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

Integrating Existentialism and Modern Structural Theory into Short-Term Psychodynamic Psychotherapy for OCD

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ABSTRACT

This article responds to two commentaries on my psychodynamic case study of "Serena," a Cuban-American woman with harm-related obsessive-compulsive disorder (OCD). In Part A, I respond to Lyon's (2025) existential-psychodynamic reformulation, which posits Serena's compulsions as defenses against death anxiety and fears of psychic disintegration. Lyon integrates Freud's dual-drive theory, terror management theory, and attachment trauma to frame obsessive rituals as maladaptive efforts to manage existential dread rooted in early relational ruptures. I reflect on how existential interventions, such as explicitly naming death anxiety, addressing uncertainty, and leveraging termination in brief treatment, might have reduced shame around OCD symptoms and deepened Serena's engagement. In Part B, I respond to Khademi and Steffen's (2025) relational-developmental critique. They challenge the limitations of Leichsenring and Steinert's (2017) manual-guided, short-term psychodynamic psychotherapy (STPP) approach, based on Luborsky's (1984) Supportive-Expressive/Core Conflictual Relationship Theme (CCRT)_model. Instead Khademi and Steffen propose a shift toward Modern Structural Theory, identifying missed enactments and the need for greater therapist self-reflection. Their commentary reframes resistance and aggression not as treatment-interfering behaviors but as developmentally meaningful expressions of Serena's emergent agency. I consider how supervision targeting my countertransference as it related to my bicultural identity could have prevented blind spots. In Part C, I synthesize the contributions, both of which call for greater emotional immediacy, cultural attunement, and recognition of the developmental origins of intrapsychic and interpersonal dynamics, while accounting for the limits of manualized therapy. Together, these perspectives offer valuable and nuanced directions for expanding the scope of short-term psychodynamic therapy with complex cases like Serena's.

Key words: short term psychodynamic psychotherapy (STTP); Luborsky's supportive-expressive (SE) therapy; core conflictual relationship themes (CCRT); obsessive compulsive disorder (OCD); Freud's

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dual drive theory; terror management theory; death anxiety; Eros and Thanatos; modern structural theory; therapist subjectivity; countertransference; cultural identity in psychotherapy; case study; clinical case study

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PART A: RESPONSE TO LYON

A.1 New Theoretical & Strategic Ideas Introduced by Lyon

Psychodynamic psychotherapy is as much destructive as it is regenerative, a process of dissolution and resolution, of unlearning and new learning. These forces are complementary, operating in synergy, as do Eros and Thanatos. Without death, there is no life. In this vein, death-awareness can be an agent of change for patients. Lyon (2025) makes a compelling argument for how an existential perspective might have catalyzed a deeper transformation in my hybrid client "Serena." Notably, Lyon grounds her existential conceptualization in a psychodynamic framework, highlighting the shared terrain between the two approaches and echoing the spirit of theoretical integration I sought to make palpable in my dissertation.

Lyon's (2025) existential conceptualization of Serena weaves Freud's (1923) dual-drive theory with Greenberg's (2012) terror management theory in a seamless fashion. She thoroughly conveys that existential and psychodynamic frameworks converge on two core concepts: the unconscious and the deployment of defense mechanisms to manage death anxiety. Lyon frames death anxiety not as a conscious fear, but as a fundamental angst that is conceivably more pronounced in Western culture. As such, the reality of death is collectively subdued and internally defended-against. It is the death instinct, Thanatos, that Serena cannot consciously tolerate, while the life instinct, Eros, is more readily embraced, given that it is championed in conventional life and reinforced by cultural norms. Lyon's formulation of obsessional schemas as comprising an "unconscious fantasy that one has the power to control death" (Lyon, 2025, p. 253) reinforces the themes I explored in my dissertation. In my case study, I also conceptualized Serena's compulsions as efforts to combat the rearing of Thanatos' head (Freud's *death instinct*); presumably, to preserve psychic equilibrium.

Moreover, Lyon's commentary addresses the existential idiosyncrasies of "harm OCD," wherein individuals keep a lid on Thanatos through ritual, control, and perfectionism, meanwhile allying with Eros through behaviors that are culturally sanctioned, self-preserving, and affirming of their physical safety. This dynamic mirrors the tenets of terror management theory, which posits that shared worldviews and self-esteem provide a cushion against existential terror. From a psychodynamic standpoint, these safeguards can be understood as defenses—both adaptive and maladaptive—mobilized to shield the ego from the overwhelming awareness of its own finitude (Lyon, 2025). Unlike the more typical (and adaptive) ways people cope with death anxiety, or, as

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Lyon notes, natural morbid curiosities, OCD coopts this universal fear into a relentless cycle of intrusive thoughts and compulsions (maladaptive defenses). Lyon's integration of existential and psychodynamic thought thus underscores the tremendous psychic labor involved in keeping death anxiety at bay—and what happens when these efforts falter, as observed in Serena's case.

