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Volume 21, Module 2, Article 1, pp. 130-250, 06-04-25 [copyright by author]

Editor's Note 1: For the interested reader, an outline of the structure of the case study of "Serena" is shown in Appendix 1.

Editor's Note 2: This case study is more expansive in its exploration of theory than the usual case study in PCSP. I have included the expanded material because of its richness, insight, and depth of scholarship. This is especially true for section 3. Guiding Conception. For section 5, the reader who wants to focus more on the case itself can go directly to the subsection titled *Short Term Psychodynamic Psychotherapy (STPP) for OCD* (pages 25-31). This subsection serves as a free-standing guiding conception for the case.

Short-Term Psychodynamic Psychotherapy (STPP) for Obsessive-Compulsive Disorder (OCD): The Hybrid Case of "Serena"

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[c] Note: This article is a reformatted and edited version of my dissertation (Campiani, 2024).

ABSTRACT

Obsessive-compulsive disorder (OCD) is a chronic incapacitating mental health condition that is underrepresented in clinical treatment settings. The worldwide treatment gap for OCD is estimated at 60% (Kohn et al., 2004), a figure that reflects a shortage of specialized services, delayed help-seeking in suffers, and a mounting cost to society. The treatment of choice for OCD is a combination of cognitive-behavioral therapy (CBT) and pharmacotherapy (SSRIs), which has been proven efficacious in measurably reducing symptoms to below the clinical threshold (McKay et al., 2015). Nevertheless, when evaluated holistically, the success rate of the first-line treatment is limited. This study provides a literature review of the various psychodynamic models of obsessive-compulsive pathology and their attendant approaches to treatment. At present, empirical evidence for psychodynamic therapies for OCD is lacking (Leichsenring et al., 2015).

To fill this gap in the research, this pragmatic case study (PCS; Fishman, 1999) aims to demonstrate the viability of short-term psychodynamic psychotherapy (STPP) as an effective treatment for OCD. Specifically, this pilot case study examines the theoretical implementation of Leichsenring and Steinert's (2017) empirically-derived, manual-guided STPP treatment for OCD, rendered as a treatment for "Serena," a 28-year-old female patient presenting with mild-to-moderate symptoms of OCD. Serena is a hybrid case, which is an aggregate of actual, de-identified psychotherapy cases and clinical examples from the relevant psychological literature. Through a disciplined inquiry approach, Serena's treatment process is systematically described.

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Treatment outcomes are analyzed both qualitatively and quantitatively. This case study attempts to illustrate the interplay between symptom expression and the not-always-linear progress toward structural change. I conclude with a discussion of the applications and limitations of the hybrid case study and STPP for OCD, as well as implications for psychotherapy integration.

Key words: obsessive-compulsive disorder (OCD); Cognitive Behavior Therapy (CBT); Exposure and Response Prevention (ERP); Short Term Psychodynamic psychotherapy (STPP); Core Conflictual Relationship Theme (CCRT); principle-based therapy manual; case study; clinical case study

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1. CASE CONTEXT AND METHOD

Rationale for Selecting this Particular Patient for Study

Psychoanalysis was originally concocted as a remedy for anxiety disorders ("anxiety neuroses"; Freud, 1895), and abided for decades as the first-line therapy for the scope of psychological disturbances observed in Western cultures. Antithetically, its modern derivative, psychodynamic psychotherapy, has suffered a trend of empirical neglect against the field's efficacy standards, which have emphasized randomized clinical trials (Chambless, 1998; Leichsenring et al., 2015). The trend of scholarly repudiation of psychodynamic therapies has been attributed to political and historical factors in the evolution of academic psychology. Issues such as the selective dissemination of research findings, discrepancies in randomized-control trial initiatives, and a disregard for effect-size findings have jeopardized the scientific standing of dynamic therapies (Shedler, 2010). For example, numerous meta-analyses show psychodynamic psychotherapies producing effect size findings comparable to other evidence-based treatments (Leichsenring et al., 2004; Shedler, 2010; Abbass et al., 2014; Leichsenring & Klein, 2014).

Vis-à-vis an extensive CBT literature, the psychodynamic research literature is underappreciated, but certainly extant. Over the last two and a half decades, short term psychodynamic psychotherapy (STPP) rose in prominence as it was subjected to methodologically rigorous clinical research. The effectiveness and cost-efficiency of STPP have been proven across various treatment settings and clinical presentations (Crits-Christoph, 1992). Moreover, disorder-specific treatment protocols based on STPP were developed for dysthymia, complicated grief, panic disorder, social anxiety disorder, generalized anxiety disorder, and substance use disorders; all showed promising results for efficacy (Leichsenring et al., 2015).

The psychoanalytic literature contains a wealth of clinical and theoretical writing on obsessive-compulsive dynamics; however, psychoanalytic therapy has never been documented as a "cure" for OCD *symptoms* (Malan, 1979; Jenike et al., 1986; Nemiah, 1988; Kay et al., 1996; Gabbard, 2001). The DSM-III task force officially scrapped the psychoanalytically-derived diagnostic category of "obsessional neurosis" and instead adopted operationalized criteria for

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diagnosing what is now known as "obsessive-compulsive disorder" (Gabbard, 2001).

Amid a reform in empirical research standards, the DSM-III trended towards biologically based etiological models of psychopathology. Since then, the CBT + SSRIs combination has enjoyed "gold-standard" treatment status within the field of OCD treatment (Kay et al., 1996). Although neuroscience research corroborates the psychodynamic view of obsessions as unconscious, threatening impulses "intruding into consciousness" (Stein, 2002, p. 401), CBT conceptualizations reign supreme. Unfortunately, no RCTs examining the efficacy of psychodynamic therapy for OCD have yet been published (Leichsenring et al., 2015). Leichsenring and Steinert (2017) argue that remission rates for CBT are unimpressive, that success rates for CBT + SSRIs are limited, and that psychodynamic therapy, by probing into unexamined causes for symptoms, may help treatment-resistant patients.

More recently, Leichsenring and Steinert (2017) tailored Luborsky's (1984) generic STPP manual to obsessive-compulsive disorder, adding to the small collection of disorder-specific, comprehensive treatment manuals grounded in psychodynamic theory. The model is an empirically-derived adaptation of Luborsky's (1984) supportive-expressive (SE) therapy, the fulcrum of which is the Core Conflictual Relationship Theme (CCRT). Essentially, the treatment weaves exposure principles with transference-focused interventions.

To my knowledge, there have been no research initiatives to validate Leichsenring and Steinert's (2017) "inhibited rebel" manual since its publication. The authors call for RCT efficacy testing of their model. This case study represents an alternative yet earnest response to their request. I execute the treatment protocol set forth in Leichsenring and Steinert's (2017) model by conducting an arguably robust and rigorous Pragmatic Case Study (PSC; Fishman, 1999) of a hybridized patient. Through this pilot project, I pioneer a mission to fill the OCD-specific evidence-gap in the STPP literature.

Obsessive-compulsive disorder (OCD) is a chronic incapacitating mental health condition that is underrepresented in clinical treatment settings. The worldwide treatment gap for OCD is estimated at 60% (Kohn et al., 2004), a figure that reflects a shortage of specialized services, delayed help-seeking in sufferers, and a mounting cost to society. Through a disciplined inquiry approach (Peterson, 1991), this paper aims to expound the clinical validity of short-term psychodynamic psychotherapy for mild-to-moderate obsessive-compulsive pathology. With this purpose in mind, I present the case of "Serena," a hybridized patient assembled from a conglomerate of actual, de-identified psychotherapy patients, anecdotal data from supervisory discussions, and case examples outlined in the relevant psychology literature. Serena's case is a synthesis of numerous clinical encounters with OCD patients across the lifespan. As a doctoral-level graduate student, my training has spanned multiple treatment settings (i.e., university outpatient clinics and an intensive outpatient program), theoretical modalities (i.e.,

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psychodynamic, CBT, existential and humanistic) and frame designations (i.e., short-term and long-term therapy).

The conception of this hybrid case sprung in the interface of my burgeoning clinical insight into OCD and my encounter with Leichsenring and Steinert's (2017) proposed treatment framework. Book's (1998) inclusion/exclusion criteria for manualized STPP treatment were used to determine Serena's eligibility for this study. Serena's case study elucidates the model's dynamic mechanisms: (a) it targets the unconscious determinants of OCD symptoms without sacrificing behavioral interventions; (b) it explores claims that symptomatic expression is not as "ego-alien" as the patient originally felt it to be, but rather symptoms are construed as compromise formations, allaying the plight of an ego cast as the commander-in-chief of an id-superego battle; (c) it shows that symptoms are contextually rich in meaning; (d) it prioritizes transference-focused interventions anchored in a relational formulation; (e) it employs a time-limited, goal-oriented approach, but is inherently principle based, with flexible parameters to accommodate creativity, spontaneity, and the idiosyncratic needs of the patient; and (f) it shows that the therapist assumes a more active stance than seen in traditional psychoanalytic therapies. The relational focus of the model not only facilitates a strong therapeutic alliance, but also targets treatment-interfering factors, such as comorbidities, resistances, and family accommodations.

Pragmatic Case Study Method

The quality control of experimental studies is unmatched. Nonetheless, top-down conclusions may be oversimplified. Due to highly selective eligibility criteria, patient samples are homogenous, and treatment settings are unrepresentative of real-world clinical practice (Shedler, 2010). Thus, the generalizability of findings can be questionable. Despite its narrow participant pool, a pragmatic case study (PCS) presents descriptive, multifaceted clinical data amenable to bottom-up inferences (Fishman, 1999).

Employing a disciplined inquiry approach, the PCS method incorporates theory, previous research, and past clinical experience. A mixed-methods approach combines the strengths of quantitative and qualitative analysis, corroborating broad theoretical claims with specific examples (Fishman, 2013). An advantage of a *hybrid* case is its expanded generalizability, as it draws from a repository of real-world clinical data, diverse in demographics and clinical complexity. This case study is also unique in examining later-stage OCD, with mild, but chronic impairment, a presentation generally associated with more shame about the symptoms, disguising of symptoms, avoidant behavior, financial obstacles to care, and skepticism about treatment effectiveness—all barriers to help-seeking—resulting in delayed access to care (García-Soriano et al., 2014).

Traditionally, efficacy trials derive treatment outcomes (i.e., response, remission, recovery, relapse) exclusively from change scores on psychometric scales of symptom severity, such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). Although germane to experimental procedures, quantitative assessments are not equipped to capture other, more nuanced dimensions of treatment outcome, such as the patient's acquisition of internal resources conducive to a fulfilling life, the softening of personality fixations, the restructuring of relational patterns, or the evolution of treatment gains in the aftermath of termination (Shedler, 2010). Given the idiographic nature of this case study, one important objective was to broaden the putative definition of treatment success, "a clinically meaningful reduction in symptoms," to include "a personally meaningful change in the relationship with one's symptoms."

STPP has a two-pronged goal of symptomatic reduction with limited, but significant character change (Book, 1998). This case study attempts to illustrate the interplay between symptom expression and the not-always-linear progress towards structural change. To this end, I utilize both quantitative and qualitative methods to systematically examine therapy process and outcome. Standardized quantitative measures situate the individual case and its outcome in a normative context. Of note, I present the reader with fictionalized data to catalogue Serena's progress on objective markers of clinical and functional improvement. Although actual data are not provided, the hypothetical results are representative of the general patterns I have observed across data I collected from multiple OCD therapy cases. To highlight best practices, I contend that treatment monitoring with objective assessments is paramount for a disorder with such behaviorally loaded, interfering symptomatology, irrespective of theoretical orientation. My clinical experience treating varied presentations of OCD across levels of care supports this claim.

Meanwhile, qualitative methods of analysis offer a descriptive, nuanced, and granular account of the psychotherapy craft. I plan to use a narrative format to describe the therapy process over the course of 5 phases. The qualitative portion highlights the psychodynamics of OCD and the mechanics of supportive-expressive (SE) therapy. The OCD-specific elements of the manual include addressing ambivalence, distinguishing between thinking and acting, tempering the superego, discussing existential issues, and exposing the patient to their feared situation as a means to invite affectively laden material into consciousness, often a gateway to work through the patient's CCRT (Leichsenring & Steinert, 2017). The CCRT formulation is at the forefront during all the stages of treatment as the "usual context for the symptoms" (Luborsky, 1984, p. 151). An early study found that improvement was best assessed via the patient's felt sense of *mastery* of their CCRT problems, as opposed to a complete eradication of the problems (Luborsky, 1977). I will evaluate changes in Serena's CCRT as the main qualitative outcome. As such, I will ask Serena to reflect on her understanding of her CCRT and its relation

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to her OCD symptoms. The termination phase is expected to raise interpersonal issues which will be revelatory of the status of Serena's CCRT at the end of treatment. In addition, I will analyze my fidelity to the treatment manual and discuss potential deviations. I will conclude with comments on the benefits and limitations of the STPP manual for OCD.

It is my hope that this study will provide practice-based evidence affirming the value of psychodynamic therapy in the treatment of OCD. Additionally, I intend to provide new insights into working with high-functioning OCD patients, serving as a valuable resource for clinicians seeking to enhance their clinical acumen in this domain. Lastly, I aspire to promote the dissemination and implementation of Leichsenring and Steinert's STPP manual for OCD.

Data Analysis Overview

In line with PSC methodology, a mixed methods analysis of the therapy process and outcome will be performed at the study's conclusion. Quantitative assessment will be conducted with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) at pre-treatment and post-treatment, and changes in these scores will be tested for statistical significance via Jacobson and Truax's (1991) Reliable Change Index. Qualitative data obtained at intake via the Relationship Anecdotes Paradigm (RAP; Luborsky, 1990) Interview will be subjected to CCRT analysis and compared to the CCRT data gathered through ongoing monitoring of relationship episodes told by the patient in sessions. The evolution of the patient's CCRT will be evaluated for indicators of "mastery" (i.e., increases in self-understanding) and modifications in component frequency.

The Clinical Setting in Which the Case Took Place

Serena's treatment took place at a psychological services training clinic in the Northeastern United States. The clinic provides an array of mental health services to university students as well as members of the community. The primary providers at the clinic are psychology graduate students.

Serena was a community patient referred to the clinic by her primary care physician following a poor response to medication for her panic symptoms. During the initial phone screening, Serena was transparent about her longstanding reluctance to seek mental health services. She stated that her decision to finally seek help was inspired by a friend's testimonial. The session fee was determined by a sliding scale, in which Serena qualified for the middle tier of payment. Serena was assigned to me by the clinic coordinators based on their knowledge of my interest in the treatment of anxiety disorders. Throughout Serena's treatment, I was an advanced clinical psychology doctoral student supervised by multiple licensed clinical psychologists with expertise in relational psychodynamic approaches as well as varied modes of CBT for OCD. The treatment covered 5 assessment sessions, 22 therapy sessions and 2 booster

sessions. It was understood from the outset to be time-limited to approximately eight months.

Sources of Data Available Concerning the Patient

Prior to the initial intake session, I was provided with a one-page summary sheet completed by the clinic coordinators following their 20-minute phone screening with the patient. This was Serena's first experience with psychotherapy, and collateral information (e.g., from family members or medical providers) was not accessible nor acquired.

Confidentiality

Given that Serena is a composite of multiple individuals, the confidentiality of my previous patients is protected by adopting a pseudonym—"Serena." Further, in the service of concealing my patients' identities, the specifics of Serena's history and presentation have been fictionalized.

2. THE PATIENT

The patient, "Serena," was a 28-year-old, Hispanic-American, cisgender woman living with her fiancée in a small apartment in a cosmopolitan city in the Northeastern United States. Serena worked as an elementary teacher at a local school. The patient presented to treatment at her wit's end, admittedly reluctant to seek help but acknowledging a dire need for services. Four months prior, Serena's anxiety symptoms spiraled. Her partner proposed to her on New Year's Day. A mere two hours after she enthusiastically accepted, Serena experienced a major "panic attack" that landed her in the emergency room. Since then, she has been increasingly inundated by intrusive thoughts about losing control and purposely injuring her own body. Serena noted that these perturbing thoughts first appeared in her early 20s, and worsened in their iterations over the years. She had gone to great lengths to conceal her suffering. Pharmacologic treatment was unsuccessful in Serena's case because she did not tolerate the side effects of medication.

This was Serena's first time in psychotherapy. At the time of intake, she met DSM 5 criteria for obsessive compulsive disorder (OCD), with good insight. Her core obsessions were aggressive/violent (e.g., graphic of injuries to herself or family). To alleviate the anxiety bred by intrusions, Serena engaged in compulsive checking and mental rituals. In counter-phobic fashion, she approached potentially dangerous situations to "check" whether her self-preservation instinct was intact (by eliciting the physiologic fear response) and thus disprove, or "undo," intrusions insinuating a wish to harm the self (death wish). When she doubted her safety, she sought reassurance from her partner. Serena avoided being alone; she endured driving, street-crossing, using knives, and electrical appliances with distress. The quality of her relationships, work ethic, mood, and health had markedly declined as function of her symptoms.

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3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Obsessive-Compulsive Disorder

Epidemiology

Obsessive-compulsive disorder (OCD) is heterogeneous, nuanced and underrecognized in both public and professional spheres (Penzel, 2017). Most cases incur a chronic course and a 90% likelihood of suffering from comorbid mental health disorders (Ruscio et al., 2010). The comorbidities most frequently observed are major depressive disorder, generalized anxiety disorder, separation anxiety disorder, social anxiety disorder, and specific phobias (Miguel et al., 2008). OCD is ranked in the World Health Organization's top 10 most disabling mental health disorders in developed countries, by lost income and reduced quality of life (Bobes et al., 2001). It is costly to sufferers, families, and society at large (Hollander et al., 2016). OCD is associated with low self-esteem, difficulty maintaining relationships, turbulent family dynamics, academic and career under-achievement, and suicidality (Hollander et al., 1996).

Perhaps the most alarming statistic is the treatment gap—calculated as the percentage of individuals who require care but have not received it—estimated at 60% worldwide for OCD (Kohn et al., 2004). Despite an estimated lifetime prevalence rate of about 2-3% (Carmi et al., 2022), the condition is shrouded in stigma. Not only is help-seeking delayed in those afflicted, but those that do seek services are likely to be misdiagnosed (Hollander et al., 2016). As such, OCD is underrepresented in mental health treatment settings. Too often, inappropriate services are rendered, which contributes to healthcare overuse, burdening a worn-out system and multiplying costs for payors. For those accurately diagnosed, access to specialized treatment is complicated by financial barriers and a scarcity of qualified providers (Fineberg et al., 2013).

Classification & Phenomenology

The diagnostic criteria for obsessive-compulsive disorder (OCD) are delineated in two major coding systems, the *International Classification of Diseases*, 11th Revision (ICD-11; WHO, 2019) and the *Diagnostic and Statistical Manual of Mental Disorders,* 5th Edition (DSM 5; APA, 2013), the latter being the prevailing reference for mental health providers in the United States. The DSM 5 requires fulfillment of four specific criteria to qualify for a full diagnosis of OCD: (A) the presence of obsessions, compulsions or both; (B) occupying more than 1 hour per day or causing a marked impairment in important areas of functioning; (C) not attributable to substance abuse nor another medical condition; and (D) not better explained by a different mental disorder (APA, 2013; see Table 1 for a full description of criteria). Insight specifiers denote the patient's objectivity on the absurdity of their obsessions and futility/excessiveness of their compulsions. The subject's endorsement of their thoughts as personally meaningful is

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conveyed in the psychodynamic term "ego-syntonic," which corresponds to *poor insight*. "Ego-dystonic" corresponds to *good insight* (Penzel, 2017). Of note, the specifier *with absent insight/delusional beliefs* was instituted to differentiate the "overvalued ideas" in OCD, which can appear delusional, from symptoms of a delusional disorder (Menzies & de Silva, 2003).

Obsessions are intrusive, repetitive thoughts, images or impulses that induce anxiety, doubt or acute discomfort. Compulsions are overt behaviors or covert mental processes carried out to mitigate the distress associated with obsessions (DSM 5; APA, 2013). Although obsessions and compulsions are distinct phenomena, in most cases, a functional relationship can be discerned. The two occur in tandem and are mutually reinforcing (Foa & Tillmans, 1980). The obsessive-compulsive cycle has been mapped to varying degrees of granularity. Menzies and de Silva (2003) outlined the typical phenomenological sequence: trigger, obsession, discomfort or anxiety, compulsive urge, compulsive behavior, discomfort reduction, fears of disaster, inflated responsibility, reassurance seeking, avoidance, disruption, and resistance. The OCD cycle is cued by a *triggering event*, which can be external (i.e., environmental stimulus) or internal (i.e., thought, mental image or physical sensation). Over time, sufferers learn to avoid situations that contain their triggers. At its extreme, *avoidance* can suffuse entire areas of life. Moreover, *obsessions* often harbor the threat of a catastrophic outcome preventable only through *compulsive ritualizing*. Rituals are governed by a rigid set of rules, which can become elaborate and increasingly time-consuming. The *relief* afforded by rituals is intermittent and short-lived, yet, it is the *prospect* of relief that strengthens the *urge* to seek it the next time an obsession strikes (Penzel, 2017).

The Obsessive-Compulsive Cognitions Working Group (1997), an international research group, distilled six schemas governing obsessive-compulsive thought processes: (a) inflated responsibility; (b) over importance of thought; (c) need to control thought; (d) intolerance of uncertainty; (e) overestimation of threat; and (f) perfectionism. Related cognitive phenomena are resistance to thought; thought-action fusion; unrealistic, magical and superstitious beliefs; pathological doubt; pervasive guilt; and rumination (Menzies & de Silva, 2003; Penzel, 2017).

OCD is remarkably heterogenous, both clinically and epidemiologically. Presentations vary by symptom quality, extent of impairment and demographics. Though research initiatives of recent decades have attempted to define subtypes of OCD, no uniform classification system exists. Still, theoretical differences believed to exist between subtypes have important implications for treatment (Menzies & de Silva, 2003). Assessment tools such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) and the Maudsley Obsessional Compulsive Inventory (MOCI; Hodgson & Rachman, 1977) categorize obsessions and compulsions by content. Categories are not mutually exclusive and can overlap in a single presentation, often occurring episodically over the course of illness (Penzel, 2017).

Aggressive obsessions are thoughts about causing injury or death to self or other, accompanied by a fear of acting on these thoughts if given the opportunity. Checking compulsions are repetitive attempts to verify, with absolute certitude, whether the feared event will transpire in the future or has already transpired unknowingly. Repetitive checking draws increased attention to the obsessive content. The compulsive "solution" inevitably sustains the problem. Checking can be tactile, visual, auditory or somatic, but also mental (Penzel, 2017).

Neurobiological Etiology of OCD

The evidence for biological loadings on OCD pathogenesis is very strong—OCD is only second to schizophrenia in this regard (Kay et al., 1996). To begin, the finding of an absence of a placebo response in OCD patients, relative to other anxiety disorders, is salient in supporting a biological etiology (Mavissakalian et al., 1990). Genetic studies have found higher rates of concordance for OCD in monozygotic and dizygotic twins (Elkins et al., 1980). Brain imagining studies where OCD brains were compared to controls have yielded the following findings: anomalies in the frontal lobes and basal ganglia (Rauch & Jenike, 1997); increased metabolism in the orbitofrontal cortex, the anterior cingulate cortex, and the caudate nuclei (Baxter et al., 1987; Swedo et al., 1989); abnormal serotonin metabolism (Greist et al., 1995); increased markers of central nervous system dysfunction (Hollander et al., 1990); and reduced volume of the caudate nucleus (Luxenberg et al., 1988).

Biological research also exists to support the heterogeneity of OCD symptoms (Stein, 2002). Considering the evidence, Gabbard (2001) affirmed that "psychodynamic conflicts frequently appropriate biochemical processes within the brain and use them as a vehicle of their expression" (p. 212), while McWilliams (2011) warned us about "becoming too reductive in neglecting the psychological side of [OCD] simply because we know more about [its] biology" (p. 284).

Existential Issues in OCD

The absurdity of obsessional fears and superstitious rituals is existentially loaded. The "feared outcomes" reported by patients experiencing obsessions (e.g., sexual, aggressive, contamination, scrupulosity) are imbued with the "ultimate concerns," or "givens of existence" defined by Yalom (1980): death, freedom and responsibility, isolation and meaninglessness. The suspension of disbelief that arises in the type of magical thinking characteristic of an obsessive trance can be viewed as an abnegation of the self's mortality. In concert, compulsive ritualizing can be construed as an attempt to resist the laws of time and space, as if mentally striving to avert the threat of impending death.

In a metaphorical sense, the rote, sterilized mechanics of both obsessive and compulsive phenomena halt the ticking of the clock. The intrusive nature of obsessive thoughts and the

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paradoxical nature of compulsive behaviors puts the conventions of "self" and "will" on trial (King, 2017). Psychoanalytic theory introduced the concept of the unconscious to explain schisms in the "self" construct. In OCD, the conscious ego is bombarded by unconscious intrusions—the surfacing of unacceptable aspects of reality—which violate the bounds of egoic reality. These intrusions oppose the accepted definition of the self, hence the term *ego-dystonic*/*ego-alien*.

A patient's simultaneous immersion in and resistance to their symptoms challenges our understanding of personal agency. Despite an *awareness* of the futility of their rituals, individuals *feel* compelled to engage in them. It is as though their willpower becomes so drained by the obsessive experience that it surrenders to the soothing allure of a compulsive trance. Nowhere is the vulnerability of the "self" or its tendency toward fragmentation more astutely exploited than in the dynamics of OCD. In a similar vein, Hoffmann and Hochapfel (2009) examined the self-preserving aspect of OCD symptoms through an evolutionary perspective, aiming to restore a *sense* of order and control to a self-system seemingly threatened by psychological entropy. For instance, the emergence of OCD symptoms in patients with psychotic or borderline conditions may conveniently stall their decompensation into dissociated or fragmented self-states (Lang, 1997).

The literature on death anxiety includes a substantial inquiry into obsessive-compulsive phenomena. Terror Management Theory (Rosenblatt et al., 1989) delves into the profound impact of death anxiety, arising from the conflict between innate self-preservation instincts and the conscious or subconscious acknowledgment of one's mortality. Obsessions, identified as unwanted, conscious thoughts about death, often prove difficult to manage. As such, patients resort to compulsions, which merely offer temporary relief by suppressing these intrusive thoughts, fostering a superficial sense of ignorance towards one's mortality (Pyszczynski et al., 1999). Paradoxically, actively avoiding such thoughts perpetuates death anxiety. Strachan et al. (2007) and Menzies and Dar-Nimrod (2017) conducted studies employing the mortality salience paradigm, revealing that experimentally induced death cognitions heightened compulsive cleaning behaviors among individuals with OCD but not among those without the disorder.

Moreover, Menzies and Dar-Nimrod (2017) identified significant correlations between scores on the Vancouver Obsessive Compulsive Inventory (VOCI) and the Collett-Lester Fear of Death Scale, indicating a notable association. Another study by Menzies, Sharpe, and Dar-Nimrod (2019) reported a substantial correlation between scores on the Multidimensional Fear of Death Scale (MFODS) and the severity of OCD symptoms. Lastly, a series of investigations conducted by Menzies and colleagues (2020) demonstrated that scores reflecting death anxiety were equally predictive of severity across six subcategories of OCD.

Iverach et al. (2014) advocate for clinicians to intensify efforts in directly confronting the fear of death during treatment. Their viewpoint underscores the widespread presence of "death anxiety" across anxiety disorders. While the authors acknowledge the significance of exposure techniques in desensitizing individuals to morbid content, they highlight the shortcomings of CBT methods. Exposure addresses exaggerated perceptions of proximal threats but overlooks the fundamental existential quandaries. Iverach et al. (2014) stress the critical necessity of addressing chronic death anxiety, which lies at the core of anxiety disorders. Engaging in existential exploration can prevent symptom substitution and decrease the likelihood of relapse in treatment-responsive patients. Iverach et al. (2014) suggest integrating components of Existential Psychotherapy, Acceptance and Commitment Therapy (ACT), Dignity Therapy, and Meaning-Centered Therapy into evidence-based protocols for anxiety disorders.

Psychodynamic Perspectives on OCD

In the realm of case disposition and treatment planning, there is practical significance in distinguishing between anxiety disorders and personality disorders, as facilitated by our current DSM nosology. However, this approach is not without its limitations, particularly for dynamic clinicians. Understanding the historical context of contemporary diagnostic labels is paramount. In 1904, Janet introduced the term "psychasthenia," which identified a premorbid neurotic state (to OCD). Subsequently, in 1909, Freud classified "obsessive-compulsive neurosis" as a subtype of general neurosis. Although Freud did not differentiate between OCD and OCPD (Angyal, 1965), his formulation dominated the field of psychiatry for decades. The paradigm shifted in 1980 with the introduction of DSM-III, which jettisoned "neurotic" language in redefining obsessive-compulsive etiology. The advent of neuroscience research steered psychiatry towards biologically based etiologies (Gabbard, 2001). Moreover, the revised DSM-III nomenclature listed OCD and OCPD as standalone psychiatric diagnoses. Evidence for the diagnostic independence of the two disorders is abundant and compelling (Wheaton & Pinto, 2017).

Nonetheless, I preface this section with the contention that obsessive-compulsive (OC) phenomena are not as discretely occurring as the DSM 5 stipulates. The obsessive-compulsive mode of thinking that pervades the myriad manifestations of obsessive-compulsive disorder (OCD), as well as the archetypal value framework of obsessive-compulsive personality disorder (OCPD), are best understood as occurring on an OC-spectrum. Historically, psychoanalytic theorists—beginning with Freud—have assumed a continuity between OCD and OCPD that "can be confusing to the modern reader because it conflates conditions that current descriptive nosologies, such as the DSM 5, regard as distinct" (King, 2017, p. 66). In her conception of obsessive-compulsive psychologies, McWilliams (2011) depicts more overlap than divergence.

Summers and Barber (2010) also claim that OCD and OCPD are born of mutual psychodynamics. They further state that the dynamic *problem* of obsessionality "does not map

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cleanly onto the DSM system" (Summers & Barber, 2010, p. 114). Although the "sources of anxiety giving rise to the symptoms" (Thomas, 2020) (i.e., latent conflicts about primitive impulses, anger and control) are comparable in OCD and OCPD, modern theorists agree that the manifest symptoms differ. A distinguishing feature is the functional characteristics of the symptoms. In OCD, symptoms are experienced as *ego-dystonic*—undesirable, distressing and out of sync with the individual's conscious goals and values. OCD patients generally have insight into this discrepancy.

In contrast, OCPD patients display long-standing traits of orderliness, obstinacy, perfectionism and callous rationality that accord with their values, or are *ego-syntonic* (APA, 2013). Interpersonally, both types tend towards an aloof disposition and constricted affect. Of note, OCPD proper does not feature the "pure" obsessions seen in OCD. In a review of the literature on the two disorders, Wheaton and Pinto (2017) noted areas of divergence along genetic risk factors, neurocognitive profiles, and responses to treatment. Jenike (1991) concluded that OCPD is generally unresponsive to behavior therapy, while a study by Barber et al. (1997) concluded that OCPD and high functioning presentations of OCD respond better to analytic therapy than moderately to highly impaired OCD.

