
Brain, Mind, and Dyadic Change Processes



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For many individuals attachment trauma is at the core of psychoneurosis and personality disorder. Combining theoretical aspects of psychodynamic therapy, developmental neuroscience, and attachment styles provides a useful framework for intensifying emotion and accelerating the course of treatment. A bihemispheric model is considered. The model addresses the challenge in treating the implicit trauma, which resides in the right hemisphere. This is achieved without resorting to interpretation, which is largely a left hemispheric process. The article presents a patient who benefits from a brief emotionally based psychotherapy that was completed after a course of a 20-year psychoanalysis. © 2006 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 62: 523–538, 2006.

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Over the past few years, I have been thinking about three lines of important research: outcome in psychodynamic psychotherapy, developmental neuroscience, and adult attachment. The confluence of these three areas of knowledge offers opportunities to improve ways psychotherapists treat their patients. In this article I describe and illustrate a model of psychotherapy designed to capitalize on the intersection of these three distinct but complementary areas of scientific information.

Psychodynamic Outcome Research

There are recent metaanalyses of many well-designed outcome studies on psychodynamic psychotherapy (Leichsenring, 2004). These studies demonstrate that dynamic

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psychotherapy is more effective for a broad band of conditions than patients who receive no treatment and are placed on a waiting list. Therefore, talk therapy based on inquiry, clarification, defense analysis, confrontation, interpretation, and support helps people secure relief from symptoms and, on occasion, change character.

There is no evidence yet that one form of psychodynamic psychotherapy is particularly more effective than any other. My own interest has gravitated to intensive short-term dynamic psychotherapy, which can best be described as an experiential form of psychotherapy that emphasizes the importance of experiencing feelings from one's past in the present as the singularly curative factor. The strongest proponents of this approach are David Malan and Habib Davanloo. During Davanloo's career he treated and video recorded 632 patients whom he personally treated (Malan, 2001). Despite the systematic approach, the data from these cases were never published. Recently, another author in this issue, Patricia Coughlin along with Malan (2006), used a single-case design to study seven patients. Their goal was to isolate curative factors. Their work supported Davanloo's earlier contention that the experience of repressed complex emotion, anger, and particularly grief about a caregiver in a therapeutic dyad created both symptomatic relief and character change.

Developmental Neuroscience Research

Some of us now think of infants from birth to about 16 months as right brain creatures with little crystallization of the left brain until 16 to 18 months. We also know that small children need consistent attachment figures and become specifically attached to their primary attachment figure at 6 months. We know that this attachment must occur, and that if it does not severe developmental–neurobiologic pathology in relationships and affect control ensues. Once attached, the child uses or requires his or her mother to regulate affect. This means that the child, lacking a mature left hemisphere, requires the correct quantity and quality of the attention of the mother in order eventually to develop a healthy sense of its self in relation to others (secure attachment).

Contrast this case to that of an insecure infant who is not receiving flexible and reliable attention. The avoidant baby internalizes the mother's desire to avoid distressing emotions and develops a false self of calm, focused interest in the outside world. The ambivalent baby internalizes the mother's worried preoccupation with her self and her infant and hyperfocuses on mother's distress, pulling away and resisting affection and thus creating angry conflict rather than relief. The galvanic skin resistance and cortisol levels are equally elevated, in both avoidant and ambivalent infants. Two measures of stress, galvanic skin resistance and cortisol, are equally elevated in avoidant and ambivalent infants despite their different behavior.

The disorganized infant represents the next level of attachment failure. Mary Main and Erik Hesse have described a subgroup of infants who were wrongly described as either avoidant or ambivalent (1990). They used slow motion videotape to discover the appearance of fright behaviors in the child associated with caregiver presence. Later, they discovered the source of this fear was unconscious threat behaviors of the mother of these children. Because these children are biologically programmed to approach the parent for comfort and safety, they see this as a classic approach-avoidance bind. They coined the wonderful phrase "fear without solution."

Schore (1996) offers data to support an intriguing hypothesis: that not only is the right hemisphere the locus of unconscious processes; in particular, the right orbital frontal gyrus is the central integrating circuit for aggression in human relationships. He believes it is uniquely situated above the limbic area, and this circuitry mediates the capacity for empathy

for others as well as modulation of retaliatory aggression. In other words, the ability to perceive the other person as having feelings and to read and respond accordingly is mediated in that area of the brain. He further argues the quality of attachment, that is, the number of flexible and successful comfort events, stimulates growth in this area. Improving this area of the brain is the proposed target area for psychodynamic psychotherapy.

Adult Attachment Research

The Adult Attachment Interview (AAI) is a conversation with an interviewer who asks you to describe your parents with five adjectives and then to provide a paragraph to support the adjectives (Main, 1998). The interview also asks about important others in the subject's life (grandparents, neighbors) and covers losses or traumas. Completing it takes about an hour. The secure subjects are called secure autonomous, and their transcripts are similar to lovely essays with poetic language and rich examples. The avoidant adults are characterized as *dismissive*. They idealize their parent and do everything they can do to keep emotions low and at bay—their narratives are skimpy and lean. The ambivalent subjects, termed *preoccupied*, overspeak and are verbally derogatory and cannot inhibit their outbursts. The disorganized are called *disoriented/unresolved (for abuse or loss)*. They manifest lapses in time sense as well as consciousness. Finally there is the intriguing group of people called the *cannot classify*, who show mixed traits but no dominant style and usually have fairly significant clinical disturbances.

