THE THERAPIST'S EXPERIENCE OF THE RISING
UNCONSCIOUS THERAPEUTIC ALLIANCE IN THE PATIENT:

The UTA Mental State

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Abstract

Traditionally, the rise of the patient's unconscious therapeutic alliance (UTA) has been described in observable, objective terms in the Intensive Short-Term Dynamic Psychotherapy (ISTDP) literature. The therapist's subjective experiences of when the UTA rises in the patient, on the other hand, has received little attention. In this paper, the author introduces a first-person account of a subjective phenomenon she experiences as a therapist when the UTA rises in the patient, which will be referred to as the UTA mental state. By defining and describing this phenomenon, the author aims to: a) invite further reflection and development of the concept in the wider clinician community, and b) suggest how the concept may provide an additional data point in the therapist's clinical decision making. To this end, an historical consideration of the UTA in the ISTDP literature is first presented. Next, a phenomenological description of the proposed UTA mental state concept is provided. Three clinical vignettes are then presented to illustrate the phenomenon, with potential benefits to clinical decision-making discussed, and consideration given to resistance against the UTA in both the therapist and patient. The paper concludes with a discussion of conceptual and practical strengths and limitations of this concept.

Keywords: ISTDP, unconscious therapeutic alliance, UTA mental state, clinical decision making, therapist experience, clinical vignette

CONFLICT OF INTEREST STATEMENT
The author has no conflicts of interest to disclose.

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The Therapist's Experience of the Rising Unconscious Therapeutic Alliance in the Patient: The UTA Mental State

The Unconscious Therapeutic Alliance (UTA): Historical Considerations

Sigmund Freud wrote that the unconscious has no other endeavor than to break through the pressure of repressive forces, and the unconscious offers no resistance to the efforts of the therapy treatment (1920/1955, p. 19). Building on this, Habib Davanloo developed the idea that, in addition to the conscious therapeutic alliance, an *unconscious* component of the alliance also exerts influence on the therapy. This unconscious therapeutic alliance (UTA) is a central force in the Intensive Short-Term Dynamic Psychotherapy (ISTDP) developed by Davanloo through careful review of his therapy videos. With resistant patients, the ISTDP therapist collaboratively works with the patient to identify, clarify, and ultimately challenge the patient's accustomed (i.e. defensive) ways of relating which have contributed to the patient's presenting problems. When effective, this leads to the patient's underlying feelings breaking through into consciousness, and becoming available to be worked through (e.g., Davanloo, 2000). A critical tipping point occurs when the patient's ego is turned against the resistance and the UTA overtakes the resistance, leading to repressed material breaking through from the patient's unconscious. This is achieved within an established conscious therapeutic alliance (CTA) where the patient has a goal to get well, a will to work towards this goal, and a willingness to face painful feelings and talk truthfully (Davanloo, 1990, p. 2). The UTA is the unconscious part of the patient's alliance with the therapist. A rise in the UTA means that the patient's unconscious begins to reveal itself in the form of associations, memories, dreams and fantasies (Davanloo, 1987). The UTA and CTA operate in tandem to bring forth previously repressed unconscious material. The UTA rises in parallel with complex feelings in the transference and works to undo the resistance (Davanloo, 2005).

According to ISTDP theory, ultimately, it is the UTA that must come to dominate the resistance (Davanloo, 2005). In a chapter by Davanloo called *The Unconscious Therapeutic Alliance* (1987), he describes how working with the highly resistant patient, the therapist puts pressure on the patient to experience his true feelings. This leads to an increase in resistance that the therapist must put pressure on and challenge until the transference feelings are experienced directly. The UTA's first dominance over the resistance occurs in the first breakthrough, or in an unlocking of the unconscious (Davanloo, 1990; 2001). An unlocking leads to the patient experiencing a state Davanloo called "dreaming while awake" (2000, e.g., p. 135). Davanloo describes that when the UTA overcomes the resistance, therapy can move into a *phase of content* where links to current and past figures can be made, interpreted, and worked through. During this phase, the UTA can be encouraged by questions such as, "What does this remind you of?". If faced with new resistance during this phase, the therapist must return to pressure and challenge in the transference (Davanloo, 1987).

