



The Darkness of ISTDP

The Grace of ISTDP

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Ethical ISTDP

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A note to readers: This essay follows my open letter and the creation of *Ethical ISTDP*, an accountability project born from three years of advocating for theoretical clarity and patient protection within Intensive Short-Term Dynamic Psychotherapy (ISTDP), particularly within its primary institutional home, the IEDTA. Since I published the website, many patients have reached out with stories of harm, one of which I share here under a pseudonym, with her full knowledge and consent. Where I name individuals and describe specific conduct, I rely on documented correspondence, public statements, or my own direct experience. My hope is to save the best of ISTDP from the dogmatism in which it is currently bound. This essay is for everyone: patients, trainees, therapists, teachers, and curious outsiders. I assume familiarity with ISTDP, though I've included broader descriptions of the model. If you find yourself lost, consult the internet. You'll find answers.

I: The Undimmable Light

In the last few years I have discovered that my existence troubles certain people. I do not mean *who* I am, but rather *what* I am. In the world of Intensive Short-Term Dynamic Psychotherapy (ISTDP), the issue is that I perceive clearly how the model distorts the truth of my consciousness, and I am motivated to articulate what I see. I am not unique. There are many like me, as well as other types of people whose minds do not match the metapsychology; the theory distorts them too. According to the ISTDP metapsychology, we are aberrant data points, inconvenient and therefore disavowed evidence within a model that is often taught, practiced, and presented as a complete and total account of the mind.

To understand the limits of the theory, then, it is useful to begin with a mind it cannot adequately explain: *mine*. What do you see when you picture Dissociative Identity Disorder? Depending on how familiar you are with extreme trauma and dissociative minds, your sense may be more or less complex and accurate. The foundational fact is that DID is a childhood-onset developmental form of PTSD and is phenomenologically continuous with the other traumatic stress disorders. DID is what traumatic stress can do to the mind if childhood trauma is recurrent and extreme. While there is both fascination and stigma, most people with DID are undetectable unless you know what to look for or what to ask. Until amnesia lessens and the structure becomes overt to the person themselves, or until a skilled therapist recognizes it, the condition remains entirely covert. By most estimates, only 5% of individuals with DID display florid switching, where the personality changes are dramatic and unmistakable. Most switches are internal, and most DID people mask them in order to respect other people's need for continuity. It is a condition where the mind hides from itself, amnesia for amnesia. The memory gaps are often undetectable, except for subtle and confusing signs of discontinuity in life. And while for some this can result in living multiple lives with total amnesia between their alters, dissociation of this kind is also a mental technology, an ability that can protect the spirit within unbearable pain.

I am DID. Or rather, my consciousness is made of many selves, containing distinct traits, memories, thoughts, action potential, and agency, each with a distinct sense of 'I'. For many people this idea evokes dysfunction: incapacity, incoherence, and a self that cannot be whole. That is not my mind. By my early twenties, after years of pursuing every type of relevant healing, a singular 'host self' had consolidated and was the 'me' I knew. The rest of my mind and alters were hidden or latent. That facet of me was great: successfully defended against the pain of the past, compassionate, smart, and engaged with life. Since I did not yet know I was DID, I felt myself to be a singular mind, a singular self.

By thirty-one, a series of events—most importantly, intensive ISTDP treatment—began to reveal what my consciousness actually is: not just DID, but what is sometimes called 'polyfragmented DID', though a more accurate term for my mind is 'exponentially fragmented'. This is the result of frequent, violent abuse that began early and continued into adolescence, a past I came to know slowly within the revelation of my mind. The experience of this awakening was harrowing, and I am glad to be on the other side. While the story could fill books, that narrative is

not meant for this moment. This writing is meant to illuminate ISTDP, the culture that surrounds it, and the potential of the luminous ideas that Davanloo channeled.

Within the ISTDP paradigm, the problem is that I am visibly capable, and I am internally whole, with no symptoms that map onto the construct of ‘severe fragility’ or the concept of having a ‘borderline level of organization’. I use the word ‘whole’ deliberately; wholeness does not require singularity. I mean that the many parts of my mind, despite their separateness, participate in an underlying coherence of kindness and purpose. Within ISTDP, this organization is theoretically impossible, and thus the metapsychology cannot see me, a tension that is longstanding in the psychoanalytic tradition. As Jean-Martin Charcot famously told a young Sigmund Freud in 1886, “Theory is good, but it doesn’t prevent things from existing.” My existence then poses a simple problem for any total theory of mind: if phenomena the theory defines as pathology exist within me as part of the architecture of health, sustaining internal coherence, psychological development, and enormous capacity for life, then the theory has confused the existence of a structure with the health of the self in which it appears. Some people are genuinely impaired by being DID; I am not. Defenses are structures. They are foundational, and they are necessary to exist as a functioning person. The question then presents itself: *when does a defense become an ability?*

Discomfort with the structure of my mind goes beyond ISTDP; that my dissociative organization is inseparable from my capacity to work, think, write, and love challenges deeply held assumptions about both pathology and consciousness. The very existence of DID has long been bitterly contested. To live as a multiple mind is to inhabit an exception that exposes the limits of nearly every theory claiming to explain human consciousness. John O’Neil, co-editor of the 2022 volume *Dissociation and the Dissociative Disorders*, puts it plainly: “A theory is as robust as the empirical tests it can survive. Dissociative disorders constitute severe tests for any psychological theory, such as psychoanalytic theory, and full-blown DID constitutes the most severe test. DID also constitutes the most severe test for any philosophy of mind.” It is perhaps for this reason that psychoanalytic writers still deny the remarkably clear multiplicity of Bertha Pappenheim (Anna O), a woman at the very origin of psychoanalysis.

High-functioning DID may pose an even more severe test for theories of mind. For many people, and certainly for me, extreme complexity is elegant and coherent. By elegant I mean efficient and precise, something working as intended. By coherent, I mean distinct waves moving in phase—each singular, each with its own purpose, yet aligned, like the light within a laser.

The system works well; it resembles a city-state that is organized and generally peaceful. I have many emotionally resourced, compassionate parts that regulate younger parts, and others that protect me by tracking danger in my environment. Child states have preserved innocence, play, enthusiasm, and delight, while trauma-holding states do the most profound work of all: holding unbearable memory. They live in the black darkness of our past so that, in most moments, I don’t have to. What they hold is not ordinary autobiographical memory; it is traumatic memory, experiences that remain psychobiologically alive because they could not be integrated when they occurred.

Barring ensnarement by sophisticated predatory personalities, my dissociative capacities operate as a honed ability rather than the liability one might think. The host and executive states that manage my/our life are compassionate, helpful, and driven by the need to protect. Far from being primarily emotionally dysregulated, I am hyper-compartmentalized. Indeed, my capacity goes far beyond the isolation of affect ISTDP associates with resistance; I isolate entire minds, entire periods of my life, entire subjectivities, in order to live.

It's not that I don't suffer—I do, enormously. DID is the far edge of PTSD; the pain is real. Yet I remain compassionate, awake, and coherent within it.

The coherence of my mind, given its extensively fragmented multiplicity, is perhaps a result of the singularity of my personal orientation. I learned early on that there is only one thing that truly matters to me: the protection of goodness. In the recurrent devastations that shattered me, I discovered that when everything is taken away, there is something that remains—truth, and orientation. I clung to truth in all the hidden recesses of my being, even truths I could not yet consciously know, and I oriented toward goodness: the beauty of the world, the energy of trees and flowers, the innocence of animals, the love of my best friend. All true light was life-saving for me. Because I was capable of seeing goodness and receiving it, I kept my heart open enough to give and receive love, and I (or we) found a way to grow and to thrive within devastation.

This love also formed my mind. Rather than being in conflict with each other, my many personalities sought to facilitate my life, build support for each other, and creatively adapt. It was not until recently that I realized the 'secret benefactor' I thought I had when I was nineteen was in fact an alter, acting outside my awareness, behind a barrier of total amnesia. It was moving to discover that I was there for myself, that I always have been. I did not identify with or take in the sadism and cruelty around me, and so I never came to see myself as broken; I identified instead with the triumph of my will in the face of cruelty. What my dissociative mind gave me, what the amnesia and multiple selves allowed, was a way to let goodness in.

The amnesia can be life-saving, as it creates a condition in which moments of relative care and calm are experienced within a localized secure attachment, despite a globally disorganizing attachment environment. A dissociative child is able to divide their consciousness into selves that hold different realities of experience; some parts contain the reality of abuse and neglect, while other parts may have total amnesia for abuse. The effect is frequently miraculous: under conditions of extreme trauma, development is preserved because, in some self states and in some moments, goodness and safety feel real. In this way, DID can be thought of as an 'atypical developmental pathway', which is also a facet of why DID is not a personality disorder; it is a structure of mind, where the self, the first-person 'I', is complexly multiplied. A DID person's global personality, the quality and kind and degree of coherence within their structure of selfhood, depends on their spirit.

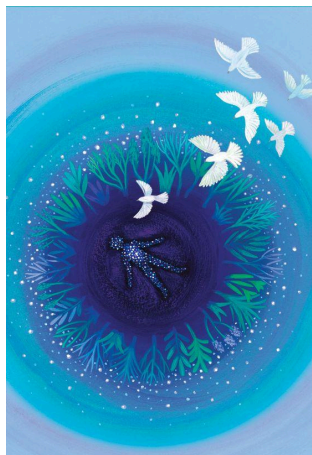
Some people with DID do have personality disorders, including severe ones, but others have no personality issues and no comorbidities at all, and are left with simply the thing itself: traumatic stress, and a multiple mind. That is where I have arrived after decades of healing work: a clear spirit, and a mind indelibly shaped by multiplicity and traumatic memory, the two

inextricably intertwined. My mind will likely never consolidate into the experience of one ‘I’ that defines more singular consciousness, but I remain a coherent and entirely organized person nonetheless. All parts know we are one body, and one consciousness; yet they remain themselves, distinct from me. It’s not that I haven’t tried. I once pointed out to another part the seemingly decisive fact that we are, indeed, the same person. Her response was difficult to argue with: “And yet here we are.”

In truth I cannot integrate fully, because I would have to integrate all the parts holding the traumatic memories, and it is their isolation that allows me to live. If they were to blend with me and flood my executive consciousness with the full reality of their memory, I would not be able to succeed in my life or my work. So I regularly dive into my consciousness and bring traumatized parts forward in time, out of the traumatic moments in which they remain and into the safety of the present. It is not always possible. They come with me if I can bear their truth and hold them in complete love and protection. The pain is great, though, and so this remains the work of a lifetime. I cannot be cured; the healing does not end.

