Twin-Factors of Resistance and Transference in major Mobilisation of the Unconscious and Intensive Short-Term-Dynamic Psychotherapy

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In our teaching I use to ask our trainees questions in order to test the quality of our teaching. One of the question is: "What is colliding in the head-on-collision?" Of course the answer is: "Unconscious therapeutic alliance head-on-collides with transference resistance." Another question is: "Why the patient becomes angry at me when I work with him on the resistances in the transference?" Also here the key lies in the unconscious therapeutic alliance: The better the therapist shows to the patient how his defences paralyse the life in- and outside of the transference, unconscious therapeutic alliance arises and weakens the resistances. As a consequence, the hidden unresolved complex feelings towards the genetic figures that have been repressed since the childhood by the resistances get mobilized and directed against the therapist, who is sitting in front of the patient.

These two examples underline the central importance of the unconscious therapeutic alliance in the overcoming of the resistances. This presentation is focussing on the question how to mobilize the unconscious therapeutic alliance against the forces of the resistances. Of course, this is a wide focus, and I will have to narrow it on a few issues.

The work on the resistances has to be precise and tight. This is evident, although it is not easy to realize. But I want to draw your attention to another principle: After a rise of the complex transference feelings, the work on the resistances also has to become more and more basic. What I want to say: The resistances have a concretely perceivable and a basic aspect. So each work on the resistances is situated in a spectrum between descriptive comments and focussing on the basic function. Descriptive is what one can see and hear. Basic aspects are the closeness in the transference, the patients being in touch with his feelings, his will to do the therapeutic work as well as his sabotage of it. I give you a few examples:

- Therapist: "What are you going to do about your paralysed position here with me?" Patient: "I wasn't aware that I'm paralysed!" Descriptive intervention: "This doesn't tell us what you are going to do about your paralysed position here with me!" A more basic comment would be: "Your answer totally bypasses my question!"
- The therapist is focussing on the sexual life of the patient. The patient becomes more and more unspecific and avoids the eye-contact with the therapist. Descriptive intervention: "You don't give me a clear picture!" Basic intervention: "You avoid my eyes and keep me in a distance!"
- Therapist: "How do you feel towards me?" Patient (smiling): "I don't understand your question!" Descriptive intervention: "This is not a feeling!". Basic intervention: "You smile gives rise to the question, if you really want to work!"

The most basic intervention of course is the head-on-collision.

Now I will focus on two specific defences, that in my experience create major difficulties in many therapies as well as in the every-day-life of many patients. And in my opinion they are basic:

Giving up oneself

2 examples:
- The patient comes obviously anxious to the trial therapy. He is awake since five o'clock in the morning. The therapist is repeatedly putting pressure for the feeling in the transference underneath of this anxiety. The patient gets in difficulties, he is digging in his head and thinking: "What does the therapist expect from me?" And he says :" What should I answer to your question?" After a certain rise in the complex transference feelings, the therapist gives a basic comment as I have explained it before: "It seems as if you had given up yourself, focussing only on the expectations of the others!" For an instant the patient is speechless. Then he becomes very sad and says crying: "This is a life-long problem of mine!". This kind of beginning is frequent in my trial therapies. The drawback is that you have to unlock the primitive murderous rage and the guilt in a second step. And the advantage is, that initial anxiety drops and unconscious therapeutic alliance arises by the early break-through of grief.

- In the 5th session of a therapeutic process, the therapist is putting challenge and pressure to the resistance against the emotional closeness in the transference. The patient says: "Obviously you expect me to get angry at you!" The therapist challenges the basic aspect of this resistance: You are portraying you as a slave to the master, having given up yourself!" This intervention might create a major turmoil in the patient, unless he is in a defiant position.

