CASE STUDY

Narrowing down the therapeutic task in ISTDP

JONATHAN J. ENTIS, PHD
PSYCHOLOGIST IN PRIVATE PRACTICE, BELMONT, MA. LECTURER, PART-TIME, HARVARD MEDICAL SCHOOL, DEPARTMENT OF PSYCHIATRY

THOMAS HESSLOW
CLINICAL PSYCHOLOGIST AT THE MALMÖ CENTER FOR ISTDP, MALMÖ, SWEDEN

Abstract

Effective use of the therapeutic alliance is key to successful therapy across different treatment modalities. In this article we argue that one of the distinctive features of ISTDP is how the therapist manages the therapeutic alliance by narrowing down the therapeutic task again and again throughout the treatment. ISTDP therapists need to strive for absolute clarity about different emotional and defensive responses, in order to keep the therapeutic alliance firmly directed towards emotional experiencing and resistance relinquishing. What is more, the patient must also share this understanding of the task at hand and bring full willingness to join with the therapist to accomplish it. This process is illustrated by pieces of transcript from a successful treatment course, where we show how the therapeutic task is developing along the different stages of the therapeutic process. Maintaining a narrowly defined task is the central means to keep treatment intensity up, and a sine qua non of facilitating major unlockings of the unconscious.

Keywords: ISTDP, unlocking of the unconscious, the therapeutic alliance, the therapeutic task, emotional experiencing, resistance relinquishing, case study.

CONFLICT OF INTEREST STATEMENT
TH serves on the Editorial Board of this journal in the position of Editor-in-Chief. TH did not participate in the peer review process, nor in the decision making procedure regarding acceptance of the manuscript for publication.

ACKNOWLEDGEMENTS
We're very grateful to the courageous patient who accepted to have his treatment dissected and discussed in this candid way. Jonathan wishes to thank John Rathauser and Patricia Coughlin for their mentorship and friendship throughout the years. Thomas wishes to thank Jon Frederickson, Ange Cooper, Allan Abbass, Tobias Nordqvist, Peter Lilliengren and Jonathan Entis for teaching him the task of doing therapy. We also want to thank Johannes Kieding, Hanna Pedersen, Peter Lilliengren, Maury Joseph, Aspasia Karageorge, Katarina Kiiskinen, Joel Gruneau Brulin and the two anonymous peer-reviewers for revising different versions of the manuscript and providing us with invaluable feedback.

CORRESPONDENCE
Correspondence concerning this article should be addressed to Jonathan Entis, drjonathanentis@gmail.com

AUTHOR CONTRIBUTION STATEMENT
Jonathan and Thomas contributed equally to the conceptualization, writing and editing of this article.

38

Narrowing Down The Therapeutic Task

In the 1970s, the psychotherapy researcher Edward Bordin created a conceptualization of the therapeutic alliance dividing it into three parts: the affective bond, the therapeutic goal and last, but not least, the therapeutic task (Bordin, 1979). The bond refers to the quality of the relationship between patient and therapist. The goal is the desired outcome of the patient and therapist, to be achieved through the therapy process. The task is what therapist and patient actually do together in order to reach the defined goals. In ISTDP, the treatment goals and the relationship bond are not necessarily different from other forms of treatment. The goals typically are to resolve some kind of emotional, relational or physical symptom (e.g., to eliminate depression). The bond, just like in any other treatment, needs to be strong for the therapy to work (e.g., the therapist respects the patient). However, the series of treatment tasks are unique.

In many forms of psychoanalysis, the task of the patient is to freely associate, while the therapist is employing evenly suspended attention, clarifying, confronting and interpreting the material the patient brings (Freud, 1912; Gabbard, 2014; Caligor, Kernberg & Clerkin, 2007). In many forms of behavior therapy, the in-session task of the therapeutic dyad is to conduct in-vivo exposure to feared stimuli, and to evaluate and develop plans for behavior change (Barlow, 2004). In ISTDP, the patient's therapeutic task is to explore and somatically experience previously unconscious feelings, and the task of the therapist is to invite the patient to experience feelings, help the patient identify anxiety and defenses blocking access to these emotions, and apply pressure on the patient to remove these obstacles (Davanloo, 2000). In cases where the patient lacks capacity to experience their unconscious impulses, the task grows to involve developing that capacity (e.g. strengthening the patient's tolerance of anxiety).

Today, emotion-focused psychotherapeutic models are flourishing. This is true for many psychodynamic models, such as panic-focused psychodynamic psychotherapy (Milrod, 1993), Transference-focused psychotherapy (Clarkin & Kernberg, 2015), neuropsychoanalysis (Solms, 2021) and even more mainstream psychoanalytic models (Shedler, 2022). It is also true for cognitive-behavioral models, such as the Unified Protocol (Barlow, 2018), Acceptance and commitment therapy (Hayes, Strosahl & Wilson, 2009) and Dialectical behavior therapy (Linehan, 1993). All of these therapies in one way or another have put experiencing feelings in the center of the therapeutic model. So is ISTDP any different? On an overarching level of treatment goals and tasks, ISTDP has much in common with these other models. All of these models help patients approach avoided feelings, and as we know from the psychotherapy literature at large, different therapies seem to have roughly equivalent outcomes on average (Cuijpers et al., 2023; Wampold, 2015). And within different models of psychotherapy, in-session emotional exposure in different ways has been shown to be associated with better outcomes (Spriggs, Kettner & Carhart-Harris, 2021; Town et al., 2022; Diener, Hilsenroth & Weinberger, 2007).

On a more detailed level, the in-session tasks and goals are more narrow in scope in ISTDP compared to other models. This is mainly due to a more precise definition of experiencing feelings employed in ISTDP; rather than just relying on patient subjective descriptions of "feelings," in ISTDP we make structured use of therapist-rated non-verbal signs to determine if someone is actually experiencing feelings, or not. In ISTDP, if a patient states that they are feeling sad, but their facial expression, tone of voice or posture suggest otherwise, the therapist is instructed to clarify this discrepancy (Davanloo, 1986). This narrow concept of feelings came from Davanloo's understanding of the role of resistance in relation to experiencing feelings. Davanloo saw the task of overcoming resistance as deeply intertwined with experiencing feelings: "One of the main aims of all forms of dynamic psychotherapy is to enable the patient to experience his true feelings, but this can only be accomplished by overcoming resistance." (Davanloo, 1986, p. 107). The task of emotional experiencing is thus intimately connected to the task of relinquishing resistance.

The therapeutic task in ISTDP is of course not limited to the main tasks of experiencing feelings and letting go of resistance. During the initial moments of an ISTDP therapy, the task is to establish a joint understanding of the presenting problem, map out the patient's defensive structure, test their capacities to tolerate anxiety and painful affects, and conduct a diagnostic evaluation. Only when these overarching tasks are accomplished, we can begin to focus on the task of restructuring and removing resistance, building capacity to tolerate anxiety where necessary, and experiencing feelings when that door is open. With patients whose resistance is not pervasive and whose anxiety is not at intolerable levels, the task is mainly to apply pressure to get in touch with feelings. With patients with syntonic resistance, i.e. a defensive system with which they are highly identified, the task is to make syntonic resistance dystonic through a stepwise application of pressure, clarification, challenge and, when the time is apt, head-on collision. And with patients who have a fragile character structure, the task includes increasing their capacity to tolerate anxiety, using the graded format of ISTDP (Davanloo, 1987b). All of these different tasks, which we've schematically summarized in Table 1 below, create the frame which lets us focus on the central task of ISTDP: feeling feelings in such a way which leads to an unlocking of the unconscious. The unlocking of the unconscious should thus be seen as

TABLE 1: THE OVERARCHING THERAPEUTIC TASKS AT THE DIFFERENT PHASES OF THE ISTDP SESSION.

PHASE OF SESSION	THERAPEUTIC TASK
Initial phase	– Establishing therapeutic alliance: bond, problem, task and goal – Psychodiagnostic evaluation (trial therapy)
Mid phase	– Clarifying, pressuring, and challenging resistance – Focusing on feelings – Increasing anxiety-regulating capacity (if needed) – Restructuring resistance (as needed) – Unlocking of the unconscious
End phase	– Working through of unconscious material – Cognitive-affective integration of learning – Treatment planning (trial therapy)

one of the treatment tasks, which increases the probability that the treatment goals will be achieved.

The narrow series of tasks in ISTDP as we discuss them in this article were defined by Davanloo and described as the Central Dynamic Sequence (Davanloo, 1989). In the present article, we use a case study to illustrate the intensive nature of the narrowly defined therapeutic task in ISTDP. As the therapy process gets stuck, the therapist is confronted with the difficult question of how to proceed with therapy when the patient is not willing to do the task – should the task change or is therapy no longer possible? We argue that the narrowness of the main therapeutic task is one of the central features of ISTDP that makes it hard to learn, but also one that makes it highly effective when mastered. Furthermore, we see the narrowly defined therapeutic task of ISTDP as one of several features that could be of benefit to other affect-focused therapies (Thoma & Abbass, 2022).

