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Presentation Atessa Firouz Pétermann: The technique of Major Mobilization of the Unconscious; the technique of Uplifting the Transference Neurosis and the technique of Direct Access to the Original Neurosis.

Introduction

Dr. Davanloo has originated a new metapsychology of the unconscious, and the techniques, to adequately address and deal with the pathological organisation of the dynamic forces of the unconscious.

His theorizing and conceptualisation is an on-going process.

There are new theoretical developments, the major one being the Intergenerational Destructive Competitive form of Transference Neurosis (IDCTN), some of the concepts have evolved and there are some new classifications mentioned in this paper, namely the concept of Transference Component of the Resistance which has replaced the Complex Transference Feelings, the Unlocking of the Unconscious now called Breakthrough and now the 3 major categories of patients whereas before patients were placed on a spectrum.

The first section of this presentation is an overview of this year's Closed Circuit Training, the part regarding Transference Neurosis, based on my notes and Dr. Davanloo's clinical updates.

In the second part I'll present the technique of Lifting the Transference Neurosis to access the Original Neurosis, also based on this year's work and with an illustration from Dr. Davanloo's work, *"Unlocking the Unconscious"*.

Intergenerational Destructive Competitive form of Transference Neurosis

One major concern of this year's Closed Circuit training has been the Intergenerational Destructive Competitive form of Transference Neurosis (IDCTN) out of which sprouts Transference Neurosis (TN) in adult life.

As IDCTN is passed down through the generations, the child is exposed to pathological traumatic attachment bonds from birth on, which becomes fertile soil for the development of later Transference Neurosis. Patients can be re-grouped inside of 3 major categories, the criteria now being the presence or absence of IDCTN and TN.

The 3 major groups

1. The first group is composed of highly resistant patients with symptom and character disturbances. Patients with multiple somatisation and functional disorders with fusion of primitive murderous rage and guilt that dates back to the **age of 4 and after**, for whom Intensive Short-Term Dynamic Psychotherapy is the therapy of choice.
From Dr. Davanloo's research results, they do not have transference neurosis.
2. The second group is the **intergenerational** group of psychoneurotic disorders with or without transference neurosis.
Patients in this group present a complex unconscious with fusion of murderous torturous or sadistic rage, sexuality and guilt that dates back to their first year of life. In this group there is a destructive competitive form of transference neurosis that runs from one generation to the next. They 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 the neurobiological pathways and unconscious defensive organisation of age 0 to 1 into the neurobiological pathways of age four and after. And mobilization by itself does not bring structural change. What they need is psychoanalytic investigation and treatment with multiple repeated breakthroughs.**
3. The third group consists of cases with intergenerational destructive competitive form of transference neurosis which has become fused with transference neurosis in the course of psychoanalytic treatment or any other form of dynamic psychotherapy or in a professional setting.
The last comprises psychiatrists whose psychopathology becomes fused with the patients' psychopathology.

In the first group of disorders dating back from **age 4 and after** the unconscious is not very primitive, there is very little or no use of any tools of aggression or lethal weapons and there is no murderous torturous sadistic rage when visualizing the murder of the therapist and of the genetic figure.
There is also no evidence of transference neurosis, as mentioned before.

For the two other groups, second and third groups, with **intergenerational or other forms of transference neurosis**, to gain access to the core neurotic structure there is a need for much higher mobilization of the Transference

Component of the Resistance, a higher mobilization of the neurobiological pathways of murderous rage, a higher mobilization of the neurobiological pathways of guilt and the actual experience of Guilt in order to achieve the actual experience of the murderous rage in the transference with the therapist.

On what basis are these groups defined?

- The Major 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 four, (age four is not meant as an exact age limit. An infant aged 2 can have the neurobiological development of child aged four and vice-versa and anywhere in between; it is a continuum but age four, more or less, marks a qualitative change in the child's neurobiology, the pathways having become by then completely functional).
- This in turn impacts on the degree of impairment of the defensive organization of the unconscious. The health or impairment of the defensive organisation of the unconscious can be measured through the degree of alertness and reactivity of the defense system, ranging from quick well-targeted tactical defenses to primitive projective, malignant. The earlier the trauma, the more impaired and primitive the defensive organisation with a sluggish system of projective and/or malignant defenses.

So now let's define what transference neurosis is

In psychoanalysis transference neurosis involves the establishment of a relationship in which the patient re-enacts the infantile conflicts within the relationship with the therapist who can then interpret them to help resolve the patient's problems.

I shall here give Dr. Davanloo's definition of transference Neurosis to be followed by two picturesque **analogies**, which I like, depicting what Transference Neurosis does with the therapist in the course of treatment.

Definition

[...] [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, his destructive need, why should the patient give it up?

Clearly the situation cements the neurosis rather than lifting it.

Transference neurosis builds on top of the original neurosis to protect it.

(in Transference Neurosis, in Clinical update, March 2009 Collected papers of H. Davanloo, M.D "Transference neurosis : clinical, technical, metapsychological, and ethical considerations")

And now the "Wild turkey hunt" analogy which is my favorite.

