

Davanloo's Intensive Short-term Dynamic Psychotherapy. Application and understanding the theoretical and technical principles of this method in treatment of resistant patients

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Summary

Dr. Habib Davanloo's long-term experiential research, which extends over 4 decades, has shown that 95% of patients who are seen by therapists present as high or very highly resistant (defensive) patients. This makes it impossible to access their core pathology.

The goal of a standard form of Davanloo's IS-TDP is the removal of resistance, preferably done in the initial evaluating interviews, to be able to access the patient's core pathogenic organisation of unconscious. The central dimension of operation in removing patients' resistance is a transference component of resistance (TCR), mobilisation and intensification of TCR and the removal of guilt.

Despite the popularity of this method many individuals continue to ask for clarification on particular points. I hope to address these concerns in this article.

The main focus of this article will be presentation of the principles of theoretical basis of the standard Davanloo's IS-TDP. To illustrate the principles of this form of therapy I will present a clinical vignette of therapy from my own practice.

major resistance / guilt / unconscious primitive murderous rage / PMR / parameters of mobilisation of the unconscious

INTRODUCTION

The pathogenic organisation of unconscious is described as a nuclear structure which centers around immediate or extended family members, and includes the trauma of a broken bond/attachment with them, the pain of trauma with rage, and then the guilt about the rage (See Fig. 1 – *next page*).

“A fusion” of primitive murderous rage (PMR) and guilt in relation to the patient's generic fig-

ures creates a core of pathogenic organisation of the unconscious. This results in the development of several psychopathological dynamic forces maintaining this organisation and therefore the patient is unable to achieve full growth and potentials. This affects the patient's cognitive and emotional level of functioning.

Before discussing theoretical and technical aspects of this therapy one must distinguish between Dr. Davanloo's IS-TDP and other models of short-term dynamic psychotherapies.

Some therapies use strict criteria requiring patients to have a good anxiety tolerance (P. Sifneos) or patients must be responsive and highly motivated (D. Malan, P. Sifneos “psychological sophistication”). [3]

In some therapies, termination was a central feature or the length of therapy was used as an

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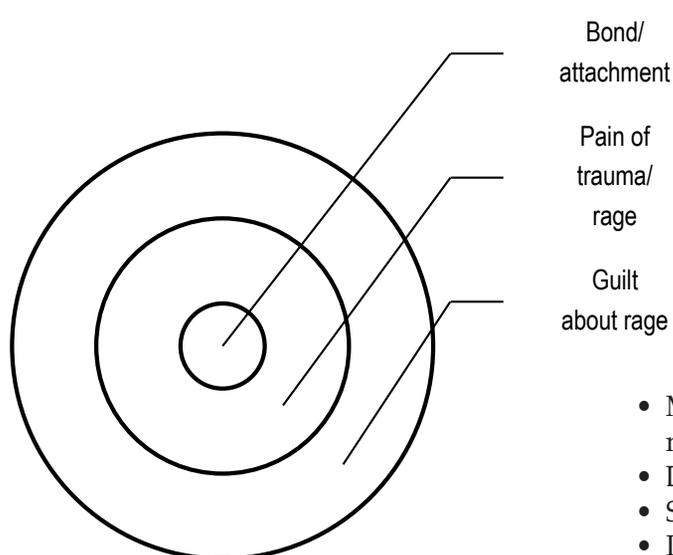


Figure 1. Pathogenic organisation of the unconscious

actual tool of treatment e.g. J. Mann used less than 12 sessions. Also, the use of interpretation was used as a curative force with less emphasis on patients' defences (D. Malan, P. Sifneos). [3]

All these criteria limited the application of short term dynamic psychotherapies to only 2 to 10% of patients eligible for these approaches.