Relevant to this discussion are cultural inclinations towards obsessive-compulsive tendencies. King (2017) delineated the prevalence of 'rituals' in standard child development, highlighting children's inclination towards rules and repetition as a source of comfort. Community-based studies on parents of preschoolers revealed a substantial 75% endorsement of obsessions about self harm, perfectionism, and the "just right" phenomena (Evans et al., 1997). As children grow older, they may engage in rituals such as goodbye ceremonies, repetitive play, and superstitious activities aimed at averting misfortune or exerting influence over their destiny. Developmental theorists speculate that compulsive behaviors serve to alleviate separation anxiety, functioning almost as a means to "force object constancy" (Adams, 1973), particularly as children become increasingly aware of their separateness from caregivers and their insignificance within a vast and unpredictable reality.

Throughout healthy development, these behaviors typically serve normative functions and are eventually relinquished. However, obsessive tendencies often resurface within adult attachment bonds, imbued with a somewhat regressive quality. The "ruminative preoccupation" characteristic of early romantic phases, as described by King (2017), evokes both disquiet and exhilaration. Additionally, McWilliams (2011) noted the prevalence of obsessional neurosis in Western cultures, where emphasis is placed on logical thinking and action over emotional intuition. Scientific rationality, methodical problem-solving, and achievement are valorized, leading to social reinforcement of behaviors such as workaholism and Type A personalities.

Numerous sources indicate a shared etiology between OCPD and OCD. A controlled study conducted by Samuels et al. (2000), involving 72 individuals with OCD and 198 first-degree relatives, revealed a significantly higher occurrence of OCPD within families of OCD patients. Furthermore, case vignettes in psychodynamic literature serve as evidence of the intertwined, and sometimes inextricable, presence of OCPD tendencies within the character profiles of individual OCD cases.

Conversely, documented cases exist of patients initially diagnosed with OCPD who, during the course of treatment, either experience or recall a history of subclinical episodes involving intrusive thoughts and rituals. This aligns with the perspectives of Janet (1904), Freud (1915), and Salzman (1980), who suggested that individuals with obsessive character types may manifest OCD symptoms when their "mature defenses" break down under acute stress. Current data on comorbidity supports this notion, with comorbid OCD in adults with OCPD estimated at 20.9% (McGlashan et al., 2000). Rates of comorbid OCPD among adults diagnosed with OCD range from 23% to 32% (Albert et al., 2004) and rise to 47.3% in treatment-seeking adults (Starcevic et al., 2013).

However, the rate of comorbid OCPD does not significantly differ between OCD and other neurotic disorders (Melca et al., 2015). Additionally, the co-occurrence of any personality pathology with a primary diagnosis of OCD is estimated to be as high as 74% (Torres et al., 2006). Furthermore, some studies have identified a correlation between checking behaviors and OCPD traits, shedding light on shared themes such as future orientation (Nestadt, 1991).

In essence, the psychodynamic perspective offers a qualitative and immersive approach, providing "a vivid description of the subjective world of the OC patient, rather than a fully coherent explanatory theory or road map to therapeutic interventions" (King, 2017, p. 70). Collectively, the psychodynamic literature suggests that OC features are not proprietary to any one diagnostic domain. Through its exploratory lens, psychodynamic treatment may illustrate how longstanding character traits bear on the expression of acute behavioral symptoms.

The Classical Model: Obsessive-Compulsive Neurosis

The publication of Freud's seminal paper on the "Rat Man" (1909) marked the inaugural analytical formulation of "obsessive-compulsive neurosis." Freud portrayed obsessions as conscious manifestations of unconscious conflicts, wherein id-based aggressive or sexual impulses (e.g., aggressive and erotic fantasies) clash with the stringent standards of an unforgiving superego. The ego finds itself embroiled in a dual struggle: one against unacceptable impulses and another against a restrictive superego (Fenichel, 1945). The ego resides at the frontlines of "relentless and unceasing battles between innate impulses and acquired moral demand" (Nagera, 1976, p. 9). Id-based impulses elude the ego's defense mechanisms. Impulses

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"seem constantly to strive for expression and to require an ever-alert vigilance on the part of the ego, which exerts the continuously operating psychological forces of the defenses to keep [the impulses] unconscious" (Nemiah, 1961, p. 120). A quintessential illustration lies in the conflict between the death wish (Freud, 1920) and the instinct for self-preservation. The friction between dissonant psychic forces gives rise to anxiety. Obsessive-compulsive *symptoms* emerge as a *compromise formation,* or a "consequence of causally related psychological forces" (Nemiah, 1961, p. 121). Alas, OCD pathology represents a costly adaptation to a covert conflict.

Regarding etiology, Freud's (1895) initial hypothesis proposed obsessions as "transformed self-reproaches which have re-emerged from repression and which always relate to some sexual act that was performed with pleasure in childhood" (p. 169). Over the ensuing decade, Freud's comprehension of OC phenomena expanded to encompass broader developmental themes of autonomy and control. By 1909, Freud attributed obsessive conflicts over aggression to anal fixations, characterizing the disturbance as a regression to challenges of the anal stage (18 months to 3 years), typically triggered by encounters with the Oedipal situation. His clinical observations revealed anal imagery permeating the speech, memories, dreams, and fantasies of obsessional patients, alongside traits associated with toilet training, such as stubbornness, cleanliness, withholding, punctuality, and control. Other clinicians have also identified anal themes—such as dirt, time, money, and morality—in obsessional content (McWilliams, 2011). Abraham (1923) delineated an anal triad of cleanliness, orderliness, and parsimony. Furthermore, Freud (1909) noted parenting patterns in the histories of OC patients, including coercion into premature bowel control by authoritarian parents. According to McWilliams (2011), experiences of powerlessness and humiliation regarding the inability to control bodily functions fostered a "sphincter morality" (Ferenczi, 1925) in these children. Simultaneously, punitive encounters stirred strong emotions of rage and shame in infants, along with destructive fantasies that were relegated to the unconscious under the directives of authoritative figures.

Numerous scholars have elaborated on Freud's (1909) originally proposed constellation of ego defenses governing OC dynamics (Fenichel, 1945; Nemiah, 1961; Summers & Barber, 2010; McWilliams, 2011; King, 2017). *Isolation of affect* involves separating thoughts from their emotional underpinnings, keeping the content in consciousness while suppressing the associated emotions. *Intellectualization*, *rationalization*, and *moralization* are also prominent defenses in OC processes, regarded as variations of isolation and thus categorized within it. In *reaction formation*, an unacceptable affect, attitude, or intention is reversed and consciously experienced as its opposite. *Displacement* involves redirecting an urge or feeling towards a safer target. *Undoing* occurs when the ego endeavors to redeem itself by seemingly reversing a perceived indiscretion in thought or behavior. *Regression* manifests when a person unconsciously retreats

to a younger state of mind due to feeling unequipped to handle current developmental challenges.

As a byproduct of these defensive mechanisms, a dualism emerges between body and mind. Individuals caught in reaction formation distrust their biological drives, seemingly opting to "renounce what is natural for what is socially acceptable" (McWilliams, 2011, p. 286). For instance, counter-dependent behavior masks feelings of rage stemming from unmet dependency needs, while strict adherence to rules conceals an underlying desire to rebel. This dichotomy extends to their perceptions of others. In cases of obsessive pathology, the mechanism of regression entails the separation of feelings of love and hatred, which were not adequately integrated during development (Gabbard, 2014). Ugazio et al. (2015) explored semantic polarities present in the subjective experiences of OCD patients and identified themes such as innocence-guilt, disgust-pleasure, good-bad, dead-alive, abstinence-corruption, and self-sacrificing-taking advantage. Overall, the emotional landscape of OCD is characterized by ambivalence and a persistent sense of doubt regarding the integrity of one's thoughts and the intentionality of one's actions.

Lastly, magical thinking—a contemporary iteration of Freud's (1909) concept of *omnipotent control*—features prominently in many presentations of OCD. Within OCD, the overvaluation of thought (and thinking) represents a double-edged sword. On one hand, logical reasoning provides solace amidst internal chaos and external turmoil. The experience of omnipotent control arises when thoughts are imbued with mystical causative powers. The superstitious rationale behind mental rituals implies that one can influence their destiny by deliberately entertaining the "correct" thoughts.

Conversely, unwanted "intrusive" thoughts are attributed equal causative power in the minds of OCD patients. Ironically, patients feel a loss of control at the mercy of their own thoughts. Rituals are attempts to regain control by undoing the (involuntary) act of thinking (intrusive) disturbing thoughts. Hence, magical thinking governs the interplay between obsessions and compulsions. Some writers classify magical thinking as a defense mechanism (King, 2017). *Omnipotent control* might be a surrogate for security, buffering against the helplessness induced by life circumstances truly beyond one's control. Rachman and Hodgson (1980) regarded compulsions (i.e., to assert control over mundane matters) as attempts to manage life problems that were felt to be insurmountable.

Core Psychodynamic Problem: Obsessionality

Obsessionality is a broad term subsuming obsessive-compulsive dynamics, symptoms and traits. Summers and Barber (2010) conceptualized obsessionality as one of six major "psychodynamic problems," with their formulation revolving around warded-off anger, epitomized in the defense of *isolation of affect.* Specifically, individuals with obsessional

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tendencies often grapple with conflicted feelings about anger due to its perceived association with aggression (Salzman, 1968). Research by Moritz and colleagues (2011) provided evidence for latent aggression in OCD pathology. Intense thoughts, actions, and impulses carry destructive implications, triggering feelings of anxiety and guilt. This conflict over aggression involves a clash between instinctual and counter-instinctual forces (Shapiro, 1965), as well as a struggle between rage at being controlled and fear of punishment (McWilliams, 2011). The experience of shame tends to be more accessible to consciousness compared to other emotions, largely owing to the superego's clout over the psyche. Patients often embrace feelings of shame as a means to uphold their adherence to moral standards.

While it would appear sensible by societal standards to withhold "hostile" emotions, the deployment of obsessional defenses induces a systemic dampening effect on the patient, described in the literature as "affectlessness" (McWilliams, 2011). Defenses inadvertently stifle the depths of feeling. The obsessive person's emotional impairs their ability to engage in intimate relationships, spontaneous play, and intuitive decision-making (Shapiro, 1965). Although their conscientiousness is generally lauded, their intellectual rigidity fetters the more sublime dimensions of feeling—humanity, love, humor, forgiveness, gratitude, empathy and altruism (Summers & Barber, 2010). Emotions are corrupted by the intellect. Their expression of affect is rationalized, moralized and subdued.

As discussed earlier, the exertion of control over behavior, emotion, and thought content is counter-instinctual, as it reflects a lack of trust in one's impulses. Shapiro (1965) noted how the obsessive-compulsive lifestyle leads to a detachment from reality and distorts the individual's sense of autonomy. The person operates with blind allegiance to internal commands ("I should") while forestalling authentic desires ("I want") (Shapiro, 1965). Consequently, their manner of functioning may give the impression of "machine-like living" (Summers and Barber, 2010).

Object Relational Models of OCD

Freud's successors expanded upon his control-centered framework to encompass interpersonal dynamics. Specifically, they correlated the fear of losing control with the threat of losing support from attachment figures (Millon, 2011). In essence, children who later develop OCD internalize the message that failing to restrain their unruly impulses could result in losing support from their caregivers. This mistrust of emotions towards significant others stems from early experiences of helplessness, where caregivers were perceived as *both* protectors and sources of threat (Fromm, 1947).

A meta-analysis conducted by van Leeuwen and colleagues (2020) affirmed a connection between attachment insecurity and OCD. Their findings revealed moderate to large effect sizes for both dimensions of *attachment anxiety* and *attachment avoidance* in OCD symptomatology.

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Similarly, a study on attachment insecurity by Seah et al. (2018) unveiled a significant correlation between higher levels of *attachment anxiety* and the severity of OCD. Moreover, the study indicated that this relationship was partially mediated by self-ambivalence.

Self-ambivalence, as proposed by Guidano and Liotti (1983), emerges from inconsistent attachment experiences, fostering an unstable self-concept (refer to the 'Self Psychology" section below). Children in this category receive both love and support, as well as criticism and rejection; their parents oscillate between being strict and lenient (Guidano, 1987). Due to their parents' lack of attunement, these children cannot rely on them for comfort, leading to a mistrust of both their own needs and their caregivers' capacity to meet those needs. This attachment ambiguity prompts these children to regulate intense emotions through logic, while the absence of validation may cause them to perceive themselves as flawed or undeserving. Consequently, they develop object-relational structures centered on a compensatory quest for redemption. They strive for goodness, embracing ideals of perfectionism, self-control, and an exaggerated sense of responsibility (Guidano, 1987).

Moreover, the attachment literature links parental impingement and intrusiveness with OCD dynamics (Esman, 1989). Through internalization, invasive attachment experiences imprint in the child's mind and later reverberate in the form of obsessive thoughts. Obsessions—"intrusions into consciousness"—felt to be "dangerous" and unpredictable—are reminiscent of caregiver intrusiveness. Compulsions, on the other hand, are a "compensatory rebound" (Rachman & Hodgson, 1980) by which the self haphazardly attempts to ward off intrusions.

A common phenomenon with OCD patients is family entrapment in the symptoms. Most times, family members believe that they are being supportive by accommodating rituals and avoidance. Naturally, loved ones choose to behave in ways to mitigate the patient's distress. Other times, however, the patient coerces family participation in their symptoms. The ensuing dynamics reveal features of the patient's object relations. Gabbard (2001) described an extreme example of an enactment between an OCD patient, family members and hospital staff. Through projective identification, Gabbard's hospitalized patient enlisted his parents and his nurse to carry the mantle of his cleaning rituals. The gravity of his contamination fears compelled those close to him to endorse them. The family's ongoing provision of reassurance was also a form of collusion with the OCD complex. As the illness conquered more territory, both internally and externally, the patient gained in omnipotent control, coming to view others as "narcissistic extensions of himself" which "existed only to respond to his needs…this was highly dehumanizing" (Gabbard, 2001, p. 215). A psychoanalytic treatment successfully targeted the patient's dysfunctional object relations, which were both consequences of and maintenance factors for biologically-based symptoms. The deepening of empathy in the patient coincided with

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a reduction in his OCD symptoms and effectively released his family from an enabling role (Gabbard, 2001).

A common phenomenon among OCD patients is the entrapment of family members in the symptoms. Often, family members believe they are providing support by accommodating rituals and avoidance behaviors. Naturally, loved ones choose to act in ways that alleviate the patient's distress. However, there are times when the patient coerces family members to participate in their symptoms. These dynamics reveal aspects of the patient's object relations.

Gabbard (2001) described an extreme example of this in an enactment involving an OCD patient, family members, and hospital staff. Through projective identification, Gabbard's hospitalized patient enlisted his parents and nurse to engage in his cleaning rituals. The gravity of his contamination fears compelled those close to him to endorse his behaviors. The family's ongoing provision of reassurance was a form of collusion with the OCD complex. As the illness expanded its grip, both internally and externally, the patient gained a sense of omnipotent control, viewing others as "narcissistic extensions of himself" which "existed only to respond to his needs…this was highly dehumanizing" (Gabbard, 2001, p. 215). Psychoanalytic treatment successfully targeted this patient's dysfunctional object relations, which were both consequences and maintenance factors of biologically-based symptoms. As the patient's sense of empathy deepened, there was a concurrent reduction in OCD symptoms, effectively releasing the family from their enabling role (Gabbard, 2001).

Case study findings reveal a robust link between obsessional symptoms and relational ambivalence (Cornelis et al., 2017). The intrapsychic conflict concerning autonomy (Shapiro, 1965), as discussed earlier, extends into interpersonal dynamics, resulting in a tension between dependency needs and a frustrated desire for autonomy. Behaviorally, this tension manifests as a fluctuation between seeking closeness through dependent behavior and seeking autonomy through escape behavior (Cornelis et al., 2017). Consequently, neither dependency nor autonomy is fully realized, and representations of self and others become muddled.

On one hand, individuals perceive themselves as morally defective and undeserving of love, while viewing others as critical, punitive, and overbearing. Conversely, they may see themselves as worthy of love, but only if they adhere strictly to moral standards, with others serving as judges of goodness and providers of conditional support. Attachment ambivalence shrouds relationships with distrust. In emotionally close relationships, obsessive-compulsive people often come across as domineering. They are known to bend others to their will, lest they stir the emotional pot. Moreover, when they find themselves in positions of dependence, their ambivalent fear is triggered. Despite yearning for closeness, they unconsciously reject affection and grant undue authority to nurturing figures, predisposing themselves to feeling controlled. While a sober expression of anger could be an adaptive tool to negotiate boundaries, constructive

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anger is hindered by obsessional defenses, and resentment accrues. Repressed rage is ultimately expressed as passive-aggressiveness (McWilliams, 2011).

Malan's (1979) object-relational model of OCD elaborates on the classical model by accentuating the affective substrata at play. Malan viewed psychological phenomena as physical forces with energy potentials. In Malan's *conflict about feelings*, a *natural feeling*, such as anger, is perceived as a threat to the person's object relations, and thus evokes an *inhibitory feeling*, such as anxiety. The expression of a natural feeling is squelched to avoid a painful emotional consequence, such as being shamed. The natural emotion is confounded, and the remaining emotional energy is converted into a psychological symptom. The symptom is a *compromise formation*, which gives a subsidiary outlet to the natural feeling while averting an adverse interpersonal (and emotional) outcome. Affective conflicts are enacted interpersonally and susceptible to *repetition compulsion*. The interpersonal feedback loops both engrave and sustain symptomatic dynamics.

Malan's (1979) object-relational model of OCD expands upon the classical model by emphasizing the underlying affective processes. Malan conceptualized psychological phenomena as akin to physical forces with energy potentials. In Malan's framework, conflicts about feelings arise when a *primary* emotion, such as anger, is perceived as a threat to one's object relations, prompting the emergence of *inhibitory* emotions, such as anxiety and shame. The expression of the primary emotion is suppressed to avoid potentially painful consequences, such as being humiliated. As a result, the natural emotional response becomes distorted and channeled into a psychological symptom. This symptom serves as a compromise, providing a makeshift outlet for the suppressed emotion while preventing adverse interpersonal and emotional outcomes. These affective conflicts often manifest interpersonally and can become entrenched through repetition compulsion. The feedback loops existing in interpersonal dynamics serve to both reinforce and perpetuate symptomatic patterns.

Emotional experiences are born from, defined, and matured through attachment bonds (Bowlby, 1980). The individual's drive for self-preservation both complements and competes with their drive to preserve relationships. Within relationships, *constructive aggression,* as described by Malan (1979), serves to safeguard the self by fulfilling various functions. These include expressing personal needs and desires, voicing anger when these needs are unmet, taking proactive steps to meet one's needs, establishing personal boundaries, articulating disagreement, acknowledging others' limitations, navigating feelings of ambivalence towards others, asserting autonomy, disengaging from others when necessary, and expressing sexual desires (Greenberg, 2022).

According to Malan (1979), natural emotions must seek outlets for expression, even if these channels distort them. Failure to express constructive aggression effectively can have

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detrimental consequences for both the individual and their environment. The fear of expressing aggression is often linked to the risk of losing attachment relationships, evoking fears of death, abandonment, loss of support, affection, care, shame, and rejection (Greenberg, 2022). When feelings of constructive aggression are perceived as threatening to attachment bonds, they may manifest in symptoms such as those seen in OCD (Malan, 1979). In OCD, obsessions serve as symbolic expressions of these suppressed feelings. Common examples among OCD sufferers include the fear of acknowledging anger towards loved ones, acknowledging ambivalence about an important relationship, or admitting their boundaries have been violated (Greenberg, 2022).

Several developmental factors contribute to attachment ambivalence, including early loss and interactions with caregivers who exhibit various behaviors. These behaviors may include being overburdened and unable to meet the child's needs, emotional instability, responding with retaliation to expressions of anger, feeling overwhelmed by intimacy, relying on denial to cope with life's uncertainties, feeling threatened by the child's emerging autonomy, withdrawing attention in a contemptuous manner, threatening abandonment, or punishing the expression of certain feelings via rejection (Greenberg, 2022).

Finally, a psychodynamic formulation of OCD reframes the cognitive-behavioral notion of "feared outcomes" (Foa & Kozak, 1986) as "core fears" about unforeseen emotional distress (Greenberg, 2022). Greenberg argues that although patients can pinpoint concrete feared outcomes, what they are truly afraid of is the emotional distress associated with those outcome. Examples of such emotional states include re-experiencing feelings of helplessness or 'being trapped' due to trauma, feeling contaminated or "not right," experiencing isolation, ostracism, or abandonment, feeling rejected, unmoored, or disoriented, feeling ashamed, inferior, or worthless, and feeling vulnerable to potential loss of attachment (Greenberg, 2022). OCD obsessions hinge upon the *possibility* that the person may inadvertently bring upon themselves a state of prolonged emotional suffering. Therefore, compulsions and avoidance behaviors are preemptively performed as measures to prevent such torment.

Self-Psychology

The Wounded Self Model of OCD. The self-wounds model of OCD (Wolfe, 2006) integrates self-psychology with cognitive theories. The tripartite model of disorder maintenance involves: (a) avoidance and ritualizing to temper anxiety-provoking thoughts, (b) obsessive catastrophic *cogitating* about the symptoms and (c) the unconscious perpetuation of self-wounds (Wolfe, 2006). Since intrusive thoughts are not subject to volitional control, attempts to suppress, neutralize, or distract from them tend to backfire. Paradoxically, actively avoiding these thoughts only amplifies their recurrence. Compulsive behaviors serve to neutralize the perceived threat posed by obsessions, albeit temporarily. However, the respite is short-lived, as distressing thoughts inevitably resurface. Central to this cycle is an unexamined self-wound—a profoundly

painful self-perception that fuels engagement in the OCD cycle. As stated in the previous section, self-views common to OCD patients are of being morally corrupt, evil, or irredeemably bad. The OCD complex is governed by ideals, as if the striving for perfection could compensate for the suspicion that one is constitutionally flawed. Even minor mistakes are interpreted as evidence of fundamental character defects, leading to extensive efforts to conceal these painful self-images from others. Relinquishing obsessive-compulsive coping strategies would entail confronting these self-wounds. The perceived consequences are both internal (accepting a negative view of self) and external (potential punishment, rejection, or abandonment by others if they endorse this view). Suppressed emotions such as rage, disgust and shame are likely to surface in this process (Wolfe, 2006).

These views of self are rudimentary because they crystallized at a very early stage of cognitive development. Wolfe (2006) theorized that parental shaming for small mistakes can instill beliefs that a child is bad, untrustworthy, and dangerous. These messages are internalized as self-wounds. Under stressful circumstances, self-wounds are activated and yield obsessional thoughts. Meares (2001) posited that painful self-images result from underdeveloped boundaries of self. Overprotective caregivers impede the natural experimentation, testing of limits, and exposure to risk needed for children to form proper self-boundaries. Early inhibitions may also contribute to the chronic doubt, thought-action fusion and conflict over autonomy discussed in previous sections. Such children are susceptible to heightened separation anxiety, which coincides with the developmental stage characterized by *primary process thinking* (Freud, 1900). Faced with the pressures of individuation, children *identify* with the omnipotence formerly ascribed to their parents (Klein, 1932). In OCD, omnipotence of thought outlives this infantile stage via obsessions, which fuse thoughts and actions. Magical thinking is preserved through ritualizing, which is selected for based on its effectiveness in soothing early anxieties.

The Ambivalent Self Model of OCD. As referenced in the section on 'Object Relational Models of OCD' above, Guidano and Liotti's (1983) *self-ambivalence* model suggests that individuals who experienced ambivalent patterns of attachment in childhood go on to develop a fragile and unstable self-concept. This implies that individuals who experienced simultaneous rejection and validation during childhood may grapple with uncertainties about their self-worth, particularly regarding their moral integrity and capacity for being loved. Individuals with OCD are particularly sensitive to intrusive thoughts because these activate their "feared self," which is fraught with distrust and (pathological) doubt about what kind of person they are. Their strong need for certainty compels them to frantically obsess over a "true" self-definition. Likewise, they perform compulsions to disprove their suspicions of badness and pursue perfection to attain a more positive self-image. Hence, the model suggests that the cognitive schemas of perfectionism and an inflated sense of responsibility emerge as means to resolve self-ambivalence.

Treatment Considerations

The first-line treatment for OCD is a combination of selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT) (McKay et al., 2015). However, this prescription is a far cry from being a viable cure for OCD. For CBT, response rates are variable, ranging from 50-70%, remission rates range hover around 25%, and relapse rates are estimated at 20% (O'Neill & Feusner, 2015). Exposure and response prevention (ERP) is the most effective treatment for OCD, but 25% to 30% of patients discontinue therapy early. Among those who continue, approximately 80% experience a positive response, but more than 20% do not respond effectively. Consequently, about half of OCD patients referred for ERP do not show significant improvement (Abramowitz, 2006). ERP in an intensive format has the lowest rates of relapse, but compliance is a challenge and drop-out rates are very high (Foa & Kozak, 1996). In a meta-analysis, the combination of behavior therapy and SSRIs was superior to SSRIs alone, but not to behavior therapy alone (Romanelli et al., 2014); while non-responders to behavior therapy benefited significantly more from an SSRI compared to cognitive therapy (van Balkom et al., 2012). In broad strokes, these findings reveal inadequacies in mainstream OCD treatments.

The comparative OCD treatment literature suggests that psychodynamic therapy typically does not reliably alleviate overt symptoms of OCD, while CBT treatment tends to address only surface-level symptoms, often overlooking the emotional and interpersonal roots of the disorder.

Although there are no randomized controlled trials specifically evaluating psychodynamic therapies for OCD, qualitative support for these approaches proliferates in the psychodynamic literature (Leichsenring & Steinert, 2017). Psychodynamic therapy is generally indicated for mild to subsyndromal forms of OCD, and especially for patients with good insight (Summers & Barber, 2010). A case study by Kay and colleagues (1996) illustrated how psychodynamic therapy helped an OCD patient who did not respond to first-line treatment. Notably, the authors inferred that psychodynamic factors might contribute to treatment resistance in OCD patients. A patient's unconscious investment in his symptoms can both undermine a therapist's efforts and lead the patient to sabotage his own treatment. For example, in relationships, interpersonal control, distancing, or bids for special treatment procure secondary gains for patients. This phenomenon is epitomized in family accommodations for rituals. Such insights can guide relapse prevention strategies and increase understanding of the interpersonal stressors that often precipitate OCD flare-ups.

Malan (1979) was the first to advocate for integrating behavior therapy with dynamic therapy. In 2006, Connors proposed an assimilative approach, integrating symptom-focused interventions into a psychodynamic model based on the degree of the patient's symptomatic impairment. Connors reasoned that patients presenting with highly distressing symptoms do not possess the emotional bandwidth to engage with process-oriented therapy. It behooves a well-

attuned therapist to do something to help alleviate acute suffering. A review of outcome research found that insight-oriented therapies are predictive of positive outcomes only when tailored to the patient's presenting problems. Mastery and problem-solving showed a stronger association to outcome than insight and self-exploration (Whiston & Sexton, 1993). Accordingly, symptom management is increasingly prioritized by psychodynamic clinicians. Proponents of active techniques used to expedite symptom relief abound in the psychodynamic literature (Ferenczi, 1927; Watchel, 1977; Gill, 1994; Frank, 1999; McCollough, 2001; Connors, 2006).

Notwithstanding, an initial course of dynamic therapy can make a patient more pliable for behavioral interventions. A patient's responsiveness to behavioral interventions increases in the presence of an empathically attuned therapist that is also invested in the patient's subjectivity (Johnson et al., 1987). Furthermore, a psychodynamic backdrop allows for the exploration of process variables influencing a patient's response to symptom-focused techniques, such as unconscious resistance to change and transference-countertransference dynamics. Decades ahead of behaviorists, Freud (1919) encouraged an active approach to obsessions and phobias, instructing patients to relinquish avoidance and directly confront their "feared situations." Contemporarily, object-relational clinicians leverage the therapeutic relationship as a medium for in-vivo exposure to interpersonal fears. The therapist is like an "object" of exposure. When working in the transference, patients are *exposed* to defended-against feelings projected onto the therapist, but also triggered by the therapist. These feelings are met with novel, validating feedback from the therapist. This exchange, referred to as a *corrective emotional experience*, induces the proper assimilation of disowned affect and dislodges ingrained, maladaptive expectations of self and other (Alexander & French, 1946).

Interestingly, a series of case studies on concurrent psychoanalytic and behavior therapies for OCD described synergistic effects between the modalities (Segraves & Smith, 1976). In all three cases, the rapid symptom reduction achieved through behavioral interventions unlocked associations ingrained in the patient's unconscious subjective organization. Contrary to popular belief, symptom removal did not beget symptom substitution. Unencumbered by energy-usurping obsessions, patients were optimally positioned to integrate unconscious material in the concurrent analysis. The researchers concluded that behavior therapy can serve as a catalyst for the work of subjective reconfiguration intrinsic to psychoanalysis. In similar vein, Frank (1992) described a dialectic between behavior change and insight—the renunciation of maladaptive symptoms corresponds with the loosening of defenses, and each proceeds in complementary fashion. As illustrated in the case studies, OCD symptoms are the tip of a complex iceberg.

The themes of transference-countertransference unique to OCD patients emanate from their conflicts around anger, autonomy, dependence and control (Gabbard, 2001). Common transferences are to view the therapist as a judgmental parent, whom they feel dependent on,

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controlled by, and resentful of. They fear retaliation as much as they dread separation from the therapist. Countertransference experiences include impatience, irritation, a wish that the patient just admit to their actual feelings, and boredom (McWilliams, 2011). It can be tempting for either party to enact a power struggle. Through reaction formation, OCD patients may consciously comply while unconsciously resisting. They may give off an undertone of hostility that is diligently concealed by a deferential demeanor. Typically, patients will present as serious, committed, responsible, and conscientious (McWilliams, 2011). However, they may ultimately seek to dominate the therapy and therapist, or engage in rebellious behaviors to counteract the *feeling* of being controlled (Summers & Barber, 2010). Before repressed affect can be elicited and worked through, moralistic and rationalizing defenses, designed to protect patients from their shame about *feeling,* must be thoroughly penetrated (McWilliams, 2011). Interpretations with this population should be carefully timed and cushioned with empathy (Summers & Barber, 2010). Treating OCD patients dynamically provides valuable training in distinguishing *intellectualized* insight from *emotional* insight and consistently challenging intellectualizing defenses.

In working with OCD patients, pathological doubt can permeate the treatment in uncanny ways. A hallmark feature is ambivalence about change (Lang, 2015). For instance, patients can experience suspicion that their case is distinctly untreatable, that they do not in fact have OCD but have made up their illness to obtain sympathy, or a belief that they are "deranged" (Penzel, 2017). Others present with a cynical attitude towards the therapy, such as distrust of the therapist. Suspicions about treatment effectiveness can belie a "fear of the treatment working" and puncturing the OCD complex.

Short Term Psychodynamic Psychotherapy (STPP) for OCD

A Manual-Guided STPP Approach for OCD: Treating the "Inhibited Rebel"

The model employed in the present case study is Leichsenring and Steinert's (2017) manual-guided short-term psychodynamic psychotherapy (STPP) approach designed for a primary diagnosis of OCD. The treatment program is empirically derived, and interventions are based on Luborsky's (1984) supportive-expressive (SE) therapy. The assessment phase spans 5 sessions and includes phenomenological and psychodynamic diagnostic methods. The treatment phase accommodates up to 24 sessions, comparable to CBT protocols for OCD. The treatment includes early, middle, and late phases, which encompass socialization to therapy, relapse prevention, and a formal termination process. Up to 3 "booster sessions" can be scheduled biweekly to phase out.