That truth was hard to learn and harder to accept. This field, psychiatry and psychotherapy, often peddles grand fictions about cures, and nowhere more than in ISTDP, where the concept of a ‘total cure of neurosis’ sits at the heart of the model’s ambition. The issue isn’t the inspiring ideal; it’s the disregard of the boundary of what ‘neurosis’ describes. I don’t take issue with the ambition for a total cure of neurosis, as long as neurosis is understood as the suffering that results from intrapsychic conflicts, which can be resolved by feeling one’s feelings, and as long as the truth of other types of pain is given its fair place in our understanding of the human condition.

A few weeks ago, a friend and I laughed when I exclaimed, “You know what? I think it is a total cure for neurosis! I really am no longer neurotic.” It was very funny, and it’s also very true. I don’t have anxiety. I don’t have depression. I feel alive, empowered, and focused. But the traumatic stress injuries and my most difficult traumatic memories remain, because they are not intrapsychic conflicts. They are unbearable experiences. And that difference is truly everything.



II: *What the Theory Disavows*

For the unfamiliar reader, ISTDP is an intensive form of psychotherapy organized around an ambitious core aim: *the total cure of neurosis*. At its heart, it is an experiential psychoanalytic model whose founder, Habib Davanloo, had a genius for perceiving dynamic conflicts in the unconscious mind and tracing the emotional and physiological phenomena through which those conflicts reveal themselves. Many of his ideas are extraordinarily perceptive and useful. Davanloo discovered that when conflicted attachment-related feelings could be activated within the transference—the therapeutic relationship itself—they could often be experienced and processed with remarkable intensity, after which symptoms might diminish and rigid personality structures could soften, enabling emotional freedom and internal aliveness. This process is organized around two brilliant diagrams formalized by David Malan: the Triangle of Conflict and the Triangle of Person. These two triangles, along with a series of technical moves/phases called the Central Dynamic Sequence, form the core of the model.

The signature event of ISTDP, taught as a core site of this transformation, is called an ‘unlocking of the unconscious’: an outpouring into conscious experience of feelings that had previously been warded off and avoided. Within the model, the warded-off feelings in question are strikingly limited: anger, grief, love, and guilt. These recur throughout the literature as the fundamental emotional sequence, despite the considerably wider range of feelings that constitute human experience, particularly traumatic experience. This specificity matters because the technique is inseparable from the theory of mind beneath it: what ISTDP expects to find determines what it looks for, and what it looks for determines what it is capable of seeing.

There is a difference between a map that is incomplete and a map that fundamentally misidentifies the territory. ISTDP has both problems, and my critique here is deliberately focused on the incomplete and misidentified territory of traumatic experience. There are other important ways in which ISTDP’s metapsychology is incomplete, including significant questions about neglect, attachment, preverbal trauma, and developmental injury more broadly, yet those distinctions deserve treatment at a level of nuance beyond the scope of this essay. My purpose here is to identify a more foundational theoretical problem: the generalization of a model of intrapsychic conflict to forms of suffering that arise through fundamentally different processes. I am concerned with what happens when the map becomes more important than the territory.

Within orthodox ISTDP, the primary pathway to what is regarded as the most important and healing event in treatment—an unlocking of the unconscious—is through the mobilization of anger within the transference. Therapists are trained to heavily encourage the patient’s experience of anger and, when sufficiently mobilized, to engage patients in the imaginal portrayal of violence, with the goal of then processing the underlying guilt about these unconscious aggressive impulses. The encouraged expressions of anger can range from harsh words to scenes of brutal torture and primitive bodily destruction. There are obvious risks in the overuse and misapplication of this technique, and the resulting harm can be severe. And yet, ISTDP is unique

among psychotherapy models in its extraordinarily useful conceptualizations of the psychodynamics of conflicts involving rage, love, guilt, and grief, and of the complex ways these feelings can organize the mind. The theory provides a map that shows how unconscious aggression and the guilt associated with it can become bound into symptoms, and how bringing these feelings into conscious experience allows them to be metabolized and released. This collision of rage, guilt, grief, and love—the prototypical mixed attachment feelings—is fundamental to human experience. When a person does in fact suffer from symptom-producing intrapsychic conflicts, skilled and ethical ISTDP treatment can be transformative.

Yet this power is itself a liability, as the world of ISTDP has generalized the metapsychology to all suffering, including suffering that is unrelated to intrapsychic conflicts. It is a dangerous mistake. What happens when we do not understand the dynamics of the clinical phenomena in front of us, if we lack language, theory, and therefore comprehension of our patients? And what would it mean to discover that the harm you caused someone came not by betraying your principles, but by following them? And what if it was not naive incompetence, but rather rigid adherence to a theory that caused true harm to someone you intended to help?

Despite its transformative power, ISTDP's totalism creates severe risks for patients with traumatic stress histories, as their suffering cannot be fully conceptualized within the model as it is currently formulated and taught. The problem is that *embedded within the theory itself is the disavowal of fear, vulnerability, and helplessness*. The paradox is real: a psychotherapy organized around helping patients stop avoiding painful reality is itself designed to disavow a painful reality—that all living beings, including humans, can be devastatingly hurt.

ISTDP, like any model, shapes perception. Yet if it exclusively shapes the perception of a clinician, resulting in total perceptual capture, patients are at risk. Those who believe in the total validity of the model believe that human suffering is fundamentally an issue of intrapsychic conflict, that suffering is generated or maintained by attachment-related emotional conflicts within the person, expressed in how they experience, defend against, and respond to these conflicts. The institutional mandate to primarily focus clinical attention within this framework is explicit; as the back of the Journal of Contemporary ISTDP reads (italics mine): "The treatment we do makes high demands of us: *every* defense should be addressed, *every* manifestation of anxiety noted, *every* feeling experienced." That sentence contains the totalizing ideology in a nutshell: *everything* must be seen, understood, and treated through the model's gaze, in pursuit of its ultimate promise—a total cure of neurosis through the experience of true feeling.

Because ISTDP provides no account of psychological suffering that falls outside the conceptualization of psychoneurosis as represented by the triangle of (intrapsychic) conflict, the model has no conceptual "outside"; all suffering must ultimately become intelligible in its terms. This is a closed epistemic loop. Totalism becomes consequential and unethical when phenomena arising from different processes, particularly traumatic injury, are misperceived and thus mis-treated. I articulated it cleanly nine months ago while writing to the EDT listserv:

"ISTDP theory uses the term trauma very broadly, flattening critical distinctions between traumatic stress and conflict-based suffering. It's easy to see why this

happens: conflict does not imply trauma, but trauma almost always implies conflict. The problem is that working through conflict does not, in itself, resolve trauma. As a result, PTSD is conceptually collapsed into neurosis, allowing the historical language of a ‘total cure of neurosis’ to implicitly extend into chronic and severe traumatic stress—despite profound phenomenological differences. This overextension obscures the limits of the model, fosters therapist overconfidence, and increases the risk of harm rather than reducing it.”

The key is this: *conflict does not imply trauma, but trauma almost always implies conflict*. This is why ISTDP seems universally applicable upon an initial meeting with a patient. Everyone contains conflicted feelings, anxious responses, and myriad defensive operations that organize their mind. These phenomena exist in a traumatized patient, too, but their presence does not inherently indicate what is organizing the person’s suffering in that moment. Sometimes it is issues bearing conflicted attachment feelings, and sometimes it is traumatic memory, which is injury to the nervous system by an unbearable stimulus. An ISTDP therapist working exclusively from within the model has no reliable way to perceive this distinction, as the unbearability of traumatic memory has not been incorporated into the framework’s metapsychology, despite the inarguable truth that traumatic memory, as distinct from ‘memory’, is neurobiologically real. This is perceptual capture, the narrowing of perception around one truth until everything outside it—even what is most clinically consequential—becomes invisible.

Where, then, does traumatic stress go? Within ISTDP, it disappears within the metapsychology. The clearest place it disappears is within the conceptualization of fear, and this matters because fear and traumatic memory are not separate clinical phenomena. Traumatic memory is the persistence of an overwhelming fear-state beyond the danger that produced it: terror, helplessness, bodily sensation, perception, and defensive response that could not be integrated when the event occurred and therefore remain capable of reactivation in the present, in fragmented form. When that memory is reactivated, the fear is not merely anxiety about something else; the fear is part of the memory itself.

Within the ISTDP metapsychology, genuine fear-states (this includes the entire defense cascade, including tonic and collapsed immobility) are categorically denied as clinically significant realities requiring direct intervention. This denial is obscured by the totalizing application of the concept of “projective anxiety” to obvious in-session fear states, a concept which describes when patients project their anger onto the therapist and then become afraid of the projection. True projective anxiety is an expression of failed reality testing, which is not the same thing as symptoms of traumatic stress. Individuals with primary symptoms of hypervigilance, flashbacks, and re-experiencing, the fundamental manifestations of traumatic memory, do not necessarily suffer from issues with externalization and problems in relational reality testing. Many are aware their symptoms are from the past, and cognitively know that the present is safe despite their symptoms. Thus, a mismatch occurs when an ISTDP therapist may be looking directly at the patient’s fear and still be unable to accurately conceptualize it, because when traumatic memory has no place in the theory it also remains outside the perception of an ISTDP-identified therapist.

The irony is real; a psychotherapy committed to freeing the patient from maladaptive unconscious constraints installs maladaptive unconscious constraints on the perception of therapists.

Within the theory, fear is not denied in name; it is denied in function. It has no place on the triangle, and no moment in the central dynamic sequence in which it is treated as the thing itself rather than as a signal of something else. Perhaps my most original contribution to this community, then, is to assert that fear is real, much as water is wet and, on clear days, the sky is blue. Beyond the entire body of research delineating fear—from the defense cascade, to fear conditioning, to memory reconsolidation and extinction—we have our own eyes and ears with which to perceive it. Every abused dog in a shelter tells you fear is real. Every veteran on the Fourth of July tells you it's real. Every woman afraid of men tells you it's real.

