*International Journal of Short-Term Psychotherapy, Vol. 7, 73–87 (1992)*

# Achieving Character Change in IS-TDP: How the Experience of Affect Leads to the Consolidation of the Self

**PATRICIA C. DELLA SELVA**
*435 New Karner Road, Albany, New York 12205, USA*

Davanloo's technique for "unlocking the unconscious" provides an unparalleled opportunity to test out theoretical assumptions regarding the development and remediation of psychopathology. It is the thesis of this paper that for a large number of patients, particularly those referred to as self-sacrificing, negative parental introjects, which distort perceptions of self and other, as well as inhibiting the awareness and experience of affect, is at the core of their difficulties. This is contrasted with the self-punitive mechanism driven by guilt that Davanloo has suggested is responsible for the symptoms and suffering of patients with superego pathology. Object relations theory has provided a context within which to understand both the impact of early relationships on development and the ways in which previously repressed feelings and memories lead to profound changes in the entire personality. A clinical example is provided to illustrate this process.

Davanloo (1980) has been a pioneer in the effort to make psychoanalytic psychotherapy, with its goals of symptom removal and major character change, more efficient and effective. While adhering to Freudian drive theory, he has radically changed the techniques for therapeutic intervention.

## The Nature of Evidence in Psychotherapy

As Davanloo (1988) has so aptly stated, long-term psychoanalysis is so complex and the material so voluminous that it has become virtually impossible to obtain any direct evidence regarding the mechanisms of change. The techniques he has developed to rapidly unlock the unconscious (Davanloo, 1990a) lead to rapid identification of the central dynamic forces which shape the patient's internal life and color his or her relationships with others. In technical terms, a successful "unlocking of the unconscious" enables therapist and patient to make direct links between the triangle of conflict (impulse/feeling, defense and anxiety) and the triangle of the person (figures in the patient's current and past life as well as in the transference). This access to the unconscious is made possible by rapid identification and subsequent exhaustion of the patient's defensive

0884-724X/92/020073-15$07.50

maneuvers and provides the opportunity to test out the validity of the metapsychological assumptions underlying psychoanalytic theory.

Now that we have the techniques for gaining rapid access to the unconscious, we are able to focus on how previously warded-off feelings and memories are integrated into the personality and the ways in which this leads to character change.

## The Psychoanalytic Theory of Character Formation

According to Freudian theory (Greenberg and Mitchell, 1983), character structure is comprised of patterns of drive and defense. The distinction between the ego and the superego is that between the regulatory functions of the psychic apparatus and the personal images that have been internalized to aid in psychic regulation.

In his classic text, Fenichel (1945) stated that, while there have been frequent attempts to dichotomize analyses of "high level Oedipal neurotics" (patients on the left side of Davanloo's spectrum of psychopathology) from those with more pervasive character disorders (the right side of the spectrum), he was of the opinion that "all analyses are character analyses." When speaking of the "character neurotic", Fenichel (1945) described patients rigidly ensconced in a certain way of being which would permeate all their feelings, attitudes and behavior. The goal of psychoanalysis in such cases, which he considered the vast majority, was to "release the personality from its rigidity."

Reich (1945) defined the neurotic character as one with ego syntonic attitudes and modes of behavior which serve as an armour against both external stimuli and internal impulses and feelings. For Davanloo (1980, 1990a,b), this armour is comprised of character defenses which create a wall against emotional closeness. While he would agree with Fenichel, that the goal of psychoanalytic treatment is to gain freedom for the ego, he has found that an active assault on the character defenses is necessary to achieve this goal in a timely fashion.

## The Function of the Superego

In Davanloo's (1988) study of self-destructive patients (those who are either actively self-destructive or engage others to "use and abuse them") he found the same unconscious dynamic operating, "namely violent and murderous impulses toward close family members which are laden with intense guilt, remorse and grief." After repeated unlockings with many patients, Davanloo (1988) concluded that "the evidence points overwhelmingly to the operation of a self-punitive mechanism identical with Freud's concept of the superego," but that Freud's view that the superego is "heir to the Oedipus complex" was not confirmed.

Davanloo (1988) has found that patients suffering from "superego pathology" display this pervasive self-destructive tendency in nearly every area of their lives and is responsible for both an inability to live up to their innate potential and sterility in human relationships. Given this, pervasive character change is

the goal of treatment. How is this achieved? As I understand it, Davanloo regards the process of working through (1990b) as a progressive weakening of the forces of superego resistance achieved via the derepression of unconscious impulses and feelings in relation to genetic figures. This presumably leads to a "restructuring" of the ego which makes more adaptive forms of tension regulation possible.