During the work of identifying, clarifying and challenging defenses and resistance, the ISTDP-therapist tries to follow the signs of the UTA. Signs from the UTA provide feedback and supervision from the patient's unconscious, and point to where the patient next needs help in overcoming the resistance. The therapist needs to be sensitive to the rise of the UTA to align with this unconscious healing force and to avoid adding to the resistance or creating a misalliance (see e.g., Abbass, 2015; Coughlin 2017; Davanloo, 2005; Frederickson, 2013). As the UTA in the patient starts to bring forth more material from the unconscious, this can be detected through different perspectives. Allan Abbass (2015; 2019) has categorized verbal signs from the UTA according to the level of mobilization in the following order: *whispers from the unconscious, slips-of-tongue, negations, clear linkages to the past, a transfer of images,* and the *dreaming while awake*[1] associated with an unlocking of the unconscious. These signs represent the rising unconscious material, or, when the resistance is still operating, a compromise between the rising feelings and the remaining resistance (Davanloo, 2000, p.155). These signs help the therapist in recognizing the UTA and the level of mobilization of unconscious feelings. Additionally, Abbass has described how the therapist's "empathic responses" can help determine the rise of complex feelings (pp. 9-10, Abbass, 2015). For example, the therapist can learn to recognize heat rising in themselves as a sign of the same heat of emotional activation in the patient (Abbass, 2015).

Patricia Coughlin (2017) has described the UTA as an unconscious healing force: *an emotional immune system* (p. 157). She argues that it comprises the two forces described by Sidney Blatt (2008, 2010): The patient's healthy wish for authentic selfhood and autonomy, and the healthy wish for authentic connection with others (Coughlin, 2023). Jon Frederickson (2017) described it as the patient's wish to become one with the Truth of their existence, comparing it to Bion's truth instinct, +K. Abbass (2019) has emphasized the role of caring actions in activating the UTA: "The loving actions of an honest, caring other person activates, and in some cases, creates, the UTA" (Abbass, 2019). Further to Davalnoo's (1987)

notion that the UTA is the unconscious part of the therapeutic alliance, Mikkel Reher Langberg has argued that the higher the resistance, the larger a part of the UTA is repressed into the unconscious. Thus, the therapist must try to help align the conscious alliance with the unconscious one (personal communication, Reher Langberg, 2023, October 11).

Although talked about by some, little has been written about the therapist's experiences when the UTA is rising in the patient. To my knowledge, there is only one study on the topic within the ISTDP framework and terminology. For his master's thesis, Max Eriksson (2022) surveyed 22 ISTDP therapists on their experiences when the UTA is active. The surveyed therapists described that when the UTA emerges the boundaries between patient and therapist dissolve, creating a shared reality where they were empathically attuned with the patient. The perception of time and space was altered, and the atmosphere of the room took on a different valence, alternatively described as full of life and creativity, or as thick with meaning and gravitas. The therapists reported sharing common language with the patient and getting visual imagery, which they described as originating from the therapist's own UTA. They also reported feeling energy and heat, or tears welling in their eyes. Some therapists reported experiencing feelings the patient was avoiding, or that were about to break through. While these reports are interesting, the therapists in the survey showed differing ways of defining and understanding the UTA.

There are further accounts worth mentioning. Marvin Skorman (personal communication, 2023, December 5) has described that later in his career, his own intuition became more important during the patient's unlocking. He would experience getting into a mind state where spontaneous associations came to him, or things to say. These were not experienced as originating from his logical mind, and also seemed to work to deepen the feelings of the patient. He likened this mind state to meditative states, where everything would drop away except the client. He described suddenly "erupting" with some words or a phrase he would then say to the patient. Skorman guessed that it was his unconscious talking to the patient's unconscious, and what he said would often simultaneously speak to Skorman's own unconscious feelings. He also observed the effect on the patient to be profound. He described that this state was not under the influence of his will, and that it happened more and more with time, but not something he himself could force (personal communication, Marvin Skorman, 2023, December 5).

Similarly, Kuhn (2014) notes that the therapist's own UTA can bring up information that often has "great therapeutic significance and should not be ignored" (p. 364). Adding further to the anecdotal experiences, Matthew Jarvinen has described that when the UTA is overcoming resistance, it gives the therapist a feeling of having a line directly "from you to them" (personal communication, 2023, August 19). Moreover, Kieding (2023) has presented his experience of clarity and connection as the essence of emotional closeness, and he describes it as a shared dream where the therapist can vividly picture and vicariously experience everything that the patient is communicating. The identification of the shared dream experience, he argues, can act as a guide in following the patient.

To summarize, the emphasis in the ISTDP literature has been on the role of the alliance in overcoming resistance. The rise of the unconscious part of the alliance, the UTA, has been described as relating to complex transference feelings brought on by the caring actions of the therapist. The complex transference feelings help the patient start to face their emotional truth within the emotional intimacy of a therapeutic alliance. Anecdotal evidence of the therapist's experiences of the UTA seems to be shared by many therapists, yet little has been written about it.