To understand why the model cannot see the clear reality of fear, we have to look at the structure of traumatic memory itself. Perhaps most problematically for ISTDP, traumatic memory does not map onto the triangle of conflict, which presents a conceptual challenge to the very heart of orthodox ISTDP. Traumatic affects (unbearable terror, devastation, aloneness, pain) are usually held dissociatively: involuntarily excluded from integrated awareness because their intensity overwhelms the mind's capacity to remain organized. Later, triggers (an image, smell, anniversary, interpersonal cue) can reactivate the traumatic memory, bringing some or all of the previously excluded experience back into awareness as some kind of re-experiencing. With sufficient regulation or time, the traumatic memory may recede and dissociate again, or heal. Their structure is therefore less a triangle than a line. The person moves between two poles: dissociative exclusion, and activation of the memory (which can be reconsolidated/healed with the right intervention). Researchers studying the brain regions associated with this have described these states as 'brakes on' (dissociated and numb) and 'brakes off' (hypervigilance, flashbacks, and re-experiencing). PTSD is 'brakes off', dissociative PTSD is 'brakes on', and DID is an alternation between the two: sometimes flooded with memory and symptoms, sometimes fully numb, derealized and depersonalized. These are different psychological processes from dynamic conflicts, and they require different forms of care.

A second place traumatic stress disappears is within the construct ISTDP calls "fragility," an overburdened and inherently derogatory term (*sensitivity* being an obvious fairer option) that is used as a kind of wastebasket for many phenomena that do not fit neatly within the model, including all the chronic traumatic stress disorders (PTSD, the dissociative subtype of PTSD, complex PTSD, partial DID/OSDD, and full DID). This conflation has resulted in traumatic stress and fragility becoming intertwined in the ISTDP imagination. ISTDP writings position enduring traumatic stress symptoms as pathology of the self: intrapsychic issues, and forms of self-punishment as in the 'punitive superego' (PSE), which enacts a reversal toward someone who may have experienced an external assault from an external perpetrator. This is not to say that some people don't have extreme PSEs. They do. I've treated them. But many people do not, and generalizing the concept to all traumatic stress is a defensive (and sloppy) theoretical move.

The major problem with the concept of "fragility" is that it is entirely intrapsychic, a natural product of the intrapsychic fundamentalism on which ISTDP is built. Fragile patients are

understood as those who cannot tolerate their mixed attachment-related feelings adaptively (by isolating affect, for example) and instead become extremely anxious or rely heavily on primitive defenses such as splitting and projection. Traumatized patients also suffer from an inability to tolerate and integrate experience, but this is precisely where there must be distinction: what they cannot integrate is not necessarily their own reactive attachment feelings, rather it is an experience that overwhelms the mind's capacity for synthesis under conditions of extreme external stress. This is less a relational problem or character issue, such as with deeply unstable object relations or externalizing tendencies, than it is a failure of integration under overwhelming force. A failure of integration thus means that experience is fragmented; knowledge of what occurred, sensations, feelings, and images, are all fragmented by the overwhelming stimulus. ISTDP translates the loss of integrative capacity under extreme traumatic stress into the language of psychological fragility, thereby acknowledging trauma while returning it to the same intrapsychic architecture used to explain neurosis. This is a fundamental category error.

The same conceptual problem appears in what ISTDP proposes to do about this loss of integrative capacity. One of the more amusing manifestations of ISTDP's totalism is the vague concept of 'psychic integration,' which is frequently presented as a 'format' of ISTDP designed for patients categorized as having 'severe fragility'—a category into which both BPD and DID are placed—despite there being no substantive account of exactly what the 'psychic integration' format is, what it entails, or what distinguishes it as a particular method of treatment. It is a grand mystification of the infinitely complex relational work of helping a shattered soul begin to find coherence and stability of mind. It's funny because the idea of the format is a hollow shell, and the community pretends they hear the ocean.

The deeper problem, though, is the assumption within the concept of severe fragility: that fragmentation and psychological dysfunction exist in a roughly linear relationship, with greater fragmentation indicating less coherence and less health. They do not. My own mind is living evidence of this. Many patients are high-functioning and developed people who nevertheless suffer from severe and complex PTSD. It is not that they lack integrative capacity globally, nor that they don't have intrapsychic conflicts; everyone does. Their integrative capacity failed locally and specifically, under conditions of overwhelming stress, but their *self* did not distort. In psychoanalytic terms, they have a neurotic level of mental organization, within which lives a deep stratum of pain, in the form of unbearably terrifying experiences that continue to live as traumatic memories.

The underlying distinction perhaps relies on the difference between internally generated affect and externally imposed force. Rage, grief, guilt, and love arise within the person's own psychological system, even when elicited by something outside it. They are responses. A traumatic stimulus does not. It is a stimulus. The magnitude of the stimulus is determined by the world and bears no necessary relationship to the person's capacity to withstand it. Reality does not calibrate what happens to us according to what our minds and bodies can bear. External force can therefore overwhelm an otherwise highly robust psychological system.

An inversion occurs when the term fragility is used to describe a person who experienced assault and primarily suffers from hypervigilance and flashbacks. Fragility locates the explanation for the injury in the frailty of the person rather than in the magnitude of the force that acted upon them. While some people are legitimately fragile in all kinds of ways, that is not a remotely generalizable frame to conceptualize why severe trauma causes severe injury. If a semi-truck runs over a rabbit and the rabbit happens to survive, we would not explain the severity of resulting injury by describing the rabbit as fragile; the relevant fact is the overwhelming force of the collision. The same principle applies psychologically. If a child is raped by a man and their sense of safety is shattered, the resulting traumatic injury cannot be adequately understood as evidence of an inherent weakness in the child. This is also true of adult victims of severe assault. Real attacks create real injuries.

This is not merely a question of how suffering is named; it determines what the therapist understands the patient to need, because the therapeutic tasks are different. A person defending against painful but essentially bearable feelings may benefit from being helped to face what they are avoiding. A person confronting traumatic material that was genuinely unbearable does not simply need more encouragement to face it; they need conditions under which what was previously unbearable becomes newly bearable and therefore capable of integration. This requires external co-regulation in the form of profound compassionate presence from the therapist, and is best facilitated by techniques that actually metabolize the trauma through accessing the brain regions in which traumatic memory is stored. This allows the nervous system the chance to release, reorganize, and synthesize what it could not integrate when the trauma occurred. That process is the process of memory reconsolidation, which applies to all effective therapy.

Perceiving this matters, because with accurate conceptualization and precise technique, traumatic memory can be healed. This occurs when the traumatic memory undergoes memory reconsolidation to such a degree that it is no longer traumatic, becoming instead an ordinary autobiographical memory that does not involuntarily intrude into awareness. Yet the dynamics of this process remain poorly understood within ISTDP because they challenge both the position of the therapist and the ethos of the model. If suffering is understood primarily as maintained by what the patient is doing—their anxiety, their defenses, their avoidance of feeling—then the therapist’s task is correspondingly organized around helping the patient observe and relinquish those processes. The locus of change remains within the patient’s will, rather than in the co-regulation of the dyad and the precision, sophistication, and timing of the techniques the therapist deploys to help the patient reconsolidate the memory. A patient may have their full heart, soul, will, mind, and spirit aligned to the task of healing, but until the relevant expertise arrives from another person, they may not improve. Often it is not patient will, but rather therapist skill that is the issue.

The deepest traumatic injuries are profoundly relational, and their resolution requires something that cannot be pressured from the patient through encouragement to simply ‘feel the feeling.’ What is required is a relational exchange in which another person brings sustained, loving attention to what was once endured alone. This asks something different of the therapist; not

merely accurate observation and effective technique, but curiosity, attunement, witnessing, and genuine altruistic care. This involves a capacity and willingness to feel genuine sadness, anger, or horror in response to what occurred; and, perhaps most importantly, to convey a profound respect for the sensitivity of another person's pain and for the time and pace that pain requires.

This position is considerably more demanding of the therapist. It requires participation as a human being, and it exposes the therapist to precisely the realities that trauma makes difficult to bear: terror, helplessness, vulnerability, cruelty, and the fact that some injuries will not heal through forceful or brief intervention.

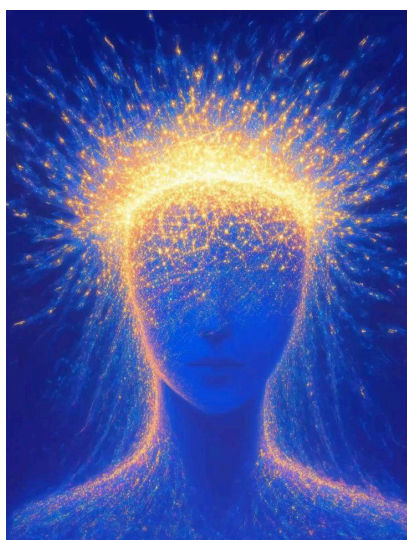
The failure to recognize traumatic injury causes harm, thus every clinician must learn to recognize traumatic stress, given its ubiquity. If we understand that some suffering is not maintained by the patient's resistance, but by a traumatic experience that remains unbearable, then the therapeutic task changes. It becomes a question of what is required to make that experience bearable, and what the therapist must bring to the encounter. To fully illustrate what I mean, I will reproduce my discussion section, as written, for an unpublished paper co-authored with two colleagues in 2023. The paper itself described the dynamics of traumatic stress within ISTDP; my discussion addressed what those dynamics ask of the therapist. I wrote:

“To understand the difference between the dynamics of the triangle of conflict and the dynamics of traumatic stress which the authors have outlined above, it is helpful to consider the function of hope. Hope is the force that seeds growth; it is the belief, even if small or weak, that something good is possible. Those feelings most emphasized within ISTDP—rage, guilt, grief, and love—exist within the sphere of connection and attachment, a place of hope. To experience these feelings is to trust that there is a point to experiencing them, that there will be something on the other side, that the aliveness of expressing rage, guilt and grief can bring a good outcome. Traumatic states are different in that they exist in a dimension of hopelessness—the unbearable has occurred, with no relief or help. While these states do not fit neatly within the triangle of conflict, they are ‘bottom-of-the-triangle’ in the sense that they represent core psychobiological, affective states that must be integrated.

If an individual or their dissociated self-states are trapped in despair—hopelessness, helplessness, profound aloneness, terror, disgust, horror, agony, shame, shock, tonic and collapsed immobility (the final manifestation of terror)—it is not because they are defending against those states, but rather that no hope has yet arrived, and their experience of terror is frozen in isolation. The therapist's job then is to reach in with hope, to bring corrective emotional experience and somatic interventions that allow the despair to resolve through reconnection to the body and to a ‘safe other.’ Rather than a focus on facilitating reactive feelings and impulses moving out toward others, dissociative fear states necessitate a greater focus on relational safety coming in (Porges, 2022). The impulse associated with fear is to seek safety in others. Thus the resolution of

traumatic dissociation requires even greater emphasis on the attachment experience within the therapeutic relationship.

