# *The Shaking Grandmother* Assessing and Addressing Multiple Pathways to Somatic Symptom Formation in ISTDP



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# Abstract

Intensive Short-Term Dynamic Psychotherapy (ISTDP) can be an effective treatment for complex cases presenting with fragility, repression, character problems and multiple medically unexplained somatic symptoms. However, in such cases, the treatment is not always "short-term," and the therapist needs to engage in the complicated task of assessing and addressing the specific mechanism involved in the formation of diverse somatic symptoms as they emerge in sessions. This case report describes the application of graded ISTDP with a patient presenting with long-standing difficulties with depression, masochistic character traits, and multiple medically unexplained somatic symptoms. Session transcripts from early, mid and late treatment phases will illustrate the assessment and therapeutic work with anxiety thresholds, as well as detecting and restructuring somatization. Further, I will illustrate how the emergence of the unconscious therapeutic alliance (UTA) in later stages of treatment can elicit high levels of anxiety in the therapist and discuss the critical role of having supervision when working with primitive unconscious phenomena in fragile patients. Outcome at termination and one-year follow-up will be presented.


*Keywords: ISTDP, graded format, medically unexplained symptoms, functional neurological symptoms, conversion, somatization, unconscious therapeutic alliance*

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# *The Shaking Grandmother:* Assessing and Addressing Multiple Pathways to Somatic Symptom Formation in ISTDP

There is growing research evidence suggesting that ISTDP can be an effective treatment for patients with so called "medically unexplained symptoms", including chronic pain (Abbass, Town & Kisley, 2020; Farzadkia, Farhangi, & Abolghasemi, 2023), irritable bowel syndrome (Shafiei et al., 2024), tension-type headaches (Shahverdi et al., 2024), somatic symptom disorder (Town, Abbass & Campell, 2024) and functional neurological symptoms (Malda-Castillo et al., 2023; Russell et al., 2016; Russell, Abbass & Allder, 2022). This body of research further suggests symptom improvements may result from relatively brief treatment courses; however, patients with multiple unexplained somatic symptoms commonly present with significant fragility, repression and/or co-existing character problems making them more complicated to treat. Such cases require careful assessment of the specific processes involved in the formation of symptoms in order to adjust interventions specifically to the patient's needs and current capacity. Even in the hands of a medium to well-trained ISTDP therapist, they typically require longer-term treatment and regular supervision is recommended to confidently handle rapid shifts in in-session symptoms and regressive phenomena (Abbass, 2015).

In this article, I will summarize the treatment process of such a complex case treated with the graded format of ISTDP. The treatment lasted four years and included a total of 147 (60 minute) sessions. Naturally, there is not room to discuss all the details of this extensive treatment process in this article; rather, I will focus primarily on the assessment and therapeutic work with the patient's various somatic symptoms as they emerged in sessions. Also, I will describe a phase in the later part of the treatment in which the patient started having in-session sensory disturbances that made me quite anxious as her therapist, and I will discuss the crucial role of having access to advanced supervision in such instances. A transcript from a later session where some of the more primitive unconscious material emerging was worked through will be provided. The main aim of this case study is to elucidate and discuss treatment processes in the hope that it may be useful to both beginning and advanced ISTDP practitioners working with patients with multiple somatic symptoms.

## Case description

The patient was a 69 year-old woman who specifically sought ISTDP on the recommendation of a family member. She arrived confused and teary about 20 minutes late to the initial 2-hour trial therapy session. She had entered the wrong building and when she finally found her way to my office, she reported experiencing nausea, dizziness, blurry vision and had trouble collecting her thoughts. After about 20 minutes of anxiety regulation, she settled in and described her current main problem as a depressive state that had been ongoing for at least two years. She described constantly viewing herself as "all bad and worthless" and expecting others to perceive her that way too, leaving her feeling depressed, hopeless, helpless, tired and weak. She also experienced daily anxiety symptoms that included tension, nausea, difficulty thinking and blurry vision. In addition, she mentioned having several somatic symptoms, including tremor in her hands and legs and pains that would affect different areas of her body (e.g., head, stomach, chest, neck, throat and back). She told me she had had these symptoms for many years, and they seemed to "come and go" without apparent reason . Her family doctor had thoroughly examined her but had not been able to find any medical cause for these symptoms.

She further described having long-standing relational problems with her husband, whom she had been married to for over 40 years, as well as repeated conflicts with her adult children. After some inquiry, it became increasingly clear that the patient had a life-long pattern of taking a masochistic, "one-down" position in her relationships. As an example, one of her daughters was very angry with her for her failure to protect her children from their father, who had occasionally been physically abusive to them during childhood. When her husband would physically discipline the children in the past, my patient described that she became "paralyzed" and "watched, but could not intervene" and that she had trouble remembering the events afterwards.

Initial psychodiagnostic assessment pointed toward the patient having a fragile character structure with thresholds to smooth muscle anxiety and cognitive-perceptual disruption (CPD) around mid-rise, suggesting "mild to moderate fragility" (Abbass, 2015). There was also evidence of syntonic regressive defenses (e.g. externalization, helplessness and weepiness) contributing to a masochistic, self-defeating pattern in her relationships. Further, her problems had so far been treatment refractory since she described no or only limited benefits of previous treatment attempts with CBT, supportive therapy and several trials with antidepressant medications (she did not medicate during treatment with me). In terms of her strengths, she had obtained a college degree and maintained a qualified job all her adult life, albeit with periods of sick-leave due to "stress" (she was now retired). From the start, I found her quite pleasant to meet with – she came across as friendly, had a good sense of humor, and conveyed a conscious determination to "get to the core" of her problems this time in therapy.

## Early assessment of somatic symptoms

Early sessions focused on building a conscious alliance and exploring specific incidents in order to make psychodiagnostic assessments of anxiety thresholds, defenses and self-observing capacity. In the second session, the patient described a past conflict with her husband that involved him telling her he needed access to her personal savings account because they were short of money to pay their bills. Consistent with her habitually taking a masochistic, "one-down" position, she had let him handle all the family finances and readily agreed to this. However, she later found out it was not true; they were not short of money and the husband had used her savings for a private investment. When she found out, her anxiety and somatic symptoms spiked. In the session, I applied pressure to feelings to assess her responses:

*Therapist:* So, what feelings come up when we talk about this incident today? How do you feel towards your husband? [Pressure]
*Patient:* [Small sigh] I feel that he took advantage of me...