The Unconscious Therapeutic Alliance (UTA): My definition

The UTA is defined in many different ways within the field, which can be a source of confusion. Therefore, I will clarify how I view the UTA (the patient's and the therapist's) for the purposes of this paper, and for then outlining the concept of the *UTA mental state*. I will use the concept of the UTA to signify an unconscious pressure in the patient that functions to break through unconscious material from the pressure of repression within the secure attachment of the therapeutic alliance. I hold the view that without a functioning therapeutic alliance with set goals and a shared understanding of the task within an emotional bond between patient and therapist (see Bordin, 1979), the unconscious remains repressed. Resistance works against the formation of a conscious alliance and signifies the attachment traumas of the patient. Resistance can also stem from therapist errors which must then first be repaired for the UTA to come online. When resistance is worked through, the UTA can start to function to bring up the previously repressed feelings and material about the origin of the need to form the symptoms and the resistance.

The UTA is, in my view, the unconscious function in the patient that is engaging in the therapeutic alliance by communicating material from the unconscious. As the UTA is an unconscious function, it cannot be experienced directly. The functioning of the UTA can only be observed afterwards, through the material it has brought forth from the unconscious. Within the therapeutic alliance, the focus is on the patient's goals. Therefore, the UTA refers to the patient's UTA that, when activated, communicates material from the patient's unconscious and past.

Simultaneously, a therapist is equipped with similar unconscious functions of the mind as the patient. Therefore, the ther-

apist also stores information about the patient in their own unconscious, including information about the patient that they were never conscious of, for example particular ways of speaking the therapist failed to notice consciously. Classically, this collecting of information is seen to be done through an evenly suspended attention (Freud, 1912). A function that brings forth relevant material to aid the therapeutic process therefore also must exist in the therapist. This could be called the *therapist's UTA*. The notion of the therapist's UTA has been described before (e.g. Kuhn, 2014, p. 364) although it has not been clearly defined. In my view the therapist's UTA should not refer to the therapist's own personal therapeutic process with the therapist's psychological conflicts at the center of investigation, but instead be seen as a part of the total UTA that is operating in the service of the patient within an established therapeutic alliance.

In this paper, my aim is to describe a phenomenon I call the *UTA mental state* phenomenologically. This phenomenon is observed to occur in the moments when there are signs of the UTA rising in the patient, which is the reason I include 'UTA' in the term *UTA mental state*. Bringing forth unconscious material is the function of the UTA (Davanloo, 1990, p. 2) and therefore the UTA refers to a function. The UTA mental state, instead, refers to an experience. How the UTA mental state phenomenon is linked to the functions of the UTA in the patient and in the therapist is a question for future theory and research.

The UTA Mental State: A Phenomenological Description

I will now describe a subjective experience I have come to associate with the rise of the UTA in the patient I call the UTA mental state. I chose the term to reflect that the experience seems to involve a change in the therapist's mental state at the moment when the UTA is rising in the patient. It is not to be seen as a mere cognitive phenomenon, but includes changes to multiple perceptual and emotional channels at once. In the unlocking, the patient is entering the state Davanloo called "dreaming while awake", which is an altered mental state the patient then experiences (Malan, 2008). My suggestion is that, in a similar way, the therapist's mental state can also change when approaching the unconscious material of the patient. This change of the therapist's mental state can also be linked to an activation of the therapist's UTA, which is the function that brings forth material the therapist has gathered in their unconscious about the patient in the form of memories or fantasies about the patient, or as spontaneously generated things to say to the patient.

I experience the UTA mental state[2] first and foremost, as a growing sense of a shift in my state of mind. The feeling is one of falling into a flow state (see e.g., Csikszentmihalyi et al., 2014, pp 230-231), immersed in the patient's world. When it rises, the experience often includes a sense of being taken over by a wave of alertness and focus. This wave brings astute attention to the patient and can be accompanied by empathic reactions to the material. Personally, the most tell-tale sign is the visual effect: There is a softening of the gaze that makes the vision blurry. The field of vision can seem to become clouded or colored by something, in some cases accompanied by tearing up with sadness. Sensations in the body seem to flow more freely. The focal point of the eyes seems to not be the external physical person, but somewhere behind or inside them[3]. The mental state is similar to when reading a good book when the outside world disappears. It seems to be largely involuntary and, with increasing momentum of the UTA, difficult to hold aside. If I resist it and try to focus on the person in a more regular way, it gives me the feeling of distance, detaching and coldness. The softening of the gaze gives a feeling of looking into the soul of the person. As such, it can feel revealing: The patient inevitably also sees me, and there is emotional intimacy between us. I experience the UTA mental state as a continuum: it can be weaker or stronger. The first signs might be more subtle, whereas the full effect can be quite strong. As it gets stronger, there is a sense of something important happening in the patient: perhaps new connections are made, or defenses become more dystonic, or associations flow more freely. The UTA mental state is not any one surprising thought that enters my mind, but I experience it as a change in my mental state that is more meditative in nature. Therefore, I still pay attention to and follow observable signaling from the patient's UTA.

