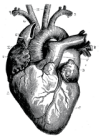
RESEARCH

The Case of the Charmer: Shape-shifting Seduction, Lethal Splitting, and a Salvaged Treatment Using Conversational Intimacy



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Abstract

This paper explores the treatment arc of a case where higher order defenses and capacities consistent with psychoneurotic functioning occurred in close conjunction with regressive defenses indicative of more severe personality disturbances. Within a theoretically-grounded exploratory case study design, several notable features of the case will be highlighted, alongside illustrative transcript excerpts. First, the importance of therapist attention to capacity thresholds in the context of the patient's unique configuration of psychodynamics will be outlined. Second, consistent with the principles of the graded format of ISTDP, we illustrate how over-threshold responses and periods of regression were addressed and ameliorated through a reduced focus on guilt-inducing torturous impulses. Third, the reader will be introduced to an adaptation of the graded approach we refer to as conversational intimacy, which we suggest facilitated progress through integrating feelings of love and hate at lower levels of intensity. Therapist self-disclosure and patient authenticity are foregrounded as primary vehicles for this integration, and generative of a titrated form of emotional intimacy. We also consider how the patient's a priori knowledge of ISTDP may have impacted the treatment. Although the treatment approach in this case shifted focus away from major mobilization of the unconscious, it appeared to build capacity and facilitate corrective emotional experiences nonetheless. We argue that this was achieved partly through emotional intimacy developed at the conversational level, which in turn led to the course correction of a previously derailing treatment process.

Keywords: ISTDP, conversational intimacy, mixed psychodiagnostic presentations, capacity thresholds, emotional closeness, case study, transcript analysis, corrective emotional experience, Davanloo, Rogerian, humanistic.

CONFLICT OF INTEREST STATEMENT
Both authors serve on the Editorial Board of this journal. JK is the Lead Editor and AK is the Managing Editor. Neither author participated in the peer review process, nor in the decision making procedure regarding acceptance of the manuscript for publication. Nil further conflicts.

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Emotional closeness and the integration of mixed and complex feelings rank high on the list of priorities for the ISTDP therapist. The most expedient and powerful way to facilitate these two objectives involves major mobilization and the unlocking of the unconscious, as well as the necessary working through phase (Coughlin, 2022; Davanloo, 1995; Johansson et al., 2014).Where a standard and unremitting approach is contraindicated, there are other avenues to achieve emotional closeness and integration, the most notable of which is the graded format (Davanloo, 1995; Whittemore, 1996). The graded format involves building patient capacity through iterations of pressuring to threshold, easing off, and going back up and staying close to the threshold in order to work at the patient's highest capacity (Frederickson, 2020).

In other instances, an adaptation of the graded format may be utilized. These include instances where corrective emotional experiences of a lesser magnitude take priority, such as: when the patient first needs to be connected to a visceral felt sense of their own subjectivity, or when even titrated forms of approaching the unconscious reinforce projections or transference resistances. One such adaptation involves what we refer to as *conversational intimacy*. Rather than approaching capacity thresholds, conversational intimacy involves framing open and honest patient responses as successful engagement in the therapeutic task. This adaptation significantly departs from the traditional ISTDP preference for focussing on treatment-impeding responses (e.g., defensive or anxiety-laden responses). According to Davanloo, when a patient demonstrates a mixture of both "genuine communication" and "resistance", challenging the resistance should be given first priority (Davanloo, 2000, p. 16). In contrast, conversational intimacy tolerates elements of resistance *in favor of* highlighting glimmers of patient authenticity and openness (i.e., "genuine communications," to use Davanloo's nomenclature). In this way, it adopts a lower standard for what is considered progress.

Though less intense than a proper unlocking of the unconscious, conversational intimacy is one form of taking down walls through authentic engagement. It embodies Greenson's (1967) notion that genuineness and realism are essential ingredients of "the real relationship" (p. 217), and parallels Lebeaux's (2000) claim that the conscious therapeutic alliance requires the patient to experience that "the relationship with the therapist is genuine, that the therapist is interested in the patient" (p. 41). For this purpose, the therapist may make judicious use of certain forms of self-disclosure to assist the patient in making informed decisions, to disrupt transference distortions, and to model authenticity (M. Skorman, personal communication, June 7, 2017). Conversational intimacy also draws from the Rogerian approach of *necessary and sufficient conditions* (Rogers, 1957) in a manner which remains true to the dynamic and experiential focus of ISTDP.

Determining which approach to take with a patient involves attending to contextual and psychodiagnostic markers. ISTDP has well-established parameters to guide such decision making (Abbass, 2015; Frederickson, 2013). These are crucial for giving therapists an orienting framework. In the praxis of ISTDP, however, complexities and complications often arise, destabilizing this framework. Anecdotally, there may be co-occurrence of multiple pathways of unconscious anxiety discharge, and defensive processes taking place alongside spontaneous collaborative gestures, (i.e., unconscious therapeutic alliance [UTA] activity). In addition, spontaneous sighs and expressed willingness to look at feelings do not negate the possibility that less obvious ego-syntonic resistances are also in operation. Emotional breakthroughs may occur in the absence of antecedent sighing. Regressive defenses can be utilized in the service of resistance against emotional closeness, and oedipal and preoedipal conflicts often admix (Frenkel, 1996; Segal, 1964). Davanloo (1978) speaks to this idea when he asserts the need to evaluate and locate the patient's major area of conflict as per the psychosexual theory of development [oedipal or preoedipal]: "the components of both are present in all individuals" (p. 19). In the context of ISTDP psychodiagnosis, when a patient exhibits a proportionate amount of both oedipal and preoedipal conflicts (i.e., one set of markers does not clearly outweigh the other), we will refer to such intermingling phenomena as *mixed presentations* (see also "mixed neuroses", Freud, 1894, p. 23; "mixed cases", Gediman, 1983, p. 59; "mixed neurotic and narcissistic cases", Gediman, 1989, p. 304).

Davanloo's metapsychology suggests that when a patient can intellectualize inner states while discharging unconscious anxiety into skeletal muscles, major mobilization of the unconscious is typically warranted (Davanloo, 1995). Contraindications for major mobilization include an absence of striated signals, regressive defenses, over-threshold anxiety, ego-syntonic forms of resistance, as well as certain forms of self-attacking defenses and transference resistances (J. Frederickson, personal communication, December 23, 2021). By contrast, mixed presentations highlight the limits of categorical clarity and instead bring in the reality of proportions. Mixed presentations call into question certainty about clinical decision-making based on binary parameters of assessment (i.e., is the will

online or not? Is this a feeling or anxiety/defense?). When a patient presents with a somewhat stable mix of the above-mentioned markers, it can be difficult to know how to proceed.

Here we present the case of The Charmer – a patient with a mixed presentation of psychodiagnostic markers not commonly seen together in both configuration and proportionality, which in turn created complexities for the treatment approach. At first glance, the patient presented with some of the features of a borderline level of character organization: regressive defenses (i.e., splitting, projection, acting out, weepiness); transient instability in the defensive structure; and indications of an oscillating transference pattern (Kernberg et al., 1989). Additionally, the patient showed intermittent and mild cognitive-perceptual disruption (CPD), so a case could be made for a diagnosis of a fragile character structure. Juxtaposed with markers of fragility, the Charmer also presented with a set of capacities indicative of psychoneurotic functioning; an ability to reflect upon and intellectualize inner states and feelings, a well-developed observing ego, active and deliberate efforts to distance from the therapist, and an ability to contain anxiety in skeletal muscle tissue at *high levels of rise* (Davanloo, 2000). Notably, the combination of striated signals and self-reflective capacities, along with regressive defenses, were consistently present in almost every session, suggesting that the mixed markers were not merely a result of the therapist shifting treatment approaches at various junctures. The Charmer's ability to intellectualize, even when regressed, appeared advanced. This combination is also why we believe that Abbass' (2015) concept of "rotating fronts" in fragile patients does not adequately capture the Charmer's presentation (p. 280).

With these psychodiagnostic and treatment complexities in mind, we will present a theoretically and abductively-oriented qualitative analysis of how the case of The Charmer evolved over time, with an eye to introducing conversational intimacy and its potential role in the patient's emotional healing. To orient the reader more clearly to the approach, we will describe specific examples of therapist behavior. These descriptions are ostensive in nature, however, and we cannot emphasize enough the vital importance of the therapist's state of mind, or stance, in bringing this approach to life. Our primary objective is to both describe and explore the trajectory of this complex therapy process through narrative form, with a focus on therapist decision-making, in order to evoke further clinical explication of the conversational intimacy adaptation (including and beyond the psychodiagnostic specifics of this particular case).

Methodology

Design

We present an exploratory single clinical case study using transcript excerpts and process reflections across a full course of treatment, with a phenomenological focus on the therapist's experience of psychodiagnostic markers, unfolding clinical decision-making, and the embodiment of conversational intimacy. Conducted within an interpretive description framework (Thorne, 2016), the design draws from the clinical case study design advocated by Willemsen and colleagues (2017) and the naturalistic case study design of Abma and Stake (2014), with priority given to enhancing methodological rigor (Iwakabe & Gazzola, 2009). Case studies of this kind which draw on practice-based wisdom can provide important contributions to the clinical knowledge base, including the psychotherapy context (Iwakabe & Gazzola, 2009, 2014; Meganck et al., 2017.; Midgley, 2006; Willemsen et al., 2017; Yin, 2018).

Participants

This case study focuses on the interactions of a therapist-patient dyad over a full course of treatment. The therapist, first author JK, was a 41-year old white male who had been using ISTDP in clinical practice for 11 years, had received regular audio-visual supervision from a close student of Dr Davanloo for 10 years, and had taught and supervised other therapists on the method both privately and in higher education for more than five years.

The patient, Mr C., will be described only in brief detail in order to protect confidentiality. He was a highly-intelligent, white, middle-aged man living with his husband in the Southwest of the USA. He was employed in the natural sciences department of a University. Mr C. presented in 2023 for online psychotherapy, once to twice per week, over 13-weeks.

Informed consent was provided by the patient for both authors to utilize treatment data in the manner outlined in this study, including viewing videos and transcripts of sessions, as well as for the publication of this paper in its final form. Steps have been taken within the paper to ensure patient confidentiality. Methods were consistent with the ethical requirements of the journal.

Patient presentation and relevant history

Mr. C presented with complaints of unstable self-esteem and interpersonal difficulties (e.g., procrastination, distancing, acting out behaviors) related to childhood traumas. He was

highly intelligent and educated and had achieved vocational and financial success. Mr. C was psychologically minded, had a well-developed sense of humor, and as the title suggests, was charismatic and charming. Mr. C leaned histrionic in his mannerisms and personality type. Though he could come across as emotionally labile, he displayed a genuine warmth and care for others. During periods of regression, his reality testing remained predominantly intact.

Mr C. tended to feel humiliated in the face of university students not taking him seriously and other forms of actual or perceived criticism. Such situations mobilized intense rage, which then activated self-defeating behaviors, including an urge to "go nuclear" through vengeful acts of sabotaging relationships that ultimately hurt the patient himself. He was also intermittently unfaithful to his husband.

Other than his university teaching, Mr. C lived a fairly isolated life where pornography and masturbation combined with sensation enhancing drug use (amyl nitrite) was a central preoccupation. His isolation was a conscious choice, as Mr. C was well aware that interactions with others could lead him to become self-destructive. In his youth, he was addicted to hard drugs. He had tried to end his life on three occasions, once by filleting his arm with a knife in several deep wrist-to-elbow cuts. During this period, he was twice psychiatrically hospitalized. He had been diagnosed with Bipolar Disorder Type II many years earlier, which he reported was well-managed with mood stabilizing medications (see Table 1 for overview of psychodiagnostic markers).