The patient shows signs of externalization and confusing the stimuli with her emotional reactions, which needs to be addressed to establish an internal focus.

*Therapist:* Okay, I'm going to stop you a bit here. Do you notice that that is a thought that describes what he did? He took advantage of you. [Clarifying stimuli vs feelings] But how do you feel towards him for taking advantage of you? What feelings are underneath that thought? [Pressure]
*Patient:* [Looks down] Hmm...
*Therapist:* Now it looks like you are thinking. Is that what is happening right now? [Defense identification]
*Patient:* Yes, I'm really trying. This is what is so difficult for me. Finding the words... [Small sigh]
*Therapist:* Is that something you want to become better at? [Pressure to positive goal]
*Patient:* Yes, absolutely! [Smiles]
*Therapist:* Okay, so if we look underneath the thoughts, what feelings are coming up towards your husband? Because you get a bit tense too, right? [Pressure]
*Patient:* [Sigh] Yes...
*Therapist:* How do you feel inside when you think about it now? When he said, "there is no money and I need your savings", but then that was not true. How do you feel towards him? [Pressure]
*Patient:* [Sigh] It hurts. It really hurts. How can one do such a thing to someone? [Patient is starting to exhibit slight tremor in hands and legs]

I noticed her tremor starting here which may indicate mild conversion and that we are close to a threshold; still, since her anxiety seemed mostly in striated muscle I continued applying pressure to feelings:

*Therapist:* And how do you feel towards him? Because that's what he did. [Pressure]
*Patient:* [Tremor slowly increasing] I feel that it was such an ugly thing to do...
*Therapist:* Right. And that's another thought that describes what he did. What he did was an ugly thing. [Clarifying stimuli vs feelings] But what feelings do you have towards him for doing that? [Pressure]
*Patient:* [Small sigh and tremor] I'm trying to find...
*Therapist:* What do you notice inside? What feelings are underneath the thoughts?
*Patient:* There is anger there... [Tremor increases more]
*Therapist:* How do you notice that inside? [Pressure to observe]
*Patient:* I get angry inside... And now I'm starting to get a headache...

As soon as she says the word "anger", her tremor increases and a headache immediately sets in. I took this as a more definite sign that we are at a threshold and decided to clarify the connection between feelings rising and her getting symptoms in the session (i.e. recap) to build self-observing capacity:

*Therapist:* Okay. Good you notice. Is it like tension in your head or? Like a tension headache? [Exploration of symptom]
*Patient:* Yes, I have tension here [points to the sides of her head]
*Therapist:* So that sounds like some anxiety. At the same time as anger rises you get tense in your body. I noticed that your tremor started too. Did you notice that? [Recap]
*Patient:* Yes.
*Therapist:* So there seems to be something about having anger towards your husband, whom you've been married to for 40 years and who did this thing with your money, that creates tension inside and increases the tremor and headache. Do you see that too? [Recap]
*Patient:* Yes...

Based on several similar early interactions, my evolving clinical hypothesis was that her tremor indicated a rise in complex feelings; however, her tolerance for the internal experience of these feelings was low since the tremor increases and she develops a headache with added pressure (suggesting presence of instant repression ; Abbass, 2015; Kuhn, 2014). Her external focus and repeated confusing of the stimulus with her reactive feelings

further indicate deficits in ego-adaptive capacity. Thus, she will need capacity-building work, including separation of the corners of the triangle of conflict and restructuring regressive defenses, in order to tolerate higher rise in complex feelings internally without developing symptoms.

## Graded work at anxiety thresholds

A few sessions later, the patient arrives to the session in a state of high anxiety with nausea and blurry vision. When her initial anxiety settled, she connected the increase of anxiety with a recent conflict she has had with her daughter. The conflict ended with the daughter excluding the patient from a previously planned trip with the grandchildren. The patient reported feeling "overwhelmed" with anxiety, tears and self-blame when the daughter excluded her. I invited her to explore her feelings towards her daughter:

*Therapist:* Ok. Right, so you got "overwhelmed" with anxiety there with her. So, what could be the emotions triggered toward your daughter when she excluded you?
*Patient:* [Small sigh and slight tremor]
*Therapist:* When you think back to it now, what feelings show up in you? [Pressure]
*Patient:* [Starts to get weepy] I feel sad. And I get all foggy in my vision again...
*Therapist:* Okay. You mean the anxiety is rising again?
*Patient:* Yes...
*Therapist:* Okay. So as soon as we talk about the feelings you have with your daughter when she excluded you from the trip, the anxiety rises inside you again and then you can notice tears start to come and also that your vision gets foggy again? [Recap]
*Patient:* [Nods]
*Therapist:* You wanted to go on the trip and looked forward to it, but then she canceled you out. So, there must be very strong feelings towards your daughter that make the anxiety go up?

The anxiety seemed to rise quickly and besides the blurry vision she also gets weepy indicating activation of regressive defenses. Here I move to a recap on the connection between mixed feelings towards her daughter and the symptoms she is experiencing in the moment. A few moments later we return to a focus on her feelings:

*Therapist:* So, do you want us to look a little bit more at how you feel towards her when she does that? [Pressure to will]
*Patient:* I get really sad and that's when I start to cry. She does this in front of the kids and I just collapse and cry...
*Therapist:* Okay. But would you agree that "sad" is more like an emotion towards you? [Clarification]
*Patient:* No, I'm sad at her.
*Therapist:* "Sad at her"? How do you mean?
*Patient:* I can't understand how she can do this...
*Therapist:* You find it hard to understand why she reacts like she does and then you get sad inside? [Clarification] But how do you feel towards her when she does that? [Pressure]
*Patient:* [Short pause] Well, I guess I feel some kind of anger...
*Therapist:* Right. So how do you experience that? [Pressure]
*Patient:* Well... [Small sigh]
*Therapist:* Underneath the sadness? How do you experience the anger towards her? [Pressure]
*Patient:* I get angry, but I don't dare to say anything... [Small sigh]
*Therapist:* Okay. Let's see if we can look at that here . Because it sounds like what happens is that you quickly get scared, sad, self-critical and "overwhelmed" when you have anger inside with her? [Clarification]
*Patient:* Yes.
*Therapist:* But then it is like the anger goes inward towards you somehow. If we can help you feel the anger outwards, maybe you'll have less of that reaction? Do you see what I mean? [Pressure to positive goal]
*Patient:* [Nods]