In Figure 1, perceptual sensations, thoughts, emotions, and physical sensations are described. It is likely not a complete list, and all sensations and feelings might not be present at the same time or with the same patient. The information accessible through different sources can stand in contrast to each other; While there might exist some irritation about the lingering resistances in the countertransference of the therapist, the thoughts might convey a sense of wanting to wait and see. What the thoughts often seem to relay is a sense of not rushing. Intervening too much could be undesirable as it might get the therapist entangled in unnecessary enactments, or make the therapist miss a fleeting sadness in the patient's eyes. Instead, giving space for the patient to freely associate could lead to the UTA gaining momentum. This space also allows the therapist's UTA to bring forth its associations and impulses to speak to the patient's unconscious. If irritation about resistances again rises in the countertransference of the therapist, the therapist can feel more confident about intervening in a more active fashion.

FIGURE 1: PERCEPTIONS, EMOTIONS, SENSATIONS, AND THOUGHTS WHICH MAY BE EXPERIENCED BY THE THERAPIST DURING THE UTA MENTAL STATE

PERCEPTIONS AND COGNITIVE FUNCTIONING	EMPATHIC MIRRORING AND/OR SIMULTANEOUS COUNTERTRANSFERENCE REACTIONS
• Blurry or unfocused vision (N.B., not due to anxiety in the therapist). • Waves of colors in the field of vision or around the contours of the patient. • Patient in the center of vision, the rest of the world falling to the sides. • Slight dizziness (not due to anxiety) • Feeling off-balance. • Hyperfocus, flow state. • Changes in the patient's face; The patient might look like a young child or more like an adult than otherwise.	• Alertness, focus. • Warmth, love. • Care for the patient. • Sadness (when breakthrough to grief) • Eagerness for the patient to face their truth, whatever it may be. • Irritation towards lingering resistances. • Being moved by the patient's story. • Seriousness.
THOUGHTS	**PHYSICAL SENSATIONS**
• Examples: "I don't know what's going on, but something is happening." "This is something important. Now I better listen." "Hold off on your theories and listen carefully." "No, don't intervene, let's see what happens first." • Thoughts about titrated interventions to overcome the remaining resistances. • Associations brought on by the therapist's own UTA. • Impulses to speak to the unconscious of the patient.	• Energy moving up or freely flowing. • Fluidity in emotional experience. • Warmth, moving up. • Teary eyes when there is sadness.
	OTHER CLINICAL INTUITION
	• Sensing being able to talk more directly to the unconscious of the patient. This can be a feeling of a hole opening in the wall of resistance, or as a more direct line of communication becoming possible between the therapist's and the patient's hearts. This feeling could also be confirmed objectively by observing that the patient is no longer defending against what is said but, for example, becoming moved by it.

Illustrating the UTA Mental State: Clinical Vignettes

I now present three vignettes (A, B and C) that illustrate the UTA mental state and how it informed my clinical thinking differently in each case. The three different vignettes are chosen in order to demonstrate that the UTA mental state can represent different aspects of the patient's process, and that it might not be clear for the therapist what the UTA mental state represents when it happens. Therefore, it is important that the therapist engages in clinical thinking around their experiences of the UTA mental state. The first vignette, Vignette A, shows how following the UTA mental state was a factor in avoiding getting into an enactment. The second vignette, Vignette B, shows how the UTA mental state can represent that the patient is becoming aware of some defensive way of relating, which in turn creates dystonicity around this way of relating. The last vignette, Vignette C, shows how the UTA mental state can be a sign of finding the resistance. Additionally, all cases show that the UTA mental state is not a sign of a complete removal of the resistance. Following each vignette, I will further discuss what can be learned about the UTA mental state as a source of information.

Vignette A: Following the UTA mental state avoids an enactment

A 31-year-old female patient[4] enters our fourth session. In our previous sessions there has been moderate resistance, and some breakthroughs to grief. Immediately when entering she has a smile. The smile has been identified in supervision as a defense worth exploring. However, right now when she enters, she is talking about positive things in a primarily non-defensive way

and the UTA mental state is present from the start. I experience a visual blurriness in the field of vision that comes in waves with a simultaneous hyperfocus on the client. I have learned to associate this with the UTA but am surprised at the timing of this happening from the outset of the session. My thoughts are:

"Wow, how come the UTA seems so strong? She is talking, but also avoiding my eyes somewhat. Am I failing to point out her defenses? I do see the smile and the gaze avoidance, but it just doesn't feel right to intervene. But looking at the video, would I see what I feel now - that the UTA is strong? Maybe not but I do feel it would be wrong not to let her speak and wait for whatever's coming - Something is coming!".