The treatment's architecture is liberal, featuring 12 thematic modules, as opposed to regimented guidelines for each session. The modules cover the essentials of SE therapy and the

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Core Conflictual Relationship Theme (CCRT) formulation as applied to OCD, with special emphasis on the therapeutic alliance. The manual incorporates OCD-specific elements drawn from Lang's (1997, 2015; Lang & Koepsell, 2004) work: addressing ambivalence, unbinding thoughts and actions, tempering the superego, discussing existential issues, and a psychodynamic variant of in-vivo exposure to obsessive fears, as originally prescribed by Freud (1919). The manual's guidelines encourage therapists to apply supportive techniques at a minimum and expressive techniques at a maximum, to adopt a more active stance than in psychoanalysis, and to rely on the CCRT formulation as the backbone of the treatment. Emerging symptoms are continuously linked to the patient's CCRT scheme. Treatment goals are limited to symptom relief and minor characterological change.

A Psychodynamic "Manual": Applicability & Rationale

Grounded in theory, a manual serves as a framework for understanding clinical problems and prescribing effective interventions. Unlike the literature, which is riddled with abstraction, a manual stands in the gap between theory and technique, making it a valuable didactic tool. The instructional layout of the manual "offers rules that provide the therapist with an objective basis for interpretive responses at any stage" (Luborsky, 1984, p. 179). Therefore, a deliberate adherence to a manual should enhance therapist fidelity to technique. Research indicates a positive correlation between therapists' adherence to prescribed techniques and treatment outcomes (Luborsky, 1984). Furthermore, manuals provide the necessary structure to achieve disorder-specific goals within a designated timeframe. This time-limited format promotes efficient use of session time, resulting in cost-effectiveness. Additionally, manuals play a vital role in therapist training by systematically organizing interventions, establishing practice standards, and defining benchmarks to assess proficiency.

Psychodynamic manuals are generally less prescriptive and more principle-oriented than traditional therapy manuals. The merit of a psychodynamic manual lies in its ability to encourage therapist adherence to theoretical guiding principles, thereby predicting a more effective delivery of treatment and improved treatment outcomes (Luborsky, 1984). However, aspiring psychodynamic clinicians should heed the limitations of treatment manuals. While manuals can inform clinical decision-making, their prescriptions, rules, and injunctions should not be regarded as dictatorial or universally applicable. They should not replace clinical judgment, which is sensitive to patient characteristics, contextual factors, and the immediacy of the clinical encounter.

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A manual is akin to a map of the terrain; therefore, it should be used as a guidepost along with the navigational tools of existing theoretical knowledge, clinical experience, and expert supervision. Manuals are circumscribed by design; their myopic focus can overlook the intricacies of the therapeutic process. While they do confer a certain comfort in reliably conquering narrow-margin goals, their parameters can equally elicit frustration in both therapists and patients with more ambitious treatment goals (Connors, 2006). Temporal constraints can limit the latitude of interventions, the spontaneity of the therapist, and the potential depth of the therapeutic relationship. Lastly, manualized treatments are notoriously unequipped to uproot the structural issues that often pervade every inch of a patient's interpersonal life.

Leichsenring and Steinert (2017) provide a compelling rationale for a manualized approach to short-term psychodynamic psychotherapy (STPP) for OCD. Firstly, they cited neurobiological findings on abnormalities in the brain's ability to inhibit processes mediated by the cortico-striatal-thalamic-cortical circuits from "intruding into consciousness" (Stein, 2002). This finding supports the psychodynamic notion of "unconscious threatening impulses" surfacing through obsessions. Secondly, they highlighted the nearly ubiquitous connection between the unconscious meanings of OCD symptoms and attachment functioning (Lang, 2015), underlining the relational aspect of their approach. Additionally, their model acknowledges the influence of dysfunctional *mental representations* in OCD (Kempke & Luyten, 2007), comparable to *cognitive distortions* addressed in CBT. While cognitive-behavioral models primarily target conscious cognitions, the STPP model addresses *both* conscious and unconscious representations. Leichsenring and Steiner's (2017) STPP for OCD manual is "empirically derived" from existing evidence supporting manualized STPP for other anxiety disorders (i.e., social anxiety disorder and generalized anxiety disorder) (Leichsenring et al., 2015).

Principles of Supportive-Expressive (SE) Therapy

Supportive-expressive (SE) therapy stands out among psychodynamic modalities due to its robust empirical foundation (Leichsenring et al., 2015). This therapy has been effectively tailored for the treatment of anxiety disorders (Crits-Christoph et al., 2005). The original STPP manual introduced a competence framework for SE therapy, operationalizing the knowledge, skills, and objectives involved (Luborsky, 1984; Book, 1998). At the core of SE therapy is the aim to bolster the patient's sense of mastery over ongoing interpersonal challenges. Luborsky's (1984) model operates on a continuum of supportive to expressive interventions. Supportive techniques build ego functions for patients whose internal resources are lacking, while

expressive techniques deconstruct ego defenses and foster insight. Expressive techniques involve interpretations linking the patient's symptoms to their core relationship theme, particularly effective when therapists work in the transference. The correct ratio of supportive to expressive techniques varies by case and is predicated on the individual patient's needs. Luborsky's original STPP manual includes an addendum featuring rating scales for therapists and patients, enabling measurement of adherence to various distinctive characteristics of SE therapy.

The Core Conflictual Relationship Theme (CCRT) Method

The Core Conflictual Relationship Theme (CCRT) method is a complex and systematic approach to case formulation. It is rooted in the object-relations school, as it links interpersonal patterns of relating with intrapersonal conflicts. A CCRT is a prototype of an adult's primary conflicts in relationships, the themes of which can be traced to early stages of development. The CCRT is derived by analyzing a series of discrete relationship episodes (REs) told during therapy sessions, from which an overarching wish [W], a response from other (the "object") [RO], and a response of self [RS] are extracted. The scoring method captures the pervasiveness of each type of component across a patient's narratives (Luborsky & Crits-Christoph, 1998).

The CCRT has garnered ample empirical support and is considered among the most psychometrically sophisticated measures of central relationship themes, with excellent reliability and validity figures (Luborsky & Barrett, 2007). CCRT components have also demonstrated significant stability over time and across relationships (Fried et al., 1990). Crits-Christoph et al. (1988) tested the reliability of the CCRT formulation method in psychotherapy sessions with a sample of trained clinicians. They obtained weighted K values ranging from 0.61 to 0.70 for interrater agreement in identifying patients' wishes, responses from others and responses of self. Moreover, the CCRT has strong convergent validity with comparable measures of transference and central relationship themes (Luborsky, 1988).

Theoretically, the CCRT *measure* intended to operationalize of Freud's (1912) "transference template." Freud's (1912) theory of transference proposed that people impute onto every new relationship the remnants of unfulfilled longings, frustrated wishes, and past expectations (i.e., drive derivatives). These transferred elements manifest as repetitive, stereotyped themes, largely occurring outside of conscious awareness. Transference mechanisms are governed by procedural knowledge about social rules and skills, a type of implicit processing (Kihlstrom, 1987). The CCRT method taps into the unconscious components of transference schemas. Founded on Freud's (1912) transference theory, the CCRT construct is predicated on four critical assumptions: (1) early interactions with caregivers instill expectations and forge

patterns of relating that become generalized to other relationships, (2) the persistence of wishes is based on biological impulses to gratify attachment needs, (3) conflictual dynamics are sustained through an unconscious proclivity to reenact traumatic, emotion-laden themes in relationships ("repetition compulsion;" Freud, 1920), and (4) the reenactment of these themes serves the ultimate goal of mastering core conflicts (Luborsky & Crits-Christoph, 1998).

The CCRT possesses several properties that render it a robust and versatile clinical instrument (Luborsky & Crits-Christoph, 1998). Luborsky and Crits-Christoph (1998) advocate for supplementing DSM diagnoses with CCRT data, thus making CCRT formulations applicable to goal setting, treatment planning, and treatment monitoring. That is, its diagnostic utility in psychodynamic practice is notable. The CCRT's structure is adept at unraveling the systematic nature of conflicts underlying a symptom. With this insight, the origins of symptom manifestation can be retraced within an individual's interpersonal history, whether stemming from conflicts between desires or between the patient's desires and expected responses from others. Luborsky's (1996) *symptom-context method* employs the CCRT to monitor symptom antecedents in real-time during a session. Of note, the CCRT formula relies predominantly on empirical observation, with minimal inference involved in categorizing the thought units directly articulated by the patient. Multiple studies indicate that CCRT themes align with DSM diagnostic categories and are correlated with defensive functioning (Luborsky & Barrett, 2007). Cierpka et al. (1998) discovered that a higher pervasiveness of CCRT components (such as increased conflict frequency, more negative ROs, and fewer positive RSs) in patient narratives correlated with greater psychiatric severity.

Psychotherapy is an interpersonal enterprise. Research indicates that the same standardized CCRT pattern is likely to manifest in the patient's relationship with their therapist (Fried et al., 1990). In this vein, establishing a baseline, overarching CCRT enables the prediction of transference and countertransference themes. Moreover, the CCRT method facilitates the monitoring of the patient-therapist interaction quality from one session to another, allowing for comparison against the patient's overall CCRT. One of the primary mechanisms of change in psychodynamic therapy is the therapeutic relationship. Luborsky (1984) contends that therapeutic progress correlates closely with a patient's growing awareness of their dynamics with the therapist. Research also suggests that the therapeutic alliance is significantly strengthened by the therapist's attunement to the patient's CCRT, which unveils potential cues for resistance as well as collaboration opportunities (Luborsky & Barrett, 2007).

The CCRT is a mainstay of supportive-expressive (SE) therapy. The goals of SE therapy are (1) to increase the patient's awareness of the CCRT and (2) to master the problems within the CCRT. The fulfillment of these goals has a direct effect on symptom expression (Luborsky, 1984). In his writing on the science of psychodynamics, Malan (1979) proposed four conditions ("Koch's Postulates") to test the accuracy of an interpretation of a specific symptom:

> (1) Events in the patient's life are precipitating factors that point to the nature of the conflict underlying the symptom. (2) A detailed mechanism can be clearly formulated whereby the symptom represents or expresses the conflict. (3) Interpreting this mechanism brings the conflict clearly into consciousness. (4) This results in the disappearance of the symptom. (p. 107)

Successful SE therapy depends on an accurate CCRT formulation to accurately inform the therapist's *interpretative focus* (DeLaCour, 1986). The "meaning-making" process of interpretation has an empirical basis—it is neither haphazard, nor purely speculative, nor does it claim fundamentalism.

A study by Crits-Christoph, Cooper and Luborsky (1988) found that the appropriateness of therapists' interpretations, based on the patient's CCRT formulation, was significantly related to outcomes of dynamic psychotherapy. Crits-Christoph, Barber and Kurcias (1993) found that accuracy of CCRT-based interpretations was associated with the deepening of the therapeutic alliance over the course of therapy. Throughout treatment, CCRT feedback is constantly incorporated to hone and maintain the interpretative focus (Luborsky & Crits-Christoph, 1998). Countertransference data must be incorporated judiciously—through the lens of the patient's established CCRT. The authors suggest that therapists test their interpretations for convergence with the CCRT formulation, endeavoring to improve the accuracy and timing of interpretations, as well as minimizing the potentially distorting influence of countertransference.

As a qualitative measure, the CCRT plays a crucial role in assessing therapy outcomes (Luborsky & Barrett, 2007). While quantitative measures of symptom reduction capture an important aspect of therapy outcomes, progress can also be gauged through reductions in the prevalence of CCRT components (Cierpka et al., 1998), shifts in CCRT patterns observed in therapist-patient relationship episodes (Luborsky & Crits-Christoph, 1998), and enhancements in self-understanding of the CCRT, which open new pathways for responding to conflict. All of these contribute to mastering dysfunctional patterns. Research has shown that mastery of interpersonal conflicts in psychotherapy is significantly associated with quantitative outcomes (Grenyer & Luborsky, 1996).

CCRT data can be gathered across multiple therapy sessions, such as through narratives obtained from an unstructured intake interview. Alternatively, the Relationship Anecdotes Paradigm (RAP; Luborsky, 1990) interview offers a more structured approach, aiming to elicit

numerous relationship episodes within a single session. Research indicates that both methods provide valuable data for CCRT scoring (Barber et al., 1995). Moreover, reliable data collection methods involving direct patient input include the CCRT Self-Report Questionnaire and patients' live, self-interpretation of their CCRT during sessions (Luborsky & Crits-Christoph, 1998).

4. ASSESSMENT OF THE PATIENT'S PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

Serena was a 28-year-old, Cuban-American, cisgender woman who presented to treatment plagued by "foreign thoughts entering [her] mind uninvited" which "barked orders at [her]" and made her feel as if she were "living under an invisible tyrant." Serena disclosed that she experienced intrusive thoughts about driving into oncoming traffic and jumping off her balcony. Other times, she became transfixed by horrific images of her dead body, swollen from drowning, or battered from blunt force trauma. When shaving her legs, she thought about slicing her skin with the razor; when handling appliances, she thought about electrocuting herself and inducing cardiac arrest. Every month, it seemed that her brain concocted novel ways to injure herself, some potentially lethal, and pitched these ideas to her unabashedly.

Serena specified that her aggressive thoughts were ego-dystonic, meaning that she had no conscious desire to harm herself. Nonetheless, she felt a gnawing sense of doubt about whether she would, one day, lose control and act on these thoughts. Despite her best efforts to resist these thoughts, they came back with a vengeance. Reportedly, she would ruminate for several minutes up to several hours, ensnared in a trance-like state where she lost track of time, where she was and what she was doing. Meanwhile, her physical symptoms of anxiety intensified. She endorsed shortness of breath, hot flashes, and heart palpitations.

During obsessive episodes, Serena felt compelled to interrogate herself, searching for hints of volition in her mind, *checking* (mental compulsion) to corroborate the valence of "her true intentions." Serena also disclosed that she engaged in behavioral compulsions to appease the tyrannical voices in her head, which involved "taking tiny risks to provoke a fear response," a ritual that reassured her that she would indeed back away from imminent danger. For example, while driving, she experienced urges to close her eyes and quickly open them; at home, she would touch the blade of a knife, or the aperture of a socket, and quickly pull away. She reported that the sudden jolt of fear soothed her. Her compulsions were a "quick fix" for obsessive doubt. Moreover, she stated that if she tried to resist these urges, her thoughts foreboded catastrophe. These superstitious threats took the form of "if you don't touch the stove right now, then your parents will die in a car accident." Serena reported she felt responsible for preventing tragedy from befalling her family, claiming that the guilt would be intolerable for her if something ever

happened. Moreover, if prevented from carrying out her compulsions, she became preoccupied with the *unknown likelihood* ("what if?") that she would inadvertently act on her self-injurious obsessions in the future. By disconfirming what she said was a "perverse wish to harm [herself]," she felt a provisional sense of safety and control.

Most of the time, the obsessive thoughts and compulsive urges struck when Serena was alone or unattended to and let up in the presence of others. Serena explained that her mother and fiancée knew that she suffered from anxiety, but they were not privy to her "diabolical thoughts." Nonetheless, she described what seemed to be reassurance seeking compulsions, yet these behaviors were covert, often unnoticed by others because they were so ingrained in her patterns of relating. She admitted to feeling shame about having perverse thoughts and feeling "weak for succumbing to them every time."

Further, Serena traced the onset of her OCD symptoms to her early 20s, right around the time she graduated from college. In the years that followed, her symptoms were mild enough that she managed to accommodate her lifestyle around them. She developed habits like avoiding solitude when handling certain appliances, hazardous cleaning products, or using a knife (she even removed sharp knives from her home). Despite tolerating certain solo activities, like shaving, with distress, she confessed to fearing spending too much time alone.

In the last four months, the distress associated with her symptoms reached a critical point, and her level of impairment in work and social functioning had become clinically significant. Of note, Serena denied suicidal ideation, intent, or plan at the time of treatment. She did, however, endorse a long history of passive suicidal ideation, of a fleeting nature and occurring on about four occasions per year. Serena denied current or past suicide attempts and non-suicidal self-injury. In assessing risk, it was imperative to differentiate aggressive obsessions from suicidal or self-injurious ideation. Although Serena experienced thoughts about harming and possibly killing herself, it is critical to note that these thoughts were disturbing to her and in contrast to her personal value system, which is characteristic of the harm subtype of OCD.

Psychosocial, Developmental, & Family History

Serena was born in Havana, Cuba during the height of an economic crisis that followed the collapse of the Soviet Union in 1991. Civil unrest grew in proportion to rampant shortages in food, medicine and transportation, as the regime stepped up surveillance and censorship tactics. The Maleconazo riots marked the peak of the depression and culminated in the 1994 Cuban Rafter Crisis, a mass exodus of civilians risking their lives to flee economic hardship. Serena and her parents were *balseros,* or rafters, who made the treacherous 90-mile journey from Havana to South Florida. After a harrowing 12 days at sea, they landed on U.S. soil as refugees. Serena was only 4 years old at the time. She claimed to have a vague recollection of the ordeal.

During the family's resettlement in South Florida, Serena learned about her father's history. He had been a prisoner of the Cuban penal system. His was a case of *arbitrary arrest* for suspected political dissent. As an esteemed professor of literature, he protested restrictions on freedom of expression and promulgated democratic ideals. Although he was modest, he was steadfast and unapologetic in his activism. He was detained for political dissent. Serena reported that his incarceration "silenced his spirit" and "stripped him of dignity"—he was interrogated, stripped of his possessions, medicated against his will, and sentenced to abject squalor for 2 years. This period transpired during Serena's infancy. Allegedly, Serena's mother coped through disbelief—she refused to think about her husband, never spoke a word about him, and reinvested her emotional energy into her daughter's upbringing. She became wholeheartedly devoted to Serena. Thrust by her imagination, she resolved to manufacture a world devoid of pain—one she would will her daughter to inhabit. Once released from captivity, Serena's father cajoled his wife to venture with him on a makeshift raft into the wild seas, toward the promise of a better life.

Against many odds, the couple accomplished an implausible deed, and one that reunited them—to raise their daughter in a land with democratic rights. The suffering of the past was actively disavowed in the household. In their efforts to assimilate to American culture, Serena's parents made meager attempts to preserve their cultural ties. Given their traumatic experiences back home, they found solace in reinventing themselves in a country whose values aligned more with their own. They desired autonomy, and they were driven to unfetter themselves from the corruption that bred them. According to Serena, they identified with the dominant American culture and rejected the ideas of solidarity propagated in migrant communities. As soon as the family earned permanent resident status, they moved away from migrant hub of South Florida. They relocated many times during Serena's development. As Serena put it, "…after my parents fled Cuba, they never stopped fleeing…they never settled."

In reflecting on her childhood, Serena said she felt embarrassed about the cloak of silence her parents draped over their migration history. Serena remembered how her early curiosity on the topic was subdued by her parents' authoritarian style. It wasn't until her late teens that she learned the details of her father's ordeal and began to patch the gaps in her narrative. In college, she pursued a double major in Sociology and Latin American Studies. Because her parents valued education, academia was a "safe place" to search for personal edification. College afforded a structured environment for the exploration of her heritage while also providing a *sublimation* conduit for her anger, and grief, about a fragmented cultural identity. As a young adult, she reconnected with Cuban relatives she had been estranged from for most of her life. Fortuitously, she met a man who shared her background—her current fiancée—and through her relationship with him she continued to reconcile her history and reclaim her cultural values.

Their connection offered Serena a newfound sense of belonging and enrichment, despite later complexities arising from gender dynamics within their relationship.

Reportedly, Serena's fussy and hypersensitive temperament proved to be a persistent challenge for her mother, testing the limits of her patience and giving way to frequent scolding. Her mother was rigid in her expectations of Serena. She punished displays of emotion with unrestrained criticism. Overall, Serena characterized her parents as domineering and overprotective. Still, she felt that they genuinely cared and were invested in her wellbeing. Supposedly, this motivated them to preserve a semblance of stability in their marriage. The family relocated frequently in pursuit of upward mobility. Although the family endured periods of financial hardship, especially early on, Serena stated that she always had her needs met. As an only child, she experienced loneliness. She believed that to feel connected to her parents she had to emulate them—contain her emotions, be steadfast in her focus, and think positively. Maintaining friendships was difficult with the many moves and school transitions. She became accustomed to transient friendships and predictable separations. Serena did well academically because her parents expected her to, but her perfectionism often undermined her confidence.

Following the precedent set by her parents, Serena dedicated herself to her studies throughout college, concurrently balancing multiple part-time jobs to help cover tuition expenses (with partial support from her parents). Serena's college years marked a departure from her reserved demeanor in school; she was more outgoing than she had ever been. Despite living with her parents, she joined a Latin dance club on campus, which connected her with like-minded friends. Nonetheless, she stated that these relationships were circumstantial, and she often felt unfulfilled by their alleged "shallowness." Post-graduation, Serena found herself adrift. The bustling college environment had provided a sense of purpose and camaraderie, but now faced with the daunting task of navigating the professional world, she grappled with uncertainty. Her once unyielding discipline began to wane, leading to a decline in mood and a sense of disillusionment with potential career prospects aligned with her degree. Serena eventually found a foothold as a teacher's assistant—a role that was meaningful because she always liked school. She went on to complete certificate coursework to obtain her teaching credential. While Serena's mother voiced concern regarding her career choice, i.e., that she "settled for a job with little growth potential," Serena's father took a more supportive stance. Drawing from his own vocation for teaching, he found resonance in Serena's decision and unexpectedly seized the chance to connect with her over it. Moreover, Serena briefly expressed regret regarding her career choices, acknowledging that her income was lower than desired. This predisposed her, perhaps unconsciously, to seek to depend on a partner for financial stability, a situation she felt conflicted about.

When queried about her past romantic relationships, Serena admitted to feeling "unlucky in love." She tended to idealize partners and fantasize about intimacy, often investing more emotional energy in these fantasies than in building real connections. This mismatch between fantasy and reality left her bitterly disappointed and resentful, leading to periods of withdrawal during which she oscillated between criticizing her partner and feeling guilty for her own demands. Despite this pattern, Serena found her connection with her fiancée, Fernando, to be the most stable and fulfilling yet. They met when she was 24, introduced through a family friend, and quickly hit it off. However, in an ironic twist of fate, the same machismo charm that initially attracted her to him now felt constricting, hindering her freedom and personal growth. Their engagement brought Serena's ambivalence about the relationship to the forefront.

Presentation at the Beginning of Therapy

Serena's current episode of obsessions and compulsions began 4 months prior to the intake assessment. The catalyst was a life-changing moment when her boyfriend, Fernando, proposed on New Year's Day. Despite her initial joy and acceptance, the celebration quickly turned into a tumultuous ordeal, culminating in a severe "panic attack" that led to an unexpected visit to the emergency room. In the aftermath, Serena was prescribed Zoloft by her primary care physician, which she stopped taking after 2 months because she could not tolerate the medication's side effects. She said that she that she was still shaken and confused about the incident. The mere memory of it triggered obsessive rumination. She eventually took her doctor's referral to our clinic. This was Serena's first time in psychotherapy.

Arriving to treatment, Serena found herself at a crossroads, grappling with a mix of cynicism and a palpable urgency for help. Initially, when queried about the content of her intrusive thoughts, Serena became reticent, as if guarding a heavily shrouded secret. I treaded lightly, inviting her trepidation, until she let up with a sigh of relief. Between effortful breaths, Serena admitted that "uncanny thoughts" had haunted her for years, yet she feared that vocalizing them would give them credence, that in doing so she would tempt fate. Serena confessed that my inquiry felt "surgical." It was the first time in her life she talked about her suffering in detail—she had, up until then, managed to evade disclosure, as if instructed by her OCD to conceal its presence. She had suffered in silence. Thus, it was startling to be confronted about these thoughts, yet she admitted slight relief at the notion that she could now delegate a portion of her psychic burden to a confidant.

Throughout the intake interviews, Serena's affect was constricted and inappropriate to the content discussed. While I detected hints of irritable affect (e.g., grimacing, sighing, flushed face, tone inflections), she worked hard to mask it under an ebullient, but trite, persona. I barely had the chance to comment on these subliminal cues before she caught herself and inverted her affect. Not only did she halt the display of emotion, but she swiftly pivoted her narrative. For

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instance, she spoke with indignation about being "shortchanged" by her parents when they concealed aspects of her native culture, only to undermine her feelings by later rationalizing her parents' behavior (e.g., "they were trying to protect me"). She abruptly turned deferential and sympathetic. She even apologized for being rude. Additionally, I noticed that the brimming of affect caused her distress—she would start shifting in her seat, tapping her feet, and fidgeting with objects. Serena's overall mood during the intake was anxious. Overall, her speech was pressured, mostly logical but at times circumstantial. Her speech rate fluctuated. I suspected that when her speech sped, she might be experiencing racing thoughts. Serena's thought process was analytical and abstract, and her insight was intellectualized.

Inclusion/Exclusion Criteria

The intake sessions were also utilized to assess Serena's eligibility for manualized STPP. First, the ego-dystonic nature of Serena's obsessive-compulsive symptoms made her an excellent candidate for insight-oriented psychodynamic therapy. Additionally, based on Book's (1998) selection criteria, Serena was considered a good candidate for exploratory therapy because she possessed significant *ego strengths* (intact reality testing, mature defenses, fair frustration tolerance, low levels of impulsivity), *psychological mindedness* (ability to see a link between present behaviors and past events), and a *capacity for introspection* (ability to reflect on the meaning of one's behavior, see self as much an agent as a victim, and see one's role in conflicts with others). When she presented to the intake, she was operating at the neurotic level of personality functioning. This implied that she would require minimal use of supportive techniques to establish a secure base in the therapeutic relationship, a place from which she could draw strength when the therapy drew disconcerting material into consciousness. Furthermore, Serena was amenable to a brief therapy model because she presented to treatment with adequate levels of *motivation* to address her difficulties within finite parameters (22 therapy sessions). Motivation is strongly correlated with positive outcomes in short-term therapies (DeLaCour, 1986; Hoglend, 1996). This trait was evident in her disposition to readily engage with the assessment tasks and actively introspect when queried about her difficulties.

Potential exclusionary factors included Serena's hesitancy about therapy, evidenced by her taciturn demeanor and equivocal answers during the first session. I addressed and normalized her ambivalence in that first session, which built rapport and auspiciously reassured her. Her level of engagement improved noticeably over the remaining assessment sessions. Moreover, Serena's history was speckled with unfulfilling, short-lived relationships, except for her current partnership, which exhibited more elements of reciprocity and potential for longevity. As such, I could not reliably predict whether Serena would develop a strong therapeutic alliance within the initial phase of treatment. Notwithstanding, her history suggested resilience in the face of rapid

relationship turnover, leading me to predict that she would be *capable of disengaging* from this short-term treatment without significant disruptions to her interpersonal functioning.

Assessment Measures

As stipulated in Leichsenring and Steinert's (2017) short-term psychodynamic therapy (STPP) for OCD manual, the intake process was designed to examine both the phenomenological and psychodynamic features of a patient's presenting problems. The diagnostic assessment consisted of an unstructured intake interview, a semi-structured interview with the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), and a semi-structured interview based on the Relationship Anecdotes Paradigm (RAP). The intake spanned the course of five, 50-minute sessions. Consent and confidentiality limits were covered as part of the clinic's protocol.

The Y-BOCS Interview

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is a semi-structured, clinician-administered interview that surveys the content of OC symptoms (current and historic) and their severity over the past week. Accepted as the "gold standard" among quantitative measures in OCD treatment, the merit of the Y-BOCS derives from its comprehensiveness, clinical utility, excellent inter-rater reliability, and high internal consistency (Goodman et al., 1989). The instrument consists of an inventory of common obsessions and compulsions and a 10-item severity scale, which quantifies the impact of obsessions and compulsions on the following dimensions: time occupied by symptoms, interference due to symptoms, distress associated with symptoms, resistance to symptoms and felt sense of control over symptoms. The severity of obsessions and compulsions is independently rated on a 5-point Likert scale from 0 (no symptoms) to 4 (severe symptoms). Ratings are based primarily on patient report and calibrated against the clinician's judgement/observations. The 10 items are tallied to yield a Total Symptom Severity Score ranging from 0 to 40, with higher scores denoting greater global severity. Severity categories are defined as follows: a score of 0–7 indicates subclinical symptoms, 8–15 mild symptoms, 16–23 moderate symptoms, 24–31 severe symptoms and 32–40 extreme symptoms.

In order to reliably assess the presence and severity of Serena's obsessions and compulsions, the Y-BOCS was administered during the intake assessment and will be administered again at the therapy's termination (scores reported in Table 2). Serena's pre-treatment and post-treatment Y-BOCS scores will be compared as part of the quantitative analysis of therapy outcomes. The difference in her Total Symptom Severity Score will be tested for statistical significance utilizing Jacobson and Truax's (1991) Reliable Change Index.

As an objective measure, the pre-treatment Y-BOCS contextualized Serena's level of impairment and informed treatment decisions (i.e., level of care, duration of therapy, goals). At the intake evaluation, Serena received a Total score of 22 (Obsessions = 12, Compulsions = 10),

placing her in the "moderate" range for symptom frequency, intensity and interference. Serena endorsed obsessions mostly in the aggressive category, but also endorsed miscellaneous obsessions, such as a need to know or remember certain things, fear of not saying just the right thing, and superstitious fears. Additionally, Serena endorsed checking compulsions (e.g., counterphobic checking that did not/will not harm self), mental rituals (e.g., undoing 'bad' thoughts), reassurance seeking, measures taken to prevent harm to self (e.g., avoiding sharp objects), and superstitious behaviors (e.g., tracing her steps or performing actions in reverse).

The Y-BOCS has proven to be sensitive to the therapeutic effects of medication and psychotherapy (Goodman et al., 1989). The international expert consensus defined a *treatment response* in OCD patients as a ≥35% reduction in Y-BOCS scores relative to baseline, lasting at least one week (Mataix-Cols et al., 2016). This translates to "a clinically meaningful reduction in symptoms." A *partial response* is defined as a ≥25% but <35% reduction in Y-BOCS scores, while *remission* is defined as a score of ≤12 on the Y-BOCS, for one week. *Recovery* means that the patient meets *remission* criteria for an entire year.

Moreover, the Y-BOCS includes supplementary items which do not factor into the Total Symptom Severity Rating Score. These serve to capture a patient's insight into their symptoms, avoidance of triggers, degree of indecisiveness, overvalued sense of responsibility, pervasive slowness/disturbance of inertia, pathological doubting, clinician-rated global severity, and clinician-rated global improvement (since initial rating) (Goodman et al., 1989). Serena was assessed on these dimensions, which added qualitative depth and richness to her diagnostic picture. The supplementary Y-BOCS items determined that Serena possesses good insight, moderate levels of avoidance of triggers, a severe degree of indecisiveness, moderate levels of overvalued sense of responsibility, mild disturbance of inertia, and extreme levels of pathological doubting (see Table 2).