While Davanloo has tended to focus on the self-punitive aspects of the superego, he has outlined two other central aspects of superego functioning: (1) the superego as manifestation of a harsh parental introject, and (2) that aspect of the superego which expresses love of parents and other important figures. Both of these functions are more directly related to the interpersonal field and are less strictly intrapsychic than the self-destructive mechanism driven by guilt. In other words, these are internal mechanisms aimed at establishing and maintaining close emotional ties to significant others, as opposed to mechanisms which are aimed at reducing instinctual tensions or guilt.

## Self-Sacrificing Patients

It is the thesis of this paper that the two aspects of superego functioning just mentioned figure prominently in the development of a group of patients that will be referred to as self-sacrificing. These are individuals who, although making an extraordinarily good adaptation to the external world, seem to feel bad inside. They tend to experience themselves as a burden to others and continually strive to validate their existence by doing for others. While rarely actively suicidal, they frequently feel they should die. More aptly stated, they feel they don't deserve to live. There is a split between the way they feel inside (bad) and both the way they behave (which tends to be exemplary) and the way that others view them. No amount of evidence to the contrary seems to convince them of their worth. These patients tend to sacrifice their own needs for self expression in order to maintain their attachment to others. In many cases this tendency is so pervasive and long standing, that they literally do not know what they are feeling. In particular, they seem unaware of their feelings and reactions toward others. The capacity to become aware of and experience their own true feelings toward others is an achievement.

## Drive Vs. Object Relations Theory

How do we understand what is at the core of this problem? What is the driving force behind such self-loathing? According to Freud (1920, 1924) and Davanloo (1988), an internal sense of "badness" would be viewed as a manifestation of superego pathology. In other words, these symptoms would be understood as a punishment for aggressive, sadistic and murderous impulses toward ambivalently held objects. The conflict is viewed as internal – a battle between id impulses and superego tyranny that cripples the ego. This is the essence of drive theory.

By the 1930's Freud began to move toward a greater appreciation of preoedipal

development. It was in his paper on female sexuality (1931) that he made his most direct statements about preoedipal object relations, focusing on the very real problem the girl faces in having to give up her primary tie to mother in order to switch love objects. In discussing the girl's disappointment with mother, Freud introduced a relational concept, referring to some actual characteristic or deficit of the mother. He then went on to say, of the girl's fear of her mother, "It is impossible to say how often this is supported by an unconscious hostility on the mother's part which is sensed by the girl."

Even though we may find the beginnings of an object relations theory here, the notion that the baby and child perceives and reacts to real attributes and/or deficits in their caretakers, it was left to subsequent clinical theorists to expand on these notions. According to Greenberg and Mitchell (1983) "Freud was never able to integrate the realistic aspects of object relations into his developmental theory."

Fairbairn (1952), one of the first object relations theorists, postulated that the primary drive in infants is for object relatedness, not pleasure via the reduction of instinctual tensions, as in drive theory. Developmental research on infants seems to support this hypothesis (Bowlby, 1969; 1973, 1980; Mahler, Pine and Bergman, 1975; Stern, 1985). Psychopathology was viewed as the result of conflicts between the child's intense need for contact and nurturance and the reality of their parents, who may be emotionally absent, intrusive or chaotic. Due to the infants very real dependent state, he cannot do without parents, yet living in a world with unavailable or unreliable parents proves to be unbearably painful. In order to manage this very real dilemma, Fairbairn (1952) suggested that the child would use rudimentary defenses such as internalization, repression and splitting in order to preserve the illusion of the goodness of the parents as real figures. The child would split-off and internalize the bad - "They are not bad, I am". Such a stance preserved the illusion of control and hope for the child - "if only I could change, be different, be good, their love and care would be forthcoming." These internalized object relations were viewed as a flight from the painful reality of real relations with the parents and were considered to be at the core of what was repressed.

It is the thesis of this paper that the techniques developed by Davanloo to enhance the patient's experience of previously repressed and disavowed feelings can trigger the derepression of the kinds of painful early memories Fairbairn has referred to in his work. According to Laikin, Winston and McCullough (1991), the experience of feeling can be conceptualized as a complex mixture of cognitive, emotional, and physiological arousal. For example, the full experience of anger would include a cognitive awareness of the emotion ("I feel angry"), physiological arousal ("I feel energized, strong and as if my blood pressure is rising"), motoric arousal ("I feel like striking out with my fists") and an ideational component ("I imagine punching my boss in the face.")