She continues to talk about good things in her life that had happened recently. There are defenses present that I could, and maybe even should[5] address. However, the countertransference lacks an irritation that had been there in previous sessions surrounding these defenses: The contrast in the countertransference feelings is stark. Letting her talk, inquiring, and gaining clarity about what she was talking about, leads to the formulation of the pattern in her upbringing of being dismissed and forgotten about when things were good, and only really getting attention when things were bad. Talking about this freely brings up the contrast to current experiences of close people showing her care and celebration also when things are good. This contrast leads to a breakthrough of grief.

Allowing myself to follow the UTA mental state that was present from the outset of the session helped me be more passive about her initial defenses. This presumably helped me avoid enacting the pattern of focusing on what was "wrong", and instead gave her space to celebrate the good. All things considered; she was relaying important information from the start. The defenses present were noticed, but the defenses' effect on her relaying her story was minimal. The same decisions could have been made without noticing the UTA mental state: The UTA in the patient could be observed to have the upper hand over the resistance also by looking at what was said. She spontaneously shared links to her own past and directed the focus to a painful theme. The UTA mental state, however, provided another point of data that informed me in that moment. The enactment avoided could only be noticed in hindsight, but listening to the UTA mental state helped me have confidence in what I wanted to do. The tactical defense of smiling could be identified and discussed in later sessions.

Vignette B: Following the UTA mental state brings insight into a defense

On our fifth meeting a 27-year-old male, resistant patient states that he wants to talk about anxiety symptoms and tiredness he suffers from in his day-to-day life. I immediately notice his distant and matter of fact way of talking. Asking about what it is like to come and see me, and about feelings coming up towards me behind this distant way of talking, reveals his resistance of intellectualization. I begin resistance identification transitioning into short-range head-on collisions[6], building on the work of previous sessions. His way of relating to me and to himself seems syntonic, so I explain why I am making him aware of the way he is avoiding, referring to the therapeutic task. He holds on to his resistance in that he can see what I mean but continues to keep the distance. After a phase of challenge and head-on collisions with the resistance, he suggests trying to stop his looking away and uncrossing his arms (a sign of the therapeutic alliance). I encourage him to do so. The UTA mental state has been growing during the resistance work and now is quite strong: it includes waves of colors of blue, yellow and white in the visual field, distortions of his face: sometimes looking sad, sometimes like a different person. I wait to see what happens: we share eye contact for a period. During this period, I am experiencing irritation with some tension but later relaxation and sadness with my eyes tearing up. As the UTA mental state is active and quite strong visually, I simply let it play out, thinking that whatever is going on might be important. Another thought I have is that this might be exhausting the defense, or at least acquainting him with it thoroughly. I am choosing not to be active as a form of pressure on his passivity. Inquiring about what was going on when he finally breaks the silence, he reports noticing how different thoughts were coming to distract him from the "exercise". This leads us to noticing a defensive pattern of observing himself perform instead of being within himself and letting me close. He can thus perform for the other person, intellectualize about the process, but does not let himself or his true feelings be known. He then has an association to his girlfriend, with whom he does not share his feelings either. I point out that when he does not share his intimate thoughts and feelings it leads to a distant relationship with me as well as with his girlfriend. He seems to react to this, so I ask about it. He replies that he feels "weird" about it. I wonder whether that is it, or if he has some feelings about what I'm saying. The patient is then able to identify feeling frustrated with me. The time has, however, run out and the session is then ended.

In this case, The UTA mental state was not an indication of the UTA having a complete upper hand over the resistance, but a loosening of the resistance. By allowing the UTA mental state to play out, it became clear how he avoided real emotional intimacy through performing and self-observing in his thoughts. The UTA then provided an important link to the current relationship with his girlfriend. Following the UTA mental state in this case led to him becoming aware of how his resistance operated. The discussion that followed allowed for driving home how this was a resistance against emotional closeness that kept others at bay and hindered our work together. This experience could be built on in later sessions.

Was it a successful intervention to follow the UTA mental state and not go for a higher rise? At the point where the

UTA mental state came on, I did not know how to intervene in a way that would generate more rise: Head-on collisions had a marginal effect and were lacking something, probably pressure on his passivity and on the performative stance, the latter of which I was largely unaware at the time. The discussion that followed revealed insight into his resistance against emotional closeness and its effects on current relationships. In the following session, the resistance against emotional closeness was diminished and the therapeutic alliance improved. This vignette shows that the UTA mental state can occur at any point, not only before breakthroughs but also when there is an important diminishment of the resistance. Following the UTA mental state helped gain insight into, and dystonicity around, the performative nature that the patient was bringing to his relationships as a way to keep others at a distance. In this example, I was following the UTA mental state for a lack of a better guess at how to intervene. Another therapist could perhaps have picked up the patient's passivity and performative façade in some other manner, but for me it was the UTA mental state that helped gain confidence in that something could be gained from letting it play out.