At this point, her "sadness" seemed to represent a combination of high anxiety and weepiness leaving her overwhelmed and in a one-down position. Since she seems tense in the moment I continue with pressure:

*Therapist:* So how do you experience it inside? The angry feeling? Is it possible to describe how you experience it inside? [Pressure]
*Patient:* Well, that's when it starts in here... [Points to her chest]
*Therapist:* What are you noticing now?
*Patient:* It's like a rush and then it gets tight. And now I can actually feel some pain in my stomach [Points to her belly].
*Therapist:* A bit of a stomach ache? Is it a bit like that gastritis-nausea like thing? [Exploration of anxiety]
*Patient:* Yes, yes, exactly.
*Therapist:* Okay. So that could also be a sign of anxiety. So, when we approach this angry feeling with your daughter, when we try to help you feel it in here, the anxiety goes up inside and then you get some pain in your stomach. [Recap]
*Patient:* [Nods]
*Therapist:* Is your vision affected too? [Exploration of anxiety]

*Patient:* No, it's not affected now, but my back is very tight... [Moves in the chair]
*Therapist:* Tight in the back? Okay. Does it feel like your back hurts?
*Patient:* Yes, that is exactly what it is... Yes, it's tight in the shoulders and head...

Here, pressure to experience the anger internally triggers tightness and some possible smooth muscle symptoms so I moved to a brief recap and explored anxiety. However, she does not report blurry vision or weepiness again and her anxiety seems mostly in striated in the moment; thus, I continue with pressure:

*Therapist:* How do you feel towards her now that you think about it? How do you feel inside towards her? [Pressure]
*Patient:* Yes, it gets back to this rush...
*Therapist:* Is it happening again?
*Patient:* Yes! [Smiles]
*Therapist:* Okay, good. How strong do you feel the rush inside now? Somewhere in your chest or? [Pressure/bracing]
*Patient:* [Sigh] Yes, I feel it here... [Points to mid part of her chest]

From here we continue to do some work on helping her experience the rise of feelings inside without avoiding it or turning anger back on herself. A few minutes later the patient reports experiencing some energy moving into her arms and I decide to move to a "intellectual portrayal" (see Abbass, 2015, pp. 232) with the main aim of further capacity building:

*Therapist:* So, if I ask you like this. In terms of your thoughts. If you couldn't protect her from it, how would it come out in your imagination towards your daughter? What would it look like if you couldn't protect her? [Pressure to portrayal]
*Patient:* At some point, I would like to tell her how badly she treats me...
*Therapist:* What do you see in your imagination? [Pressure to portrayal]
*Patient:* You know, now I just thought of another thing. I have a lot of anger inside of me because I have dreams about anger. I grab people by the hair like this and then I stand and shake. [Moves both her arms in a shaking motion] I shake, and shake, and shake...

Here the patient spontaneously associated to her dreams of shaking people. I interpret this as a sign of the unconscious therapeutic alliance (UTA) being active to some extent and decide to use the imagery to explore her feelings with her daughter some more:

*Therapist:* Can you see yourself doing that to your daughter?
*Patient:* Yes, I could do that. I could shake her like this...
*Therapist:* The anger wants to shake her. How long would it last if it just came out unchecked? Like in a dream?
*Patient:* I would shake until it felt good.
*Therapist:* Until it felt good. How many shakes would that take?
*Patient:* I would continue to shake her... When I have a dream like this I wake up at this point and think: "Oh my God, what am I doing? Poor you!". Sometimes I dream it is a child too. It's really distressing...
*Therapist:* If you look at that image inside. If you had shaken your daughter like that. What would it look like afterwards? Can you see that in front of you?
*Patient:* Yes, I would be very sorry that I had done that... I would ask for forgiveness... [Starts to tear up]
*Therapist:* It's very painful to think about this, but also very important. It's like you want to protect her from your anger, but instead it's like you're punishing yourself. Punishing yourself with anxiety, punishing yourself with self-attack and then punishing yourself by agreeing to things you don't want to do [alluding to her masochistic pattern we had discussed previously]. Like the guilt over getting angry drives you to act in ways that become self-destructive. [Recap]
*Patient:* Yes [Sigh]. For sure...
*Therapist:* It's a painful thing to have there. So mixed feelings with her...
*Patient:* And it's the same feelings I have towards my husband too...

There is some painful feeling in her eyes and thoughts about guilt here. Following this passage, a memory of her mother emerges. In the memory, her mother is talking to her first-grade school teacher and says: "It is okay for you to hit her when she has been naughty". Some grief passes in relation to this memory.

This session indicates that some of the patient's somatic symptoms (i.e. blurry vision, nausea and stomach aches) likely reflect thresholds in her anxiety tolerance. These symptoms seemed to respond well to standard graded work with alternating pressure and recaps (e.g. "bracing", Abbass, 2017). Using the graded format in the session, she was eventually able to tolerate some rise and even a small partial unlocking (Abbass, 2015; Davanloo, 2005), without being overwhelmed with anxiety, using regressive defenses or developing somatic symptoms. This is a sign of her capacity increasing; still, the rise in impulse (e.g. "shaking") was not very high and we need to keep in mind that she started the session with blurry vision. This suggests she will need

more capacity building work before being able to tolerate more primitive impulses that will likely need to be worked through in later sessions.

## Direct work on somatization with a first passage of guilt

The therapy process continued with graded work in a similar fashion for several sessions. We alternated between looking at feelings and anxiety in recent examples and in the transference with me when indicated. Slowly, but steadily, her tolerance for holding complex feelings inside seemed to increase. However, she repeatedly experienced pains in her body that did not appear to be affected by our work thus far. Also, the manifestations of these symptoms did not clearly "fit" with the anxiety pathways. For example, she could describe pain localized to specific points in her body, like the chest, throat or head. I started to suspect they may be due to the process Davanloo (2005) termed "projective identification and symptom formation", which involves the emergence of symptoms in the body that match the impulses and damage the patient unconsciously wants to inflict on others . Other writers have referred to this as "somatization" (e.g. Coughlin Della Selva, 1996; Frederickson, 2013; 2020) or "sympathy symptoms" (Abbass, 2017; Abbass & Schubiner, 2018) since the symptoms are hypothesized to be driven by unconscious guilt over the rageful impulses towards loved ones.