It likens the treatment of a patient who has Transference neurosis to a wild turkey hunting trip. You walk in the mountain with your rifle at the ready. You hear the gobbling noise to your left, you walk half a day towards it only to find out that the turkey is not there and now you hear the turkey call to your right, so you walk half a day towards the new noise. At the end of the day you have hunted nothing, you come back empty handed and you are completely exhausted.

And the "Avalanche" analogy.

The Original Neurosis has become buried, fused and cemented under the transference neurosis. And sometimes even under many layers of transference neurosis. That is the "avalanche effect".

To reach the original neurosis and remove it you need to dig layers and layers of transference neurosis that have piled up on top of it. You keep uncovering and you see nothing.

Let's look at The issue of Transference neurosis from the IS-TDP perspective

It is regarded here as an issue in three different ways:

With regard to the patient/therapist relationship and the therapeutic alliance.

With regard to the therapist's work and the therapeutic process.

And finally with regard to the therapist's own psyche as was mentioned before.

- **As regards the patient/therapist relationship**, Transference Neurosis exists as a destructive entity against patient/therapist therapeutic

alliance at the unconscious level. **Transference neurosis builds on top of the original neurosis to protect it.** When transferring onto the therapist the patient repeats in the therapeutic setting all of the elements of his original neurosis and within it the specific unconscious defensive organisation and resistance which will forbid the therapeutic alliance and block the way to the unconscious.

The first and main hindering mechanism here is projective anxiety and resistance to closeness.

- **As regards the therapist's work**, when the presenting problem is not the original neurosis, but a transference problem derived from the original neurosis, the therapist is lured in the wrong direction, like in the turkey analogy. The forces of the Resistance of the Guilt use Transference Neurosis, at an unconscious level to protect the core neurosis. With a transference neurosis wrapped around it, **the original neurosis becomes very complex, it is sealed it up and becomes invisible.**
- **As for the issue of the therapist's own psyche**, the percentage of transference neurosis within the profession is high. To quote Dr. Davanloo's statistics, most psychiatrists have transference neurosis. The percentage in the medical population is of 20%, including within the psychiatrists-to-be group, whereas within the psychiatrist profession it rises to 75%. This is a very specific and major concern. And this is due to transference neurosis acquired in the professional setting with the patients. The patient's transference neurosis fuses with the psychiatrist's own psychopathology, then blankets buries and cements it.

So an important question regarding the profession is: how can psychiatrists protect themselves? How can they de-fuse and flush out of their own psyche the transference neurosis picked up from the patients?

And this brings us to the technique of lifting up the transference neurosis in order to access the original core neurosis

Dr. Davanloo says, and I quote:

"We are in the beginning of a major move from Transference Neurosis as a Tool to Transference Neurosis as a Massive Hindrance. Transference has become a human right issue. It is even worse than just having the original neurosis."

And also:

“We should think of transference neurosis as a malignant disease”.

In psychoanalysis, Transference Neurosis has been the tool of choice for treatment, but what it actually boils down to is inviting the therapist to become part of the patient’s problem, with the conviction that having re-created the neurosis in laboratory controlled settings, so to speak, the therapist can then examine and monitor all of its components and access the core neurosis, and there is the hitch, after having overcome the resistance of course.

When the patient has not transferred onto the therapist, even when the Resistance is high, the defenses are quick, well targeted, they are tactical defenses. The defensive system is not impaired and there is no projective anxiety.

When Transference Neurosis appears in the therapeutic setting it necessarily means that, there is an issue of intergenerational destructive competitive form of transference in the patient’s life and therefore that the defensive organisation of the unconscious has been impaired from early on. The defenses are malignant or projective.

Dr. Davanloo’s approach represents a radical departure from the psychoanalytic approach.

The establishment of a transference relationship is viewed as an attempt by the patient’s unconscious to protect the original core neurosis, to avoid complex feelings, towards the early attachment figures, that are mobilized when the therapist gets close.

The non-interpretive approach in IS-TDP involves helping the patient turn against his own defenses to allow the avoided feelings to rise to the surface so that the patient can experience and work through them. For this to happen the therapist needs to **be aware of transference resistance and to deactivate it when it arises.**

What is Transference resistance ?

- **Defense is a mechanism used for the avoidance of a true feeling.**
- **Resistance is the use of such a defense in a therapeutic setting.** *(In Intensive Short-term dynamic Psychotherapy, Selected papers of Habib Davanloo, MD, p.113)*
- **Resistance in the transference or Transference Resistance is the sum total of defenses used to avoid the therapist, to avoid emotional closeness and the experience of true but complex painful and**

unacceptable feelings. *(Nat Kuhn, MD Intensive Short-Term Dynamic Psychotherapy A reference)*

- The goal of the therapist is therefore to bring the character defenses into the open, to bring them in the therapeutic setting, in other words to tilt the patient's character resistance into the transference, so that they will become a tool, and this tool we call "The Transference Component of the Resistance" or TCR for short.
- The therapist must exert pressure until the TCR crystallizes in the transference, in the relationship.
- The TCR having been brought into the open, the therapist can clarify it, help the patient to become aware of its destructiveness so that the patient can turn against his defenses.