In short, we have a tremendous amount of prospective data that demonstrate that attachment experiences from 6 to 16 months of life define what our linguistic capacity for coherent narratives will become in adulthood. Furthermore we know that these capacities reflect the ways we think and behave in relationships. Mothers who have these linguistic impairments create children who have the same linguistic impairments!

If we tie some threads together, we can see what the AAI actually measures. As the subject is asked to create a narrative of his or her life, the right hemisphere repository of emotional memory is activated. The subject is relating to the interviewer while adhering to linguistic coherence. The more troublesome the attachment memories the more pressure is placed on the mind's ability to sustain narrative coherence. Thus avoidant subjects decrease the amount of emotional memory available by narrowing their attentional focus and create dry, brittle, idealizing narratives. Preoccupied subjects lose attentional focus and are flooded with highly charged negative memories and become derogatory, overinvolved, and overly inclusive in their stories. The disorganized subjects show momentary lapses of consciousness that compromise their attention as they deal with issues surrounding loss or abuse because the recall of these events mobilizes their unprocessed affective memories. Their narratives are thus fraught with temporal contradictions and linguistic violations.

Schore (2002) is eloquent in his neuroscientific thesis that the AAI is an instrument that can measure the health/integrity of the right orbital frontal gyrus in containing the affective data required to script a coherent autobiographical narrative. My research interest has revolved around examining recorded clinical interviews from a linguistic perspective to assess whether an attachment-savvy clinician can accurately assess attachment status through a dynamic interview.

Finally, Main and Hesse's (1990) research into the origin of disorganized attachment style reveals a strong link to unresolved trauma in the mind of the mother. Close analysis of videos reveals showing of maternal eye teeth, subaudible hissing, and anomalous fear-provoking behavior; as these mothers who are unresolved for trauma approach their children to comfort them, they are showing threat behavior. The way I interpret this finding is that the mother is reading the attachment longings of her child in her right

hemisphere. The infant activates the unconscious memory of the parent's threat behavior and the parent responds to the child as if the child were his or her own threatening parent.

Synthesis: A Bihemispheric Model

How do these threads join in a useful way for understanding brief psychodynamic psychotherapy? The outcome studies of dynamic psychotherapy indicate to me that *the experience of feeling that frightened one in the past in an atmosphere of care, compassion, and safety* is the singularly most crucial healing factor in dynamic psychotherapy. Further, I propose that the time a therapeutic dyad spends raising right hemisphere feelings to consciousness increases the likelihood that symptoms will be reduced in the patient and that character change will ensue.

This task sounds simple but it is in reality enormously difficult. The reason for this difficulty was first described by Freud in 1896 when he noted that even the most highly motivated of us (secure?) resist therapy aimed at recollection trauma from the past. It seems our brains develop an elaborate defensive structure to protect us from (1) fear without solution or (2) upsetting our mother beyond her emotional capacity. I contend that for psychodynamic therapy to be successful it must overcome these transference patterns (and countertransference reactions) in the sending and receiving of feeling information.

What makes successful therapy so difficult to achieve is that the target organ, the right hemisphere, has no language. It is stimulated by and communicates through images, sensations, and facial expressions and creates bodily sensations, which we interpret as feelings—happiness, sadness, anger, pain, and so on. Traditional psychotherapy has been largely verbal and interpretive and thus limited in its ability to create rapid change. With Malan and Davanloo's input a large number of therapists are now placing themselves in the experiential camp. Studies of improvement (Malan & Coughlin, 2006) show ability to access sad feelings reduces symptoms and ability to access anger correlates with character change. Table 1 illustrates the challenge inherent in psychotherapy by contrasting the different ways information is processed in the two hemispheres.

I want to suggest that the right hemisphere is shaped at between 6 and 16 months of life and is shaped along the lines of Ainsworth and Main's four styles (1998). Defenses surround the profound experience of loss of "good enough mothering states." For these loss experiences to be processed successfully the infant needs the actual presence of the

Table 1
What Makes Psychotherapy a Challenge

Left brain explicit information processing
Locus of conscious processes
Logical, linear (time based), language based, storage bin for conscious memory, "makes sense of"
Is in charge of memory storage and retrieval
Easy to communicate with verbally
Shaped by culture and education
Right brain implicit information processing
Locus of major unconscious processes
Impressionistic, responds to images and facial patterns, linked to autonomic sensations (feelings)
Storage bin for unconscious memory and traumatic experience
Difficult to communicate with verbally (no language)
Shaped by attachment experiences

mother's interactive right brain in a state of "care, compassion, and comfort." Attachment failures lead to unprocessed feelings of unregulated grief, which, without the empathic other, create unbearable states of aloneness that can only be regulated with defenses. If the trauma is prolonged, the infant creates an internalized representation of the attachment failure in the form of a punitive superego that ends the state of unbearable aloneness, but at a price.