The RAP Interview

The inclusion of CCRT results in the diagnostic section accords with Luborsky and Crits-Christoph's (1998) directive to supplement DSM 5 diagnoses with information about a patient's psychodynamics. Relationship episode (RE) data were gathered through administration of the Relationship Anecdotes Paradigm (RAP; Luborsky, 1990) interview. The RAP interview prompted Serena to narrate *specific exchanges* with any persons in her life—past, present or in dreams—and to indicate when it occurred, the identity of the other, the behaviors and/or feelings of the other in response to her own, the conclusion of the interaction, and the temporal location of the exchange within the broader interpersonal narrative. These exchanges were deemed to be personally important or problematic. She was instructed to tell a total of 10 narratives, each one occupying no more than 5 minutes. The interview was tape-recorded and transcribed.

The first step in the procedure of deducing Serena's CCRT was to demarcate the relationship episodes (REs) (narratives with a clear beginning, middle and end) in the transcript and extract the relevant text. For each RE, the main other person with whom Serena interacted was identified, and the episode was labeled *current, recent* or *past*. *Current* is defined as occurring within that session or within the last 2 weeks (RE_c); *recent* occurred in the last 3 years (RE_r); all else is *past* (RE_p). In the scoring of each RE, embedded components were partitioned (with slash marks) and identified as *single thought units*, to be classified as either a wish [W], response from other [RO], or response of self [RS]. In scoring, wishes were differentiated: explicit wishes were labeled 'W,' while implicit but moderately inferable wishes, including the *denial* of a previous wish, were labeled '(W).' A single relationship episode can contain multiple wishes. Moreover, RO statements predominantly capture the patient's *expectations* about how the other person might respond to them in the context of their wish. Thus, the data conveys the patient's vantage of the interaction, which is not necessarily an objective account of the other's behavior. RS statements contain both behavioral and affective aspects.

In scoring ROs and RSs, a distinction is sometimes made between the *positive* (P: noninterference with satisfaction of the wish or sense of mastery in being able to deal with the wish) and the *negative* (N: interference with satisfaction of the wish) Of note, I did not apply this distinction consistently in the coding, but certainly appraised the distinction in the process of formulating interpretations. Additionally, although the components of an RE can be causally related, this is not always the case, therefore the sequential order of components, referred to as "linkages," was not coded.

Individual *thought units* were coded based on an abstracted W, RO or RS. Next, a standard-category label and its corresponding # was assigned to each thought unit. The standard-category method provided a uniform language for conveying Ws, ROs and RSs. The markup for each RE was transferred to a scoresheet, where all the identified thought units were compiled and tallied by component. These were further organized into clustered categories, based on the CCRT Standard Category Clusters, Edition 3 (Lebowski & Crits-Christoph, 1990).

Serena's overarching CCRT was formulated from the clusters with the highest thought unit count for each component: W to assert self and be independent, RO of rejecting and opposing, and RS of helpless and out of control. Table 3 illustrates the standard-category coding method as applied to a sample RE from Serena's RAP interview. Table 4 displays Serena's score sheet and Table 5 displays her summary sheet. Serena's CCRT formula was obtained from the most frequently occurring components; however, her CCRT's variants, outlined in Table 5, arose recurringly in the *working-through* of therapy.

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Diagnosis

- **300.3 (F42.2) Obsessive-Compulsive Disorder, with good insight:** Serena endorsed repetitive and persistent thoughts, urges and images that were intrusive and induced distress (obsessions), and repetitive behaviors and mental acts intended to reduce obsessive anxiety and prevent dreaded outcomes (compulsions) (Criterion A). Obsessions and compulsions were present for approximately 3 hours per day and caused clinically significant impairment in social and occupational functioning (Criterion B). The disturbance was not attributable to the effects of a substance or medical condition (Criterion C), nor was it better explained by another psychiatric disorder (Criterion D). Serena's insight into her OCD symptoms was good because she recognized that her thoughts were bizarre, irrational and involuntary (i.e., ego-dystonic) (see Table 1).
- **R/O: 300.01 (F41.0) Panic Disorder**: A diagnosis of panic disorder was ruled out because the occurrence of panic symptoms did not sufficiently constitute a panic attack. Moreover, Serena was not preoccupied with the future possibility of experiencing a panic attack. Her panic symptoms occurred only in the context of obsessive-compulsive episodes.

Goals and Strengths

When queried about treatment goals, Serena stated that she was hoping to overcome her urges and to cultivate "peace of mind." She aspired to be more assertive in decision making, i.e., to reduce obsessive doubting. In addition, Serena hoped to explore what she valued in a relationship, which would enable her to be more transparent in communication.

As mentioned previously, Serena's level of motivation to engage with therapy was mixed at the outset, and it grew exponentially stronger with the passage of time. Even though this was Serena's initial encounter with therapy, and despite feeling ashamed about revealing the content of her thoughts, as well as her initial reluctance to commit to weekly sessions, she successfully completed the treatment with perfect attendance and consistently arrived on time for appointments. Importantly, Serena invested herself in the therapeutic relationship, which offered a quality and purpose distinct from any past relational experiences. Moreover, Serena was a resilient, resourceful, and hard-working young woman, for whom migratory experiences had meaningfully enriched her psychological life.

Serena seamlessly integrated, and actualized, session material in her daily life. Not only was her insight into obsessive-compulsive phenomena good, but her capacity for introspection was a notable asset. In similar vein, Serena was remarkably responsive to confrontation, even when her defenses were activated.

Her intellectualizing defense was a double-edged sword. While at times it impaired her affective processing, it also lent her an auspicious ability to grasp complex psychological phenomena on a cognitive level. Although "intellectual insight" is not the final goal of therapy, it

befits the initial phase of therapy, which is primarily educational. The patient's understanding of their dynamics lays the groundwork for "emotional insight" to come (Crits-Christoph et al., 1993).

5. CASE FORMULATION AND TREATMENT PLAN

Formulation

The CCRT Formulation

The most pervasive conflict for Serena was between her wish to be self-contained and autonomous in her emotional expression, and her expectation that others would respond to her in rejecting, critical, or controlling ways. Similarly, her response of self was to feel ashamed and anxious (obsessions) and attempt to assert control through repetitive behaviors (compulsions), which eventually rendered her helpless and out of control, undermining her original autonomous wish. Perhaps her self-ambivalence, self-distrust, and resulting drive to control her impulses arose because of an expectation that others would thwart or condemn her self-expression. Although she was somewhat aware of this conflict, she was less aware of some aspects of the conflict, such as that her wish for sovereignty conflicted with a regressive wish to be controlled by and dependent on others, and thus, to *feel* taken care of by another, a feeling that was associated with safety.

The Classical Model

The pathogenic cycle of obsessions and compulsions was an internalized replica of Serena's CCRT. Obsessive-compulsive phenomena represented compromise-forming defenses, or "unconscious resources used by the ego to reduce conflict between the id and superego" (Freud, 1937). In Serena's case, the primary defense mechanisms were reaction formation, undoing and intellectualization. Secondary defenses were isolation of affect and regression in the service of the ego. The conditions of Serena's infancy constituted the perfect storm for an anal fixation. Serena's father was arrested soon after her birth, leaving her mother to fend for herself in the tasks of child-rearing. The separation may have accentuated her mother's domineering qualities, driven by preoccupation, as if to compensate for the absence of a father in the family. Perhaps in her rigidity, Serena's mother thwarted her daughter's natural impulses to explore, experiment and take meaningful risks. These learning experiences punished Serena's impulses and sowed distrust in her sensory experience, subsequently contributing to her inability to differentiate between thinking and acting (*thought-action fusion* or *omnipotence of thought*).

Moreover, Serena's mother's denial of her father's incarceration was laced with elements of magical thinking, modeling an overreliance on thought, and denial, to cope with loss and uncertainty. Rather than succumb to despair, Serena's mother painted a rose-colored portrait of family life. *Omnipotent control* ascribes a false sense of control to thoughts, enabling the ego to

deal with an otherwise insurmountable reality. The high-spirited emotional landscape penalized the manifestation of painful affect, barring opportunities to learn adaptive emotion regulation. What's more, experiencing painful affected was equated with danger. As such, Serena became accustomed to disavowing "disruptive" emotions like anger and sadness. In moments of dysregulation, she resorted to mentation to self-soothe, cementing the *intellectualization* defense.

After a prolonged absence, Serena's father's homecoming generated an Oedipal situation, which colored the family dynamics for years to come. Serena's father's homecoming sparked feelings of jealousy and resentment towards him in her mother, as she perceived him as a threat to her authority and control over the family unit. Meanwhile, Serena's relationship with her mother became strained as she felt a subconscious sense of competition for her father's attention and affection, heightening tension between them. Turbulent family dynamics, compounded by the stress of resettlement and recurrent separations from peers, likely triggered a *regression* to anal-stage issues around retention and control. According to Freud's drive theory, aggressive impulses, such as those expected to arise in response to coercive discipline, were intercepted by a scrupulous superego. In this context, the defense of *reaction formation* was an effective way to convert aggressive impulses, perhaps even retaliatory urges, into dutiful obedience.

Both internal and external pressures to withhold hostile feelings had the unintended consequence of brewing obsessive content, which would later rebound as intrusive thoughts. Preserved under a tight lid for years (*isolation of affect*), aggressive impulses reemerged as obsessions and compulsions, except that they were directed at the self. Meanwhile, the *omnipotence of thought* defense devolved into *thought-action fusion*, which convinced Serena that her obsessive thoughts would materialize (i.e., cause harmful behavior, bring about danger) if left unattended (i.e., inflated sense of responsibility). Herein, the primal death wish collided with the instinct for self-preservation (Freud, 1920). The defense of *undoing*, carried out through counterphobic compulsions, allayed the death anxiety brought about by intrusive thoughts.

Core Psychodynamic Problem

As discussed in the section above, aggression was latent in Serena's presentation, and preserved by a specific constellation of defenses. In her adult life, her OCD symptoms "broke through" ego defenses with every flare-up. A *psychodynamic problem* emerged from the repeated isolation of hostile affect and resulted in a loss of touch with her biological impulses (i.e., drives and internal cues pertaining to emotional needs). Counter instinctually, her aggressive impulses reverberated inwards, a torment which outlasted her childhood years. Serena was impaired in her ability to express anger appropriately (i.e., *constructive aggression*; Malan, 1979) and constricted in her range of affect. Rather, Serena's conscious experience involved "willfully directing" her desires and emotions according to the rigid expectations of an "internal overseer" attempting to control aspects of her psychological functioning (i.e., drives and

behavior) that are typically beyond conscious control (Shapiro, 1965). As evidenced by her CCRT, the elusive battle for control distorted Serena's sense of agency, making her unable to assert her wishes (i.e., "I want" instead of "I should") or make confident, autonomous decisions. As Shapiro (1965) put it, "the obsessive-compulsive person lives in a continuous state of volitional tension" (p. 36).

Object Relational Model

The object relations model sheds light on the underlying dependency issues against which obsessional operations defended. Serena's OCD symptoms were ego-dystonic and surfaced when defenses faltered. The symptomatic cycle coopted Serena's autonomous wish. As a young adult, she yearned to be autonomous. Yet, she feared solitude just as much—because solitude was when her obsessions rung loudest. Obsessions convinced Serena that she was "a danger to herself," cornering her into a powerless position. Succumbing to compulsions and reassurance-seeking restored a sense of safety and control; yet, ironically, her compulsions controlled her.

For Serena, representations of others vacillated between the idealization of an omnipotent other and distrust of the connection to a critical, demanding, and ultimately insufficient other. Serena was raised by an authoritarian mother and a permissive father. She received mixed signals about the empathic reliability of her caregivers, associating them with both fear and protection. From a child's state of dependence, this dichotomy was disorienting. Ambivalence around emotional connection, propelled by the threat of losing support from attachment figures, culminated in superstitious thinking. In other words, Serena was governed by the pathogenic belief: "I won't get my needs met if I don't succumb [to others' demands]."

An object-relations perspective suggests a disruption in the task of separation-individuation (Mahler, 1963). It can be deduced from Serena's accounts that her mother's behavior provided idealizing object functions but failed to provide the mirroring object functions crucial to the development of healthy self-esteem and emotional regulation (i.e., self-soothing). In Serena's first years of life, her primary caregiver had a low tolerance for intense emotions and thus displayed a limited capacity to soothe her child when she was distressed (e.g., temper tantrums). Instead, her mother restricted Serena's behavioral experimentation.

Because their boundaries were enmeshed, Serena clung to her mother instead of developing self-soothing functions. Although her mother was physically present, she was not emotionally available, and her dominant nature overpowered Serena, who surrendered her will to comply with her mother's rules in the hopes of obtaining a modicum of consolation. Mostly though, she felt helpless in the face of frightening emotions. Serena was both insecurely attached and mentally fused with her mother. Her internal model of her mother was characterized by ambivalence; thus, her development of a defined, confident self-concept was thwarted.

Dependency became associated with helplessness and was compensated for through counter-dependent behaviors. Meanwhile, agency was *also* associated with helplessness and loss of control. As such, Serena sought to fuse with others, succumbing to their desires in exchange for the *reassurance* that she was taken care of and protected. In other words, she unconsciously pursued relationships with controlling others to stabilize her sense of safety. Eventually, she would feel suffocated by this arrangement and rebel to restore her sense of agency.

Serena's father was absent in her earliest years. When he reentered her life, he tended towards withdrawal and aloofness, which was justified by his provider role. Serena's mother was inconsistent in her attunement. On the one hand, she provided practical support and was generally responsive to Serena's needs. On the other hand, her support was laced with subliminal contempt and disparaging remarks. Serena recalled getting into vehement arguments with her mother, which culminated in tearful remorse that "made her want to run away and hide."

The presence of Serena's mother in Serena's life may have been intrusive—she judged Serena's appearance and demeanor, she rejected her opinions and feelings, and she smothered her daughter to fulfill her intimacy needs. Serena reported that while she was made to believe she was special, especially having been the center of attention as an only child, she was also shamed for not living up to her mother's ideals. Based on Serena's descriptions of early exchanges with her primary attachment figure, it is possible that [her mother] used control tactics, such as induction of guilt, to compel Serena's collusion in a manicured version of reality. The invalidating effects of her mother's *denial* (i.e., magical thinking) may have contributed to the pervasive sense of doubt she felt.

Serena's affective development is likely to have been compromised by implicit relational trauma. Perhaps, Serena's mother harbored split-off feelings of insecurity and contempt, i.e., feeling incompetent to care for her daughter in her husband's absence, which were potentially deposited in her daughter via *projective identification*. Through projective maneuvers such as blame, she provoked feelings of fear and shame in Serena, who in turn introjected an omnipotent, yet inadequate mother. In identifying with her mother, her self-concept was endowed with omnipotence, in equal parts to a perceived incompetence to take care of herself.

Within the family dynamic, boundaries were blurred, and Serena found herself unwittingly immersed in a distorted version of reality. The cloaking effects not only convinced Serena that her mother's aggression was her own, but also cued her to keep retaliatory feelings in check (i.e., destructive and rebellious fantasies) to preserve the bond with her mother. Relatedly, Serena harbored feelings of guilt, which congealed into a heightened sense of responsibility. Through repeated empathic failures, Serena learned to automatically succumb to her mother's predilections.

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These dynamics translated onto Serena's adult relationships. In her present-day romantic relationship, the influence of cultural *machismo* in her partner's behavior mimicked the subliminal control she experienced in her relationship with her mother. As her CCRT suggests, Serena conflated love and affection with being controlled, because it signified protection. Due to these unattended conflicts, her engagement to Fernando triggered her fear of commitment; the event was a clear antecedent to her most recent OCD flare-up.

Wounded Self Model

As described previously, in her earliest years, Serena's mother behaved as if she possessed omnipotent power to protect Serena from all sources of danger in her environment (i.e., harassment, persecution, food scarcity, disease). The extensive degree of parental control imposed a figurative harness on the developing self. In addition, the punishing of adverse emotions, including fear reflexes and aggression, possibly seeded views of the *self as dangerous and untrustworthy* (i.e., the belief that "badness only exists within, not out there"). At the time the family fled Cuba on a raft, the unprecedented perils of reality bled through the cracks of the illusion. Serena caught on to her mother's limitations as a protector. She became privy to her mother's covert distress. The realization of her own physical vulnerability, and her dependence on a fallible caretaker, overwhelmed her. Perhaps, at this critical point, a forming schema of the *self as helpless* primed the cognitive styles of *overestimation of danger* and an *inflated sense of responsibility*. According to the self-wounds model, Serena's OCD symptoms were adaptations to a perturbed self-concept, maintained through compulsive efforts to combat feelings of helplessness.

Cultural Considerations

From a generational perspective, Serena's OCD symptoms were emblematic of the subjugation of individual rights, repressive censorship, and political harassment that her relatives endured under Castro's dictatorship. The motifs of control, aggression, and domination-submission vividly colored her Cuban lineage. The affective conflict between rage at being controlled and fear of being punished (McWilliams, 2011) was reminiscent of her father's experiences of persecution and harassment.

Treatment Plan and List of Treatment Goals

Serena's treatment plan was structured to follow the 3-phase, 12-module format of Leichsenring and Steinert's (2017) STPP treatment manual for OCD, with interventions based on Luborsky's (1984) supportive-expressive (SE) therapy. Serena's treatment plan centered on mitigating her most prominent OCD symptoms and engendering limited, but meaningful changes in personality functioning.

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As aforementioned, the manual is not directive, rather, it provides scaffolding and an evidence base to intervene on the multiple dimensions of an OCD patient's presenting problems. The manual is designed to be adaptable to the therapist's style and tailored to the patient's goals. Each module has a distinct objective and offers congruent strategies which have proven efficacious in clinical encounters with OCD.

The early phase of treatment was largely comprised of supportive interventions to socialize Serena to psychotherapy: psychoeducation, frame negotiations, goal setting, enhancing motivation, addressing ambivalence, and building alliance.

The middle phase of treatment involved mostly expressive interventions to explore Serena's CCRT and modify the maladaptive, or defensive, components. The middle phase also featured existential inquiry and opportunities to work through lingering resistances to treatment.

The final phase addressed termination issues, from a relational vantage, and prescribed tools for relapse prevention.

Booster sessions were offered to sustain treatment gains, as needed.

Treatment goals were discussed briefly at the intake and elaborated upon in Module 2 of Leichsenring and Steinert's (2017) manual, after Serena's ambivalence about treatment had been sufficiently worked-through. The setting of goals promoted Serena's readiness for change and commitment to the therapy process. Explicit, circumscribed goals define the targets of change and serve as an index for tracking the patient's progress throughout the course of therapy. Goals function to attenuate regression, which is vital for patients that are suspicious or afraid of dependency; strengthen the helping alliance; sustain the patient's motivation to change; and inspire a sense of accomplishment in both parties (Luborsky, 1984).

According to Luborsky (1984), the goals of short-term therapy should be attainable within a limited time frame and formulated in the patient's language. Realistic goals are focal in nature; they should not include comprehensive personality change or complete symptom remission. Once the therapist gathers pertinent information, they work with the patient to integrate symptom reduction goals with insight-oriented goals. Finally, goal setting should account for the natural evolution of treatment goals, which occurs as the patient's resistance lessens and their burgeoning insight changes their perspective on their problems.

In consolidating the therapeutic contract, I prioritized patient-therapist goal consensus, which is among the top predictors of therapy outcomes (Tryon & Winograd, 2011). *Goal consensus* encompasses patient-therapist agreement on goals, the extent to which goals are clearly specified, a shared understanding of the origin of the patient's problems, and explicitly defined expectations regarding the tasks of therapy (Tryon & Winograd, 2011).

The Patient's Stated Goals for Treatment

- *Patient Goal* #1: Reduce the time spent on compulsions and the intensity of obsessions.
- *Patient Goal* #2: Reduce self-doubt and improve decision-making.
- *Patient Goal* #3: Determine what I want from relationships and communicate transparently.
- *Patient Goal* #4: Choose how much I commit to others and assert boundaries accordingly.

The Therapist's (Psychodynamic) Goals for Treatment

- *Therapist Goal* #1: Symptom relief brought about rapidly through behavioral and affective exposures and sustained through defense relinquishing in the context of the CCRT.
- *Therapist Goal* #2: Soften characterological rigidity by addressing ambivalence, experiencing a wider range of emotions, challenging pathogenic beliefs, and increasing tolerance of uncertainty.
- *Therapist Goal* #3: Increase *self-understanding* of CCRT themes around control and ambivalent dependence on others.
- *Therapist Goal* #4: Increase *self-control* of CCRT components: work through transference distortions [RO] around control and rejection; practice *adaptive* responding to triggers [RS] in place of reactive responding (i.e., guilt, anxiety, withdrawal).
- *Therapist Goal* #5: Foster autonomy and empowerment through corrective emotional experiences in the therapeutic relationship (e.g., experiencing angry and destructive feelings without entering a power struggle).
- *Therapist Goal* #6: Master Serena's CCRT -- make the unconscious wish (i.e., *regressive wish* towards dependency) conscious, and actualize the *adaptive wish* for independence.

6. COURSE OF TREATMENT

Note: The following abbreviations are used throughout Section 6.
RE = relationship episode;
W = wish, need or intention;
RO = response of other;
RS = response of self;
SE = supportive-expressive; and
STPP = short-term psychodynamic psychotherapy

This section presents a qualitative report of the treatment process, structured according to the 12 modules outlined in Leichsenring and Steinert's (2017) STPP for OCD manual. I covered the modules in 22 therapy sessions and 2 booster sessions. Based on Luborsky's (1984) guidelines for supportive-expressive (SE) therapy, I tracked the emergence of relationship episodes (REs) in every session while I strived to maintain an active focus on Serena's CCRT.

In each section below, I elaborate on the main objectives of each module, comment on my application of supportive and expressive techniques, and document Serena's response to my interventions. I share ongoing reflections of Serena's progress. Moreover, I include select excerpts from sessions to showcase the relational focus of supportive-expressive (SE) therapy, particularly when "working in the transference."

Early Phase: Sessions 1-8

Module 1: The Socialization Interview

The socialization interview is a primer on short-term psychodynamic psychotherapy. Socialization to therapy has been linked to positive outcomes (Luborsky, 1984). First, I presented Serena's assessment results, which encompassed her diagnosis of obsessive-compulsive disorder (OCD), her CCRT formula, and my proposed treatment plan. During our discussion, I provided *psychoeducation* on the disorder and a rationale for the treatment of choice, supportive-expressive therapy. I thoroughly explained the *roles* of the patient and the therapist. I welcomed questions. To close, I discussed the parameters of our work together (i.e., the *frame*).

Psychoeducation on OCD. Summers and Barber (2010) emphasize the value of psychoeducation in the psychodynamic treatment of OCD patients, on account of their love of rules and order. In this segment of the module, I informed Serena of her OCD diagnosis. I defined *obsessions* as unwelcome, perturbing thoughts, employing some of the language she used during our intake interview. I commented on her *good insight*, proven by the quality of her descriptions. I clarified that the thoughts about injuring her body were *ego-dystonic*, i.e., incongruent with her core values. I also normalized the bizarre nature of obsessions, clarifying that most people have intrusive thoughts like hers, but what differentiates "pathology" is the individual's reaction to their intrusive thoughts. I communicated findings on the genetic loading of OCD etiology, as well as the psychodynamic view of OCD as a coping mechanism for past attachment injuries or traumatic experiences. I hoped to diffuse some of the stigma she had internalized about her aggressive thoughts. Based on Serena's sustained alertness during this segment, I gathered that she felt validated and receptive to learning the science behind her struggles.

I defined *compulsions* as repetitive, laborious behaviors carried out in response to the feelings of anxiety, rage, disgust and shame generated by obsessions, and providing temporary relief. I explained how, in her case, most compulsions involved *mentally* undoing her intrusive thoughts (e.g., checking the reliability of her physiologic fear reflex, scanning her body for impulsive cues). Behavioral compulsions also appeared, i.e., seeking reassurance that her superstitious thoughts would not come true. I questioned the effectiveness of these compulsions in reducing her obsessions, suggesting instead that they contributed to her distress by monopolizing her time.

I explained the role of *avoidance* (of triggering situations) as a strategy to keep her anxiety under control. I drew examples from her repertoire: the avoidance of knives, driving on the highway, and extended periods of solitude. I reviewed the personal cost of Serena's symptoms, drawing attention to the chronicity of her struggles and her mounting impairment. Together, we reflected on how OCD was impeding her from living an autonomous life (e.g., at times, relying on a partner to drive her to work), having healthy relationships (e.g., instability in her romantic relationship, scarcity of stable friendships), and getting adequate downtime (i.e., self-care). I communicated that her current level of impairment was *moderate*.

Presenting the CCRT. Following the RAP Interview, I presented Serena with her CCRT analysis and appraised her response:

> **T:** Based on what you've shared about your relationships, here's my take. (*Leans in, maintaining eye contact*) When you get close to someone, you start losing your grip. You begin questioning if they really care, so you twist yourself to fit their mold. You might get their approval, but you lose sight of who you are. Then comes the fear – fear that they'll drown you in their demands or shut down your voice. Guilt pushes you to make compromises, but deep down, you're seething with resentment, creating chaos both in your relationships and in your head.
>
> **P:** (*Nods slowly, processing*) That's... a lot to digest. Gosh, it sounds like a mess.
>
> **T:** It's a lot to unpack for sure. You value connections, but you're also all about independence. Problem is, you feel like you can't have one without sacrificing the other.
>
> **P:** Hmmm. (*Eyes widen in recognition*) Yes!
>
> **T:** But here's the thing – being independent isn't a walk in the park either. When you're alone, doubts creep in and drain your energy. Then it feels unsafe, to be in that state, so you cling to someone you see as stronger.
>
> **P:** (*Sighs, shoulders sagging*) It's like I'm swinging back and forth. My emotions are all over the place.
>
> **T:** Yup, exactly. We'll dig into this tug-of-war during our sessions and see how it links up with those intrusive thoughts you've been wrestling with.

The CCRT synopsis *should* resonate with the patient. It is a focused summary of what the patient has already told their therapist (Book, 1998). The sense of *being understood* is a common response and one that fosters rapport. I was pleased by Serena's enthusiasm and insightful remarks. I was afraid she would react with cynicism or resistance, but I underestimated her intellectual curiosity. Maybe I earned her respect by cushioning the formulation with pertinent findings on OCD, applicable to her life and her struggles. In portraying myself as

knowledgeable, it was possible to cultivate an idealizing transference (Leichsenring & Steinert, 2017), which I could draw upon as a resource in future moments of ambivalence.

Setting the Frame. I specified that we would meet once weekly for 1-hour face-to-face sessions, and transition to biweekly sessions when we began the process of phasing out toward termination. Book (1998) underscores the importance of communicating the session limit, and committing to the limit, when working within an STPP framework. We agreed to meet for a total of 22 treatment sessions and 2 booster sessions. I projected our termination date to roughly 6 months out. I requested payment before each session with our clinic receptionist and reviewed the clinic's cancellation policy. Additionally, I discussed our handling of no-shows and premature termination. I informed Serena that out-of-session contact would be limited to scheduling issues. I explained that I was willing to schedule short phone check-ins in the event of a crisis, but I would not be available on demand.

I had already introduced myself as a clinical psychology doctoral student under the supervision of a licensed psychologist. I reiterated (since the intake) our limits of confidentiality, the necessity to record sessions, and reviewed Serena's right to informed consent. To conclude, I emphasized the importance of honoring the frame. In the event of a deviation, I intended to discuss it during session, as it would be grist for the mill. She agreed to everything but became hesitant to commit to weekly sessions. She expressed objection in a roundabout way, insinuating that therapy would take too much time out of her week, especially given the clinic's far commute. I probed with motivational interviewing-type questions until we consolidated a time. I flagged this exchange to revisit in the next module on motivation. I mentally noted the exchange as meaningful CCRT data.

Role Clarification & Rationale for STPP. A central goal of the socialization interview is to define the therapist and patient's respective roles in dynamic therapy (Luborsky, 1984). Providing a rationale (the why and how of therapy) can ease the patient's fear of losing control (Leichsenring & Steinert, 2017). This was paramount in Serena's case because it was her first time in treatment. Even though the STPP manual prescribes a more directive stance for the therapist than is usual in psychodynamic practice, I wanted to retain the principle of *free association*, so I oriented Serena to this mode of responding (Book, 1998):

> **T:** So, I know this is your first time coming to therapy, and I want to show you the ropes around here. (*Leans forward, offering a warm smile*) I also really want to make sure you're comfortable here. Throughout the assessment phase, I've been doing a lot of talking, but now I want to switch gears. I want you to take the lead. Your task today is to open up about whatever's on your mind. (*Pauses, giving space for the patient to process*) I encourage you to let go of any filters you might normally use in day-to-day conversations. This is a space for raw honesty. Dreams, thoughts, feelings – it's all fair game. And don't worry about

> protecting my feelings either. I'm here to listen, no matter what comes up. (*Nods reassuringly*) I know it can be intimidating, but I'll really try match your pace as we go.

Next, I elaborated on the idea of the unconscious and how STPP targets the meaning, or symbology, of OCD symptoms. I alluded to the therapeutic relationship as a change mechanism in STPP.

> **T:** Alright, let's dive in. (*Leans forward, maintaining eye contact*) We'll pay attention to what's happening between us, as it often mirrors dynamics in your other relationships. Therapy's a chance to dissect those patterns as they unfold, right here and now. (*Pauses, allowing for understanding*) I'll be transparent about my feelings, and I want you to feel comfortable doing the same.
>
> **P:** (*Furrows brow, looking puzzled*) I thought therapy was about me telling you my problems and you giving me advice.
>
> **T:** (*Nods in recognition*) That's a common belief, but therapy's not about me handing out advice. Instead, it's about empowering you to take charge of your choices and embrace your own autonomy. I'll help you untangle the motivations behind your actions, even if they seem contradictory. (*Offers a reassuring smile*) Sometimes, it's those contradictory feelings that fuel our anxiety. My job is to guide you through exploring the parts of your mind that might feel shadowed – thoughts you might be embarrassed about or emotions that feel overwhelming. All of this in a safe space.
>
> **P:** (*Sighs, leaning back*) But what if I don't have imposter?
>
> **T:** (*Nods understandingly*) It's okay to sit with the silence. Sometimes, it's a sign of something beneath the surface that you're avoiding. Other times, it's the place from where insights emerge.
>
> **P:** But won't I be wasting time without a plan?
>
> **T:** (*Leans forward, reassuring*) You don't need a script. I'll keep us focused. We'll address what you've been avoiding and develop skills to tackle your anxiety head-on.

In STPP, there is a tradeoff between the alliance and the transference. The therapist can leverage this tension strategically (Greenson, 1967). In the dialogue above, I affirmed Serena's autonomy to bolster the alliance, but at the expense of delaying a build-up in the transference (Leichsenring & Steinert, 2017). Based on her object relations (CCRT), Serena would probably have expected me to infantilize her. If this were the case, affirming her autonomy would have disproved her relational expectations.

Module 2: Motivating, Addressing Ambivalence, and Setting Treatment Goals

As we geared into treatment mode, I was consistently struck by Serena's effortful demeanor and depleted affect. A general ambivalence, both about therapy and about how she

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wanted to live her life, was evident in her restive mannerisms and pressured speech. A polished presentation belied her inner torment. Of note, her word choice was unusually sophisticated, her tone monotonous, and her eye contact steady but calculated. Her facial expressions seemed reigned in, as if to convey politeness at the expense of authenticity. She seemed to be trying to prop up an idyllic state of affairs, and she went to great lengths to persuade me. Serena spent 15 minutes belaboring the orderliness of her life—her commitment to her partner, her wedding plans, and her tight work schedule. I was having a difficult time following what sounded like a laundry list of obligations. It felt rehearsed, recited as if from a script she lugged around in her mind. Despite her apparent composure, there was an undercurrent of pressure in Serena's speech, a sense of urgency as if she needed to convince not just me, but perhaps herself, of the orderliness of her life. The content of her speech, while focused on logistical details, lacked depth and genuine emotional engagement.