Analytic method

In line with study objectives, the analysis was conducted within an interpretive description paradigm (Thorne, 2016) to produce a narrative that highlights key aspects of the treatment trajectory. The narrative form was selected based on congruence with the nature of an unfolding treatment process (Clandinin & Connelly, 2004; Nasheeda et al., 2019). Data comprised session videos (recorded as standard part of treatment process), verbatim session transcripts, therapist self-report and notes, and patient written reflection post-termination (Yin, 2014).

Analysis was undertaken by the first author/therapist (JK; previously described in Participants section) and the second author (AK). AK was a 39-year old female ISTDP-informed clinical psychologist who had practised as a therapist for nine years and as a qualitative researcher with academic experience over 15 years. She had not been part of the treatment process. The patient (also previously described) contributed to the analysis through iterative cycles of checking and contributing feedback to manuscript drafts, consistent with participatory and ethically-informed approaches (Scher et al., 2023). The analytic method was checked by an independent expert researcher who was highly experienced in qualitative analysis of clinical case data. In this way, analytic rigor was enhanced through triangulation, member checking, persistent observation, reflexivity, and independent scrutiny (Burdine et al., 2021; Korstjens & Moser, 2018; LeCompte, 2000; Moon, 2019), but with the therapist perspective foregrounded in a manner responsive to study objectives.

The analytic process was conducted in an iterative manner that combined clinical practice wisdom and qualitative mechanisms. First, verbatim transcripts of the full treatment process were read alongside therapist notes, correspondence from the patient about the therapy experience, and watching video of recorded sessions. Second, the authors selected transcript segments which responded to questions of a) complex psychodiagnostic markers in operation, b) differing approaches on the part of the therapist, and c) explication of the conversational intimacy approach. These segments were chronologically plotted to reflect the unfolding treatment process. Next, the authors reflected on the structured transcript segments through the lens of two questions: 1) what clinical tensions or considerations might this segment evoke for the reader in terms of ISTDP praxis? and 2) how and why were the therapist's perceptions of the patient and process influencing his approach at this point? Analyzing data in this way was intended to produce findings responsive to the study objectives, with particular emphasis on clinically-relevant implications for ISTDP therapists (Burdine et al., 2021; Nasheeda et al., 2019; Thorne, 2016).

Therefore, with the aim of providing the reader an unfolding sense of a dynamic treatment process, the findings consist of a combination of chronologically-ordered transcript excerpts and therapist commentary, as well as process reflection summaries at key junctures. In line with the focussed objectives of the case study, we have had to sacrifice detail in certain places in favor of overarching summaries.

Notes on style

For the sake of readability, the therapist will be referred to throughout the findings in the first-person (I, me, my). The patient is referred to interchangeably as Mr C. and 'the patient', and pseudonyms are used in place of real names. For transcript excerpts, the therapist's tone is calm, gentle, and matter of fact unless otherwise indicated.

TABLE 1: ANALYSIS OF MARKERS IN THE CASE OF THE CHARMER AS RELATED TO EACH SPECTRUM (FRAGILE, PSYCHONEUROTIC, OR BOTH)

AREA	MARKERS
FRAGILE SPECTRUM	
Anxiety	• **Intermittent access to mild cognitive disruption**
Defense	• **Occasional depersonalization** • **Weepiness and whiny tone** • **Transference patterns of behavior based on splitting and projection** • **Projective identification**[a] - suggestions that the therapist was unethical - disclosures of desire to "fuck" and drain therapist of his semen - mild irritation in the counter-transference
Conflict	• **Preoedipal conflicts**[b] - annihilation anxiety (i.e., intense need to dominate therapist lest he would "be nothing") - longing to be held - longing to be reassured/nurtured ("give me a crumb!") - acting out behaviors (e.g., withdrawing and procrastinating) - frequent references to excrement - intense need for control and "going nuclear" if thwarted
Consequent phenomenon	• **Intermittent loss of reality testing** • **Difficulties tolerating internal conflict (see also superego pathology)** - attempts to elicit interpersonal conflict - acting out behaviors involving threats • **Signs of mild identity diffusion**[c] - fear of who he would be outside of the charmer role - vulnerability to intense shame, humiliation, self-loathing
PSYCHONEUROTIC SPECTRUM	
Anxiety	• **Spontaneous sighing during phases of major mobilization** • **Musculature contained tone, firmness, and animation**
Defense	• **Advanced ability to intellectualize, isolate affect**
Conflict	• **Oedipal conflicts** - need to compete, dominate, and be punished by therapist (see also superego pathology) - need to replicate triangular conflicts through acts of unfaithfulness - eroticized feelings towards genetic figures - conflicted around developing successful relationships
Consequent phenomenon	• **Reality testing predominantly intact** • **Moments of cognitive disruption quickly resolved** • **Pervasive ability to intellectualize about feelings** • **Advanced observing-ego function** • **Active, frequent distancing from the therapist (resistance against emotional closeness)** - explicit opposition towards the therapeutic task - intermittent gaze-avoidance - indefinite speech - attempts to distract and obfuscate as a tactic to keep parts of himself hidden • **Classic signs of transference resistance** - tendency to perceive therapist as authority figure and the relationship as unequal - intense compulsion to repeat and replicate his maternal relationship - rage and pain in response to when the therapist's stance prevented him from replicating maternal relationship, at one point pleading: "comfort me by punishing me, like my mom"
FREQUENTLY RELEVANT TO BOTH SPECTRA	
All areas	• Ready access to impulses[d] • Superego pathology and masochism[e] - three suicide attempts, one gruesome in nature - historical addictions to methamphetamine and alcohol - tendency to sabotage relationships (i.e., "go nuclear") - tendency to act "nasty" to others - interpersonal isolation

a: Evacuation of his insecurities and attempts to forcibly push them into the therapist (Hinshelwood, 1991)
b: oral and anal (primarily expulsive-type) conflicts related to stages of development (Freud, 1905; Spotnitz & Meadow, 1995)
c: a loss of self-awareness due to the fragmenting effects of splitting and projection, resulting in a failure to coalesce around a stable and intrinsic self-conception (Kernberg et al., 1989)
d: classically codified at extreme ends of each spectra
e: see also 'difficulties tolerating internal conflict' in Fragile section

Findings: The Case of the Charmer

Early stage of the treatment

This phase of treatment includes sessions one through four.

Experientially eliciting the patient's priorities

The first session was three hours in duration and began as follows:

Therapist: So, I got your paperwork and obviously I'm interested in your priorities for therapy. But before we go there, you know, given your history, I know it was a long time ago, but given that there were some real safety concerns, would it be okay with you if we just start there?

Patient: Yeah, yeah, yeah.

Therapist: Okay. Can you just explain to me what led up to the suicide attempts? What was going on?

Patient: Oh, um. So. It was around sexuality and my father especially having a really hard time with my being gay. Um, and. Yeah, I think that was one of the main causes. Another one involved. Dad was an alcoholic. Until what, age? 11. He got sober and he... He's since passed. Um, he turned into a really great guy. But in... in the very beginning, um, since, um, since childhood, it was... it was a pretty hard, um. Pretty scary. So I think those are... those are some of the things that led up to that.

Therapist: I imagine there's quite a bit of pain there.

Patient: Yeah. Uh huh. Yeah.

Therapist: Even now, as we talk about it, it looks like there's a strong emotional charge in your face.

Patient: Yeah, it's very painful.

Therapist: This pain that we're seeing right here on the surface in regard to your very painful childhood, and your father — is it a part of what you're hoping we get to and help you with in our work together?

Patient: Right. Yeah. It's.. it's.. something that despite... [medium size spontaneous sigh] I've just never worked on in therapy before [the patient's voice now sounds choked up with pain, and some tears are coming down his face at this point]. And so... Um, yeah, but I feel like it's holding me back. Um.

Therapist: Yeah. Can you elaborate a little bit? Tell me about how it's holding you back.

Patient: Um. I just feel like I've buried it. A lot of the pain. And I don't think it's good that I have buried it.

We are organically getting to the patient's goals for the treatment by virtue of first prioritizing safety concerns, and then naturally inferring that the obvious and palpable pain that emerged in the patient is likely part of why he wants help.

Clarification of defensive repertoire and the patient's familiarity with ISTDP

[continued]

Therapist: Why do you say it's not good that you have buried the pain?

Patient: Yeah, because... well, guess I feel like I've got to play a role in life and pretend like everything is fine, and, um. Then guess I'm good at it. And the older I get, it's just the more exhausting it becomes. And, you know, I was in AA [Alcoholics Anonymous] for a long time and I learned that you are only as sick as your secrets.

The use of equivocations such as "guess" amounts to indefinite speech, a tactical defense. These defenses are not impeding the flow of the session so I opt not to comment on them at this stage. The patient agrees with the characterization that he "puts on a happy face," and elaborates on his performative mode as a means of keeping others at a distance:

Patient: The charm, the distraction. Uh huh. Yeah.

The patient goes on to describe how far back these difficulties go. He paints a picture of a mother who emasculated him, calling him a loser, worthless, a burden, and other emotionally abusive characterizations:

Patient: Sorry. I'm just... a lot of a lot of emotions [the patient's voice is extremely choked up, to the point where the words appear almost forced out of his throat, and he is tearful].

Therapist: Yeah. You don't have to talk right now. Just stay with what you're feeling. There's a strong emotion inside. You don't have to cover it up with words right now. Just take your time. And then when you feel ready, you can tell me what the emotions are.

Patient: Oh, it's... a lot of anger, a lot feel... Like a... lot... A lot of anger, and pressure... Like right here in my chest, and like a fire in my belly, and um.

We go on to look at how anxiety is mixed up with his anger, and how he spends most of his waking hours trying to pretend that he is confident and happy although he is often not confident, and in fact is angry and sad. The patient is clear on how draining this is for him, which suggests that this defensive strategy is at least in part ego-dystonic. At this stage, a dynamic, phenomenological inquiry naturally interlaces with mild pressure and clarification of the patient's triangle of conflict. A prominent dynamic now begins to emerge. The patient describes a lifetime of hiding

behind a facade, something which stands in contrast to how open he is being with me about these difficulties. This sets the stage for looking at feelings he might be having towards me, since he is doing something (being open and honest) that is very different from his typical behavior. The patient reports that leading up to this session, he has had mild panic attacks, headaches, and some nausea. He is clear that these symptoms relate to his dread of "facing his shit." This information suggests a lower ego-adaptive capacity, though his in vivo responses to pressuring interventions ought to yield a more reliable psychodiagnostic picture.

...

Ten minutes into session one, the patient begins to display some gaze-avoidance and reports a fear of being fired by me. When his gaze-avoidance is pointed out, the patient discloses eroticized feelings towards me. He reports that when he has fights with partners, he tends to suddenly feel sexual and compelled to seduce them. He further discloses that in sharing his sexual feelings towards me, he is really afraid that I will reject him. The patient then reports that he tends to sexualize relationships as a way to squelch his angry feelings:

Patient: I have a tendency to objectify, and kind of sexualize stressful relationships where I'm with a man who is in authority, and I know you're not in authority, but you know, part of me sees you as authority [spoken as if it were a question].

A transference relationship is therefore being imported, as the patient's sexualized response is *specific* to "stressful relationships with men in authority." He has already made the link that this could be in the service of avoiding anger, but I am concerned that if I press for feelings towards me at this stage, I will be reinforcing the transference resistance where we are in a "stressful relationship," on unequal footing.

Patient: there's kind of a primal part of me that objectifies you. Sexualizes you. You know what I mean? Finds... finds, you know, gratification in doing so.