In summary, our patients value their superego because their superego is a defense against loneliness. They stubbornly refuse to separate from their superego because they are flooded with separation anxiety and inability to regulate their affective states. I see anxiety as the archaic recording of affects that the patients feared exposing to their caregivers. I see patients who have had hundreds of hours of dynamic psychotherapy and psychoanalysis and whose superego has not budged. The patient whose case I summarize had analysis for 20 years. However, the treatment failed to expose or deconstruct his highly ego-syntonic punitive superego. Once the superego is relinquished the therapist can become a new attachment figure and rapidly improve attachment status. Preliminary data from an AAI study of patients in my practice seem to confirm this assertion (Neborsky, 2004 b).

The psychotherapy that I have refined has a number of sources—all intended to raise unconscious trauma into consciousness (Neborsky, 2001, 2003, 2004). Table 2 outlines the factors utilized in my approach.

Intensive short-term dynamic psychotherapy (ISTDP) in part originated from a basic dissatisfaction with interpretation. To solve this, Davanloo (1990) applied therapeutic pressure to the patient to feel the unconscious emotions and simultaneously addressed the patient's gymnastics (resistance) to feeling traumatically based emotions. His goal in each session became helping the patient address the developmental origins of his or her difficulties and to help the patient feel the trauma exactly as he or she felt it at the time it originated. He heavily used confrontation and coached, goaded, or challenged patients to defeat their own resistance.

Davanloo proved this approach to be effective in relieving symptoms and character but unfortunately never published his results for peer review. However, his students have carried his work across the world and it is now in its third generation. Proof of its effectiveness is now strong (Leichsenring, 2004).

Relying on his pioneering work I have applied the scientific developmental research on attachment and states of mind to the clinical situation. I also try to deemphasize

Table 2
Attachment-Based Intensive Short-Term Dynamic Psychotherapy

Adapted from Short-Term Dynamic Psychotherapy (STDP) and Intensive Short-Term Psychotherapy (ISTDP) (Malan and Davanloo)

Pressure, challenge, head-on collision
Pathways of unconscious anxiety discharge
Emphasis on visualization for processing

Applies Adult Attachment Interview (AAI) (Main & Goldwin)

Elements of Gestalt (Perls)

Empty Chair
Inner Child
Talking to the Dead

Elements of Psychodrama (Moreno)

"Doubling"
Alter ego

Ideas from Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro)

interpretation and have reemphasized the Gestalt elements of the process by asking the patients to speak directly to their punitive introjects and encourage them while monitoring the use of coherent discourse. If the patients flounder, I “double,” as in psychodrama, for them until they are able to maintain narrative coherence with their imaginary traumatizing parent. Finally, I ask patients to talk to their traumatized images of self as child in a way that their parent could never speak. In so doing they are creating the intersubjective experience a securely attached child would have had with his or her security-promoting parent.

This pattern of treatment moves from focus to focus until a critical mass of trauma memory networks is exposed and processed by the therapeutic dyad. Once this is achieved, symptoms resolve and character change occurs. Patients who have this therapy report decreased avoidance behavior, improved mood, decreased somatization (medication seeking), improved interpersonal relationships with enhanced intimacy, improved empathy and mutuality, and shifts from insecure to secure states of mind as measured by the AAI.

As a child of the information age, I propose a model of the unconscious based on research, clinical observation, and my own fantasy about how the mind actually operates. We can now diagnose the structure of the right hemisphere with tools developed from the AAI. Psychotherapy can be seen as the process of freeing the right hemisphere from encapsulating defenses, which, as scar tissue does, prevent healing. The right hemisphere difficulties are diagnosed by observing the defenses mobilized as the patient attempts to explore unconscious affects as well as observing the general physiologic patterns of the patient’s anxiety. Is the majority of the anxiety held in striated muscle pathways as tension (secure pattern), or is the anxiety pathway primarily mediated by parasympathetic smooth muscle (insecure pattern)? If the anxiety is associated with a cognitive pathway, then disruptions to thinking and perception occur, and these patients frequently suffer from disorganized attachments that are unresolved as a result of abuse.

The following is an annotated, edited text of a successful 9.5 hours of attachment-based intensive short-term dynamic psychotherapy (ISTDP) of a patient who had a highly avoidant attachment style. The process begins with the patient’s stating his or her problem and goal. The therapist begins to probe the affectively charged areas in which the background of the story is told. Patients inevitably begin to defend against the emergence of their traumatized feelings with either defense or superego (negative treatment of self). The therapist begins to clarify defenses and discourage the patient from using defenses. Anxiety is mobilized and its pathway is recognized. The patient and therapist work hard to overcome the resistance until the traumatized feelings are fully felt and processed by the dyad. The traumatizing other is addressed in a secure coherent way with his or her role in the trauma. The traumatizing other is symbolically buried and sent away. Guilt is felt over whatever aggression is fantasized and the patient learns to accept destructive and rageful feelings compassionately as part of the historical past. The patient discovers the multigenerational nature of the attachment trauma. As defenses disappear, insight (cause and effect) appears, and a new calm and somber affect appears. This affect is reflected back by the therapist, and both are in “core state” (Fosha, 2000). The relationship complexity of the patient and therapist grows and facilitates more and deeper explorations into the patient’s unconsciousness.