In the case that will be presented, it is the experience of the previously repressed and split-off affects of rage, pain and longings for love and closeness that evoked memories of what the patient's early relationship with her mother was actually like for her. As the early perceptions of her mother became clear, the need to protect both her mother and herself from these terrifying memories by internalizing the "bad" became understandable but no longer necessary.

## A Clinical Example

This young woman presented with an excellent adaptation to the external world very different from Davanloo's self-destructive patients. She had been a straight A student, won a full academic scholarship to college, obtained a graduate degree from an Ivy League school, was a star athlete and, although shy, had many life-long friends. She married her college sweetheart and reported having a happy marriage, describing her husband as loving and devoted. She complained of only one symptom – an intensely critical internal dialogue that would abate only when she was busy and productive but would resume with a vengeance whenever she had free time. Weekends and vacations were described as particularly painful. At such times, she would "go into a black hole" and feel immobilized. No amount of duty and service to others would quell this internal voice telling her of how unworthy and selfish she is. There was literally no peace, no rest for this woman.

I initially viewed this woman's intense self hatred as a manifestation of a punitive superego and spent the early sessions going over the triangle of conflict (Davanloo, 1980; 1990), acquainting her with her defense and getting to the underlying affect. She was highly responsive to this work and proved capable of tolerating a high level of anxiety as well as intense and primitive affect. Despite this, there was little real change in her view of herself. Significant character change did not occur until we were well into the treatment (between 30 and 40 sessions).

During the first 30–40 sessions there were repeated experiences of unlocking her unconscious in the transference and linking the derepressed impulses and feelings to a large number of genetic figures (father, siblings, grandparents and other members of her extended family). The patient's mother was conspicuously absent from this phase of the work. As the feelings toward these initial figures got worked through, the focus began to shift to early feelings and memories regarding her mother. A comment by her mother on the patient's recent birthday brought anger to the surface but the full impact of these feelings was not experienced until the following session. Her mother said, "Don't think that breast feeding will protect you against pregnancy." The patient was born 18 months after her sister, the first born, and she was conceived while mother breast fed this child.

## Feelings of Rage Toward the Therapist with a Link to the Mother

The feelings of anger toward her mother began to surface and created an intrapsychic crisis, as she had several nightmares, woke up terrified and had to sleep with the light on. She entered the next session reporting a dream: the patient was a little girl and she was overtly angry with her mother. She screamed at her mother, who then vanished. Once her mother was gone, a "big black cloud" descended upon her. She also expressed irritation with the therapist for having a magazine in the waiting room (*Vanity Fair*: June, 1991) which she felt glorified the war in the Persian Gulf.

*Pt:* *I'm shaken by that picture of Dolly Parton and Desert Storm.*
*Th:* *Would you like to examine that?*
*Pt:* *Oh, I don't know. I'm just upset. My counseling has been hard lately. I think that comment I made to you just now about the magazine was like an acting out of the dream. I really wanted to say "Why do you have that horrible magazine?" In the dream I was angry – I wanted Mom. She didn't want to be bothered with me. I called out for her but then the blob of darkness descended and took me up. I kept calling.*
*Th:* *Who?*
*Pt:* *I don't know. Mom I guess.*
*Th:* *You're not sure?*
*Pt:* *No, I'm sure. It was Mom. I was getting desperate.*
*Th:* *The feeling?*
*Pt:* *Frantic, absolutely frantic. (Pause) I was not getting help because I was acting out – or, I don't know. I'm feeling scattered – I blocked the dream when I woke up. It's like now, I'm all fidgety and feel like I'm hanging out all over the place.*
*Th:* *But it seems what you're not letting out is the feeling. You're angry at your mother but you don't let it out.*
*Pt:* *In the dream I wasn't holding back.*
*Th:* *And that's what you're saying your mother couldn't tolerate. She left you and then you were vulnerable to the black. Let's see if you can let it out directly here with me.*
*Pt:* *(Pause) I think I'm toying around with you right now. I just felt angry when you seemed impatient with me.*
*Th:* *Can you face that directly?*

For the next 5 minutes or so the patient went in and out of an experience of rage toward me. She would declare an impulse to scratch me, punch me in the mouth and pull my hair, but would chastise herself for it. We worked at pushing the judgements aside.