A Case of Syntonic Character Resistance

A 27-year old man presented with highly syntonic character structure and great difficulty identifying internal problems he wanted to resolve. Lack of clarity about the nature of the problems is a common consequence of having a highly syntonic character structure, as the overidentification with the resistance (i.e. "I can't feel anything", "I'm worthless") blocks a detailed knowledge of the inner world. The therapist initially worked to help the patient clarify the problems bringing him to therapy, which included problems asserting himself, difficulty resolving conflicts, a history of cheating on his girlfriend that he does not understand and worries he will do again with his next partner, a history of problematic alcohol use, and generalized anxiety. The patient has provided written consent for publication.

As is typical in ISTDP with syntonic patients, the therapist spent much of the early session attempting to help the patient link his presenting problems with difficulties regulating unconscious emotional conflict. The therapist focused heavily on aiding the patient to see and differentiate the corners of the triangle of conflict (anxiety-feeling-defense), using examples both in his current life and in the here-and-now relationship with the therapist (the transference). The patient demonstrated a syntonic and rigid belief that avoiding negative feelings was in his best interest, and he struggled to understand how ignoring feelings could harm his mental health.

The patient's flat vocal tone, global confusion around emotions and social interactions, and detachment raised questions about constitutional factors, such as the autism spectrum, that may limit what is possible in psychotherapy. Initially the therapist adjusted his expectations and worked slowly with areas of confusion, trying to determine if an emotion-focused therapy was even possible.

The Trial Therapy

In the trial therapy, the patient reports that he simply does not understand why feelings like anger or sadness are helpful to feel or share. The following short vignette demonstrates some of the early work in that first session which focuses on linking the patient's problems with the triangle of conflict, and in particular the way the patient avoids his feelings. The therapist's attempts at clarification are initially met with irritation and hostility, and the task of building a working alliance, which is complicated

with patients with heavy levels of syntonicity, takes priority. Thus, the therapist intervenes to deactivate projections relating to will, defiance, and other expressions of transference that are contributing to the difficulty of forming a solid working alliance. The following excerpt from the transcript of the trial therapy is meant to demonstrate the patient's level of syntonicity:

Patient: A reason why... A reason why I'm feeling uncomfortable about this process is that I feel that there are certain value judgments being placed on me wanting to, you know, not necessarily express negative emotion. I don't see that as necessarily as much of a negative problem as like it might not be the best thing for me to do, but I don't think that it's necessarily a bad thing that I carry myself in life... as somebody who wants to minimize the bad and project the good only.

Therapist: I'm never here wanting to push you to do something you don't want to do. And I want to just look at your statement, that there's a part of you that doesn't like you sharing tears with other people. Okay? You'll, you'll express the feeling verbally with ease. And I see that. But when it comes to actually demonstrating the feeling, sharing the feeling itself, there's something inside that doesn't want to do that.

Patient: Yeah.

Therapist: And, and so then, you know, we earlier we talked a lot about anger, but now I'm getting a picture that it's not really just about anger... that there's an issue here about emotional closeness.

Patient: Yeah. It's the emotional closeness of anger, of sadness. But also, like I said earlier, like a little bit of sharing joy and success. My success, I think. And it's another thing where... for whatever cosmic reason or whatever... I've always been the person where... I've had people offload a lot of suffering or challenging issues to me but I don't tend to share with them.

An Impasse

As the patient and therapist work together, the problems surrounding emotional closeness are clarified and linked to his presenting problems. The therapist helps the patient see how his avoidance of emotional openness in session, that is, his avoidance of the therapeutic task, is blocking him from reaching his goals of resolving his presenting problems. The focus on syntonic resistances remains a therapeutic focus for the first few sessions, as the patient slowly is able to understand his defense mechanisms and how they affect his life and the treatment. Every effort is made to make the syntonic elements of the resistance dystonic, and it is determined within a few sessions that the patient can withstand an unlocking of his unconscious. The patient comes to understand that the task of experiencing his feelings and sharing them with the therapist is a path towards resolution of his difficulties, as he sees that avoidance of his feelings generally is causing great suffering in his life. Nevertheless, he reports lacking the conscious motivation to fully explore his feelings, and in particular reports wanting to consciously avoid exploring his angry impulses because it is against his "beliefs." Despite acknowledging that he indeed has angry impulses–both towards the therapist and others in his life– and that continued avoidance of them is causing him suffering, he reports he simply does not want to examine them.

Taking a Break From Treatment

"I can walk out when we say good-bye to each other, and accept that I failed. I can afford to be a failure – what can I do? I can do my best and say, okay I failed, what can I do further? But can you afford to be a failure?" (Davanloo, 1989b, p. 45)

By the end of the sixth session, the therapist and patient both sense that the therapy is getting stuck. The patient is consciously avoiding the therapeutic task at hand – to get fully in touch with his mixed feelings. He does not want to be fully emotionally open with himself nor the therapist. The therapist keeps the task narrow as he respectfully tells the patient that without a commitment to re-establish an inner connection with himself, to examine his feelings fully, the treatment has reached an impasse and there is no point in continuing to meet. This part of the head-on collision is designed to deactivate defiance and the omnipotent transference. The therapist also tells the patient that if he changes his mind and is at some point willing to explore his emotions, he should feel free to get back in touch with the therapist to resume treatment.

This intervention should be seen as a part of an extended head-on collision with the resistance, where the patient is faced with reality: if he keeps an emotional wall up with the therapist, therapy will be useless as no work on experiencing feelings can take place. The therapeutic task is impossible. This intervention can only work if the therapist can effectively and honestly convey a sense that this discussion is in the service of the patient's growth. Otherwise, the patient might believe he is being abandoned or feel criticized. Following the intervention, the patient acknowledges the impasse, and agrees to take a break from the treatment so that he can reflect on whether he really wants to do this work. This marks the end of the first phase of the treatment, where the graded format was applied in an effort to make syntonic resistances dystonic (Whittemore, 1996). This was partially successful, as the patient gained a stronger sense of how he was engaging in behaviors that were to his detriment. But since he was unwilling to fully let go of these behaviors, no major changes were happening in his life.

In other forms of therapy where similar stuck points are reached, the therapist might decide to bide his time, lean back

and see if the process will work better in subsequent sessions. We suggest that in ISTDP every effort should be made to refuse a collusive relationship, including proposing termination in the way described above if a patient has truly declared an unwillingness to take on the tasks of treatment. As part of a head-on collision with the resistance, this is one of the ways in which ISTDP establishes and maintains a uniquely narrow concept of the therapeutic task. As Davanloo aptly put it in the case of the BB Gun man, "If you don't care to look at yourself and ramble around, then why are you here?" (quoted in Schubmehl, 1995, p.10). Rather than seeing this as premature termination, we argue that this is an attitude of treating the patient in a very respectful way, keeping the door open for more therapy if and when the patient is willing to do the task of emotional experiencing and resistance relinquishing.

Ready For The Task of Therapy

After a six week pause, the patient wrote to the therapist saying he did indeed want to continue treatment. The therapist begins the session by emphasizing the therapeutic alliance: framing the problem, task and goal in order to set up the session with optimal chances of boosting the alliance and, eventually, unlocking the unconscious. This is session seven.

Therapist: Also, I think it's important to get clear on the problem, task and goals. That's how I like to think about it. Okay. So let's revisit that. But, you know, my sense is what we've talked about over the few months that we worked together is that, you know, one of your, one of your goals is to deepen access to emotion so that you can have better relationships with yourself and with other people.

Patient: Yes.

Therapist: Because you're recognizing that the blockage and the disconnection is ultimately hurting you and sabotaging what you want out of your life, right?

Patient: Yeah.

Therapist: Does that sound right?

Patient: Yeah. I think that's like the biggest thing is to just let like... Like a way I've been thinking about it is to figure out a way to kind of open the doors completely so that when emotions come, I can fully realize them, fully become in touch with them and then handle them and communicate fully rather than have them be like they were before. Some emotions were completely closed off. And now it's like the gates are partly open, right? Um, but then, you know, that's why I want to keep going because, you know, they are partially open and that feels really good. And I've been noticing the fact that I'm more in touch and can communicate better.

The patient is describing some partial benefits from the treatment, and some previously syntonic, rigid elements of his resistance have given way to greater emotional flexibility – dysonification. The therapist again frames the task at hand, aiming to continue the task of making syntonic resistance dystonic.