The Man Who Had to Hang His Head

Patient Description

The patient is a married (second) 63-year-old professional who looks his age. He is of slight stature and has a scholarly look. The patient’s areas of disturbance are continuous

anxiety, aggravated in performance situations, and low self-esteem, with self-accusations of being a fraud. He has moderate obsessive-compulsive disorder (OCD) and undoes his fears with rituals and magical thinking. He avoids intimacy with everyone. He feels that all men are his rivals and believes that this fear began with his father's rejection of him as a child. He says that his father was a kosher butcher, whom he observed cutting the throats of animals. He says his father put him down, made him the butt of jokes, and humiliated him.

Session 1. The psychotherapist pressures the patient to experience his feelings toward his father. The patient becomes resistant, argumentative, and then passive. We enter 80 minutes into the session when the right hemisphere begins to reveal its presence with imagery.

PATIENT (P): Two images come to mind when you talk about that.

THERAPIST (T): Uh-huh.

P: both of which are directly physical . . .

T: Uh-huh.

P: I would have cut his beard off.

T: With scissors or a knife?

P: I don't know, probably with a knife.

T: Okay.

P: And, the other one is that he used to walk a lot . . . arrogantly showing his body. I would pull his underwear down. His underwear . . . I have never thought about that before.

The session continues after a short break. The patient notes that whenever he visualizes confronting his father, he feels fear and anxiety. We are 140 minutes into this session.

T: And why does your anxiety go up?

P: the retaliation . . . the fear of retaliation

T: Excellent. "I am afraid my father will kill me. If I stand up for myself, I am afraid he will cut my throat like he did the ox, or the cow, or like he cut."

P: Absolutely, absolutely

T: I'm seeing feeling in you. You don't understand what you have been dealing with. To me, that is a very moving insight and I hope that you will feel your full feeling . . . with respect.

P: Huh?

T: With respect for what you feel. What is the feeling that you feel? The emotion that you feel, about having lived like that . . .

P: (*sighs*)

T: Feel it.

P: What a waste, what a pain.

T: What's the feeling? Empathy, isn't it?

P: Empathy, empathy really empathy is . . .

T: Very different

P: Soulness

T: So from this place inside of you, if you let this side of you become the most dominant side of you, the most powerful side of you, what would you like to say to yourself? What would your advice be to you?

P: Enough, enough, enough putting your neck down (*audible sobbing*).

T: To be killed like an animal.

- P: (*sobbing*)
- T: Stay . . . stay with your empathy; don't withhold empathy from yourself. Okay?
- P: Uh, I hope nobody hears me . . . stupid comment.
- T: Why is it a stupid comment? It's a put-down, isn't it?
- P: Yeah
- T: it's like your pain, your sadness, for what you suffered is . . .
- P: . . . lack of, you know . . .
- T: but it is the put-down side of you.
- P: that is the put-down side, the defensive side.
- T: Of course.
- P: The defensive side.
- T: Sure. The side to keep a low profile, you see?
- P: Yeah, absolute yes. Yep, yep. That's the side.
- T: That lived in so much terror of his father that he couldn't express himself, he, you couldn't assert yourself. You understand that? You feel like every time you assert yourself you have to lay your head down to have your throat cut.
- P: Absolutely. It's like I guess if I cut my head, in fact, you know, if I bring my head down it won't be cut. That's exactly it.
- T: You have to show submission.
- P: Yes, that's exactly, I feel like I am a dog.
- T: You feel pain about that, about having to live like that. No human being should . . .
- P: I believe you. It's my secret and nobody knows that. You may know it, but nobody knows it.
- T: So how do you feel about the fact that we know it?
- P: What?
- T: How do you feel about the fact that we know it?
- P: Well, I am going to say that I love you for hearing me. (*audible sobbing*)
- T: Stay with the love.
- P: But then I don't know that I deserve that
- T: (*loudly*) ababababa—what's that? Catch it.
- P: Because it was the anticipation of you kicking my ass and saying "aw, come on, get off it"
- T: Do you see how you project your father onto me?
- P: Yes, yes.
- T: He comes between you and me?
- P: Yes
- T: He comes between you and everybody.
- P: Yes, absolutely right.
- T: So your wife will cut your throat, your friends will cut your throat, anybody you stand up to, even with me, you were standing up for your loving feeling towards me, and you treated yourself like you never deserve to feel it, feel that for me.
- P: Yes, absolutely. Right, right.