In cases where traumatic dissociation predominates, resistance and anxiety are not the only problem or even the main problem. In such cases, the patient is locked into a closed system of involuntary psychobiological response (Kozłowska et al., 2020)—that is, stuck in places of genuine despair. So the therapist reaches in with hope, which takes the form of consistent attunement and a relentless offer of relationship as a solution: I am here, I am safe, there is a way through, I will hold this with you. It is the quality of the real relationship that allows disorganized and fragmented traumatic material to begin to cohere and organize. When persistent, caring witness is paired with relational safety and somatic interventions that address the entire experience of traumatic dissociation, integrative capacity increases, and what was once unendurable can be endured and what was fractured can be made whole.”



III: What Grace Requires

To illustrate the heart of this process, it is necessary to understand how traumatic memory actually appears within ISTDP sessions. Once traumatic memory is permitted to exist conceptually, and the therapist knows what to look for, it can become remarkably clear. Imagine a patient, an older woman who has suffered from extensive physical abuse in the form of brutally severe beatings as a child. She is very smart, and highly successful professionally and relationally, but suffers from traumatic intrusions and dissociative symptoms when triggers occur. She does not neatly fit into the concepts of resistance or fragility, since her overall ability to isolate affect

through honed dissociative exclusion is highly adaptive, and she can tolerate high levels of complex mixed feelings including rage and guilt when processing current relationships. The past, however, is largely inaccessible, held behind dissociative walls of amnesia.

Let's say that within a session, she and her therapist are working in the transference, trying to get to feelings underneath striated anxiety that is present, and the therapist is providing attuned pressure to access feelings within the transference. The therapist pressures, recurrently, for the feelings within the transference, and as ISTDP theory predicts, the patient identifies transferred anger toward the therapist as the buried feeling. As anger rises, the patient's anxiety drops. This makes sense as a phenomenon of intrapsychic conflict related to attachment feelings, and so far what has emerged is congruent with the ISTDP metapsychology.

But then something else happens. As the therapist asks how the anger is experienced, the patient gets a faraway look and says it feels "burning." The therapist notices increasing fear in the patient. She clarifies: is this burning feeling a part of her anger? The patient, with increasing expressions of pain and horror, says that no, it is not; it actually feels like the impact of being beaten, a feeling of strongly burning skin. The therapist, being attuned to traumatic memory, instantly recognizes the shift in phenomena. The attachment stimulus within the transference has activated an associative traumatic-memory network, and because traumatic memory is experienced with the quality of present-tense reality, therapist and patient have effectively time-traveled. She is no longer experiencing anger toward the therapist. Now, she is simultaneously the adult woman sitting safely in the consulting room and the terrified child, alone, in pain, with burning skin. The therapist immediately stops pressuring for the presumed feeling underneath the anxiety, because there is no longer any reason to assume that anxiety is an obstacle standing between the patient and some deeper feeling. **The terror and the pain are the feelings.**

The therapist instantly changes her stance, and begins to speak with deep compassion and conviction, encouraging the patient to stay with her, and with the feeling. It sounds something like this: "Can you stay with me now, even as you're feeling the burning? I'm here. I can see how afraid you are, and how afraid you were. We can bear this together. One breath at a time." The therapist does not flinch or look away or avoid the horror of what is emerging within the patient. The therapist tracks how well the patient is tolerating the emergence of traumatic memory, by closely noticing if the patient begins to slip into a decompensated state of overwhelming fragmentation; the key to processing will be integrative capacity, keeping present safety stronger than the horror of the past. Depending on that balance and on the patient's needs, the therapist adds specific brain-based neuro-experiential techniques. These suggestions are collaborative: does she want to try gently adding alternating bilateral stimulation by butterfly-tapping (arms crossed over chest) on her shoulders? Or, would it be helpful to find a fixed gaze point that feels resourcing and regulating? Would she like to focus her attention on sensations in her temples, forehead, behind her eyes, and her brainstem, to help more quickly release the underlying shock? The techniques are suggestions, and the therapist and patient experiment to see what works to help her nervous system to release this pain in the easiest, most effective way. Other techniques can be

offered, too, like visualizing healing light around the child part within, or invoking powerful resource figures such as spiritual beings or beloved pets, all ways of nurturing the heart and spirit so that the pain can be finally integrated and put to rest.

The mandate is to find ways to increase integrative capacity, so that traumatic memory will reconsolidate as completely as possible, and the experience will finally be put to rest. The dialectic between encouragement to focus on sensation processing and encouragement to allow in the compassion and presence of the therapist is alive throughout. At every moment, she is empowered to choose what happens next. The therapist is grounded in their unshakable commitment to witnessing the truth of this woman's experience so that she is not alone, so that what was unbearable can now be borne in a shared field of compassion.

A core part of this process is recognizing that often the feelings themselves within traumatic memory are not the endpoint of what is unbearable; what is the final and most unbearable thing is what the feelings point to, *the existential meaning*. The meaning is often something like the devastating truth of "*I live in a world in which terrible things happen*", or "*No one protected me*," or perhaps the deepest of all, "*I wasn't loved*." Being able to realize and accept that truth is an essential and extraordinarily difficult achievement for many people with severe trauma histories. When parents don't love their child, the child may project their own love onto their parents as a survival necessity. Removing that projection, recognizing that the love was always yours and never theirs, creates a searingly painful existential vertigo. Enduring that vertigo, reorganizing one's sense of reality, and truthfully comprehending the severity of what occurred—as with this older woman who was regularly severely beaten—is a spiritual task of meaning-making. It requires a therapist who understands the task, and who can provide a relational field with enough genuine love and grace to provide containment in the pain.

The therapist in the above vignette, trained within ISTDP, would not have learned this clinical work inside an ISTDP core training, nor would any orthodox ISTDP supervisor encourage these interventions, not because they don't work—they do—but because the theory cannot recognize they are needed in the first place. I also did not name the traditions from which the neuro-experiential techniques emerged (EMDR, Brainspotting, Deep Brain Reorienting), because the utility and potential of the techniques is more relevant than the bounded protocols of the models from which they arose. The techniques themselves stand as clinical tools that can be freely used without particular allegiance to their respective models or originators, provided the clinician understands how the interventions work, how they go right or wrong, and can clinically justify their use with a particular patient.

There is one other image that may bring home the point, and it is a story I recently heard about a small dog rescued from the streets of rural Mexico. A woman found him in a state of extreme shock, barely able to move, trembling constantly, and terrified. She took him to a vet; he was physically fine. But his condition did not improve, and despite being on the beach with her other dogs, he could not play; he just trembled and shook. She attempted to play with him, to get him more active with the other dogs, but he could not. Eventually, he got up and went under a nearby car, to sleep in the shade. The woman then had an idea: she got up, went over to the car,

climbed underneath it and lay next to him. She decided to just be with him, to breathe, and to give him her full presence and compassion, so that he would not be alone in his pain and fear. After a while, she got up and returned to playing with her other dogs. Then, rather quickly, the terrified dog came out from under the car, stretched deeply, and suddenly turned into a bright ball of fun, romping along the beach. Underneath the trembling, shaking, and frozen fear was a very happy and loving spirit. But he couldn't complete the traumatic stress response until safety had arrived. And safety is possible only when someone is willing and able to bear the full reality of the pain with you.



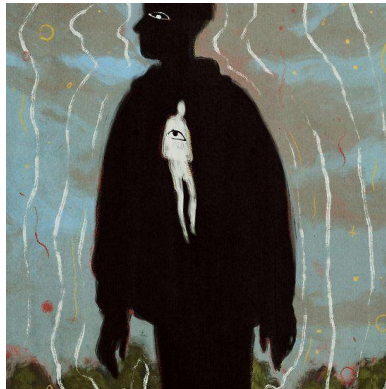
IV: Injury and Inversion

Why would a field that prides itself on facing painful truth find this truth so hard to bear? I believe the answer lies in the price of witnessing the true pain of this reality. This price is perhaps the most significant reason DID evokes such visceral reactions: it brings up dark aspects of our world that most are afraid to understand, truths our world cannot bear to fully know. Nancy McWilliams describes the problem thus: “Along with many other therapists who have treated dissociative patients, I have found myself construing the controversy about ‘whether dissociative identity disorder exists’ as a pervasive social countertransference to a condition that can be unbearable to imagine.” It’s right there, the obvious and painful truth that ISTDP theory has not yet integrated: some experiences are completely unbearable. Not painful, not uncomfortable, not repressed—repression being a construct that indelibly implies voluntary psychic actions even if unconscious—but rather dissociated: a neurobiologically involuntary fracturing of experience under overwhelming force.

The issue with this distinction, and the perennial conflict surrounding it, is that it challenges the status quo. Once some suffering is understood as injury, we can no longer look only

at the injured person. We must look outward, toward the reality that injured them and, where there is one, toward the perpetrator. Their suffering then makes a claim upon us: to recognize what happened, comprehend the truth of the harm, and provide the kind of presence in which healing can occur. This is existentially difficult, as it challenges comforting and tightly held beliefs, such as the idea that all parents love their children, or that all therapists care about their patients, that the world is a just place where people get what they deserve. Genuine witness is costly; it requires allowing the reality of another person's suffering to affect us. Identifying pathology within the injured person offers an escape from this. If the injury can be primarily relocated inside them, the therapist is no longer tasked with bearing existentially painful truths about the world with the patient. In this way, ISTDP therapy and its intrapsychic fundamentalism can be a primary defense against painful perceptions. The distinction between pathology and injury, and between intrapsychic conflict and traumatic memory, is not only clinical; it is a question of who holds the power to define reality, and who that power protects.

Indeed, the human capacity to disavow the suffering of others is so extreme it is hard to fully comprehend. For instance, imagine men being sent into the horror of trench warfare, and then when some of them are terrorized to the point of utter decompensation and incoherence, they are tried for desertion and cowardice and executed by firing squad. That is real, that is history. Nearly a century later, in 2006, Britain formally pardoned the men they had terrorized and killed, yet they did not admit fault or apologize for murdering their own soldiers after shattering their minds. It is worth remembering that the men who sentenced these soldiers were not betraying their principles. They were following them.



V: A High-Control Group

In order to hold a full picture of human suffering, therapists in the world of ISTDP have to push against both the model and the culture that protects it: a culture organized less around inquiry than around loyalty, where deviation from orthodox technique is treated less as clinical

experience and judgment and more as a kind of heresy. What is happening across parts of the ISTDP community, then, is not merely a love of ideas; it is much closer to *zealotry*, the state of mind that animates those at the top of high-control groups.

