Interview

From the time Davanloo developed his model of ISTDP, he also experimented with different ways of passing his method on to students. Around the mid-80s, he developed the core training format. Alongside it, he ran traditional supervision groups and held his yearly metapsychology conferences in Montreal. It appears, however, that Davanloo found his method difficult to teach. By the beginning of the 2000s, Davanloo had come to recognize that the major barriers to learning ISTDP encountered by his students stemmed from their own unresolved neuroses.

Jody Clarke *Inside Davanloo's late mobilization workshops*

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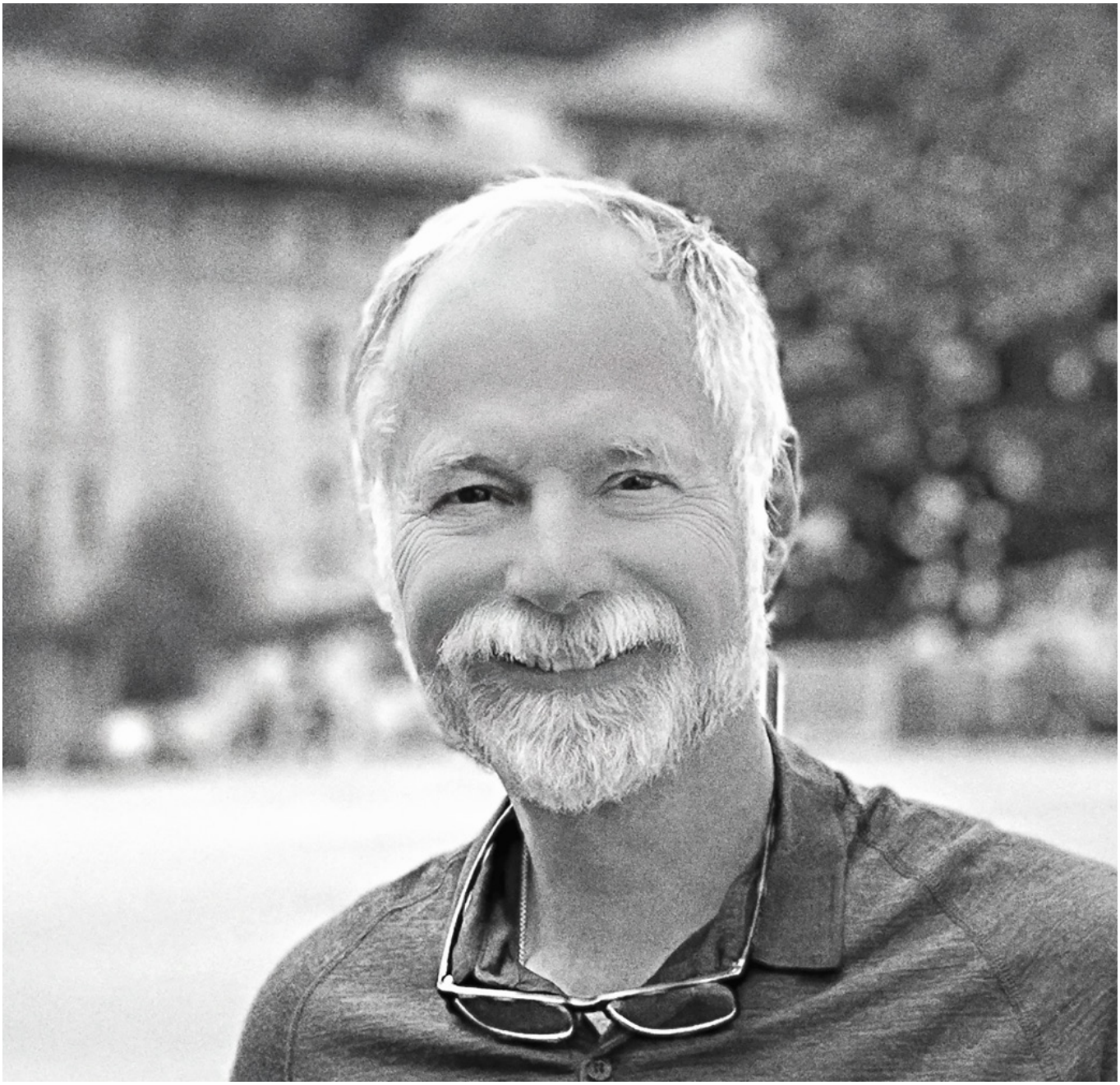
To address this issue, Davanloo developed his "Montreal Training Workshops in Mobilization of the Unconscious," also known as the "Closed-Circuit Training Workshops," which he ran from 2007 until 2020, when COVID-19 forced him to retire. In these workshops, Davanloo and a small group of students would engage in an experimental combination of supervision and therapy specifically designed to identify and overcome his students' emotional obstacles to the practice of ISTDP. Unfortunately, however, the exact nature of what transpired during these workshops is not described in any considerable detail in the literature on ISTDP.



The few notable exceptions that do shed some light on the topic are Cathrine Hickey's *Understanding Davanloo's ISTDP* (2018) and Angela Schmitt's *Davanloo's Psychotherapeutic Techniques:* Notes from Montreal (2024). In this interview, Jody Clarke, who attended the Mobilization Workshops for many years, offers a detailed description of the course of these workshops and discusses the profound impact they have had on his and his colleagues' work. Clarke is a Professor of Pastoral Theology at the Atlantic School of Theology in Halifax, Nova Scotia, Canada.

A good place to start here today is if you would like to just say a few words about yourself and what you do professionally – you have an interesting background.

– Thank you, that is a great place to begin. My name is Jody Clarke. I'm a Professor of Pastoral Theology at Atlantic School of Theology in Halifax. The focus of my interest as an educator and researcher is on trauma, loss, grief, and bereavement. My doctoral work was in parental bereavement. In addition to my academic work, I have a small therapeutic practice.

In order to understand and appreciate grief, it is critical to understand attachment-based psychological modalities. So, for many years, I studied and worked with object relations theories and self-psychology, primarily the work of Heinz Kohut. And then, by virtue of a set of interesting circumstances, I encountered a psychiatrist who was in training with Dr. Davanloo.

At the time, there was a very active community of psychotherapists in Atlantic Canada who were closely following the work of Dr. Davanloo. After a series of conversations, the group decided to invite Dr. Davanloo to Halifax and host a one-day symposium. The venue for this event was the campus of the Atlantic School of Theology, which is a pretty little campus situated on the edge of the Atlantic Ocean. That is where I first met Dr. Davanloo. This was also my first introduction to Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP).

Shortly after that event one of the psychiatrists who organized the symposium offered to serve as my supervisor as I began to import some of Dr. Davanloo's theories into my own clinical practice. A few months later, I was invited to Dr. Davanloo's Metapsychology Symposium in Montreal. That was well over twenty years ago. That experience was mind-blowing.