Accessing his right hemisphere allowed him to see cause and effect; his fear of his father caused him to be submissive and distant. He felt deep compassion for self and close to me but projected his castrating superego into me to attempt to sabotage our connection.

Session 2. The patient returns the next day. He begins the session by recalling that his mother taught him to be afraid of other men. The psychotherapist tells him that he has

a choice between continued loyalty to this self-destructive system or freedom from it. The patient reacts with confusion, intellectualization, and then defiance. We are 45 minutes into the second session.

T: What are your feelings toward me when I say that to you?

P: (*hem and haw*)

T: Did you have a feeling towards me or not?

P: What do you mean do I have a feeling towards you?

T: Do you have a feeling towards me?

P: I just told you.

T: No you are not; you are being passive

P: The feeling that you are pushing me (*with tension in voice*)

T: Not “that”; why do you have to add “that”?

P: (*chuckles*), I feel

T: What is the feeling, *yeah?* I want to know your feeling.

P: I feel you are pushing me. (*irritated*)

T: Now it’s “you’re pushing me.” (*with mild irony*)

P: wh . . . wha . . . wha . . .

T: Stop with all the linguistic gymnastics.

P: (*shows helplessness*)

T: What is the feeling you are experiencing towards me? Honest man, direct man. Overcome what your mother told you.

P: I’m doing it. (*defiantly*)

T: I’m waiting; what is the feeling . . . in your body towards me? I am mobilizing, by my behavior a lot of feelings toward me, aren’t I? Aren’t you having a lot of feelings at me? You have tension in your body. What’s making you tense? Own your own feeling!

P: The feeling that I’m not satisfying you.

T: Oh, you go passive, you go submissive. (*with irony in voice*) You do the same behavior, yet you expect a different result. You want to communicate your feeling to me, or not?

P: I’m doing it. (*turns head away*)

T: No, you’re not—that is absolutely a distortion.

P: The only thing I have now is the image of me grabbing you by the neck. (*makes strangling motion*)

T: Stay with that. Do not hold back.

P: (*Angrily*) It’s like . . . I have no way to escape.

T: Feel the rage. Don’t talk about it; feel it. Describe yourself strangling me, grabbing me by the neck, instead of pushing it down. Encourage yourself to feel it . . . that desire to strangle me.

P: I can’t. (*becomes anxious and squirms in chair*)

T: Why do you want to go backwards? That’s the self-destructive, self-sabotaging, undermining side of you. You break through to the point of imagining killing me, and then you back off, and you won’t let yourself enjoy it. Will you let yourself enjoy it for a moment? Did you feel powerful for a second, when you imagined choking me?

P: It was too brief; it was just an image—a fleeting image.

T: Well, go back to it.

P: It’s gone.

T: (*gently*) Go back to it.

P: If I see you as my father, I feel rage. You know something? You look a little like him.

T: And describe?

- P: I would push you . . . him, out of the way. I would grab him and get him out of my way.
- T: That's a certain degree of your rage. But face the full extent of your rage. You have extensive rage.
- P: I don't know if I'm ever capable of feeling the fullest extent of my rage.
- T: Now you take a helpless position and you remain loyal to them (*the superego*). Do you want to be loyal to the self-destructive system, to deny your rage—to be passive in the face of your rage? Is that what you want to do? Or do you want to face the full extent of your rage? It's your choice. Do you want to keep hiding your rage—living life like a submissive dog?
- P: No, I don't. (*strongly*)
- T: So tell me about the rage that's inside the dog . . . if he doesn't cower when he is enraged.
- P: You remind me of something. I had a terrible fear as a 3- or 4-year-old kid, of dogs. And I think I identified my father as a biting dog.
- T: Let's not use projection. You be the biting dog.
- P: I'm the fighting dog?
- T: Don't project the dog into your father. You be the dog.
- P: Then if I'm the dog, I would grab (*smacks his lower leg*) and go to his throat, and I would be tenacious, and there would be no end to it. The end would be death.
- T: Just feel it. The teeth are in your father's neck? Powerful jaws?
- P: Yes. It breaks his neck. All the blood, I guess. All the blood that I've seen flying from chickens would . . . enormous amount of blood

After stomping on his father's neck, he guiltily thinks of murdering his mother to gain his freedom. He says, "I'd be like Cain, running to the end of the Earth." Dr. Neborsky encourages him to speak to her corpse. He is resistant to holding her responsible for manipulating him. He defends her as being sick. But he begins to see that she pulled him into her anxious world and made it impossible for him to leave her in her pain. We are now 90 minutes into the session.

- P: I couldn't walk away.
- T: (*nods*) Tell her.
- P: (*sighs*)
- T: Face the truth; it's painful.
- P: I have the right to be enraged. She created a miserable life for me (*crying*). She created a miserable life for me. I was frightened . . . I don't remember a day of not being frightened . . . whether to tell my brother I was doing well in school or whether to go out to the street—frightened of disobeying her. And all this was woven with a great tapestry of love—"You're so special." But she created . . . she castrated me. Maybe she did it. I had thought my father did it.
- T: No, she did it. But more specifically, *you did it*, rather than facing your rage at her. And I want to congratulate you for reclaiming your right to your rage.
- P: No. She did it. My sympathy for her . . . let me just say to you (*points finger at therapist*) you're really wonderful. Really. You started saying empathy for myself, why not empathy for this woman?
- T: We'll get to that in Part 2. Let's stay with Part 1.
- P: OK.
- T: You said something about your feelings toward me.
- P: You're not, you're not . . . you're doing it for me. You are not doing it for yourself.