Those two examples illustrate the defence that we could call: "Giving up oneself": The patient automatically focuses on the expectations, thoughts and feelings of the others. He sees himself through the eyes of the others. His self-esteem depends on the assessment of his performances by the other. He is making a major effort to create in other people a positive image of himself. The position of the patient goes beyond submissiveness, because he is no longer aware of his own needs, feelings, thoughts and his responsibility for himself. The only way to escape from the system might seem to be defiant. But this is an illusion: If the patient does what the others expect or if he does the opposite, in both ways he reacts in function of the expectations of the others. This is no freedom.

Giving up oneself goes back to the earliest childhood: On the one hand this defence represses - as any other defence - primitive murderous rage, guilt and grief towards the genetic figures. On the other hand giving up oneself has an adaptive function in the childhood: The baby gives up his own needs, because the parents are overwhelmed by the management of their own problems. On the one hand this stabilizes the family-situation. On the other hand the child has a major problem throughout his life. He is unsure about his own needs and feelings, and he is constantly busy with the expectations of the others. I am ending my focus on these defences with two examples outside of the therapeutic situation:

- Many patients get in panic when they should give a presentation. They are so anxious, that they risk to forget what they wanted to say. Their only concern is: "What do they think about me?"

- In the first years of my supervision with Dr. Davanloo I tried not to show my difficult tapes, but my seemingly best ones. Creating a good image of me was more important to me than the better profit in the demonstration of the difficult tapes. (But in the supervision I came to see, that also the seemingly better tapes were full of difficulties. So nevertheless I learned a lot.)

Missing integration of experience

These examples come from a number of sessions after the trial therapies:

- A patient declares that his father had no problems in experience of anger, because he often screamed, threw things to the wall and hit his wife as well as the children.

- Under the pressure by the therapist, a patient smiles and looks to the floor. He declares, that these are signs of anxiety.

- Asked by the therapist, a patient admits, that he continues driving his car after drinking a bottle of wine.

- A female patient declares being hurt by the accusations of her husband.

- The therapist is pressing for the feeling of the patient towards his boss who was unfair to him. The patient says: "What should I have done, I could not let my anger out against my boss!"

- Etc.

The common resistance in these examples is a lack of integration of the therapeutic experience:

- They have not learned, that explosive acting out is a defence.

- They can not differentiate between anxiety and defence.

- They continue being massively self-destructive in the every-day-life.

- They confuse experience of rage with reactions.

- Etc.

In my experience many patients don't sufficiently integrate what they have experienced during the sessions. Even after good break-throughs into the unconscious and in-depth- working-through-processes. Not learning out of experiences, efforts and mistakes is a basic aspect in human neurosis, be it inside or outside of the transference. In no other species learning is such an important task of life as in human. And not learning is extremely destructive!

In my view, the integration of the therapeutic work inside and outside of the transference must be repeatedly assessed by the therapist and the patient. If there is a problem in this field, the therapist first has to check, if the mobilization of the unconscious and the process of working through have really been sufficient. As a next step, the therapist can ask the patients, which defences and which types of anxiety they observe in their every-day life. Often the patients can't answer to these questions. This may create a rise in the complex transference feelings with an unlocking of primitive murderous rage. Or the therapist encourages the patients to ask their family-members or friends who know about the therapy, what they consider as still unsolved problems of the patients. This can improve the dystonicity of the patient regarding his defences. When the lack of therapeutic work remains, the therapist must head-on-collide with this resistance and declare it as what it is: A sabotage of the therapy and a hostility against the therapist! After such an intervention the patient may have a break-through of massive grief. One of my patients declared, that his father had refused learning out of experience: He three times had a workshop ?? together with a colleague. Each time he let himself be abused and ended bankrupt. The patient again and again appealed at his father to stop his masochism - without any effect. And now, the patient comes to see, that he is doing the same.

I'm at the end of my presentation. I wanted to demonstrate the spectrum between concrete and basic aspects of the resistances. And I wanted to put my emphasis on two examples of rather basic resistances: The giving-up oneself and the missing integration of the therapeutic work.