In session 25, the patient wanted to focus on a recent incident with her husband that triggered anxiety and somatic symptoms, including pain in her stomach, chest and back. After some work on externalization to reestablish a clear internal focus, the patient experienced some rage in her body and in a portrayal imagines jumping on her husband. However, no guilt emerged; instead the patient started reporting a "stabbing sensation" in her chest directly after jumping on him. I decided to explore this symptom as a possible indication of somatization:

*Patient:* [Points to her chest] There is a stabbing sensation here...
*Therapist:* There's a stabbing in the chest now? [Exploration of symptom]
*Patient:* Yes...
*Therapist:* Is it like a constant pressure or?
*Patient:* It's like there is a knife in here and working around...
*Therapist:* Okay. So, it sounds like some of the anger still goes back on you? [Clarification]
*Patient:* [Nods]
*Therapist:* So, one way to think about this is that there may be more anger underneath. When the first impulse to jump on him has passed, there may be stronger impulses that still go back on you? [Clarification to restructure somatization]
*Patient:* [Nods]
*Therapist:* You say it is like a knife towards you. So, how would the knife go outwards if it was allowed to do so in your imagination? [Pressure]
*Patient:* [Sigh]
*Therapist:* Can you allow yourself to feel that? What would it look like? [Pressure]
*Patient:* [Tremor in hands and legs start]
*Therapist:* Do you notice that you are now starting to tremble more again? We're not talking about doing anything in reality. It would obviously be a disaster to stab him in reality. We're just trying to help you find other channels for these feelings that are so much turned back on you and give you anxiety and pain. [Clarification of task]
*Patient:* [Nods]
*Therapist:* For one thing we see here is that there seems to be a relationship between you getting pain in your body and impulses to make him have pain in his body. Now there is like a knife in your chest. That would suggest that there might be impulses to put a knife in his chest? [Clarification to restructure somatization]
*Patient:* [Nods] Hmm...
*Therapist:* But if we don't help you channel it that way, it will stay inside you. [Clarification of price] Do you see what I mean?
*Patient:* Yes...
*Therapist:* It's like there is a direct link between what is happening in your body and what you would like to inflict on the other person. Not in reality, but there are impulses inside. [Clarification to restructure somatization]
*Patient:* That's right. That feels just right...
*Therapist:* Okay. So how would the knife go towards your husband? How would it go on him then? If you completely let go and couldn't control the impulses in you. What do you see in front of you then? [Pressure]
*Patient:* [Patient is clearly engaged in her internal imagery] I'll push the knife into him when he's lying there...
*Therapist:* In the chest or in the stomach?
*Patient:* Right in chest. The same place where I have pain... [Points to her chest]
*Therapist:* So now he has pain in his chest. You push once or several times?
*Patient:* Once. I would push it deep... He's bleeding...
*Therapist:* He's bleeding. Okay. Right. How does it feel to do that? How strong do you feel when you do that? Because it takes power to do that? Can you allow yourself to feel the strength? [Pressure] Not to do it in reality, but...

*Patient:* [Sigh] The pain is easing off in here… [points to her chest]
*Therapist:* Then we know we're on the right track. So now he gets pain in his chest and then it eases off in you?
*Patient:* Yes…

The patient goes on to describe stabbing the husband several times with force in her arm. As she imagines this, the pain in her chest continues to decrease. A few minutes later patient reports feeling calm inside and I decide to explore the imagery to see if some guilt can pass:

*Therapist:* Can you describe the scene now?
*Patient:* He is lying on the floor and there is blood on his chest.
*Therapist:* Is he dead?
*Patient:* No, he doesn't have to die… I'd feel really bad about that…
*Therapist:* But how could he still be alive? If you stabbed a knife in his chest like that would he survive it?
*Patient:* No, no. [Clearly engaged in the internal imagery] Now he died… [Tears starts forming in her eyes]
*Therapist:* It's coming up, do you notice? Just let it go through your eyes…
*Patient:* [Starts to cry with pain on her face]
*Therapist:* Because it's very mixed in you. There are very strong angry impulses in there, but you feel guilty about it too. It's hard to feel this, but just let it go…
*Patient:* [Cries with pain]
*Therapist:* So, it doesn't backfire on you. The more you feel the guilt, the less need to punish yourself…

A few weeks after this session, the patient reported that she had finally decided to divorce her husband. She had been contemplating this for many years but had not felt she had the strength to make the move. At this point in therapy, the patient experienced that her depressive symptoms had decreased significantly, and she also felt more confident that she had the capacity to manage living on her own.

## Further work on somatization and experiencing guilt

The patient's decision to divorce her husband brought up a number of issues in the family and for a while her anxiety increased. Her somatic symptoms fluctuated too and would typically flare up in situations of interpersonal conflict; however, she seemed to manage this without getting depressed again and was also more able to recognize the feelings involved. In one later session, she described a situation where the daughter criticized her, and she immediately developed an intense headache:

*Therapist:* How did you feel towards her when she criticized you? [Pressure]
*Patient:* At that moment I got "hit by a frying pan in my head".
*Therapist:* *You* got hit by a frying pan in *your* head?
*Patient:* Yes! When she criticized me like that, it was like I got hit by a frying pan in my head.
*Therapist:* Do you see the pattern? Who do you want to hit with a frying pan in the head?
*Patient:* My daughter, but I get it myself…
*Therapist:* It's like what we talked about before with the stabbing in the chest, with the strangulation in the throat, with the pain in the back, right? You get pain where you want to inflict pain on someone. [Clarification to restructure somatization]
*Patient:* [Nods and puts her hand on her forehead]
*Therapist:* Did you get a headache just now?
*Patient:* Yes! [Smiles].
*Therapist:* So, you get another frying pan on your head in here when we talk about it?
*Patient:* Yes, indeed!
*Therapist:* It's like you're directly being punished. Which in a way is also protecting others by hitting yourself in the head with the frying pan? Do you see that? [Clarification to restructure somatization]
*Patient:* Yes…