Additionally, Lyon interprets Serena's harm-related obsessions as auspicious manifestations of the death drive, describing them as efforts to negotiate mortality, more so than uncanny aberrations. Lyon does not make a clear distinction between physical death and psychological disintegration, instead speaking of "entropy and dissolution," a language I also employed in my target case study of OCD as a defense against "psychological entropy" (Campiani, 2025, p. 140). This choice of terminology leads me to the conjecture that Serena's primary fear was not of physical death, but of psychic fragmentation, what some theorists refer to as the fear of annihilation. Her compulsions might have been attempts to guard against the collapse of ego boundaries, the erosion of internal order, or a descent into what could have even felt like psychotic disintegration. This possibility reminds me of Jung's (1959) concept of *ego death*. Lyon's commentary helps bring this into focus: Serena's intolerance of ambiguity, her perfectionism, and her magical thinking can be understood as existential defenses designed to fend off this feared state of dissolution. In an existential formulation, the death drive does not merely symbolize external mortality—it represents an internal threat to psychic cohesion, one that Serena was perpetually and desperately working to keep at bay.

Practicing death awareness, as prescribed by existential psychotherapists, is in essence a practice of uncertainty. Intolerance of uncertainty is particularly accentuated in OCD, and Lyon's commentary highlights how an existential frame might invite Serena to develop an emotional tolerance for ambiguity. This approach coheres with the inhibitory learning model in behavioral exposure therapy, which posits that change does not transpire through habituation only, but through forming new, non-fearful associations with previously feared stimuli. In the existential register (e.g., Breitbart, 2018), uncertainty tolerance is not a passive practice; it demands reaching toward Eros in the face of Thanatos, toward life, meaning, and spontaneity. In sum, the existential idea is that passionate engagement with life is a poignant experience precisely because of its impermanence.

There is a line in Leichsenring & Steinert's (2017) manual that relates to this existential theme, "obsessive-compulsive symptoms may also be a bulwark against life's transitoriness," (p. 371). To address the issues of Lyon's commentary, Leichsenring & Steinert's reiterate Mann's (1973) statement that the structure of short-term treatment itself "revives the horror of time." Lyon strives to bring this latent fact to the forefront, urging us to treat the time-limit of STPP not

as an administrative constraint but as an existential catalyst, soliciting an *explicit* dialogue with the ticking clock that is all the more salient in a *brief* therapy.

A.2 Application of Lyon's Ideas to "Serena"

Naming Thanatos and Normalizing Death Anxiety

Had I followed Lyon's lead more explicitly, I would have introduced the *death instinct* at the outset of treatment, de-shaming Serena's intrusive images by framing them as "emissaries of truth" rather than moral failings. When she feared plunging off her balcony or electrocuting herself, I might have said: "These images may be your mind's way of grappling with what none of us can escape: mortality and loss of control." Such normalization could have diffused Serena's shame and opened an alternative line of inquiry.

Linking Present Symptoms to Developmental Ruptures

I was particularly moved by Lyon's sensibility to Serena's childhood trauma in the way she unpacked the preverbal seeds of death anxiety in the patient's narrative: the family's dangerous migration, her father's disappearance into prison, and her parents' repudiation of their Cuban roots. Attachment theory supports the view that when caregiving is unpredictable, the child's dawning awareness of death fuses with helplessness and boundary diffusion (Bowlby, 1980; Erikson, 1959). I realize that this is an underexplored area in my case study of Serena, and Lyon offers actionable examples of interventions that leverage traumatic material to up the ante on existential themes. By virtue of its manualized structure, STPP therapy is likely to preclude a thorough exploration of childhood traumas. This was certainly the case in Serena's treatment, where I felt pressured by the time limit and accomplishing measurable treatment goals. In retrospect, I see that I did attempt to dive into certain formative experiences when their footprint was substantial in Serena's present-day relational patterns. For example, I linked the push-and-pull dynamics in Serena's romantic relationship to very similar experiences she had with her mother, her primary attachment figure during developmental years. Lyon, on the contrary, suggests a more thorough exploration of the *loss* of her father, a trauma that arguably has a more direct link to death anxiety.

Lyon's emphasis on formative *loss* invites me to speculate whether Serena's panic attack after her engagement was reminiscent of childhood moments when the promise of safety seemingly collapsed overnight. Along these lines, I propose infusing an existential-developmental inquiry into the behavioral exposures in the STPP treatment. For example, the knife-exposure in Module 8 could pave the way for such questions: "When you hold the blade, what does the panic remind you of?" The patient (with the help of the therapist) might trace the helplessness to nights spent waiting to learn whether her father was still alive. Linking the bodily

surge to that childhood terror would help her recognize current compulsions as attempts to mend the same wound in the self. In my case study, developmental territory was only partially explored by therapy's termination, a common pitfall of brief dynamic work. A longer course would have allowed me to draw more explicit ties between early neglect and Serena's present-day fear of psychic entropy.