The patient then reports that when his mask "slips off," he tends to be "nasty to people." This turns out to mean highly critical and condescending—defensive expressions of his anger. Since he has been relatively unmasked with me, this again implies that there could be angry feelings towards me.

...

Forty minutes into the initial session, when asked about feelings and perceptions towards me, the patient appears to become competitive. He discusses a desire to corrupt me, a wish for me to break rules for him, and how erotic this would be for him:

Patient: You speak very confidently and some of it comes across as to me, the way I interpret it is like an arrogance. But also it's that aspect of you that I'm sexually attracted to you. And it's like, so that's where a part of me kind of experiences your power. And in some way I have it in my fucked up head that that, you know, you are confident and you are arrogant. But I sexualize that. Or maybe I objectify and sexualize you, that part of me. Because if I can - and this has been the goddamn fucking theme of my life, and thank God I don't do it anymore, and I carry a great burden of guilt around it - that if I can kind of seduce you or whoever, whatever object, then I can take your power. I can have power over you because, because I'm able, I mean kind of figuratively and literally. When I'm successful at seducing someone, you can extract semen. And semen is the life force. The power force. And so, in a way, if I'm able, like a vampire, to extract that fluid consistently, then at least I can take your power. Does that make any sense?

The patient is not entirely acting out these more malignant defenses, but is primarily disclosing them to me as he becomes aware of them in a spirit of collaboration (and likely to impress me as well). This is a very different situation from a patient who merely enacts their defenses without the presence of mind to verbalize and reflect on them, and suggests higher ego-adaptive capacities. Having said that, I opt not to engage the standard format of major mobilization of the unconscious at this juncture. My reasons include the infrequent nature of sighs, the presence of headaches, panic, and nausea leading up to this session, my concerns about reinforcing a compliant transference resistance, and a felt sense that there could be some fragility in this patient.

...

An hour and 20 minutes into the initial session, Mr. C refers to having viewed the therapist's public online video content about the practice and metapsychology of ISTDP, as well as videos by other ISTDP practitioners. He comments on how he is comparing what he knows from the video content with what he is doing in the therapy room:

Patient: Oh, yeah. Yeah. Because, you know, I've been. Well, I watch you online. You, Jon, and Patricia are my favorite to watch. And I've seen your video on, like, the partial unlocking. And are you just looking for a technique and it's just all... So, I'm constantly wondering, like, is this real? Is this false? Am I doing it right? Am I not doing it right? Like, is it I'm doubting myself? Is this something? Am I just looking for a trick?

Therapist: So, somehow, you're in this kind of performance mode where you're looking to perform correctly, right?

...

An hour and thirty minutes in, Mr. C's defensive performance mode continues to create a relational barrier while driving an anguish-filled experience for him (i.e., self-punitive resistance against emotional closeness):

Therapist: Isn't the first step now to get consensus on what we're dealing with here?
Patient: Yeah.
Therapist: Do you agree that there is a barrier here that is getting erected through performance, through strategizing, through trying to get it right?
Patient: Yeah. I didn't realize... Yeah, I didn't... maybe I was looking away from that kind of... yeah, I can see how it'll be a big barrier and I [medium sized sigh]... I'm scared about... If that barrier comes down, what are we going to find there? There is a great fear.
Therapist: Sure. Yeah. You know, it can be scary. So, first of all, that's valid. I mean, certainly it can be quite scary. But I think the $64 million question is how important is it to you? How urgent is it to you to actually get to the bottom of this cancer in your life? That has to do with draining yourself, huh? And the low self-worth, the low confidence?

"Cancer" refers to the draining and corrosive effects of what has been identified as performance-mode and his tendency to feel bad about himself. The patient reports that he wants to do the work and he even elaborates on the painful downsides of his status quo, but there are no sighs, and his voice now sounds playful and jovial:

Therapist: See, what strikes me is that there seems to be a discrepancy, right? Because the way you're talking to me and the way you are, you actually seem comfortable. At the beginning of the session, I got more of a sense for what's painful for you in your life in terms of draining yourself, keeping up the mask and this not feeling worthy, low self worth. Right? But the more I'm taking you in and listening to you right now, I'm realizing you don't look very pained. You seem actually quite comfortable. This is how you are coming across right now. There's two contrasting pictures here. What's coming to mind about this for you?

The most salient dynamic between us is the discrepancy between what the patient is saying and how he presents. This indicates that the defensive component in the patient has increased vis-à-vis the collaborative component. Consequently, I try to enlist the patient's collaboration in understanding what is occurring:

Patient: [jovial tone] I am getting a little pissed off at you.
Therapist: Care to elaborate?
Patient: [back to typical tone] I don't know... [medium sized sigh]. I guess I just don't want to feel this. I can tell I am trying to keep you at a distance.

Overall, the patient's eye contact has been very good. Here he looks away, but then resumes eye contact. The patient has discussed how he analyzes the process because he has read up on ISTDP, and then he reports that he fears that I will reject him. With this last comment he takes a deep, spontaneous sigh. His "I guess" is again a tactical defense, but it is not sufficiently interfering in the treatment to warrant explicit focus.

Process Reflection. It became clear at this juncture that the patient's major column of defense involved efforts to manage the therapeutic relationship. These efforts took the form of impression management, compliant performing, and intermittent attempts to rattle and dominate me via provocative behavior (i.e. he spoke about a wish to have sex with me, extract my semen to drain me of my power, the appeal of corrupting my ethics, and made veiled threats). The provocative behaviors appeared to be in the service of evacuating his own insecurities and attempting to forcibly push them into me, consistent with projective identification (Hinshelwood, 1991). I experienced fleeting and mild irritation when the patient engaged these behaviors. The patient showed signs of distancing through gaze-avoidance and expressing a wish to distance, without signs of instability or cognitive disruption at a mid-rise of feelings.

Further, the patient's a priori knowledge of ISTDP was used defensively in the service of trying to manage the relationship. Though these defenses appear contingent on grossly distorted perceptions of me ("you will reject me so I have to try to manage the relationship") this appears to capture but one aspect of a mixed process. To make sense of the other aspect, we must appreciate that the patient's reality testing was primarily in operation, but was also intermittently interrupted by distortions (i.e., there were periods when the patient was genuinely fearful that I would reject and abandon him). He did not simply enact these defenses, he was also able to *collaboratively describe them* to me. This marker of a highly developed observing-ego function, in combination with sighs and the patient's active opposition to the task ("I don't want to feel this, I am trying to push you away") suggests a somewhat crystallized resistance against emotional closeness where the patient's primary aim was to push me away. This equal proportion of regressive processes and higher order capacities amounts to a mixed presentation.

Ease of Access to Impulse and Fear of Rejection

Two hours into session one, Mr C. began to describe his relationship with his sister. Here I decided to move into a more intense mobilization phase. My decision-making was guided by: Mr.

C's striated signaling through intermittent sighs; that he again appeared in touch with how painful his defenses were; and the fact that it could provide psychodiagnostic clarifications about his actual ego-adaptive capacity.

Therapist: We've seen your memory collapse, the strategizing and performing mode, analyzing mode. These mechanisms, they seem to cripple your ability to spontaneously experience your emotions and relate authentically, but only you can know for sure if that is the case.
Patient: [sigh]. They are.
Therapist: Let's see what we can do about that. What do you feel towards her?

After a couple of minutes of asking about his feelings towards his sister and pointing out that he was a step removed from the anger, the patient experiences homicidal rage, energy moving up in his body, and he describes murderous impulses:
Patient: I see myself driving her over with the car!

He first experiences relief when he sees the image of the dead body of his sister. A couple of minutes later he cries and reports feeling very guilty:

Patient: I would fall on my knees and I think I would just cry, and I'd hold what was left of her hand, and I would tell her I'm sorry.

The processing of the guilt goes on for several minutes, including some self-attack:

Therapist: What's the last thing you say and do? If this is an eternal goodbye? An eternal goodbye?
Patient: [speaking tenderly] I'd say I'm sorry. And I'd probably fucking kill myself.
Therapist: You'd want to kill yourself. But there is a guilt. I mean, there is an "I'm sorry"?
Patient: [rhythmically rubbing his arm] Yes.

Throughout the processing of guilt, I observe that he is fidgeting with his fingers in a way that suggests that he is still anxious, and I am unsure as to what extent the patient is truly experiencing guilt vis-à-vis performing guilt. Intermittent sighs were observed during the mobilization phase, but I wager that a dual process is at work: some actual feelings, and some lingering defensive performance.

...

After the portrayal of impulses towards his sister, the patient's mood brightens considerably, and he shares spontaneous memories of his sister and his mother that are relevant to key themes of emotional conflict in his life. However, the fidgeting of his fingers has continued, suggestive of defensive discharge. The session comes to an end with me summarizing and consolidating the main insights. These insights include the theme of self-sabotage and the patient's intense fear of experiencing anger towards me, as he fears that his anger will contaminate his positive feelings. The patient gains insight into his difficulty in allowing himself to feel more than one way towards me. When offered the interpretation that his fear that I will reject him is a result of his own projected wish to reject me, he agrees but reports lightheadedness as the interpretation sinks in. The patient quickly recovered from this and was again able to reflect clearly on the process. This indicates that facing the reality that a part of him wishes to reject me elicited anxiety-laden feelings causing mild CPD.

Process Reflection. With his regressive defenses in mind, I was cautious even as I attempted to mobilize the unconscious. My caution was further supported by his report of headaches and nausea leading up to the initial session, a distant history of three suicide attempts and psychiatric hospitalizations, and his access to mild CPD. There were obviously feelings towards me in the transference, but the lightheadedness in response to my interpretation suggested that the patient was not ready yet for more mobilization of feelings towards me directly. Though there were no indications that we had been working significantly above the patient's capacity, there were suggestions that he had difficulty holding mixed emotions in the transference, indicative of challenges to his integrative function. The patient was fearful that his anger would contaminate his positive feelings towards me. His intense fear that he would be rejected by me is suggestive of a heavier projective process, in conjunction with the transference resistance where I am a stress-inducing male authority figure.

On the one hand, the patient relied on splitting/projecting and had access to mild CPD, indicating a lower ego-adaptive capacity. He tended to imagine interpersonal conflicts between us, and engaged in provocative behaviors designed to rattle and dominate me. On the other hand, the patient was very collaborative, even when engaged in his defenses. In this way, his observing ego-function appeared very well-developed. He could readily intellectualize about his feelings and the process, his striated muscles contained anxiety for several portions of the session, and he quickly bounced back from the experience of mild CPD at the end of the session.

Furthermore, the partial unlocking occurred without the uniform solidity of firm detachment associated with crystallization of resistance. Though a good amount of defense and alliance work set the stage for this, the patient gained access to his impulses with minimal pressures, indicative of either low resistance at the far left end of the psychoneurotic spectrum or mild fragility. Taken together, these factors clearly amount to a mixed presentation.

Regressive and self-attacking defenses in the service of resistance against emotional closeness: "a drop of sewage in the bottle of wine turns the wine into sewage"

In the second session, the patient begins:

Patient: I had a dream last night, you were in it last night, you texted me and said, 'oh, sorry, can't make it. I've got allergies.' And I thought, you know, at first I was like, 'fuck him, allergies?!'

The patient spends a few minutes discussing concerns about his sexual feelings towards me. He then changes the topic and says that now that he knows me better, he sees that I do not not live up to his fantasy of being corruptible, nor am I willing to break rules to make him feel special:

Patient: And so also, um, your competence, your kindness and you not being corrupt -- actually I respect that about you. And I also resent that about you.