*Th:* *Let's put the judgements aside, you feel what you feel and in this case it is anger toward me.*
*Pt:* *(With a sudden burst of feeling accompanied by appreciable anxiety in the striated muscle) The last time I was really focused on a part of you, and I didn't realize it until now. You were wearing your red dress and I was focusing on where the V of the dress comes down, by your breast and your heart. So it's something about your heart, you know?*
*Th:* *You want to go for my heart?*
*Pt:* *Yeah.*
*Th:* *How?*
*Pt:* *(Intense anxiety and rocking) Well, it's complicated. I had that feeling of transference and all that stuff – Mom, and going for her breast and her heart.*
*Th:* *Do you have one?*
*Pt:* *Yeah . . . I had an image just now of biting her breast. "Give me that breast" you know, like that (big exhale and sudden reduction of anxiety and tension).*
*Th:* *So it switched to her just then?*

*Pt: Yeah. It's like, "I want your damn breast," you know. Come on.*

*Th: So the desire is so strong and the frustration so great that all you want to do is attack her breast and heart. Is that what you have to do . . .*

*Pt: Yeah, to get some milk. She doesn't want to give it up. I'm imaging saying "I'm going to have your breast whether you like it or not, whether you like it or not. Stop fussing! Don't you fuss! I'm going to slap you across the face. Stop fussing! Let me have your breast right now. Right now! Sit there, don't you squirm, stop your squirming." (pause)*

*"I'm going to have this whether you like it or not. I am going to be in this world whether you like it or not. I am going to be here. Do you know what it feels like to try to find a place for yourself in this world – to try and fit? Do you know what it's like to try to be so good so that you'll be wanted so that, somehow, there will be justification for you being in the universe?" (pause)*

*"I don't find a place where I'm comfortable in your damn house. I have never felt like I had a place in your house. The only time I feel I have a place is when I hide. I have to hide in a closet and then I feel safe. At least I don't have to try and fit – I'll just go hide." (pause)*

*"I don't give a shit if you didn't want me in this world. I don't give a shit if I was a burden to you. I was a baby! I was a baby! I was a baby!"*

The anger in the transference was linked with repressed rage toward the mother. While there was a tremendous amount of anxiety in the striated muscle as the anger began to build, it dissipated rapidly with the passing of the impulse (in this case, it was to bite the breast). Then the rage emerged spontaneously and came in waves. This enabled her to face and put into words that she felt her mother never wanted her.

This material led me to believe that this patient's sense of herself as bad, selfish and unworthy was not a manifestation of a punitive superego, as I had originally thought, but was an introjection of her mother's view of her. The experience of rage toward the mother was an essential step in undoing this introjection and cleared the path for differentiating and then consolidating an authentic sense of self based on her own experience. Rather than accepting responsibility for her mother's impatience, the patient began to see the relationship more clearly and was able to declare "I was a baby!" Then, there were waves of grief and sadness for what was lost. As painful as unearthing these feelings and memories was (it seems impossible to convey the intensity of her feeling on paper), the patient began to feel liberated and, for the first time in her life, could declare a strong desire to live. This seemed to be a crucial aspect of the work and proved a turning point in her treatment.

*Th: Your anger is a reaction to feeling so unwanted and unloved. And there's the sense you would have to fight and claw.*

*Pt: Yes, and I've had to feel guilty about wanting it.*

*Th: Now you are able to declare you needs and your right, as a baby, to have those basic needs met.*

*Pt: Absolutely right! I'm fed up with it, you know. I'm here and that's a good*

*thing. It's a great thing that I'm here. I'm here (smiling, with tears in her eyes), and I want to be here.*

*Th: You don't want to die, to crawl into the hole?*

*Pt: No, no! I want to pound on the piano. I want to plop on the couch. I want to live in the house and live in the world. Because it's good, it's very, very good. And I really think that giving me milk . . . she was lucky to have me and she didn't even know it. 'Cause I am good and I'm a better woman than I was even a little girl.*

*Th: Now you don't have to justify your existence – you can just be.*

*Pt: That's right.*

*Th: It is only as you get through the rage and the pain, that you are able to get to all that you are – the feeling of goodness and joy in life.*

## Process of Mourning

This is material from the next session.