And so that's what really brought me to the work of Dr. Davanloo. And I found Dr. Davanloo's work to be resonant with what I practiced and how I saw the therapeutic journey. Patients of mine, prior to any introduction to ISTDP, responded well when I moved directly toward the issue or point of suffering. When I worked as a Spiritual Care practitioner or chaplain, the patients often expressed their gratitude when we addressed matters no one else was willing to talk with them about. This was particularly true when spending time with people who had a terminal diagnosis. They would say, "I really like it when you treat me like I am alive, like my issues matter. Most people are too gentle, too saccharine, too sweet." In my experience, people appreciate deep, meaningful conversations. The people that I worked with were the great teachers.

So, when I encountered Dr. Davanloo, I thought, "Here is a man who has constructed an entire theory around honest engagement with patients. And more importantly, he does not believe in wasting the time of either the patient or the therapist." I say this because, at the time, I knew a lot of therapists who chit chat with the patient rather than working with their suffering.

We're here because you made a presentation for the Scandinavian ISTDP Academy, which I facilitated. Before your presentation, you and I had an interesting conversation about your experiences with Dr. Davanloo and the Montreal Training Workshops in Mobilization of the Unconscious, and I would like to continue that conversation here today. Maybe you could start by describing that workshop and how it differs from Davanloo's yearly "Metapsychology Conference"?

– Well, Mikkel, there were three types of gatherings, at least three of which I am familiar [with]. There was the large Metapsychology gathering that took place every October in Montreal. This was a week-long symposium. There were usually between one hundred and one hundred and fifty therapists from around the world in attendance. Dr. Davanloo would lecture and present video content that addressed a particular theme over a five or six-day period. Attendees would see the actual interviews, many of which were featured in his books. The symposium would also consist of panels and guest lecturers. But ninety percent of the event revolved around Dr. Davanloo. It was a very rich environment and a great privilege to meet so many wonderful therapists from all over the world.

Then, for many years, Dr. Davanloo offered a supervisory group. Dr. Davanloo would meet with about twenty therapists for five or six days and review their clinical work. And that would be the kind of classical supervisory model. Each clinician would have two hours with him, we reviewed tapes, everyone would observe, no one else could comment. It would just be Dr. Davanloo working with the individual therapist or supervisee. And he'd do some analysis, some teaching. The attendees would have a chance to see about forty hours of videotape of our colleagues and hear Dr. Davanloo comment on their work.

Then, in 2007, Dr. Davanloo shifted his focus radically. He abandoned the supervisory project and worked exclusively with the Closed Circuit Training Workshops (CCTW) format. This was the most intense of all learning experiences. Dr. Davanloo would bring together about fifteen therapists. Everyone would gather for five or six days, and there, we would begin a process of interviewing each other. The interviews would be videotaped and then reviewed by Dr. Davanloo within the context of a plenary group. And Mikkel, this is what I think you are most interested in.

And would there be several groups? Or would this be the same group that got together each year?

– Again, a really good question. It was, by and large, the core group that consisted of about a dozen regular trainees. And the other five or six would filter in and filter out depending on their schedules. We got together four or five times a year for a weeklong session. The last one was convened just before COVID hit in February of 2020.

I'll just tell you quickly, anecdotally, about that. At the time, Dr. Davanloo was in his early 90s. That particular five-day CCTW began first thing on a Wednesday morning, and we

went until about five, 5:30 that day. He is the supervisor. He's in complete command of the ship. I'm not kidding. He is aware of everything that is going on consciously and unconsciously in the room. It is quite extraordinary.

Then, on the second day, we went from about 9:30 in the morning until six o'clock in the evening. On the third day, Friday, we went to about 6.30. On the Saturday, the CCTW went until almost 8:00. And the man with the most energy in the room was Dr. Davanloo. And then on Sunday, I think we went until about six o'clock. It was quite extraordinary, the total force of a man in his early 90s was wonderfully evident. It was really remarkable. And for me, as a theologian, it was a Spiritual experience.

Yeah, yeah, let's talk about that. But let's just get the structure of this thing totally in place. So when you get together, what's the setup? Is it like a closed-circuit setup? Or is it a group setting? Or how does it work?

–It's a completely closed-circuit format. The group gathers in one room with Dr. Davanloo. This was the plenary group. Then, in an adjacent room, there would be two chairs set up with a camera facing each chair. One on the interviewer and one on the interviewee. Dr. Davanloo may give the interviewer a few suggestions. And once they are both settled, the session begins.

But before the entire process starts, and this is a wonderful dimension of Dr. Davanloo's brilliant pedagogy, he would review some of these classical tapes with us or a few tapes from previous Workshops. This review work accomplishes several things: it reminds us about our task, and it also served to animate or mobilize the unconscious of the participants.

Dr. Davanloo would share with the group what he was thinking, what he was seeing and also what he sensed the CCTW should explore or examine. In this way, the CCTW was a venture in experimentation, innovation, and the expansion of his theories. Toward the end of that first day—after reviewing a few tapes—he would invite two therapists to go into the adjacent room and begin a process. He would suggest a twenty-minute interview. It basically starts out with what we classically think of as the central dynamic sequence, no big surprise there.

The other thing that is critically important is that everyone in the room acknowledges that there are things in our own unconscious that need to be adjusted or dealt with. And as we all know, within the world of therapy, some of the most highly resistant people are therapists.

The interviewer and interviewee, selected by Dr. Davanloo, would begin. Despite the fact that all the participants had explicitly stated that our "wills" are firmly in place, resistance would inevitably make its presence known. The interviewer would work with the resistance either with a head-on-collision, with a composite form of the HOC, with rhetorical questions to the unconscious, or a total blockade of the resistances. A couple of things happened during that period: if the resistances had malignant features or were for some reason entrenched, Dr. Davanloo might send in a note to the interviewer. It might read something as simple as, "Go back to the feelings." Or, "Go back to the feelings toward the mother."

And you can see it on the videotape, Dr. Davanloo's question inevitably turns the interview in the correct direction. And we'll see with that intervention and the subsequent impact it had on the flow of the interview. And you can see it probably; I mean, the beauty of the unconscious is [that] it has physical manifestations. We can see the anxiety go up, or see the murderous rage come through, or observe the physiological response to the animating line of inquiry.

On occasion, Dr. Davanloo might send a note into the room and ask the interviewer to suspend the session for a few minutes and be invited to return to the plenary group. There, Dr. Davanloo would offer some instruction and a little coaching, make a couple of recommendations, and then send the interviewer back in. And it's all recorded, right? We can all analyze it. So, not only does Dr. Davanloo do analytical work on it, but we do work on it, too. And that's a lot of material.

If both the interviewer and interviewee are struggling, Dr. Davanloo might enter the interview and take over from the struggling interviewer. I saw less and less of this as the years progressed. In great humility, Dr. Davanloo consistently noted that such an intervention—namely, his intervention—was predicated on the work of the previous interviewer. He would also graciously ask both parties if it was alright for him to sit in the shoes of the interviewer. Please know no one objected!

So, just to be clear, he would write a note, and then he would go in with it? Or have someone do that?