After a break, Dr. Neborsky asks the patient to visualize burying his dead mother. At first he has the thought of touching her, but then he imagines wrapping her in white sheets.

T: What do you do next?

P: Just cry

T: Cry as long as you want to.

P: (*laughs softly*) It's a good way that we part . . . it's a good way that you're dead. I have to remember that you're dead.

T: "I'm not your husband; I've never been your husband."

P: "You treated me like I was better than your husband."

T: "You made me feel like I was better than your husband and that was *wrong*"—hold her responsible.

P: Why did you participate in that surreptitious corruptive game?

T: "I don't want to be your husband." (*30 second silence*) Tell her who she belonged to . . .

P: My father (*laughter*) Why don't you accept that I'm just a little child. I can't deliver all that you want me to deliver. You've ruined my life to this point but I won't let you continue to ruin it. In the few years I have left I won't let you ruin it. That's it, rest in peace. (*tearfully recites Kaddish—the Hebrew prayer for the dead*)

T: Feel your grief for your beloved mother; she's *only* your mother.

P: I love you but leave me alone. I have to be out of that crazy world that you created.

Session 3. The patient returns the next day. He says that whenever he feels an aggressive impulse, he feels guilty. The therapist notes that he allows his conscience to punish him for his fantasies as if they were his actions.

P: Listen, in a court of law, the prosecutor will say, "You wish this, you wish this, you wish this," and the prosecutor says if you had the opportunity to stab in the back—without being identified—you might be doing it. You haven't quite yet done it . . . but

T: Is the prosecutor on your side?

P: No, he's not!

T: Oh, are you entitled to a defense attorney?

P: Ummm. Oh, that's an interesting one (*laughs*) Oh I see what you are saying.

The patient feels he has found an ally within himself to protect against his punitive superego. He remembers how his mother gave him the job of taking care of her emotional needs. He cannot identify the feelings that memory evokes in him. Dr. Neborsky says that his choice is to side either with the crippled part of himself, or with the healthy part, and to be free to feel whatever comes up. He begins to process his grief and anger toward his mother but cripples his emotions with anxiety and tension in his chest. The therapist confronts this. We are 60 minutes into this third session and in hour 7 of the therapy.

T: Tell your mother of your sadness. Don't put on this false, happy, well-adjusted golden child.

P: Get off my back. Go; let me stay. Go; let me play. Prepare the breakfast. Don't compare me to my brother. Don't tell me I shouldn't complain. Don't tell me how lucky I am. Don't tell me how reasonable I am, because then I can't (*sighing*) . . . when I have fears I'm supposed to be the perfect guy.

- T: "I will not ever again hide my feelings from you in order to protect you, Mother."
- P: I will not hide my feelings to protect you. I have to go on with my life. You will have to deal with your own problems. I can't cut my balls for you. (*sighing*) You have to face your own fears. I won't kill you when I tell you that. You won't die, and I'm angry at you for putting me through it, for emasculating me. For making me into a hostile, frightened . . .
- T: For redirecting my anger away from you, towards everybody else.
- P: For redirecting my anger, which I should have done to you, and now I have felt that my whole world is the enemy, when you are my enemy—you are my enemy. You know, she *was* my enemy. If it weren't for these games, these incentives, unrealistic competition that you seem to encourage between my brother and my father, I would have been happy; I would have had a chance. I paid only to think that you'll give me what I can't take from the world, but you couldn't give it to me. You really couldn't and I didn't turn to the world to get it, and I want to [turn to] the world. You couldn't give it to me; it was false. You know something, I've paid all this price with relationships so the woman would choose me . . . it was false. I never got it. I never got it! All I got is the flip side, the race to get rid of everybody else, which was supposed to deliver her, but she really delivered very little.

The patient admits to long-standing hatred for his mother. The therapist asks him to look at what that hatred feels like and what it wants to do. The patient then experiences an impulse to strangle his mother. He visualizes the impulse and begins to resist by shutting down and becoming defiant and intellectual. The psychotherapist confronts his resistance and the patient is given a choice to face his feelings or not. A wave of unconscious guilt passes through his psyche. We return to the interview 1 hour and 20 minutes into it, as the patient visualizes kissing his mother's murdered corpse.