By this session we have seen this pattern several times and the patient quickly gets it. Since the symptom appeared in the session, it suggests feelings are rising unconsciously and the symptom replaces the experience of guilt in the moment. Therefore, I decide to press directly on guilt by focusing on how it would look like if she had done that to her daughter (e.g. "the immersive approach", Abbass, 2017):

*Therapist:* So, if we turn that around, if you had hit her with a frying pan, what would that look like? [Pressure]
*Patient:* [Sigh] It would be very painful. Yes, she would have fallen flat on the floor…
*Therapist:* Can you see that? With your inner eye?
*Patient:* [Nods]
*Therapist:* Does anything happen to your headache when you see her lying with a frying pan in her head?
*Patient:* It's starting to ease off and I can feel it lifting… [Touches her head]
*Therapist:* Okay. How do you hit her with the frying pan?
*Patient:* I drop it from the top like this. [Moves her arm] Bang. Flat on the head.
*Therapist:* How does she look in the eyes? Can you see them?
*Patient:* [Starts to cry with a painful look on her face]

During this treatment phase, we also started to see clear links

between her reactions with her daughter and her memories of her relationship with her own mother. She had several partial unlockings, typically starting in current incidents with her daughter, moving through some capacity building and defense work in the transference, and then portrayals where she would feel some anger, grief and sometimes small amounts of guilt with links to her mother. She remembered a strong longing for connection with her mother, but experienced her as distant, cold, rejecting and demanding. As a child, she often felt like she could not do anything right in her mother's eyes. This typically got triggered today when she helped out with her grandchildren and experienced her daughter as "cold, demanding and critical" towards her:

*Patient:* It's all the time, all the time. I am constantly being told what to do. And I think it's starting to feel a bit much… Now my throat is tightening…
*Therapist:* So, what might be the feelings that are triggered here when you describe these situations where your daughter tells you to cook for her and look out for the children? [Pressure]
*Patient:* [Sigh] I feel angry at her. I find it very difficult that she commands me what to do.
*Therapist:* But how does it feel inside? How does that anger feel? Can you feel it now as we speak? [Pressure]
*Patient:* Yes, now I'm getting a bit angry in my arms too.
*Therapist:* A bit in the arms. What happens to the throat then? Is it still tight and painful or?
*Patient:* No, if I get it out into my arms then the pain in the throat disappears. There is little left but…
*Therapist:* Let's see if you can get it all the way out in your arms and away from your throat? So that it doesn't go back on you. [Pressure to task]
*Patient:* [Sigh]
*Therapist:* What about the shakiness and tremor?
*Patient:* [Sigh] None! It's very strange… [Looks at her hands with a surprised look on her face]
*Therapist:* When it goes out into your arms, you don't have to be shaky… [Clarification]

This session was conducted on Zoom due to the COVID-19 pandemic and I did not see her hands directly and had to ask about the tremor. I continue with some more pressure and she describes feeling anger all the way to her hands without tremor in the moment. She says it "wants to come out" so I invite a portrayal:

*Therapist:* In your imagination, as we sit here and talk and you feel this wanting to come out, is there anything the hands want to do in your imagination? [Pressure]
*Patient:* How strange. Now the pain in the throat came right back again!
*Therapist:* But then it goes back to you.
*Patient:* Yes, I know. At first, I thought I would like to strangle her. When I had that thought the pain in the throat immediately returned.
*Therapist:* Good you see that connection. There is an impulse when you have the anger active outwardly to strangle her. Not in reality, but in imagination. But immediately it is as if you are being punished and you are the one being strangled. It hurts your throat. Do you see what I mean? [Clarification of price]
*Patient:* [Nods]
*Therapist:* So, let's see if we can help you feel through all of the emotions? [Pressure to task]
*Patient:* My thought was that I would twist her head around. That I would grab the head but also twist it. Something that is impossible, but still, that was my thought.
*Therapist:* The idea was that? So, the neck breaks?
*Patient:* Yeah, that was my idea to twist it around…
*Therapist:* Can you feel that in your arms and hands now? Without doing it, but just feeling it? [Pressure]
*Patient:* [Sigh] Yes…
*Therapist:* And if she lay there with her neck twisted like that. Is she alive?
*Patient:* No. No.
*Therapist:* She is dead.
*Patient:* Yes, she is dead. She is stone dead. Her eyes have rolled and it is…
*Therapist:* It's over…
*Patient:* It's over… [Sigh]
*Therapist:* Is your granddaughter in the picture too? How would she react if she saw her grandmother twisting her mother's neck? [Pressure to feel guilt]
*Patient:* [Patient has painful expression and starts to sob heavily]
*Therapist:* It is very painful inside. Let it go through, it's very important. It wants to come out through the eyes. It is so painful that you get such intense feelings with your daughter…

Later in the session we connect her reaction with the daughter to a memory of her mother who demanded that she help out with preparing dinner for her father, but then criticized her for the way she did it. In the memory, the patient was about the same age as her granddaughter is now.

The patient's relationship with her father also came up repeatedly in treatment. She described feeling very scared of him as a child and never felt they were close growing up. He was an alcoholic and could get very angry when drunk. He could also get paranoid and morbidly jealous (he was convinced the mother was having an extramarital affair) and

repeatedly threatened to kill himself when he had arguments with her mother. Her mother also threatened the patient that the father would discipline her if she did not obey her. The patient also had memories of her father beating her with a belt when she was very young, with the mother standing next to her watching. These latter memories had a chilling resemblance to the interactions that she described having taken place with her own husband and children, pointing towards "intergenerational transmission of trauma" in the family (Zhang, Mersky, Gruber, & Kim, 2023). In several sessions, when her feelings rose towards her husband and/or in the transference with me, she linked her feelings to memories of her father and how scared she had been of him growing up.