–No, so one of us, one of the group members, one of the trainees would go into the room, just to hand it to the therapist. If he went into the room, it was to pick up the interview. Before he did this, he would ask permission from both the interviewer and the interviewee. But essentially, he might make a suggestion and allow the interviewer and interviewee to proceed with their work.

So you'd go on for 20 minutes or something, and then what?

–Yes, two or three things would happen. Either the resistance would be really firm, you could see the resistance, and nothing happened. Or you might have a very powerful breakthrough into the unconscious. As an interviewee, I had numerous breakthroughs in the unconscious, extraordinary material. So, I can't say enough about my colleagues and the level of vulnerability that I experienced myself, but also their competence in working with this material. So, just a phenomenal experience.

Twenty or thirty minutes may seem to be a relatively short period of time, but remember, the entire CCTW is itself a mobilizing experience.

But after the 20-25 minutes, the interviewer and interviewee would then go back into the plenary session; they would sit directly in front of Dr. Davanloo. And then Dr. Davanloo would just look at them and say, "So what happened? What's your

experience? How are you feeling? What did you see?" And then we'd analyze the tape together. Dr. Davanloo might pause the tape and point something out. He might ask either the interviewer or interviewee how they were feeling at certain points during the interview, "What are you experiencing here?" So, it really was a workshop, we really did work on things as a group. And he'll say, "You notice this, you see this here."

There is the immediacy of Dr. Davanloo saying. "Dr. Clarke, what were you experiencing at this moment?" And the moment he is referring to took place only a few minutes earlier. The proximity to the actual experience offers an acuity to the learning event that is unrivaled. As a result, the amount of data that was garnered from that kind of pedagogy, that kind of workshop format is massive.

Others can ask questions of either the interviewer or interviewee or Dr. Davanloo. And because the unconscious of both the interviewee and interviewer is so fluid, the responses are clear and wonderfully honest, containing little to no anxiety.

And then Dr. Davanloo would say, now, two more people will go in. Or he might send the same two back in, only this time they are equipped with greater clarity. It was fascinating.

So, you would work in these relatively short blocks and then take a break. How long would you spend analyzing what had happened before you proceeded?

–It depends on what took place during the interview; it may just be a clean and clear, good, solid breakthrough, no need for comment, just a really good application of the technique. Good, solid work. Dr. Davanloo would inquire about the experience, point out very briefly how and why it was effective, and then move on to two other participants. And he might review the tape the next day or come back to it a few days later. But it can vary; it really depends on what's going on in the unconscious of the various participants. Fascinating.

Let me take a step back. You know, there are lots of questions about this kind of learning, you know, because it's a workshop, and we all understand ourselves as learners, but there is a highly charged therapeutic dimension to the entire ethos. That cannot be undervalued or understated. It must be acknowledged. And I think it's incumbent upon us as therapists to really get in touch with those blocks, internal blocks that we have. And I think that the CCTW is one mechanism for doing that. To enter into a therapeutic process ourselves. But I think working in this collective format provides an incredibly powerful learning environment.

You know, my understanding is that over the years, if you look at Davanloo's articles, his way of teaching his method changes. He narrows in more and more on certain aspects of the technique, for instance, emphasizing sustained pressure to feeling. Reading the articles, one is left with the impression that he struggled with finding an adequate way to help his students integrate his technique, not just to understand it, but also to be able to practice it. When he started the mobilization workshops, it seems that he finally accepted that in order to be able to do this work, therapists need to work through their own emotional blockages. It's as though that fact couldn't be ignored anymore. It seems that he had been trying to get his students to work in the way that he did for many, many years. And then he reaches a point where he says okay, now we need to try something new here. How does that sound to you?

–I think that's spot on, you know, I'll go back to my earlier experiences when I would sit in the supervisory sessions, you know, and, and I'll be watching one of my colleagues present a tape and think, "Why aren't you moving to transference?" or "Why did you move into the transference without the resistance?" The block that was impeding the therapeutic process belonged unmistakably to the therapist. Please know I am not claiming any super-knowledge; we all have blocks. The key is to get at them and eliminate them from our lives. There is no doubt in my mind that Dr. Davanloo saw this phenomenon and decided to do something about it.

To build on what I am suggesting, Dr. Davanloo realized he had to find a different kind of process for the elimination of those unconscious structures in the therapist that can harm and hurt patients. What Dr. Davanloo came up with was a process in which the therapists can work at eliminating those internal structures that cripple their lives and their work while learning about how to embody his therapeutic theories. I think that's certainly a factor for Dr. Davanloo.

It definitely resonates for me. We have all had the experience of critiquing our own videotapes and reflectively asking ourselves, "Why am I not doing what is so obviously called for? I have learned the technique, I can see the defenses, I know what I should be doing, but I am not doing it." We can have all the knowledge in the world, but if our own unconscious is laden with superego pathology, transference neurosis, moral masochism, a need to perpetuate our own suffering, then our work will be flawed.

To practice the theory is demanding, but the great obstacle is our unconscious material. Working at learning the principles and then integrating them into our lives is the strength of the CCTW—breaking that barrier that enables the practitioner to apply the technique. And it's repeat and repeat and repeat, you know, again, you know, the interesting pedagogy for Dr. Davanloo is repeat, repeat, repeat, repeat.

And it sounds so strange because, you know, we are all a product of a Western liberal education. One in which we learn a theory and apply it. But as long as we have an unconscious, that has to be trained as well. And the only way to deal with that is to move into it and understand it, but then just repeat, so it becomes almost second nature. Davanloo's theory has to become embodied; it needs to seep into the muscle memory of the unconscious.

In 2007, Dr. Davanloo started the closed-circuit video workshops meeting four or five times a year. From there, he begins to do more work with the themes that emerge from within the group. These issues can be examined and closely monitored over time, such as projective anxiety in the therapist, superego resistance, transference neurosis, and the intergenerational transmission of psychopathology.

And Mikkel, you asked a wonderful question about the repetition of the phrase, "What have you done?" That question elicits guilt but also addresses the projective anxiety. "What have you done? What have you done?" It is a very animating question, but only when the resistance is glaringly obvious. As a group, we spent a lot of time looking at projective anxiety. The other thing I think he became more acutely aware of in the therapists, this is important, I think, for us, is the degree of transference neurosis. There are two primary sources: one is our families or history, which we are aware of, but also the transference neurosis we pick up from previous therapists and sometimes supervisors. So, and again, that's where classically Freud began to talk about it. He was concerned with Jung and transference neurosis, that's where the term originated. Of course, Dr. Davanloo's understanding of it is very different from Freud's understanding of it. But that's such a brilliant, brilliant move, you know, so he began to see these themes in us, in the interviewees and interviewers.

Within the context of the CCTW, we explored Superego Resistance. According to Dr. Davanloo, projective anxiety resides at the center of superego pathology; by removing the projective anxiety, the punitive superego dies away.

So this is interesting. Based on the experiences he had in the mobilization workshops, he would then develop his metapsychology and take some of the experiences there back to the metapsychology conference. So it was also like an empirical laboratory? He developed istdp further on the basis of these workshops?