The patient then discloses anger and jealousy when he imagines the successes in my life compared to his own. He reports wanting to strangle me, but there is a quick shift and he reports: "I want to hug you as a human. I don't want to fuck you as an object." He reports that he wants to be held.

...

15-minutes into the second session:

Patient: I mean, you're penetrating... you're penetrating a pretty thick wall that I've been pretty decent at putting up. And it's like, 'how the fuck can he slip in?' And... you know what I mean? And I can't... I can't 'damn' you in my mind, like I can, you know, other folks who try to get close to me, I just, um, you know, I know you're human and you have your faults like any human, but I just... I can't 'damn' you in my head.

Therapist: What I'm hearing you say is you're not able to find a reason to disqualify me.

Patient: Right.

...

In the third session, clarifying Mr. C's fear and conflict about emotional intimacy becomes a more explicit conversational focus of the ongoing treatment. Ten minutes into this session, the patient discusses doubts and thoughts that he is fragile and "beyond neurotic:"

Patient: "I know I'm frightened of my anger. I'm very frightened of my anger."

...

Almost 50-minutes into session three, after a breakthrough of feelings towards his father:

Patient: I think, too, there's a great fear of intimacy. And part of my hesitation, anytime I get close with people... I disappear. I haven't [disappeared] with my husband. I tried that a couple of times, but he... he's pretty stubborn. But, yeah. So, there's a part of me that wonders, am I... Am I going to, you know, self-sabotage, and just... you know... like, just stop doing therapy?

...

In the fourth session, 20-minutes in, Mr. C's conflict about letting the therapist get close is further clarified:

Therapist: And then the incident with the car. And so, there's a real history here.

Patient: Yeah.

Therapist: And so, you have feelings about the prospect of her [the sister] treating you poorly and rejecting you?

Patient: Yeah.

Therapist: But then you get anxious, and you go into damage control mode, and what sounds like tap-dancing and over-functioning.

Patient: Yeah.

Therapist: To try to mitigate against the odds of her treating you poorly [patient now takes a deep, spontaneous sigh followed by a four-second pause. The patient is looking down, half a smile on his face]. Mm?

Patient: [jovial, dramatic tone] I am getting mad at you for summarizing it and not letting me cover it up and don't want to feel this. I'm smiling. I put my glasses on. I'm trying to keep you at a distance [gestures with hand in a motion as if to push me away, chuckles].

The deep spontaneous sigh suggests that the patient's anxiety is channeled into striated musculature and that the therapeutic focus has succeeded in bringing the patient into proximity of a genuine internal conflict. It also suggests that my summaries of painful details and events from his life are sufficiently interfering with his defensive efforts and mobilizing feelings and anxiety, which his defenses are now failing to completely control. The fact that the patient is describing his own defensive behaviors and his wish to push me away indicates a well-developed observing-ego function, a strong collaborative therapeutic alliance, and an ability to intellectualize about his feelings at this stage.

(continued)

Patient: I'm getting mad. And I also appreciate you. Yeah.... well, just you're just... uh... it's painful, and it fucking pisses me off, and it makes me feel very sad [the patient is now getting very tearful and choked up].

Therapist: Mhm.

Patient: And I'm being... I'm being childish and I just feel

like, well, why am I getting mad at you about it? Mad at you? [his tone is now whiny and full of protestation].

The combination of weepiness and a whiny tone suggests that the patient is now relying on regressive defenses to avoid his feelings towards me. "I'm being childish" suggests that the patient is also utilizing the defense of self-attack. He has expressed both positive and negative feelings towards me, so the regressive self-attack appears primarily to serve the function of both avoiding the full internal experience of these feelings while also ensuring that he keeps me at a distance.

(continued)

Therapist: But you are. The fact is that I'm shining a light on the brass tacks issue here.

Patient: Yeah. You're not... you're not getting annoyed, and you're not ignoring me. I mean, I want you to get annoyed at me and to ignore me because I don't want... I don't want to feel this [the patient is weepy, rubs his face, and his tone is whiny].

A dual process is occurring here. On the one hand, the patient is consciously protesting and resisting his feelings and remains weepy, but on the other hand, in what appears to be a spontaneous fashion and without premeditation, the patient is also shining a light on a core conflict pertaining to a failure to get me to treat him like his mother treated him, and how this brings up painful feelings. This suggests an activated unconscious therapeutic alliance (UTA) that is interlacing with his resistance.

My reflections and summations of significant details of the patient's life and his triangle of conflict appeared to undermine the patient's defensive efforts to eliminate any contrast between his mother and me:

(continued)

Therapist: Mhm mhm. So, this is a very painful spot in you and I'm shining a light on it. You're angry with me but you're also appreciative. And there's tears. Okay. And just so we're not flying blind, are they angry tears or sad tears, or what are these tears?

Patient: I feel sad [the patient is tearful and is now gaze avoidant].

Therapist: You are sad. You are sad. Okay.

Patient: You... you hit... you hit a nerve. Especially when you said the [patient refers to a painful detail that I had recalled from his past]. And I'm... I'm mad at you for fucking... for remembering details. I'm getting mad about that because I don't like it. I don't want you to remember the hard things! [He is tearful and remains gaze-avoidant]. I don't want to talk about it.

Therapist: Oh, I see. So, as I bring these painful recollections to your mind, it's angry-making to you because they're painful.

Patient: Yeah.

Therapist: You don't like to be reminded of things that are very painful. [the patient takes a small sigh here].

This sigh appears to be a sign that anxiety is coming down and is now contained in striated muscles, given the drop in tension in his face and vocal cords. He is also becoming less tearful, and he has resumed eye-contact:

Patient: Uh huh, no I don't.

The patient now appears to try to pre-empt me by saying that he understands the connection between avoiding painful things and anxiety that keeps him up at night. He reports that he is still angry with me and apologizes for being "dismissive and disrespectful." He sighs again, this time due to an increase in anxiety:

Therapist: You're angry at me. I'm bringing painful things [his sister] to your attention.

Patient: [the patient is no longer tearful] And I'm grateful for you too. But the nice thing now is I don't feel like it's contaminating anymore. I know that that's been a theme before about like, 'oh, don't express your anger toward him because he'll... you know, you know, one drop of sewage in a bottle of wine turns it into sewage.' Like, that's the crap that I've been afraid of... So, I don't feel like that now. I feel like you can still, we can care about each other still. My anger isn't tainting that [deep, spontaneous sigh].

...

Further on in session four (at 40-minutes), the patient has spent a few minutes comparing himself unfavorably to me, and I respond:

Therapist: So, here's the thing: I find myself sad that you're not clear on your intrinsic value. I have an affection and admiration for you already after only a short period of knowing you. And it strikes me as quite sad that you don't seem clear on that, on what you bring to the table, intrinsically, in just being you. [The patient looks pained]. It's painful?

Patient: [pauses for about ten seconds] The painful part is that I can believe you for what you say. You have a level of admiration for me and respect... and that's the painful part. I actually fucking believe you.

Therapist: There's something very painful here.

This feedback was provided to the patient in an attempt to disrupt projections and transference distortions. The intervention

also underscores the pain that the patient must feel in not being clear about his own worth.

...

Session four ends with consolidation of insights into how the way I attend to him with detail and care is a painful reminder that his mother did not attend to him in that way. At the end of the session, I suggest to the patient that we see each other twice per week so as to expedite the treatment. My rationale for this was based on the patient's level of distress, his eagerness to find relief, and my growing faith in his potential fueled by an affection and admiration for the patient's level of openness and honesty.

Process reflection. In this section, several key dynamics had crystallized. First, we saw a collaborative alliance manifested in the patient's honesty about his anger towards me for highlighting painful material and for reminding him of what he did not get from his mother (i.e., kind, caring attention). The patient collaborated when he shared his urge to push me away, which is different from the *act* of pushing me away.

Second, we saw an oscillation between the patient being able to isolate affect and relate to me directly, but then going to gaze-avoidance, self-attack, and regressive weepiness with a whiny tone. Moving to self-attack and regressive weepiness could be understood as an over-threshold response. However, given the intermittent gaze avoidance, the relative absence of cognitive disruption, and the consciously articulated attempts to push me away, the self-attack and regressive defenses appear to be in the service of self-punitive resistance against emotional closeness. This is in contrast to signifying a genuine lack of capacity with the current level of intensity.

We also see a developmental achievement in the patient being able to hold mixed emotions towards me without fear that "the drop of sewage in the bottle of wine turns the wine into sewage." The patient demonstrates intact reality testing and an ability to acknowledge the caring statement from me, and this evokes mixed and painful feelings.

Finally, we see the patient gain insight into the psychodynamic origins of his mixed feelings towards me, with links to his mother. It seems likely that the patient's experience of being understood and attended to by me interfered with his transference resistance (i.e., his wish to repeat the maternal relationship). My self-disclosure of sadness in relation to the patient's neglect of self-worth seemed crucial in piercing transference-based distortions and allowing the patient to perceive me realistically, in turn precipitating his own experience of pain ("that's the painful part. I actually fucking believe you," expressed with evident emotion). Feedback of this kind also foreshadows an important component of conversational intimacy, an approach which will become more salient as the treatment progresses.

...

Between sessions five and eight, I utilize the graded approach which emphasizes capacity building, restructuring of defenses, and chipping away at the transference resistance. By embodying a therapeutic stance so different from the conduct of his mother, the patient's defensive efforts to eliminate contrast between her and myself could not succeed. By session eight, the patient appeared ready for a more unremitting approach.

Middle stage of treatment

This phase of treatment consisted of session eight through ten.

Over-threshold responses and an exacerbation of symptoms

At the start of session eight, the patient reports "loss of zest" and "agitation" in the context of having been very triggered recently by a student as well as his mother undergoing surgery, which had major psychodynamic significance to him. The focus is on his anger towards his mother:

Therapist: [the tone of voice is now more forceful and energetic] Your claw-like gestures right now are directed at you. If you turn those hands out?

Patient: [fingers pointed out, laughs nervously] It feels better this way [claw-like fingers pointed to himself]. This [fingers out again] feels too attacking towards you.

Therapist: We have been focused on your mom. The question is, how do you feel this rage towards your mom?

Patient: With animation and apparent ease, claw-like gestures now pointed outward] I want to scratch her eyes out! Fuck you! I feel power and confidence in my chest right now.

This leads to sexualized rage towards the mother involving violent sodomy. The patient displayed hand gestures demonstrating the urge to strangle along with verbal reports of wanting to strangle. With deep sighs the patient reports energy moving up through his body. The patient indeed looks and sounds angry. He sighs as I press him on facing the depths of his sadism, leading to demonstrations of highly animated gestures and reported imagery of him ripping his mother's intestines out of her body while still alive. When invited to say goodbye to his mother, the patient cries and reports tender, guilt-laden feelings. He reports feeling "very guilty," and recounts several memories of pushing his mother away from him, "stewing in resentment," and stealing money from her to purchase methamphetamine. The patient gains insight into how his self-punitive tendencies have covered up the guilt tied to his sadism.

...

In this session, the patient also shares spontaneous trauma-laden memories from his childhood which he reports "bubbling up." At the end of this session, however, there is evidence of some lingering self-attacking defenses:

Patient: I will punish myself for the rest of my life to make up for this.

There was not sufficient time to look more closely at these self-attacking defenses and underlying feelings.

...

In session nine, the patient appears anxious. He reports dreading having to talk about painful things, and that he feels very guilty about the sexualized sadism towards his mother in the previous session:

Patient: I mean, I'll use the fucking technical term. Um. The portrait [the technical ISTDP term for the description of impulses in *fantasy*]. I absolutely don't want to go into that again. I feel terribly guilty about what came out last time.