Using Milestones as Awakening Experiences

Lyon also highlights how life events mark the passage of time. In the session where Serena recounted her fiancé's proposal, I could have paused the relational analysis and instead remarked: "Engagements, birthdays, graduations—these events can jolt us awake to the fact that time is moving, whether we feel ready or not. How does that land with you right now?" Framing the proposal as an existential milestone would help Serena see the panic not merely as relationship ambivalence but as a confrontation with the impermanence of all things (including her mind).

Using Imaginal Exposure as an Existential Doorway

In Module 10, I guided Serena through *imaginal* exposures to self-harm scenes, aiming primarily for habituation. Through Lyon's lens, those scenes could have become portals into death talk: "As you picture yourself losing control of the steering wheel, do you sense a part of you that longs to just *let go*?" Inviting that longing through explicit language would have honored both Eros and Thanatos, rather than relegating the latter.

I see the therapist's role as that of an alchemist, chiseling away at rigid self-structures by nudging the patient to defy what is safe and familiar, and perhaps discover—or stumble into—a cognitive paradigm wholly unknown to their minds, yet vastly more accommodating of the full spectrum of emotion. The work of therapy, especially through an existential lens, is not only to ease fear but to encourage the patient to relate differently to it. To test out new ways of being with fears, including existential fears. The goal being to ignite a *desire to let go* of thinking processes that generate suffering because they constrain a patient's experience of reality.

Challenging Omnipotent Control as a Fantasy Against Entropy

I often interpreted Serena's perfectionism as superego harshness, whereas Lyon reframes it as an existential attempt to out-organize chaos. With this insight, I might have asked, "What if your rituals work only because they briefly disguise the fact that life is uncertain, and messy, for all of us?" This may have shifted the focus from behavioral mastery to existential acceptance.

Moreover, *free association* to death, as a general concept, could reveal that perhaps Serena fears not only literal dying but the disintegration of her sense of self.

Embedding Death Awareness in the CCRT Formulation

Were I to revise Serena's CCRT, I could restate one of her wishes as, "to feel independent from the pull of death (or psychic entropy)," and the regressive counter wish, "to merge with an omnipotent other who might protect me from the fear of death." Making these polarities explicit could help guide moment-to-moment interventions. For example, when Serena scanned my face for reassurance, pleading, "You're certain I'm not going to do something terrible, right?" I could have verbalized the existential dilemma playing out interpersonally: *"*One part of you seeks absolute safety in me, while another part intuitively knows that no one, not even I, can protect you from this fundamental uncertainty." In this way, I *name* both the comfort of "merger" and its impossibility. Highlighting the polarity in that precise moment transforms her checking ritual into a shared, here-and-now encounter with Thanatos, rather than remaining a reflexive defense.

Leveraging the Countdown to Termination

Short-term therapy amplifies the ticking of a clock. Mid-treatment I might have said, "We have nine sessions left. Every time we say goodbye it's as if we are rehearsing for the big end." Consciously anchoring us in a timeline, such a reminder could be a live exposure to impermanence. Serena would then practice the awareness of upcoming separation in vivo, preparing her to consciously welcome life's inevitable losses outside the therapy room.

Nearing termination, developing *the capacity to be alone* prepared Serena to face the void without escaping into merger or dissociation (Lyon, 2025). The therapeutic relationship became a transitional space where Serena began to experience solitude not as withdrawal, but as the ability to be alone in the presence of a reliable other. This shift required something of me as well: the willingness to sit with her in silence, to bear what emerged without prematurely rushing to resolve it, nor "intruding" on her experience. Also, to sit with my discomfort at this (Module 11). Our therapeutic relationship was expressly impermanent, which made the shared experience of aloneness poignant and profound. The capacity to be alone, as Winnicott (1958) frames it, is not just a developmental milestone; it can also be a corollary of authentic existential inquiry, for patient and therapist alike.

Therapist Readiness

As much reverence as I have for the existential lens, I think there is a limitation insofar as therapist readiness and willingness to "go there" with death anxiety. It can be a daunting task for

any person to acknowledge existential dread, let alone approach it without the shield of the intellect, i.e., in an emotionally engaged manner. Rendering existential therapy summons a special kind of vulnerability in the therapist, and one that I wish I would have leaned into had I had more time to explore these themes. Lyon advocates for the therapist to rise to the occasion of their own mortality, or risk reenacting unspoken dread. A parallel process can ensue where the therapist's discomfort with death is triggered by its sudden salience in the here-and-now, mirroring the anxiety of the patient. Recalling sessions where existential material surfaced only in undertones, I see that my own reservations may have stalled a deeper exploration. I may have engaged in avoidance behaviors or superficial engagements with Serena (Yalom, 2008). A more deliberate embrace of my vulnerability might have emboldened Serena to tolerate ambiguity without retreating into ritual.

Taken together, Lyon's commentary urges me to treat death anxiety as a central analytic object. By naming Thanatos, linking it to Serena's history, and holding the duality of self-preservation and self-destruction in the room, I could have transformed moments of symptom management into opportunities for existential integration—helping Serena loosen her grip not on life, but on the illusion that she must hold it perfectly together to feel safe within it.