–Yes. Dr. Davanloo used numerous interviews from the CCTW as a way of illustrating his emerging theories within the context of the larger Metapsychology Symposium. At least one or two of mine were used for such a purpose. My unconscious is exposed in front of one hundred and fifty colleagues, but it is never demeaning or embarrassing; we all have a common cause, namely the advancement of closeness and intimacy while eliminating those forces that cripple the human spirit. We are there to create healing environments and optimize our capacity to care for those who suffer.

So let's get back to that because that sounds quite overwhelming. It sounds like a very intimate experience in the closed circuit workshop, in contrast to the Symposium. So I wonder - you joined your first cycle in 2007?

–I joined in 2008. So, I was actually resistant.

Why? Can you tell me about that?

–Well, probably because I was resistant. Like, I was happy to be hidden in the supervisor group. In 2007, Dr. Davanloo had the two going simultaneously. He had the supervisory group, of which I was a part, and he had the CCTW. It was a lot safer to stay in the supervisory group.

Really, who in your right mind wants to do that? But then, I would talk with my friends who were in the CCTW, and I did my own internal head-on collision and a year later I asked if I could join, and Dr. Davanloo was kind enough to extend an invitation.

But I wonder, what were your reservations? Was it just fear, or were you also skeptical of the format?

–No, no, I wasn't skeptical, actually, I think it's a really good format. Spiritual care education places a great deal of emphasis on self-awareness. As a result, I was familiar with this kind of format, though not with this level of intensity. My reservations all had to do with my own unconscious material, my own resistances saying, "You don't want to dig me up! You don't want to open your own family tomb! You can't handle the truth, better to keep it all buried!"

Going into those places, working through the layers of guilt has had a huge impact on my life. I was in the CCTW process while my father was dying. There was a lot of destructive competitiveness, a lot of superego pathology in our relationship that goes back to the earliest year in my life. It was a difficult relationship. As the guilt was drained, I was able to find peace and love in the relationship. As my father died of cancer, I would help shave him, and we shared a degree or a quality of intimacy that we had never been before. For me, you know, that's worth a million dollars, right, or a billion dollars. It was priceless. To be at peace with my father and being affectionate and loving was remarkable and a great experience. It was not perfect, but that is the beauty of it. Neither of us was crippled during those last weeks of his life.

I wrote to Dr. Davanloo many times about this and expressed the debt I owe to him.

So it has had a really significant impact on you personally.

–Unequivocally.

What was it like to go there the first time?

–Well, incredibly anxiety-provoking. Dr. Davanloo would never tell us beforehand who the pairing was going to be. There is as much anxiety about being the interviewer as being the interviewee, perhaps more! When I was first invited to be the interviewee, I can say that the experience was incredibly painful, and yet instantly one of the most important events in my life.

As that initial interview unfolded, it was Dr. Davanloo who guided me through my first breakthrough. It was in a closed-circuit format. This is what I was avoiding: the murderous feelings towards my father and then the subsequent guilt. I had done some work on it before with a previous therapist, but not to this degree. After all these years, I can rehearse the session with Dr. Davanloo verbatim. It was quite remarkable;

not only the passage by the volume of guilt-laden feelings but the subsequent relief and the way it began to shift my relationship with my father was also incalculable.

The interview began with me being interviewed by another therapist. He was doing a good job, and he did, in fact, remind me consciously of my father. But there was an element of my resistance that the original interviewer and I could not overcome. So, Dr. Davanloo stepped in. He was very focused and very gentle, and of course, this is what I longed for from my father, gentleness and presence. Then he said, "Dr. Clarke, you know you're loaded with the emotion, you're loaded with the emotion. Why do you not let yourself feel the fullness of this emotion? Why do you need to continue to torture yourself?" A nice rhetorical question to my unconscious. He continued, "You know that you are full of rage; you are crippled, frozen, why do you not bring the fullness of this rage toward me?"

The subsequent breakthrough was very graphic, very torturous. The resulting portrait was ripe with guilt and finally, love and affection for my father. Over the years, Dr. Davanloo and I would have a number of these experiences. And I had similar breakthroughs with many of my colleagues in the CCTW.

How did your relationship with your colleagues in the group develop?

–I think two things took place. Both reside at the heart of Davanloo's teachings, greater intimacy and closeness. Within the CCTW, there is a high degree of vulnerability. I'm still in touch with a number of them, and we connect periodically. I would suggest that we have forged lifelong friendships. I know if any one of them called me tomorrow and asked if I could come, get on a plane and visit, I wouldn't think twice about it, you know, that kind of intimacy and an extraordinary level of respect. There's nobody in the workshop that I don't respect and have a great, great affection for.

And again, because we're complicated people, some people I resonate with more than others. But I deeply respect their courage. Yeah, I think that the CCTW format undermines or attacks destructive competitiveness, which we see, I think, inside any kind of therapeutic modality where therapists can attack each other, or theoreticians can undermine each other. That's our unconscious. I mean, that's the mechanism inside us. It's okay to critique. But when the critique becomes an attack and destructive, when we become punitive with each other we lose sight of the metapsychology of the unconscious.

So you felt there was an openness to discussion and to having opinions about each others' work?

–Yeah. Yeah. First of all, we have to acknowledge that Dr. Davanloo and the videotapes serve as great teachers. In reviewing the tapes, we study the unconscious. What we are exploring is obvious, it is in front of the entire group. So, the suggestions are never accusatory, they are more like, "What would have happened had you done this?" Or, "What do you sense?" There is a major distinction between an accusatory comment and an animating comment. So even to learn how to work with each other, I think, is of paramount importance.

We could have a conversation with both the interviewer and the interviewee. And in the spirit of exploration, kindness and curiosity ask, "What else could you have done here? How could you have moved here? What were you experiencing at this point?" We are committed to a real sense of inquiry, of trying to understand, of investigation. And again, as we become more open, the answers become more honest. And, of course, that's a part of the whole process, honesty. The invoking of honesty always raises the specter of anxiety.

I guess the core virtue of ISTDP is honesty, isn't it?

–Honesty, and our capacity for intimacy and closeness. Remember, this is also a parameter that we're monitoring. So, there is closeness and intimacy, caring and affection. I think this is really a vital piece of it not only for the dynamic within the CCTW but also for our work as therapists.

Did you feel that Dr. Davanloo would calibrate the group or take care of potential conflicts, or how would he handle this? What would his role as supervisor be in this process? Because, you know, when you hear about this, it sounds like a kind of crazy format with a very flat structure. Everyone's the therapist, and everyone's the patient, and everyone's the supervisor, and everyone's the supervisee. This breaks all the rules that you're basically taught with respect to mixing therapy and supervision and hierarchies. Some people will say there's a reason we have these structures – they are there to protect the participants in the group. But when you talk about your experience, it sounds like this flat structure actually facilitated the development that was supposed to take place.