Therapist: So then part of our task, okay–

Patient: [sighs]

Therapist: based on what we've seen, is to get you deeply in touch with all your emotions. And there is a place for rage because we know you have rage. All right? And I know you don't like that, but that is a piece of what we've seen. And we know that when we start to look at that, there is going to be a part of you that resists that. And that's just a part of the process. There's no criticism there. It's just, it's just part of what happens. All right? But then the success of this work, or failure, is going to be determined by whether there's a true willingness to overcome that resistance and get deeply in touch with emotions like rage and others that you find to be anxiety-provoking.

Here, the therapist has provided a few clarifications. First, he has clarified the corners of the triangle of conflict and their links (feelings-anxiety-defense/resistance). Second, he has highlighted the positive task (to get in touch with his emotions), the negative task (the patient's responsibility to overcome and stop his resistance), and the stakes (success or failure rests on willingness to push past resistance). This type of clarification boosts both the conscious and unconscious alliance.

Therapist: Okay? So with that in mind, let's look at whatever you're wanting to look at so that we can help you get in touch.

Patient: [takes a sip of water] Yeah. Okay. That's helpful. Yeah. Um, so today, I think I want to talk about is...

The patient reports he wants to talk about his relationship with his brother, and in particular how the brother did not respond to him over the holidays when he tried to coordinate a trip to see him.

Patient: And then right when I asked him, I said, "Hey, I'm trying. It was a very like A to B text, it was like, hey, I'm trying to coordinate this trip, like I mentioned. Um, do you have any update on your paid time off? And then no response! Like nothing immediate. It was like a second right after I texted him about, you know, this other thing. And he was engaged and texting. And then when I text about this, there's just nothing. And then....[patient takes a long pause

and has a sad look in his eyes, which are going to the ceiling]

Patient: So that, that definitely...

Therapist: You just paused. Did you have some feeling as you...?

Patient: [sighs]. I do, I mean [patient again wells up, takes a big sigh].

Therapist: Let's see. Hold on to it. It's very important. Just hold on to your feelings. Something painful is coming up. But your eyes are going down with your pain. Stay, stay with me. Let's do this together, okay?

Patient: [takes a big sigh] The feeling that's welling up inside me is... One of I mean, it's a lot, it's very, it's a, it's a feeling of sadness. Right? But it also, it's like a feeling of like helplessness in a way. It just feels like I keep knocking at the door and trying to have these conversations and try and be, you know, fair and straightforward and trying to, like, have normal conversation and also just try and like.... Basically just have this trip with him and like, see him. And when I'm communicating about trying to make sure when I offer that I will cancel my trip so I can see him. And then he doesn't respond to a text trying to coordinate that. That really, really fucking hurts! [patient looks on the cusp of tears, but holds back]

Therapist: Yes, it does. And that's understandable. Make... make some space for this. This is an honest feeling. But here also, I'm wondering, as you're sitting here, you know, there is some blockage to the feeling. But also, what I'm wondering is, what else are you feeling? Because, you know, you're saying you're knocking at the door and like no one's answering, basically, and you're getting the runaround. What are you feeling other than sad?

Patient: I feel angry.

Therapist: Were you aware of that or am I only now drawing your attention to it?

Patient: I was aware of it.

Therapist: You were?

Patient: Okay. And when I think about it, it's conflicting. It's like both of them, put together. Um. And, you know, in the past, like there were, I would feel guilty. I don't feel guilty now. But I do feel angry because, I know, that this behavior is not acceptable to me. But I haven't communicated that to him.

Therapist: Okay.

Patient: I let that text sit. I haven't responded to it, you know.

Therapist: Fair. Fair enough. Let's try to get you clear on all of your feelings. And then, you know, you might put something into action, but best to get clarity internally before you put something out.

Patient: [nods]

Therapist: You say you're angry, right? How do you experience your anger towards him?

Patient: I... the recurring pattern, whenever I feel really angry towards him is I want to hurt him verbally. Like I want to...

Therapist: But we'll look at impulses later. Okay? We'll look at that. But first, physically, let's try to see how you feel it physically.

Here some feelings were beginning to break through, but resistance showed up and blocked their full passage. This indicates that more resistance work needs to be done at this point. Here, the positive task of experiencing feelings needs to be complemented in a more comprehensive fashion with the negative task of making the resistance come to an end. Even at this stage, when feelings are beginning to break through, the therapist's task is still to turn the patient against any residual resistance, clarifying all the major and minor obstacles that block feelings from fully breaking through.

Patient: It's really my jaw.

Patient: It gets very tense and locks up.

Therapist: But when you say "locks up," you know, because your jaw can tighten with anxiety or it can tighten with rage. The rage feels more like strength, like you want to bite. Whereas...

Patient: Yeah. It's not like an aching. Yeah. It's like [patient bites down].

Therapist: Okay.

Patient: Yeah.

Therapist: What else?

Patient: My quads, like are, feel strengthened. And it kind of moves up into my upper back. Like, it's not like I'm hunched, but, my back feels tight.

Therapist: Tight.

Patient: Yes. And then feel it kind of loop in my lats.

Therapist: But "kind of" in your lats. Or you do feel it in your lats?

Patient: I feel. I feel it. Not "kind of." Yeah. I feel it in my lats and it works up to, across my biceps. But if I stick with it, I feel it in my fingertips. Like in my hands.

Therapist: But also listen to your voice. There's almost no feeling there. Now, again, I want to, I want to be clear. I'm not talking about yelling, which would be discharge. But, there's... your voice still actually sounds more sad than anything else. Sad, kind of deflated. There's no anger in it. And also, your face, too, also looks more sad and deflated than it does angry. See, I'm trying to draw your attention to all the areas of disconnection that you're carrying.

Patient: Mhm.

Therapist: So to deepen access to the feeling means to end that

type of disconnection. Okay? How else do you feel that if you don't disconnect?

Patient: Like I feel it in my chest.

Here the patient is referring to the beginning of the breakthrough of the physical pathway of rage, but vagueness is still standing in the way. The therapist is keeping the task narrow by providing pressure for clarity and challenging the patient not to disconnect.

Therapist: But "like" you do, or you do?
Patient: No, I do [patient's eyes are looking away].
Therapist: Where are your eyes going?
Patient: And, what?
Therapist: Your eyes were going over there.
Patient: Yeah.
Therapist: I know, but is it easier to talk to the wall about your anger than it is me?
Patient: Yeah.
Therapist: Okay. But see, this is. These are the disconnections, right?
Patient: [Sighs]
Therapist: Like how you learned to hide anger from Dad so you don't show it in the face, you inhibit it, you don't show it in the voice. You don't make eye contact. It's the hiding you learned.
Patient: That actually makes a lot of sense. Yeah.
Therapist: Try to come out of your shell and, you know, just be you. You're angry. You don't need to hide it.

Here the therapist uses a number of interventions to clarify and apply pressure on the patient's wide array of non-verbal and verbal defenses – deadening of the voice, inhibition of facial expression, use of indefinite speech and cover words. This both increases complex transference feelings and shifts the process into the therapeutic relationship, as the therapist's interventions are both appreciated and a source of irritation for the patient.

Therapist: How do you experience it?
Patient: I mean. Yeah, like it's, I feel, I feel it, you know, up and down my arms. And I feel it in my quads, my legs, like I said. And. But it feels like I'm bracing my lats and my back to, like, be ready to confront something.
Therapist: What do you mean, "something"?
Patient: Well, him, I mean, to confront like that.
Therapist: Why do you put it on "something"? If it's him, why do you put it on "something"?
Patient: [Patient again looks away, shakes head and smirks].

Here we see the first signs that we're reaching a mid rise of complex transference feelings: eye avoidance and smirking emerges (Abbass, 2015). At this point, feelings in relation to the therapist, and the therapist's way of helping through using pressure and challenge, are becoming stronger. The patient is starting to resist emotional closeness in a more pronounced way in relation to the therapist. The therapist takes note of this, slowly preparing to tilt the task from exploring feelings with the brother to feelings about the therapeutic relationship.

Therapist: And you're smiling.
Patient: Because, it's, I mean... [eyes continue to be away].
Therapist: And looking away again.
Patient: I can intellectualize it, but it's really because I feel...
Therapist: To intellectualize it means you don't want to get to the core of it and you want to circle around it. To intellectualize it would be to say that we're not able to actually go right to the feeling and examine it. That there's some part of you wanting to distance from that.
Patient: Right. I mean, there's a feeling of guilt, too, and I said earlier, like it's [pauses].
Therapist: But guilt about what? What are you guilty of?
Patient: Well, truly, what it is, is like feeling that... So, like I'm stopping myself because I know my anger is justified. I know it, but I don't fully feel it. And what I do feel is like feeling like he doesn't fully deserve it because he's a tortured person.
Therapist: What I'm hearing, though, is not true guilt, but a kind of rationalization where you, you rationalize away your feeling and basically invalidate yourself and say, "I don't have a good reason to be angry because X, Y, Z. Or they don't deserve my anger because of X, Y, Z." That's not guilt, that's self-attack. That self-invalidation. Another way to stop yourself from having your honest feelings. You know, I want you to look at all these mechanisms and for yourself, decide if they're what you want to hold on to or if maybe this is part of the baggage you've been carrying in your life that's weighing you down. And that's for you to decide.