Vignette C: The UTA mental state signals finding the resistance

In our seventh meeting, a 25-year-old bisexual woman with resistance against emotional closeness and declaring her will reports feeling better. Nevertheless, we have not been able to get closer to the root of her suffering and her saying she feels better seems to be a way of avoiding declaring what she wants to work on in the session. Reflecting on the case, I notice the significance of my failing to address her way of not speaking honestly and openly about everything that is going on in her life. She consciously (and maybe somewhat defiantly) decided to leave out important details, not deeming them important, which I did not challenge at the time. In this session, she talks about having a sense of being dishonest and hiding parts of herself as she has not come out to her conservative Christian family, afraid of their reaction. She is vague and indecisive in her speech, qualifying what she says with a "maybe" or a "could be" and not standing firmly by anything she says. I start addressing the indecisiveness and her way of leaving things non-committal. I express how this will inevitably leave us stuck in not knowing what she wants from therapy and lead to further not-knowing and hiding in her life. She admits to a fear of not getting accepted as herself if she was to reveal her true self. She says she feels sad about it, but we notice how she keeps herself and her feelings at a distance. This leads to another phase of resistance identification, bringing up the next defense of a self-neglecting attitude towards her feelings and herself. We notice how she explains and thinks about her feelings rather than wanting to feel them.

At this point there is irritation in the countertransference, but not really any good signs from the patient's UTA. I then move back to talking about the price of her way of neglecting herself by not choosing to listen to her feelings and putting on a compliant but non-committal façade. This is the moment the UTA mental state comes on and there is an increased focus in the visual field with everything else falling to the sides. It is accompanied by the sense of being able to talk through a small hole in the wall. I draw on the information gathered from previous sessions whilst trying to talk to her unconscious from my own heart. However, while this leads to more activation seen in fidgeting and sighing, she continues to avoid and put her feelings to the side. This crystallizes the resistance of ultimately not being committed to herself, her feelings or even to getting help. During the rest of the session, the resistance prevails.

In this case, the UTA mental state seemed to give confirmation that the resistance identifications were hitting some real, experienced dilemmas in the patient that she could not dismiss. Before the mental state came on, the interventions seemed to bounce off her at a greater degree. It therefore seemed to be the sum of the preceding resistance identification work that led to a more comprehensive picture of her suffering, which started to produce the signs of a rise in the UTA (sighs) and the UTA mental state (narrowing of the visual field). The UTA mental state along with sighs and other signals from the UTA functioned as feedback of something starting to happen, which helped me know where to focus to mobilize the patient further. Further elements of the head-on collision that would have highlighted the destructiveness of her avoidance patterns to the therapeutic process would likely have been necessary for a higher mobilization.

Challenges for the Therapist and Patient: Resistance and the UTA

The emerging UTA mental state seems to correlate with an opening in the patient's resistance. As described in vignette C, the UTA mental state comes with a sense of a beginning "hole in the wall of the resistance" and it is important that the therapist's actions do not block this opening. The therapist can instead talk through the "hole in the wall", speaking to the unconscious behind it. I have observed that the UTA mental state often occurs before a loosening up of the defensive structure, for example before breakthroughs to grief. This loosening brings up more significant material from the unconscious, which is a function of the UTA (Davanloo, 1990, p. 2). Simultaneously, the patient can continue to present with defenses that come in as a last effort to hold off the emotions or memories and block the opening in the resistance. As the vignettes exemplify, the level of the remaining resistance determines the level of the pressure and challenge needed to break through. When the rise has been high enough, the defenses that come in seem like a last effort to cling to the character armor, including an effort to resort to old defenses. Curi-

ously however, this clinging also seems to exhaust the defense due to the UTA already secretly having the upper hand.

Not only the patient can defend against the rising UTA. The therapist's defenses and resistance to emotional closeness could also get in the way of experiencing the UTA mental state (see also Abbass, 2015, chapter 4). For the UTA mental state to occur naturally, the therapist needs to first tolerate the emotions evoked in resistance work with increasingly higher rise.

Next, the therapist needs to be able to allow the UTA mental state, that is, not try to hold it off but learn to follow it. Allowing the UTA mental state seems to help the therapist's UTA along in bringing up necessary information about the patient. This, however, requires an attitude of surrender, which can pose a challenge for the usually active ISTDP therapist. The therapist must switch gears: During the phases of defense and resistance work, the therapist has a curious but bold attitude about getting clarity from the patient about the function and price of a defense or resistance so that it can become dystonic and worked through. The therapist must take their observations of defensive maneuvers seriously, whilst simultaneously having the attitude of curiosity and not-knowing. When the patient's UTA takes the driver's seat, however, the therapist must be ready and willing to switch to a greater attitude of surrender and receiving. This can be difficult for the therapist if there is a tendency toward omniscience (see Brightman, 1984), an overidentification with the active therapist ego, or a difficulty in creating emotional closeness.