The patient reports that he vacillates in his own mind between devaluing himself and devaluing me. He is in an agonized state, and his sleep is becoming disturbed:

Patient: I am angry all the time now.

...

Later in this session, the patient, in a manner suggesting that he was only half-joking:

Patient: I have to be honest. A part of me is like, why is he [referring to therapist] not doing more hard-core head-on collisions with me? I want you to comfort me by punishing me. Like my mom.

Process Reflection. The patient's capacity to tolerate the de-repression of his unconscious appeared greater after the first seven sessions. The patient spontaneously mobilized in session eight. His customary mode of performing, charming, and seducing were greatly diminished. The patient appeared engaged, spontaneous, and to be driving the session. After some initial self-attacking defenses were brushed aside, he gained access to intense rage with concomitant sadistic impulses. He reported spontaneous visual and auditory imagery of a sexualized torture scene where he sodomized his mother and, with scalpel in hand, sliced her open – not dissimilar to how he sliced his own arm open in his youth.

Though he appeared fluid, undefended, and able to acknowledge mixed feelings towards me for having facilitated such a painful experience, the self-attacking defenses did seem to intensify towards the end of the session. The most obvious example being the comment: "I will punish myself for the rest of my life for this." There was also a low-level fidgeting (i.e., anxiety discharge) in operation, pointing to the fact that internal conflict was not entirely worked through.

Session nine and ten confirmed that we were working above the patient's capacity. His symptoms were exacerbated, and his sleep was becoming very disturbed. I hypothesized that the sexualized sadism stirred up more guilt than the patient was able to metabolize, again suggestive of a less than robust ego-adaptive capacity. Distressing symptoms (which he described as "therapy hangovers") included worsened sleep, headaches, malaise, and post-session fatigue. In addition, the patient reported that he was recently unfaithful towards his husband, behavior he had not engaged in for some time. The patient showed up late for his sessions. He was preoccupied with pleading behaviors, wanting to get reassurance from me that there was cause for hope. He spoke of his historical tendency to become self-destructive in the face of emotional pain, referring to past suicide attempts and drug use.

Final stage of treatment

This phase of treatment refers to the time between session 11 and session 20.

Course correction: Introducing conversational intimacy

The middle stage of treatment (sessions eight through 11) had been characterized by symptom exacerbation and rumination about an exit strategy from therapy. It was clear by now that we had gone above his capacity of emotional tolerance and that his standard intellectual defenses had collapsed, leaving primarily self-attacking and primitive defenses in play. As such, there was a need to reduce the intensity of the treatment. I therefore began to take more of an interpretive tact. Without any pressure that the patient might perceive as my demanding that he change himself, I began pointing out the ways in which he was trying to shift our relationship into one where I primarily offered comfort and emotional support, and how this was another manifestation of his tendency to be seductive. I linked this to his initial chief complaint of feeling drained due to trying to manage relationships. The sighing resumed with these interventions. This approach is illustrated during the eleventh session:

Patient: So, there's some fear behind it.

Therapist: Sure. So, if truth be told, you're actually terrified of letting go of this facade of the charmer, the seducer, the tap-dancer.

Patient: Yeah. I didn't realize again that it took so many forms. But now that I do, it's sort of like, okay, you know, it's sort of like I just wanted to clip the wing that is the sexual component. But now that I know, it's... Oh, you know. And you're right. It is absolutely exhausting. It's exhausting. But I don't know another way, I've had to... This is... This is how I had to be. I don't know if I'm anything else.

At this point, the patient looks and sounds relaxed, if a bit sad. His customary theatrics appear to be in abeyance. The acceptance and mirroring of his fear appears to help relieve the patient of some anxiety and to come out of performance mode. The patient's comment that he does not know if he is anything other than "the charmer" indicates a modicum of identity diffusion (i.e., loss of self-awareness due to the fragmenting effects of years of reliance on splitting and projection), revealing that his performance mode had deeper ego-syntonic roots.

(continued)

Therapist: Yeah. And so, check it out now. The way you're communicating to me right now, letting me know this internal battle between seeing the pain of this way of being, but being not totally convinced that you want to let it go. Okay? It's endearing. We're not here for my feelings, and it's not your job to charm me. But I do feel closer to you when you are in this state. In other words, you openly acknowledging that you're not sure you want to let it go seems to be you getting out of tap-dancing mode. This comes across as you just being honest with me: 'here's the battle inside of me.' Okay?

Patient: That's interesting.

Therapist: Yeah. And so, but just because I find it encouraging, and just because I feel closer to you, and I have a preference for you being this way since I get a clear window into you and what's happening inside of you–that does not mean that you have to feel the same way. Maybe you like it, maybe you don't like it. Maybe you have mixed feelings about it. What's it like for you to have this level of candor? Just letting me know of this internal struggle?

Patient: Well, it feels good because I trust you. And, I mean, I feel… I feel energized, you know, again, it's that prickly tingle which… Which I question in terms of it's like… An overlap, because that's what comes up when I feel angry, but it also comes up when I feel, um, when I feel powerful. Right? I didn't know that I'm being authentic, as fucked up as that sounds. But it's… I feel good to hear that you are actually seeing this. Um, and I feel good that I actually am having an experience where… 'Oh, my God, I can be…' It's actually having a positive effect. I don't feel shrunken, diminished. So, it actually feels good. I feel energized, I don't feel overwhelmed.

Therapist: Okay, Okay. Because you look a bit more relaxed. You're a little less keyed-up.

Patient: I feel it. I really feel it, I feel. Yeah!

Therapist: There's a drop in anxiety, as far as I can tell.

Patient: Yeah, because it's not usually the anxiety that feels like it starts shifting up to the head and then the head starts spinning. But actually, I'm in my body right now. Like, I can feel my feet. I can feel my legs, I can feel my arms, that it's not just this, all of this. Yeah I do [gestures with his hands upward, gesturing that the normal anxiety that moves upward is not there right now]. It feels different. It feels different.

Process Reflection. In the face of clear indicators that the patient had gone over threshold, I shifted to a lower-intensity approach (i.e., *conversational intimacy*). The standard ISTDP maneuvers of facilitating an intrapsychic crisis and attempting to help the patient turn against his ambivalence are nowhere to be seen in the interventions illustrated in this section. Instead, with these interventions, the patient's candor and honesty about his fears and ambivalence were framed as one way of taking down barriers and showing up with his authentic subjectivity.

The approach provided a corrective emotional experience which helped the patient begin to let go of the defense of impression management. Furthermore, my self-disclosures about my experience of the patient's communications were made in the spirit of modeling openness and honesty, and to alleviate the patient's fears that he is only lovable when performing with charm and seduction. In my estimation, the patient needed this feedback. I was aware that my self-disclosures risked reinforcing the patient's compliance. This risk was outweighed, however, by the potential benefits of the patient gaining clarity that he was engaging authentically, and that he was *no less* endearing without his performative defenses. The risk of reinforcing compliance was lessened by the therapist: a) monitoring closely for striated signaling, b) being prepared to address the compliance if activated, and c) positioning a therapeutic stance and attitude that continuously sought to convey that the patient did not need to be an extension of the therapist.

Lastly, the patient's comment, "I don't know if I'm anything else [other than his defenses]" suggests an ego-syntonic aspect to his resistance and possibly an element of identity diffusion. This contrasts with earlier statements where the patient sounded clear that he was employing strategies, and that these strategies were draining to him. We can speculate that either, a) the patient was saying what he thought I wanted to hear with the earlier statements without actually being able to observe the defense as apart from himself, and that the truth is coming out in the latter statements; or alternatively, b) the latter statements are tactical in the service of coming up with reasons to avoid letting go of a defense that he is not yet ready to give up.

Therapeutic progress and termination

The eleventh session continued with the conversational intimacy approach at the fore. We now provide transcript of the session in more uninterrupted detail to try to allow the reader to get a clearer sense of this approach:

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Therapist: Yeah. You seem more relaxed. And so if we linger here now for a moment. And if you let in the idea that you're actually being emotionally intimate and letting me know that you're not sure you want to give up the facade. But there's an intimacy now here between us. You're more relaxed. You're speaking your truth. [pause]. Let's see what else you become aware of if we linger here another moment. [patient sighs]. Anything else about this experience for you in terms of your feelings? Positive, negative, or mixed?

Patient: [longer pause] I don't know [then another sigh, and the patient's tone suddenly took on a whiny, complaining tone]. I'm not right yet… Conscious of any… Anything else is coming up. [the patient appears to be losing some of his articulation] I'm worried. I'm putting up defenses right now.

Therapist: Yeah. So, let's take a step back right now. Are you feeling performance anxiety? Like you have to deliver on my question?

Patient: Yeah, yeah, yeah. So, I'm not going to.

Therapist: Yeah. But let's look at this: somehow, my curiosity about what else might be there, it activates a performance anxiety [sigh in the patient]. Okay.

Patient: Like I've got to have the right answer.

Therapist: Yeah.

Patient: Out of fear that what if I don't have the right answer and I have to be uncomfortable, and I'm going to have this god damn hangover afterwards. I'm going to be useless for the rest of the day.

Therapist: Yeah, yeah. And so again, let's review.

Patient: It pisses me off. I'm pissed off at you and you ask me that. Is there more? Is there more? [the patient again has a strained smile and a facial expression that suggests he is about to chuckle. His voice is now emphatic, but the anger appears to be getting filtered through a jovial, almost humorous tone].

Therapist: There is an anger in you towards me for asking what else is inside of you about this intimacy.

Patient: Yeah, yeah.

Therapist: Okay. And it's not just the right ISTDP answer? Is it really there?

Patient: No, it's really there. And there's gratitude and there's… And there's anger. It's almost like, 'why can't that be enough?' You know, like what we've covered. But, you know, and there's gratitude because it's like, okay, surrender into it. There is more, there is more. This is helpful. Be authentic. Stay with it.

Therapist: Okay.

Patient: Do you want me to try to answer your question, or am I running away from where we need to be?

Therapist: Well, what is it that you want to launch into? And then we can both weigh in with our impressions.

Patient: Well, I kind of want to dig a little. I want to internally answer your… Your question. It's a good question. How are we on time?

Therapist: We're fine. But just to look at this though, because the statement about why can't it be enough? Suggest that there is still a portion of you that is structuring your experience around delivering [patient takes a deep sigh] and fulfilling my hopes, my wants, and my expectations.

Patient: Yeah, yeah. To get me out of the spotlight. Uh huh! [said very emphatically.]

Therapist: Yeah, yeah.

Patient: Yeah. Like to manipulate you… Yeah.

Therapist: Say more.

Patient: Oh, yeah. Just to sort of, you know, the first thing that comes to my mind is like, okay, figure out what he wants to hear. Tell him. Tell… Try, you know, I mean, he hasn't fallen for that yet… So, keep trying. And it's not like I can zap you […] It's just like maybe one time I can… You know… Tell my therapist what he wants to hear so that… We can call it good! [patient wipes his hands together in a gesture of hand-washing, suggesting "to be done with.' His voice is emphatic and contains a touch of irritation].

Therapist: Call it good. Right? And so, to review. There was an intimacy between us. And your anxiety went way down. In other words, you simply being candid that you could see the facade [patient takes a sigh], the tap dancing, the dance of seduction.

Patient: Yeah.

Therapist: But you're not sure you want to let it go because you're not sure what there's going to be left of you if you do.

Patient: Yeah.

Therapist: Right. And there's concern about losing your husband.

Patient: Yeah.

Therapist: Anxiety went way down. Okay. Then I was honest with you, and I said, it's positive for me, but just because I feel that way, it doesn't mean you have to feel the same way.

Patient: Okay.