SPECTRUM OF PSYCHONEUROTIC DISORDERS ACCORDING TO DAVANLOO'S CRITERIA

There is a broad applicability of this method to different spectrums of psychoneurotic disorders, from mild obsessional neurosis, phobic, and depressive disorders to life-long character neurosis with major characterological disturbances. According to Dr. Davanloo's criteria the spectrum of psychoneurotic disorders can be classified into five major groups. These groups are based on the degree of the patient's resistance and are used for psychodiagnostic classification. [1] There are as follows:

1. Extreme Left on the Spectrum

Patient is highly responsive to dynamic psychotherapy.

Suffering from: Mild obsessional neurosis of recent onset, mild phobic disorders etc.

Main features:

- Highly responsive
- Circumscribed problem
- Single psychotherapeutic focus
- No major resistance
- Tactile defences only

2. Mid-Left Side on the Spectrum

Bond/
attachment

Pain of
trauma/
rage

Guilt
about rage

Patients show some degree of resistance with mild characterological disturbances. Suffering from: obsessional neurosis, episodes of depression. Patients are highly responsive to this form of therapy and required around 30 sessions of an hour to hour and half each.

Main features:

- Moderate degree of resistance; presence of major resistance
- Diffuse symptom disturbances
- Some degree of characterological disturbances
- Presence of unconscious violent rage, guilt- and grief-laden unconscious feeling in relation to the early generic figures

3. Mid-spectrum

Patients have higher degree of resistance, they are still suitable candidate for the intensive short-term dynamic psychotherapy.

Main features:

- Presence of high degree of resistance; major resistance and the tactical organisation of the major resistance
- Diffuse symptoms and characterological disturbances
- Presence of unconscious murderous rage and guilt
- Fusion of sexuality and murderous rage
- Complicated core pathology

4. Mid-right on the Spectrum

Patients have complicated core pathology related to early life fusion of guilt and PMR (before 3 years of age). They are more suitable for a long-term therapy (more than 40 hours) or block therapy.

Main features:

Suffer from life-long psychoneurotic disturbances

- Very high degree of resistance
- Diffuse symptoms and characterological disturbances; life-long character neurosis
- Core pathology highly complicated
- Presence of an unconscious primitive murderous rage, guilt- and grief-laden unconscious feelings

- toward generic figures in their early life, "Perpetrator of unconscious" [1, 2]
- Deeply fused sexualised feelings with murderous rage and guilt

5. Extreme Right on the Spectrum

Patients have very complicated core pathology, requires multiply breakthroughs into unconscious to consolidate diffusion of PMR and guilt. They only suitable patients for the long-term therapy or block therapy.

Main features:

- Extreme degree of resistance
- Symptoms and major characterological disturbances
- High degree of masochistic character traits
- Highly complicated core pathology
- Presence of highly primitive unconscious with torturous murderous rage and intense guilt and grief, multidimensional in relation to early generic figures
- Sexualised feelings, when present, deeply fused with unconscious guilt and primitive murderous rage (PMR)

It is important for therapists to become familiar with the theoretical principles of metapsychology of the unconscious in order to properly apply them during the process of psychodiagnostic assessment and treatment.

Theoretical principal of metapsychology of unconscious based on a case presentation

To illustrate a basic principle of this method I will present a clinical vignette of therapy from my practice.

Unless the patient comes to the interview with the presence of mobilised transference feelings, it is imperative for the therapist to look for the patient's resistance in transference.

The following vignette describes a psychotherapy session with a 45 years old, professional woman who was suffering from life-long obsessional thoughts and compulsive behaviour with resistance against emotional closeness. The patient entered the session with anxiety in the form of striated muscle discharges (the presence of transference component of resistance). The patient's consent for publication of her case was obtained by the author.

T: How you feel coming, seeing me?

P: I'm nervous right now, I'm not sure why...just driving here...

T: What else beside anxiety do you feel?

P: It's different, I have been feeling really good this last week... it's different, last two weeks have been different, this week is different than last week, my rumination has been replaced with... it just my rumination are always negative, it is kind of humiliating...and it's totally replaced with good thoughts. If I have experiences, that I am kind of thinking about, fun things to happen, a good things to happen. It's a bit strange, why my head is filled with that, it's different, it's kind I have noticed. (*numbers indicate minutes of the recorded interview)

*1:11 T: What you account for this anxiety?