After surrendering to the experience of the UTA mental state, the therapist must have a willingness to be open and speak to the patient's unconscious. These words could also speak to the therapist's own unconscious and trigger feelings, which the therapist needs to be able to make room for and not ward off. Becoming aware of wanting to avoid or withdraw at this moment can help the therapist make a conscious choice to face and be moved by whatever rises in the patient or in themselves.

Discussion

Why describe the UTA mental state? First, psychoanalysis has traditionally been interested in the subjective of not only the patient but also of the therapist, and in the analytic "third" that emerges between the two parties (Ogden, 1996). In ISTDP, although the therapist's subjective feelings and experiences are talked about in teaching and supervision, this is not yet as well formulated in the literature. Davanloo's focus on observable video data has led to an emphasis on objectively measurable cues, mainly verbal and physical ones. This focus on observable signs using video recordings has some advantages: Not only does it help the learner to know what signs to look for in a concrete way, which helps the therapist learn to listen to the patient with their eyes and ears, but it also brings verifiability and objectivity to the process. Subjective cues are less salient and less discriminatory on whether they stem from the patient or the therapist themselves; this makes them less reliable. In the case of countertransference reactions, there have been efforts to categorize countertransference into objective and subjective, (Winnicott, 1949) or as totalistic, including all therapist emotional reactions (Kernberg, 1965). These concepts aid therapists by offering mental categories to help them think about their subjective experiences.

Psychoanalytic literature stands on the shoulders of giants who have brought forth previously unadmitted subjective experiences of therapists such as hate in the countertransference (Winnicott, 1949), to name but one concept. Describing the therapist's emotions, perceptions and sensations helps practitioners get in touch with and prepare for the range of human experiences that can be present. I believe an experiential model such as ISTDP should aim to describe subjective experiences of the therapist with the same precision as when exploring the patient's feelings and asking for the psychological label, the physical sensations, and the motor impulse of a feeling. A more precise picture could further the understanding of the healing processes in operation and create mental representations of them. Having mental representations has been found to aid understanding and learning (Ericsson & Pool, 2016). Therefore, mental representations of subjective experiences could help estimate which experiences in the countertransference are induced by the patient, by the common connection and alliance, and which have their source in the therapist's own emotional reactions on a certain day. The more I have focused on defining and describing the UTA mental state phenomenon, the more ubiquitous and easily recognizable it has become.

Treating all therapist's subjective experiences and countertransference as sources of information presupposes a need for clinical thinking and hypothesis testing. Different sources of information can help verify or falsify hypotheses about the psychodynamics of the patient, or between the patient and the therapist at any given moment. Through vignettes, I have shown how the UTA mental state can be thought of as an additional, although not sole, source of information whenever it is available. As the phenomenon is not dichotomous – it's not

an on-or-off but a sliding scale – the therapist still needs to simultaneously be aware of other signals of resistance, complex transference feelings, and the patient's UTA.

Describing a phenomenon also lends it to scientific investigation and theorizing. The term UTA mental state was chosen to convey a perceived shift in the mental state coinciding with a rise in the UTA in the patient. Although I have based the description on my own experiences, anecdotal evidence suggests that others share the experience of it. In my estimation, it is likely that concepts such as flow (Csikszentmihalyi et al., 2014) reverie (Bion, 1962/2023), evenly suspended attention (Freud, 1912) or the therapist's unconscious being receptive to the "drift" of the patient's unconscious (Freud, 1923, p. 239), refer to similar mental states. Furthermore, Freud encourages the analyst to allow his own unconscious to enter a resonance with the patient's (Freud, 1912, p 114).

Limitations and future research questions

It is important to consider some limitations to introducing the concept of the UTA mental state and some research questions that follow. Firstly, although the UTA is an accepted concept in the ISTDP model, there is no research that has substantiated an ontological basis for it. The concept was described by Davanloo based on his case studies (e.g., Davanloo, 1987; 2000). The concept of the UTA mental state also needs further exploring and substantiating. While not being written about in ISTDP literature before, there likely exists theory or research on the phenomenon within psychoanalytic literature or in neighboring fields of psychology. For example, what could be learned from research into states of mind occurring in humans in meditation or in hypnosis? What can neuroscience and brain imaging bring to the discussion, and how can the phenomenon be understood psychoanalytically? Differences and commonalities with concepts such as reverie (Bion), life instinct, the models of the unconscious (Freud) and dreaming while awake[7,8] in unlockings (Davanloo), could be discussed further.