Therapist: I said, how is it for you? And then soon thereafter, soon thereafter, you're back in this performance mode and the need to please me.

Patient: Yeah. The real answer was and is, I don't know how this is for me. I don't know how this is for me. I mean, I feel calmer, you know? And I don't know… For you, it's good, for me, I don't know. I really don't know.

Therapist: Mhm. Mhm. Mhm.
Patient: That's the truth.
Therapist: Sure. And is there a concern about that being a disappointment to me?
Patient: Yeah. Yeah, yeah. Well, yeah. And yeah!
Therapist: Mhm. Mhm. Mhm. Mhm. And this is what characterizes much of your life, right? This, trying to structure your life to avoid others being disappointed in you or avoid rejecting you [patient takes a very deep, spontaneous sigh].
Patient: Yes, yes! Or battling me. You know, it's this... You know, okay. Is.. You know. If my therapist, If I tell him 'I don't know,' is he going to sit here and you know, 'Yeah, you do know. You do know.' [patient is chuckling]. 'If we waste our...' I appreciate the process, but I hate it at the same time, you know. [Mocking, derisive, and affected tone now] "Oh, you know, are you going to die a lonely man looking back, blah, blah, blah. Are you, you know, poisoning the well!" You know, that it's like, okay, a cigar is a goddamn cigar. I don't know, you know what I mean? Like, believe me, I don't know. That's the truth. That's the authentic... And my wanting to do all of this and perform for you is... yeah, to manage you, to manage this process. I just told you the truth.
Therapist: Yes. So now we can see what happens.
Patient: I feel settled. I feel like you're strong. I trust that you're strong, that you know... That you can handle the truth. You can handle my truth. Because there's a lot of, you know, there's a lot of hate... You know, I've noticed that... That's another thing I've noticed in this last week is, you know, I really walk around with quite a lot of hate. My mom always told me, [mocking, derisive tone:] "No, don't harbor hate in your heart". And it's like, so I've had to manage her and pretend like there's no hate in me.
Therapist: Let me interrupt. I'm sorry, but just to interject. I'm having two reactions, okay? One is that this could be really important. I'm sure there's something here that's important to really get at. Right. But I also have the sense you might be talking over some inner feeling right now.
Patient: Toward you?
Therapist: I don't know, I have no idea. But all I know is that you were settling into something that felt more authentic and real for you, which is that it is not clear to you how it is about me getting closer to you. Okay? And so that question is unsolved.
Patient: Yeah.
Therapist: And then you go on and chat about other things.
Patient: Yeah. Yeah. I guess part two is 'I don't know. And I want to know.' And I guess part three is, 'and if it's not the answer I want it to be, I'm going to have rage. I'm going to have so much disappointment in everyone and everything. You see what I mean? I mean, that's really the reality. I don't know. I want to know, but if it's an answer I don't like, I'm going to fucking be pissed [expressed emphatically, with the word "pissed" being almost a whisper for dramatic effect].
Therapist: What would be an answer you don't like?
Patient: I guess the first thing that... Not that, 'I guess,' the first thing that comes to mind is, 'what if I decide I don't want to give up this seductive many-forms? So, I do, and I don't, but what if that's the dominant piece? Um, you know, and then the reality is, is that I will fucking suffer, as I suffer, as I have suffered. Um. You know.
Therapist: Yeah. Okay. Okay. Again, you seem to be stepping out of your defenses right now.

...

[A few minutes later]

Therapist: Yeah, yeah. And so, here we are [the patient has a smaller sigh].
Patient: I feel good, I really do, I feel good!
Therapist: Okay!
Patient: Don't you dare fucking tell me to feel bad! [wry smile]. No, I feel good, I feel... I really do. I feel like we could... That is a crumb. That's what I needed!
Therapist: Yeah. And so, there's a real shift. There's a qualitative change in you when you're in performance mode, tap dancing mode, trying to shift our relationship mode. Seduction mode. Okay. And when you're just being yourself without being affected in any way, just letting me know, 'Here's how it is for me. These are my genuine thoughts and feelings.' And when you're being yourself, you're free from the facade. Which we know you have really mixed feelings about.
Patient: Yeah, yeah.
Therapist: But also positive, because it feels better.
Patient: It really does [he appears relaxed].

Less affected and with a lot of spontaneity, the patient goes on to recollect trauma-laden memories involving being a young child needing to undergo a major surgery, and how he was alone in the hospital without his mother. This seems to explain why his mother's recent surgery was so triggering for him. The low intensity-pressure of this session led to the kind of outpouring of affective memories and associations that may constitute a form of unlocking the unconscious:

Therapist: Now, as you're connecting to that pain, what's it like

to realize that we're here together and that you're not alone right now?

Patient: Well, it feels good. And when you… When you said… I saw your reaction… About, you know, like, you know, you were… That was pretty surprising for you… At least that's what I read, and that I appreciate. It's, you know, it's validation and it's… And then when you use the word 'oh, you, you know, abandoned,' you're spot on, you're spot on. So, it feels… to be connected. And for you to actually care about me actually feels pretty good and validating right now, as opposed to me, you know, 'stay the fuck away,' like it was before.

Therapist: Right. So right now it feels positive.

Patient: Yeah.

Therapist: Is there a smaller part of you that still doesn't like what's happening between us?

Patient: No, not that I'm aware of. I mean, I feel I feel seen, I feel seen.

Therapist: Mm hm. Okay.

Patient: Thank you. And no one has seen me before [referring to his deep emotional pain]… except my sister used to… kind of, see me, and care.

…

The treatment continued in this vein, with the conversational intimacy approach remaining in the forefront and the patient making progress towards his therapy goals. Therapeutic progress appeared to occur without the processing of rage and guilt at this juncture.

…

In session 14, in an emotionally stable and less guarded state, the patient reflected on the early phase of our work:

Patient: In those early sessions I felt an intense need to dominate you. That if I didn't dominate you, I would be nothing. If I didn't make you feel like shit, I would be shit. And even if I managed to make you feel like shit, I would somehow still be the shittier one.

…

In session 16, Mr. C reported significant improvements to self-esteem and procrastination:

Patient: What we just talked about [referring to his psychopathology] would, in the past, have sent me into a major tail-spin of shame and humiliation. Nothing of that sort now. I am less triggered in class now, too. I wrote that student back with feedback on their paper [something he had been procrastinating on due to intense anger at not being listened to and taken seriously by the student.]

…

In session 20, Mr. C reported that his life was going well. His mood was bright, as it had been for the past several sessions. About 30-minutes into the session, after the patient had not declared a problem to work on, and after reporting that he felt his initial chief complaints were mostly in abeyance, the treatment terminated. Mr. C stated that he would reach out if he felt the need for continued treatment. He reported mixed feelings about saying goodbye, but it was clear that whatever psychological problems were still unsolved did not pose significant distress or emotional pain for him.

Process Reflection. In this section, we saw the continuation of the conversational intimacy approach. In this adaptation of the graded format of ISTDP, the notion of what constitutes successful engagement in the therapeutic task is significantly modified. Though standard attempts at mobilizing the unconscious were not entirely without merit, they had begun to exacerbate symptomatology. Standard forms of pressure and attempts to turn the patient against his defenses appeared to reinforce the ways that Mr. C was already pressuring himself, albeit defensively. The patient's spontaneous recollection of trauma-laden memories, communicated with emotional charge, appears to confirm that conversational intimacy may also function as a form of attunement with the potential to mobilize the unconscious therapeutic alliance (UTA).

The patient's initial communications around his performance mode suggested that this defense was in part ego-dystonic. It seems, however, that deeper layers of this defense were indeed still ego-syntonic. It appears to have been therapeutic for the patient to be supported in his authentic voice, irrespective of the fact that he remained ambivalent and defended in some ways. We suggest that this amounted to a corrective emotional experience for Mr. C, which not only regulated his anxiety, but also appears to have helped him let go of his need to perform. The conversational intimacy approach was used until successful termination at session 20, at which point the patient reported significant gains and improvements of his wellbeing and self-esteem.

Follow-up communication

Several months after termination, the patient sent the therapist a follow-up communication, including a reflection on his experience of the therapy process and the therapist's change in approach. Specifically, the patient shared:

Patient: I've been thinking about our work together. It dawned on me that splitting is the deadliest of all my defenses. For example, I was splitting during all of my suicide attempts and when I was being destructive with drug and alcohol use. Splitting here in our relationship would have caused me to disappear [prematurely terminate therapy], like

I've done in all of my previous therapies. Had you not let me tell you the honest truth about how I felt towards you—no matter how shocking, I would have ditched therapy altogether. You actually showed care for me—which felt authentic—and this made a huge difference. It [conversational intimacy statements] cleared up all these ideas about who I wanted you to be — corrupt, unethical, inept, seducible — so that I could objectify and overtake you. Instead, you became a real person, and I felt close to you. I was able to drop the act and actually let you care for me. And I care for you. You've shown me that I do this [split] with my mom, sister, and students. It's [projections causing pathological distortions] not real though. They cause me to act out and I end up feeling guilty and alone. This [insight on the primitive defense processes of projection and splitting] is huge, because of its life-threatening aspect. This is something that I have to watch for at all times.

Discussion

Treatment arc

The case of The Charmer showcases a unique constellation of psychodynamic and treatment ambiguities. We have explored how the therapist's treatment approach evolved over time; starting with a graded format, eventually a standard format, and lastly an adaptation of the graded format that we refer to as *conversational intimacy.* In the first treatment phase, the graded format titrated intensity through a low-pressure focus in the transference and greater focus on current and past life orbits. In the middle phase, the standard unremitting approach unearthed sexualized sadism leading to intense guilt that appeared too anxiety-provoking for the patient. In response, his self-punitive tendencies intensified, symptoms were exacerbated, and Mr. C became very preoccupied with a premature exit strategy from therapy. The final phase of treatment was conducted by way of the conversational intimacy adaptation, which appeared to salvage the treatment by allowing the patient to integrate love and hate without symptom exacerbation. It was in this phase of the treatment that the patient apparently relinquished his performative theatrics and that his self-esteem stabilized. At termination, the patient considered himself quite free from his initial chief complaints, including his customary vulnerability to shame, humiliation, and procrastination.

Although precise mechanisms of change can only be speculated, the patient reflected in his final session on the most helpful aspects of the process. First, he considered the increased session frequency and spontaneous recalling of painful childhood memories during more unremitting portions of treatment as crucial to his healing. Additionally, a key mechanism of change from the patient's perspective was his experience of the therapist as someone who was able to withstand his provocative behavior, therefore allowing himself to receive the therapist's care and concern, and to tolerate mixed feelings towards the therapist without splitting. Further, the patient himself reflected in his post-termination communication that the shift to a conversational intimacy approach was experienced as a) crucial in the prevention of premature termination, and b) a significant factor in his treatment outcome. Taken together, these factors point to the intended goals of conversational intimacy, perhaps providing some confirmation that foregrounding authenticity and honesty in a relational context, with a role for occasional self-disclosure on the part of the therapist, can promote emotional healing outside of major mobilization of the unconscious.

Conversational intimacy as an adaptation of the graded format

Since what we have been describing as conversational intimacy has not yet, to our knowledge, been documented in the ISTDP literature, we wish to clarify a few of its key components. Conversational intimacy involves well-timed clarification of defenses in terms of their impact on emotional intimacy, as well as therapist self-disclosures about how the therapist experiences the patient's level of openness or guardedness. From a Rogerian perspective, this adaptation embodies three of the "necessary and sufficient conditions" of therapeutic change. In particular; 1) that "two persons are in psychological contact", 2) "the therapist is congruent or integrated into the relationship", and 3) "the therapist experiences unconditional positive regard" for the patient (Rogers, 1957, p.95).