P: It must be something left... even last night I wasn't feeling good...

T: How do you feel towards me?

P: Good.

T: How do you experience this?

P: It's not just good, there is ambivalence, and I am telling you the dark staff... I am feeling kind of fear...,oh goodness..., here we go again...

If there is no presence of the transference component of resistance, the process starts with a phase of inquiry into the patient's problems and dynamic inquiry. This is followed by a phase of pressure towards the patient's feelings (this component is a part of a dynamic sequence) [1] in order to raise the transference component of resistance (TCR).

TCR is a centre of operation during the therapy [1, 2] and needs to be constantly monitored during the whole therapy. In general terms TCR is a constant build up of tension between the patient's transference feelings and the patient's resistance in transference.

The process of therapy should be accompanied by increased striated muscle discharges (increased unconscious anxiety involving deep sighs, tension and clenching hands, thumb pressing) by the patient. The absence of these physical signs may indicate that the pressure being applied to the underlying feelings by the therapist is too low or there is a significant fragility in the patient's characterological structure. This

needs to be reevaluated by the therapist as each of them requires different approach.

Raising by the therapist of TCR (2) can be achieved through:

1. Focusing on the patient's feelings
2. Focusing on the patient's resistance (not avoiding it but also not challenging)
3. Focusing on the patient's resistance against emotional closeness (RAEC) with the therapist

It is expected that this phase of the therapy mobilises the patient's defences, especially resistance against emotional closeness which is very desirable development.

If resistance is becoming clearly noticeable, this indicates that the process is going in the right direction. The therapist should not avoid the patient's resistance. This is crucial since many therapist wants "to comfort" the patient. This can be a technical issue (poor understanding of metapsychology of unconscious) or be a part of therapists' problem involving an activation of their own unconscious with increased unconscious anxiety during a session. Highly resistant patients usually want "to shut up" the therapist which is a part of the patient projecting his/her guilt onto the therapist (projecting of his/her unconscious onto therapist).

Projection needs to be removed/undone, so that the patient does not perceive the therapist as somebody who has provoked him/her. This, as well as other malignant defences (objectional character traits, defiance) needs to be addressed and undone before proceeding further into therapy.

Mobilisation and intensification of TCR; meeting the patient's defences.

A constant build up of tension between the patient's transference feelings and the patient's resistance in transference starts at the initial contact with the patient (unless there is known contraindication e.g. severe fragility of patient's characterological structure with inability to tolerate any form of anxiety as in laryngospasm, cognitive disruption, dissociation like episodes, acting out etc).

The presence of striated muscle discharges (e.g. the presence of deep sighs, thumb pressing, hands clenching etc) in the patient has important psychodiagnostic significance as it indicates that patient can tolerate further pressure

with intensification and mobilisation of his/her underlying feelings in transference.

At this phase the therapist also encounters the patient's resistance with different forms of defences, which again has important psychodiagnostic value. Some of the patient's defences can be of a tactical nature. Some of them can be entrenched in the patient's core pathology and need to be dealt with directly through further pressure or head-on collision towards them [1].

It is strongly recommended not to challenge the patient's defences in the early phase of therapy as this will create misalliance and not allow for the significant rise of unconscious therapeutic alliance; the patient may feel he/she is being criticised by the therapist.

We return to the case: As a result of pressure, pressure and head on-collision towards her defences, the patient showed a mobilisation of her unconscious complex feelings in transference. It is important to monitor the level of her unconscious anxiety as she starts experiencing the impulse. There should be an absence of any form of anxiety which will indicate that "a free" passage of primitive murderous rage (an impulse) is imminent.

Note: Impulse referring to neurobiological pathway of primitive murderous rage. A neurobiological pathway of primitive murderous rage impulse starts usually in the pelvis, spreads into the abdomen, chest, shoulders, arm, hands. It is described by the patient as a fire ball, volcano, pressure cooker [1]. Feeling is referring to experience of grief, guilt, mourning.