*Pt: I went to visit a woman I've worked with who just lost a breast. And my friend's grandmother died. She was her last living relative.*

*Th: She all alone?*

*Pt: All alone. And I think she was alone even when her Grandmother was alive because her Grandmother was so caught up in her own sadness.*

*Th: These losses – it's something you can reverberate to.*

*Pt: Yes.*

*Th: What about that?*

*Pt: Mourning for what I haven't had – what I might leave behind. I think of living behind the family's sadness. All of my aunts had their breasts removed. But, in a way . . . yesterday was really hard. I was in and out of the hospital all day long but I feel different. Almost feel I was better able to experience this poor woman's pain than she was.*

*Th: The more you can feel your own loss, what it's been like to be alone, you can be there for others in their sadness and you feel different.*

*Pt: Yes I do. I haven't had a real close person die and I think maybe I don't really understand what it's like but at the same time, the sadness of wanting to get to the pain they can't deal with. I see how heavy it is and how much they defend against it.*

*Th: You didn't lose a breast or a close person through death, but you've lost a lot and you can empathize.*

*Pt: It reminds me of Mom and wanting to get through to her, to break through her defenses.*

What seemed so striking here, was the profound effect the previous session had on her ongoing sense of being. Even though the days were difficult, she felt different. She also felt better able to connect emotionally with others and had a desire for greater closeness with her mother, in particular. Another major change was her ability to use her own inner feelings as a gauge of her experience, rather than dismissing it and accepting other's views or projections. This was

illustrated later in the session when she compared the reactions that others have to her now as she tries to get close to them and compares that with mother's reaction, which was to regard her as a pest.

*Pt: When I really was angry and really said "I want to live," I felt so good. And it doesn't mean I want to be disconnected, but more connected. It cannot possibly be a lie if I feel so much more alive and want to be more connected to Mom – it can't possibly be wrong, what I'm feeling. When I start to come down on myself and say "Well, she's really not so bad" – then I start to feel guilty and I know it's less true.*

## Vacation

In the past, free time, and vacations in particular, were torturous for this woman. This session occurred during a week's vacation which she was enjoying tremendously. She came in talking about her loving and erotic feelings for her husband, which had been especially intense lately. She reported lying next to him and "drinking up his scent." She wanted to make love to him but did not act on these feelings, stating, "I think there's another level here we haven't gotten to yet."

*Th: As we do this, you're saying there's tremendous freedom – life is better, richer, fuller.*
*Pt: That's what I basically came in saying. But there's something there, it's still not quite right.*
*Th: But it's scary and tempting to want to get away from it.*
*Pt: I'm imaging me as a small child in a cage, shaking on the cage right now, screaming and going around like a caged animal.*
*Th: How do you imagine this?*
*Pt: It's dark. I'm in a cage, like a beast in a little girl's body. I picture sharp teeth – teething, or something – and imaged shaking, rattling the cage and, uh, wanting to get out.*
*Th: What are you screaming?*
*Pt: No words, just screaming. But, it's like I'm a wild animal and how do you let a wild animal out of the cage? Could do violence. She's so enraged.*
*Th: So if someone were to finally come and respond to your call you say it would be a violent scene?*
*Pt: Yeah. I'd be on all fours like a dog that rips something apart – I'd bite their legs.*
*Th: Who do you see?*
*Pt: My parents.*
*Th: Both of them?*
*Pt: I pictured Dad first. Biting and ripping at his leg with my teeth. He would try to kick me away but I'm a wild animal after all and even small wild animals can be dangerous and vicious. I could get at his veins.*
*Th: You're going for his veins.*
*Pt: Yeah and getting down to the bone. I'm just ripping and ripping and ripping.*

*I taste the blood and it's warm and tastes good. It's kind of like drinking in that scent.*

*Th: What is the feeling as you go to this image?*

*Pt: (Becoming tearful) Well, it wasn't rage so much as it was longing. I just want him. I want him to hold me in his big arms and I want him to give me a bottle, I don't want to have to suck my thumb. It's warm and nourishing.*

*Th: What is this like?*

*Pt: He sees how much I need him. I've been worried about what to do about his leg but, well, he takes care of it and he just wants to hold me.*

This material seemed to confirm, in a very vivid manner, what Guntrip (1969) referred to as "love gone hungry" or desire gone mad. The infant's need becomes rage and despair when left unmet for too long. The image of the cage was clearly a metaphor for the crib. It turns out it was no coincidence that her father is the one who is able to come and deal with the vicious animal. He was the one who was able to, as Winnicott (1958) put it, "survive and accept both aggressive attacks and reparative efforts," which enables the infant to accept responsibility for the impulse and leads to the development of concern. The patient's father was clearly the one who had a closer relationship with her as a young child and, I believe, explains her ability to have formed such a healthy marriage despite her difficulties.