I allowed her to carry on, in keeping with Luborsky's (1984) directive to listen thoroughly and avoid premature intervention, until I determined that the monologue was a defensive operation against ambivalence. The defense was *reaction formation* (McWilliams, 2011). The conflict was between *order* and *disorder*. Entering treatment confronted her with her fear of losing control. Instead of facing her fear of losing control, she was fixating on the side of *order*. I understood Serena's ambivalence to be elegantly couched in magical thinking: if she convinced me of how put together she was, she would not need to make any changes. Initially, Serena's intense absorption in her polished façade seemed to limit her attunement to my reactions. She failed to fully register or interpret any cues (from me) that challenged her narrative. I became a little impatient and interrupted her, hoping to expose the *reaction formation*. I started by siding with her resistance:

> **T:** As your therapist, I find myself wondering if you need my help after all. It sounds like you're managing quite well on your own.
>
> **P:** *(Nods)* I've been trying to get back on track, but there just never seems to be enough time in the day.
>
> **T:** *(Furrows brow)* It sounds like you're juggling a lot. Do you think these sessions will interfere with your big plans?
>
> **P:** *(Looks down, voice trailing off)* It feels like I'm being dragged here against my will. It doesn't sit right with me. *(Looks at the floor, averting therapist's gaze, holds breath)*
>
> **T:** *(Notices the patient's discomfort, leaning forward)* What's going on? Are you okay?
>
> **P:** *(Flushed and flustered, looks down, long pause)* I'm sorry, I just... I heard this ringing in my ears, and everything went blank. I was talking so fast, I forgot to breathe.

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The dialogue above portrays a *confrontation*, an expressive technique used in the broader analysis of resistance. By first siding with her resistance, I affirmed Serena's struggle to maintain a sense of control in the face of overwhelming uncertainty and fear. My ensuing attempt to play the devil's advocate disarmed her. I successfully elicited her ambivalence, but the consequent anxiety overwhelmed her. Luborsky (1984) wrote about "attending to shifts in state of mind," by watching for changes in the patient's condition (i.e., affect and behavior) during the session. I suspect that the confrontation triggered intrusive thoughts (symptom), which strained her cognition until her "mind went blank." I named the inhibitory affect (anxiety) and then used my voice to co-regulate in the dyad. I repeated, "You are okay. I am here with you. *We* are in this together." Supportive interventions are useful during peaks in anxiety and contribute to the alliance (i.e., the use of the word "we" denotes collaboration; Luborsky, 1984). Moreover, I purposefully infused gentleness to disconfirm her expectation that I would respond to her "forcefully" [RO-expected: strict, controlling]. Instead, I invited her to lean on me so that she could pick herself back up. I generated a corrective emotional experience in healthy dependence.

The in-vivo feedback from these initial sessions helped me constellate Serena's dominant defenses. The manifestation of OCD symptoms correlated with breakdowns in her defenses. Based on this observation, I predicted that the interventions intended to restructure defensive patterns would activate and possibly aggravate her symptoms in the short-term. In the dialogue below, Serena discloses that obsessions (e.g., fear of not saying the right thing, fear of forgetting) emerged during my confrontation, followed by a surge in anxiety. The obsessions pierced the veil of the *reaction formation* defense and catalyzed anxiety. Because I was engaging her throughout, she did not have the chance to carry out her compulsions. This event was therapeutically positive:

> **T:** Let's backtrack a bit. What was going through your mind just before things got overwhelming?
>
> **P:** (*Shrugs, then crosses arms*) I honestly don't know.
>
> **T:** (*Sighs*) Alright, let's pause for a sec. What triggered this sudden change?
>
> **P:** (*Leans back)* The intrusive thoughts just came out of nowhere.
>
> **T:** Can you remember what you were talking about before that?
>
> **P:** (*Tightens grip on hands, exhales sharply*) I was saying about getting my life together and feeling good.
>
> **T:** Got it. And then?
>
> **P:** (*Tenses jaw, shifts uncomfortably in chair*) I felt like you weren't buying it, and I started doubting myself.
>
> **T:** Did my interruption throw you off?

P: (*Looks away*) Yeah, it kind of caught me off guard. I wasn't expecting it.

T: (*Softens expression*) You probably noticed I wasn't fully convinced. Why did that make you doubt yourself?

P: ...that's when I realized I wasn't buying it either.

T: (*Maintains gentle gaze, nodding empathetically*) You know, what made me jump in was a feeling that you were speaking in a "pretend mode" – almost like you were putting on rose-tinted glasses...to hide the pain or uncertainty or something. It reminded me of how you described your mom talking to you when you were younger.

P: (*Sits up straight, eyes widen*) Ugh, I hated when she did that. She'd put on this fake sweet voice and like a buttery smile. I used to think, that's what a parent should do. I never understood why it bugged me so much.

T: (*Nods*) I found myself getting frustrated when you did it too.

P: (*Furrows brows, looks surprised*) Really?

I proceeded to extract the CCRT components from the interaction and interpret the arising symptoms (obsessions) and affect (anxiety) in a relational context (both the immediate relationship and past relationships). This whole exchange constitutes a relationship episode (RE). In CCRT terms: she wanted to appear independent and to have self-control (W), I encroached [RO] when I questioned the credibility of her narrative [RO], which elicited her doubt and anxiety [affective RS], thus she retreated into a helpless state [behavioral RS]. I continued, aiming to foster self-understanding:

T: Let's dig into the cycle you're caught up in and figure out how to break it, together.

P: Okay. (*Looks around nervously*)

T: It seems like you want to handle things on your own, but deep down, you doubt whether you can. And you're hesitant to ask for help because you're worried about others meddling in your business. You're afraid they won't take you seriously or understand you, or worse, they'll try to control you. (*Pauses, assessing*) It's like you're stuck in a bind – you don't trust others, and sometimes, you don't even trust yourself.

P: Yeah, it feels like I'm just spinning my wheels most of the time. (*Sighs*)

T: And when you start feeling like things are slipping out of control, those obsessions start creeping in. It's like unwanted thoughts barging in, right? (*Raises eyebrows, mirroring the patient's concern*)

P: Yup. Exactly.

T: Dealing with OCD can make you feel pretty helpless, like you're at the mercy of those thoughts. It's almost like external forces are intruding on your life.

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P: (*Nods*) Yeah, it's terrifying.

T: Do you find that when you're feeling this way, you tend to pull back from others?

P: Sometimes, yeah. But I can't handle being alone for too long. (*Bites lip*) Even when I push my boyfriend away, I end up going back to him, hoping he'll reassure me. (*I noted that she said "boyfriend" instead of "fiancée," but did not comment on this just yet.*)

T: Right, that's what we call reassurance-seeking. It's clear how much pain this causes you. It's like you're torn – skeptical about therapy because it means relying on someone else, yet when you try to handle things alone, the obsessions take over.

P: Honestly, it's like my thoughts bully me with the idea that I might do something terrible [thought-action fusion]. It's torture. The only relief I get is when I give in to the compulsions, like when I test my reflexes, as I told you about before. (*Gazes off into the distance, visibly distressed*)

T: (*Nods in understanding*) When those distressing thoughts come up, you feel this urge to act on them, even when you know you'd rather not.

P: Yeah, it's like I can't help it. Giving in to the compulsions is the only thing that quiets those threats. (*Slumps in chair*)

T: It's a tough spot to be in. (*Maintains reassuring eye contact, offering support*) But something I've noticed in my work with OCD patients is that there's often some kind of payoff to staying in this cycle, despite all the suffering it causes. We can explore what benefits you might be getting from staying stuck in this pattern.

I proceeded to conduct a cost-benefit analysis, a traditional motivational enhancement technique, but with a psychodynamic spin (McCullough & Andrews, 2001). Using examples from her life, we collaboratively determined the *primary* and *secondary gains* of remaining symptomatic. For example, the anxiety bred by obsessions muted affects of anger and anguish (primary gain). Meanwhile, the shame-laden OCD cycle, which consumed her mind, led her to withdraw emotionally from others and thus *avoid* interpersonal conflict (secondary gain). As Kempke and Luyten (2007) observed, "thinking is over-emphasized and uncontrollable issues such as feelings and interpersonal relationships are avoided" (p. 295). This intervention was more supportive than expressive. It helped Serena comprehend her motives with impartiality and compassion.

As exemplified above, Serena was receptive to both expressive and supportive interventions. She acquired intellectual insight into her ambivalence, her conflict around control, and her ubiquitous experience of doubt. Insight at the intellectual level is developmentally appropriate in the Early Phase of treatment. According to Leichsenring and Steinert (2017), ambivalence and resistance are bound to resurface throughout treatment (see Module 11), and the clinician will need to readdress these issues in the manner illustrated above. Yet, ambivalence

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was such a structural feature of Serena's presentation that these interventions were more central than incidental. The *working-through resistance* of this module created an excellent foundation for the upcoming CCRT work.

To round out the module, we revisited Serena's treatment goals, listed in section 5. Case Formulation and Treatment Plan. The setting of realistic, agreed-upon goals anchors the patient's motivation (Leichsenring & Steinert, 2017). It was important to remind Serena that full symptom remission is *not* a realistic goal of STPP. Our goals comprised measurable symptom reduction *and* insight into the psychodynamics behind her symptoms. Within these two categories, we narrowed our targets to concentrate efforts and boost morale (Luborsky, 1988).

Most patients come to therapy seeking an end to their symptoms. A distinctive challenge for STPP therapists is achieving patient buy-in for *psychodynamic* work. To this end, I emphasized the link between OCD symptoms and relational difficulties. I wanted her to resonate with her CCRT, so I sketched it out from different angles. I used the whiteboard to map out the component sequence, and Serena appreciated having a visual representation. Because she had no prior context for therapy, her expectations were not entirely formed. Thus, she embraced my emphasis on *psychodynamics* over a fixed behavioral prognosis. Throughout treatment, I championed Serena's autonomy (i.e., treating her as an "adult counterpart;" Leichsenring & Steinert, 2017) by leveraging *her* desire to achieve *her* goals. By so doing, I countered her fears of dependency and interrupted any regressive tendencies.

Module 3: Establishing a Secure Alliance

The discussion of goals crossed over into Module 3. Tryon and Winograd's (2011) research on predictors of outcome weds *goal consensus* and *collaboration*. Goal consensus stipulates the parameters of therapy, while a collaborative relationship operationalizes the therapeutic contract. Collaboration is an active process where therapist and patient pool their efforts to achieve the patient's goals. In psychodynamic psychotherapy, there is an emphasis on establishing a *secure* therapeutic alliance. Freud (1913) called the alliance "proper rapport" and made it a condition for psychodynamic work. For patients with attachment trauma, the process of *approximating* a secure attachment involves a series of corrective emotional experiences throughout the course of therapy. In STPP for OCD, secure attachment provides a "secure base" from which the patient can face their feared situation. The patient who internalizes a secure bond will reap benefits beyond the termination of therapy, such as the ability to mentalize during periods of emotional dysregulation (Fonagy, 2005, as cited in Leichsenring & Steinert, 2017).

In supportive-expressive (SE) therapy, establishing a secure alliance is on the supportive end of the spectrum (Leichsenring & Steinert, 2017). Luborsky (1984) makes an additional distinction between two types of alliance. Type I is one-way support (the therapist gives, and the

patient receives). Type I interventions include empathic mirroring, conveying respect for the patient and acceptance of their struggles, and encouraging the patient's personal investment in getting better. On the other hand, Type II is about teamwork, homing in on the patient's experience of working *collaboratively* with the therapist towards mutual goals. One such example is described in Module 2, where I use collaborative language to encourage the "we bond" (Luborsky, 1984). Ideally, each party is equally invested in the helping relationship, and the alliance is strong enough to withstand ruptures. The consolidation of insight after expressive work also plays a supportive function. According to Luborsky (1984), supportive-expressive techniques occur on a continuum. STPP calls for a greater part of expressive to supportive interventions, but the ratio is adjusted per the patient's level of impairment.

A transference prediction was disproven in this module. Reflecting on the features of omniscience reportedly present in Serena's rearing, I predicted that she would come to view me as an all-knowing therapist. My previous clinical experience taught me that it is not uncommon for OCD patients to attribute magical powers to their therapists. On the contrary, Serena was skeptical about my competence for the entirety of the beginning phase. Over multiple sessions, she dealt with this feeling by acquiescing [RS: compliance] and withdrawing from the relationship [RS: withdrawal, doubt] to conceal the fact of her distrust. During Module 3, I deciphered these dynamics and confronted her. She disclosed feeling ashamed about her lack of trust in me. Then, she clarified that she did feel connected and understood by me but that my being a graduate student concerned her. For me, her disclosure sparked the infamous imposter syndrome. I addressed it thoroughly in supervision. I was intentional about averting an enactment here, despite feeling pulled to *prove* my competence as a therapist. Supervision helped me process my countertransference reactions.

The unfolding event prompted me to clarify the transference template. After experiencing the invalidating effects of magical thinking through her primary attachment bond, Serena became apprehensive about coercion in attachment relationships. She expected me to be domineering as a therapist [RO-expected: controlling] because I was in a position of authority. Although she felt ashamed [affective RS: shame] of it, she *justified* her preconceived distrust by focusing on my novice clinician status. The relationship episode (RE) between us revealed her ambivalence about dependency. It was ironic that, within the broader context of her relational paradigm, she unconsciously gravitated towards controlling others [W: to be hurt and controlled]. Consciously, she feared dependency, but inadvertently, her behavior [behavioral RS: submission and withdrawal] was governed by a regressive, unconscious wish to be controlled by others. In subsequent modules, we would work on bringing this wish into conscious awareness.

Although I did not identify the transference the moment it transpired, I used supervision and the time between sessions to clarify the events in terms of the CCRT. I returned to it in the

next session: I broke down the patient-therapist RE into components W, RO, and RS. The RO-expected is also called a "transference distortion" (Book, 1998). Inquiry into RO discrepancies improves the patient's reality testing, modifies transference expectations, and provides a corrective emotional experience. Serena admitted that she experienced me as "forceful." I pointed out the discrepancy between Serena's *expected* response of other (that I would try to control her) and the reality (my actual, non-controlling behaviors). We explored the evidence for and against her transference expectation that I (an attachment figure) had been controlling and strict. I inquired about specific behaviors of mine that may have given this impression. I believed I had *not* been forceful, nonetheless, we collaboratively explored the proposition that she experienced me as such. In addition, I examined how my *delivery* could have contributed to Serena's RS of acquiescence and withdrawal. By this point, there was sufficient trust and rapport for us to engage in a curious and meaningful exploration of the "here-and-now" in our relationship.

By the eighth session, we had effectively begun uncovering the "childhood determinants" of her CCRT (Book, 1998). Serena took the transference work one step further when she offered an insightful comment linking the present RO with how her mother responded to her in the past. She recalled that her mother became upset [RO] when Serena appeared to be struggling, as if it were a personal offense that her child was floundering. In this context, Serena came to distrust the attachment relationship, and her mother's ability to tolerate, much less attend to, Serena's distress. This would lead her to feel more helpless [RS] and eventually guilty [RS] about burdening her mother with her needs. I elaborate on childhood determinants in the Middle Phase.

Serena's astute interpretation was a testament to her advanced *psychological mindedness* (i.e., ability to see a link between present and past events) and *capacity for introspection* (i.e., to see oneself as much an agent as a victim), qualities that were outstanding for a first-time therapy patient. I reflected these observations back to her for encouragement, a supportive intervention acknowledging the patient's progress in STPP (Book, 1998). I hoped to continue facilitating Serena's active involvement in session and her burgeoning *self-understanding*. Her engagement during the Early Phase was a good prognostic indicator. I continued to calibrate my treatment plan based on Serena's responses to my interventions.

Middle Phase: Sessions 9-20

Module 4: Identifying & Presenting the CCRT Underlying OCD Symptoms

The cross-cutting objective of the Middle Phase was to recursively *work-through* the components of Serena's CCRT. As featured in the table of REs from the RAP Interview (Table 4), Serena's CCRT had variants, all of which eventually surfaced during the course of treatment. Another focus was to teach Serena to actively recognize her CCRT in the unfolding of

relationship episodes (REs) of her life. Due to Serena's ego strengths, we were able to build a robust foundation for exploratory work during the Early Phase of treatment. By now, I reckoned she was well-equipped to delve into her CCRT in this Middle Phase.

The process of linking symptoms to the patient's relationship episodes is at the heart of the expressive component of SE therapy (Luborsky, 1984). In SE therapy, a *symptom* is defined broadly as a "dysfunction of a usually intact function or capacity" (Freud, 1926, as cited in Luborsky, 1984, p. 95). It follows that symptoms are like warning lights on an operating system, which become portals of entry into a chamber of conflict. Viewing OCD symptoms through the lens of the CCRT, they can be personified. While obsessions are clearly ego-dystonic, emitting unconscious material into consciousness, I contend that compulsions can be seen as ego-syntonic, serving as defensive operations in support of the ego. The CCRT/OCD *repetition compulsion* is unconsciously mediated, or "reproduced repeatedly like a theme and variations of a theme in spite of its self-hurtful nature" (Leichsenring & Steinert, 2017, p. 359).

Although it is unusual to assign homework in psychodynamic treatment, the brevity of STPP, coupled with the behavioral quota of symptoms, calls for a more direct and active approach. Considering that two months had elapsed since I measured Serena's symptoms with the Y-BOCS, I assigned a monitoring log for the week preceding Module 4, where she tracked the content, duration and frequency of triggers, obsessions, and compulsions. I was surprised when Serena told me she scrapped the monitoring log for a "diary." She said that journaling on her episodes helped her catalogue OCD's strikes more cohesively.

I appreciated Serena's ingenuity, and her initiative in adapting the assignment to better suit her needs. I sensed a desire to express herself in a more creative, rather than rote, format. This represented a stride in the direction of her wish for self-expression. From these diary entries I reconstructed a CCRT: "I wish to express my impulses [W], but others punish my self-expression [RO]. Thus, I fear that my impulses are dangerous, even lethal [RS: obsessions; thought-action fusion; omnipotence of thought; overestimation of threat]. I reassure my doubt by withdrawing from or avoiding danger [RS: compulsions; inflated sense of responsibility]."

Obsessive neurosis generates a stark duality between id drives and superego pressures. Ego defenses, such as reaction formation and isolation of affect, preserve this duality by overwriting affect with thought. Intolerance of uncertainty hinders the process of reconciling opposing views—for example, love vs. hate and life (self-preservation) vs. death. Within a pathologic state of ambivalence, opposites cannot coexist, nor can gradients. As Serena's case demonstrates, obsessive defenses are intricate and intertwined, such that the conceptualization itself incurs contradictions. In her CCRT, one major theme was dependence vs. independence: a latent wish to "be controlled by others" was the regressive counterpart of a mature wish for "self-control." Another theme was sadism vs. masochism: where sadism was unacceptable, it was

converted to masochism. Intrusive thoughts about self-harm could be interpreted as a reaction formation to sadistic drives. Superstitious obsessions regarding averting a *fatal accident to her family* hinted at suppressed sadism. What's more, counterphobic rituals serve dual purposes. When confronting perceived "danger" (such as touching a hot stove), Serena succumbed to an aggressive impulse; simultaneously, by withdrawing from the perceived "danger" (for example, swiftly pulling her hand away from the hot stove), she regained a sense of self-control and momentarily alleviated obsessive doubts regarding the potential lethality of her actions. As illustrated here, actions were conflated with thoughts through *thought-action fusion*.

In this module, I borrowed Summers and Barber's (2010) strategy of having the patient conceptualize her own problems, which also offset the power dynamic. In doing so, I gratified her wish for self-expression [W]. I valued her input and rewarded the insight she had acquired thus far, which augmented her motivation to continue to work hard in sessions. According to Summers and Barber (2010), this approach promotes a sense of control and mastery in the patient, with the caveat that "the therapist does not get seduced into too much theoretical back and forth" (p. 118). Their warning spoke to a particular dynamic between Serena and me where we connected over a shared penchant for intellectualization. Early on, our joint intellectualizing increased the alliance; at this juncture, it was more likely to reinforce Serena's affect phobia (McCullough & Andrews, 2001).

By the end of Module 4, we distilled Serena's CCRT in her language:

> *I wish to express what I feel [W], but others oppose and control what I feel [RO], so I believe that what I feel is dangerous [RS: obsessions] and calm my doubt by withdrawing from danger [RS: compulsions].*

This CCRT statement was authentic and meaningful to her. It became her *OCD formula*. The OCD formula is a tool that transposes the "working-through" *within* sessions to *between* sessions (Leichsenring & Steinert, 2017). The formula is a "map" that helps the patient identify signs of an ensuing RE, in real time. REs which will typically precede symptoms. I wrote it on a sheet of paper and suggested she review it at least once a day. Additionally, I instructed Serena to monitor her emotions when symptoms were present, including bodily sensations. In the following weeks, I noticed that her awareness of disowned affect markedly increased.

Module 5: Experiencing the Wish (W) Component: Disavowed Affect

Although I theorized about it, I did not directly confront the provocative content of Serena's obsessions just yet. Leichsenring and Steinert (2017) warn therapists about getting lost in the morbid details of the patient's defensive material, particularly because of the digressive speech patterns observed in obsessive patients (McWilliams, 2011), which could detract from the

active focus on the CCRT. A defended patient is prone to discuss gruesome content circuitously, such as by negating thoughts they just verbalized or disqualifying an alluded-to emotion.

In Module 5, we focused on the wish [W] component of the CCRT, which typically lodges a concomitant, disowned affect. Using the concept of *affect phobias* (McCullough & Andrews, 2001), a distinction is made between the *activating* affects (anger, fear, anguish, grief) and the *inhibitory* affects (anxiety, guilt, shame). Expressing her wish evoked anxiety because it exposed Serena to her fear of losing control when experiencing activating affects. Activating feelings, though threatening to the patient, are conjectured to motivate adaptive behavior (i.e., Malan's concept of *constructive aggression*). Serena's wish for independence was motivated by *anger*, while her wish for dependence was motivated by *fear* and *anguish*. These wishes were two sides of the same coin. When one was illuminated, the other was in the shadow. Though I conceptualized Serena's wish "to be controlled" as regressive and maladaptive, I realized that within it was an *adaptive* wish for healthy dependence. The more the wish to be dominated by others became conscious, the more agency she obtained to actualize its adaptive counterpart.

We were nearing the tenth session, and by this point, Serena knew the drill: I invited her to share relationship episodes (REs) from her week. Still, Serena preferred to wait for me to prompt her to speak, and rarely did she initiate sessions or direct the dialogue. Her general temperament was timid, but strained, throughout most of our sessions. When I asked, she told me she had been applying her OCD formula between sessions, so the themes were ripe and "experience-near" (Book, 1998). I was pleased at how adept she became at speaking the CCRT language. She appeared pensive as we sat down:

> **T:** You look…agitated today. (*Coaxing her*) What's going on?
>
> **P:** There's something I've been meaning to talk to you about. You know we [fiancée and I] moved in together 3 months ago. I had a bad feeling about it…in my gut… it just didn't feel like a decision I was ready to make [RS: uncertain]. But I couldn't stomach the nerve to say something about it [thwarted W]. I mean, I made this whole list of reasons why moving in together made sense, and I kinda convinced myself to go for it. I kept thinking, "If I am not ready now, when will I ever be? I'm almost 30!" [RO: opposing, critical]
>
> **T:** Can you tell me more about this "bad feeling" you had?
>
> **P:** Well, maybe I was overreacting. Sorry if I'm making him sound like a bad person. I mean, he loves me a lot [reaction formation]. (*Forces a smile, but eyes convey uncertainty*)
>
> **T:** You didn't sound like you were blaming him. You admitting to having a "bad feeling" isn't the same as criticizing him. [confronting thought-action fusion]. (*Gently nods*)
>
> **P:** But I don't for a second doubt that I love him [reaction formation]. (*Looks at therapist expectantly*)

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T: Of course you do. You don't have to convince me. (*Pauses*) Is it possible to experience some doubts about him and *still* love him? [confronting reaction formation]

P: Huh, hadn't thought about it that way. I do feel kind of guilty [RS: guilt] though, admitting that I had doubts about moving in.

T: It's good you're recognizing that guilt that's so strong in you. It seems like that guilt might be stopping you from talking more about the "bad feeling" you had. I don't want to gloss over this cause it's important. Can we go back to that moment?

P: Okay. To where? (*Looks concerned, uneasy*)

T: To the "bad feeling" you had when Fernando asked you to move in with him. What was that about?

P: We were driving up to visit with his parents and he just sprang it on me that he'd already told them we're moving in together. He said they were excited to celebrate. That's when I got that "bad feeling." It was like a knot in my stomach, you know? It didn't feel like something we decided together [W: to express myself]. I felt cornered [RO: controlling]. Then it turned into this sinking feeling…like a free fall…I felt sick to my stomach [RS: anxiety, helplessness] …well, there was nothing I could do at that point. I had to show up and like, "feign" excitement. I was scared I wouldn't be able to fake it. (*Pauses, grimacing slightly*)

T: So, he didn't *ask* you to move in. He made the decision by himself and expected you to oblige.

P: Yep, exactly.

T: Did that make you mad?

P: I didn't want to be mad at him. He's my fiancée, and he takes good care of me [reaction formation].

T: It sounds like you were maybe feeling angry or annoyed at the time when the "bad feeling" hit, but then you tried to brush it off.

P: I guess I felt guilty [RS: guilt] because I'd been avoiding talking about this for months, and I knew how much he wanted to move in together. I felt like I owed it to him to just go along with it and not make a fuss, you know?

T: How did that work out for you?

P: That day, I was super anxious [RS: anxiety, helplessness], but I managed to keep it together. We didn't really talk about it. I mean, I get along great with his parents, so we had a nice dinner together. But the next day, I left the apartment and turned my phone off cause I needed a break from everything [RS: withdrawal]. I drove away…far away…to the beach by

myself. (*Averts gaze, shakes head*) I didn't tell him though, and he totally freaked out when he found out [RO: upset]. (*Sighs*) We argued all through the night.

T: So, is there a reason you're bringing this episode to me now? You said it happened a while ago.

P: Yes! You asked me to work on my OCD formula, and I just kept thinking back to that time because my OCD went off the rails that day.

T: So, you were so anxious that day that it triggered your OCD.

P: Like big time. It was so bad that I had to take like half the week off work.

T: When you describe this episode, I get a visual of you under a tight harness.

P: (*Nods in agreement*) Yeah, that sounds right. I felt trapped.

In this exchange, I steered Serena towards a more accurate perception of 1) her squandered wish [W] to assert herself and 2) the activating affect associated with her wish (the "bad feeling"). I mainly used the expressive technique of clarification of affect. This involved redirecting her to concretize a vaguely defined feeling, prompting her to elaborate on generalizations (i.e., provide examples), and confronting classic reaction formation maneuvers (i.e., disqualifying any hint of hostility/anger by reaffirming love). I noticed that Serena's affective literacy (using more nuanced language to describe emotion) improved as she made contact with the physical sensations (i.e., gastric discomfort) associated with the "bad feeling."

Moreover, the dialogue reveals a dichotomy between love and hatred, as in Freud's (1915) *vicissitudes of instincts*. Serena was caught in obsessional ambivalence because she could not reconcile feeling love and hatred towards the same object, her partner. As evidenced in the dialogue above, Serena stewed quietly [RS: helplessness] instead of expressing opposition. I likened it to being strapped into a harness. Because she felt dubious about the move, she was ashamed [RS: shame, guilt] to speak up. Although defenses were effective in temporarily suppressing feelings of anger (to preserve harmony), in due time, her aggressive impulses made themselves known. When her defenses gave out, she enacted her unconscious rage by stonewalling [RS: withdrawal] her partner. As expected, her behavior triggered Fernando's anger [RO: upset], and they entered a hostile feedback loop.

I dedicated an additional session to this module to explore a broader issue raised by this relationship episode: Serena's fear of commitment. Moving in with Fernando was symbolic of a progression in their level of intimacy. It was also expected by their families. Yet, it portrayed her predicament with such clear strokes that it expedited the expressive work we were doing in therapy. Although their growing intimacy brought to consciousness a powerful wish to be taken care of [W], in her mind, the wish was associated with being controlled [RO]. I turned to childhood determinants: forsaken dependency needs. We delved into the past like archeologists. I

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asked Serena to imagine her child self in a prime state of dependence and to free associate. The first image she reported was a toddler atop her father's shoulders, buoyed by his strength, in jovial spirits. She said moments like these were fleeting; she savored them when they came around. Before she knew it, he was gone, for days at a time and sometimes weeks (her father worked as a truck driver during their early resettlement years). As a child, Serena missed him dearly during his extensive shifts. If she asked about him, her mother dismissed her, telling her that she had to learn how to live without him. If she cried about it, her mother would wipe her tears, take her to get ice cream, and tell her to think about happy things instead.

Moreover, she recalled a time when she was teased by a boy on the bus about having crooked teeth. She came home very upset, slamming the door on her way into the apartment. Both parents yelled at her. She told them what happened, and they responded by saying it was no good reason to slam the door. They insisted it was her choice to allow her peers' words to hurt her, suggesting that if she were confident, she would not be bothered. Being a victim, they affirmed, was a choice. They also warned her to stop being so loud, or else the neighbors would think something was wrong with her. Then her mother added, "Your teeth look prettier when you're happy."

Primarily, to depend on her parents meant to be her vulnerable to criticism [RO], and often invalidated. It also exposed her to intense feelings of frustration, and hatred, in the moments that her powerful wish to be taken care of was dismissed. Her mother overpromised what she could provide; she was smothering. Her father was mostly absent. Steered by reaction formation, she grew up putting stock in her wish for independence and divesting her dependency wishes from consciousness.

Considering Serena's investment in her Cuban heritage, I weaved cultural suggestions into the fabric of the free association. I asked whether the fear of depending on others could also be traced to the persecutory fears that plagued her family under an oppressive regime. I provided psychoeducation on the transmission of generational trauma through interpersonal dynamics. Furthermore, I raised the concept of *machismo*, which became a healthy conduit for her feelings of anger towards the "forces of coercion" in her psyche. She owned her annoyance about the cultural mandate for women to embody a dependent role. Yet, she wanted to feel like she belonged in her culture, so she succumbed to these values. Marrying a Cuban man represented an opportunity to feel validated by the whole of the Cuban culture.

Serena responded eagerly to this exploration. There was a synergistic tone, which we both seemed to appreciate. Through my initiative to explore her cultural identity, we inevitably encountered her CCRT, which invited ambivalence and hinted at disavowed affect. We spoke to both sides of the ambivalence, and I encouraged her to hold contrary attitudes. Subsequently, I guided our focus towards the disavowed affect that I could palpably sense. Leveraging the

momentum of our discussion on cultural phenomena, I used an "intellectual angle" on culture as an entryway to her warded-off anger. Eventually, I abandoned conceptual discussions and guided Serena step-by-step towards experiencing the *activating feeling* (McCullough & Andrews, 2001). Instead of confronting anger directly, we magnified the imagery evoked by our discussion. Then, I guided her to focus on "experience-near" sensations, such as the heat in her chest, pulsing in her head, and tightness in her throat. This approach was very similar to an imaginal exposure.