T. How do you feel towards me right now?

P. It's rage.

T. How violent is this rage if you don't close eyes if you look straight into my eyes? How violent, this powerful impulse of rage actually feels, physically in your body if you let this out completely uncensored?

P. I'm kind of little bit in touch with it right now..

T. ..how violent...

15:47 P. It's everywhere, I can feel in my arms

T. From which part of your body is coming...

P. Right here (pointing to lower abdominal area)

- T. If you build up in the fullest intensity.
 P. Pressure, it is, it is more like a volcano.
 I don't know why I have always an image of volcano.
- 16:22 P. It's just percolating, constantly, it's just through all my body, it's different that I had, it's just percolating.
 P. I don't feel hot, I feel more pressure.
 In the above dialogue the patient shows a full activation of her neurobiological pathway of primitive murderous rage (PMR) accompanied by an absence of her unconscious form of anxiety. A breakthrough into her unconscious with an experience of PMR and a passage of guilt should occur without difficulty.
- 16:41 T. ...and if you build this pressure in the fullest intensity you have, here with me, ...
 P. It's murderous rage.
 T. How this murderous rage feels, if you unleash in the fullest intensity you can?
 P. It's more physical.
- 17:11 T. How violent?
 17:43 P. It grabbing you, I'm not sure why you and it, that's same kind of throwing you against the wall and ripping you apart with my hands.
 T. Grabbing me by what?
 P. Grabbing you by neck.
 T. By neck, how tight?
 P. ...and strangling you.
 T. Are you in touch with this?
 P. That's what I want to do, I want to, ...it is not a volcano, it's very physical, primitive...
 T. How primitive, what this impulse...
 P. How much more primitive you can get?
 P. Tear you, limb from limb...it's not even tearing... break your bones and by throwing you around like a rag-doll. But I am a person, I am not an animal. I want to do with my hands...
 P. I want to be done with my hands.
 T. Than you starting with which bone.
 P. Your arms.
 T. Grabbing which arm first?
 P. That arm. (Pointing to the therapist's left arm)
 T. How you ripping this, just...
 P. Breaking it just force, apart, stepping on your leg like a piece of wood...I can, snapping everything and breaking your neck.
- T. You starting, left limb, right, leg...
 P. Breaking it like pieces of wood.
 T. How this feel to release this powerful, primitive murderous rage?
- 22:28 P. (deep sigh) (she stays silent and tearful)
 23:04 T. If you look at my body, dismembered... look at my eyes. What this impulse feels like, is it gone?
 23:18 P. (starts crying)
 T. there is a wave of painful feeling, don't hold this in. Your life depends on this? As much painful there are, you can tolerate them. As you bring my eyes into the focus, what this powerful impulse... torn my body. As you looking into my eyes...
- 25:29 P. It's my dad.
 25:42 T. How do you feel as you looking at his eyes?
 P. (wave of painful feeling)
 T. As you looking at your father's eyes. What colour of eyes do you see?
 28:16 P. Blue (another wave of painful feelings)
- 29:47 P. He just lying on my lap.
 T. How do you feel towards him as you looking at his eyes?
 What this impulse has done to him?
- 30:33 T. As you looking at his blue eyes... don't hold to your feelings, let this go through.
 P. (another wave of painful feelings)
- 32:14 T. Is he still on your lap?
 P. Yap, I feel a bunch of different feelings towards him, I feel love of course, I feel grief. I feel like I have never really understood him. I spent so much time of my life not to be like him and at least ... he ...some dark staff...so many wonderful things that I like... him that...I feel badly about that...

Mobilisation of the unconscious is necessary for the passage of guilt. If the neurobiological and somatic pathways of PMR are in optimal position than a passage of guilt is assured (see Fig. 2 – next page).

Note: The guilt is the most painful experience of the whole process. It usually comes in waves with strong involvement of respiratory muscles (diaphragm, intercostals, neck muscles) with a contraction of the vocal cords presenting on some occasions with choking like qualities.