## The Emergence of in-session "hallucinatory" experiences

During the mid phase of the treatment the patient started reporting very vivid dreams and also strange in-session experiences with "hallucinatory" qualities. For example, she described suddenly experiencing my eyes as "completely black", or like "empty holes", and she could also experience blurry vision in parts of her visual field that "blocked" her seeing my eyes (while everything else in the room was clear). Some sessions she also described seeing a "dark shadow" behind me and at other times she saw a "white light" around my head. These visual distortions were very vivid to the patient and I had trouble understanding them. I started thinking that this could indicate cognitive decay and/or that she was on the verge of a psychotic breakdown, which naturally made me quite anxious! Fortunately, I had access to qualified supervision where I could show tape and discuss these phenomena. In supervision, we concluded that the patient clearly had intact reality testing and, additionally, she was also actually making progress outside the sessions during the same time period. How could she be on the verge of a psychotic breakdown if she was improving? Since my thought was that the distortions indicated that she was "above threshold", I got anxious about the possibility of "causing harm" with further pressure, so I typically switched to anxiety regulation and recapping when she reported having these experiences. However, my supervisor suggested that these phenomena were more likely signs of her UTA being active and encouraged me to keep the pressure up and explore her experiences deeper instead.

In session 80, the patient came in with some anxiety activated in striated muscles and we started exploring feelings towards me coming in. After some pressure and helping her turn against self-attack, she reported feeling "frustrated" with me. However, as soon as we moved towards her experiencing that, she started seeing my eyes as "black". Rather than viewing this as CPD or a "big-p" projection (Kuhn, 2014), I decided to encourage her to experience her feelings towards my "black eyes":

*Therapist:* If we leave those eyes here with me, how do we feel about this figure over here who has these eyes? [Pressure] Do the eyes look stern or do they look angry?

*Patient:* Because they're so dark, they look a bit angry... [Tremor in arm increases]

*Therapist:* Now you get more tremor in your arm, do you notice it?

*Patient:* [Nods]

*Therapist:* Shall we see how you feel towards me? Towards these eyes? After all, we know that you and I are only here to examine your feelings. But it's like your mind wants to place those eyes over here. How do you feel towards these eyes? [Pressure]

*Patient:* Now I get strangled. [Points to her throat]

*Therapist:* Okay. But then it's like it's going towards you again, right? [Clarification]

*Patient:* I know. Just because I tried to think of something, I was immediately strangled.

*Therapist:* Okay. So that's the mechanism that directs angry impulses towards you. [Clarification] Is it possible to feel it outwardly here towards me? [Pressures]

*Patient:* I will try.

*Therapist:* What is the impulse towards this person who has these black eyes right now? [Pressure]

*Patient:* [Sigh and some tremor active].

*Therapist:* We know that there is a tremendous power in you, but it's like you can't access it. This punishment system - the strangulation, the self-criticism, the headaches, the shaking - all of that blocks your power. [Clarification]

*Therapist:* And as far as we know, you haven't done anything criminal. But it's like you're being punished, like you've done something bad to someone. [Clarification]

*Patient:* [Nods]

*Therapist:* So, let's see then. Is there still a stranglehold on you or not?

*Patient:* No, it dropped.

*Therapist:* Okay, good. How do you feel towards me? If I am the holder of the eyes? What kind of impulses are coming up towards this person? [Pressure]

*Patient:* [Tremor increases]

*Therapist:* Is it still difficult to get any power in the body?

*Patient:* Yes, I'm shaking. I'm trying to keep my legs still. [Sigh]

*Therapist:* If you hold back the shaking and just let it rise inside. Can you do that? [Mild challenge and pressure]

*Patient:* [Patient shifts in chair and sits up more] I want the support from the chair.

*Therapist:* Okay, good. Is there any energy going up and through the body? If you just "surf" on it? [Pressure]

*Patient:* Yes. [Patient looks intensely at the therapist and there is a short pause] I'd like to scratch my father's eyes out.

The patient had not mentioned her father previously in this session, but the internal picture of me had shifted to his eyes in previous portrayals several times. She now sits up in the chair and seems to experience more primitive impulses compared to previous sessions.

*Therapist:* Scratch them out? Can you see it in your imagination? How do you attack the eyes? [Pressure to portrayal]
*Patient:* I dislike his eyes so much that I would… I would tear them out… [Raises one hand]
*Therapist:* Tear them out with your fingers? With one hand or both hands?
*Patient:* I kind of would… [Raises both hands but lowers one again] With one hand, one hand…
*Therapist:* With your nails or fingers?
*Patient:* I'm going to gouge out one eye.
*Therapist:* Gouge it out? What happens next?
*Patient:* Yes, I gouge it out and step on it.
*Therapist:* What about the other eye? [Patient displays more tremor] Your hand starts shaking more again.
*Patient:* It is the eye of my ex-husband. [Looks intensely directly at the therapist]
*Therapist:* Do you want to scratch it out too, or?
*Patient:* But you know, it's weird. Because it's just like cataracts or something like that. That is, a gray film that covers that eye, it kind of disappears. It's like I can't just get to it.
*Therapist:* You can't reach it. How frustrating is that for you? Isn't that frustrating?
*Patient:* [Sigh] Yes, it's very frustrating.
*Therapist:* What do you need to do to get to it?
*Patient:* I'll stick a fork in it. I'm going to stab it straight in. There's splashing, blood and everything.

The patient is sitting straight and is fully engaged in the imagery. Still, I notice she has some tremor in her arms here and I want to make sure she is feeling as much of the somatic pathway of the rage as possible here.

*Therapist:* Can you feel any such force in your hand that it wants to stab? Would it have the power to stab? I see that you have some tremors at the same time, although less now than at the beginning of the hour. We're not talking about doing it, but would you have enough power to do it? [Pressure]
*Patient:* Yes. [Moves her arms and the tremor stops]
*Therapist:* Okay, is it one stab with the fork or several?
*Patient:* Several. At both eyes. Smashing, smashing. Crushing.