–Well, Dr. Davanloo is clearly the captain. He's in charge of the ship. He is the supervisor. My sense is that what the entire group really appreciated about him was his genuine curiosity. He has some pretty strong opinions and pretty strong thoughts. Don't diminish that at all. But as I said, he was in charge of the venture. And I think everyone else would be equal. I mean, we're all equal in the group. We may not always agree with each other, but I do not recall any conflicts within the group.

Periodically, Dr. Davanloo would check back with the group and ask if we were on point. By and large, the group didn't kick back.

He might have an idea about where to go next, but a member of the group might approach him and ask to be interviewed because the person had a sense that they were close to a breakthrough. And in my experience, Dr. Davanloo would say, "Sure." It might not take place immediately, but it would happen.

So there would still be this sense of leadership, a sense of very clear guidance. He's the leader. The entire group was interested in his perspective on things. He's the leader.

I remember the last workshop. It began on a Wednesday and ran through until Sunday, which was February 17, 2020. On

the Saturday before the last Sunday, we went until nearly 8:00 in the evening. Everyone was hungry and tired, exhausted, wanting to put up our hands and say, "we surrender, we need a break." But Dr. Davanloo is still pressing. He's still pressing. Yet, despite our fatigue, we were all in the room, and we're all paying attention; we all knew that we were in the presence of greatness. He is still offering insights, and we are drinking him in. We all deeply admire Dr. Davanloo's energy, vitality, and willingness to lead by example.

You mentioned chaos in your question; at no time was it chaotic. It was always systematic and focused. And highly professional.

When it comes to someone trying to duplicate the process, someone would have to be in charge, or a small group of therapists would have to provide some kind of containment.

Remember, this is clearly a program that works with the unconscious of a group of therapists, but it is also an experiment, a journey of discovery. You know, Dr Davanloo would use old video. He would use previous tapes just to illustrate points. If he saw things that needed to be underlined, he'd underline them in the group. We were all riveted because he was so precise. He often saw things that might take group members several takes before we could properly appreciate the point that he was trying to make. He might play a tape from a session two years prior. And then again and again, with each review, we would see things differently. He had the capacity to tease out invaluable insights.

For example, he might review one of my old tapes and say "Look at Dr. Clarke two years ago; look at Dr. Clarke now to see the distinction." And again, this is the beauty of videotaping. And I know many therapists with their patients say, look, this is your first tape and here's your last tape, right? And the patient can see their own difference, which is really quite remarkable.

Are you saying that Dr. Davanloo would basically remember all the sessions? Would he be able to remember what transpired a few years before?

– Well, that's the extraordinary thing about him. He would, he would go back, he keeps all the tapes and then he would bring back a tape from a previous session if it facilitated the collective learning. He might even replay one of his original tapes if it served to advance our learning. Dr. Davanloo carries with him a huge briefcase full of video cassettes. And he'd come back after a break or sometimes during the workshop and replay a related tape that may be two days, five years, or forty years old. And the captured vignette underscored exactly what we are looking at: projection, transference neurosis, destructiveness, masochism in the unconscious. It's remarkable. And he's taking notes too. He is paying attention.

And because the group members know each other, it's not like we're starting [at] ground zero. He might ask me to interview someone I have interviewed six or seven times. And I begin with, "So here we are again now. I remember our last session." So we pick up themes that we've encountered already in our colleagues.

How do you feel that your own work developed over the course of those years? Your own work outside the workshop?

– I think it went from two or three miles an hour to about a thousand miles an hour. I like to think that I was reasonably competent before. And it is not about speed, it is about becoming familiar with my own unconscious and repeatedly familiar with the unconscious of others.

In practice the difference was significant. I can't say enough about the way it's impacted my practice. It's just been astronomical. And even my life, you know, intimacy and closeness, resistance, being able to work with my own anxieties, being able to work with the anxieties of others, you know, it's had a remarkable shift.

The other thing, and I say this a lot to people, when I made notes during the CCTW, I noticed Dr. Davanloo's tone of voice because it is not just the words; it is how they are said.

One of the major critiques of ISTDP is that it can be perceived as being harsh, confrontational, even abrupt. And remember, we are going after the resistance. So, you know, it's a tough battle, particularly when the resistance is malignant or really debilitating. But I noted his voice and tone of voice. He is often very gentle or very firm, never barking, abrupt or harsh, never condescending or confrontational. And I find some of our early trainees would often speak harshly to patients, using a very demonstrative voice. And I noticed in myself and looking at my videotapes that I'm too activated, you know, that is my own unconscious stuff. Watching Dr. Davanloo helped me dial that back.

As I became more familiar with the importance of closeness, I became more gentle and more focused. It could be something very simple like, "So, how do you feel here with me as we move toward this material? You know, I noticed that you want to avoid me. So how do you feel here toward me?" Said very gently. That underscores the transference component of the resistance. You notice this resistance here. Now, that has implications for the feelings buried in the transference. You begin to head-on collide with a very gentle but firm voice. And I think that is very powerful and penetrating. And I know Dr. Davanloo did that frequently. The movement into the heart of darkness is graceful, not forced or abrupt.

This is one of the things, when I see your work and I read Cathrine Hickey's book and some of the other published material on post-closed circuit workshop- ISTDP, it leans quite heavily on the head-on collision. I get the impression that the whole session is one long head-on collision. The session seems to lean heavily on a metapsychological level of communication. Going back to what we talked about earlier, this seems to be one of the areas where the workshop has impacted the practice of ISTDP. Within

the closed circuit workshop, where everyone is familiar with ISTDP, its language, and the therapeutic process, this makes sense. There's an openness to this kind of high degree of metapsychological communication. But can you take that kind of approach and apply it to, you know, garden variety patients? Do you find that feasible?

– Yes, absolutely. Every so often, a patient will say to me, "We're moving too fast!" Because we are bringing important material to the surface in a relatively short period of time. But then they also say, "This isn't like any therapy I've ever had before. We are actually getting places!" In my experience, the resistance begins to formulate fairly quickly. As practitioners, we are trained to move toward it. We are asking them to actually sit with what they are actually feeling and allow it to build. Who else asks this of a patient? Since we live in a world dominated by a culture of avoidance, what we do can be disconcerting for patients.

It is not a matter of speed; it is a question of discipline. Moving with the patient and inviting them to challenge their old way of being. And if we do it smoothly and with precision, then it's a sharp scalpel we're using, not a dull knife. That can be disconcerting for people.

But again, you know, I've had lots of patients who've had a breakthrough in their first session. People who are brand new to the technique, people who don't know anything about what we're doing. But I explain to them as we proceed and then we talk about it afterwards. So I think you can apply it and move much more rapidly than we thought possible. You know, again, the limiting factor may be our anxiety as therapists.

I have had patients that have said, "We're moving too quickly." And I say, "Tell me more about that. Like, what is it? You know, what are you not used to? The feelings, all the things that you want to avoid." And they can get there fairly quickly.

The key is to have tremendous respect for the patient. I loved your comment earlier, you know, that there's a structure to Davanloo's understanding of how we should approach a damaged unconscious, you know. And one of the things I appreciate about it is that the structure is egalitarian. As therapists, we can't go anywhere unless the patient wants to take the journey. And I often use the analogy of climbing a mountain, which seems to resonate well with patients. I am constantly reminding them that it is their mountain that we're climbing. I am climbing it with you. But it is your mountain.