Differentiating true guilt from self-attack is a crucial component of accessing anger with patients who internalize anger and turn it onto themselves, and it is part of the overarching task of relinquishing resistance. Here, and in the next sequence, the therapist emphasizes the patient's free will in deciding whether to give up his resistance, and continues to put pressure on tactical defenses that stand in the way of being honest and clear about where he stands.

The following passage shows how pressure to experience feelings leads to more resistance getting mobilized, which in turn gives the therapist new openings to clarify and challenge the patient to do something about the resistance. This work

can be thought of as "two-pronged," applying pressure on the resistance while maintaining pressure to underlying feeling (Rathauser, personal communication, April 18, 2020).

Patient: Yeah. It is. I think you're right. I know you're right. Because this anger is justified [sighs].

Therapist: Your anger, there's always going to be a reason for it. Putting it out might not be the best option, but internally feeling it, being aware of it always there's going to be a good reason for that. But you've got to actually allow yourself to examine the feeling before you even make sense of it.

Patient: Right. Okay.

Therapist: So let's see again how you feel it, because you're still holding in. I can tell you're you're not fully in touch with it.

Patient: Okay. Well. Like we were saying, there's that tension along the arms and it exists into my hands. And then I feel, like I feel it in my quads [jaw tightens as he says this\. And it strengthens. Strengthening my back. And I feel like it's in my molars, like my back molars [patient is grinding his jaw, but his voice continues to sound detached and flat].

Therapist: But there's still detachment that you're carrying. I can feel it. It's not, you don't seem alive and energized with it. It's like there's a restraining. Do you know what I mean?

Patient: Yeah.

Therapist: And in your voice, too. There's a deadening in your voice. You actually had more feeling and emotion in your voice when you first came on the [video] call. This is the kind of deadening that you do when it comes to anger.

Patient: Hmm mhm.

Therapist: But "hmm mhm" isn't enough. I mean, you say you want to get in touch, but then obviously there's another part of you that really fights getting in touch.

Patient: Yeah. I mean, it's like that's the part that, like you said, is always like, because everything feels so high energy, but there's always been these pressures to...

Therapist: Yeah, that's true, but what are we going to do about it now? Because, I mean, just ruminating about how it's always been isn't going to help. We have to see what we're going to do to change it. And you are capable of change. You've proven that time and again. The question is, are you going to put your full will to overcoming these automated mechanisms? Because ruminating about it's not going to help.

Patient: Yeah, I know, I know.

Therapist: But knowing is not enough. Let's see what you're going to do.

The Task Of Experiencing Feelings In Relation To The Therapist

The therapist has been steadily increasing his pressure on the patient's resistance, stacking pressure, challenge, and clarification to tilt the process into the therapeutic relationship. We now see clearer signs that feelings about the therapist are rising as the patient begins to look away from the therapist. The therapist applies pressure on these feelings and the resistance in relation to the therapist, maintaining the narrow focus on experiencing feelings and relinquishing resistance. In the passage below, the therapist is intervening at a faster pace, to match the intensity of the resistance.

Patient: [eyes roll away]

Therapist: And your eyes look away. How are you feeling towards me right now?

Patient: I feel like...

Therapist: "I feel like" is not a feeling. It's going to be a thought. How are you feeling towards me?

Patient: [eyes again roll sideways]

Therapist: As your eyes want to go away again? This is, this is where you want to go away.

Patient: Yeah.

Therapist: There's a strong pull to disconnect, right?

Patient: Yeah.

Therapist: Because I am asking you to really be emotionally engaged and present, and there is a part of you that's resisting that. Right?

Patient: [sighs, nods his head].

Therapist: So I am pushing you to get in touch with a feeling and a part of you is resisting it. So how does that part feel towards me for pushing you to do something a part of you doesn't want?

Patient: Angry.

Therapist: Okay. So can we look at that?

Patient: Yeah.

Therapist: How do you feel this anger towards me now?

Patient: This anger is like, it's like a sensation of fire that starts in my chest, and it's moving out to my extremities. And it's something that's like, this does feel energizing! Like it's like the feeling of, like, wanting to, like stand up and confront.

Therapist: Okay.

Therapist: We'll look at that. But first, let's bring up the full feeling. So it's energy up here in your chest.

Patient: [Sighs] Definitely energy in the chest. And it stays there. But as it starts in the chest, it's expanding.

Therapist: Uh huh.

Patient: And kind of moves out over my shoulders and into my...

Patient: "Kind of," or it does?

Patient: It does!

Therapist: End the disconnection. The "kind of" keeps you disconnected.
Patient: Yeah, it's moving... it's a fire that's moving up and over my shoulders, down the backs of my arms.
Therapist: Right.
Patient: And it's something that I can now actually feel moving down my quads and into my calves and then into my, into my feet.
Therapist: How high does it go? Chest or higher?
Patient: No, it's like upper...
Therapist: Upper chest? But does go into your head?
Patient: It feels like it's going into my face.
Therapist: All right, so hold on to it. Now, what about you jaw? Jaw's still tight?
Patient: Yes.
Therapist: Okay. What about hands?
Patient: My hands are clenched.
Therapist: Your hands are clenched?
Patient: Yes.
Therapist: Now, what percentage of this rage do we have mobilized right now?
Patient: I'd say like 60%.

The patient's acknowledgment that only sixty percent of the rage is activated is a sign that the alliance is strong. There is an explicit commitment to working with the therapist to deepen his experience of emotion, as well as non-verbal signs indicating that compliance is not a significant issue at the moment. Aware of the patient's history of academic excellence and the huge effort he put into his schoolwork, the therapist applies pressure to his will to do the task. This is a variation of the 100% intervention, which is designed to boost patient motivation and block any sense that therapy will work even though the patient is not giving their 100% (Frederickson, 2013).

Therapist: 60%. Now, knowing what you can do academically, would you settle for 60%?
Patient: No.
Therapist: So then why would you want to do that with your emotional life?
Patient: I don't.
Therapist: So then let's see what you're going to do about the other 40% of you.
Patient: [Sighs heavily]. Okay. I feel it moving into my back, like my full back, not just my lats. It's something that's like, centered along my spine and is moving out towards my shoulders from that.
Therapist: Okay.
Patient: Matching the feeling in the front of my chest.
Therapist: Good.
Patient: And I still feel it in my face.
Therapist: All right.
Patient: And it's like this sensation that it's, like, not... Hot. It's like, not tingly, but hot.
Therapist: Okay. Yeah.
Patient: And then... I'm starting to feel like my elbows get really, like... it's like the feeling of that my biceps and my forearms are being connected through my elbows.

Strength and power connecting the full span of the limbs to the trunk is a sign of high rise of complex feelings, with rage in the front (Davanloo, 1995). The resistance has been considerably weakened, but more resistance work is to be expected.

Therapist: That's right.
Patient: And I can still feel my wrists, kind of... not "kind of"! My wrists are starting to become fully supportive of my fists.
Therapist: That's right. You're physically getting stronger. Let's see what else.
Patient: Yeah, something that is starting to feel it's moving from my quads to my calves. I feel it bracing. My ankles and my feet feel planted in the ground.
Therapist: Uh huh. But what about your voice? I still don't hear the... It's more energized, but there's no feeling in the voice.
Patient: Yeah. It's like...then that's like the last part. It's like everything else is kind of oriented around...

The therapist quickly moves in to challenge the rumination, keeping the task narrowly defined: emotional experiencing and turning against the resistance.

Therapist: But let's not ruminate about it. Let's just see what you're going to do about the voice, because that will block your ability to access the full feeling and open up your unconscious in a way that we can really see what this is all about. So let's see what you'll do about the deadening here.
Patient: Okay.

The therapist makes sure that there's no confusion about the patient's will by deactivating defiance.

Therapist: Unless you don't want to. I don't want to push you to do something you don't want to do.
Patient: It's just... I want to do it. But I just think it's something that...
Therapist: I want to do it "*but*." I want to "*but*."

Again, the therapist rapidly intervenes to block the intellectualizing and highlight the patient's ambivalence. Keeping the task narrow: again and again showing the patient how the resistance

is present, how it's getting in the way of emotional closeness, and encouraging him to do something about it.

