Intensive Short-Term Dynamic Psychotherapy (ISTDP)

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William James College, 2016-2017

This Course

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- Didactics
- Patient video
- Active learning / experiential: role-plays, etc
- Consultation (not supervision)
- Breaks
- Continuing education (28 hours)
- Your feedback is welcome (nk@natkuhn.com)

Knowledge, Skills, and Attitudes

- Attitude is the most important part: to be present in a nonjudgmental, genuine way, with a desire to help patients achieve their goals
- Knowledge comes from lectures, reading, conversation…
- Skills come from watching video, practice...
- Knowledge helps you know when to use which skill
- Psychotherapy is based on implicit/procedural knowledge

About Video

- ISTDP could not have been developed or taught without video; it can't be learned without video
- Confidentiality is bedrock of what we do
- If you recognize the subject of the video, please interrupt and remove yourself; I'll make it up to you
- You are free to record any of the non-patient video portions of the presentation but you may not record or copy the video in any way

Record Your Own Sessions

- The way to improve is to get feedback
- The way to get feedback is through video
- The feedback can be your own, as well as from a consultant/supervisor
- Therapists are reluctant to record their own work
- Patients are not as reluctant as therapists like to think they are
- Clinics may be reluctant

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Authorization and Release to Record Psychotherapy

Name	First		MI	Last			
Address			Apt #		Phone	( ) -	
City		State		Zip		Birth Date	___ /___ /_____

I authorize Dr. Kuhn to make audio and/or video recordings of my treatment interviews. I understand that the use of these recordings will be restricted to the following purposes: (1) to be reviewed by Dr. Kuhn and me; (2) for consultation by Dr. Kuhn with colleagues to maintain and improve the quality of his treatment; (3) for research; (4) for training of mental health professionals.

This authorization shall remain in effect until Dr. Kuhn's retirement, or until revoked by me.

Conditions of Authorization	I understand that: • I do not need to sign this authorization, in which case no recording will take place. • I will not be denied treatment if I choose not to sign this authorization. • I am entitled to a signed copy of this authorization. • My full name will not be revealed. • The interviews, recordings, and any accompanying descriptive material will be used in accordance with the ethical standards of professional confidentiality for licensed mental health professionals. However, with the use of recorded material it is not possible to guarantee that I would not be identified. • These recordings will not become the property of anyone other than Dr. Kuhn or me. • I will not receive financial compensation for the use of these recordings. • I can revoke this authorization at any time, by written request to Dr. Kuhn, and that the recordings themselves will be destroyed on my written request. • The revocation is effective immediately on Dr. Kuhn's receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request.
Modifications	I have crossed out or modified any aspects of this authorization that I wish to change.
Signature	Signed: _____ Date: _____

The PDF of this form is available at: istdpboston.net/wjc-2016-17, along with other course materials

Dynamic Psychotherapy

Similarities:

- The unconscious is real, and complex
- Some aspects of psychoanalytic theory are validated, others not

Differences:

- Active therapist, to the point of relentlessness
- Focus
- Emphasis on experience of affect (experiential therapy)
- Focus on the body
- Interpretation only after unlocking, if at all

ISTDP Resources

ISTDP Boston

- Goal: to build a vibrant, welcoming ISTDP community in Boston
- www.istdpboston.net
- Email list: tiny.cc/IBsubscribe