Why would thoughtful clinicians give themselves so fully to a culture of control? I've reflected on it for a long time now, as I was so drawn in myself. I've found that it is because ISTDP, as with all groups that tend toward high-control dynamics, contains something incredibly beautiful, real, and profound at its center. Without that truth and transcendent promise, the group would have no draw or power. I was completely taken by the transcendent ideal of ISTDP. *A total cure of neurosis*—could I really be entirely free? *Cured...*? This hope captured me utterly, even desperately. I did not yet know that neurosis and traumatic stress are distinct problems that require different kinds of care. So I attended as many trainings as I could, and I discovered that the theory and technique transformed my clinical work. The community's leadership quickly recognized my deep affinity for ISTDP. Early on, in 2022, I was invited to a psychedelic retreat in the Netherlands composed entirely of ISTDP teachers, despite being a new student. My extensive professional experience with psychedelics was genuinely valued in that context, yet I sensed the invitation also reflected a belief that I was a potential asset to the community: someone who would 'get it,' and become a voice that could champion and transmit ISTDP. I feel deep gratitude to those who recognized me and appreciated my mind, my heart, and my desire for truth and healing, for it was the first time in my life I felt so clearly seen. This gratitude makes the closure and darkness I later encountered in the community, its disavowal and its dynamics of domination, all the more saddening.

For a long time I resisted the word *cult*. It felt too large, too easy to dismiss, and unfair to the many people who use ISTDP and are open and humane. I remain careful with it here, yet find that there is a fit. A high-control milieu does not require that a whole community be captured; it can live within a larger group, concentrated around particular teachers and their circles. What finally made that possibility undeniable to me was an online interview screening with a European ISTDP teacher, Kees Cornelissen, who trained extensively with Davanloo. He described at length what, in his opinion, ISTDP students must learn. Therapists, he said, must be so powerful in their ideas about the psychodynamics of the person in front of them that they "take control" of the process, and those unwilling to take charge have then abandoned the patient, because they "let him swim." Asked directly whether ISTDP retraumatizes patients, he did not answer the question; he responded by affirming, again and again, that the most important thing is that the treatment is a "cure". The word 'cure' was repeated fervently. When asked about what is 'most important' in studying ISTDP, he said:

"Colleagues learn a lot of things about psychotherapy, and they need to 'de-learn' it when they enter the training. One of the biggest problems for them is that they are not used to take (*sic*) charge of the process. You must be so powerful in your ideas about the psychodynamics of the person in front of you, that you take charge... if you're not willing to take charge of the process, from the therapist's point of view, then you will never learn this."

Kees Cornelissen sounded completely convinced and sincere, and that is precisely what makes his words so instructive and troubling to me. In his study of thought reform, the psychiatrist Robert Jay Lifton identified a set of features that characterize totalistic environments. Two of them are visible in this interview. The first is sacred science: a doctrine held as ultimately and unquestionably true. The second is doctrine over person: when lived experience conflicts with the doctrine, it is experience that must yield. In my impression of Cornelissen's expressed views, ISTDP functions as a sacred science, and the patient's autonomy is subordinated to it, doctrine over person, since the therapist must "take charge" as a condition of competent practice. The same certainty may explain why the question of retraumatization did not need an answer, as the doctrine had already answered it: the treatment is a cure. Later I reflected upon the emphasis on control and power, and it seemed to me that within ISTDP's orthodox culture, negative capabilities—patience, waiting, still presence—are an unknown species of interaction.

The imperative that therapists must 'take control' of their patients has a troubling counterpart within the training culture itself: while learning to subordinate their patients' experience to the model, trainees usually find their own perception and judgment increasingly subordinated to it. Over a year ago, an ISTDP practitioner posted on Facebook about losing trust in themselves during ISTDP training, and then effortfully and painfully regaining it after letting go of their identification with the model.

The post received 57 comments in which ISTDP clinicians nearly all described similar losses of self-trust: intense idealization of the model or its teachers, increasing distrust of their own clinical judgment, pressure to conform to prescribed technique, and fear of dissent. All continued to value ISTDP, yet felt harmed by what the learning process had done to their sense of epistemic authority: their trust in themselves, and in their own perception. There was agreement that the misuse of power and authority, and the cult-like dynamics that result, are serious problems worth addressing within ISTDP and the IEDTA.

These dynamics are not purely self-inflicted; rather, there is an external force, a stimulus, that helps sustain them. In my observation, one such force is an attitude of omnipotence in the public engagement of some of ISTDP's leaders: behaviors that communicate they are above error, critique, or reproach. I cannot know what is happening in the minds of these individuals, nor do I claim to. What I can describe is a pronounced pattern of public engagement that appears to convey a personal identification with omnipotence.

Jon Frederickson, one of ISTDP's most prolific writers and eminent leaders, provides an example of what I mean. In my public exchanges with him, each time I raised a point about the limits of the metapsychology, he ceased engaging. I have seen him publicly correct, assert, and declare, but I have never witnessed him openly acknowledge that another person's contribution had materially changed his understanding. In my experience, his engagement forecloses the open admission of fallibility that might otherwise temper idealization.

More troublingly, I witnessed a Facebook exchange in which an ISTDP practitioner argued passionately that it is not appropriate to claim there is always enough Unconscious Therapeutic Alliance (UTA, the 'healing force') available for treatment success, particularly in

cases of extreme depression and suicidality. Frederickson countered at length, and the thrust of his argument was that the UTA is always available if the therapist can discover how to activate it with the patient. It read to me as a directly omnipotent claim. Coming from a senior figure, such a position may install in the learner's mind the idea that every clinical failure is the student's own fault. It is an example of the disavowal of genuine, reality-based helplessness, in this case the therapist's.

Allan Abbass, another eminent teacher within ISTDP, appears to me equally unable to tolerate discourse that challenges the truth or supremacy of the model. I encountered this when he claimed, in a public exchange, that "the last 1/3 of my main book is on the treatment of dissociative disorders," a characterization of the book's contents that is materially inaccurate. When I challenged the discrepancy, he did not account for it. For those who feel I am overstating the matter, I invite you to read his book. There is no description of dissociative disorders and no discussion of how to diagnose them, which is an art form in itself, given their predominantly covert presentation. Nor is there any reference to the five primary symptoms that define the dissociative disorders: derealization, depersonalization, identity confusion, identity alternation, and amnesia. The words appear exactly zero times in the text. Despite this, some in the community were upset when I named his conduct as unequivocally unethical; indeed, some went so far as to accuse me of being "nearly" defamatory.

I worry about the state of our field when challenging a senior teacher's unsupported claim to specific expertise is so intolerable that moral scrutiny immediately reverses direction. For a community that bases its identity on facing the truth and tolerating hard realities, I find this reversal to be an indictment of the culture. If a senior teacher is unable to admit fault and graciously inhabit their human fallibility, I do not believe that they are worthy of their position.

Yet the deeper problem is not simply an absence of clarity or expertise among ISTDP's leadership. Some of the necessary knowledge is already present. The question is what happens when someone can perceive beyond the boundaries of the prevailing framework, but does not publicly challenge those boundaries.

There is one senior teacher who clearly understands the limits of ISTDP with traumatic stress, at least as expressed in his presentations, and that person is Robert Neborsky. I have watched his trainings and heard him directly describe turning toward the same neuro-experiential tools I use when a patient is experiencing terror from a traumatic stimulus that will not reconsolidate through other methods. He is fully competent in advanced trauma theory and in techniques such as EMDR and Brainspotting; he understands what neuro-experiential processing and the associated memory reconsolidation look like in practice. And still, to my knowledge, he has never used his position to publicly name the risks to patients when ISTDP is treated as total, or to help the community understand the serious consequences of what is missing. He has not joined the conversation about the risk of patient harm, despite possessing expertise that I believe would make that risk exceptionally visible to him.

This reveals another dimension of a high-control culture: it is not necessary for everyone within it to believe the doctrine completely. It is only necessary that those who see beyond it

remain silent. Seeing is not enough if one is unwilling to protect others. Once harm is visible, silence is no longer neutral; it protects the status quo. A tradition that asks patients to face the most painful truths of their lives must be willing to face painful truths about itself.

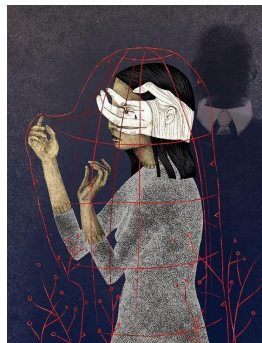
The consequences of idealized authority are particularly serious in a profession where the learner's own perception is an essential instrument of clinical work. Most senior teachers do not openly discuss their own fallibility in a way that conveys authentic humility, such as directly acknowledging concrete limitations to their expertise, or attesting to their failures and continued learning. These treatment failures are well known to me, as I was in the community long enough to hear about them from patients themselves. No matter what level of expertise one achieves, psychotherapy will always sometimes exceed our ability. To make it very basic, sometimes a dyad is just a terrible fit. Every therapist experiences ruptures, failure, confusion, and the fact of their own human limitation. This matters because when senior leaders cannot publicly embody an integrated awareness of their own imperfection, imperfection has to go somewhere, and so it goes down to everyone below. The teacher remains idealized while the trainees carry the badness: the mistakes, inadequacy, confusion, and shame that belong to the complex human condition of both. The student then measures their actual, imperfect self against a teacher whose imperfection has been concealed. This off-loading of shame and badness is the primary mechanism through which self-trust is destroyed. This is how idealized authority preserves itself: *fallibility moves downward, while certainty remains at the top*. Reclaiming self-trust requires perceiving how this transfer of 'badness' is a form of control through devaluation, and then finding within oneself the strength and clarity to leave the undermining relationship.

When a leader or teacher holds the model as total in their teaching, public communication, and engagement with others, their influence carries that perceptual capture and zealotry into the culture around them. It shapes the culture's norms, its boundaries of acceptable thought, and the degree of thought-termination required to belong. A third feature Lifton described in his work on cults is what he calls 'loading the language': the compression of complex human problems into brief, definitive-sounding phrases that end inquiry rather than open it. He named these thought-terminating clichés, and they are pronounced within ISTDP. The primary one goes something like this: 'all symptoms result from defenses and anxiety arising from avoided unconscious attachment feelings'. Some version of this statement appears regularly in books, papers, and teaching. Often it appears precisely where there should be depth or complexity: the ghost of complex suffering has been spotted, and the thought must be terminated. It functions more as a statement of belief, or allegiance, than as a clinical truth, though its adherents will not see it that way. It is simply exceedingly easy to disprove. Apart from the problem of injury I have illustrated at length, there is the foundational fact of human development through meaningful connection. The deepest psychotherapy is often a process of development through an enlivening relationship. If someone has never been deeply listened to or cared for, or never experienced another mind fully attuned to them, then the therapeutic relationship itself can produce profound growth: the person evolves under the kind gaze of a caring other.