Patient: Right [patient begins to throw up arms].
Therapist: This is the issue.
Patient: Yeah.
Therapist: Let's see what you're going to do about it.
Patient: [Sighs heavily and pauses].
Therapist: Again, unless this "but" part is going to be an obstacle.
Patient: It's not going to.
Therapist: All right, so then let's see you mobilize to the full extent. For your freedom and your sake, not mine.
Patient: Yeah. Okay. I mean, it's definitely like something that... I don't want to yell, but it feels like everything's building up to the point where I'm ready to, like, orient myself to communicate and, you know, use the anger into whatever, whatever avenue that it wants to go [Patient's voice now sounds angry and is louder and more engaged].
Therapist: What are we at now? 80%? 90?
Patient: Feels like close to 90.
Therapist: Close to 90? End the disconnection. Your life depends on it. The well-being of your life depends on you accessing all your feelings, not cutting off 10%. Would you be willing to cut off 10% of your body?
Patient: No.
Therapist: So stop cutting off 10% of your emotional life.
Patient: I won't. Yeah.
Therapist: So bring up the full thing.
Patient: Yeah. It's done. I mean, it's done. I mean, there's not going to be... There's not going to be anything that I leave, okay, I leave inside or behind. I mean, the anger is like... I feel it completely in my body at this point.
Therapist: All right.
Patient: And there's nothing left.

Even though we're about to see a strong emotional breakthrough in the following pages, it's of note that the therapist is using the intervention of pressure to feelings sparingly. The main route for mobilizing feelings has been through a focus on seeing and turning against the resistance. The intensity of the breakthrough of feelings stands in direct proportion to the amount of resistance having been mobilized, clarified and turned against (Davanloo, 1989).

The Task Of Portraying The Murderous Impulse

The patient is looking directly at the therapist, is upright, with hands in fists, and has described the full somatic pathway of rage. Knowing the patient's previous anxiety around imagining violence, the therapist offers the prompt of picturing himself as a "homicidal maniac," and encourages him not to move, in order to discourage any discharge of feelings. The use of a third person offers the patient the defense of displacement, which can be of help during early breakthroughs (Abbass, 2015).

Therapist: Let me guide you then. If in terms of thoughts and imagination, you become a homicidal maniac... And I'm not saying you'd actually do it, but just in terms of thoughts without moving. What do you do? Just use your imagination. What do you do to me?

It should be noted that throughout this portrait of rage, the patient is relatively still but shows some body movements consistent with the imagery, in keeping with what Patricia Coughlin has called the "passing of the impulse." (Coughlin Della Selva, 1992, p. 79).

Patient: I stand up and headbutt you.
Therapist: Okay.
Patient: Like, take my head and headbutt you on the bridge of the nose. And then, as you're doubled over, I would take my knee and knee you in the, in the jaw... Over, like, twice at least. And then as you double back, I push you in the chest against the wall behind you and start punching your ribs. Breaking a couple of ribs.
Therapist: Okay.
Patient: As I go. And then, I take my leg and kick your feet out. And then as you fall, I would just start hitting your face. Over and over. And then as I do that, I would put a knee on your chest and I would continue to just hit you over and over and over and over again!
Therapist: Okay.
Patient: [Looks sideways and pauses].
Therapist: Don't censor yourself. It's important you look at the full thing.

In the following, the patient describes strangling the therapist to near-death. Not completing the strangulation is interpreted as a sign of mixed feelings coming up and the therapist stays with the patient to allow the unconscious therapeutic alliance (UTA) to carry the process (Davanloo, 1987).

Patient: And then I would take my hands and I'd wrap them around your throat [patient makes strangling motion with his hands] and I would start to squeeze and I would squeeze until I felt like you were just at that threshold of passing out. And then I would remove them and just get up and kick you on the same side that I was punching.
Therapist: Keep going. Don't hold back anything. Anything you hold back will be a blockage.

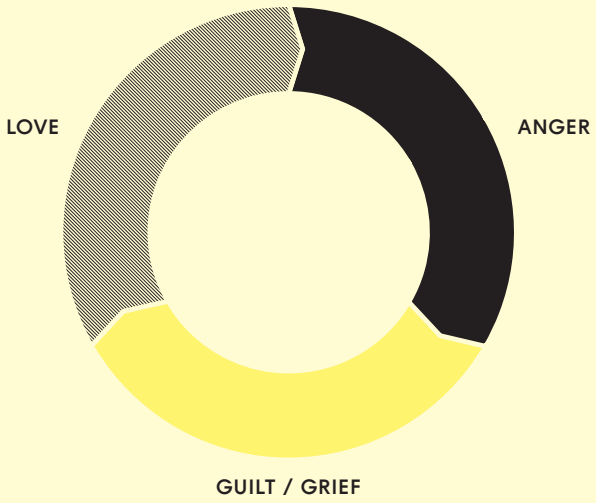
Patient: [Sighs]
Therapist: We need to see the full thing.
Patient: And then get to the other side of your body. So not the side that I was hitting over and over and over again. But what I would do is I would roll you over and just start kicking the other side of your body.
Therapist: Okay.
Patient: So you'd be face down and I would just start kicking you on your back and your left rib cage. So opposite of the one that I was hitting before making sure that I completely worked over both sides of your body. And then before I was done, like the last thing I would do is I would take the back of your head, wrap my hand in your hair, and I would just hit your head on the ground once [patient has mimed this motion].
Therapist: What happens to my head when you hit it on the ground?
Patient: There's... your nose breaks and there's a spurt of blood.
Therapist: Okay. Check in. Is there more?
Patient: There's nothing more. I was going to say that the feeling of... watching the blood pool. That's when it starts to turn into the sensation of, like horror at what I did [patient now has a sad look on his face].

The Task Of Experiencing Grief And Guilt

As the murderous impulses are allowed to break through, this makes way for the other attachment feelings to pass through as well. Commonly, as rage passes, feelings of grief, guilt and later love emerge. See figure 1 for a visual representation of this process. Thus, after accomplishing the task of experiencing rage, the therapist carefully starts shifting to the task of experiencing grief and guilt. In what follows, the therapist does this by directing the patient's attention to the body in the image.

Therapist: Okay. All right. So stay with it. If you stay with whatever feeling comes to you. Okay? You keep looking at my body on the ground with all the blood. And try not to fight any feelings that come to you. Okay? They're all healthy for you.
Patient: Yeah. I mean, it would just remind me of what I'm capable of. And I would feel... [patient pauses]
Therapist: Not "would" feel. You do feel.
Patient: Yeah, I feel appalled. That I was even incentivized, or did something like that.
Therapist: Keep looking at my body and describe what you see. Describe how I appear to you.
Patient: Limp. Like crumpled on the floor [voice breaking]. And in that state, not as someone with wherewithal or anything, but just defenseless. Completely. And needing support and needing to be taken care of. But no one's doing anything. And you're just, like laying there bleeding. But because of what I did.

FIGURE 1. THE CYCLE OF COMPLEX TRANSFERENCE FEELINGS.



The Task Of Letting The UTA Reveal Links To The Past

As resistance weakens, the attachment feelings are experienced more strongly and the UTA is more available. As we can see in the process below, the therapist needs to have clarity of the task at hand in order to maximize the intensity of the experience. Residual resistance and avoidance needs to be dealt with for the whole cycle of complex transference feelings to be completed. See Table 2 below for a schematic description of the cyclical process.

The therapist now goes on to ask the UTA for links, by focusing on the eyes.

Therapist: Am I face down? Is that how you left me, face down?
Patient: [Nods head].
Therapist: Okay. I want you to imagine me face up. You turn my body over so you can look at me.
Patient: Okay.
Therapist: Okay. So you turn me over. You see all the blood and all the damage to my face, my body? [patient looks sad, nods]. Keep looking at my face, okay? Not here at me [therapist points to his face], but my face on the ground. Okay. And look to my eyes. Are they open or closed?
Patient: Open.
Therapist: Open. Where am I looking?
Patient: You're not looking at me. Like you're looking past me.
Therapist: So these are eyes that look past you.
Patient: But I can still see your eyes are blinking. But you're looking past me. You're not going to, you're not even looking at me.
Therapist: Look closely at the eyes that don't look at you. What kind of expression you see in them?
Patient: Like horror and heartbreak.
Therapist: Keep looking at the eyes. What color are they?
Patient: Brown.
Therapist: You recognize these eyes?
Patient: They're my dad's eyes.
Therapist: Be sure. Let yourself be sure. Look to the hairline. Let it fill in. Let your unconscious do the work.
Patient: It's.. They're my dad's eyes.
Therapist: [Speaking softly and slowly] So this is the father that's looking past you. He's not looking at you? [patient's eyes fill with sadness]. Now, that brings a lot of feelings.

We skip ahead a couple of minutes. The UTA is largely in command of the process at this point, but the breakthrough has not yet been completed. The patient mentions that he does not want his relationship with his father to end the way it is. The therapist picks up the implication, and presses for the feelings underlying the 'end' of their relationship.