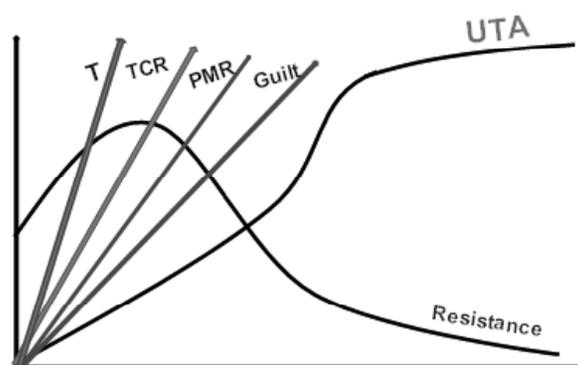


Figure 2. Parameters of mobilisation of the unconscious

T - transference

TCR - transference component of resistance

PMR - somatic and neurobiological pathways of primitive murderous rage

UTA – unconscious therapeutic alliance

Mobilisation or repetitive mobilisation and the passage of guilt are central factors in bringing about unconscious structural changes and the removal of symptoms and characterological disturbances. As long as guilt is in operation the therapist should continue mobilisation of the patient's unconscious.

The experience of PMR and breakthrough into the unconscious does not constitute the end of the therapy process. The patient needs to experience series of breakthroughs of PMR e.g. in the mid spectrum disorders more than 10.

Psychic integration and multidimensional structural changes

For psychic integration and multidimensional structural changes to occur, these processes should be applied soon after each breakthrough into the patient's unconscious. The patient's experience should be integrated so that the patient has a clear picture of his experience during the therapy and his unconscious material has been brought out during the session. For example while the patient experienced PMR during the above session, this does not actually happen during the therapy; "the murder" happened in the patient's past. The patient should learn about having PMR in their unconscious since early age (childhood) with its associated guilt and grief and its impairment on his/her intellectual functioning. This has resulted in an allowance by

the patient to be used and abused by others, not achieving full potential in their live etc. This represents a part of psychic integration.

During the process of multidimensional structural changes (which is extremely important in working with fragile character structure patients) the therapist should address anxiety first to increase tolerance of it, with restructuring of patient's defences.

In early sessions of therapy, the therapist has to keep the unconscious therapeutic alliance (UTA) "alive" by constantly increasing TCR ("pumping it up"). UTA previously referred to by Dr. Davanloo as a "dreaming while awake" [2] phenomena is introduced during the therapeutic process when the dynamic system of the unconscious is mobilised: neurobiological pathways of PMR and guilt are in maximum operation while anxiety is not noticeable.

An actual experience of the patient's underlying feelings is an indicator that UTA (see Fig. 2) is in a full operation and the reservoir of pathogenic feelings and conflicts are drained. At this point a process of working through is implemented as a part of the therapy with upcoming termination of the therapy. It is imperative that during this process the therapist monitors the affective response of the patient. There should be dominance of the affective responses over the cognitive during this phase of therapy. Threshold of affective over cognitive continuum is a regulator of the process of working through. There should not be any presence of resistance against emotional closeness at the end of the therapy.

CONCLUSION

In his later works, Freud talked about destructiveness of superego resistance [5] and other dominant instincts on the lives of patients [4] but his position regarding a therapeutic approach to demolish those resistances, remained pessimistic. On the other hand Davanloo's research shows that it is possible to deal with the resistance of superego (presently used in his writing as a major resistance of guilt). In cases of patients with neurotic spectrum disorders this task can be accomplished through direct access to patient's unconscious by bringing to the surface their impulses of murderous rage, experi-

ence them in the fullest intensity followed by experience of guilt feelings related to their generic figures. This process if done in systematic way creates permanent defusion of primitive murderous rage and guilt in the patient unconscious within their pathogenic organisation structure. It allows patients to give up their destructiveness in their life and towards their close ones.

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