## Derepression of Early Memories

This material is from the following session:

*Pt: I had the most wonderful walk in a nature preserve the other day. It was a journey that was happy but violent. For instance, a bird attacked me.*

*Th: Did, in fact?*

*Pt: Yes, I must have been near it's nest. To see this bird attacking me was out of character but, on the other hand, it's not. I've been thinking about Mom and our last session and I'm wondering if she felt destructive toward her babies. It's strange but I can sympathize with her. You know that impulse, like if you can make something, you have the right to destroy it. You know that childhood feeling of wanting to undo a mistake. You made it so you can destroy it. I can understand that, but it's pretty hard when you're the mistake ... Out there, in that wild place, I was thinking about those wild feelings.*

## Ability to Tolerate Ambivalence

As the patient became increasingly aware of and accepting of her own intensely ambivalent feelings toward those closest to her, she was better able to tolerate evidence of ambivalence in others as well. The patient's mother stood out as her most intensely ambivalent object relationship. When previously repressed memories regarding her mother erupted into consciousness, they were accompanied by intensely painful mixed feelings. On the other hand, she was able to relate to her mother and what she called a childlike desire to undo your mistakes but also state, "It's hard when you're the mistake."

*Th: You sensed that in your mother – a destructive impulse in her?*

*Pt: I'm thinking about a game she used to play with us – it was the only game she ever played. It was called "Shark." We used to paly this when we were down in Florida with my mother's parents. She was "off duty" in a way and would play with us, but this is the only game she ever played. I remember her eyes, those sinister eyes. She would stalk us. It's the only time I remember having eye contact with her.*

*Th: This is the sense of her as devouring and destructive.*

*Pt: I was scared to have her look at me because that was there. We'd both have to face it.*

*Th: How does that feel?*

*Pt: Numb. Like I have to catch my breath. Not so much numb as like every cell is aware.*

*Th: How do you see it?*

*Pt: I see myself on a raft, like the boy in the movie "Jaws."*

*Th: You see a little boy?*

*Pt: Well I remember vividly having an ear infection and being on a raft in the pool.*

*Th: You do?*

*Pt: Yeah.*

*Th: You sense her lurking?*

*Pt: Instinctively wanting to kill me.*

*Th: What does that mobilize in you?*

*Pt: When you're a child on a raft you're helpless to a large predator, so I don't even know how I'd do it . . . how I'd do it, ha ha ha.*

*Th: You mean fight?*

*Pt: Fight for my life, before I was killed.*

*Th: It looks like that was the situation, it's you or her.*

*Pt: When I was home this winter with my sister and Mom at the mall and she said "I had dreams too." I know very well what those dreams were, they were dreams without us, dreams of a childless life. Those are her fantasies.*

*Th: She told you this or . . .*

*Pt: Oh yes, her dreams of being with Tom Selleck are of a childless life. She's always telling us about that.*

*Th: So that's what she wanted and, specifically, not to be alone but to have a man all to herself without children getting in her way. So more and more evidence that a part of her wishes to wipe you out, this has been a mistake in her life.*

*Pt: (Nods) The adrenaline is up. The defending my life mode is inside of me.*

*Th: How would that go, to fight for your life and defend yourself against this murderous mother?*

*Pt: I have to get out of the pool. I might be cut in the bargain but I must get out of the pool, out of her domain, where she's stronger and, I guess, I'd have to keep her there. When I get out on land I'd be in some control.*

*Th: First, you get out of danger and on safe, dry land.*

*Pt: It's hard to do this. I image having to have something to hit her hands so she can't get up on land.*

*Th: You'd bat her down?*

*Pt:* *Yes.*
*Th:* *'Cause you see her coming after you.*
*Pt:* *Yes ... Well, not really. Once I get out, the game is no longer. The shark face stops and it stops, so it's only if I go into the water, only if I go in the water.*
*Th:* *It's very specific. You sensed if you got too close, in her space, with eye contact, that's what's dangerous and evokes the devouring instinct in her. The way for you to survive is to get out. And it's safe but detached, out.*
*Pt:* *My sense of that safe place is cement where I remember falling. It's hard, nothing soft at all. The water is still more attractive, you know.*
*Th:* *So you want to dive in but it feels dangerous. It's the same with (husband) and everyone really, to get close is somehow dangerous.*
*Pt:* *There was no safe, warm place (shakes head and becomes tearful). (Pause and tears pass.) I'm amazed of the image of the pool – it's so clear. My 29-year-old self is fascinated, how the truth is told in this game of the shark.*

The patient's newly developed ability to face the truth she had previously defended against by internalizing these feelings of dread had a profound effect on her.

Winnicott (1965) stated, "I think it will be generally agreed that id-impulse is significant only if it is contained in ego living. An id-impulse either disrupts a weak ego or else strengthens a strong one." What will be so clearly displayed in this next session is how facing her own feelings and impulses, as well as those she perceived in her mother, have strengthened the ego and led to massive character change. In the past, such feelings and memories would have led to immobility.