Relatedly, I reflected on the juxtaposition of collectivistic and individualistic values in her CCRT—portrayed in the seeming clash between her wish for independence and her misconstrued wish for dependence. This configuration, I thought, was intriguingly reminiscent of the acculturation challenges experienced by immigrant children in the U.S.—a clashing of values that I personally navigated upon moving from South America. U.S. culture condones rugged individualism, a stance that often pathologizes dependence. I had to be careful not to overemphasize this sentiment, which had biased my thinking in the past. Hispanic cultures, on the other hand, find fortitude in dependence, and strive to preserve relationships, even at the expense of personal drives. Although Serena did not ask me about my own background (I think she did not want to pry), I disclosed some of it, particularly the similarities to hers, to earn some credibility on the topic and to increase rapport. She looked surprised, as if she had not stopped to consider that I might have more in common with her than meets the eye.

To summarize, I clarified the self-imposed binary between Serena's wish for independence and her less conscious wish for dependence. I used interpretation to foster insight into a state of tension that disabled her from truly satisfying either wish. A mark of progress was when Serena began to recognize both wishes as deserving of conscious gratification. Organically, she began to emerge out of the ambivalent space; this had the downstream effect of reducing her symptoms. Obsessive dynamics are a compensatory response to ambivalence. The less she resided in the ambivalent space, the less prone she was to experiencing symptoms.

Module 6: Modifying Internalized Object Relations (RO): Mitigating the Superego

Module 6 was a deep dive into the orchestrating force of Serena's object relations, the *transference*. Through clarification, I elicited Serena's expectations of how others would react to her [RO] if she spontaneously expressed either of her wishes. In turn, I linked Serena's current ROs to childhood interactions with her parents, from which unresolved feelings were transposed to current objects. I posed the "worst-case scenario question" to determine feared interpersonal consequences from current relationship episodes. I determined that her RO had three prongs: fear of upsetting the other, being controlled by the other, and being criticized by the other (thus, rejected). At the start of my inquiry, Serena's demeanor was contained, but it loosened gradually as she gained confidence in her sharing. I noticed a pattern where she oscillated between righteousness and doubt in her speech. Though her insight was intellectualized, the content she

offered was rich. The more I probed, the more the "defense" aspect of intellectualization softened, evidenced by pauses in her speech and other non-verbal indicators of affect (i.e., tone inflections, hand gestures, eye movements).

In the interest of brevity, here is a quintessential relationship episode capturing the RO themes we worked through in this module:

> Serena punctured a tire as she was driving on the highway. She thought of calling Fernando for help [W: dependence] but felt uncomfortable with the idea of being indebted to him later [RO: controlling]. After a flurry of emotions [RS: helpless, anxious], she regained her composure and decided to deal with the situation herself [W: independence]. She called roadside assistance because she didn't know how to install the spare [RS: self-controlled, self-confident]. She effectively resolved the problem but decided she wouldn't tell anyone about the incident [RS: self-controlled, controlling]. Several weeks later, Fernando found a receipt from the auto repair shop and confronted her. She told him what happened. Fernando was offended [RO: upset] that she didn't call him for help. He accused her of secretly seeking attention from other men [RO: critical, controlling]. He later mocked her for "flaunting her independence" and "thinking she is better than him."

There was a lot to unpack in this RE. The RO is Serena's fear of being controlled by her partner. When her car broke down, her immediate wish was to ask for help, but she recoiled at the fear of giving him emotional currency to use against her by asking for help. She was alluding to a *fantasy* about being manipulated by Fernando if she expressed a genuine wish for help. I helped her to clarify the fantasy. She envisioned him bragging about his chivalry, using the event as leverage to get her to do what he wanted.

In the process of interpreting the fantasy, I asked about past events where her dependency came at a cost. Serena remembered that her mother scolded her for seeking her father's support when she was sad, saying "he's too busy to deal with your problems." Although it was easy to access her mother's consolation when she sought it, she risked that her vulnerability was weaponized. When she asked for support that her mother was incapable of providing, she would make sarcastic comments, insinuating that her daughter was weak for making the request. Understandably, Serena distrusted attachment figures to respond to her emotional needs.

The beauty of working with the transference in such a raw and direct way is that the patient is invited to assimilate feelings previously disallowed by the superego. Processing painful memories in the empathic container of the therapeutic relationship provides a corrective emotional experience (Book, 1998). This was the first time Serena appraised the extent of her distrust, which had driven her to defy her needs through a counter-dependent stance. I urged self-compassion as I validated the compounding effects of guilt on her conscience. I made space to digest feelings of disappointment as they bubbled into consciousness, which seemed to have a

ripple effect in eliciting more unconscious associations. Disappointment morphed into anger, which morphed into anguish. I observed overt changes in her affect and facial expression. Initially guarded and reserved, Serena's demeanor softened as she allowed herself to experience the cascade emotions. As her therapist, in a helping role, I responded differently to the way her caregivers historically dealt with her bids for dependence. I responded with attunement—I validated her feelings, I did not retaliate, and I consequently earned her trust—all of which contributed to resolving the shame around her dependency needs.

I decoded the second half of the relationship episode. Driven by anxiety over the fantasized RO, reaction formation converted her dependency wish into self-sufficient action. My analysis here was twofold. In part, Serena fulfilled her wish for independence by calling roadside assistance, thus resolving the problem without the help of an attachment figure. I commented on the meaning of this action—proof of a burgeoning effort to actualize her wish for autonomy outside of session. Another achievement was her independently regulating her frustration in response to the incident.

Book (1998) stressed the importance of the therapist *marking* and *mirroring* the patient's gains as a source of positive reinforcement (a supportive element) in route to achieving their goals. Nonetheless, despite her actions, Serena failed to *assert* her independence (she lied about the event) or acknowledge her hidden wish to ask for help because she was propelled by an RO fear of retaliation and control. Although the RO was originally based in fantasy, it materialized some weeks later when Fernando found a receipt as evidence of her lie. He was offended [RO: upset] and derided Serena [RO: criticism] in a way that felt manipulative [RO: controlling]. I interpreted the act as a self-fulfilling prophecy, characteristic of repetition compulsions. Serena's RO predictions cued her RS of taking back control of the dynamic by withholding information, which in turn provoked controlling behavior in her partner and confirmed her expected RO.

Rather than work on reality-testing her RO expectations, as Leichsenring and Steinert (2017) suggest, I asked her to reflect on her role in the unfolding of events. Serena's RO *did materialize*, even if it was mediated by her RS (which we will address in Module 7). The conversation was fruitful owing to Serena's ego-strength of psychological mindedness, including her ability to see herself as much an agent as a victim (Book, 1998). It yielded insight into the unconscious power that Serena's RO wielded, not only in conditioning others' behaviors but more broadly in attracting attachment relationships where the characters enacted roles similar to those embodied by early objects.

Further, because the patient's RO is mediated by the superego, confronting the RO has the benefit of tempering a hyper-strict superego (Leichsenring & Steinert, 2017). Based on the historical context provided, I linked the genesis of Serena's strict superego to an introjected censuring mother. My interpretation drew forth the imprint of a recurrent childhood experience

she had of her mother scrutinizing her body movements and appearance. When she sat down to eat, there were comments on her posture or the way she chewed her food. Most times, she noted, the facial expressions of disapproval were more impactful than words. To earn her mother's approval, enter *superego*: she had to curate her behavior, tame her "natural" feelings and conceal the fact of her flaws. In conjunction, she feared the sting of rejection [RO] through any such interactions. She admitted that as an adult, she still "walked on eggshells" around her mother; any misstep could provoke a condemning smirk or an eye roll.

In the present, the introjection resembled a sort of inverted *hostile attribution bias* (turned inwards). Leichsenring and Steinert (2017) instruct therapists to "identify the absurd strictness of the superego" (p. 365) and to apply a non-condemning attitude towards the patient's unaccepted aggressive or sexual impulses. Given Serena's inflated sense of responsibility, I used *externalization in the service of therapy* (Watchel, 1997) to help her forego responsibility for inherited attitudes and modulate guilt. This intervention involved fostering insight into early-life reproaches that may have engendered pathogenic beliefs such as "There's something wrong with me," "I am helpless," and "I *should not* feel angry." Next, I addressed the cost of these beliefs and compensatory feelings, such as shame [RS]. I dissuaded her from blaming attachment figures for empathic failures. To this end, I utilized mentalization techniques to reflect on factors that could explain her parents' empathic failures, i.e., the fear and paranoia they experienced as victims of persecution could have been emotionally impairing. This exploration conceded a more balanced, compassionate view of herself and her parents.

The discussions throughout this module engendered a shift in our dynamics. I noticed Serena relax into the relationship, suspend her reservations, and volunteer sensitive material without much prompting on my part. Her speech had a new ring of candor. Her usual linearity gave way to more spontaneous associations. Instances in which her affect was on par with content were more frequent now. I could tell by the shift from polite but insincere smiles to natural, unpressured expression along the spectrum of emotions.

In the culmination of the module, she broke her reticence on the topic of her engagement, which had been a major detonating factor for her current struggles. At the intake, she attributed the onset of her obsessions and compulsions to the panic attack she had on New Year's, which she struggled to make sense of because it seemed so out of place. What initially seemed like a festive New Year's Day marriage proposal had swiftly devolved into a tumultuous ordeal. When she described the episode at intake, I noticed a sense of shame and secrecy in her tone, as if she wanted to write it off as a mere "glitch." Since then, I felt in the sessions as though an power stgruggle in the room—or an incongruity—stood out every time she talked about her relationship in an idyllic tone. My countertransference echoed her fear, and it is possible that I, not wanting to corner her, colluded in her avoidance. But it is also possible that all this time, I was slowly

disarming her (through defense restructuring) and gaining her trust, thereby preparing her to approach conflictual topics on her own.

I patiently awaited her initiative, aligning with my goal of treating her as an "adult counterpart" (Leichsenring & Steinert, 2017). The session that she did, she approached me with a sense of urgency, recounting a recent dream that had been weighing on her:

> In Serena's dream, amidst a serene garden backdrop, Fernando knelt down with a ring in hand, proposing to her. She hesitated, unable to give a clear answer. Suddenly, Fernando's expression turned from hopeful to puzzled, and then to despair. His face grew pale as he collapsed to the ground. Serena watched in shock as Fernando fell ill before her eyes. This time, it was he that ended up at the hospital.

Serena admitted that her OCD threatened tragic consequences concerning Fernando if she did not disclose this dream in therapy. While I was somewhat relieved to hear her talk about it, I stressed how concerned I was that *we* had ignored the conflict around her engagement all this time, especially considering how much the event had influenced her decision to seek treatment. Further, I disclosed that I found her tendency to sugar-coat her relationship confusing. This had struck me as an attempt to *undo* her ambivalence. And yet, the dream vividly portrayed her ambivalence and fear of losing Fernando, providing a launching pad for us to address her commitment fears, relationship indecisiveness, and pervasive guilt. The mere act of talking about all of this was an "exposure"—to a well of ambivalence, and ultimately, to warded-off affect.

Module 7: Modifying Maladaptive Responses of Self (RS): Relinquishing Defenses and Avoidance

After a cathartic session the week before, I was naturally expecting Serena to be ready to consolidate insights gained into her RO, which would begin to release its grip on her RSs of guilt, anxiety, helplessness, and withdrawal. However, the transference had gained notable momentum, and its intensity galvanized an enactment. An enactment occurs when the patient's RS manifests in the therapy relationship in concert with a perceived RO in the therapist's behavior (Luborsky, 1984). Therapists should be attentive to the clinical marker of an enactment: a precipitous change in the patient's affect and disposition (Book, 1998).

Rather than viewing an enactment solely as a form of resistance, it is advantageous for the therapist to seize it as an opportunity for a more profound understanding of the patient's subjectivity. Still, Leichsenring and Steinert (2017) warn therapists to expect a resurgence in resistance at any stage of treatment. The dialogue below is reminiscent of the dynamics that transpired between us in earlier sessions. I was forewarned of the magical thinking features embedded in Serena's CCRT during Module 2: Addressing Ambivalence. So, I recognized the defensive *undoing* patterns and promptly addressed the enactment within the same session.

T: *(Smiling warmly*) I'm reminded that last session stirred some strong emotions in you. How are you feeling after our last chat?

P: (*Shifts in chair, gazes into the distance, distracted)* I'm feeling alright today, actually. Went for a walk this morning... [RS: withdrawal] Um, about last session... I'm having trouble remembering that [undoing]. It's fuzzy.

T: Did you think about our last meeting? At all?

P: (*Tapping foot nervously*) Nah, not really. In all honesty, I should tell you that I don't feel like digging into my past anymore. I think focusing on the present is more important [undoing].

T: (*Brows furrowed, puzzled*) That's interesting. Remember when I explained how therapy works? [RO: upset, strict] We dig into the past to understand your present. You see, your fears are typically reactions to circumstances of the distant past, not current ones. It's like they're outdated, or misplaced. Knowing this gives you the choice to let go of your OCD symptoms…To let go of the guardrails, so to speak.

P: (*Sighs, shoulders slump*) I feel bad for venting about my family last time [RS: guilt]. I think I was being rude and disrespectful.

T: (*Tilts head sympathetically*) Cut yourself some slack. You were just speaking your mind. And remember, there are always different sides to every story.

P: (*Fidgets with hands, avoids eye contact*) What if I was just making stuff up to get your sympathy? (*Glances at her watch, then around the room*) [RS: anxious, more withdrawn]

T: (*Notices fidgeting, raises eyebrows*) I can't help but notice you seem a bit antsy. Got somewhere else you need to be?

P: (*Nervously chuckles, shifts in seat*) Sorry, that was rude of me. I, um, have another appointment after this, so I was just checking the time [RS: ashamed].

T: (*Apprehensive*) You say you want to focus on the present, but you seem a bit elsewhere right now. It's like you're throwing out all the work we've done together and we're just spinning our wheels now [RO: upset, critical].

I yielded to the stalemate, paused, and reflected on the implicit process. I did my best to avert a "control battle," which would have been counterproductive (Summers & Barber, 2010). Entering an enactment, though not ideal, afforded me the chance to understand Serena's world better—to experience the parental dynamics that were playing out in the here-and-now of the therapy relationship. To work through the enactment, I had to translate what was tacit in our dynamic to CCRT terms, a task which proved incredibly challenging for me in that moment.

There seemed to be a *displacement* of her recalcitrant sentiment towards her family onto the treatment. In "forgetting" the catharsis of the previous session [RS: doubt, withdrawal], she

was *undoing* her insights, which felt to me like an attempt to sabotage our relationship. The writers of the manual dubbed the OCD patient an "inhibited rebel" (Leichsenring & Steinert, 2017), alluding to these patients' idiosyncratic rebelliousness masked by an obedient guise. The subversion of the treatment was yet another manifestation of ambivalence. I highlighted the rebellious sentiment to her and linked it back to her ambivalent commitment at the beginning of treatment. Although it was difficult for her hear, she understood my point. Still, I carefully monitored the sturdiness of her engagement with me and the authenticity of her responses. In moments like these, she was susceptible to acquiescence, a mild form of disengagement used to avert conflict.

The enactment began with Serena's guilt-ridden, aloof presentation [RS: withdrawal], to which I reacted with counter-transferential dismay [RO: upset]. I leaped too quickly to confront what appeared to be therapy-interfering behaviors [RO: strict]. Preoccupied with the time limitations of STPP, I became impatient, not wanting to disrupt the momentum we had. Instead of appraising how remorseful she felt, I made comments that were critical [RO: critical]. I overlooked the influence guilt [RS] exerted over her entire CCRT. Guilt [RS] had activated her withdrawal [RS]. My attempt to course-correct by enforcing the frame exacerbated Serena's guilt [RS] and confirmed her RO expectation that I would be strict and domineering.

Notwithstanding, I felt devalued by her blasé dismissal of our work together because it felt like a dismissal of my investment in her growth. In supervision, I realized that I downplayed these countertransference reactions, both in the moment and later when I debriefed the enactment. I felt responsible for triggering her RO [critical] and her RS [withdrawal]. When I took ownership of my own behavior, I may have exaggerated the scale of my criticism and strictness. I overlooked the influence of her RO *expectations,* which I may have identified with, and through that lens overinterpreted my own behavior. Perhaps, the working-through of the enactment was, unbeknownst to me at the moment, an unconscious extension of it.

After dismantling the enactment, I was compelled to explore the dissonance between her culture's collectivist values and a therapy whose premises are fundamentally individualistic. A patient's RO is assumed to be a derivative of the empathic failures sustained in their upbringing. The RO analysis exposed problematic dynamics in her family system. This "exposure" posed a threat to the cultural values of *familismo* (loyalty to the family's belief systems and upholding cohesion) and *respeto* (children respecting their elders). The moment that *reaction formation* was suspended, she had to own her rebellious attitudes and their attendant affects, rage and fear. However, after the session, when she visited her parents, she was inundated with obsessional doubt that she betrayed them [RS: guilt, obsessions]. The pressure to adhere to the traditional values of her culture, coupled with the fear of rejection by her culture, heightened her sense of guilt, ultimately leading to the activation of the *undoing* defense. In confronting the undoing

defense here, I posed questions intended to divorce thoughts from actions: "Does challenging collective beliefs amount to betrayal? Is disagreement synonymous with disrespect? Can skepticism and reverence coexist? Is feeling angry an offense?"

Later, I revisited cultural issues to highlight the tension between our therapeutic exploration and the cultural expectation *not* to challenge family norms. I openly shared my biases favoring therapeutic exploration while encouraging Serena's agency in choosing whether to engage with me rather than being driven by an automatic withdrawal response [RS]. Serena revealed instances of blindly complying in therapy, recognizing that this might be culturally influenced. I shared how I sensed a rebellious underbody to her outward conformity.

Relatedly, we explored her father's legacy in her psychology. She associated her rebellious impulses with her father's activism as a political dissident. I thought this was an excellent parallel. He was victimized because he protested the Communist regime, and while she understood that his actions were patriotic, it was difficult for her to contend with the belief that he betrayed his country when they fled. I saw an opportunity to elicit feelings of anger, which she admitted feeling toward her parents for abandoning Cuba.

Moreover, Serena's RO fear of being controlled by others could be interpreted as a legacy of her father's experiences of oppression. I extended the interpretation to include Serena's RS of withdrawal, used in the present to flee from the "emotional specter of oppression" that was her RO fear (of being controlled). Winnicott (1958) described the "withdrawn state" as a "defensive organization implying an expectation of persecution" (p. 416). In the present, her RS was leveraged to *avoid* interpersonal conflict and its painful repercussions. Yet, I interpreted further, her RS of withdrawal reflected an unconscious identification with her father's "emotional absence." For OCD patients, withdrawal is maladaptive because it breeds resentment, incites passive-aggressiveness, generates doubt, and maintains obsessions and compulsions. I used self-disclosure to highlight my negative reactions to her withdrawal—confusion, frustration and impatience.

As per McCullough (2001), authentic transformation occurs when the patient feels sorrow over letting go of defenses. Giving up defenses is like temporarily surrendering one's armor. When Serena's maladaptive relational strategy surfaced earlier, I missed the opportunity for a more attuned response, which could have prevented an enactment. This served as a reminder to infuse extra empathy in both interpretations and confrontations, a strategy that works well for OCD patients with criticism-sensitivity (Summers & Barber, 2010). Summers and Barber (2010) advise therapists to "guide and encourage with a light touch, avoiding…a control struggle" (p. 119). One aspect of this strategy involves validating the patient's perspective by providing logical reasoning for their schemas (Summers & Barber, 2010).

An illustrative example of this approach, specifically addressing the intellectualizing defense, follows: "Your deep connection to your heritage appears to anchor you firmly in tradition. But then there's this anger [warded-off affect] bubbling up because you're not as connected to Cuba as you'd like to be. It's like you're torn between this strong sense of duty to be a good daughter [RO: likes and accepts me] and the guilt [RS: guilt] that piles up because you feel so angry about the situation. Sometimes it feels like that guilt is just weighing you down. And when you're scared to let out that anger, you sort of retreat from your family [RS: withdrawal] to keep your emotions in check. Instead, you channel your energy into learning more about Cuban culture, like you're trying to fill that emotional gap intellectually."

Module 8: Addressing Behavioral Symptoms within the CCRT: Exposures

Taking an active therapeutic stance, I designed an exposure hierarchy (see Table 6) to target Serena's "feared situations" (Freud, 1919). The list included real-life triggers for intrusive thoughts, such as interpersonal circumstances where *activating affect* (McCullough & Andrews, 2001) was implicated. For example, one item asked that she set a boundary while allowing herself to feel *constructive aggression* (Malan, 1979). I explained that the purpose of these exercises was to "give up avoidance" (Freud, 1919) and disconfirm expectations of losing control and causing harm. Importantly, I instructed Serena to make the *conscious decision* not to carry out her compulsions during exposures (i.e., response prevention). In her case, this meant not *trying to figure out* whether she would act on her thoughts and cause harm to her body (i.e., defusing thoughts from actions). It also meant *not checking* whether her fear reflex worked. For example, I asked her to retrieve her kitchen knife set from her parent's place (she had removed all knives from her home) and prepare meals that required their use. Serena predicted having thoughts such as "What if I chop my fingers off with this knife?" or "What if I stab myself in the throat?" She was asked to handle the knife as directed by the recipes, without: checking the sharpness of the blade with her fingers, monitoring and reviewing her hand movements as she chopped, mentally rehearsing all the ways in which she could injure herself, mentally debating whether she would stab herself to "get it over with," or reassuring herself that she "is not the type of person that would do that," while listing all the things she cherishes about life.

After completing this exposure at home, Serena reported that the response-prevention piece was especially difficult for her because her compulsions were predominantly mental. She complained that she "couldn't get out of her head." Wolfe's (2006) term, *cogitation,* captures the experience of mental compulsions, which could become hypnotic to the point of dissociation. Like static on a phone line, it impaired Serena's cognitive-affective faculties. Exposures were designed to first elicit and then disrupt the vicious cogitation circuit. Drawing on my clinical experience, I told her that I understood how obstinate these compulsions could be, but I also knew from my training in Exposure and Response Prevention that compulsion-blocking is *the*

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active ingredient in exposures. Over time, exposures would strengthen Serena's observing ego, which I explained as the part of herself that does not get swept up by the obsessive-compulsive trance.

Leichsenring and Steinert (2017) discourage STPP therapists from conducting behavioral exposures during session. Rather, the therapist functions as a consultant who prescribes exposures for in-between sessions. This intervention falls on the supportive end but still aligns with the goals of expressive CCRT work, as the patient utilizes the assignments to collect experiential data for discussion during sessions. In contrast to CBT exposures for desensitizing anxiety, our objective here is "to use the aroused experiences to work on the underlying conflict" (Leichsenring & Steinert, 2017, p. 341). I advised Serena to deliberately study her reactions, and those of others, when completing her exposures (e.g., how does her partner react when she stops seeking reassurance). When she brought this material to session, I took an insight-oriented approach to clarify *the precise nature of her triggers*, an understanding that helped Serena foresee and prepare for triggering situations in the future (Greenberg, 2022).

Serena told me of a novel trigger that arose naturalistically at work. She was a second-grade teacher. She said she was out on the playground watching her students play during recess, and she became overwhelmed by thoughts about jumping off the building's second floor. The urge to ritualize followed, "If you don't scan your mind and body to confirm that you won't do it, one of the kids will get hurt under your watch." She reported being aware of the thoughts as such, in the moment, and taking the opportunity to practice exposure by stopping and affirming the thoughts *as thoughts*, without going to the second floor to *check* whether she would jump or not. I decided to revisit the episode during session in an imaginal format. Simply talking about it in session was a practice in exposure:

> **P:** It was recess. We were outside, I was watching the kids. Next thing I know I was obsessing about going upstairs and jumping off the second floor. I suppose it's not a long way down, but who knows what would happen to me. I got so annoyed, because like, it got worse from there. It threatened that if I didn't do the checking, then something terrible would happen to one of my students. I pictured…a kid hitting their head on the metal bars, knocked unconscious.
>
> **T:** (*Nodding*) It sounds like you were very *aware*, in the moment this unfolded…
>
> **P:** Then I had the urge to close my eyes for a prolonged period of time, so that I couldn't see what they were up to. The thought said that if I didn't close my eyes, I would jinx it and one of them would get hurt. It would be my fault. (*Sighs*) I know that doesn't make any sense!
>
> **T:** It's okay. (*Makes eye contact, focusing*) Let's make it simple and look at this one thought: "If I don't check my impulses, my students will get hurt. Or I will hurt myself."
>
> **P:** Yeah.

T: What are you trying to control? Like, what are you afraid of that you don't want to happen?

P: I don't want to be the cause of pain. For myself or for anyone.

T: (*Nods in agreement, maintaining a gentle gaze*) Yeah. That's natural, isn't it? I wouldn't want that either. Can you connect with the place inside of you that wishes for the wellbeing of everyone?

P: (*Bites lip, brows furrowed*) It's hard. I feel like I have a dirty little secret where I actually want to people to suffer.

T: Yes, I know, and I suspect you're having a lot of feelings about that, because it's unsettling. Let's home in on the thought again. I'm going to ask you to close your eyes and imagine the feared outcome. Can you picture a student getting hurt? Make it like a scene from a movie. Put yourself back on that playground, the day you got triggered, assume you're watching them and then one of them slips and cracks their head open. Let your imagination run wild, make it gory.

P: (*Grimacing*) Oh my gosh. Really?

T: (*Offers a reassuring smile*) Bear with me. It's a big ask, I know. Trust me that I'm not doing this to torture you, there's a purpose here. Let's focus on that image. On the playground. An accident happens. You're watching. What do you feel?

P: (*Eyes shut*) Like, what am I feeling?

T: Yeah. What do you feel right now as you're watching that?

P: (*Nods gently*) Anxiety.

T: Okay. See if there's something more. Maybe fear? Fear is like, more pure in the body than anxiety, I think. Anxiety is more of a heady emotion, it comes with a lot of thoughts.

P: I'm scared, for sure. (*Puts head in hands*) There is one connection that comes to mind really easily though…the guilt [RS].

T: Can you connect with the guilt *right now*?

P: Right now? Well, not right now. (*Remembers to focus and closes eyes*) Okay, yeah, when I see this situation getting worse with the kids and all, guilt starts to come out.

T: Good. If the guilt could speak, what would it say?

P: (*Voice quivering*) That I somehow caused this situation [the child's accident] because I wasn't paying attention. (*Exhales, pauses*) I don't want anybody else to suffer in the long term.

T: (*Maintains a supportive presence*) See, this comes full circle. Guilt is about control, isn't it? Cause it's saying, "It's *my* responsibility…to prevent accidents." It's trying to convince

you that you have more control than you actually do over natural forces that lead to accidents. Why? Because if accidents happen, if danger rears its head, *someone* might get hurt, right? And inevitably, *you* will feel pain, right?

P: (*Opens eyes*) Yeah. (*Nods slowly*)

T: And you don't want to feel pain, no one does. So it's easier to feel guilt, I suppose, because it gives you hope, hope about resolving the pain. Makes you feel in control.

P: (*Shrugs*) I wish I could take myself out of the equation as much as possible.

T: You can when you accept what you cannot control.

Serena's struggle to articulate intense emotions underlying her obsessions was evident. The desensitization of her overwhelming anxiety and guilt (inhibitory affect), the "fuel" of the obsessive-compulsive cycle, freed some bandwidth for exploratory work. As featured above, we worked through of the RS of guilt. Next, I clarified the precise nature of the trigger—the "visual" of the kids prancing on the playground and getting hurt—from which I deduced a *displacement* of Serena's vulnerability, and fear of danger, onto her students:

T: There's one image in this scene I want to hit pause on: a child in pain on the playground. What happens when you focus on that image? Take your time.

P: (*Closes eyes. Prolonged pause as she engages with the practice. She grips the armrests of the chair tightly, her breathing becoming shallow.)* I feel afraid. Very afraid.

T: Of what?

P: (*Pursed lips, furrowed brow*) Of what will happen next.

T: Stay with the fear. What do you see in your mind's eye?

P: (*Furrows brow deeper, a slight tremble in her hands*) This is weird but…it's like I'm looking through my mom's eyes right now. And the child I'm looking at, that's me as a kid. Me as a second grader.

T: (*Nods encouragingly*) Very interesting! Let's keep going. Who are you right now? Are you Mom or little Serena?

P: (*Shifts in her seat, crosses her arms over her chest*) Strangely…I'm both.

T: (*Leans forward, showing engagement*) That's cool that you can actually *be* both right now. Okay, so *who* feels the fear?

P: (*Bites lip, eyes dart around the room before settling on a point in the distance*) Both of us. Neither one knows what's coming next. Mom is slamming out inside and I can tell. But on the outside she's frozen. Her eyes are empty. Like she can't even look at me for a second. Because she doesn't know what to do. I wish someone would help her. She looks right through me, like I don't exist…She's there but she's gone. Now I've lost her!

T: (*Nods in understanding, mirroring the patient's body language*) So your mother can't help you. It sounds like she also can't look at you? Because it hurts her?

P: (*Blinks rapidly, tears welling up*) Yes! (*Eyes closed*) She's in so much pain right now.

T: (*Hands patient a tissue box*) How does little you feel?

P: (*Takes a tissue, dabbing at her eyes*) Hurt. Alone. Rejected. Abandoned. I can't do anything to help her, or to help myself. Scared for my life. Scared for Mom's life.

T: (*Nods sympathetically*) How would Mom feel if she lost you?

P: (*Gasps then exhales, shoulders slumping*) It would break her heart. I was her whole world. (*Tears flow freely now*)

T: (*Offers a gentle smile*) This scene is so sad, huh?

As depicted in the dialogue above, exposure unearthed traumatic memories, and associations, from Serena's past. For as long as she could tolerate, I had Serena stay with the "catastrophic imagery" (Wolfe, 2006) elicited by the exposure. Her imagery encapsulated a painful experience of helplessness in the face of physical pain and feared abandonment. The images were symbolic of her child self's "loss of innocence." She appraised her defenselessness in the face of danger, and the limitations of her caregiver in protecting her. This could have marked the inception of her core conflict around control.

Moreover, the scene suggests an internalization of her mother's deep-seated fear of losing her, a fear that reverberated in her own consciousness as a heightened sense of responsibility to protect her vulnerable mother from having to deal with injury or loss of her child (i.e., *role reversal*). For Serena, the fear of injury was governed by a larger peril—being estranged from her mother. As I probed for feared outcomes, she said that she feared her mother would abandon her from the sheer intolerance of *seeing* Serena's pain. In contrast, if she successfully killed herself, *she* would be the one to abandon her mother. In either case, her child self perceived a fragility in the attachment bond. She feared her own power to rupture the bond. As depicted above, these insights gave way to the direct experience and articulation of the *activating* feelings of fear and anguish.