Here the ‘everything is unconscious feeling’ thought-terminating cliché carries a darker implication: through its intrapsychic reductiveness, real human relationship is devalued. With it, all the solace, learning, growth, and healing that come through kindness, attunement, and creative therapeutic interactions are devalued as well. The model cannot recognize the degree to which those attuned interactions are a primary mechanism of healing. It is notable to me that almost every highly experienced ISTDP therapist I knew told me at some point something like ‘in my own therapy, the deepest change happened in moments when I felt my therapist truly valued me as a human being, truly cared.’ This is unsurprising to me, as that is how I have healed too, in the deepest places. Change often comes not only from ‘unlocking the unconscious’ but from the experience of being held in the heart and mind of another. That truth is functionally devalued within the paradigm of ISTDP. The result, from what I witnessed in my five years within ISTDP, is a fixation on control through theory and technique at the expense of learning to be a wiser, more emotionally available therapist.

The pattern does not stop in the training room; what flows down from leaders finds its way into treatment. ISTDP explicitly trains therapists to narrow the process toward the direct experiencing of feelings, and I do consider the ability to corner someone in the transference (relentlessly addressing defenses until feelings break through) an exceptionally important clinical skill. Yet the ability to narrow the therapeutic task is not the same as the wisdom to know when that narrowing actually serves the patient, or when other essential therapeutic tasks, such as making meaning, or simply allowing someone to be fully heard and understood, are more relevant. When a patient comes seeking a healing relationship and instead encounters a demand to follow the central dynamic sequence, particularly when the therapist’s warmth or regard becomes contingent upon compliance, technique becomes domination.

There is increasing recognition, including at the level of the law, that psychological domination is a severe injury. Coercive-control statutes reflect this shift: disparate behaviors can form a pattern that progressively constrains another person’s autonomy, perception, and freedom. The same principle applies to institutions. When a culture normalizes domination and punishes dissent through silence, it enables foreseeable harm, and responsibility no longer belongs only to the individuals acting within it. It becomes a question of institutional liability.



VI: The Darkness of ISTDP

When limited principles are lived as final absolutes, and all else disappears, horrifying things can and do happen. Certainty and zealotry are, at root, defenses. They protect a person from doubt, helplessness, and the vulnerability of not knowing, the kinds of experience this essay has argued ISTDP disavows. In many people, these defenses are situational: they loosen as a person grows or as they begin to feel the cost of holding them, and so they can be seen, questioned, and relinquished. In others, these defenses harden into character. They are no longer something a person does, but who that person experiences themselves to be. An ego-syntonic defense doesn't feel like a defense. It feels like being right.

Every rigid defense has costs, and we hope that it is a person's own suffering that eventually motivates change: anxiety, loneliness, the growing sense that something is wrong. Yet when the costs of a defense fall primarily on other people, and the person inflicting the pain lacks the ability or the incentive to recognize their impact, that internal desire to change never arrives. As Thomas Sowell stated with devastating simplicity, "It is so easy to be wrong—and to persist in being wrong—when the costs of being wrong are paid by others." Those with characterological zealotry find that their certainty is rewarded rather than questioned, while others absorb the damage. Such a person cannot relinquish the defense because they never feel its weight. This is true of individuals, and it is true of institutions. In these situations, the only way to protect others and restore truth and justice is to expose wrongdoing and demand accountability: to make the cost visible. If one has been harmed, gaining the courage and finding the clarity to engage the battle at all is a healing achievement.

That achievement is where I now stand. Getting here has been harrowing. It required me to understand, piece by piece, what happened to me during my years inside ISTDP, and to let myself feel the pain I had been keeping out of awareness. I do not come to this as an observer. Beyond my training in ISTDP, I spent more than 300 clinical hours in an ISTDP treatment that was both life-changing and damaging, a paradox I can now hold, and will illustrate in what follows. In early 2024, I also organized the drafting of the IEDTA's current ethics guidelines. During that process, the then-president invited me to join the IEDTA board, despite knowing that my treating psychologist, Dr. Matthew Jarvinen, was serving on it. I declined. That the invitation was extended at all, in the middle of writing ethics guidelines, reflects how easily boundaries blur in an insular community.

My treatment with Dr. Matthew Jarvinen lasted from September 2021 to January 2025. He is an ISTDP teacher, training institute owner, and IEDTA board member. I came to therapy for moderate depression, with a disclosed history of childhood sexual assault. I thought I had mostly healed my PTSD at that point, and I did not yet know that I am DID, nor did I recall the truth of my childhood. I've often said the treatment saved my life, and that still feels true in a way, yet it also damaged me profoundly. Over hundreds of hours, I unlocked my mind again and again, becoming real to myself, and emotionally strong. When grief finally came, I cried for six months.

Releasing anger and guilt freed me internally; I felt spiritually connected and alive. Yet strangely, the deeper I went, the worse my PTSD became. I spent two years in an unmitigated psychological hell of extreme flashbacks and pain; and in this time, Matt's approach never changed. Eventually, I was fighting Matt to hold on to my reality and my mind, while trying to disentangle myself from a powerful attachment induced by intense transference work, and from the ISTDP world's refusal to see me as a real person.

From the beginning, I was afraid of him, and he treated my fear as projection. As my experiences of sexual assault became the focus of the treatment, he pressured me to portray sexual acts toward him, reading my intense anxiety about it as a sign to go further to uncover buried feelings. I once asked him if he was getting off on hearing about my past; he said no, but I didn't find his tone or affect believable. As my flashbacks, re-experiencing, and hypervigilance grew ever more severe, his answer was always to go deeper, feel more, unlock more. That guilt or self-punishing super-ego dynamics had nothing to do with my traumatic memories was not something he could accept, despite the accruing years of clinical evidence that there was no enduring relationship between deep rage and guilt and a reduction in PTSD or pain. I tried to explain it to him in a hundred different ways, advocating for myself as much as I could, including writing an entire paper on it. I'm fairly certain he never read the paper.

In early 2023, unsettled by the chronically palpable erotic field between us, or rather what I read as Matt's conspicuously unmanaged sexual countertransference, I asked him directly whether he felt attracted to me. "Yeah, of course," he said, without qualification. I immediately changed the subject, and avoided it for the next seven months. What I now consider grooming became more overt: a text calling me a "tiny blonde," and, at a large training he facilitated, the disclosure of a session in which I experienced an unlocking involving a particularly violent rape I endured at ten, shared publicly without my permission, directly in front of me. The shock, confusion, and feeling of manipulation are horribly memorable: it felt like he was elevating the 'specialness' of our work while violating my privacy at the same time. And yet still, I took my mistrust of him as evidence of my pathology, attachment being a strong pressure to falsify perception. There was no room in his mind for the possibility that he, and the treatment, could be the problem.

When DID became undeniable, and I was in what I consider a psychological free-fall about my mind and life, Matt continued to apply ISTDP, and began to treat dissociative self-states as defenses to be blocked rather than aspects of me to be patiently and kindly engaged. The results were disastrous. He refused to learn how to treat DID; after eight months of asking him to get trauma-literate supervision, I realized he never would. In his mind, I would always be the problem.

That is how the theory worked: my discomfort was resistance, my distrust was projection, my wish to stop meant we had to push through. ISTDP gave Matt a complete language for overruling my perception, and left me nothing with which to defend it. There is a name for this: *epistemic coercion*, the use of power to override another person's capacity to know and interpret their own experience, forcing them to surrender the authority of their own perception to someone who claims to know their mind better than they themselves do.

After three years of being told my fear was projection, Matt finally showed his hand. In one session very close to the end of the treatment, I described how confusing and boundaryless our relationship had become, how the connection felt strangely infinite, both spiritually and psychologically. He responded by extending my language: "Yes, spiritually infinite, psychologically infinite, *even physically infinite*." I perceived no ambiguity in what I read as the open sexual invitation on his face as he said the words; I felt disgust, contempt, and clarity in the parts of me that could bear to perceive the true horror of it. I changed the subject; by then, I knew not to challenge him; when I had done so in the past, he sometimes appeared to me to be enraged. After I ended the treatment without a termination session—there was nothing left to say—I dissociated from the whole experience and tried to recover my stability and sense of reality.

Over the next fifteen months of slow healing, and as my dissociation eventually loosened, the dominoes fell. Every boundary violation, every sense of him being a danger to me, all the damage to my self-trust collapsed into a cold truth: after years of fighting to heal from extensive sexual violation, I understood that my therapist had expressed interest in a sexual relationship with me. The treatment had destabilized me and conditioned me to accept domination, and in my vulnerability, my perception is that his instinct was to use me. It is difficult to bear the complete disinterest in my wellbeing that I perceived in him; in the moments I can bear the reality of it, I must then feel the depth of the pain of it. The years with him were long and hard. I needed safety, I needed to matter. I needed to be cared for.

I believe the theory facilitated the harm. It could never be that the therapist was untrustworthy; it could only be that the patient was afraid of her feelings. In late May of this year I filed a formal complaint against his license, supported by years of time-stamped documentation, as I believe his behavior toward me was predatory. I provided the entirety of the 37-page complaint to the Board of the IEDTA; I wanted to give them a final chance to decide to do something about patient harm within ISTDP, although I had little confidence that they would take meaningful action, and so far they have not. In my view, the dynamics of a high-control group make it impossible for the community to openly acknowledge harm that implicates its own authorities.

In my treatment, I came to understand ISTDP on multiple levels: the brilliance, the flaws, and the darkness. I saw that when a therapist's perception is captured, and proving the model right supersedes perceiving the truth of the patient, harm will occur. This awareness has fueled my advocacy and my conviction. I know the pain of suffering within a treatment while under coercive pressure to believe that the suffering itself proves the treatment is right. And I have since learned that I am not alone in it.

Early this past April, I received a message from a middle-aged woman I will call Emily Johnson, who discovered Ethical ISTDP while seeking accountability for the harm she experienced in October and November of 2024 during six sessions of ISTDP with Allan Abbass. I met with her and her husband over Zoom. Their devastation was palpable, and I could feel how meaningful it was to them to have found someone able to understand and willing to listen.