For the lifting of the Transference Neurosis then, the therapist will monitor TCR. The standard technique is summarized as follows:

(Davanloo, Unlocking the Unconscious, Selected Papers, p. 48)

- Pressure towards the experience of repressed feelings, which leads to an intensification of resistance.
- Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of the resistance.
- Systematic pressure and challenge to the Transference-Resistance leading to a further intensification of the resistance.
- Up to a point where the character resistance tilts into the transference with the therapist. The therapist thus mobilizes and brings into the open the defensive organisation protecting the core neurosis.
- Head-on collision with the transference resistance.
- Crystallisation of the character resistance in the transference.
- Creation of the intra-psychic crisis with turning of the patient against his own defenses.
- Direct experience of complex transference feelings.
- Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious or breakthrough as it is now called.
- Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.
- Major de-repression of current or recent and distant past conflicts leading to a direct view of the dynamic unconscious and multi-focal core neurotic structure.

I have chosen from Dr. Davanloo's work, some interventions that illustrate the lifting of the transference neurosis. It is the case Dr. Davanloo calls "the Woman with the Machine gun".

(In "the Unlocking of the Unconscious" Selected papers of Habib Davanloo, M.D., p.53 § *The transference Implication*)

She is a single woman of 30. Suffers from characterological depression, chronic anxiety, severe disturbances in interpersonal relations, no emotional closeness, takes the role of victim, lets herself be used and abused.

Severe sexual difficulties with severe pain during intercourse and totally anorgasmic. A pattern of constant self-defeat and self-sabotage, self-directed aggression, lifelong characterological problems, characterized by distancing, detachment, shifting from passivity and compliance to defiance, inability to assert herself.

She had previous psychotherapy with a psychologist on a once a week basis. She had gone to the previous therapy for depression, but the therapist had focused on her sexual difficulties.

A situation has developed in her previous therapy in which she passively complied with her therapist's choice of focus, and ends up being exposed to humiliation, [which] is in itself an expression of characterological problems, one being an inability to assert herself and the other a tendency to get into situations in which she is used and abused.

Here the therapist focuses first on some aspects of her characterological problems, exerting some pressure and mobilizing the complex transference feelings, to be followed with the transference implications of these problems in the therapeutic setting.

TH: [...] It looks like you have gone for many major difficulties, most important of all you depression, but he decides to treat your sexual difficulties and you follow him without raising any question.

TH: Are you the follower type? Do you have problems with assertiveness?

What emerges is that her inability to assert herself is much more pronounced with men.

So now the therapist brings into focus the transference implications for the present relationship.

TH: You see in every relationship you say you are either very passive, compliant or you take flight.

[...]

TH: Now my question is this. How would that apply here? Is it going to be compliant in relation with me or are you going to take flight from here?

[...]

TH: How about the other side, submissiveness and bending over backwards to please, how that would apply here with me?

And now he challenges the Resistance in the Transference, the transference component of the resistance.

TH: And you prefer to call me “people” rather than me. Do you notice that ?

The therapist then brings into focus the problems the patient has with intimacy and closeness (which always appear in transference neurosis).

TH: In a sense you say “I don’t want to share with you or to let you get close to my intimate thoughts and my intimate feelings. This is what you are saying.

And then the head-on collision with the Resistance in the Transference.

TH: This is an obstacle. Let’s look at it.

You and I are here together. The aim of this is that you and I, establish what is the nature of the difficulties and problems that are paralyzing your life.. And then also to get to the core of your problem, to understand what is the engine to all these difficulties that you have. So this means if you put a wall, intentionally or unintentionally, when the wall comes up between you and me, we will not be able to understand the nature of your difficulties and we will not be able to get to the core of your difficulties, to the engine of your problems.

[...]

Then this process is doomed to fail. Up to the time the wall is there.

Up to the time you don’t want me to get to your thoughts and feelings, then we would neither understand your problems nor get to the core of

the problem.

Then I would become useless to you on one hand. We depart from each other. I did my best to understand this woman's difficulties in life but then I failed. I can afford to fail because I cannot always be successful, but can you walk from this office and perpetuate your paralyzed life. Can you afford that?

Those interventions are specific to preventing or lifting the transference neurosis. What comes next is the standard procedure without transference neurosis, about which other speakers will tell you.

This is followed by an Intrapsychic crisis, the turning of the patient against her own defenses and the first breakthrough to the unconscious. The patient has to experience the impulse in the transference situation, which means that the defense mechanism of instant repression of the aggressive impulse is no longer in operation, which can be ascertained with the fact that the tension is gone from body and jaws. The impulse breaks through the repressive barrier.