The *working-through* of exposure-derived REs attests to the integrity of the CCRT and the iterative process of interpretation to refine it. In the following session, we discussed her at-home knife exposure. We analyzed the chain of internal events, frame by frame, and fleshed out the CCRT components: "I wish to cook dinner for myself [W: to be self-efficacious] but I worry that I'll mess up and cause trouble [RO: don't trust myself], so I *feel* anxious [RS: helplessness, obsessions] and must control myself [RS: controlling, compulsions]; alternatively, I seek reassurance [RS: helplessness, dependence]." I clarified the warded-off "healthy" feelings underlying the symptomatic experience of helplessness. Preceding the intrusive thoughts and

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urges to ritualize, Serena experienced *fear* of flailing while handling a knife and *frustration* about lacking the skills to cook a simple meal, in other words, to care for herself. This was an "RE-Self," meaning that the "other" was not a person present but an "internalized voice" of Serena's object relations.

Transferential forces [ROs] govern *intrapsychic* dynamics just as strongly (i.e., by internalization, introjection, and identification) as in interpersonal dynamics. I interpreted the RO of "not trusting myself" as a remnant of early scolding as well as experiences of infantilization in her adolescence. In response to this, Serena remembered an incident where she stayed the weekend at a friend's home and accidentally spilled nail polish across the carpet. The friend's parent yelled at her for "vandalizing their stuff" [RO: angry; don't trust me]. A mundane incident like this one had a lasting impact on her psyche, engraving an RO that was likely already underway. I made a secondary interpretation based on what I knew about her attachment history: the natural expression of *fear* and *frustration* once threatened her attachment to her mother (Malan, 1979). As such, OCD symptoms were compensatory, both for her distrust in herself (i.e., self-ambivalence) *and* her fear of experiencing activating affects in relationships. By fostering insight into the once protective function of OCD symptoms, Serena could see that OCD's "life rafts" were essentially obsolete in the present. This insight would strengthen her resolve to abstain from compulsions during out-of-session exposures (Greenberg, 2022).

Rather than avoid cooking altogether [RS: uncertainty, avoidance], call a loved one for reassurance [RS: helplessness, dependence], or ruminate to avoid a feeling [RS: controlling], Serena was actualizing her wish [W: to be independent] by gaining the confidence to cope with painful emotions. Although trying out new interpersonal behaviors and expressing feelings to others is valuable (Leichsenring & Steinert, 2017), a kernel of psychodynamic exposures is to experience disavowed affect. According to Greenberg (2022), "What is essential to getting better isn't expressing feelings, but rather being able to *acknowledge and validate them for oneself*" (Integration with ERP, paragraph 4).

At this level of analysis, the exposure resembled McCullough and Andrews' (2001) affect phobia model, where the patient is asked to confront *activating affect* instead of habituating to the *symptom* of anxiety, as in CBT exposures. Additionally, attending to natural feelings may resolve the urge to ruminate (i.e., give up mental compulsions) (Greenberg, 2022). I suggested that the next time she practices exposure, she allows herself to feel the natural emotion of *fear* and then allows herself to feel the natural emotion of *frustration*.

Module 9: Restructuring Internalized Responses of Self (RS)

As illustrated by the "RE-Self" in the previous module, Serena's "pathogenic internalized object relations" were composed of an *object representation* [RO: critical, rejecting other], a

consequent *self-representation* [RO: untrustworthy self], and an *affect* adjoining them [fear or anger]. Long-term psychodynamic therapy acts upon the pathogenic object through a gradual accumulation of corrective emotional experiences with the therapist, by which a benevolent object is internalized (Leichsenring & Steinert, 2017). STTP takes a hands-on approach by strategically modifying the self's responses to internalized objects—the RS component of the CCRT—using cognitive strategies. Self-defeating "inner dialogues" are considered *maintenance mechanisms* for obsessions and compulsions (Leichsenring & Steinert, 2017). In Module 7, we *worked through* the maladaptive RS. In this module, we identified ways to replace Serena's self-defeating dialogue with a compassionate, encouraging one.

The encouraging dialogue resembles affirmations. Serena could choose to implement these every day; additionally, when faced with triggering situations, she could borrow courage from her dialogue to face her fears. For example, response to the RS of withdrawal, she might say, "I can stay *present* even while I'm angry at my friend." In response to a superstitious obsession, she was to say: "My family won't die in a car accident if I don't put my fingers in that power outlet. It is only a fantasy." Thanks to my training in Exposure and Response Prevention, I was aware of the potential for these mantras to be converted into mental rituals. I warned Serena to be mindful of this possibility, and that she could "spoil" such compulsions by affirming the uncertainty of her feared outcomes, like so: "I don't know if my family will die in a car accident, and nothing I do now will make a difference."

Moreover, I explained that she could generate encouraging statements in the immediate by asking, *what would my therapist say*? By teaching Serena to become her own therapist, I accelerated her internalization of me, while also increasing her agency in the therapy process. A couple of weeks later, she reported that the affirmations helped to optimize her morning commute. Driving on the highway was a trigger for urges to close her eyes while driving. Over the past several months, she accommodated by taking a detour that avoided the highway, which often caused her to arrive late to work. She repeated to herself that her obsessions were innately powerless over her actions since they existed only in her mind. She also reminded herself that being in control of the car was easy as long as she stayed alert and focused on her senses.

Serena told me that these statements were the most practical thing she had used to combat her OCD, and she was very glad they were working. Additionally, she remarked that they reminded her of the self-help mantras she had learned from a college friend. Encouraging statements would serve as a versatile tool in her "response" repertoire. These self-affirmations helped her overcome her fear of driving on the highway, and they could be generalized to other anxiety-provoking situations. I also explained that the encouraging dialogue could be applied prophylactically during times of heightened stress.

Cognitive techniques, just like behavioral ones, are considered supportive interventions in STPP (Book, 1998). The authors of the manual would agree that insight alone is unlikely to generate behavior change lest the patient makes a concerted effort to alter their reactive response to obsessive fears. Supportive interventions *put into action* the insight achieved on the expressive end of the supportive-expressive continuum.

Module 10: Addressing Existential Issues

This module represents a unique addition to the STPP for OCD manual. I was enthused to delve into the existential core of Serena's symptom profile. I tailored the existential inquiry to align with her idiographic relationship themes. I came to this session with notes, having brainstormed three distinct avenues of exploration along Yalom's (1980) existential givens of existence. I will elaborate on each, noting that due to time constraints in STPP, it was not feasible to explore every aspect thoroughly. Serena's responsiveness to my leads dictated our exploration's breadth, depth, and direction. I validated my interpretations upon her feedback and we proceeded collaboratively (Luborsky, 1984).

In keeping with the interpretative focus, I examined the two central wishes of Serena's CCRT through the lens of Yalom's (1980) given of existence, "freedom and responsibility." Of note, her inflated sense of responsibility often culminated in indecision—a distorted way to cope with the existential burden of "freedom and responsibility." As much as Serena yearned for the freedom of independence [W], she was fearful to bear the concomitant weight of responsibility [RS: anxiety]. Hence, an unconscious, regressive wish to be controlled, hurt and not responsible or obligated [W] expressed in the form of obsessions to harm her body.

Correspondingly, self-harm obsessions could be interpreted as an escape fantasy—escape from the challenging task of negotiating the expectations of others [RO] while preserving her boundaries [RS]—in order to actualize her wish for autonomy [W]. Hence, Serena's "death wish" (Freud, 1920) alleviated the enmeshment that she felt in attachment relationships. The phantom of death extinguished the alleged permanence of commitments. As such, obsessions [RS] were ego-syntonic for the "inhibited rebel" seeking respite from social expectations. Relatedly, the regressive "death wish" may be developmentally linked to the *separation-individuation* task (Mahler, 1963). Resolving Serena's obsessive fears, according to the CCRT perspective, would enable a mature handling of the dialectic between self-reliance and relatedness (Lapsley & Edgerton, 2002).

> **T**: (*Nervously*) What I'm about to say may deviate from how we usually think about intrusive thoughts and OCD… this may sound a bit…uncanny. Remember how we've talked about your tendency to fantasize?
>
> **P**: (*Tilts head quizzically*) Um, yeah?

T: Okay, so I was wondering if these self-harm thoughts, which to you feel so violent, may actually be more innocent than you think. Like some kind of fantasy. Like a child using their imagination. So, you know, I have this sense that maybe— (*Pauses, as if looking for the right words to use*) maybe they come from a part of you that just wants to escape the stress of being alive…and be free. [W: to be freed from obligation]

P: (*Taken aback, shoulders drop, leans into chair*) Hmm, I wasn't expecting that.

T: I'm not agreeing with the thought content per say. I'm pointing to their underlying intention. Almost like I'm supposing, if these thoughts were alive, what do they want?

P: It makes sense when you put it that way. Sometimes, when I'm caught up in those thoughts, it's like I'm trying to break free from something, some pressure inside holding me back. (*Sighs, leans back, looks relieved*)

T: Break free from what?

P: Let me see. (*Pauses, exhales loudly*) From this anxiety I feel all the time…from fear!

T: (*Enthused*) From the fear of being *alive*?

P: Yes! Being alive…can be too much to handle sometimes. But why? (*Frustrated*) Why is "mutilation" the way out?

T: Well, what would "mutilation" would get you?

P: Ugh I damn well hope I don't get to that point!

T: It's okay, we both know you won't act on intrusive thoughts. I want to remind you and make it very clear—we are exploring the *fantasy* here—the *unspoken* fantasy behind these gnarly thoughts, not reality. If you were injured, or dead, what do you imagine would change?

P: (*Exasperated, raises tone*) You know I *hate* thinking about that, but fine, whatever. I trust where you're going with this…(*Long pause, contemplating*) The madness in my head would end! No more doubt, no more fear. No more danger.

T: No more *efforts to avoid* danger. You'd be immune to threat. (*Pauses*) I appreciate your courage in going there with me.

P: Thanks, I guess. I tried…

T: Also, the fact that you'd be inflicting the harm yourself means you'd be in control, as if you could stave off unpredictable sources of future pain by getting it over with now.

P: (*Gasps*) Oh, you know what else? If I'm severely injured, someone would have to take care of me. Like, by default they would. I think that's part of the fantasy.

T: Very insightful. Yes, you would have no choice but to seek help if you wanted to mend your wounds. [W: to depend on, to be taken care of]

Exploring the above theme was in some ways retrospective because Serena had gained significant stewardship of her CCRT already. As we explored the fantasy, we also consolidated gains. The expressive interventions had chiseled away at her escape fantasy, and by Module 10, Serena was actively recalibrating her sense of agency. For example, she could establish deliberate boundaries with loved ones and set deadlines to make important decisions [positive RS: self-confident and respected]. At the end of our session, I shared a quote by Eleanor Roosevelt (1960): "Freedom makes a huge requirement of every human being. With freedom comes responsibility. For the person who does not want to carry his own weight, this is a frightening prospect."

As hinted in the dialogue above, and perhaps on a more fundamental level, the magical loop of OCD was a perversion of the unalterable fact of her mortality. During an obsessive trance, she fixated on the *power* she possessed to harm herself, resembling an omnipotent fantasy. Stemming from issues with control, an impaired tolerance for ambivalence, and a history of restraining her impulses, Serena's self-preservation instinct was hyperbolized in her OCD symptoms. This imbued the ego with a false sense of control over an unforeseeable event: death—another of Yalom's (1980) givens of existence. From a Terror Management Theory (TMT) angle, counterphobic compulsions (as in *undoing* a potential threat) helped the ego manage death anxiety (Rosenblatt et al., 1989).

I saw much value in the idea of universal death anxiety, but I suspected it would be difficult to explore with a patient so ensconced in magical thinking. It would require her to face the fact of her mortality outside the realm of fantasy, where she could not bend and twist it with her will. This is evidenced by her hesitation in the dialogue above, when I prompted her to imagine what it would be like to be dead. Since Terror Management Theory transcended CCRT territory, and we had limited time, I decided not to pursue it in the current treatment. Still, in the exchange above, I did hint at the element of *control* imbued in her death fantasy, which is in the domain of terror management.

The third existential angle helped me prepare for termination. In this conception, I weaved Yalom's (1980) existential fact of "isolation" with Winnicott's (1958) "capacity to be alone." Winnicott distinguished the *capacity* to be alone from the *wish* to be alone and the *fear* of being alone. An essential feature of Serena's initial presentation was that she *avoided* being alone (physically)—because that circumstance was a breeding ground for obsessions [RS]. Meanwhile, in the presence of others, if she felt anxious [RS], she resigned herself to a "withdrawn state" [RS] (Winnicott, 1958, p. 416), where she was defended and equally incapable of being alone—that is, alone with her thoughts. Withdrawal was yet another form of avoidance—of experiencing solitude while in the presence of another. It is this "paradox" that Winnicott wrote about, that the "capacity to be alone is based on the experience of being alone in

the presence of someone, and without a sufficiency of this experience, the capacity to be alone cannot develop" (1958, p. 417).

At this juncture, I reflected on the therapeutic relationship as a proxy for the "ego-supportive mother" needed to "build a belief in a benign environment" through "satisfactory instinctual gratifications" (1958, p. 417). The supportive element of our therapy offered a scaffolding to assimilate id-experience, which was not entirely available to Serena during her infancy. By and large, my efforts at deconstructing the power dynamic invited her to suspend any drapery of propriety and, instead, abide in a free-roaming state, to be unruly, to be capricious without reproach.

Based on Winnicott's prescription, an "id-relationship" occurring in a context of "ego-relatedness" is therapeutic to the extent that it exercises the ego's capacity to inhabit "personal experience," which is intrinsically solitary. Through our work on clarifying affect together, Serena learned to unbind feelings of *constructive aggression* (Malan, 1979) from potentially destructive actions. If she explored *rage* in my presence and was met with supportive feedback, she need not fear the loss of control. Winnicott (1958) correlates the *capacity to be alone* with emotional maturity—Serena was certainly moving in that direction.

In our final sessions, I planned for interactive moments of silence. I invited her to share solitude with me during moments when she noticed the urge to withdraw [RS]. Serena had already demonstrated an aptitude for detecting CCRT components in real time; the narratives she told in session reflected an enhanced awareness of her patterns outside of session. In our remaining sessions, she would continue *internalizing* the ego-supportive environment of therapy. The internalized *mirroring functions* of the therapist would be an asset towards exercising *the capacity to be alone* post-termination.

Module 11: Addressing Nonresponse and Resistance

I reviewed the directives in Module 11 and utilized the checklist from the manual's appendix to assess my adherence to the protocol over the course of treatment. Citing Freud's cautionary tales, Leichsenring and Steinert (2017) warn of the "danger of nonresponse," noting nonresponse rates of up to 50% for empirically validated OCD treatments. In the context of STPP, non-responsiveness can manifest as blindly agreeing to the proposed CCRT, having intellectually understood but emotionally unintegrated insights, compartmentalizing therapy insights within daily life, and persistently avoiding feared situations.

Noncompliance with homework assignments, i.e., the OCD formula (Module 4), the exposure hierarchy (Module 8), and the application of the encouraging dialogue (Module 9), may indicate nonresponse, although other factors like low motivation could be at play. Drawing from my CBT training, where homework often posed hurdles for patients, I, as a psychodynamic

clinician, initially hesitated to enforce assignments. However, in Module 11, I came to think of these exercises as *transitional objects* (Winnicott, 1953), with special significance as we approached termination.

During our discussion, Serena mentioned consistent engagement with the assignments for the first 2-3 weeks, but eventually, she admitted, they fell by the wayside. Determining that the exposures exercises, particularly the ones at the top of her hierarchy, accrued the most resistance, I realized I had not adequately prepared Serena, during the psychoeducation section, to tackle her exposure hierarchy. I provided a recap of the exposure procedures and troubleshooted obstacles to implementation. According to the Exposure and Response Prevention literature and my own clinical experience, it is relatively common for patients undergoing exposure therapy to back down when facing their most daunting situations. I suggested applying her encouraging dialogue to boost her courage.

Throughout treatment, Serena's resistance remained subliminal, concealed by her polished veneer, and true to the "inhibited rebel" persona. The STPP manual suggests monitoring the patient's responsiveness in every module, particularly at the midpoint (sessions 13-15). Despite Serena's clear grasp of her CCRT and the evolution of her insight, I neglected to pause midway for a formal discussion on her overall responsiveness. Still, I consistently provided positive reinforcement for her gains.

However, there was one notable sign of resistance which colored the first half of the therapy: Serena's avoidance to admitting her ambivalence about marriage. In hindsight, I acknowledge colluding with her ambivalence. Serena initiated the conversation herself towards the end of Module 6. I believe it would have been appropriate for *me* to address this issue, especially around the halfway point. My supposition is that given the relational primacy of STPP and my previous training, I was more inclined to focus on *process* variables over the *content* of the narratives discussed. As such, I was more interested in the interpersonal events occurring in session over incidents transpiring in her life.

I wanted Serena to learn the blueprint of her CCRT (so that she could work on it herself), rather than fixate on the content of any one relationship episode. These ambivalent dynamics on my part suggested that her ambivalence about marriage was likely mirrored in her ambivalence about therapy. This played out in our relationship. Still, I could have been more directive in broaching the topic of her engagement, considering that the avoidance of it was reinforcing her characteristic defense of *undoing* painful events. Finally, in Module 7, in which Serena rejected the opportunity to explore her past, an unintended enactment occurred, representing a minor *regression,* but affording a chance to work through ambivalence once again.

Termination Phase: Sessions 21-22

Module 12: Termination and Relapse Prevention

I broached the topic of termination approximately a month in advance. Serena acknowledged this fact with apparent indifference, leading me to suspect she had been mentally counting down our sessions, anticipating the end date even before it was topic of discussion. By our 21st session, Serena appeared fatigued and preoccupied. I inquired about her feelings regarding the coming end. I reminded her of the diligence she exhibited throughout treatment. She tried to craft a logical response, but her gaze wandered, and she abandoned the effort to speak coolly. Her face became flushed. Before I got another word out, tears poured forth unabated, a stark departure from her usual apology-laden, nervously restrained demeanor. We sat together in a shared silence, both recognizing the rarity and long-anticipated nature of this emotional release.

Twenty minutes later, Serena disclosed that she had called off her engagement. The synchronicity of this revelation, almost staged, prompted me to consider an unconscious influence, as if it were destined to coincide with our termination. This presented an opportunity to process multiple losses simultaneously. She had not broken up with Fernando. She said they decided to stay together and work on their relationship. But it was still difficult for her to contend with what felt like a failed relationship. Our conversation delved into mourning the fantasy she harbored of a "perfect relationship" and cultivating more realistic expectations for an honest relationship. We discussed what such a relationship would require of her in CCRT terms. She reflected on her fear of losing the approval of her family and betraying cultural values by stepping away from marriage. I reframed this incident as a chance for her to actualize her wish [W] for independence, which did not exclude healthy dependence [W].

Instead of completely disengaging from the relationship [maladaptive RS: withdrawal], she was now *rethinking* her level of commitment in accord with her wish [positive RS: self-control, self-confidence]. Additionally, she mentioned consciously practicing the adaptive RS of requesting "space" in her relationships, without the RS of guilt. We discussed strategies for challenging expectations associated with her RO, particularly concerning potential judgment and opposition from her family and friends when sharing the news about her engagement. It was indeed possible that her expectations would be disproven, such that she would feel respected and embraced [positive RS], instead of condemned, for having made a self-contained decision. In this case, her RO expectations of criticism would be subjected to "reality-testing."

Book (1998) advises STPP therapists to pay attention to their countertransference reactions to termination. One potential issue he highlights involves therapists believing they must "cure" the patient within a limited timeframe. Unconscious behaviors could emerge from this

belief, like elongating the treatment, glossing over material that conflicts with the formulation, or avoiding confronting negative affect to guarantee a harmonious unfoldment. Reflecting on my own reactions to terminating therapy with Serena, I noticed that it felt precipitous and unnatural, likely due to my lack of experience with short-term therapy. It is possible that I delayed talking about termination until necessary to avoid feeling the pressure of time. In addition, I relied on the subconscious sense that Serena was monitoring the passage of time herself.

Furthermore, Book (1998) and Leichsenring and Steinert (2017) highlight that symptom relapse is common during termination. For relapse prevention, I once again reminded Serena to apply her OCD formula from Module 4 (namely, "I wish to express what I feel [W], but others oppose and control what I feel [RO], so I believe that what I feel is dangerous [RS: obsessions] and calm my doubt by withdrawing from danger [RS: compulsions"]; to practice the exposures from Module 8; and to implement the encouraging dialogue presented in Module 9 (that is, to replace Serena's self-defeating dialogue with a compassionate, encouraging one, resembling affirmations).

Moreover, symptom recurrence at termination can be attributed to the re-activation of the patient's CCRT in the therapeutic relationship. This could lead to an enactment. After all, CCRT conflicts are *transference potentials* awaiting the right conditions to manifest (Luborsky, 1984). Understanding this, I anticipated that Serena might interpret termination as a critique of her life choices [RO: critical] and experience shame regarding her vulnerable emotional state in the final sessions [RS: shame, helplessness]. In Session 21 of this module (described above), we shared a powerful experience of solitude, whose relational charge was amplified through a mutual reverence for the affect permeating the room.

I worried that she might withdraw [maladaptive RS] again during or after this episode. Contrary to my expectations, Serena dropped her defensive withdrawal [maladaptive RS] and stepped into the here-and-now of our relationship. Her willingness to inhabit a vulnerable state, in my presence, without disowning its affective intensity through reaction formation, undoing, or intellectualization was a testament to her gains in *self-control* [adaptive RS]. Still, I was cautious to avert another enactment because it would leave us with little time to consolidate gains (Book, 1998).

I regularly checked in with Serena about her feelings regarding her progress and her perceptions of my views on her progress. With confidence, she expressed pride in her accomplishments and said she felt supported by our work together. In our final session, she acknowledged feeling sad about the termination, but she also admitted to a sense of relief. The work of therapy had been laborious.

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Finally, I framed the therapeutic relationship as a model for relational autonomy. I hoped that the qualities she experienced in the helping relationship would leave a lasting imprint. I aimed for these attributes to serve as a resource during moments of doubt, allowing Serena to draw upon her introjection of me as a benign object and utilize the tools I taught her in therapy (Luborsky, 1984). In the concluding portion of that session, we reviewed the gains specific to each phase of treatment, captured in her own words. She summarized her progress by saying:

> It's the first time in a while I don't feel caged in. I feel renewed…free to roam, free to make mistakes. Also, I can't take my aloneness for granted anymore. It's kind of a gift. Thank you for walking with me.

Booster Sessions: Sessions 23-24

The post-treatment Y-BOCS was administered one week after session 22, but before the booster sessions. Post-termination, 2 booster sessions were scheduled over the next month at 2-week intervals. The intention was to keep the booster sessions separate from the working through of termination. These sessions were succinct and supportive in nature. We reviewed and celebrated her gains. I provided psychoeducation on what constitutes relapse versus a minimal recurrence in symptoms. She did not demonstrate any signs of relapse. I advised her to continue working on her CCRT independently and to expose herself to her feared situations at least once a week. During the final session, she asked me for a referral to couples therapy, and we discussed the potential benefits. We exchanged words of gratitude and cordially parted ways.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

Therapy monitoring was conducted by documenting the relationship episodes (REs) that transpired between the patient and me as the therapist (in-session) throughout treatment. Table 7 displays patient-therapist REs by module with a respective analysis of the CCRT components manifested in each RE. As a "transference template," the CCRT helped me track the transference in the therapeutic relationship. In addition, I actively monitored Serena's response to the therapeutic tasks of each module, which helped me decide on the number of sessions to devote to each module. I also calibrated the ratio of expressive to supportive techniques based on her response to interventions. After introducing exposure exercises in Module 8, I checked in regularly about Serena's engagement with these homework assignments. I used any experiential data she collected outside of sessions to work through her CCRT. Finally, I tracked the emergence of resistance during interventions (see Module 11) and addressed ambivalence (see Module 2) accordingly.

While I did collect quantitative data of Serena's OCD symptom severity (reported in Table 2), I only did so at pre- and post-treatment assessment points. Y-BOCS scores informed

my initial treatment planning and offered a reliable measure of therapy outcome through comparative analysis.

Throughout the course of Serena's therapy, I attended weekly supervision with multiple licensed clinical psychologists. Supervision helped me refine my case conceptualization, check the accuracy of my interpretative focus, brainstorm interpretations of the emerging relationship episodes, and work through my countertransference reactions. Serena's progress in therapy was discussed at length in supervision.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

The Outcome of Serena's Therapy

As the quantitative and qualitative data below indicate, Serena had a favorable response to treatment. Despite recurring bouts of resistance and an equivocal sense of commitment to the process, Serena possessed insight into the pathological nature of her ambivalence and was highly motivated to dispel it. I believe that Serena's capacity for introspection and her willingness to engage in transferentially charged exploratory work contributed greatly to the success of the therapy. Serena internalized the gains she made throughout treatment.

Quantitative Results

Table 2 displays Serena's scores on the Y-BOCS. During the intake assessment, Serena's Total Symptom Severity Score of 22 was indicative of clinically significant OCD symptoms in the moderate range of severity. By the end of treatment, Serena's Total Symptom Severity Score was 14, in the mild range of severity, but still above the clinical threshold of the Y-BOCS. This 8-point reduction (from 22 to 14; ≥35% reduction) in Serena's pre- to post-treatment Y-BOCS Total Symptom Severity Score represents a "treatment response," indicating a clinically significant outcome by international standards (Mataix-Cols et al., 2016). Though Serena still met diagnostic criteria for OCD at post-treatment, her total Y-BOCS score reduction constitutes a "reliable clinical change" (i.e., change not due to chance) in OCD symptom severity as measured by Jacobson and Truax's (1991) Reliable Change Index (RCI).

Table 2 also displays Serena's scores on the subscales of the Y-BOCS. Her Obsession Symptom Severity Score dropped 6 points (from 12 to 6) from pre- to post-treatment administrations, while her Compulsion Symptom Severity Score only dropped 2 points (from 10 to 8). The larger drop in her Obsession score suggests that Serena experienced a greater reduction in the time spent on, interference from, distress associated with, resistance against, and degree of control over her obsessions, in contrast to the extent of her compulsions. This difference may indicate a higher acquisition of insight in contrast to behavioral change. A

reliable change index calculation for the subscales of the Y-BOCS was not possible due to the lack of applied research.

Scores on the supplementary items of the Y-BOCS were not factored into the Total Symptom Severity Score. Still, Serena's pre- to post-treatment changes on these items may be indicative of modifications in the schemas underlying OCD symptoms. For example, Serena's Overvalued Sense of Responsibility decreased from moderate (2) to mild (1) and her Degree of Indecisiveness decreased from severe (3) to mild (1). Her score on the Pathological Doubting item dropped from 4 to 2, indicating a change from extreme to moderate uncertainty about sense perceptions and memory perception. Serena's Insight into Obsessions and Compulsions improved from good (1) to excellent (0), denoting an improved awareness of the ego-dystonic nature of her symptoms.

The remaining items in Table 2 captured changes in behavioral features associated with OCD impairment. Serena's Pervasive Slowness reduced from mild (1) to none (0), indicating improved agility in completing tasks and reduced tardiness. Her degree of avoidance of triggers dropped from moderate (2) to mild (1), as indicated by the Avoidance item. Based on my clinical judgment, Serena's Global Severity of Illness rating improved from moderate (3) at pre-treatment to mild (2) at post-treatment, and her Global Improvement was rated as *much improved* (5).

Qualitative Results

As described in section 6. Course of Treatment, I began consolidating therapy gains with Serena well in advance of termination. In our final session, Serena reflected on her self-observed changes over the course of treatment, and I shared my perspective on her progress. The following reflects a summary of the qualitative results.

Serena reported feeling much less daunted by the arrival of an intrusive thought, which decreased her overall levels of anxiety and associated panic symptoms. Correspondingly, the amount of time she spent engaging in mental compulsions dropped from approximately 3 hours per day to about 1. In concert with these symptomatic improvements, Serena's ability to function stabilized across multiple domains. Serena stated that she was gradually, but actively, giving up her routine avoidance of triggers. As such, her issues with tardiness improved, for example, because she stopped avoiding the highway on her commute to work, which had been a major form of OCD accommodation. Serena said she no longer became "paralyzed" by obsessive-compulsive episodes, which in the past would lead her to isolate and call out sick from work. Thanks to her successful efforts in interrupting nighttime ruminations (i.e., response prevention), she felt more relaxed at bedtime, leading to much improvement in the quality of her sleep. Consequently, she had more time and energy available to reconnect with old friends she had

shunned during her crises. Of note, her belabored posture and inhibited demeanor loosened noticeably toward the end of our work together.

Though the skeleton of her CCRT remained intact, by the end of therapy, Serena gained stewardship of her CCRT, such that she could actualize her wish for independence without being bogged down by RO-fears of criticism or coercion. Thereby, she acquired a degree of agency over her RS feelings of guilt, helplessness, and anxiety, all of which were catalysts for OCD symptoms. By approaching her fears instead of withdrawing, Serena was more prone to experience wish-congruent, positive RS feelings of self-confidence, respect, and acceptance.

Interpersonally, adaptive RS behaviors involved using her *encouraging dialogue* (Module 9) to soothe herself, instead of asking her partner for reassurance; learning how to enjoy spending time alone, rather than succumbing to despair; asking for space from loved ones instead of withdrawing; and expressing frustration or disagreement when appropriate, instead of avoiding conflict at all costs. As part of her encouraging dialogue for approaching disagreement, she came up with the maxim, "Agree to disagree but don't flee." Although she still defaulted to her maladaptive RSs, such as withdrawal, she exited treatment with a repertoire of positive RSs to flexibly manage the tension between her wish for dependence and her wish for self-reliance. These adaptive RSs encompassed the *internalized* self-object functions of the therapist.

More concretely, Serena decided to break off her engagement right before our final session, which attested to her gains. She finally broke out of a many-months-long decision paralysis and confidently expressed a wish for independence within her relationship. She was prepared to deal with Fernando's reaction in a compassionate, conciliatory way, instead of withdrawing at the first glimpse of opposition. Cognizant of her competing wish for closeness, her love still alive, she asked him to remain partnered. She vulnerably disclosed her problems with trust and guilt and said she needed more time to work through these problems before committing to marriage. Taking this firm stance not only required Serena to give up avoidance, but it also eased her overvalued sense of responsibility to upkeep appearances of a "perfect relationship." To her surprise, Fernando respected her decision, and did not get too upset, which buffered her default guilt RS. Concurrently, she faced fears of disappointing her family and feeling rejected by her culture. Existentially, she embraced the *uncertainty* that the event introduced to her life, including a fear of running out of time.

Lastly, the process of termination instigated a shift in Serena's affective processing. In session 21, her tense, inhibited temperament unraveled, and she embraced a powerful experience of sadness, an *activating* affect. She was grieving both the loss of her engagement and the loss of the therapy relationship. For the entirety of session 21, her characterological defenses relented, making her vulnerable in the here-and-now of the therapy relationship. Instead of reenacting her CCRT at termination, she owned her emotions and metabolized them. Sitting with me in silence,

she demonstrated a *capacity to be alone* (Winnicott, 1958) with intense emotion, while still leaning on the relational space for support. In that penultimate session, she embodied relational autonomy.

Results in Context of Original Treatment Plan

As described above, Serena attained quantitative and qualitative outcomes that were discernibly consistent with the treatment goals outlined in section 5. Case Formulation and Treatment Plan. As stipulated in section 5, patient-therapist goal consensus (Tryon & Winograd, 2011) played an important role in Serena's therapy. The therapist-stated goals described the psychodynamic mechanisms instrumental to achieving the patient's desired outcomes. In the end, patient- and therapist-stated goals converged.