Conversational intimacy assumes that well-timed defense clarification and therapist self-disclosure about emotional intimacy will strengthen psychological contact within the therapeutic dyad, *while also* ensuring that the person of the therapist indeed is "congruent or integrated into the relationship" (Rogers, 1957). When the patient is forthcoming in ways that depart from defensive norms, this is framed as *one* form of taking down walls and furthering therapeutic progress. In doing so, the therapist helps the patient build awareness and

cognize about the status of in vivo relational authenticity, and how this relates to the broader therapeutic endeavor *while leaving room for the patient to assert their own views on the matter*. Tone of voice, prosody, pace, body language, and timing are important non-linguistic conduits for the realization of these aims. The focus on the immediacy of what is transpiring in the session ensures that the work remains honest and experiential, consistent with Davanloo's (1995) ethos.

In conversational intimacy, the therapist's self-disclosures are narrowly tailored in function. The therapist may disclose their experience of closeness to the patient in relation to how defended or open the patient is being in the relationship. For example, the therapist may disclose, "when you tell me that you don't like what I am doing, I see that as a form of you being emotionally intimate. I happen to find that encouraging, but you may feel different." When these words are shared in a way that highlights the possibility of differences of opinion and that this would not jeopardize the relationship, the therapist is both inviting the patient to tolerate two separate minds, while bolstering their self-determination.

If timed well and applied with precision, therapist self-disclosures may undermine compliance, insofar as the therapist can also demonstrate unconditional positive regard towards the patient's *autonomy*. This does not preclude the therapist's ability to opine on the self-defeating nature of a patient's defensive stance, however. In such a scenario, unconditional positive regard would be ensured by conveying to the patient (through demonstration more so than verbal reassurances) that they will not be penalized or devalued should they choose to remain defensive. If the therapist can embody a Rogerian stance whereby the relationship is not contingent on the therapist being placated, then the therapist's integration into the relationship actually *undermines* projections and promotes psychological contact (i.e., emotional closeness). Conversely, self-disclosures would amount to nothing more than behavioral manipulations should the therapist withdraw engagement when a patient responds unfavorably (i.e., with defensiveness). Indeed, in order for compliant patients to be able to experience the therapist's self-disclosures as anything other than demands, they may first need to experience the therapist's ability to tolerate their guardedness. It is therefore critical that the therapist remains engaged and interested, *even when* the patient frustrates the therapist's wishes for progress.

In ISTDP, the therapist tends to focus on offering reflections about the patient's defenses and the manner in which these defenses contribute to the patient's suffering, with a lesser emphasis on what the patient is doing that is helpful. In conversational intimacy, the therapist's reflections about what the patient does to *contribute* to their healing is emphasized *in concert with* defense clarifications. Additionally, this case highlights how conversational intimacy may function as a form of attunement which bolsters the unconscious therapeutic alliance (UTA). Evidence of this was seen by the patient's increasing openness and collaboration in response to the approach, most notably his spontaneous recollection of trauma-laden memories.

Therapist self-disclosures of the kind we are describing do not increase risk of enactments any more than an abstinent therapeutic stance (Cohen, 2005; Renik, 1999; Rosenblum, 1998) or indeed any intervention (Marcus, 1998). Davanloo himself made use of occasional disclosures about his personal hopes for the patient. In the *Case of the "Fragile" Woman*, he said to the patient: "...if you move to avoidance, we are not going to get there, and I hope that your decision is that we get there" (1995, p. 253). Cohen (2005) refers to therapist disclosures of this kind as "standing in sharp contrast to clever interpretations" (p. 39); rather, they are emotionally intimate in nature. In disclosing a hope for the treatment process and for the patient, or "playing one's cards face up" (Renik, 1999, p. 521), the therapist may mitigate the risk of positioning himself "behind a wall of theory" where the patient "can not find him" (Marcus, 1998, pg. 577). Indeed, many others have argued for the value of purposeful self-disclosures by the therapist in a particular manner and for a particular purpose (Cohen, 2005; Gelso, 2011; Greenson, 1967; Hoffman, 1992; Knight, 2009; Meissner, 2002; Renik, 1993; Ziv-Beiman, 2013), the therapeutic benefits of which "have to do with degree and effect" (Meissner, 2002, p. 845).

We hope that by now it is clear that conversational intimacy is not an impartial stance. It is not an aimless ramble, nor a re-packaging of active listening and validation as per micro-counselling skills, nor a passive acceptance of the status quo. Neither does it consist of the therapist engaging in indiscriminate self-disclosures in the manner of a friendly conversation. It is a highly purposeful method of engaging the patient that involves working out a therapeutic, while also human, relationship (Menaker, 1942). This relationship is centered on supporting the patient to connect with their basic felt sense of subjectivity through honest input about how conversationally open and forthcoming the patient appears from the vantage point of the therapist. *Appears* is a key word here, as the therapist must always couch their language in ways that leave room for diverging patient views.

We have provided specific descriptions and examples of therapist behaviors that fall under the rubric of conversational intimacy. However, it would be a mistake to try to implement this way of working with a procedural mindset. This may be true for psychotherapy as a whole, of course, but it is particularly important here. Conversational intimacy is ultimately concerned with a therapeutic stance single-mindedly focussed on the immediate status of emotional intimacy on the part of the patient. This surgical focus must be coupled with the person of the therapist embodying emotional availability, transparency, and acceptance toward the patient. This therapeutic

stance requires that the therapist's communications come from their own depths, their own authenticity, and the reverberations within the therapist of the unconscious therapeutic alliance (Kuhn, 2014). As such, premeditated and rehearsed interventions applied algorithmically are antithetical to the therapeutic stance and the head (or heart) space required of the therapist.

Of final note, conversational intimacy is an adaptation of the graded format, not a standalone technique. This adaptation remains true to the ethos of ISTDP in that it is ultimately focused on the patient working out how to engage an emotionally intimate relationship (M. Skorman, personal communication, September 9, 2016). Furthermore, because the focus is on whether or not the patient is being open and collaborative, and because the input is immediate and direct, the approach in and of itself applies pressure on the patient to grapple with unresolved conflicts pertaining to emotional closeness. Although this pressure is not *applied* by the therapist in ways normally seen in the standard and graded formats, pressure is there nonetheless. In addition, there is still a role for the unlocking of unconscious material, albeit in a manner less dramatic than a major unlocking from unremitting pressure, and this unlocking is considered critical to significant emotional healing (Johansson et al., 2014). Finally, the experiential component that is so central in ISTDP remains alive in this adaptation through the provision of direct, real-time input from the therapist about the patient's behavior (Davanloo, 1995).

Psychodiagnostic reflections

In this case study, we have proposed that Mr C. presented with a mixed presentation of psychodiagnostic markers. First, a mosaic of indicators pointed to fragility in the patient's character structure. Other indicators, however, pointed to greater capacities (see Table 1 for detailed breakdown of markers) perhaps consistent with psychoneurotic functioning in the category of what Davanloo (2005) referred to as "extreme degree of major resistance" (p. 2633). In line with this designation, the evidence for superego pathology and masochism in Mr. C was convincing, albeit improved in recent years. It seems apparent that capacity thresholds alone are therefore insufficient in understanding this patient. Instead, Mr. C. presented with a complex interplay of co-occurring responses, including both resistance against emotional closeness and over-threshold responses. The patient himself confirmed this suspicion when reflecting that his earlier reactive states contained both compromised cognitive functioning *alongside* defensive efforts to keep the therapist at a distance. The case of the Charmer, then, illustrates an example of regressive defenses operating in the service of resistance against emotional closeness. Based on these two somewhat contradictory pictures of the psychodiagnostic markers, and with Dr. Coughlin's reminder that "resistance is not a stable trait" (P. Coughlin, personal communication, November 21, 2023), we maintain the merits of the *mixed presentation* designation.

... Could a greater focus on facilitating a higher rise of complex transference feelings have been more effective at mitigating the patient's decompensation, as well as his regressive and malignant defenses?

An alternative interpretation of what appears as a mixed presentation is that Mr C.'s shifting diagnostic picture was instead reflective of his growing capacities over time. Perhaps, where some areas of his functioning progressed, other aspects simply lagged behind. In addition, where clinical decision-making is involved, therapist fallibility is always an important consideration. This includes the possibility of an inaccurate psychodiagnostic assessment due to therapist coding error, problems in the application of pressure (e.g., target, timing, dose), and/or iatrogenic interventions which promoted further performance or compliance behaviors.

Remaining questions and study limitations

The case of The Charmer raises a number of unanswered questions. First, could a greater focus on facilitating a higher rise of complex transference feelings have been more effective at mitigating the patient's decompensation, as well as his regressive and malignant defenses? This line of reasoning would be consistent with arguments made by others (e.g., Schubmehl, 1995). Second, could the patient's prior knowledge of ISTDP and his finely honed acting skills have led the therapist to overestimate the patient's capacities? Third, could the markers which were assessed as co-occurring instead have been chronologically discrete, but taking place in rapid succession? Fourth, could the reduced pressure and the positive feedback in the conversational intimacy approach have colluded with the patient's regressive wishes to be soothed, and could whatever changes that were perceived and reported actually have been the result of gratifying regressive

desires, as opposed to genuine character change? Fifth, could the patient's exit strategy from therapy have remained intact since its inception? Sixth, what effect, if any, did the patient's Bipolar II and associated medication have on the treatment, and perhaps vice versa? These questions remain unsolved.

Considering Mr C's severe trauma-load and major psychological disturbances, it is unlikely that he reached 'the top of the mountain' required for complete character change and removal of all resistance (Hickey, 2017). Then again, it is possible that the treatment sufficiently addressed his emotional conflicts to the point where whatever might remain unresolved in his unconscious no longer warranted the need for continued treatment. And is this not the most meaningful aim of the psychotherapeutic endeavor?

Of note, the primary purpose of a case study design is not to produce theoretical propositions that are assumed to be broadly applicable. Instead, a thick description of a particular course of treatment between one therapist and one patient (and one relationship) is presented as a means to encourage further exploration, interrogation, and innovation of particular ideas and themes arising from the case. It is a form of social and clinical inquiry that takes practice-based clinical judgment as a serious form of knowledge, with necessary cautions and limitations noted (Creswell & Creswell, 2017; Iwakabe & Gazzola, 2009; Yin, 2018). As Willemsen and colleagues (2017) remark, "a case study becomes richer if the author can acknowledge aspects of the story that remain unclear [...] there should be some loose ends" (p. 9).

Broader implications

This case study contributes to the ISTDP knowledge base by elucidating complex therapeutic dynamics which are central to the psychotherapy context. When it comes to addressing psychological disturbances and neurotic suffering, there are likely few things more therapeutic than the unlocking of the unconscious (Johansson et al., 2014; Town et al., 2013). Mr. C had painful memories surface in the context of unlocking experiences, and in the final session he disclosed that these recollections contributed greatly to his improvements. But it was the approach of conversational intimacy that appeared to be most effective in helping him to let go of impression management, become less affected in his mannerisms, and hold mixed feelings of love and hate without splitting and projection. This approach also did not preclude further spontaneous memories from arising. This case suggests that, in certain psychodiagnostic contexts, facilitating an experience where the patient feels understood and cared for can undermine transference resistance more effectively than standard pressure and challenge. It also stands to reason that, if conversational intimacy can significantly neutralize anxiety and resistance while mobilizing the unconscious therapeutic alliance (UTA), then the unconscious may also be unlocked even if emerging feelings are less intense (Kuhn, 2014). This suggests that a broader view of what traditionally constitutes an unlocking of the unconscious may be warranted.