At the end of the day, and I think Dr. Davanloo has said this too, the patient takes the final ascent. This is very moving, the patient's final press for freedom. It is driven by their desire for health that undermines the development of transference neurosis. It undermines the idea of the omnipotent therapist, which is very deadly and cancerous in our practice.

"I was in the CCTW process while my father was dying. There was a lot of destructive competitiveness, a lot of superego pathology in our relationship that goes back to the earliest year in my life. It was a difficult relationship. As the guilt was drained, I was able to find peace and love in the relationship. As my father died of cancer, I would help shave him, and we shared a degree or a quality of intimacy that we had never been before. For me, you know, that's worth a million dollars, right, or a billion dollars."

So we take the incredible respect that we engender in each other through the brilliance of Dr. Davanloo's CCTW and then bring this to bear in our work with our patients and in the way we try to live our lives as human beings. This is a sacred trust.

That makes sense to me. I wonder, though, if we can draw a distinction between a "new format" of ISTDP developed around Davanloo's discoveries in the closed circuit workshop, and a "traditional form" of ISTDP, which, I guess, was developed in the late 70s? It feels like the traditional ISTDP, which most of us who haven't gone to the mobilization workshops use, takes off more from a conscious level. There's a process of building a conscious level of understanding of things such as: what are the issues?

How does this defense work? What do I want out of therapy? It's more of a gradual process, whereas, in the newer format, you move straight to an unconscious level. For instance, interventions like "What have you done?" are right in the foreground very early in the process. Would you agree there is a difference between these two types of ISTDP? And if so, how do you manage to avoid things like compliance, for instance, where the patient doesn't quite consciously comprehend what's going on but follows the process based on faith?

–The classical work has not been abandoned; the framework is still there. A naming of the problem, a commitment on the part of both parties to move toward the problem, the animation of the will. And at that point of the initial interview, there is generally some anxiety. If it is a new patient with no experience of Davanloo's work, I ask a little about any previous therapies, only because I want to monitor the possible presence of any transference neurosis. We then explore how the stated problem is active in the patient's life. As I said at the outset, we don't indulge in chit-chat, but move with care and precision to the heart of the matter. What we have also discovered is that people are much more robust than we give them credit for. Remember, Dr. Davanloo has consistently emphasized the importance of respecting the patient while having no respect for the resistance.

As the patient begins to reference feelings, we move toward the experience of feelings. This line of inquiry invites intimacy within the therapeutic relationship while challenging the patient to do something that seems virtually impossible, namely the experience of actual emotion. Almost instantly, the patient offers up a series of tactical defenses; they may even move to more malignant or regressive defenses. The therapist gently but firmly points out this dynamic to the patient. Here, we monitor how much pressure the patient can tolerate and then either gradually increase their ability to tolerate a higher degree of pressure with an understanding that we are moving forward together as a team.

The resistance is in play. The key is resistance. This is pointed out to the patient. They need to understand how their unconscious is operating and how it is failing them. Resistance always indicates the presence of negative feelings in the transference. Again, this dynamic needs to be communicated to the patient. The process must center around feelings in the transference. For new patients, this may not make sense to them at a conscious level, but again, the therapist's responsibility is to assist the patient in becoming familiar with their resistances. The presence of a negative or hostile feeling can't be denied, and the therapist is inviting the patient to experience, perhaps for the first time, the full manifestation of this long-buried but undeniably present feeling in the transference. It has to be in the transference. Anything else will miss the mark.

My first breakthrough with Dr. Davanloo was one of pure rage; at a meta-conscious level, I was thinking, "How dare you try to get close to me, how dare you encourage me! I hate you!" and bang, a massive breakthrough into the unconscious. I wanted to feel the feeling, and I hated the presence of the feeling in my life. In all honesty, I did not know that the feeling was directed at my father until I was asked to look into Dr. Davanloo's eyes. Instantly, I saw the blue eyes of my father. To make matters worse, my attack began with an assault on his ocular nerves, and while my father was dying of cancer, he was also going blind. I can still recall the way my stomach constricted with that first wave of guilt.

But returning to your question, the other benefit of the CCTW is repetition. It is like muscle memory in the unconscious. The spirit of repetition permeates the therapeutic journey, too. The repetition of phrases such as "What have you done?" serves as what Dr. Davanloo refers to as "an echo in the unconscious." He even suggested that members of the CCTW ask this question to themselves regularly in order to avoid the trap of self-delusion.

That's interesting. Clearly the closed circuit workshop is a spectacular training opportunity, and it sounds like it has been invaluable for you. But when many of my colleagues who do ISTDP hear about it, they have the same reaction to it, namely "Oh my god, you can't do that!" Actually, it's a similar reaction to one we often get from people who don't do ISTDP when they are first introduced to it: "Oh my god, you can't do that", or even worse, "I could never do that with my patients, they are way too sensitive." Have you experienced that reaction?

–I get inklings of it every so often.
You know, people say, is it ethical to move this quickly with patients. Freud was accused of being unethical. Dr. Davanloo, you know, in the early years of ISTDP, was accused of being too invasive. Any time you have a vanguard, any time there are those people like Dr. Davanloo who push the science, they are going to bump into those questions, and those are good questions.

My suggestion to the skeptics is not to criticize until you've done it. Once you've done it, then come back and critique it. So, you know, I can't say enough about the benefits in my life and the impact it's had on my patients.

In Davanloo's work, there are multiple checks and balances. The stating of the problem, the animation of the patient's will, the physical concomitant of anxiety, the inevitable crystallization of resistance, then resistance in the transference, inviting the patient to feel the full magnitude of their primitive murderous feelings, the monitoring of the cordial and subcortical system of the brain in the expression of the rage. Throughout this entire process, the therapist has to walk beside the patient, consistently checking to ensure that the patient sees the connection between their issue, the subsequent resistances, and the impact this has on their lives. These messages are all contained within a well-constructed head-on collision. We check regularly to see if we are moving in the right direction; this

checking serves to inoculate the process against the presence of transference neurosis because we are clearly following the path of the patient and not that of the therapist. Moreover, it increases the patient's capacity to move into the unknown.

Sometimes, it is the therapist who wants to avoid the intensity that comes with closeness, vulnerability, murderous rage, grief, and guilt.

There seems to be a faithfulness and a generosity in this format. And for me, it seems to resonate quite well with the spirit of ISTDP, which is meeting the patient at their highest level of capacity, right? You don't meet them according to how far they can regress into illness. You meet them in terms of their highest capacity. And you address them eye-to-eye as equals? Here, there seems to be the same kind of faith in the trainees and a faith in each other, which flows through the format. I think that sounds very precious.

–Exactly, I think it's really important.