- T: Tell me about the kiss. Feel the kiss.
- P: Which I was afraid to do as a child. I kiss her and I would tell her, "You go your way; I have to go my way; it will be better this way." (*sobbing*)
- T: Mourn your mother.
- P: You meant well, but you couldn't do it.
- T: "You created these murderous feelings in me and I have been prosecuting myself as though I were a criminal because I couldn't face the full extent of my murderous rage toward you, Mother. I couldn't do it until now."
- P: And I couldn't. And I felt that your love was conditional upon my getting rid of other men. This was the insidious thing. It was conditional upon this. I walked around trying to kill the men in the world, to win you.
- T: To make her happy.
- P: To make her happy so she could love me. Yes, yes, that was the trade-off; that was the legacy (*begins rubbing his neck*) It's over, it's over.

The patient contrasts his experience of these three ISTDP sessions with his 20 years of psychoanalysis.

- P: I understood a lot of it, but I did not understand the need to separate and to be proactive about it. I was talking with somebody yesterday and what is so unique and refreshing about it is what you said in the first meeting with me, "Is this the healthy part or the sick part?" That is very important for me. Because in the other therapy it was like a continuum; the lines are not drawn very clearly to separate them, label, and make

you aware. Not to give in to the unhealthy part. That was an eye opener. For me it was very very important.

T: Define the healthy part?

P: The healthy part is the part that wants to be free, that wants to walk straight . . .

T: And wants to explore and investigate his feelings.

P: I wouldn't have added those terms.

T: The part that wants to investigate his rage, his grief, his sexual feelings.

P: I wouldn't have added grief. I would always shut myself off and would walk away, and it is a self-destructive part of my defenses. This is really remarkable; I am counting on it. I am feeling like I am on a threshold. I really have to tell you (*leans forward, touches the leg of the therapist*) I have to tell you very positive, but very profound. It's not like, "Gee, I'm a new man"; it is very somber, but very liberating—like I've gotten the key.

Session 4. The patient returns 5 days later for his termination session. He is now able to feel rage toward his mother without resistance. He visualizes killing her by cutting off her head with a sword. He visualizes burying her, and, once more, kissing her dead body.

P: I guess I will have to kiss her good-bye.

T: Describe the kiss.

P: I would hold her and kiss her, which reminds me of when I was a kid. She would grab me to kiss me and I was afraid, because I thought she would seduce me. But I'm not afraid anymore. I didn't have the comfort of a mother, any real comfort, any care of a mother, because she claimed she was ill. She couldn't do; she couldn't get out of bed.

T: Tell her.

P: You couldn't prepare meals; you couldn't prepare the house; you continuously frightened us that you would have a heart attack. We couldn't disagree with you because you would get agitated and have a heart attack. You surrounded us with unreal dangers, a frightening world, frightening events that would happen—it was a nightmare, Dr. Neborsky; it was a nightmare. (*yells*) *It was a nightmare.* (*sobs*) *It was a nightmare* and it continues . . . (*sobbing*)

T: Face your grief and face your rage.

P: She caused it; she caused it. But why do I fall back to sympathy for myself, for the nightmare? I guess I deserve the sympathy; I deserve it. (*sobbing*) God knows I deserve it.

T: Yes, you do.

P: I have never cried like this; it was a nightmare from the moment I got up to the moment I went to sleep; I was frightened, and the bed-wetting, the enemies, the evil eye, and her sickness, *oh my God*, I had no life. No life. And I barely managed to maintain this façade. It's got to change. You should have looked after me. *That's it.* You didn't look after me. You looked after your own. I'm now strong enough to look into my anger against you, Mother. I am strong enough to walk away from you. I am strong enough to say good-bye to you. I'm strong enough to know you are buried and I can go on with my life. Yes, you are out of my life. I will not do it again.

T: Do what again?

P: Allow myself to speak for you and to subjugate me. If I don't allow myself, then I won't allow other people. But I have been doing it; I have been doing it and I've been

doing it, not realizing that I've been speaking your voice. But you have no voice anymore . . . you have no voice. You are just a body, just a corpse.

T: "I choose to bury you."

P: And now you are buried. I choose to bury you, so I don't have to have you on my arm, back of my head; you're gone. Bye bye.

The psychotherapist interprets that he rejected his father because his mother unconsciously encouraged him to do that.

T: Your father did let you down, but at the same time, I would sense that you didn't give him a chance, either.

P: That's true. Yes, yes, it was a mutual nonrecognition of each other. I treated him in some way, as an imposter, and that's sad—because of my mother. He was very aloof and insecure and maybe was challenged by me in some ways.

T: In many ways, your mother set you up to be the husband and him to be the outsider.

P: You mean she had the *intention* to separate us? You're not confident in that. Why do you say that? She did it; she shouldn't have done it, but I don't know that she *wanted* me separated from my father . . . Why? (*appears stunned*) (*silence*) Yes. There is no shred of doubt about it. The interpretation. *No* shred of doubt. It makes me sad again.

T: Let me hear the words between you and your mother.

P: I'm going away now. I'm leaving you behind. I have to go away. But even if you were alive, I would have been away from you now. I've severed the ties. I've cut the rope. I now understand how you have used me, have acted the opposite of a mother. You have made me insecure; you have frightened me; you have turned me into what I have feared, which was a beast . . . worse than a beast. You made me competitive, hateful of other men, and insecure with women. And that has ended. I've seen through it. I've seen that it was all out of your needs. The world is not like that. Men are not my rivals. My father was not my rival, because you were not my wife. You were never going to be my wife. No, he was not, and I projected on him for a long time.