PART B: RESPONSE TO KHADEMI & STEFFEN

B.1 New Theoretical & Strategic Ideas Introduced by Khademi & Steffen

Khademi and Steffen's (2025) reformulation advocates for a theoretical shift. This shift is from the traditional psychodynamic framework utilized in Serena's therapy—that is, Luborsky's (1984) Supportive-Expressive (SE) therapy, featuring the Core Conflictual Relationship Theme (CCRT) formulation—to Modern Structural Theory with developmental considerations. Both Luborsky's method and Khademi & Steffen's alternative recognize that unconscious processes and relational dynamics both play a significant role in symptom expression and its treatment. However, the locus of therapeutic intervention differs markedly between these approaches.

The SE therapy/CCRT method I employed positions the locus of therapeutic change in *intrapsychic* insight. I conceptualized Serena's OCD symptoms as compromise formations—attempts to strike a truce between unconscious drives and superego prohibitions, dynamics which are then transposed onto interpersonal relationships. Consequently, the therapeutic task is to identify, interpret, and track these relationship themes, making implicit patterns explicit, thus reducing their need to manifest as symptoms. The traditional psychoanalytic approach I opted for is more analytic, interpretive, and emotionally removed, situating the therapist as a kind of expert observer/authority. In my case study, this stance was further reinforced by the demands of a manualized treatment protocol, which echoed the directive, efficiency-driven ethos of mainstream CBT manuals and managed-care imperatives.

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In contrast, Modern Structural Theory shifts the locus of therapeutic change to the live, cocreated enactments between therapist and patient. This approach to treatment, as Khademi and Steffen underscore, is distinctly *relational*. Therapy is not primarily geared on interpretation of patient narratives but on active recognition, acknowledgment, and exploration of interpersonal dynamics as they spontaneously arise *in* the therapeutic relationship. This relational stance requires significant self-reflection from the therapist. Khademi and Steffen consider it an imperative for therapists to deeply ponder and honestly dissect their own cultural identity, parenting background, and personal relationship patterns. They recommend that therapists engage in introspection proactively to increase their perceptiveness in the dyad, such that they can forecast enactments. Khademi and Steffen note that my own self-reflection may have fallen short in my work with Serena. In this vein, they suggest I misconstrued my countertransference reactions in favor of stereotypes of OCD patients, which precluded me from of recognizing my own defensiveness and subsequent aggression.

Drawing on Freud's (1925) idea of psychoanalysis as a *cure through love*, the commentators ask two deceptively simple questions: "Did the patient feel loved and was the therapist loving?" (Khademi & Steffen, 2025, p. 263). This reframing elevates the emotional tone of the relationship to a clinical priority. It challenges me to consider whether Serena could have internalized a relationship in which affection, gratitude, frustration, and aggression were all welcome, and whether I was attuned enough to meet her there.

Another important contribution is their spotlight on culture and migration. Serena's Cuban exile history and my own immigrant identity, they suggest, accentuated one another and became active forces in the therapeutic field. They suggest that shared and unacknowledged cultural heritage—dynamics around compliance to authority, deference, and perfectionism—likely shaped both the enactments that emerged and my responses to them. While I recognize some of this in hindsight, their commentary prompts me to consider how, in many therapy dyads, cultural background is just as critical to the therapist's subjectivity as it to the patient's.

Finally, while SE therapy's structured, interpretive style tends toward technical language, Khademi and Steffen advocate shifting the locus of therapeutic communication toward plain, jargon-free language. They propose that authentic, emotionally immediate language fosters greater intimacy, accessibility, and relational authenticity. Simplifying my language may have enhanced Serena's capacity to internalize the therapeutic relationship and modify her relational templates. Reflecting on my clinical style, I acknowledge my own struggle with being overly technical and abstract in my language, perhaps creating emotional distance rather than closeness. In part, this feature was more pronounced in Serena because this was a hybrid, composite case based on actual cases I have encountered. I fictionalized dialogues and session content to protect

confidentiality and consolidate content. This fictionalization made some of the dialogues more artificial than they might have actually been. I suspect that this may have inadvertently diluted the immediacy and emotional authenticity that is more typical of my clinical style.

B.2 Application of Khademi & Steffen's Ideas to Serena's Therapy

Resistance as a Key Target of Psychodynamic Treatment

I was originally instructed by the treatment manual to conceptualize resistance in my patient as an indicator of low motivation, something to gently "redirect" or address with techniques such as psychoeducation or motivational interviewing. As such, I was predisposed to view Serena's resistance to homework or her hesitation to disclose personal setbacks as idiosyncratic deficits (i.e., reflective of an obsessive character style) to correct through discipline. Khademi and Steffen propose a much deeper understanding of the patient's resistance and view it as a key element of change, a portal rather than a barrier. Rather than dealing with resistance as friction to be smoothed over, these authors point to its aliveness, its potentiality. In this case, Serena's resistance harbored aggression, which is discussed below. From their psychodynamic perspective, resistance is not reluctance but a defensive expression of unconscious conflict, a communication that conveys data about early attachment patterns, fears of engulfment or abandonment, and the struggle to assert agency in a world that once punished autonomy. Instead of "rolling with resistance" or patrolling it, these authors urge me to interpret it more deliberately in the context of the therapeutic relationship.