Conversational intimacy appears intimately connected to the provision of a corrective emotional experience. Arguably, one of the most powerful forms of facilitating a corrective emotional experience in ISTDP is through major mobilization with unlocking of the unconscious. Short of this, however, we assert that a corrective emotional experience of lesser magnitude is not necessarily of lesser value. In the case of the Charmer, the patient's relationship with the therapist grew in strength and closeness the more he opened up. This was in sharp contrast to his relationship history. The patient displayed an intense compulsion to repeat and replicate his maternal relationship. He was enraged and in pain when the therapist's stance prevented him from doing so, at one point pleading, "comfort me by punishing me, like my mom." The therapeutic stance of conversational intimacy, as we have described, appeared to indirectly undermine attempts by the patient to have the therapist reenact the patient-mother dynamics. The patient was unable to enact a scenario where he would dominate the therapist, nor where he would be dominated by the therapist. Within this context of "re-experiencing the old, unsettled conflict but with a new ending" (Alexander & French, 1946, p. 338), the patient was finally able to experience a relationship going right, in contrast to all the relationships where things had gone so wrong.

Finally, we believe that the methodology of this case study makes a notable contribution to the research base. Within an interpretive description paradigm (Thorne, 2016), we utilized an iterative analytic process involving the clinical framework, qualitative research mechanisms, and practice wisdom to unpack the case, examine treatment decisions, and draw out theoretically-derived practice implications. This design is an example of how clinicians may be able to analyze and document clinical knowledge in a manner that balances clinical complexity and skill with the more traditional scientific rigor promoted within the quantitative-based research arena.

Future research directions

Further research and explication are still needed of the conversational intimacy adaptation outlined in this case. Analyzing instances of the approach across multiple cases will be an important next step in understanding the relational contours, as well as instances across multiple therapists (Iwakabe & Gazzola, 2009, 2014). Further research is also needed to gain insight into the therapeutic merits of the conversational intimacy approach more widely, and how this might relate to dyadic particularities and psychodiagnostic markers, so as to produce practice-based knowledge outcomes that take into account complexities inherent to the therapeutic encounter (Reed & Shearer, 2017). Although further work is necessary, we also note that this quest is always held in tension with the limitations inherent to measuring such inter-relational phenomena.

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Conclusion

In developing ISTDP, Davanloo broke away from the clinical orthodoxy of his time. This took courage. But he was also armed with tremendous discipline and commitment to stay the course, and to stay true to his motivations. This fortitude eventually led to groundbreaking discoveries of how to work with the unconscious – undoubtedly one of the most important developments in the field of psychotherapy (Malan, 1980). Davanloo's (1995) loyalty to his own intuitions was a form of authenticity or, to use Rogers' (1957) nomenclature, *congruence*. If ISTDP is to remain responsive to the complex needs of the individual, it is vital that we keep Davanloo's pioneering spirit alive. By foregrounding innovative applications of the principles that undergird ISTDP, we honor the original spirit of valuing practice-based wisdom *alongside* conventionally sanctioned clinical knowledge.

It is our view that, to remain tethered to the essence of ISTDP, innovations must continue to promote the very congruence and authenticity that makes intimate, healing relationship possible. In this respect, Coughlin has remarked, "we are inviting patients to open up in an authentic manner so we must ask ourselves, are we an authentic presence?" (P. Coughlin, personal communication, October 23, 2023). Conversational intimacy embeds the *authentic presence* of the therapist into the therapeutic process, while explicitly recognizing moments of patient authenticity. As Mr C. himself remarked post-termination, "you actually showed care for me—which felt authentic [...] you became a real person, and I felt close to you." Although conversational intimacy does abandon the agenda of major mobilization with unlocking of the unconscious, its focus on undefended and transparent patient communications remains consistent with the ethos of Davanloo, as well as integrating that of Rogers. In fact, one might say that conversational intimacy is the alchemical child of these two figures, embodying both authenticity and emotional intimacy. And wherever these two interplay, a corrective emotional experience becomes possible – something of the past can give way for something new.

References

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

Abma, T. A., & Stake, R. E. (2014). Science of the particular: An advocacy of naturalistic case study in health research. *Qualitative Health Research, 24*(8), 1150-1161.

Alexander, F., & French, T. (1946). *Psychoanalytic therapy*. The Ronald Press Company.

Burdine, J. T., Thorne, S., & Sandhu, G. (2021). Interpretive description: A flexible qualitative methodology for medical education research. *Medical Education, 55*(3), 336-343.

Clandinin, D. J., & Connelly, F. M. (2004). *Narrative Inquiry: Experience and story in qualitative research.* Wiley.

Cohen, B. (2005). The intimate self-disclosure. *The San Francisco Jung Institute Library Journal, 24*(2), 31-46.

Coughlin, P. (2022). *Facilitating the process of working through in psychotherapy: Mastering the middle game.* Taylor & Francis.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.

Davanloo, H. (1978). *Basic principles and techniques in short-term dynamic psychotherapy*. Spectrum.

Davanloo, H. (1995). *Unlocking the unconscious: Selected papers of Habib Davanloo, MD*. John Wiley and Sons.

Davanloo, H. (2000). *Intensive short-term dynamic psychotherapy: Selected papers of Habib Davanloo.* Wiley.

Davanloo, H. (2005). Intensive short-term dynamic psychotherapy. In B. J. Sadock & V. A. Sadock (Eds.), *Kaplan & Sadock's comprehensive textbook of psychiatry* (Vol. II, pp. 2628-2652). Lippincott Williams & Wilkins.

Frederickson, J. (2013). *Co-creating change: Effective dynamic therapy techniques.* Seven Leaves Press.

Frederickson, J. (2020). *Co-creating safety: Healing the fragile patient.* Seven Leaves Press.

Frenkel, R. S. (1996). Oedipal and preoedipal transference transformations: Comments on the analysis of a latency-age boy. *The Psychoanalytic Study of the Child, 51*(1), 326-347.

Freud, S. (1905). Three Essays on the Theory of Sexuality. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (1901-1905): A Case of Hysteria, Three Essays on Sexuality and Other Works*. (pp. 123-246). Hogarth Press and the Institute of Psychoanalysis.

Freud, S. (1894). *The Neuro-Psychoses of Defence (Reprint 2014)*. Read Books Ltd.

Gediman, H. K. (1983). Annihilation anxiety: The experience of deficit in neurotic compromise formation. *The International Journal of Psycho-Analysis, 64*, 59.

Gediman, H. K. (1989). Conflict and deficit models of psychopathology: A unificatory point of view. In D. W. Detrick & S. P. Detrick (Eds.), *Self psychology: Comparisons and contrasts* (pp. 293–309). Analytic Press, Inc.

Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change.* American Psychological Association.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis.* International Universities Press.

Hickey, C. (2017). *Understanding Davanloo's Intensive Short-Term Dynamic Psychotherapy: A guide for clinicians*. Karnac Books.

Hinshelwood, R. D. (1991). *A dictionary of Kleinian thought.* Jason Aronson Inc. Publishers.

Hoffman, I. Z. (1992). Some practical implications of a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues*, 287-304.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4-5), 601-611.

Iwakabe, S., & Gazzola, N. (2014). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. In W. Lutz & S. Knox (Eds.). *Quantitative and qualitative methods in psychotherapy research* (pp. 327-341). Routledge.

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.

Kernberg, O. F., Selzer, M. A., Koenigsberg, H. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* Basic Books.

Knight, Z. G. (2009). *Conceptual considerations regarding self-disclosure: A*

relational psychoanalytic perspective. South African Journal of Psychology, 39(1), 75-85.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124.

Kuhn, N., (2014). *Intensive Short-Term Dynamic Psychotherapy: A reference.* Experient Publications.

Lebeaux, D. J. (2000). The role of the conscious therapeutic alliance in Davanloo's intensive short-term dynamic psychotherapy. *International Journal of Intensive Short-Term Dynamic Psychotherapy, 14*(1), 39-48.

LeCompte, M. D. (2000). Analyzing qualitative data. *Theory Into Practice, 39*(3), 146-154.

Malan, D. H. (1980). The nature of science and the validity of psychotherapy. In H. Davanloo (Ed.), *Short-Term Dynamic Psychotherapy*. (pp. 13-23). Aronson.

Marcus, D. M. (1998). Self-disclosure: The wrong issue. *Psychoanalytic Inquiry, 18*(4), 566-579.

Meganck, R., Inslegers, R., Krivzov, J., & Notaerts, L. (2017). Beyond clinical case studies in psychoanalysis: A review of psychoanalytic empirical single case studies published in ISI-ranked journals. *Frontiers in Psychology, 8*, 1749.

Meissner, W. (2002). The problem of self-disclosure in psychoanalysis. *Journal of the American Psychoanalytic Association, 50*(3), 827-867.

Menaker, E. (1942). The masochistic factor in the psychoanalytic situation. *The Psychoanalytic Quarterly, 11*(2), 171-186.

Midgley, N. (2006). The 'inseparable bond between cure and research': Clinical case study as a method of psychoanalytic inquiry. *Journal of Child Psychotherapy, 32*(2), 122-147.

Moon, M. D. (2019). Triangulation: A method to increase validity, reliability, and legitimation in clinical research. *Journal of Emergency Nursing, 45*(1), 103-105.

Nasheeda, A., Abdullah, H. B., Krauss, S. E., & Ahmed, N. B. (2019). Transforming transcripts into stories: A multimethod approach to narrative analysis. *International Journal of Qualitative Methods, 18*. https://doi.org/10.1177/1609406919856797.

Reed, P. G., & Shearer, N. B. C. (2017). *Nursing knowledge and theory innovation: Advancing the science of practice.* Springer Publishing Company.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *The Psychoanalytic Quarterly, 62*(4), 553-571. https://doi.org/10.1080/21674086.1993.11927393

Renik, O. (1999). Playing one's cards face up in analysis: An approach to the problem of self-disclosure. *The Psychoanalytic Quarterly, 68*(4), 521-539.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95.

Rosenblum, S. (1998). Abstinence anonymity and the avoidance of self-disclosure. *Psychoanalytic Inquiry, 18*(4), 538-549.

Scher, B. D., Scott-Barrett, J., Hickman, M., & Chrisinger, B. W. (2023). Participatory research emergent recommendations for researchers and academic institutions: A rapid scoping review. *Journal of Participatory Research Methods, 4*(2). http:/doi.org/10.35844/001c.74807

Schubmehl, J. Q. (1995). Management of syntonic character resistance in Intensive-Short-Term Dynamic Psychotherapy. *International Journal of Short-Term Psychotherapy, 10*(1), 3–19.

Segal, H. (1964). *Introduction to the Work of Melanie Klein.* Basic Books.

Spotnitz, H., & Meadow, P. W. (1995). *Treatment of the narcissistic neuroses.* Jason Aronson Inc.

Thorne, S. (2016). *Interpretive Description: Qualitative Research for Applied Practice*. Taylor & Francis.

Town, J. M., Abbass, A., & Bernier, D. (2013). Effectiveness and cost effectiveness of Davanloo's intensive short-term dynamic psychotherapy: Does unlocking the unconscious make a difference? *American Journal of Psychotherapy, 67*(1), 89-108.

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, 11(1), 21-39.

Willemsen, J., Della Rosa, E., & Kegerreis, S. (2017). Clinical case studies in psychoanalytic and psychodynamic treatment. *Frontiers in Psychology, 8*, 108.

Yin, R. K. (2014). *Case study research: Design and methods* (5 edition ed.). Sage Thousand Oaks, California.

Yin, R. K. (2018). *Case study research and applications* (Vol. 6). Sage Thousand Oaks, CA.

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration, 23*(1), 59.

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