Therapist: You don't want the relationship to end this way?
Patient: No.
Therapist: But this is on your mind. Okay? The idea of this ending in this way is on your mind.
Patient: [nods head].
Therapist: So stay with the image. And I know it's very difficult, but if this were your last moment with him. Your final moment. The damage that you've done to him is very significant. How would you spend the final moment with him?

The patient's face now contorts in pain and what follows is an extended major unlocking for over 10 minutes, with waves of sobbing that interfere with his ability to speak. Feelings of guilt, grief, and love rotate and break through, and the patient is repeatedly immobilized by the intensity of his sobbing. The UTA is now fully in command of the process, and the patient brings forth memories of the loving bond he once had with his father.

TABLE 2: THE THERAPIST'S TASK DURING THE CYCLE OF COMPLEX TRANSFERENCE FEELINGS.

THE CYCLE OF COMPLEX TRANSFERENCE FEELINGS	THERAPIST TASK
Feelings in current relationships	– Pressure to feelings – Clarifying and challenging resistance
Resistance crystallizing in the therapeutic relationship	– Managing resistance (clarifying, challenging, head-on colliding)
Feelings in therapeutic relationship	– Pressure to portrait angry impulse – Pressure to experience guilt/grief – Pressure to experience love/positive feelings
UTA activity	– Exploring the UTA material

49

Therapist: [speaking softly, slowly, and reassuringly] The wave of feeling is coming through. Just hold on to it. Yeah. Just hold on to the feeling. It's very painful. But you're strong enough to have it. Yeah.

Patient: I would... [sobbing too hard to talk now]

Therapist: Okay. Another wave. Just let yourself have it.

Patient: [Sobbing]

Therapist: Yeah, very painful feelings. You're strong enough to have them.

Patient: I would talk to him about... [interrupted by sobbing] just like all the good times of...when we were...Like when I was a kid. And there was no barrier and there was no wall...[sobbing too hard to speak now].

Therapist: Another wave of feeling. Just let it move through you. These feelings are here to help you. Yeah. Very painful feelings.

Patient: [patient is sobbing throughout, leading his speech to be halted and interrupted by waves of uncontrollable feeling] I would want to talk to him, remind him about the time where, you know, it was a fully honest relationship between us. We could, you know, it was just easy and, you didn't have to second guess about, how to deal with stuff and I never felt like I needed to hide things! [more feeling breaks through]

Therapist: Yeah. Yeah.

Patient: And I don't want to now!

Therapist: Mhm. Another wave.

Patient: I just keep thinking like if it... Like with anybody or like with him or [brother's name], if anything were to happen today. It's not...[sobbing intensely again] this is not how I want anything to end with anybody! I don't want to have any relationship where it hasn't been complete...Completely me!

Therapist: Mhm. Yeah. Have you been hiding yourself from some of the people you love?

Patient: Yeah! [sobbing hard again] And I'm not going to do that anymore! Because it's not worth it! Like if today was, right now, if it were to be the last time, like... [patient shakes head, slows down and stops crying].

Therapist: Tell me about... tell me about some of these memories that you're having with your dad as a boy when the, when the barrier was down. You tell him about what? What would you remind him of in this final moment you have with him?

Patient: [Begins sobbing again very intensely, unable to speak]

Therapist: Very painful.

Patient: [immobilized by painful feelings].

Therapist: Yeah, it comes in waves, so just let it come. These are very healthy feelings.

Patient: [Sobbing] I would talk to him about cooking together, when I was a little kid. And wearing, you know, we just... [sobbing profusely, cannot speak]. He used to give me one of his aprons to wear.

Therapist: Oh, yeah.

Patient: And it didn't fit. But we both laugh about that!

Therapist: Yeah.

Patient: Or when he got me, like a fake shaving kit and I used to stand with him in the bathroom and pretend shave.

Therapist: [reassuringly] Yeah.

Patient: [crying too hard to speak] And reading stories before bed.

Therapist: Yeah.

Patient: Or helping him garden. And the first time that I used a shovel [sobbing] And he never cared if I was good at any of it [sobbing, unable to speak].

Therapist: Mhm. Yeah. Mhm. Mhm. Mhm. Mhm.

Therapist: There's so much love in these memories. So much feeling.

Patient: And. I don't want to stop making those now!

Therapist: Mm. What would your final words to him be? Like an eternal goodbye.

Focusing on the final goodbye elicits more guilt than grief, which up until now had been more prominent.

Patient: [Unable to speak, sobbing].

Therapist: Yeah. Yeah. Just let the pain pass.

Patient: [Again, unable to speak]

Therapist: Another wave of feeling. So just stay with it. Just stay with it.

Patient: I would tell him that we'd be okay. And I'd be okay.

Therapist: Yeah.

Patient: Just tell him that I love them. And that through saying that he'd know that I'm sorry! [again crying too hard to speak].

Therapist: Yeah. That you're sorry?

Patient: Yeah!

Therapist: Yeah. Yeah. Just let the feeling break through. It's very important, it's here to help you. Another wave. Yeah, another, another wave, so just stay with it. Yeah.

Therapist: Mhm. Yeah. More feeling comes. There's so much feeling with Dad.

The sobbing continues. We skip ahead a few moments. Therapist and patient are now focusing on the task of working through unconscious material and strengthening the conscious links between past and present. The patient links his mixed emotions to feeling his father did not love the emotional part of him, and was very rigid and restrictive, especially about sad or angry feelings.

Patient: It all comes from, I think, the root of it, is just such a strong feeling of connection and love. I mean, that's

the only thing that can kind of...That's the only thing that can originate feeling so angry because the love doesn't feel reciprocated. Like also, the love generates so much pain at the idea of, you know, not having him around anymore. And just wanting... Like, sometimes I take a relationship for granted. But with him, it's like when I think about the fact that he's not always going to be here. I don't want to have a relationship where I don't feel like I can be fully relaxed if I feel angry or fully, you know...

Therapist: If you have your barrier up.

Patient: Right. Right.

The patient brings forth a memory from primary school where he was crying and his father told him to "turn off the waterworks". He explains this was typical of his father's dismissive attitude towards his pain and anger.

Therapist: Well, that's an important one, him telling you that you can't have your feelings. I mean, your feelings are a major part of you. Look how powerful they are within you. So being told you can't have them or they're not good. That hurts.

Patient: Yeah. And, it's almost like there was a tipping point. You know where, and again, all those memories as a kid, it's when there wasn't an expectation that I had to, you know, "turn off the waterworks." Like when that expectation wasn't there, you know, things were free flowing.

Therapist: You could be you.

Patient: I could be me. And then once that expectation arises, arose, when it came about with the, you know "turn off the waterworks" around that middle school-ish... not middle school. Elementary school age.

Therapist: Elementary school. Yeah.

Patient: Like around the start of it. That was really a pivotal thing.

Therapist: Yeah.

Patient: Because it started a trend of, "You're, you know, you're not meant to do that" even in my own home. It was attacked. Where, the way to address feeling really stressed out or scared about situations was to say, you know, "don't cry about that."

Consolidating The Session

We skip ahead a few moments where the patient is reflecting on how comfortable he is becoming with his emotions. Ultimately, the unlocking of the unconscious works by experiencing feelings and connecting those to cognitive processes. Recent findings have shown this insight-oriented work to be necessary for symptom improvement over time (i.e. Town et al., 2022). The task here is thus to do a cognitive consolidation of the affective processes covered in the session (See table 1 above for overview).

Patient: It feels natural to, it's not like I've never, you know let myself feel. But not to the severity of what I felt today! It feels natural! I mean, it does. And it is.

Whereas in the trial therapy the patient had described his tendency to listen to other people but not share his own feelings as a "cosmic mystery," he now sees this as part of the defensive system he learned to adapt to his childhood environment and hide his true feelings, which were not accepted by his father and which, in their intensity and the guilt and pain they brought him, created massive anxiety. We move ahead a few moments.

Therapist: And so you stopped turning to other people for comfort and being direct with your emotions?

Patient: It feels like I developed a way to talk about feelings in a way that felt comforting because by talking about everything and putting my feelings in perspective over and over and over again...It's an easy way... It was an easy way for me to avoid feeling them. Because if you can put it in perspective to somebody else, that was easier for me.

Therapist: To intellectualize and talk about them without actually experiencing them?

Patient: Mhm. And so, that made me a great listener. And a great support system for other people and, I've always, you know, found myself listening and talking about everyone else's feelings. And it was just how I moved away from my feelings.

Here, the patient is clearly understanding parts of the history of his resistance, the value of it, and also acknowledges the enormous price he's had to pay for sticking to it. The session ends by consolidating what's been learned and planning the coming session.

A Second Unlocking Of The Unconscious

In the seventh session discussed above, the therapist and patient were successfully maintaining a narrow task on experiencing feelings and turning against resistance, until an internal shift allowed the unconscious to unlock. For the eighth session, the patient comes in with a major increase in openness and an even higher readiness to work on the task of therapy. In the session, there is another major unlocking of the unconscious in relation to the therapist.