Had I met Serena's hesitation and apparent "noncompliance," not necessarily as signs of ambivalence, but as encrypted expressions of her more vulnerable, "true self," I may have more effectively validated her burgeoning authenticity. I may have also leveraged opportunities to *work through* the subtle ruptures in our relationship. I could have offered opportunities for her to feel *seen*, which Khademi and Steffen argue would have been more therapeutic for this patient than what my unconscious response transmitted: her feeling *controlled* by virtue of being "kept on track" by her therapist (in an authority role). This is a perceptive observation which proves that enactments are counterproductive in that they *reinforce* the patient's dysfunctional relationship patterns (i.e., Serena's CCRT). Additionally, the authors' reframing encourages me to meet resistance with a new kind of developmental compassion, one in which I could have offered *attunement* where Serena's caregivers were unable to.

Notwithstanding, early in the treatment, there were what I believe to be bona fide examples of resistance that support my conceptualization of resistance as "ambivalence towards change." Imposing a relational framework on this kind of resistance would have been inaccurate, as the transferential build-up had not yet taken place. In Module 2, I interpreted Serena's polished monologue about her orderly life as a reaction formation, or resistance to 1) admitting

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that she suffers, 2) feeling helpless in the face of inner chaos, and 3) asking for help. Although there were relational avenues through which to confront her ambivalence, I believe that her reluctant presentation would have been consistent in any initial therapeutic encounter. In similar vein, her strained, calculated politeness and excessive emphasis on the "correctness" of her life choices early on—such as wedding plans and career duties—were defensive maneuvers aimed at denying the underlying dissonance that brought her to therapy. Her somatic episode during my confrontation (i.e., ringing in her ears, blanking out) further suggests that the pressure to maintain this facade was unsustainable. Moreover, when presented with prompts that invited her to relinquish control over her mind (e.g., free association, discussing intrusive thoughts), Serena frequently deflected with logic or shifted to logistical concerns, behaviors that served as subtle expressions of avoidance. In these moments, her resistance was less rooted in interpersonal dynamics and more in her ego's efforts to maintain psychic equilibrium. These instances exemplify *resistance* in pure psychoanalytic terms: an effort to conserve the very defenses that repel anxiety-provoking affect and sustain a semblance of internal order.

Aggression and Love in the Therapeutic Dyad

Khademi and Steffen's (2025) commentary challenged me to more consciously explore how aggression—both Serena's and my own—permeated the therapeutic field in ways I did not fully appreciate during the treatment. Their psychodynamic lens draws attention to key enactments that I failed to anticipate, therefore responded to defensively. In reflecting now, I recognize that this overlooking may have been in service of adhering to the Leichsenring and Steinert (2017) manual, which required me to maintain a certain momentum to achieve short-term treatment goals. Looking back on my work with Serena, I concur with Khademi and Steffen: these enactments were not distractions from the treatment—they were cornerstones.

I was particularly impressed by Khademi and Steffen's detection of evidence supporting a "quiet rebellion" in my patient. The examples they highlight, which emerged in the later parts of the treatment, once the relationship was established, include passive-aggression, repression or "forgetting" of previous session content, modifying homework assignments, limited disclosure of details, and omission of important events in her life (i.e., her "secretiveness"). These behaviors, which I had interpreted as treatment-interfering, were recontextualized by Khademi and Steffen as meaningful communications—unconscious tests of the therapeutic relationship's capacity to withhold Serena's *protests*. Indeed, these moments reflected her emerging agency and offered entry points into her struggle with self-assertion in relationships, which was the hallmark of her CCRT. Her inhibited demeanor and habitual compliance were adaptive responses to early family dynamics characterized by stringent expectations and capricious responsiveness to emotional needs. As Khademi and Steffen indicate, young Serena learned that expressing anger, frustration,

or need could destabilize already fragile attachments. Within this context, her small acts of defiance in therapy were less a disruption and more of an effort to test whether she could risk showing more of herself and still be accepted.

In this light, Serena's aggression toward me signaled psychological health. Her withdrawal, sarcasm, forgetfulness, and deviations from structure were not signs of regression; rather, they may have been bids for connection. Her ability to express anger, after months of presenting a compliant false self, suggests a growing sense of safety in the therapeutic relationship.

As Khademi and Steffen emphasize, such aggression likely emerged from her "true self." Drawing on Bolognini's (1994) concept of *affectionate transference*, they argue that patients reveal disavowed affects—like anger and defiance—only to love objects they trust will neither retaliate nor abandon them. This suggests Serena perceived me as sturdy enough to receive her aggression. Khademi and Steffen extend this view through a Winnicottian lens, proposing that her aggression may have been an unconscious attempt to "kill the mother" in fantasy—an act of psychological separation that, if survived by the therapist, fosters individuation. Malan's (1979) idea of *constructive aggression* frames such candid assertiveness as a developmental milestone: a test of whether the therapist can withstand the patient's full emotional range. As Khademi and Steffen note, these moments were invitations to deeper relational work. Had I recognized them as such, I might have responded with steadier curiosity and preserved our emotional connection, rather than retreating into a directive stance. I missed opportunities to collaboratively mentalize the mutual aggression in the room—interventions that might have affirmed for Serena that even her darker affects could be tolerated by both her therapist and the therapeutic relationship.