This goes on for a few minutes more and I just follow her pictures as they unfold. The patient is clearly engaged in her internal pictures at the same time as she is looking straight at me - it feels like she is actually "dreaming while awake" (Davanloo, 2005) at the moment. I am alert to any indication that guilt may be moving to the front. A few minutes later the patient starts reporting that one of my eyes is changing:

*Patient:* Your left eye is shifting. The eye that wasn't there just now. Now it's kind of "watery".
*Therapist:* Watery?
*Patient:* Just like my dad had. Towards the end of his life, his eyes were watery like that.
*Therapist:* Ah, when he was old?
*Patient:* Yes. They often looked tearful.
*Therapist:* So now a teary eye comes up here. What is it like to look at that teary eye?
*Patient:* [Starts crying heavily with a painful look on her face]
*Therapist:* Just let it go through your body. So much pain. Seeing his tear-filled eyes towards the end of his life. There's love at the bottom of this too.
*Patient:* [Nods while crying]

Here there was a passage of pain, guilt and grief that went on for about eight to ten minutes. At the end of the passage, the patient describes a clear positive memory with her father for the first time. In the memory, she is about 4-5 years old and is sitting on the steering wheel of her father's bike as they ride to the local convenience store to buy groceries. Repeated recaps on the connections between the rise of mixed feelings in the transference, links to her relationship with her father and ex-husband, and the formation of somatic symptoms, sensory distortions, as well as her guilt-driven masochistic character pattern, followed this unlocking.

## Outcome at termination and follow-up

The patient started bringing up the possibility of termination about six months prior to our setting the actual termination date. Although she could still have days when she felt anxious and experienced transient somatic symptoms, she had been quite stable for some time at that point. We decided to see how she would manage during our seven-week summer break and, if she still felt okay, we would set a termination date after that. This is from the opening of the first session after the summer break:

*Patient* I don't know what to talk about today! [Smiles]
*Therapist:* How do you feel coming here?

*Patient* Good! I don't know if it's too big to say, but I feel like I've "landed" this summer. I have reached a state of calm. I never thought I would get there.
*Therapist:* How do you notice that calm?
*Patient* That I am much calmer. I don't feel any worry. I have a good relationship with my daughter.
*Therapist:* How has it changed?

Here we explore some of the changes she experienced in her relationship with her daughter. She described the changes as reciprocal – she could stand up for herself better and set firmer limits and she also experienced her daughter as warmer and more appreciative towards her. I continued to inquire about her somatic symptoms:

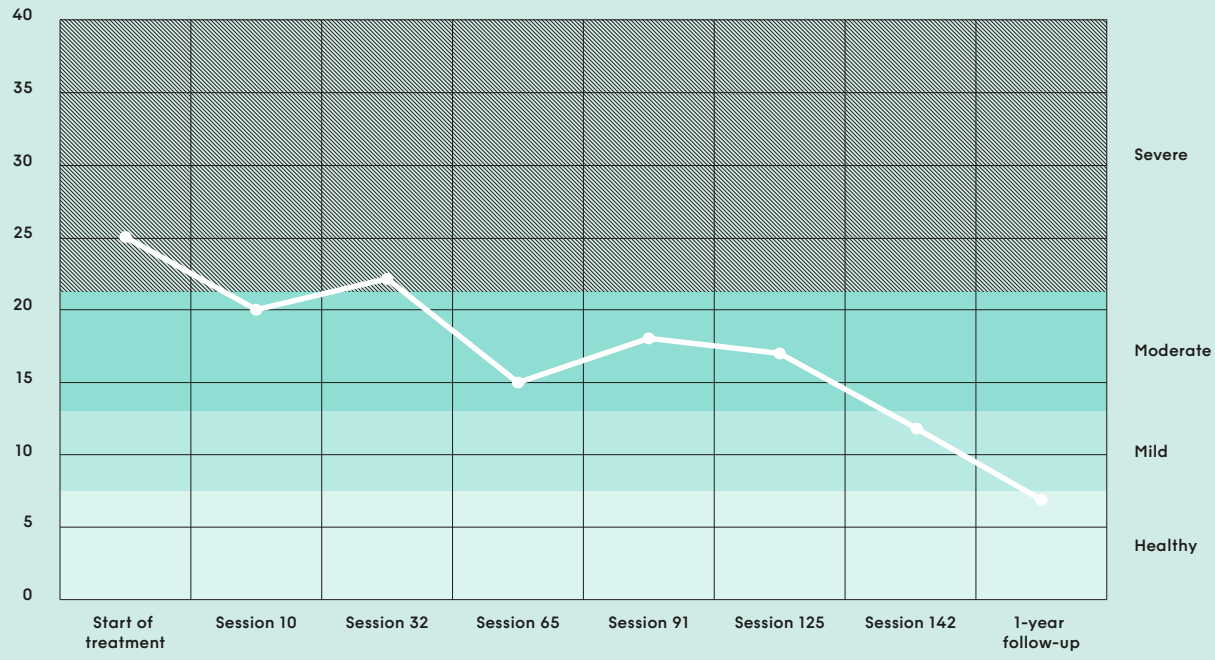
*Therapist:* One thing we've talked a lot about is your somatic symptoms, such as headaches, pains in the body and stomach problems. How has it been during the summer?
*Patient* Good! I haven't had any of that. I've been so calm and I've been enjoying things, like going to senior dances... It feels really good!
*Therapist:* Things have really settled down then?
*Patient* Yes.

We went on to discuss and set a termination date about seven weeks later. The termination phase mainly involved work on grief connected to multiple losses she had experienced in her life, including the therapy relationship, as well as repeated and extensive recapitulation on the whole treatment process.

The patient filled out CORE-OM as a measure of overall distress and functioning about every 6 months throughout the treatment (see Figure 1). At the start of therapy, she scored 25 points, which suggests "major distress" according to normative data. Her score fluctuated somewhat (there was a slight increase around the time of the divorce for example) but overall, the curve decreased over time. At termination her score was 12, which indicates "mild distress" and is still somewhat above the population mean.

At one-year follow-up, she described that her improvement had continued in several areas and that she felt generally "stronger" inside. She further reported that she had not experienced any stressful somatic symptoms in the last year or so and scored 7 points on CORE-OM which is below the clinical cut-off.

**FIGURE 1.** CORE-OM TOTAL SCORE



# Discussion

In this article I have presented segments from a treatment of a complex, treatment refractory, mild to moderately fragile patient with multiple unexplained somatic symptoms. The treatment lasted 147 sessions over four years and given that length, one might rightfully question the "short-term" part of the ISTDP acronym in this case. Still, considering her long-standing problems with recurrent depression, masochistic character traits and low ego-adaptive capacity, one might also argue that 147 sessions is actually quite short. Further, we also need to keep in mind that the patient was 69-years old when entering treatment and, although both research and clinical experience suggests older people typically benefit from psychodynamic treatments just as much as younger people do (Choudhury, John, Garrett, & Stagner, 2020), age can involve certain limits in processing speed, flexibility and readiness for change.