As you know, at the end of a classical session, we do a brief summation of the patient's work, no interpretation, simply analysis. That is such an incredibly important part of the healing process. Dr. Davanloo notes that there are two things that need to occur simultaneously. As important as it is for the patient to move into the unconscious, move through their resistances to work with the feelings in the transference, and drain the guilt-laden reservoir, they must also understand what's taking place. It's no good just to have a breakthrough in the unconscious and have them blubbering and crying. That's facile. That's nothing. What's critical is they have the experience, but then they have an opportunity to understand the experience. And the two must be married together.

Early in my time with Dr. Davanloo, he said people need to work through their problems. A bad outcome would be that they might say, "I was treated by Dr. Clarke, or I was treated by Dr. Davanloo." No, that's the worst outcome. What they have to say is, "I had a therapeutic process. It was very good; I climbed the mountain." This is only achieved when the patient does their work and understands the nature and quality of their journey.

And even when the patient and I bring an end to the therapeutic relationship, it is critical that they leave because they have climbed the mountain and know it. They have climbed their mountain, not because Therapist X took them up the mountain. The therapist has had the honor of accompanying them. But if they believe that Jody Clarke took them up the mountain, I failed. This would be the worst indictment against me as a human being and as a therapist. And that is unethical. But if the patient, through the process, climbs the mountain, then we have achieved something. And so it's a powerful metaphor.

Your question, Mikkel, also points to the aspirational character of Davanloo's work. We want the best for the patient. We are interested in their liberation, their freedom. This spirit very much permeates the CCTW. We all want the best for each other because this will have a direct bearing on the lives of our patients.

How does that work? I mean, does it have the same effect without Dr. Davanloo present? And do you recommend doing that?

–Well, Dr. Davanloo can't be replaced. The entire group deferred to his wisdom and experience; it does not mean that we always agreed, but there is no doubt that Dr. Davanloo's presence gave the process an incredible level of integrity.

Could we have a CCTW without Dr. Davanloo? Yes. But it would require an aspirational spirit, a commitment to discovery, and genuine curiosity. We must never lapse into a protesting of our own understanding of orthodoxy or truth. I have seen Dr. Davanloo replay and replay a vignette in the interest of making a new discovery or teasing out a hidden gem as opposed to falling back into old assumptive patterns.

It is good that therapists seek treatment from other therapists. I recommend it. It is something that we must do periodically. Otherwise our unconscious will become labored and encrusted with the residue of the material we encounter. Who do we, as therapists, go to for treatment? I think it's incumbent upon us to do treatment, but then, you know, at a certain level, because of the nature of our resistances, we do require a very skilled therapist.

The peer work that we are referencing is slightly different. If you have a colleague that you feel comfortable with, one with whom you are familiar, who is skilled, and a person who is familiar with you, then the two of you can set up a closed-circuit video process. Mikkel, let's say you and I agreed to do that, and we will get together for two or three days. I treat you for three or four hours. You treat me for three or four hours. I have done this now several times, and on each occasion, the work that we are doing on day three is qualitatively different; why? Because the unconscious of both parties is becoming more fluid. The safety net is the video work; the camera does not lie.

Given the sheer reality of what we do in therapy, where we go, what we see, how else do we as compassionate, loving, and theoretically sound therapists, stay clean? How else do we stay fresh? How else do we stay sharp? We need to do that.

Over the years, I have spoken with countless therapists, and I am interested in hearing your thoughts about this matter. But after a while, our unconscious gets heavy just because we've seen so much tragedy and so much misery, so much torture, so much sadism, you know? We've seen horrors that other people haven't seen. So, how do we keep our own unconscious fluid?

This is a really important issue, for we are practitioners of a very sacred art. Particularly because it's ISTDP. And again, I don't want to be critical of other modalities. But they don't go into this, into that kind of depth. You know, the primitive murderous rage, the betrayal of the parent, the betrayal of the grandfather, the grandmother, the opening of the family tomb,

the intergenerational transmission of psychopathology. Oh, you know it's pretty heavy stuff. We, as therapists, have to stay fresh. It is our ethical obligation. I think that is what Dr. Davanloo was onto with the development of the CCTW.

Most people would say that then we have to find a therapist who is just a therapist. Is there a benefit to doing mutual therapy with someone?

–I think there is. I think I'm open to experimentation, exploration. Because it consists of two competent people who are not compliant. If we were both compliant, then we would reaffirm unhealthy habits.

As individual therapists, we can do some analysis and systematic analysis of the work you're doing. But the question that we are dealing with in this interview and the big question for our profession is how we can remain healthy and focused as practitioners. This brings us back to the question that Dr. Davanloo was asking nearly twenty years ago: how do therapists stay well? How do they improve? And from there, how do they advance the science of what we're trying to do?

I think Mikkel, you and I are wrestling with the same kind of question: How do we continue to do that? To be frank, I don't think anybody who is practicing ISTDP, and I always try to be frank and honest, should do it unless they have visited their own unconscious, and not just once, but many times.

If you have not visited that land, then you just don't know; you don't know what it is to break into the unconscious. You have no idea what the rise is like. You have no idea what murderous, primitive murderous rage is like unless you've accessed this yourself. You know, we can talk about it in theory. But until you see it, until you understand how primitive the resistances can be in yourself, in ourselves, and in our patients, then we have no business taking them on this journey. I don't think we can. Practitioners can do something they think is ISTDP, but it is likely not.

So it's also on your part an invitation to colleagues to be more bold in examining these areas in themselves, being more open together, and having the courage to experiment with the work?

–Yes, spot on. Experiment, explore, and ask questions in the service of kindness, intimacy, and closeness, not in the service of ego or our own omnipotent grandiosity. Be gentle, humble, courageous, because our task is to work with patients that they work at eliminating suffering and pain and distress from their own lives. And we must enable ourselves to do that better, and Dr. Davanloo brilliantly developed and offered the Closed-Circuit Training Workshop as a possible avenue to facilitate such maturation. Dr. Davanloo remained focused and insightful throughout his entire life. We owe it to his legacy to take care of ourselves and each other as we attend to the wounds of the world.

That sounds like a very good place to end our talk today. Thank you!

Following the submission of the interview, the board of the JCI wanted to expand on a few themes touched upon in it and invited Jody to reflect on three follow-up questions. These questions and Jody's answers to them are as follows.

How would you respond to concerns that the CCTW, while effective for some, could be seen as existing in an ethical "gray zone" where the boundaries between 'supervisee,' 'trainee,' and 'patient' are blurred? Do you think the common professional role boundaries should change in order to make psychotherapy training more effective?

–As a person who participated in approximately fifty Closed Circuit Training Workshops (CCTW) or roughly 4 per year from 2008 – 2020 (the workshops began in 2007), I had no sense of blurred boundaries between myself and the colleagues with whom I shared in the training process. Without any equivocations, Dr. Davanloo was the supervisor, and the participants were all co-equals. The learning atmosphere was one predicated on respect and collegiality. My sense is that we were—as a collective—dedicated to learning and growing. The learning and growing came in multiple forms; annotations and interventions by Dr. Davanloo throughout the process, watching and learning from the interviewer and the interviewee, and then occupying the experiential role as either the interviewer or interviewee. And then there is the matter of the videotapes, a sacrosanct dimension of the world we occupy as practitioners of Intensive Short Term Dynamic Psychotherapy (ISTDP). Once again, within the pedagogy of the CCTW, the tapes were used for multiple purposes. Some interviews were reviewed with arduous and painstaking frequency. On these occasions, the goal was attaining a deeper understanding of the unconscious.