The cycle of complex transference feelings ends with the UTA bringing forth a link to the patient's mother. Here he

again processes heavy grief and guilt, and gains deeper understanding about what had been a syntonic barrier he placed between himself and others. We start the transcript after the transfer to his mother and during the passage of these guilt and grief laden feelings.

Patient: [Heavily sobbing, unable to speak]
Therapist: Do you think you've been open with your mom with your deeper feelings? Do you think she knows those feelings?
Patient: [Shakes head "no" as he cries]
Therapist: No, she doesn't know them either. So if she died today, then she'd also die not knowing you?
Patient: [Sobbing heavily again]
Therapist: [Supportively] Yeah.
Patient: [Sobbing as he talks] She'd only know the parts I chose to share, which are like the "good" parts.

Again we see a massive shift from the trial therapy, where he declared that he only wanted to feel and show positive feelings, to acknowledging and experiencing the pain that concealing his feelings has put in his, and others', lives. Narrowing down the task of treatment to removing resistance and getting in touch with feelings, paradoxically leads to a wider openness within the patient. Once our patients accomplish this task they allow many degrees of freedom for change and growth well outside what either patient or therapist might preemptively imagine.

Patient: But like... like we've been talking about like, of course in words I've told both my mom and my dad, stuff. But now, like after what we've been doing [i.e. ISTDP], like, the feeling and the realization of that is not everything. It's like, really...[Sobbing too hard to talk now] ... So I know, such a simple truth, but like everybody, I guess in my life I deserve to, just see...and know how I feel. And...
Therapist: And you deserve that too, right?
Patient: Yeah.
Therapist: Because it's lonely for you if people don't know your feelings.
Patient: [Sobbing throughout] And if they don't... For a long time I was, like, scared of letting people in, in that way, but, now, it's just totally not worth it. And I'm not scared in the same way. Now I'm just sad. It's not fear that's holding me back, nothing is. And it's just realizing how important it is that just makes me... that's what makes it so painful to think, like if it all ended today...It makes it so painful because it's so easy and it hasn't always been easy to, like, share my feelings, but it's so simple!

Treatment Outcome

The treatment lasted 42 hours and included multiple major unlockings with links to all the major figures in the patient's life, resolving the patient's presenting concerns and leaving the patient with a sense of pride in his accomplishments. He experienced not only symptom relief but also deep character change. As an example, prior to starting therapy, he had a history of ending a sexual relationship by getting drunk and cheating on his then-girlfriend. At the time his behavior had been a mystery to him, but over the course of treatment it became clear that this was his way of avoiding negative feelings and conflict and forcing his partner to leave him. In contrast, toward the end of this treatment, while seeing another woman whom he realized he did not love, he confronted her directly, even breaking down in tears and sharing with her his pain at ending the relationship but knowing it was the right thing to do.

The following quotation comes from the final session, where the patient reflects on the treatment:

I feel grateful! I tried a couple of therapists before starting our work together and the interesting thing is I didn't continue because I didn't feel challenged and it felt more like a 'pat your back' situation. But when we started working together, and months into it we had a good session, and I said, "I had no idea how hard this would be." But it's the right thing because, it's like with anything, the only situations that you're going to grow in are the ones where you're stretched and meet resistance. It's like you need to be tested, otherwise you're not gonna grow. And it truly has been so worth it.... Emotionally, I've done a complete 180. [When we started] I felt so controlled when actually I had no clue what it meant to feel angry at the beginning...I had all the blockages...a lot of types of core feelings that I didn't know how to experience, but now I do!

The outcome of the case supports the hypothesis that keeping the task narrow allows major change to happen. We provide a narrowly defined therapeutic space in order for a wide space to open up in the patient's life at large.

Discussion

In this article, we have described the successful overcoming of the resistance in a case of high resistance with syntonic elements, and then we have described some of the emotional unfolding that can take place once the resistance subsides. We have emphasized one aspect of the conscious therapeutic alliance, the centrality of the therapeutic task, in making the therapy course a success. Having a narrow concept of the main therapeutic task can help orient the therapist throughout the whole process of ISTDP. Once the therapist and patient have agreement that one of the tasks is to identify and remove each aspect of the patient's resistance to facing their feelings, the challenging teamwork of making this happen begins. To the degree that the patient is identified with the resistance, the successful ISTDP therapist must be emotionally capable of dogged clarification, confrontation and persistence in addressing the resistance, all the while maintaining a warm and empathic connection to the patient as a person. This is no small feat, and the emotionally taxing nature of the process for the therapist is, we propose, one of the reasons for the difficulty in mastering ISTDP.

Given this patient's initial reluctance to commit to the tasks of the treatment, how do we then understand the success of this therapy? First, it cannot be overstated how important it was that the therapist patiently and persistently held the patient to examining his resistance in an attempt to make it more visible, conscious and dystonic: inviting the patient to do a very narrow task. Second, the therapist balanced communications about the resistance with interventions speaking directly to the alliance: emphasizing the positive potential of the therapy alongside the negative consequences of the resistance. Third, an uncommon feature of the treatment course, is the respect that the therapist showed to the resistance by applying a very strong form of pressure: "if the major part of you does not want to do the work of examining your feelings, what is the point of us meeting?" In this intervention the therapist is holding the patient fully accountable for his actions, and made it clear that he would not continue to urge or push the patient against his will. In respecting the patient's will, the therapist invited the patient to struggle intrapsychically. This avoided a potential interpersonal conflict with the therapist. This intervention requires a lot of tact, sensitivity and, at its core, a willingness to let go of omnipotent fantasies in both patient and therapist.

"The event of an unlocking of the unconscious can be argued to be the result of a successful narrowing down of the therapeutic task: the unlocking can only happen when the therapist and patient work in tandem towards this very goal. ... For an unlocking to happen, both therapist and patient need to have a clear understanding of the joint task, the emotional strength to endure it and a full willingness to allow the process to unfold in that direction."

Are there risks related to narrowing the task of therapy down this much? Yes. If the patient is not fully understanding the treatment process, due to lack of conscious alliance, unaddressed syntonicity or capacity misevaluation by the therapist, using the intervention described above can be misinterpreted by the patient as rigid, controlling, abandonment or criticism. All of these are common issues in learning ISTDP, and they should be dealt with by using humility, adequate supervision, and openness to repairing alliance ruptures should they occur. On the other hand, are there risks related to having too broad a task? We believe there are. ISTDP can all too easily become an intellectual form of talk therapy if the therapeutic task is too wide. We've suggested this concept of the narrow task in order to be able to speak about the great value, and the risks, of adhering closely to the central dynamic sequence – and to be able to speak about the risks of nonadherence.

The event of an unlocking of the unconscious can be argued to be the result of a successful narrowing down of the therapeutic task: the unlocking can only happen when the thera-

pist and patient work in tandem towards this very goal. Since these events have been shown to be extraordinarily effective (Johansson et al., 2014; Abbass et al., 2017; Lilliengren et al., 2017), more work needs to be done to understand what factors contribute to this in-session event. In Davanloo's own writing, the unlocking of the unconscious is described as a "technique", rather than as a task of the therapy (Davanloo, 1988a). We think seeing it as a technique risks underemphasizing the collaborative nature of the unlocking. For an unlocking to happen, both therapist and patient need to have a clear understanding of the joint task, the emotional strength to endure it and a full willingness to allow the process to unfold in that direction. A therapist that tries to force an unlocking on a patient, using excessive confrontation and premature portrayals, will never see it. Instead, they will see alliance ruptures. Likewise, a therapist that broadens the therapeutic task too much, allowing the resistance to dominate the session, will not see it either. Instead, they will see patients dropping out due to losing hope. It's also worth noting that failing to have the unlocking happen can easily be abused in the service of different therapist superego strivings, leaving the therapist vulnerable to his own inner dynamics. This is why we suggest that restructuring the resistance–while keeping anxiety at a safe level–should be the main task of the ISTDP therapist, with the task of unlocking the unconscious proceeding organically from that.

In randomized-controlled trials, the average ISTDP patient has large benefits on both symptoms and functioning (Lilliengren et al., 2016). Despite this, not all patients benefit from treatment. The treatment we discuss in this article fulfills a number of factors that all coalesce to contribute to the rapid and sustained improvement shown, such as: 1) the patient having emotional capacity to withstand the unlocking of the unconscious, 2) the patient having an honest willingness to grow, with no major superego pathology standing in the way, 3) the patient having cognitive capacity to track the process and collaborate with the therapist, 4) the therapist having emotional capacity to withstand the unlocking of the unconscious, 5) the therapist not getting caught in countertransferential or enactment processes (cf. Joseph & Witter, 2024), 6) the therapist having adequate supervision to make sure that treatment decisions are well processed. In cases where those therapist-patient characteristics are not present, the treatment will necessarily take another path.