Equally powerful was Khademi and Steffen's call to recognize my own disavowed aggression. According to them, this helps explain why I failed to metabolize Serena's passive resistance, which in turn provoked my own frustration and led to an enactment. I certainly agree. My aggression toward the patient was expressed not overtly but through subtle retorts, premature interpretations, or even well-meaning reassurances that may have overridden her *resistance* and inadvertently invalidated her experience. Their interpretation of my comment—"Got somewhere else you need to be?"—as carrying unacknowledged irritation prompted me to reflect on how easily tone and body language can belie the therapist's inner state. I reckon that body language is a crucial component of *relational technique*. When we are unconscious to our affective responses, our nonverbal cues can misalign with the patient's needs and jeopardize our attunement. To my understanding, Khademi and Steffen's appeal to *therapeutic neutrality* does not call for the absence of feeling, but rather for the therapist's capacity to *be with* uncomfortable feelings—in this case, frustration and aggression—in service of the patient.

Khademi and Steffen's integration of Modern Structural Theory and developmental psychoanalysis helped me better understand the aggression that both Serena and I enacted—and tried to defend against. They suggest that Serena's aggression may have been an unconscious test to see whether I, like her early caregivers, would pull away or become destabilized in response to her more authentic self. Her quiet acts of defiance were not meant to damage the relationship, but to see if it could tolerate her independent drives. I now recognize that when I responded with rigidity or redirection, I may have unintentionally communicated that those parts of her were not welcome. Khademi and Steffen also raise the possibility that I struggled to hold Serena's aggression because of my own difficulty managing conflict and dissent, shaped by both my developmental history and the insecurity I felt as a novice therapist.

There is no doubt that I experienced imposter feelings during the treatment of Serena. These include anxieties about whether I competent enough to manage complexity and rupture. As Khademi and Steffen point out, I may have leaned on the manual to protect against those anxieties. These challenges weren't just about clinical skill; they were also personal. I now see how parallel background factors may have influenced my reactions to Serena's resistance and created blind spots. While I did not endure the kind of traumatic migration experiences Serena did, I was raised by immigrant parents in a tightly wound, matriarchal family system hinging on mandates of controlling one's emotions, keeping up appearances, and deference to those with more power. I was separated from my home country at a young age and often felt torn between two cultural identities. These experiences shaped how I personally relate to both *authority* and *autonomy*. In parallel, my extensive clinical experience with refugees and asylees has deepened my sensitivity to themes of persecution, displacement, and identity fracture, core undercurrents in Serena's case. In fact, I related so intimately to the interpersonal conflicts that Serena grappled with, that it may have even caused me to "mistake her subjective experience for objective facts," as Khademi and Steffen (2025, p. 271) note, entering a kind of complicity that resulted in me *colluding* with her CCRT in precise instances.

This raises an important question: if Serena could express aggression toward me—however subtly—might she also have done so with close others in her life, without recognizing or reporting it as such? In the early modules of treatment, Serena reports being consistently wronged or misunderstood by family members, coworkers, and romantic partners. As Khademi and Steffen note, her narratives typically positioned her as the passive recipient of others' cruelty or neglect. Rarely did she outright *acknowledge* her role in contributing to interpersonal conflict. While this framing may have reflected her genuine perspective, it is equally plausible that aspects of her own aggression were disavowed or inaccessible to conscious awareness. Just as I failed to register Serena's subtle provocations in real time, she may have been equally unaware of her own hostility in other relationships. This is not to suggest deliberate deceit, but rather a

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defensive structure so deeply internalized that it filtered what she could afford to know about herself (another parallel with my own internalized dynamics). Serena's silence around such behaviors may have functioned as a protective omission, akin to the "secretiveness" Khademi and Steffen identify in her in-session behavior. Had I been more aware of these dynamics, I would have deliberately speculated about her aggressive behavior in close relationships. Mentalization (Fonagy et al., 2002) would be an optimal technique to achieve this aim.

Still, Serena's treatment was not without moments of *insight* and *repair*. In Module 7, for instance, I described my inner process of *becoming aware* of a charged enactment that had unfolded following Serena's visible withdrawal (from me) and the emergence of guilt. I recognized that my strict and somewhat dismayed response may have reflected an overidentification with her RO expectation: that authority figures would be critical or domineering. Supervision was instrumental in helping me process my frustration and better appreciate the emotional meaning of her withdrawal, not merely as resistance, but as a re-enactment of her ambivalence about asserting her needs within a relationship. In subsequent sessions, I attempted to gently name this pattern, linking it to her early relational experiences and her struggle to reconcile autonomy with loyalty to family and loyalty to culture. That said, Khademi and Steffen helped me to see more clearly how my response in Module 7 was misattuned, such that it invalidated Serena's experience of guilt and opened the gate for my own aggression. While I may have failed to reflect deeply enough on my unconscious motivations in the moment, I was trying to manage a fraught countertransference under the pressure of a manualized treatment. This does not excuse my defensive posture, but it does remind me that the therapist's mind best remains a site of ongoing inquiry.