## The Consolidation of the Self

This is the final session of this sequence. She looks, feels and behaves in a flowing and integrated fashion.

*Pt:* *This is my peasant garb. I bought it last week, during my vacation. I'm walking around and it's like wind chimes (motions to earrings).*
*Th:* *How do you feel? Because you look great and even your body movements seem more free-flowing.*
*Pt:* *It's fun. I don't usually think of this kind of skirt as me, but I feel good wearing it so ...*
*Th:* *It's a part of you.*
*Pt:* *A part of me, yes. And I go such different ways about my hair. I love having it down, I do, I just, I do, but lots of times I put it back (in fact, most of the time). It's nice to have this feeling. And I never buy earrings this big, this freaky. It feels nice. It feels free.*
*Th:* *That part of your is coming out more and you're drawn to things that express that?*
*Pt:* *Um hum. It's kind of nice. I even think when I go to work today, it's different and I feel different. Sometimes I think others notice too; even when I'm not*

*dressed differently. Maybe others are easier in my presence. Yesterday I had a day that was very happy. It was a very difficult work day. It was the first day of the program for the children and we had hordes of kids, which was too much, but I had a great time. There were some struggles but they had fun and I had fun. Even the boy who said "This is boring!" ended up enjoying the project. Even, OK, I had come up with a theme song. I thought, "Oh, this would be a great theme song." Well, the kids didn't know the song. It's their kind of music, it's Reggae, it's up, but they don't know it. They know M.C. Hammer, Vanilla Ice and C & C Music Factory. So they didn't want it. But, I'm OK, that's OK, it can still be my theme song.*

The patient went on to talk about several difficult tasks and trying interactions with others that she handled with aplomb. Her internal sense of calm and well-being pervaded and she felt able to connect with others, despite their differences.

This patient's physical appearance changed as psychological changes became consolidated. She entered treatment looking very tense and timid. Although statuesque, she tended to crouch and seemed to want to make herself disappear. Her voice was low and constricted. As she became increasingly able to tolerate all of her own intense and conflicting affects and to accurately perceive those in others without needing to defend against them, her whole body presence became relaxed. While she had previously looked almost boyish, by this last session, her hair was flowing and her clothing was feminine and sensuous. She was now able to be feminine and sexual with her husband without fear of abandon and, of particular significance, she decided to become pregnant. This seemed the final step in coming to terms with the conflict that had signified her relationship with her mother. Now she could look forward to motherhood and was not afraid that her own inevitable ambivalence toward the baby would be overwhelming. This naturally ushered in the theme of termination.

## Summary

Case material was provided to illustrate the process of character change, as it occurs in Intensive Short-Term Dynamic Psychotherapy (IS-TDP). It is the thesis of this paper that patients described as self-sacrificing, while highly functional in many respects, frequently have an internal self representation that is grossly distorted and has been based on the internalization of negative parental introjects. In many respects, their outward appearance and behavior constitutes what Winnicott (1965) called a "false self." There is a marked disparity between their internal sense of themselves as bad, selfish, and unworthy and their outward manner, which is typically exemplary. The "true self," or real feelings and perceptions of self and other, gets buried and is covered over by the "false self" which adapts to the environment and protects the "true self" from harm.

Davanloo (1990b) has demonstrated that the most accurate and timely means for obtaining an assessment of ego functioning is to gain access to the unconscious. Once the patient has faced his own true feelings and impulses, the need to distort memories in order to avoid these dreaded feelings is no longer

operative, so a clear view of the past becomes possible. Before "the unlocking of the unconscious," Davanloo warns that information about the past is highly suspect.

While "getting to the truth" of one's own repressed feelings and impulses is an essential step in this process, it is only the beginning. It is the experience of these feelings which leads to the derepression of crucial early memories. Obtaining this information allows patient and therapist to understand the situation faced by the child and makes symptoms and defenses comprehensible. The patients, who had been so harsh and critical of themselves in the past, gain an appreciation for their attempts to adapt to harsh and unforgiving circumstances.

Those (Pine, 1985) who study mother–infant pairs stress that the input from primary caretakers is enormous and argue that it is not given anywhere near its due in classic psychoanalytic theory. It has been argued that the crucial early years of development are organized, not solely or even primarily around instinctual factors, but include other aims, experiences and developmental tasks. Of particular importance are primary attachments, the development of basic trust and self–other differentiation. It seems that Davanloo has erred in the same fashion as the classic analysts, by putting what appears to be a nearly exclusive focus on the patient's impulses and feelings (the instinctual life) while minimizing the very real effects of parental neglect and abuse.