To conclude, this case illustrates the successful use of ISTDP with a highly syntonic patient, emphasizing the narrowing down of the therapeutic task as a way to direct the attention of both therapist and patient. By keeping this the focus of this article, we hope we've conveyed the centrality of this process to the reader. Many forms of ISTDP can indeed be effective, but we believe that the intensive element in ISTDP rests on a successful narrowing down of the therapeutic task. Once the conscious therapeutic alliance around the task of emotional experiencing is firmly established, pressure, clarification, challenge and head-on collision should be applied to bolster the unconscious therapeutic alliance, map the resistance comprehensively and help turn the patient against the resistance in a decisive way.

References

Abbass, A. (2015). *Reaching through resistance: Advanced psychotherapy techniques.* Seven leaves press.

Abbass, A., Town, J., Ogrodniczuk, J., Joffres, M., & Lilliengren, P. (2017). *Intensive short-term dynamic psychotherapy trial therapy: Effectiveness and role of "unlocking the unconscious".* The Journal of nervous and mental disease, 205(6), 453-457.

Barlow, D. (2018) *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders Therapist Guide.* OUP USA.

Barlow, D. H. (2004). *Anxiety and its disorders: The nature and treatment of anxiety and panic.* Guilford press.

Bordin, Edward S. (1979). *The generalizability of the psychoanalytic concept of the working alliance.* Psychotherapy: Theory, Research & Practice, 16(3), 252–260.

Caligor, E., Kernberg, O. F., & Clarkin, J. F. (2007). *Handbook of dynamic psychotherapy for higher level personality pathology.* American Psychiatric Pub.

Clarkin, J. F., & Kernberg, O. F. (2015). T*ransference-focused psychotherapy for borderline personality disorder: A clinical guide.* American Psychiatric Pub.

Coughlin Della Selva, P. (1992). *Achieving character change in IS-TDP: How the experience of affect leads to the consolidation of the self.* International Journal of Short-Term Psychotherapy, 7, 73-87.

Cuijpers, P., Miguel, C., Harrer, M., Plessen, C. Y., Ciharova, M., Papola, D., ... & Karyotaki, E. (2023). *Psychological treatment of depression: A systematic overview of a 'Meta-Analytic Research Domain'.* Journal of Affective Disorders.

Davanloo, H. (1986). *Intensive short-term psychotherapy with highly resistant patients. I. Handling resistance.* International Journal of Short-Term Psychotherapy, 1(2), 107-133.

Davanloo, H. (1987). *The Unconscious Therapeutic Alliance. In: In Buirski P. (Ed), Frontiers of Dynamic Psychotherapy - Essays in Honor of Arlene and Lewis R. Wolberg.* Mazel and Brunner, New York.

Davanloo, H. (1987b). *Intensive short-term dynamic psychotherapy with highly resistant depressed patients. Part I. Restructuring ego's regressive defenses.* International journal of short-term psychotherapy, 2(2), 99-132.

Davanloo, H. (1988a). *The technique of unlocking of the unconscious. Part I.* International journal of short-term psychotherapy, 3(2), 99-121.

Davanloo, H. (1989). *The Central Dynamic Sequence in the Unlocking of the Unconscious and Comprehensive Trial Therapy. Part I. Major Unlocking.* International Journal of Short-Term Psychotherapy, vol. 4.

Davanloo, H. (1989b). *The central dynamic sequence in the major unlocking of the unconscious and comprehensive trial therapy. Part II. The course of trial therapy after the initial breakthrough.* International Journal of Short-Term Psychotherapy, 4(1), 35-66.

Davanloo, H. (1995). *Intensive short-term dynamic psychotherapy: Major unlocking of the unconscious – Part II. The course of the trial therapy after partial unlocking.* International Journal of Short-Term Psychotherapy, 10(2), 195.

Davanloo, H. (1999a). *Intensive Short-Term Dynamic Psychotherapy – Central*

Dynamic Sequence: Phase of Pressure. International Journal of Intensive Short-Term Psychotherapy, vol. 13.

Davanloo, H. (2000). *Intensive Short-Term Dynamic Psychotherapy: Selected Papers of Habib Davanloo.* Chichester; New York: Wiley.

Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). *Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis.* American Journal of Psychiatry, 164(6), 936-941.

Freud, S. (1912). *Recommendations to physicians practising psycho-analysis.* The Standard Edition of the Complete Psychological Works of Sigmund Freud, 12(), 109-120.

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice.* American Psychiatric Pub.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2009). *Acceptance and commitment therapy.* Washington, DC: American Psychological Association.

Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T., ... & Miles, J. R. (2014). *To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy.* Psychotherapy Research, 24(3), 299-315.

Johansson, R., Town, J. M., & Abbass, A. (2014). *Davanloo's Intensive Short-Term Dynamic Psychotherapy in a tertiary psychotherapy service: overall effectiveness and association between unlocking the unconscious and outcome.* PeerJ, 2, e548.

Joseph, M. & Witter, M. (2024) *Internalized Object Relationship as an Advanced level of Psychodiagnosis.* Journal of Contemporary ISTDP #1.

Lilliengren, P., Johansson, R., Lindqvist, K., Mechler, J., & Andersson, G. (2016). *Efficacy of experiential dynamic therapy for psychiatric conditions: A meta-analysis of randomized controlled trials.* Psychotherapy, 53(1), 90.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford Press.

Milrod, B. (1997). *Manual of panic-focused psychodynamic psychotherapy.* American Psychiatric Pub.

Schubmehl, J. Q. (1995). *Management of syntonic character resistance in Intensive-Short-Term Dynamic Psychotherapy.* International Journal of Short-Term Psychotherapy, Vol .10, 3-19

Shedler, J. (2022). T*hat was then, this is now: Psychoanalytic psychotherapy for the rest of us.* Contemporary Psychoanalysis, 58(2-3), 405-437.

Solms, M. (2021). T*he hidden spring: A journey to the source of consciousness.* Profile books.

Spriggs, M. J., Kettner, H., & Carhart-Harris, R. L. (2021). *Positive effects of psychedelics on depression and wellbeing scores in individuals reporting an eating disorder.* Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 26, 1265-1270.

Town, J. M., Falkenström, F., Abbass, A., & Stride, C. (2022). *The anger-depression mechanism in dynamic therapy: Experiencing previously avoided anger positively predicts reduction in depression via working alliance and insight.* Journal of counseling psychology, 69(3), 326.

Thoma, N. C., & Abbass, A. (2022). *Intensive short-term dynamic psychotherapy (ISTDP) offers unique procedures for acceptance of emotion and may contribute to the process-based therapy movement.* Journal of Contextual Behavioral Science, 25, 106-114.

Wampold, B. E. (2015). *How important are the common factors in psychotherapy? An update.* World psychiatry, 14(3), 270-277.

Whittemore, J.W. (1996). *Paving the Royal Road: An Overview of Conceptual and Technical Features in the Graded Format of Davanloo's Intensive Short-Term Dynamic Psychotherapy.* International Journal of Short-Term Psychotherapy, vol. 11.

Winston, A., Laikin, M., Pollack, J., Samstag, L. W., McCullough, L., & Muran, J. C. (1994). *Short-term psychotherapy of personality disorders.* The American Journal of Psychiatry, 151, 190–194.

Jonathan J. Entis

Jonathan Entis, Ph.D., is a licensed psychologist in private practice in Cambridge, Massachusetts. He is on the faculty of Harvard Medical School, where for the past five years he has taught and supervised in ISTDP. He is an IEDTA-certified teacher in ISTDP and has presented both nationally and internationally. Jonathan leads a number of international online training groups in Davanloo's ISTDP, and is co-leading an advanced Core Training in Amsterdam with John Rathauser. He is also a co-author with John Rathauser and Mikkel Reher-Langberg on the upcoming book, Fundamentals of Davanloo's Intensive Short-Term Dynamic Psychotherapy, Volume I.

Thomas Hesslow

Thomas Hesslow is a licensed clinical psychologist and ISTDP therapist. He's one of the founders of the Swedish ISTDP Institute and the Malmö Center for ISTDP. He provides ISTDP therapy, supervision and core training in Malmö in southern Sweden.
He was trained by Tobias Nordqvist, Jon Frederickson, Allan Abbass, Peter Lilliengren, Ange Cooper and Jonathan Entis.
He teaches at Lund and Linneaus Universities, and regularly offers core training in Sweden. He's the Editor-in-Chief of the Journal of Contemporary ISTDP. He's the author of the upcoming book (in Swedish) *Intensive Short-Term Dynamic Psychotherapy – An Introduction*. Together with Jon Frederickson, he runs a Training for Trainers program in southern Sweden.