In future work, I will strive to *befriend* aggression. Rather than view it as a clinical derailment, I can see it as a creative, powerful force that, if engaged thoughtfully, can support individuation *and* reciprocity. If I were to revisit Serena's case with Khademi and Steffen's insights in mind, I would be slower to interpret and quicker to pause—to wonder aloud with Serena about what was happening between us, especially when I felt pressured or perplexed. I would more explicitly affirm the moments when she dared to assert herself and strive to foster the therapeutic conditions for a breakthrough.

Khademi and Steffen's contributions have deepened my commitment to staying awake to the emotional climate of the room, which is always cocreated. As they beautifully argue, *therapeutic love* is not always gentle. Sometimes it requires us to withstand and address the heat of the moment—not to temper it, but to understand what ignites it.

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Supervision as a Developmental Platform for a Therapist's Clinical Identity

Khademi and Steffen propose a supervisory stance that prioritizes the therapist's inner world as much as theory and technique. Drawing from Polkinhorn (2018), they propose that supervision, like therapy, should be transformative in the way of promoting personal insight. This includes helping supervisee shift the focus from "What is the patient communicating?" to "What in me is responding, and why?" Especially in the context of enactments, this kind of supervision can help unpack how the therapist's developmental history and cultural background give rise to parallel processes in the clinical encounter.

I must mention that Serena's case was a "hybrid" case constructed from composite case material for the purpose of my dissertation. As such, there was no single supervisor overseeing the full course of treatment. Given this, it is expected that Khademi and Steffen noticed the absence of the *supervisor* in the case material. They question whether my own cultural identity—as the daughter of immigrants raised in a rigid, matriarchal family system—was sufficiently explored in supervision. From this vantage, the omission of supervision could have contributed to my occasional misattunement to Serena's resistance and unconscious enmeshment with her relational dynamics. It may also explain my lack of insight into the automaticity of my sudden swinging to a position of omnipotence. Taking a family systems perspective, it was as if I *entered* Serena's family structure as someone who already knew its emotional grammar. For example, my urgency to *get the exposures done* may have reenacted parental pressure. The family's expectations, unspoken rules, and conflict-avoidant scripts felt familiar to me, and I may have instinctively adapted to them instead of *intervening*. That said, I believe it may be too ambitious to expect the hypothetical supervisor of a case like Serena's to attend to all these elements, considering the circumscribed nature of the therapy. As Khademi and Steffen state, this supervisory goal would have predictably fallen by the wayside in favor of the priorities of the treatment manual.

Taking an honest look at my case study of Serena, I feel that I did explore my cultural identity, countertransference, and subjectivity more than most case studies do. For example, in Module 5, I shared a little on my own immigration experience from South America and noted how this helped build credibility and rapport with Serena. In Module 7, I reflect on how my bias for individualistic values may have shaped a particular interpretation. Here, I actively reflect on my subjectivity regarding collectivism vs. individualism and attempt to use this insight to avoid imposing too much of my own *will* on the patient. I also bring awareness to Serena's experience of *familismo* and *respeto*, and how confronting her family's failures could feel like a cultural transgression. In Module 10, I note that Serena's RO expectations were colored by intergenerational trauma from political persecution, and I posit her withdrawal as an inherited

"emotional absence." Here, perhaps, I could have delved into my own generational inheritances and to what extent these complexes mirrored or differed from Serena's, as was relevant to the therapeutic encounter.

Had I had an appointed supervisor, I would have appreciated the opportunity to deconstruct my identity more punctually as it relates to the case material. Yet, I recognize that doing so is a vulnerable process and not all supervisors are willing to entertain an authentic discussion of their supervisee's identity. I would only feel comfortable to do so if my supervisor created an atmosphere of trust, where candor was valued and there was some initiative to level the power differential between supervisor and supervisee.

Moving forward, I intend to reflect more intentionally on how my own history enters my clinical work. Actualizing my *clinical identity* can help me stay present in difficult moments and forestall enactments. This commentary prompted reflection on how my own cultural inheritance, as both an insider and outsider to U.S. culture, informs my emerging clinical identity. As Nayar-Akhtar (2015) writes, developing a multicultural therapist identity involves actively integrating dual legacies into one's professional self.