Emily entered treatment at the direction of her family physician, as a last effort to see if her physical symptoms would respond to psychological treatment despite the fact that many of her

symptoms began with a job-related chemical injury. She had already tried ISTDP with a different therapist years prior, and not found it helpful, but her physician wanted her to see Abbass. She has a background of serious trauma, including surviving childhood sexual abuse, rape at twelve, a suicide attempt as a young teenager, and the murder of two members of her family. Allan Abbass knew all of this background, as he documented in his first letter to her physician. As Emily explained to me, she felt apprehensive from the start. She had tried ISTDP over a decade earlier and not improved from it, and was familiar with the academic culture of Dalhousie University, telling her physician she had a feeling that Allan Abbass "wants my data for a research paper." Emily reports that Abbass told her her symptoms would improve within approximately thirteen sessions, and so she began treatment.

During one of the sessions, Emily reports that Abbass had her imagine running over a man who had been bullying her and then walking among his bloodied body parts. She says the desire to kill him persisted after she left the office, and that suicide began to feel like the only way to ensure that she would not act on it.

By the second session, she had become destabilized to the point of acute suicidal intent. She left the session wanting to drive her car into a transport truck and kill herself. Her physician documented the change a week later, writing, "Clearly stuff from therapy is being brought up and is affecting her severely." The suicidality persisted. When I later asked Emily how close she had come to killing herself, on a scale of one to ten, she said nine.

Her physician became increasingly alarmed. By October 28, he documented that she felt "like a wreck since starting this ISTDP therapy," was crying constantly and having thoughts of self-harm. He wrote that it was "really affecting her in a way I've never seen her before," and advised her to cancel the next session "to buy us some time."

Abbass's understanding of what was occurring appears to have been very different. In his communication with her physician, he understood Emily as experiencing complex feelings of rage and guilt about rage, manifesting as anxiety and a chronic "self-destructive tendency." His conclusion was: "Overall, the process seems to be going reasonable [sic] well from my perspective."

The phrase is revealing: *from my perspective*. I don't need to assume bad faith to understand what may have occurred. Abbass may have sincerely seen a patient working through the difficult consequences of productive treatment, even as Emily felt herself coming apart and her physician was actively documenting it. The facts were visible; their meaning was not shared. I believe that is perceptual capture. Whatever the model, decompensation is real, serious, and clinically significant. Yet her reports of suicidality, and her physician's communication with Abbass reporting the same, did not result in the treatment being stopped.

The harm Emily experienced went beyond decompensation. Under the pressure to imagine extreme violence, Emily experienced severe moral injury, a phenomenon that is still unsymbolized within the ISTDP imagination. Emily is a devout Christian, and her husband is a pastor. In her sessions, she describes being encouraged to undergo repeated portrayals of killing people in her life: burning members of her childhood church alive; and, under intense pressure,

killing her husband. She refused the last portrayal and instead imagined protecting him with her own body. When we spoke, she described the portrayals as a direct violation of her faith and of the Ten Commandments. In her complaint, she wrote: “This was one of the worst things for which I have ever had to repent.”

Emily described experiencing flashbacks from the unlockings, including flashbacks from an unlocking during her previous ISTDP therapy, in which her therapist had encouraged her to imagine pushing her husband down the stairs. The fact that she experienced intrusive traumatic imagery associated with both courses of ISTDP treatment suggests that the therapy itself had become a source of traumatic stress, with the more recent treatment also reactivating traumatic material associated with her earlier ISTDP experience.

In her final session, Emily tried to explain to Abbass what it was like to have traumatic material torn open and then be sent home, with no tools, into the community in which her traumas had occurred. She said Abbass kept steering back toward the ISTDP process, and when she said she didn't want to do ISTDP, he ended the session rather than offering a different style of care. For Emily, this was the most pronounced trauma of all: protesting, and feeling that nothing she said would affect the treatment. That this experience directly activates the memory of being treated as an object and forcibly overridden in childhood sexual abuse was not lost on her, or on me. I validated her experience, offered theoretical context, and encouraged her to find care with someone who could help her process traumatic memories of unbearable terror and pain.

Emily and I also explored the way ISTDP's Central Dynamic Sequence can become a near-perfect fit for the interpersonal aggression of DARVO—deny, attack, and reverse victim and offender—the sequence abusive people use to avoid accountability. This can happen no matter what the therapist's conscious intention is. If a therapist follows the sequence, it usually begins like this: a patient shares their real fear and pain from a real recent or past experience, and the therapist asks how they feel toward the attacker, entirely ignoring the significance of the traumatic affects. The therapist then pushes for feelings toward the abuser, convinced that these feelings are the problem rather than the injury, pain, and unmet need. If the patient follows along, accesses their rage, enters a portrayal, and then feels guilty, the reversal is complete. Now the patient is the perpetrator, and somehow, the actual injury and the patient's pain have disappeared. The therapist denies the reality of the injury, attacks the patient's experience by treating it as pathology, and reverses victim and offender by transforming the injured person into the guilty aggressor.

After the treatment ended, Emily's suffering continued. Her husband told her that it seemed as if her soul had been sucked out. She was severely destabilized and began making concrete plans to escape her life and move far away, imagining how to disappear from everyone she knew. Her family was stunned by the degree of her detachment; she describes this period as harrowing and terrifying.

In our discussions, Emily conveyed how deeply disturbed she felt by mischaracterizations of her in the clinical notes. In her complaint, she writes: “I do not agree with the part of his assessment where he writes I have ‘...longstanding social anxiety and strong feelings around people and fear of vulnerability...’ I have never felt such levels of social anxiety or fear of vulnerability

around people. In fact, I have been told by many professionals I am resilient, resourceful, and a woman of strong resolve.” She also disputes the characterization of her as self-destructive, and feels that having it written into her medical record is an injustice and a violation.

I understand why. Having supported her as she wrote an extremely clear human rights complaint and a complaint to the College of Physicians and Surgeons of Nova Scotia, I came to see her as exactly the kind of patient ISTDP has the most trouble conceptualizing. Her traumatic stress is severe and chronic, but her spirit, mind, and heart are bright and clear. I saw no sign of character pathology; rather I was amazed and moved by how insightful and perceptive she was about what had happened to her. She is exceptionally smart, empathic, and funny. She told me how horrified she felt at the thought that other patients, perhaps more vulnerable than she was, might experience the same thing, and she wondered whether people had died because of ISTDP without it ever being documented or reported, given how close she had come. As she writes: “How many people dropped out of the 13 to 20 sessions like I did? Did any of them die? That is the question that needs to be answered.” While I cannot answer that question, I share Emily’s interest in discovering the truth of the situation. Two years later now, Emily is still recovering from her experience within ISTDP treatment. She and her current therapist are working with more expansive modalities that make room for her full experience at a pace that feels safe to her.

Her experience brings up issues of basic safety when patients with dissociative organizations, such as people with structural dissociation due to complex trauma, are treated as if they are a classically resistant patient. In truth, they do not fit anywhere on ISTDP’s spectrum of psychoneurosis, because when traumatic memory underlies someone’s symptoms, they need effective treatment for the memories themselves, rather than aggressive focus on mixed feelings. Once again, it is a category error. The danger of going for a huge emotional release is that *affect is associating*—strong emotional experiences will bring up memories, including traumatic memories. And if those memories are traumatic and contain unbearable affects, then the person will invariably decompensate unless sustained and attuned safety and regulation are immediately provided. Without that safety, bringing up traumatic memory is retraumatizing. It re-enacts the original trauma: alone and afraid. And in the case of the ISTDP treatment, a new trauma is added: being gaslit by the therapist into thinking that more anger will help, when anger has nothing to do with the unbearable stimulus itself.

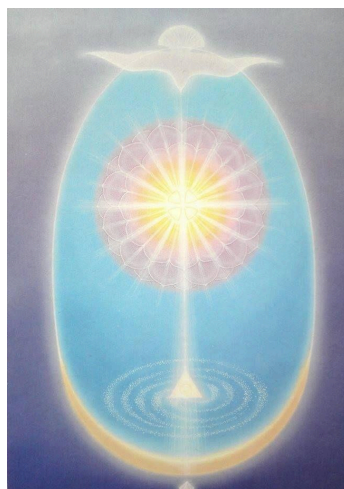
At a deeper level, these cases (mine, and Emily’s) bring up questions of ISTDP’s ethos as a model, and how it could endanger anyone. The license to use force—it’s right there in the language; *pressure, challenge, head-on collision*—can easily become abusive if the therapist enjoys power and control, or believes they are infallible. A model that sanctifies force as therapeutic technique must therefore reckon with the kind of person who may be drawn to that permission, and with what the authority of the model allows them to do. Unless someone genuinely lives underneath a rock, it is nearly impossible to avoid the realization that some non-trivial percentage of people in this world find the pain of others to be gratifying, and enjoy power and control. It follows that the license to use force, and the horror within the violence of ISTDP unlockings, could potentially be an avenue for a therapist to satisfy their impulse for domination.

I vividly recall learning from one of my ISTDP teachers about his experience within the closed-circuit training in Montreal, in which Davanloo would regularly demonstrate ISTDP on trainees, while the group observed. He described a training day in which Davanloo guided a trainee into an unlocking that involved a portrayal of violently raping a child, as the rest of the trainees watched. Afterwards, everyone ate lunch together, including the person who had just publicly portrayed the rape of a child. My trainer found this distasteful and disturbing. I think it is worse than that. Let's look at it from a bird's eye view. A group of people all watching an emotionally embodied enactment of the violent rape of a child, and pretending that what is happening is a healing experience. The image, the energy, the sadism—it reminds me of my childhood. *That* is the darkness of ISTDP. It must be exorcised.

To be able to even perceive this darkness requires that the ISTDP community develop the capacity to comprehend that splitting and disavowal are similarly pathological defenses that fundamentally distort reality, yet do so in opposite ways. Splitting is a failure to tolerate complexity, to see shades of gray. Disavowal is a failure of differentiation, an avoidance of seeing unmixing reality: darkness, and light. The scene I described above is dark. There is no light in it. It is violation, it is unethical, and the energetics of it are present within the ISTDP community.

When a therapeutic culture elevates the recognition of mixed feelings into a universal ideal, it can justify the view that moral clarity is evidence of psychological pathology. The person who accurately perceives darkness can be accused of splitting, while the person who refuses to perceive it can imagine themselves to be psychologically sophisticated. The highest ideal of the model, and its most brilliant insight, is thus corrupted into a means of disavowal.

There is another kind of disavowal at work here, and it is the appropriation of the language of psychological depth. The model has claimed to go to the root, the core, yet it systematically denies the truth of what lies there. It has borrowed the language of the abyss for something that was built to stay well above it. I know this, because that is where I come from. I know what is there. I am qualified to perceive it.



