment problems, acculturation process issues, moral violence
and marital violence, work with women
Analytical individual psychodrama

2001-2008 Geneva, Switzerland
Private practice: 10, Place de Grenus, 1201, Genève
Supportive therapay
Sophrology
Sophrology sports mental training
Individual analytical psychodrama
EMDR Eye Movement Desensitization and Reprocessing

In the field of translation and interpretation
French, English, Persian, Dari afghani
2012-on
Administrative Detention Center LMC Frambois, Geneva: for psychologist, psychiatrist,
medical staff, social worker and administrative staff

Police and law enforcement authorities – Office of the State Counsel – Labour courts
In cantons Geneva, Vaud and Fribourg, Switzerland

In the field of volunteer work
2011-2013
Legal representative for the Association ELISA.ASILE, 2 rue de la Roseraie, 1205
Geneva, Switzerland

Free Legal assistance, interpretation-translation and social assistance for asylum seekers

In the field of sports

2008-2009 Iran

Private coaching in Squash, Revolution Sports Club

2001-2006 Suisse

Squash Instructor Bois-Carré Sports Club and Cologny Sports Club, Geneva

Team trainer and captain for the Chambésy Squash Club Women's teams, Geneva

Mental training for the Bossey Golf Club Women's team, France