PART C: CONCLUSION

Taken together, the commentaries by Lyon and by Khademi and Steffen offer rich, complementary lenses through which to reappraise my treatment of Serena. Lyon's existential-psychodynamic integration illuminates the unconscious dread that may have animated Serena's obsessional defenses. Her commentary argues that the tension between Eros and Thanatos was prevalent in Serena's presenting problems. Lyon proposes that obsessive-compulsive symptoms are not merely strategies to maintain control but desperate attempts to fend off psychic dissolution, to hold the self together in the face of Thanatos. She encourages a therapeutic stance that welcomes ambiguity, confronts mortality directly, mitigates shame and transforms compulsive defenses into opportunities for meaning making. Lyon's suggestions make way for a deepening of the work through vulnerability, creativity, and the acknowledgment of mortality, particularly in the emotional posture of the therapist.

Khademi and Steffen, in contrast, offer a compelling critique of the relational enactments that ensued within the dyad—many of which I either failed to recognize or interpreted too narrowly. They reposition the locus of therapeutic change from interpreting intrapsychic conflict (characteristic of the SE/CCRT model) to actively engaging the relational, developmental, and cultural forces at play in the therapeutic field. By emphasizing live enactments, emotional authenticity, and the therapist's subjectivity as essential tools, they offer a more dynamically interactive approach. Their emphasis on aggression as an instrument of growth reorients my understanding of moments I viewed as missteps in my work with Serena. Their developmental-

relational stance challenges the sterility and emotional distance of some manualized therapies and highlights the value of deliberate therapist self-reflection. Such an approach transcends the goal of symptom reduction and invites the patient into a fuller experience of being seen, known, and loved.

Each set of ideas would have meaningfully enhanced Serena's treatment—had I been more attuned to them at the time. That said, there were structural limitations intrinsic to the Leichsenring and Steinert (2017) STPP manual and SE/CCRT therapy, which, while theoretically integrative, still prioritizes symptom relief and prescribes a specific sequence of interventions. These imperatives may have truncated deeper exploration in favor of directive interventions. As a trainee bound to a manual, I struggled to balance fidelity to protocol with responsiveness to relational and existential currents in the room. Nevertheless, neither Lyon's nor Khademi and Steffen's frameworks stand in direct contradiction to the manualized model; rather, they reveal potential for deeper work, particularly if the treatment were to be extended. I feel immense gratitude towards these scholars for engaging genuinely, thoroughly, and critically with my work, thus expanding my thinking.

REFERENCES

Bolognini, S. (1994). Transference: Erotised, erotic, loving, affectionate. *International Journal of Psychoanalysis, 75,* 73-86.

Bowlby, J. (1980). *Loss: Sadness and depression* (Vol. 3). New York: Basic Books.

Breitbart, W. (2018). Existential guilt and the fear of death. *Palliative & Supportive Care*, *15* (5), 509 – 512. https://doi.org/10.1017/S1478951517000797

Campiani, A. (2025). Short-Term Psychodynamic Psychotherapy (STPP) for Obsessive Compulsive Disorder (OCD): The hybrid case of "Serena." *Pragmatic Case Studies in Psychotherapy*, *21*(2), Article 1, 130-250. Available: https://pcsp.nationalregister.org/

Erikson, E. H. (1959). Identity and the life cycle. *Psychological Issues*, 1, 18–164.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.

Freud, S. (1923). *The ego and the id* (J. Riviere, Trans.). Hogarth Press and the Institute of Psychoanalysis.

Freud, S. (1925). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20, pp. 75-172). Hogarth Press.

Greenberg, J. (2012). Terror management theory: From genesis to revelations. In P. R. Shaver & M. Mikulincer (Eds.), *Meaning, mortality, and choice: The social psychology of existential concerns* (pp. 17–35). American Psychological Association. https://doi.org/10.1037/13748-001

Jung, C. G. (1959). *The archetypes and the collective unconscious.* 2d ed. Princeton University Press.

Khademi, M. & Steffen, V. (2025). Enhancing manualized Short-Term Psychodynamic Treatment for OCD by considering developmental and modern structural theories. *Pragmatic Case Studies in Psychotherapy*, *21*(2), Article 3, 262-280. Available: https://pcsp.nationalregister.org/

Leichsenring, F., & Steinert, C. (2017). Short-term psychodynamic therapy for obsessive-compulsive disorder: A manual-guided approach to treating the "inhibited rebel." *Bulletin of the Menninger Clinic, 81*(4), 341–389. https://doi.org/10.1521/bumc_2017_81_07

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* Basic Books.

Lyon, S. (2025). The ambiguity of being alive: Turning an existential lens to the case of "Serena." *Pragmatic Case Studies in Psychotherapy*, *21*(2), Article 2, 251-261. Available: https://pcsp.nationalregister.org/

Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics.* London: Butterworths.

Nayar-Akhtar, M. (2015). *Identities in transition: The growth and development of a multicultural therapist* (1st ed.). Routledge. https://doi.org/10.4324/9780429475696

Polkinhorn, H. (Ed.). (2018). *The Ralph Greenson training seminars: The technique and practice of psychoanalysis (Vol. 7).* SDSU press.

Winnicott, D. W. (1958). *The capacity to be alone*. International Journal of Psychoanalysis, 39, 416–420

Winnicott, D. W. (1969). The use of an object. *The International Journal of Psychoanalysis, 50*(4), 711–716.

Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death.* Jossey-Bass.