Dr. Davanloo was very intentional about refraining from referring to the participants as "trainees or supervisees." And while those who knew Dr. Davanloo can attest to the fact that he was a man of formidable opinions, within the context of the CCTW, he regularly sought the input of the group.

Unlike a purely therapeutic relationship, within which the patient and therapist establish a therapeutic covenant, the implied covenant within the CCTW was that of exploration, practice, and discovery. The CCTW did not have the healing arch found within the context of a more traditional therapeutic relationship; that was not its purpose. Having said this, there is no doubt that most—if not all—of the participants were able to come to a much more profound appreciation of the unconscious forces that can seriously compromise their lives.

With regard to the second question, allow me to respond by noting the prevalence of transference neurosis within psychotherapy as a practice and its educational model. I would not suggest that this is true in all cases, but its prevalence is something our discipline must take seriously. Transference neurosis occurs when the neurotic structures of a therapist or

clinical supervisor are passed onto the patient or supervisee. One of the strengths of the CCTW is that it can isolate and eliminate the presence of transference neurosis in therapists—the case in point Dr. Catherine Hickey's *Understanding Davanloo's Intensive Short-Term Dynamic Psychotherapy: A Clinician's Guide* (2017)—while also creating a learning environment that guards against its perpetuation.

Now, to directly address the second question, yes, Dr. Davanloo's development of the CCTW was brilliant. If the ultimate goal of psychotherapy is that of putting a dent in human suffering caused by the presence of neurotic structures in the unconscious, then we—as a discipline—are obligated to consider new models of learning.

You mention that some practitioners believe they are practicing ISTDP, but they are not. You seem to have a narrow definition of ISTDP, which naturally has its pros and cons. How do you define ISTDP, and do you think there is a way to establish this definition clearly without causing unnecessary division? There has been quite a bit of innovation within ISTDP in the past decades, which in a way, means that there's an introduction of "non- ISTDP" elements to the mix. Do you think there's a risk that a narrow definition of ISTDP might stall the development of ISTDP?

–Over the past few years, I have had the honor of treating a number of ISTDP-trained therapists. It is their voices that have indicated to me that what they encounter in our treatment is "different" from what they had been taught. What they have shared with me is the emphasis that our work puts on "feelings in the transference." Please know that I make this observation as a statement and not an evaluative comment on the efficacy or orthodoxy of training programs; I simply attempt to follow what I have been taught. Setting the therapeutic task, moving into the phase of inquiry, monitoring the resistances, attending to the presence of anxiety, pressure to actual experience of the feeling, enabling the patient to see and appreciate the way in which the resistances—and particularly the resistance to emotional closeness—are working against the patient's best interest, highlighting the transference implications and then animating a head-on collision with the forces of the resistance in the transference, is by far the clearest and safest path for the patient (and the therapist). This brings us to the breakthrough of murderous and often torturous feelings toward the therapist. With the satiation of murderous rage and anxiety, the patient fixes on the eyes of the genetic figure. From here, the patient encounters a myriad of emotions, perhaps more rage, but more frequently guilt, remorse, and feelings of tenderness.

This is only one part of the work; now that the therapist and the patient are in the unconscious, without the presence of anxiety and fortified by the actual experience of emotional closeness with the genetic figure, the patient can explore deep dimensions within what Dr. Davanloo referred to as the "family tomb." It is within this space that the patient can experience the restructuring of the unconscious.

"Personally, I welcome conversations about innovation. I also do not think that istdp has anything to fear when in dialogue with other therapeutic modalities. But I will offer a caution, if a therapist is frightened of emotional closeness, and is unable to work with the implicit intimacy found within transferential feelings, then they would be wise to explore their aversion to closeness."

At the core, I do not think that a practitioner can call themselves an ISTDP therapist if they are unable to work in the transference. And if the measure of a successful treatment is merely a "breakthrough into the unconscious" – the breakthrough is simply the opening of a doorway. Yes, it is helpful for the patient to become familiar with their resistances, but it is just as important for them to understand and appreciate their own unconscious world.

Personally, I welcome conversations about innovation. I also do not think that ISTDP has anything to fear when in dialogue with other therapeutic modalities. But I will offer a caution, if a therapist is frightened of emotional closeness, and is unable to work with the implicit intimacy found within transferential feelings, then they would be wise to explore their aversion to closeness.

I know, too, that many critics of ISTDP argue that it can appear badgering, condescending, demanding, or even punitive. Ideally, what an outside observer should notice is the systematic application of attention and kindness. As Dr. Davanloo noted, it is the experience of focused and innocent attention that activates the most painful alarm bells in the unconscious of the patient (Davanloo, 1990).

ISTDP, under the guidance and wisdom of Dr. Davanloo, refused to be a static science. As a discipline, we have an obligation to hold true to its central tenets while at the same time remaining self-critical. Dr. Angela Schmitt's recent publication (2024), is a wonderful example of the ongoing maturation of Dr. Davanloo's work.

Davanloo used the metaphor of a "reservoir of guilt" to speak about the fuel of the superego pathology. In a human body, however, there is no real reservoir of guilt and no liquid guilt to actually drain out. Is it really possible to drain the metaphorical reservoir of guilt? Don't you think there's a risk that this kind of metaphor fuels omnipotent fantasies of being "cured" once and for all?

–I find myself smiling as I consider this final question and ask rhetorically, "What is real?"

There is a reality to the build-up of guilt in the unconscious. The reservoir of guilt in the unconscious fuels the perpetrator within the unconscious; haplessly, the patient who is living with the tyranny of a superego pathology lives a life marked by broken relationships, massive self-sabotage, and destruction. Therapists would be prudent to suggest two things when it comes to draining the massive reservoir of guilt; the first is to establish firmly with the patient that the draining of the reservoir must be done mutually; in other words, much of the evacuating will be done within the crucible of the therapeutic relationship—via feelings in the transference—but once the guilt becomes manageable the patient, in living life with greater freedom, kindness, and love, will accomplish the final purging.

Several years ago, I wrote a paper, The Metapsychology of Character Change: A Case Study of Ebenezer Scrooge (2009). The paper was based on Charles Dickens's primary antihero found in the pages of *A Christmas Carol* (1843). In the paper, I suggest that the key elements of Davanloo's ISTDP are woven into the fabric of the novella and that it is these features that serve to liberate the miserly soul. Yes, the book is a work of fiction. Interestingly, for Dickens, the character of Scrooge served as a metaphor for a society that was in the grip of its own superego pathology, one that perpetrated cruelty and indifference to human suffering. It stands the test of time as an optimistic understanding of humanity's capacity for resilience and perhaps a "cure."

Thank you so much!

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