An additional issue possibly related to the patient's age concerns her tremor. Although this symptom seemed clearly related to activation of complex feelings, genetic and age-related factors was likely also partly involved since both her mother and other relatives on her mother's side of the family had developed essential tremor in late-life. About three years into the treatment, the patient started using a low dose beta-blocker which seemed to have a general positive effect. Still, even with the beta-blocker, her tremor would increase with a higher rise in complex feelings in sessions (as indicated by the transcripts above), suggesting there were emotional factors involved as well. At termination and follow-up, she reported a clear improvement in her tremor, particularly in relation to emotionally stressful situations.

Besides the tremor, this patient suffered from several other medically unexplained somatic symptoms, some of which exemplifies the mechanism Davanloo (2005) termed "projective identification and symptom formation", or "sympathy symptoms" for short (Abbass, 2017). This phenomenon may seem far-fetched to clinicians not trained in ISTDP or psychodynamic/psychoanalytic thinking in general, but having seen this phenomenon in multiple cases of my own and those of other trainers and trainees, it is hard *not* to accept its existence. Still, it is also important to remember that not *all* of this patient's somatic symptoms were caused by this mechanism. Rather, several symptoms seemed more related to her anxiety shifting to smooth muscle discharge (e.g. nausea, stomach cramps) and CPD (e.g. dizziness, blurry vision) at higher levels of rise. These phenomena responded well to standard graded work involving cycles of pressure and recaps, as well as using portrayals at lower levels of rise to build anxiety tolerance and self-reflective capacities (Abbass, 2015; 2017; Frederickson, 2020).

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Just like with anxiety discharge patterns, the therapist needs to carefully psychodiagnose patients' responses to intervention in order to "test" and "rule in" that a specific symptom actually represents a "sympathy symptom". According to ISTDP-theory, *unconscious* guilt over rage toward loved ones is the driving force behind these symptoms; thus, experiencing the complex feelings consciously would make symptoms "unnecessary". In support of this hypothesis, the patient experienced an *instant decrease* of symptoms as soon as she allowed herself to experience rage internally and imagined directing it outward and, of utmost importance, this further allowed increasing levels of guilt to pass *consciously*. This process of *making the unconscious conscious* (Freud, 1917/1963, p. 435) is of course the hallmark of any psychodynamic or psychoanalytic treatment, but is rarely as explicitly exemplified as in cases like these.

The "disturbing" in-session experiences that gradually emerged in later parts of the treatment made me quite anxious as her therapist. Again, given the patient's age, my first worry was that her quite vivid visual experiences may indi-

***"...the treatment process described in this article suggests graded istdp may be helpful even in complex, treatment refractory, cases with multiple medically unexplained somatic symptoms. The treatment may need to be medium- or even long-term to reach satisfactory outcomes, but given the often life-long struggles and multiple failed treatment attempts many of these patients' experience, this could be both justifiable and cost-effective in many cases."***

cate cognitive decay and/or an emerging psychotic breakdown. My second worry was that the treatment process was conducted "above thresholds" and that her experiences were indications of cognitive-perceptual disruption and/or projective processes; hence, I initially tended to become careful and supportive and intellectualized a lot with her when she started to describe visual distortions in the session. Although "erring on the side of caution" may seem sympathetic , this was likely not the most efficient way to work with her at that point in the treatment since dropping pressure may have unintentionally prolonged the treatment somewhat.

In retrospect, I can see several indications that suggest these phenomena were related to the UTA rather than signs of cognitive decay or an emerging psychotic process. For example, the patient was quite calm when describing her experiences (I was more anxious than her!), and she also reported that she had had intermittent experiences like this throughout her whole life (which is not uncommon in fragile patients), but she had never been psychotic. Further, she did not attach the experiences to any delusional ideas; rather, her thought processes and reality testing were fine, and she was both curious and open to the possible meaning of her internal, "dreamlike" experiences. Also, she only reported having these experiences in the room with me and was clearly making good progress in line with her goals between therapy sessions. She also had vivid dreams with very meaningful content during the same treatment phase which, again, is another indication that UTA was active.

I am very grateful that I had the opportunity to show video and discuss these phenomena with an experienced ISTDP-supervisor. Although I was already well-trained and had been practicing ISTDP for several years post core training, I had not encountered a patient describing *concrete* visual distortions in sessions before, and I'm not sure I would have dared to stay with pressure and exploration of feelings in the transference without the support of my supervisor when she had these experiences. I believe phenomena like this, and how to distinguish them from *actual* cognitive deterioration and/or emerging psychotic processes, are underdiscussed in the ISTDP literature. Clearly, misinterpreting emerging psychotic phenomena as signs of the UTA may have disastrous effects, but my experience with this case suggest that misinterpreting the UTA as emerging psychotic phenomena may also hamper the patient's progress in treatment. I look forward to reading other case reports as well as theoretical discussions (and someday, hopefully, formal research) on this topic in the future.

While keeping the many limitations inherent in uncontrolled case studies such as this in mind, the treatment process described in this article suggests graded ISTDP may be helpful even in complex, treatment refractory, cases with multiple medically unexplained somatic symptoms. The treatment may need to be medium- or even long-term to reach satisfactory outcomes, but given the often life-long struggles and multiple failed treatment attempts many of these patients' experience, this could be both justifiable and cost-effective in many cases. One possible developmental avenue for future research in this area would be to identify and specifically target patients that may not respond to other, first-line, treatments and evaluate longer-term ISTDP for more complicated cases (Abbass & Schubiner, 2018).

This article also highlights that although the ISTDP-framework is a very powerful and useful tool, the work is often challenging for the therapist (as well as for the patient). It requires both in-depth theoretical knowledge and the ability to adjust to rapidly shifting in-session processes, as well as tolerating your own anxiety when trying to figure out what is going on in the moment. Having access to supervision with an experienced supervisor is highly recommended. My hope is that this article will encourage other ISTDP clinicians to continue to work, learn and develop their skills working with this patient group. We have much to offer these patients and even more to learn from them.

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