Serena experienced a global improvement in her functioning, as indicated by clinically significant reductions in obsessions, compulsions, and avoidance of feared situations. As captured by the supplementary items of the Y-BOCS, Serena showed moderate adjustments in the obsessional attributes of indecisiveness, pathological doubting, and overvalued responsibility. Based on these change scores and my observations, I inferred a softening of her character rigidity. Moreover, Serena's affective bandwidth expanded to include "healthy" feelings of anger, sadness, and fear, which bettered her communication of boundaries and thus, supported her connectedness to others. By working on her ambivalence, her ability to *trust* things that are naturally unpredictable and uncertainty-ridden, such as relationships (e.g., the therapy process and the therapeutic relationship), improved.

On indexes of CCRT *mastery*, Serena's results were very positive. By the midway point of therapy, she was versed in her CCRT pattern. Her *self-understanding* evolved steadily as we analyzed more and more relationship episodes in sessions, and as she applied her *OCD formula* between sessions. In our later sessions, Serena regularly referenced CCRT components "spontaneously" (Book, 1998) when recounting relationship episodes.

Yet, Serena's burgeoning awareness of the unconscious aspects of her CCRT did not directly interrupt her interpersonal patterns. In other words, her degree of *self-control* over CCRT components lagged significantly behind her *self-understanding*. This may have been due to Serena's behavioral inhibition and her comfortability relating to others on the intellectual plane. That is, Serena's insight was precise and profound, but it tended to congeal at the intellectual level while isolating emotional feedback from the transference, which is critical to the fruition of (emotional) insight. As such, gains in *self-control* directly impacting her interpersonal functioning transpired very late in the treatment, once corrective emotional experiences were amply *internalized*, lending her the courage to confront her RO-fears in real time without resorting to her ingrained RS reactions.

Of note is that the focused nature and active stance of STPP for OCD did not permit a thorough investigation of Serena's identity. This brief course of therapy surfaced a lot of material but indubitably left loose ends untied. Although we touched on the childhood determinants of her CCRT, the resolution of these issues, such as Serena's longstanding anger at her parents for suppressing her Cuban heritage, was outside the purview of STPP. As proposed in the original treatment plan, the overarching benefit of STPP for OCD was in allaying Serena's *ambivalence* around issues such as this one. That is, she gained awareness of her contradictory feelings and came away with a more balanced view of her past, less *polarized by magical thinking.*

Discussion of Broader Issues Raised by Serena's Case

STPP Outcomes: Symptom Reduction vs. Structural Change

Serena's case supports psychoanalytic claims of a shared etiology between OCD and OCPD. The constellation of defenses and relational conflicts explored in this treatment are intrinsic to both diagnostic categories. As Serena's history attests, the presence of obsessive-compulsive traits predated the emergence of clinical-threshold OCD. Throughout her early adult life, symptom outbreaks were sporadic and context-dependent (triggered by relational stress). As such, it seems reasonable to conclude that her episodic OCD occurred against the backdrop of an obsessive-compulsive character style.

The treatment arc vividly displays the interplay between symptom expression and the non-linear progress towards structural change. My assessment methods only captured the pre- to post-treatment difference in Y-BOCS symptom severity, which represented a clinically significant reduction. Yet, symptomatic expression fluctuated *throughout* the course of therapy. Although difficult to quantify, what is most notable is that Serena articulated a meaningful change in her *relationship with her symptoms* (see Qualitative Results section). The quantitative evidence for this shift is in Serena's endorsement of higher control over and less distress induced by obsessions *and* (mental) compulsions (items #3, 5, 8, and 10 on the Y-BOCS), which corresponds with her gain in *self-control* over the RS component of her CCRT. In addition, Serena's insight into obsessions and compulsions (item #11 on the Y-BOCS) increased to an *excellent* rating in the post-treatment evaluation. What's more, this internal shift can be interpreted as an actualized CCRT wish [W] for *autonomy* from the tyrannical grip of OCD. Arguably, the shift in her relationship with symptoms came about by working through Serena's CCRT, which confronted the schemas, or pathogenic beliefs, that mediate symptom expression.

Moreover, utilizing a higher dosage of expressive than supportive interventions, made possible by Serena's ego strengths, was conducive to *nudging* the underlying structures of her acute behavioral symptoms. As such, her CCRT blueprint remained intact, but she gained some control over its components: her expectations of others, her choice to respond adaptively instead

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of reactively, and her initiative to actualize her wish. That said, achieving *significant* structural change goes beyond the scope of STPP (Luborsky, 1984). STPP *initiates* the process of defense relinquishing, which is a gradual and continual effort rather than a one-and-done deed. Characterological defenses are usually refractory to initial insights, which was the case for Serena.

As demonstrated in 6. Course of Treatment, structural defenses morphed and regrouped throughout Serena's treatment. A cardinal example of this phenomenon occurred in Module 7, when *reaction formation* transformed into *undoing*, right as an enactment ensued. According to psychoanalytic theorists, insight brings about changes in defensive functioning such that there is a "lifting of repressions" (Luborsky, 1984, p. 20). Structurally, an outcome of interest is the patient's rise to a higher level of organization, which brings with it improvements in functioning (Luborsky, 1984).

Importantly, a successful treatment entails that defense restructuring will continue well beyond its formal conclusion (Shedler, 2010). The effectiveness of short-term psychodynamic therapy lies in its capacity to instill a transformation *potential* that transcends the confines of the therapeutic setting. Transformation is not a static outcome measure but encompasses the ongoing tenacity to actualize insight and grow in self-understanding, a process that outlives treatment termination. Therapeutic mechanisms of change are internalized by working through the meaning of termination (Luborsky, 1984). This phenomenon, albeit challenging to quantify through empirical methods, finds extensive documentation in the psychodynamic literature, and its manifestations have been personally observed throughout my clinical training.

Due to the lack of longitudinal data in the present study, these claims remain speculative in Serena's case. Herein lies an auspicious avenue for future investigation: the evolution of longitudinal gains in STPP. Follow-up assessments, such as with the RAP interview (Luborsky, 1990), should measure the patient's *mastery* of their CCRT conflicts, *not* their CCRT blueprint, which is known to be resistant to change. According to multiple studies, the CCRT blueprint is consistent across the lifespan, consistent across relationships, and typically remains unchanged throughout psychotherapy (Luborsky & Barrett, 2007). As such, a promising tool for longitudinal assessment is the *Mastery Scale* (Grenyer, 1994).

The *Mastery Scale* is an empirically validated and reliable 6-point content-analysis scale assessing degrees of *self-control* (i.e., adaptive responding in triggers; flexibility in the RS component) and *self-understanding* (i.e., spontaneous recognition of CCRT in action; heightened awareness of unconscious components) scored by a clinician from relationship episodes told by the patient. Changes in self-understanding and self-control are associated with positive therapy outcomes (Luborsky & Grenyer, 1996). Specifically, the "RS-late-in-therapy" was found to be a

good index of psychological health (Grenyer & Luborsky, 1996); it can be monitored at follow-ups.

The Pragmatic Case Study: Applications & Limitations

The practice-based evidence presented in this case study fulfills a literature gap vis-à-vis the psychodynamic treatment of OCD. Because this study employed a pragmatic case design, it lacks the experimental controls necessary for obtaining efficacy figures for Leichsenring and Steiner's (2017) manual. Thus, RCTs are still needed to advance the manual's empirical standing.

Yet, the merit of this study lies in its qualitative transmission of process variables that make for an effective course of STPP for OCD. Qualitative accounts of therapy process and outcome are a valuable resource for clinicians new to psychodynamic work. By detailing my execution of Leichsenring and Steiner's (2017) seminal model, I offer an example of *how* to customize the CCRT method for effectively addressing hallmark OCD issues like ambivalence, pathological doubt, thought-action fusion, a hyper-strict superego, existential concerns, and avoidance of feared situations. What's more, I demonstrate a flexible and responsive calibration of supportive-expressive techniques to align with the goals of one hybrid patient. Through transference work and exposure to feared situations, Serena reexperienced warded-off affect and impulses. Serena's transformation was driven by Luborsky's (1984) *curative factors* (i.e., change mechanisms) of self-understanding, the therapeutic alliance, and the internalization of gains. These brought about sufficient corrective emotional experiences to breed emotional insight.

I believe that my work with Serena also has much in store for psychodynamic scholars. I have pooled more than a century's worth of scholarship and clinical musings to sketch a vibrant architecture of obsessive-compulsive dynamics. Throughout this case study, I draw attention to various themes that are subtle and often overlooked in treatment manuals, clinical didactics, and RCT studies. For example, I delved into the motifs of polarization, dualism, and ambivalence as I conceptualized Serena's defensive functioning. The therapeutic process invited the possibility of paradox, exposing my patient to an inescapable landscape of uncertainty that is shared among humans. As Nemiah remarked, "Obsessive-compulsive disorder illuminates the psychoanalytic concept of psychodynamic conflict perhaps better than any other psychoneurosis" (1984, p. 9). May this case study serve as a hub for analytic enthusiasts and a springboard for psychology students who, like me, enjoy free-associating to the arcane tune of our field's founding figures.

As expected, a major challenge in the pragmatic outlook of this case was bridging theory and practice. In my thinking, I struggled to synthesize manifold psychodynamic angles on Serena's problems without getting lost in the weeds of theory, strewn with intellectual cul-de-sacs. In practice, I towed a fine line between parsimony and reductionism. After grappling with

these issues in supervision, I remembered the holy grail of the STPP manual: "maintaining the focus on a circumscribed area of the patient's CCRT" (Book, 1998).

The CCRT formula, or transference template, is well-suited for customization to OCD, particularly given the established connections between relational themes and narrative complexity across different diagnoses, and the associations of CCRT themes with defenses and defensive functioning (Luborsky & Barrett, 2007). The greater pervasiveness of CCRT components across narratives is also linked to greater psychiatric severity (Cierpka et al., 1998). Moreover, I observed a noteworthy parallel between the chronicity and pervasiveness of the CCRT and the chronicity and pervasiveness of obsessional traits. As illustrated in section 6. Course of Treatment, both of these exemplify the phenomenon of repetition compulsion. Overall, the CCRT's adaptability makes it a valuable framework to conceptualize OCD in relational terms. Meanwhile, the wide selection of CCRT component categories accommodates the heterogeneity of OCD.

Nonetheless, adhering to a structured STPP manual proved effortful. My clinical style leans spontaneous, so conducting sessions off a written plan felt counterintuitive, and at times mechanical. A related challenge I encountered in Serena's treatment was adjusting myself to the brief therapy model. Virtually all my psychodynamic training cases heretofore have been in a long-term format. Administering STPP for OCD presented unique challenges, including: maintaining a single interpretative focus, setting circumscribed goals, strengthening the alliance within a short timeframe, and handling my countertransference towards Serena's doubts about my competence and the effectiveness of the treatment. I grappled with the issues of identity, self-esteem, and guilt apropos to therapists accustomed to long-term treatments, as described by Messer and Warren (1995). As I disclosed in section 6. Course of Treatment, the termination process was startling to me because it crept up abruptly. Unconsciously, I probably harbored a fear of underdelivering interventions given the limited time. However, I did not pressure myself to achieve changes beyond the scope of STPP. My commitment to a formal case study prevented me from accidentally slipping into long-term therapy with Serena (Book, 1998). The learning curve was prolific, infusing my clinical style with pragmatism. Conducting this study disabused me of the notion that psychodynamic psychotherapy must be protracted to be effective (Bauer & Kobos, 1984).

Notwithstanding, STPP for OCD is not a permanent "cure" for pathology and it should not replace long-term psychodynamic therapy where indicated. To benefit from STPP, patients must meet the inclusion criteria outlined in section 4. Assessment (Book, 1998). I believe that Serena prospered from STPP because of her ego strength, psychological mindedness, and excellent insight into childhood determinants. Her motivation to commit to therapy was lower than optimal, but it stemmed directly from a constitutional ambivalence and issues with trust,

which were direct targets of the CCRT focus. As the alliance grew in trust, her buy-in increased. Overall, her genuine willingness to introspect, both in and out of session, is what I believe propelled her therapeutic profits. Despite its widespread applicability and straightforward implementation, the CCRT method of STPP is not appropriate for patients with a low-level personality organization, ego-syntonic OCD symptoms, issues around separation, or severe interpersonal difficulties that would obstruct the alliance (Book, 1998).

This *hybrid* case afforded a far-reaching exploration of various potential themes and clinical complexities in OCD treatment because it was not bound to the particulars of one individual patient. While Serena's case study documents a valuable example of a successful psychodynamic treatment of OCD, the conclusions drawn from this hybrid case should not be applied universally to patients diagnosed with OCD.

It is essential to note that OCD is a heterogeneous disorder, meaning that individuals may manifest a wide range of symptoms and experiences. Also, it is important to recognize that the motifs exhibited by patients in therapy can vary based on demographic factors and diversity characteristics. This acknowledgment underscores the need to avoid sweeping generalizations from one case study. Conducting more case studies, particularly with a focus on multicultural factors, can better inform the applicability of these findings to diverse populations.

Also in this regard, Leichsenring and Steiner's (2017) manual does not account for diversity factors. Given Serena's complex migration history and culturally fragmented identity, it was imperative that I apply a cultural lens to her CCRT formulation and interpretative focus. Clinicians choosing to implement Leichsenring and Steiner's (2017) manual are advised to similarly adapt their approach, particularly when diversity elements are proximal to the patient's CCRT.

A Note on Psychotherapy Integration

As I reflect on my execution of the treatment, I contend that Leichsenring and Steiner's (2017) STPP model makes an important contribution to psychotherapy integration, a movement that has gained prominence since the 1990s (Norcross & Goldfried, 2005). This STPP model upholds the integrative principles of personalized interventions, a strong focus on the therapeutic relationship, and treating the patient as an active participant. It addresses various dimensions of functioning and aligns with contemporary APA guidelines on evidence-based practice (Zarbo et al., 2016). More specifically, Leichsenring and Steiner's (2017) STPP model exemplifies *theoretical integration* in its synthesis of intersecting theories: Freud's (1912) theory of transference, Luborsky's (1984) object-relational CCRT model and supportive-expressive therapy, McCullough and Andrews' (2001) affect phobia therapy, and principles of exposure therapy. Exposure therapy, pioneered by behaviorist Mary Cover Jones in 1924, arguably traces

its roots back to Freud's introduction of similar principles in 1919. Additionally, existential therapy (i.e., Yalom, 1980) is strategically etched into the time-limited framework of STPP to accentuate the transitoriness of life. The result is a standalone STPP for OCD model, whose throughline is the CCRT. The model's strength lies in its cohesive integration of theory, research, technique, and clinical judgment, in stark contrast to the indiscriminate and unsystematic intermingling of interventions seen in *technical eclecticism* (Zarbo et al., 2016).

In a similar vein, I ventured forth on my own integrative frontier as I conceptualized Serena's case, delivered the treatment, and synthesized various angles of analysis throughout this case study. My synthesis represents a *theoretical* integration. As detailed in section 3. Guiding Conception and section 5. Case Formulation, I combined multiple perspectives on the psychodynamics of obsessive-compulsive phenomenology and attendant treatment strategies. I examined: (a) the classical model of obsessional neurosis (Freud, 1909; Fenichel, 1945; Nemiah, 1961); (b) Summers and Barber's (2010) core psychodynamic problem of obsessionality; (c) McWilliams' (2011) obsessive-compulsive character style; (d) Gabbard's (2001) commentary on the unconscious meaning of biological determinants of OCD; (e) Malan's (1979) object-relational notion of *constructive aggression;* (f) Wolfe's (2006) wounded-self model; and (g) Guidano and Liotti's (1983) ambivalent-self model, among others.

All these theories converge on the premise of psychodynamic change, encompassing the fundamental change mechanisms of insight, affect, and alliance (Messer, 2013). Moreover, in section 6. Course of Treatment, I furthered Leichsenring and Steiner's (2017) integrative initiative by introducing Winnicott's (1958) *capacity to be alone*, an object-relations idea that enhanced Serena's CCRT by accentuating the role of *defensive withdrawal* (an RS). It also explained the process of internalizing the therapeutic relationship, framed the therapy as an ego-supportive "mothering" environment permitting the re-experiencing of an id-relationship, and addressed the existential problem of isolation by proposing *relational autonomy*.

In my research, I came across related issues that merit further investigation. The first area of inquiry concerns the clinical value of clarifying the differential between OCD and OCPD vs. opting for a unified conceptualization of OCD and OCPD on psychodynamic grounds. Based on literature spanning over a century, it seems appropriate to view these disorders as two ends on an OC spectrum, where acute OCD symptomology occupies one pole while pervasive, longstanding obsessive-compulsive traits sit at the other. This may explain the vast heterogeneity of cases cited in the literature. Following from this, I propose that integrative models, with their tailored interventions, could more suitably address the clinical gradients of the OC spectrum.

Integration acknowledges that one-size-fits-all psychotherapeutic approaches may not be effective or suitable for every patient, issue, or situation. In accordance with Malan (1979) and Gabbard's (2001) claims, I propose that integrative models built on a psychodynamic foundation

are more apt for the subset of patients at the characterological end (OC phenomena of an ego-syntonic nature), while models with a larger concentration of behavioral interventions are indicated for patients nearer the symptomatic end (OC phenomena of an ego-dystonic nature).

My hybrid patient fell somewhere in the middle of the spectrum (her level of symptom impairment was mild-to-moderate), so Leichsenring and Steiner's (2017) model suited her well. To apply this model to patients with more severe symptoms, I recommend clinicians implement *in-session* behavioral exposures, rather than just assigning these for homework (see Module 8 of the STPP manual). Given that behavioral interventions are categorized as supportive interventions in supportive-expressive therapy, my suggestion aligns with Luborsky's (1984) guideline to increase supportive interventions in proportion to symptomatic severity.

On the topic of integration, I also want to highlight that *assimilative integration* models are equally promising for OCD treatment. A prime example is McCullough and Andrews' (2001) affect phobia therapy, an STPP therapy with a home in psychodynamic *theory* that integrates experiential and cognitive-behavioral *techniques* (i.e., systematic desensitization) to facilitate emotional processing. As mentioned earlier, Leichsenring and Steiner (2017) borrow from McCullough's wisdom on affective exposure to enrich the expressive interventions outlined in their STPP for OCD manual.

Another promising avenue is the integration of psychodynamic techniques into CBT treatments for OCD. I came across an excellent article by Michael J. Greenberg (2022) advocating for the assimilation of Malan's object-relational model of OCD (1979) into an Exposure and Response Prevention (ERP) framework, following from Malan's (1979) claim on the impermeability of OCD symptoms to psychoanalysis. Testing Greenberg's (2022) approach with treatment-resistant or refractory ERP cases would make for a compelling research study.

A final aspect concerns the broader implications of psychotherapy integration. Could Leichsenring and Steiner's (2017) STPP model benefit from an *integrative* classification to increase its dissemination? In other words, would integration expand the model's reach and streamline its implementation? Could these endeavors leverage resources towards more efficacy trials in the future, with the net effect of bolstering the empirical reputation of STPP and psychodynamic therapies as a whole?

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Table 1: Diagnostic Criteria for 300.3 (F42.2) Obsessive-Compulsive Disorder*

Criterion	Description	Criteria Met?
A	Presence of obsessions, compulsions, or both: Obsessions are defined by (1) and (2): 1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress. 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion). Compulsions are defined by (1) and (2): 1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. 2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. **Note:** Young children may not be able to articulate the aims of these behaviors or mental acts.	✓
B	The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	✓
C	The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.	✓
D	The disturbance is not better explained by the symptoms of another mental disorder.	✓
Specifier	*Specify* if: 1. **With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true. 2. **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true. 3. **With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.	**With good insight**
Specifier	*Specify* if: 1. **Tic-related:** The individual has a current or past history of a tic disorder.	**N/A**
FULL CRITERIA MET?		✓

*As defined by the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) (APA, 2013).

Table 2: Serena's Scores on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

	Pre-Treatment Assessment (Intake)	**Post-Treatment Assessment (After Session 22)**
Obsession Symptom Severity Score	12	6
Compulsive Symptom Severity Score	10	8
Total Symptom Severity Score*	22	14 ^ [a]
Total Severity Ranges+	Moderate	Mild
11. Insight Into Obsessions and Compulsions	1	0
12. Avoidance	2	1
13. Degree of Indecisiveness	3	1
14. Overvalued Sense of Responsibility	2	1
15. Pervasive Slowness / Disturbance of Inertia	1	0
16. Pathological Doubting	4	2
17. Global Severity (0-6)	3 (Moderate)	2 (Mild)
18. Global Improvement (0-6)	N/A	5

* Clinical cut-off for Total Symptom Severity Score is 8 or above.
+ Global Severity Categories: subclinical (0–7), mild (8–15), moderate (16–23), severe (24–31), extreme (32–40).
^ An 8-point decrease in Total Symptom Severity Score is ≥35% and constitutes a "treatment response" (Mataix-Cols et al., 2016).
[a] Decrease between pre- and post-treatment Total Symptom Severity Score is statistically significant as measured by Jacobson and Truax's (1991) Reliable Change Index.

Table 3: Sample CCRT Scoring of a Relationship Episode (REc 10 of RAP Interview)

REc 10: Mother

PRS: Self-confident
W: To assert myself, to have self-control

NRO: Oppose me, is not understanding

NRS: Ashamed, anxious
NRS: Out of control, helpless
W: To assert myself; to be understood and accepted
NRS: Ashamed, anxious
NRO: Rejecting, don't trust me, don't respect me

NRS: Ashamed; helpless, uncertain

//[PRS]I felt good when I called her [mother] last week//[W]to tell her I was considering a new medication because my anxiety symptoms were getting out of hand.//[NRO]She cursed Pharma for brainwashing me and asked if I had tried yoga yet.//[NRS]I told her no and my throat got tight.//[NRS]I felt myself entering a familiar tailspin of doubt.//[W]I wanted to tell her about my conversation with Dr. Koch that day but//[NRS]her rising indignation silenced me.//[NRO]She quoted, "insanity is doing the same thing over again and expecting different results."//[NRS]I thought about my last experience with medication and felt stupid, and alone./

Table 4: Serena's CCRT Score Sheet for RAP Relationship Episodes, Standard Categories

Patient: Serena Number of REs: 10 (In RE number 1-10)			Intake RAP Interview Date: 02/15/2023
RE No. Person	**Wish, Need, Intention (Cluster #)**	**Response From Others (Cluster #)**	**Response of Self (Cluster #)**
REc 1 Boyfriend	To be my own person (1)	Strict, controlling (2)	Ashamed, guilty (8) Helpless (6)
REr 2 Self	To have self-control (1)	Don't trust me (*internalized object*) (5) Strict, controlling (2)	Controlling (5) Out of control, helpless (6)
REp 3 Mother	To *not* be responsible/ obligated (3) To be helped (3)	Out of control (3) Unhelpful (5)	Anxious, guilty (8) Helpless (6)
REc 4 Coworker	To assert myself (1) To be hurt by others, to be controlled by others (3)	Oppose me (5) Angry (3)	Anxious (8) Controlling (5)
REc 5 Boyfriend	To be loved and understood (6)	Loves me (7)	Feel comfortable and accepted (3)
REr 6 Mother	To be independent (1)	Strict, controlling (2) Don't trust me (5)	Helpless, out of control (6) Dependent (6)
REr 7 Cousin	To be like others (3)	Strong, independent, happy (1)	Like others (3) Self-confident (5)
REp 8 Friend	To be my own person (1)	Dependent, hurt (3)	Uncertain (6) Anxious (8)
REp 9 Ex-Boyfriend	To be my own person (1) To be helped (3)	Is not understanding (5) Dependent, anxious (3)	Helpless (6) Anxious (8)
REc 10 Mother	To assert myself, to have self-control (1) To be understood and accepted (6)	Oppose me, is not understanding (5) Rejecting, don't trust me, don't respect me (5)	Self-confident (5) Ashamed, anxious (8) Out of control, helpless, uncertain (6)

Table 5: Serena's CCRT Summary: Standard Categories

Patient: Serena Number of REs: 10 (In RE number 1-10)	Intake RAP Interview Date: 02/15/2023
Standard Cluster Edition 3 (RE No.)	**Frequency Across REs**
Wish, Need, Intention	
1: To assert self and be independent (1, 2, 4, 6, 8, 9, 10) *To have self-control, to be my own person, to assert myself, to be independent*	7
3: To be controlled, hurt, and not responsible (3, 4, 7, 9) *To be hurt, to be controlled by others, not to be responsible or obligated, to be helped, to be like others*	4
6: To be loved and understood (5, 10) *To be loved, respected, understood, accepted, liked*	2
Negative responses from others	
5: Rejecting and opposing (2, 3, 4, 6, 9, 10) *Don't trust me, don't respect me, are not understanding, rejecting, dislike me, are distant, unhelpful, oppose me, hurt me*	6
3: Upset (3, 4, 8, 9) *Hurt, dependent, anxious, angry, out of control*	4
2: Controlling (1, 2, 6) *Strict, controlling*	3
Positive responses from others	
7: Likes me (5) *Loves me, respects me, likes me, gives me independence*	1
1: Strong (7) *Strong, independent, happy*	1
Negative responses of self	
6: Helpless (1, 2, 3, 6, 8, 9, 10) *Out of control, helpless, uncertain, dependent*	7
8: Anxious and ashamed (1, 3, 4, 8, 9, 10) *Anxious, ashamed, guilty*	6
Positive responses of self	
5: Self-controlled and self-confident (2, 4, 7, 10) *Self-controlled, independent, self-confident, controlling*	4
3: Respected and accepted (5) *Feel comfortable, happy, loved, respected, accepted, like others*	1

Table 6: Exposure Hierarchy (Homework Exercises)

Avoided Situation	**SUDS Rating**
Whispering an intrusive thought	25
Saying an intrusive thought out loud	40
Singing an intrusive thought	40
Plugging and unplugging appliances	50
Stating disagreement with mother about an important topic	70
Cooking a meal that involves using a knife	75
Read short news stories about suicides	80
Asking coworkers to get lunch together and disclosing a conflict	85
Imagine hurting self with razor (stay with the mental image)	90
Imagine parents dying in a transportation accident	90
Driving on the highway	90

Table 7: Transference Monitoring: Patient-Therapist Relationship Episodes and CCRT Analysis

Patient: Serena							Select REs from Therapy Sessions
Module No.	**Wish**	**RO (Therapist)**	**RS (Patient)**	**Enactment?**	**Main Defense**	**Activating Affect (possibly warded-off)**	**Possible Interpretation of the Transference**
1	To *not* be dependent	Strict Respects me	Ambivalent, uncertain, helpless	No	Reaction formation, Justification	Fear	I noticed that you are hesitant to commit to weekly sessions, yet you've showed up consistently for the intake sessions and you showed up today. What keeps bringing you here? What makes you think you might need my help?
2	To have self-control	Encroaching, forceful Don't trust me, Oppose me	Self-confident, cool, aloof Out of control, helpless	No	Reaction formation	Fear, frustration, anger	You want to have control of your life and you don't want me to interfere. If I question you, you feel intruded on and start to feel like you're losing control.
3	To *not* be dependent;	Strict, controlling	Uncertain, suspicious, dependent (acquiesces) Ashamed, (withdraws)	No	Justification	Shame, fear	You go along to get along but you secretly distrust me. …Even though I understand your hesitation, I wish you would give me a chance to help you.
4	Self-expression	Respects me, gives me independence	Self-control, mastery Feel accepted, respected (present, engaged)	No	Intellectualization	Unclear, any	You express what you *think* to me, and I listen intently and validate your ideas. We build on your ideas together, but we might accidentally get stuck in ideas and lose touch with *feelings*.

Table 7: Continued

5	To be loved and understood	Happy, strong Likes me, respects me	Happy, loved, respected (present, enthused)	No	Intellectualization	Joy Some anger	We both get excited talking about your culture. We connect on the intellectual plane, but I suspect there's some anger somewhere about these topics that isn't showing up just yet for you.
6	To be dependent, to be helped	Respects me Gives me independence	Feel comfortable and validated Self-confident	No	None	Frustration, sadness	You trusted me to broach your most difficult dilemma—your engagement. You were vulnerable and confident in sharing. How did you hope I would respond?
7	To not be responsible or obligated	Upset Controlling, strict	Guilty Anxious, helpless, pressured (withdraws)	Yes: Power struggle	Undoing, regression; withdrawal	Anger, fear	I felt that you were negating the work we had done in previous sessions, and I became upset. I didn't realize you were feeling guilty about "betraying" your family. I felt that you were "gone" from the room, and I became frustrated because I really wanted to engage with you.
10	To assert self and be independent To be accepted and loved	Gives me independence; doesn't scold me; respects me Strong, independent	Self-confident, self-controlled A little anxious and distrusting	No	None	Rage	I so appreciate that you finally allowed yourself to rant and rave in my presence. I welcome any chance you have let off steam in therapy. You were unapologetic about it. Did you notice how that *feeling* didn't lead you to lose control?

Table 7: Continued

11	To be independent	Strong Strict Gives me independence (empowering)	A little ashamed Anxious Trusting; respected	No	Isolation of affect; avoidance	Fear	I realize that I forgot to explain just how important it is to be consistent with exposure practice. I know how diligent and brave you are, and I encourage you to commit to doing these at least once or twice a week. Our therapy is ending soon, so I won't be able to check in so much anymore. I am confident you can keep yourself accountable for doing these. It will help prevent OCD after we end therapy.
12	To be loved To depend healthily	Gives me independence Loves me Strong	Feel comfortable and accepted Self-control (in vulnerability)	No	None	Sadness; grief	I love how you were able to feel deep grief about all these changes in your life, without holding back or writing it off. I was feeling it with you when we were both quiet together.

APPENDIX 1. OUTLINE OF THE CASE STUDY "SERENA"

1. CASE CONTEXT AND METHOD
   - ***Rationale for Selecting this Particular Patient for Study***
   - ***Pragmatic Case Study Method***
   - ***Data Analysis Overview***
   - ***The Clinical Setting in Which the Case Took Place***
   - ***Sources of Data Available Concerning***
   - ***Confidentiality***

2. THE PATIENT

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

   - ***Obsessive-Compulsive Disorder***
     - Epidemiology
     - Classification & Phenomenology
   - ***Neurobiological Etiology of OCD***
   - ***Existential Issues in OCD***
   - ***Psychodynamic Perspectives on OCD***
     - The Classical Model: Obsessive-Compulsive Neurosis
     - Core Psychodynamic Problem: Obsessionality
     - Object Relational Models of OCD
     - Self-Psychology
   - ***Treatment Considerations***
   - ***Short Term Psychodynamic Psychotherapy (STPP) for OCD***
     - A Manual-Guided STPP Approach: Treating the "Inhibited Rebel"
     - A Psychodynamic "Manual": Applicability & Rationale
     - Principles of Supportive-Expressive (SE) Therapy
     - The Core Conflictual Relationship Theme (CCRT) Method

4. ASSESSMENT OF THE PATIENT'S PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

   - ***Presenting Problems***
   - ***Psychosocial, Developmental, & Family History*** add comma
   - ***Presentation at the Beginning of Therapy***
   - ***Inclusion/Exclusion Criteria***
   - ***Assessment Measures***
     - The Y-BOCS Interview
     - The RAP Interview
   - ***Diagnosis***
   - ***Goals and Strengths***

5. CASE FORMULATION AND TREATMENT PLAN
   - ***Formulation***
     - CCRT Formulation
     - The Classical Model