VII: The Grace of ISTDP

Years ago I had a vision, and in this vision I saw ISTDP as a luminous golden egg, held by dark figures within a cave, and the mission was to rescue the golden egg and bring it into the sunlight. Later, a new vision came. This time, ISTDP was a gorgeous deep red robe with long, wide sleeves that opened in front like a kimono, and it felt luxurious to wear, yet the bottom edges of the garment contained poisoned pale yellow-ish threads that needed to be shaken out. I grasped the robe in front and forcefully shook it, loosening the corrupted threads until they fell to the ground. In doing so, the robe suddenly transformed into a pair of enormous deep red wings, and I took flight. As I flew, red feathers dropped to the ground, and each time someone picked up a red feather, it instantly transformed into their own set of vibrant red wings, so they too could fly.

There is much gold in ISTDP, yet what glows most brightly is Davanloo's conviction, built into the very bones of the model, that people can be saved from the cages they've built to protect themselves, and that there are specific, efficient ways of helping them break free. He is said to have told his trainees, "The therapist cannot allow the patient's life to go to waste!" I believe this conviction is his most sacred legacy, for he is invoking the language of moral law: if we can help our patients, we must help, and we must do so with the energy of our whole being. Davanloo's genius for recognizing and naming therapeutic processes and phenomena—complex transference feelings, resistance against emotional closeness, the anxiety pathways, character resistance, tactical resistance, and so much more—gives therapists the raw materials to perceive psychodynamic processes clearly and thus provide life-transforming help, especially to people that may be unreachable through any other method. And even those patients who are less resistant benefit from a therapist that has learned to perceive dynamic conflicts with precision.

The conceptual clarity of the metapsychology—the way the physics of psychological change in the realm of dynamic conflict is so helpfully operationalized—is easily transportable to any style of therapy or healing. For example, consider the power of the instruction to always locate 'the front of the system' by accurately perceiving what is alive in a patient in the here and now. If we take away the dogma, it's easy to see that the front might be feelings, anxiety, or defenses, or traumatic memory, or the need to feel connected to another loving heart and be truly heard. What matters is knowing that you need to look for 'the front' at all, and without that wonderful phrase and concept, it's harder to fully conceptualize the centrality of that process. Broadly speaking, the concept is a systems-theory truth contained within a psychodynamic model. As an idea, it does not belong to ISTDP; it is a first-principles level articulation of something far more general, and it is useful across human relationships, especially healing ones. Powerful ISTDP concepts can be applied everywhere, as long as the person has a clear heart and mind and understands how they are using the ideas.

And while I have heavily critiqued ISTDP's concept of 'fragility' for being vague and poorly defined, I do believe there are many patients whose difficulties fit this conceptualization.

For these patients, the diagrams Allan Abbass has developed to illustrate ‘rotating fronts’ and the operation of self-punishment can be remarkably helpful in guiding treatment.

Moving to my second vision, I think the robe could represent entering the tradition of ISTDP and identifying with it: learning to follow the central dynamic sequence, and giving oneself fully to the art form in its classic form: working with resistance. This is an entirely worthwhile aim. When a patient arrives who needs this kind of direct, forceful therapy in the transference, and you have the courage and the training for it, you may well save their life. I have achieved this a few times, though one treatment in particular stands out to me as my most miraculous clinical work, and it was pure ISTDP.

It took the shape of carefully breaking someone free of their malignant character resistance so they could rejoin humanity. The work felt like a spiritual war, and the unlockings were heartbreakingly real—rage, guilt, grief, pain—all expressed within the transference and contained by my witnessing presence. Together, the patient and I won; the UTA won. It was beautiful. So I value the discipline required to learn the heart of the model; it counts.

In that treatment, ISTDP was grace itself descending from the heavens. It was not just me; it was me in the magical robes of the model, in concert with an extraordinary degree of courage and motivation in my patient. The model gave me the conceptual clarity and conviction to go head-to-head with my patient’s most malignant and regressive defenses, and their life was certainly saved. This was a moment when therapeutic force was placed in the service of freedom, and I am grateful I learned how to use that force. What makes therapeutic force grace rather than domination is whether the force accurately answers the reality of the person to whom it is applied: force applied to a mind that has turned against itself is grace; the same force applied to a traumatized mind suffering from unbearable memories rather than resistance, or to a mind that is simply healthy and kind and lacks deep conflicts related to buried guilt, is domination and abuse. ISTDP must differentiate itself from the latter, for that is not the heart of the model.

The liberatory power of ISTDP can truly be stunning. I watched one of my trainers go through the process of “searching for the resistance”—tracking every little sigh and signal—with a patient who could not articulate any of their conflicts at all. He was able to accurately detect where the conflict was, facilitate an intense unlocking, and ultimately help the patient transform their inner world. It was revelatory to watch. Watching him, absorbing his skill, I realized I needed to sometimes objectify some of my patients in order to help them. I would track and assess—where was the sigh, where was the signal—observing the patient primarily as a ‘system’ rather than a full person, in those moments when they needed me to be a bloodhound on the scent of defenses, anxiety, and feelings. It’s not that I lost track of their humanity; it’s that in order to clearly see what was happening dynamically, I needed to turn down my heart and turn up my mind and analytical capacity. Much as a surgeon must focus on anatomy rather than on the whole person, I became focused on the anatomy of dynamic conflicts rather than the entire shape of my patient’s personhood, at least in certain moments when it was needed. That capacity is also part of the gold: an intensely analytical way of observing a person that allows the therapist to truly help.

Within the red robe of ISTDP, I believe that the poisoned threads are dogmatic loyalty and zealotry. When truth becomes fused with institution, identity, authority structure, and totalizing doctrine, the healing endeavor is corrupted. Yet if those threads of dogma and control are removed from ISTDP, what is left is the beautiful truth itself—the good ideas, the things that work—and liberated capacity. No one can claim ownership of healing ideas; the patent expires the moment the idea is articulated. Acknowledging a source is not the same as submission. When we take truly good ideas and make them our own, allow ourselves to know what we know, to see what we see, the ideas come fully to life. They become a language to study, a place to develop fluency.

In the realm of the skill of healing the psyche, I believe fluency is the greatest possible dream. There is no such thing as mastery. A living system cannot be mastered. The human psyche is not wood to be carved; it is a garden to be tended. There is no terminal end point to clinical excellence; the far horizon is learning to move with ever more discernment, grace, and precision, becoming fluent in the phenomenology of the evolution of consciousness. ISTDP does not merely add to that fluency; it multiplies it, exponentially increasing what a therapist can perceive and offer. ISTDP contains a truth that many minds have understood, and it is that when we can hold paradox, we evolve. Whether the paradox is rage and love held simultaneously, or darkness and grace within the same tradition, it is our ability to hold the tension between them that allows a miraculous new reality to emerge.

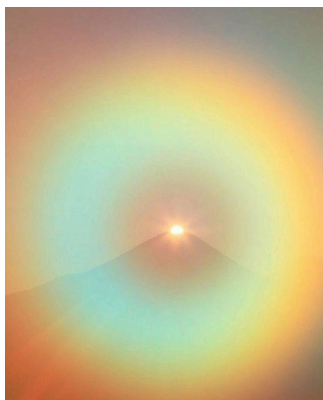
Evolution cannot be stopped, because the truth cannot be caged: the knowledge of healing is a birthright of humanity. The robe will become wings. The feathers will fall as it does, and whoever picks one up does not need permission to fly. *That* is the grace of ISTDP.



VIII: The Grace of Goodness

Healers are bound to the pursuit of goodness; if we lose that orientation, then we are no longer healers. Goodness, as I know it, is the orientation of consciousness toward the value of what exists beyond itself: other life, other minds, other truths. The greatest good is life itself, and the evolution of consciousness that is its greatest expression. We grow, we change, we heal, we *evolve*, as do other animals and the earth itself. We become more fully human as our capacity to perceive reality expands. The deepest sickness, then, is not rigidity itself, but a failure to evolve at all: a will that refuses transformation and maintains rigid structures against inner growth. I do not think ‘personality disorder’ describes this adequately, since some people with highly rigid personality structures do heal and transform because the person really tries, as the best of ISTDP demonstrates. I believe a better term is *spirit disorder*: a condition in which the will itself has become bent against life, against becoming.

ISTDP understands this territory. Malignant character resistance *is* a disorder of the spirit: devaluation, contempt, characterological detachment, provocation, and sadism without guilt; the dissociation of other people’s pain, needs, and intrinsic worth; an orientation organized against connection and change. That ISTDP can move in these places at all is a testament to Davanloo’s inspiration and insight; he found a way to exorcise darkness from the human spirit by evoking a more powerful light. That is a miracle of goodness. The paradox is that he himself appears to have contained a disorder within his spirit while simultaneously transmitting a technology capable of transforming it. Whatever he understood about guilt, resistance, and transformation did not reliably lead him to recognize and repair the harm he caused when he betrayed his trainees by excommunicating them from his circle. He did not make it right. Had he been able to fully turn his own method upon himself, he might have transformed. Then the grace of ISTDP, the *grace of goodness*, would have been his, too.



About the author:

I am Mae Ana Sefami. Ana is pronounced 'Ah-na'. I am a writer, psychotherapist, and theorist working at the intersection of psychoanalysis, contemporary traumatic stress studies, the philosophy of science, and relational field dynamics. All my work is grounded in *The Conditions for Freedom of Perception*, a framework I inferred from first principles in response to pervasive perceptual capture across the paradigms that claim authority over human becoming. This framework articulates how to sustain perception that is genuinely alive and responsive to reality, and thus dynamically ethical. Synthesis across domains and precision in naming patterns are my primary modes of thought—I trace and illuminate the real structures that run across frameworks, and find words that make these structures visible. My bedrock commitments are to accuracy, protection, and compassion.

My mind is complexly dissociated, shaped by deep trauma. It is also coherent, vital, and spacious—and that combination has given me perceptual access to the interior of transformation. As such, my work is irreducibly formed by my proximity to trauma, the light I've found in healing, and the love I have for all those braving the dark while holding to truth and goodness.

The stars I am following currently take the shape of three projects: *Ethical ISTDP*, *Healing Fluency School*, and *My Friend Ibogaine*. Ethical ISTDP is an advocacy and accountability project addressing the generational transmission of disavowal as the pillar defense across the lineage of ISTDP. Healing Fluency School is an educational project re-associating the field of psychotherapy through its shared underlying grammar. My Friend Ibogaine is more expansive and more personal—a gift of wayfinding and illumination, of sharing my clarity so that others may find their way.



If this essay speaks to something you have seen or lived and you would like to connect, you are welcome to reach out to me at ethicalistdp@gmail.com. If you'd like to follow this work as it unfolds, you can join the Ethical ISTDP newsletter.

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