As a way of gaining a greater common basis for research on the UTA mental state, an expert panel could be organized around discussing and sharing experiences and views around what it represents and what place it should have in theory and training. Furthermore, a therapist survey could be conducted, as well as deeper theoretical deliberations made to clarify the relationship between other concepts, such as those mentioned above, and the UTA mental state. Another question to be answered is whether entering the UTA mental state relates to the therapist accessing their own unconscious with its associations. As noted by Skorman (personal communication, 2023, December 5) the mental state seems comparable to meditative states. Could meditative states and meditation be a helpful skill for the therapist to learn? Furthermore, could the therapist entering the UTA mental state in some way help induce a similar state in the patient? Is it correct to assume that the therapist's capacity for emotional closeness and readiness to surrender impacts their ability to access their own unconscious with its associations?

A second limitation of introducing the concept is that it might introduce a bias towards focusing on cues from the UTA over working with the resistance and building a conscious therapeutic alliance. In working with resistant patients, the therapist needs to have endurance (Frederickson, 2023). Only after the UTA has been activated enough in the patient, certain phases in the process can become meaningful, for example a phase of content and exploring relations outside the transference (Davanloo, 1987, p. 65-66). Thus, the groundwork for working with the unconscious needs to be laid first, so that the UTA can awaken. In the vignettes provided, the UTA mental state was not an indicator that the resistance was overcome, but rather it seemed to suggest that I was touching on some central aspect of the patient's psychopathology and history. Pursuing "content" prematurely when the resistance still has the upper hand could lead to an overly cognitive and intellectualized process (Davanloo, 1990, p.17).

Thirdly, introducing the concept of the UTA mental state might contribute to a broadening of the concept of the UTA that could ultimately water down what it refers to. There is a risk of both the UTA and the UTA mental state becoming buzz words that get equated with the therapists' intuition or some hard-to-attain altered states of consciousness. A therapist could become too invested in being on the lookout for the UTA mental state, which could lead them to overemphasize its role in decision making. In my view, it is best used as a quiet consideration and accompanied with analyzing other signals and the recording to understand the patient and the phenomenon better. In this paper, I have tried to define my understanding of what the UTA refers to, but further debate is welcome.

Lastly, although the UTA mental state seems to be connected to communications from the UTA as well as with a rise of feelings, is it correct to associate it with the alliance? Kieding (2024) has defined the UTA's signals as "spontaneous collaborative gestures that shine a light on where [the patient] needs help and where [the patient] remains conflicted". If this definition is considered, associating the described mental state with the alliance may be inaccurate. Perhaps it would be more appropriate to talk about "the mental state associated with the rising unconscious material". Furthermore, the concept could, due to its focus on the therapist, falsely reduce the concept of the UTA into something that occurs in the therapist rather than in the patient and in the alliance. The coinage can be defended by its brevity, by considering that the UTA mental state seems to have a communicative function in letting the therapist know that something important has been touched upon, and by considering its relationship to a loosening up of the defensive structure.

Conclusion

In this paper, the UTA mental state has been introduced and described and then discussed using three vignettes. As a subjective state of mind, the UTA mental state cannot be observed from video in the same way as observable signs of the UTA, rising complex feelings, or anxiety signaling can. Therefore, the concept's contribution to supervisory session analysis is limited. Nevertheless, describing the UTA mental state can help therapists observe, accept, and allow it to occur as a part of the therapeutic process. Furthermore, the therapist can learn to think clinically about the UTA mental state through analyzing it as one source in an array of sources of information as I have demonstrated. I have discussed limitations in introducing such a concept, cautioning on an overemphasis on the UTA mental state over the (sometimes laborious) work of analyzing session recordings and supervision, and on it becoming a buzz word that loses its intended meaning and precision. Research is needed to clarify the nature of the UTA mental state and its relationship to other mental phenomena.

Footnotes

1 Davanloo also called it "visual imagery" (2005)

2 I was deliberating whether to call it UTA-countertransference. However, the phenomenon I describe is an experience rather than something I feel in response to the patient in the way countertransference often is thought of (see, e.g., Racker, 1957 on concordant and complementary countertransference). Furthermore, simply calling it emotional closeness would not convey the full depth and the sense of change in the mental state.

3 The softening of the gaze is similar to when looking at autostereograms (Magic Eye 3D Illusions).

4 Client details have been anonymized in the vignettes.

5 It is easy for the ISTDP-therapist to get self-critical about the process in a way that could interfere with listening to the UTA mental state.

6 See, e.g., Davanloo (2000, p. 237; 2001, p. 50) for mentions of the short-range head-on collision.

7 Malan (2008) described dreaming while awake as a previously unrecognized mental state of the patient.

8 Interestingly, Ralph Greenson (1970) argued that the ultraclarity of some dream details reveal that there is a special relationship with the cathexis of looking and memories (p. 523). This could explain the dreaming-while-awake -phenomenon during an unlocking, but also why the UTA mental state often brings up visual distortions and phenomena."

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