While there are clearly cases, like those he outlined in his paper on superego pathology, where a self-punitive dynamic is operating, in the majority of cases in which there is self-loathing, I have found evidence for both a negative parental introject and an attempt to spare the parent by accepting this introject. If this is the case, then interpreting the patient's suffering as punishment for their own sadism runs the risk of confirming their worst fears ("I must be a hateful person") and may deepen their despair. In other words, this kind of interpretation ("Do you see how you beat yourself up as a way of punishing yourself for the impulse to beat your mother?") can reinforce the patient's tendency to assume blame, rather than to understand their feelings as a reaction. To maintain a focus solely on intrapsychic processes reinforces this tendency. I believe it is crucial to recognize and articulate that such feelings were reactions to trauma.

Once we have gained access to the unconscious, we need to step aside and let it speak. In this case, once the patient's rage toward her mother was understood as a reaction to frustrated longings (as opposed to confirmation of her innate "badness") and the impulse to bite the breast (not to murder the mother, as might be the case with one of Davanloo's self-destructive patients) was experienced, the patient's symptoms, which were a veiled expression of this, were no longer necessary.

Once the patient's own feelings and impulses were fully experienced, her perception of her mother's hostility also became clear. This had to be dealt with as a very real factor in her development and not as a projection.

Object relations theory provided a context within which to view and understand both the impact of the early relationship between mother and child on development and the ways in which facing previously repressed and dissociated memories and feelings lead to profound changes in perceptions of self and other. The integration of Davanloo's techniques of unlocking the unconscious with

object relations theory and developmental psychology provided a powerful and comprehensive basis for providing a therapeutic environment within which major character change has been able to occur in a matter of months (6–18 months is typical, in my experience), rather than years.

## Bibliography


Bowlby, J. (1969). *Attachment* (New York: Basic Books).

Bowlby, J. (1973). *Separation: Anxiety and Anger* (New York: Basic Books).

Bowlby, J. (1980). *Loss: Sadness and Depression* (New York: Basic Books).

Davanloo, H. (1980). *Short-Term Dynamic Psychotherapy* (New York: Aronson).

Davanloo, H. (1988) Clinical Manifestations of Superego Pathology, *International Journal of Short-Term Psychotherapy, 3*, 1–24.

Davanloo, H. (1990a). *Unlocking the Unconscious* (New York: Wiley).

Davanloo, H. (1990b). The Process of Working-Through in Short-Term Dynamic Psychotherapy. Presented at the Summer Immersion Workshop, Killington, Vermont.

Fairbairn, W. (1952). *An Object Relations Theory of the Personality* (New York: Basic Books).

Fenichel, O. (1945). *The psychoanalytic Theory of Neurosis* (New York: Norton).

Freud, S. (1920). *Beyond the Pleasure Principle*. Standard Edition, Vol. XVIII.

Freud, S. (1924). The Economic Problem of Masochism. Standard Edition, Vol. XIX.

Freud, S. (1931). Female Sexuality. Standard Edition, Vol. XXI.

Greenberg, J. & Mitchell, S. (1983). *Object Relations in Psychoanalytic Theory* (Cambridge: Harvard University Press).

Guntrip, H. (1969). *Schizoid phenomena, Object relations and the self* (New York: International University Press).

Laikin, M., Winston, A. & McCullough, L. (1991). Intensive Short-Term Dynamic Psychotherapy. In Crits-Christoph, P. & Barber, J. *Handbook of Short-Term Dynamic Psychotherapy* (New York: Basic Books).

Mahler, M., Pine, F. & Bergman, A. (1975). *The Psychological Birth of the Human Infant: Symbiosis and Individuation* (New York: Basic Books).

Pine, F. (1985). *Developmental Theory and Clinical Process* (New Haven: Yale University Press).

Reich, W. (1945). *Character Analysis* (New York: Orgone Institute Press).

Stern, D. (1985). *The Interpersonal World of the Infant: A view from Psychoanalysis and Developmental Psychology* (New York: Basic Books).

Winnicott, D. (1958). The Sense of Guilt. In *Through Paediatrics to Psychoanalysis* (London: Hogarth Press).

Winnicott, D. (1965). The Capacity to Be Alone. In *Maturational Processes and the Facilitating Environment* (New York: International University Press).

Winnicott, D. (1975) Ego Distortion in Terms of True and False Self. In *The Maturational Processes and the Facilitating Environment* (New York: International University Press).