T: Yeah.

As a way of deconstructing his OCD, he remarks on the world of fear and superstition his mother surrounded him with, "from morning till night." We are 85 minutes into this termination session, and 9 hours into treatment

P: To some extent it was a perversion of reality. The reality was not reassuring.

T: Amplification, all danger was amplified.

P: And, in a scary way, potentially under your control, if only you carried garlic and salt to ward off the evil eye. If only you don't go to the street . . . If only you don't think about going to sleep, you fall asleep. And as a result of it, I, all my life, tried to deal with the world. . . . Now I'm getting uptight because I'm controlling the fear with . . .

T: Through magic.

P: With magic or with your body. The body was perverted, instead of reassuring. Oh my God! It's as I talk about it, I just realized for the first time I have more sympathy for the world I've lived in. It's a world of horrors. From the moment you get up, there is nothing reassuring. It wasn't: so if you're afraid about hunger—but you have love and protection. It's a world of running away and manipulation—hiding . . . say good-bye to that.

After a 5-minute break, the patient says that his psychoanalyst never explored his relationship with his mother in any depth. He expresses gratitude for the clarity he has now.

- P: He talked about that she wasn't caring for me; he didn't put it together, to stay on it. That is news to me after 20 years. You can see I have a lot of insights, which if you do it long enough, you become introspective. But I didn't see that.
- T: I noticed a rise of emotion towards me.
- P: I'm sad that I'm going away, but that's life. I have to go away. I have to work on it. I have to remember and I have to fight it.
- T: Emotions toward me.
- P: Which is quite different from when I came in. I'm in shock. I didn't get to the point of seeing my mother critically, or feeling my rage, or even thinking that I was entitled to it. And as a result of that, she was always benevolent, and enticing. She had an enticing side to her. For a child, it was very intoxicating. "I'm going to make you better than your father." That was the payoff for which I gave up my will. I gave up any resistance. I went beyond it for the little favors. She created an idealized image of me and I created an idealized image of her, and we were trading.
- T: That's correct.
- P: And this is a very corrupting, very sinister, destructive—it sucks you in, gratifying at a certain level. In the system, the rest of the world was your enemies . . . and I see it now. I reject it. I've seen it already with my life, even after just 3 days here. What I'm doing to her is unfair . . . trying to suck her into that game.
- T: Oh, you are doing to her what your mother did to you.
- P: Yeah, trying to suck her into that game. "If you would just understand me, I wouldn't have to express my wishes, and all the other things that go with it." I created a problem with my wife, with sex and other things. Here's the other thing: my mother—my wife, I was going to say—continuously always tested me. So, you have to perform. She couldn't just confer it, and it's done, so I am sucked in, into this rivalrous activity . . . and I'm always afraid that I will fail . . . in that enticing, collusive, seductive relationship that I am recognizing and rejecting. So I have a lot to do.
- T: So there is going to be a lot of change in the relationship with your wife, as you set her free.
- P: *Absolutely*. And I've seen it already . . . it's very nice. I've seen it with her, and I've seen it with men. I've seen the impact already. It's the right solution for me. It feels terrific. I have to thank you.

Clinical Issues and Summary

Despite 20 years of psychoanalysis, this patient still carried within him a punitive superego and used maladaptive defense. Beneath this self-punitive and defensive structure lay his unresolved attachment trauma. It was concealed by a prolonged unconscious idealization of his mother. He continued to enact the script that his histrionic and superstitious mother played out with him in their attachment to each other. She mandated that he always be "the best" in order to ward off danger—if he was, she rewarded him with her exclusive love.

We see multiple possible unresolved attachment traumas. His actual nonidealized experience was that his mother was "unloving" (narcissistic, somatic, manipulative), was "involving/reversing" (son replacing father as idealized love object), and used "pressure to achieve" on him in order to satisfy her needs. These traumas created a severely disturbed oedipal relationship with his father that resulted in both a symptom and character neurosis. Both of these malignant structures were deconstructed in this therapy.

By my measures, the patient left therapy a changed man. Healthy self-assertion replaced fearful submission. His genuine longings for intimacy with his wife and male friends became actualized. His anxiety disappeared, and his obsessive compulsive disorder (OCD) normalized. At 6 months follow-up these changes remain intact.

Two people—patient and therapist—join together in a therapeutic venture. The therapist listens and absorbs historical and dynamic information that activates the mind of the therapist. The therapist through ISTDP technique can access the patient's unconscious in a remarkably short period by following the sequence of interventions invented by Davanloo and elaborated by Malan. If the dyad can overcome the constraints placed against feeling traumatically based emotion, rapid and long lasting change can and does occur. Deeply felt long-lasting emotional insights sustain the patient and reinforce the changes made during the psychotherapy.

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