IEDTA

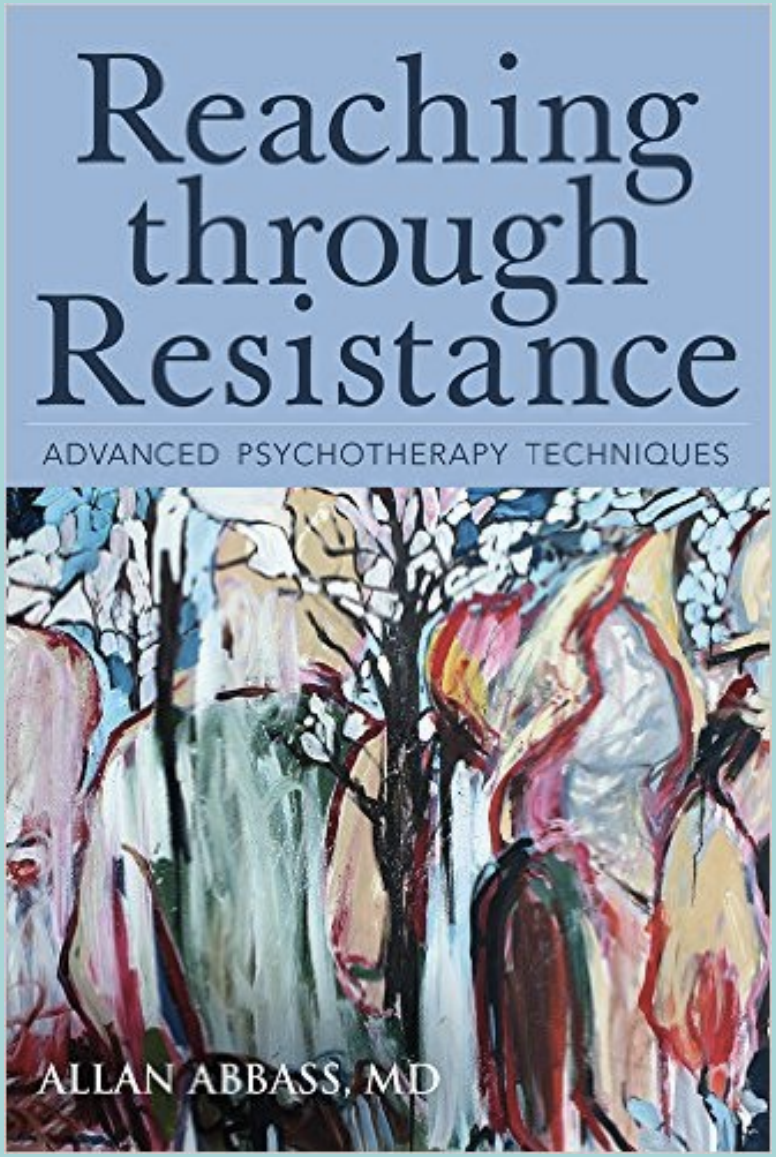
- The IEDTA was founded by trainees of Davanloo as a form for all of the Davanloo-influenced and like-minded "experiential dynamic therapies" (ISTDP, APT, AEDP, etc.)
- www.iedta.net
- EDT-List email discussion group (listserv)
- International meetings every two years
- Next meeting: Amsterdam, 3-5 November 2016!

Websites

- Jon Frederickson: istdpinstitute.com
- Allan Abbass: istdp.ca
- Calif Society for ISTDP: istdp.com
- Habib Davanloo: davanloo.ca

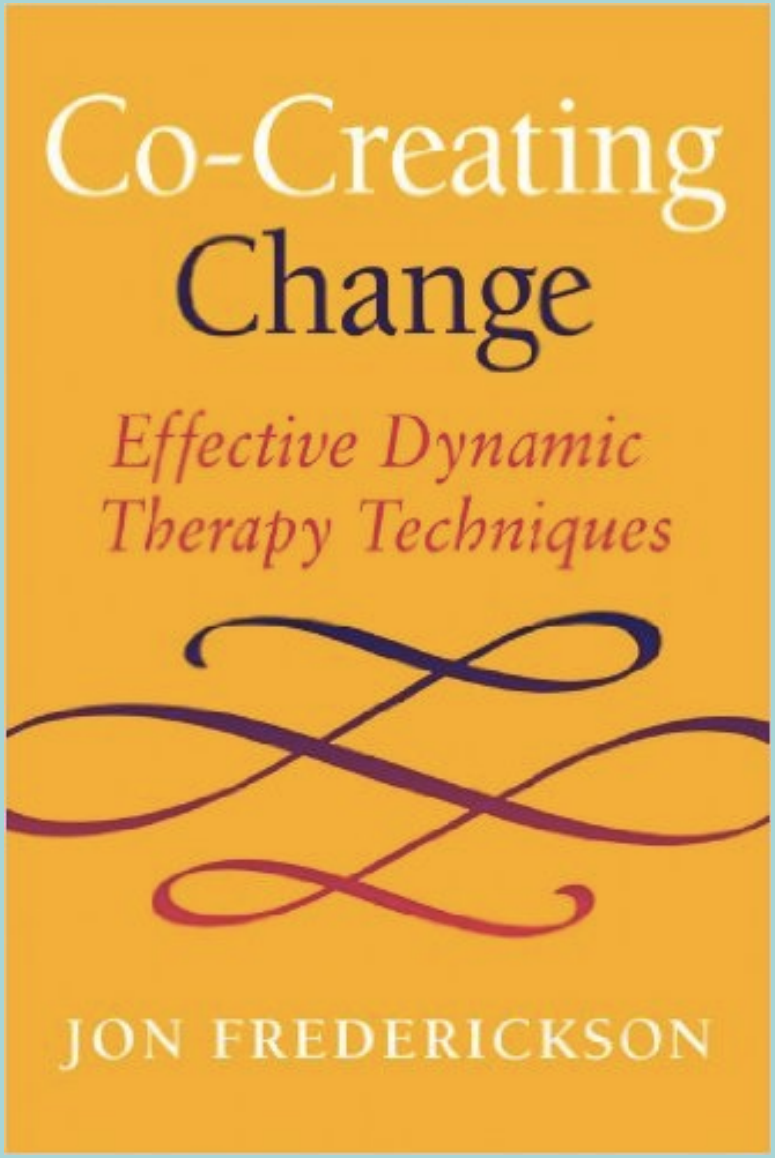
Books—I

- Best place to start for a well-grounded overview of ISTDP



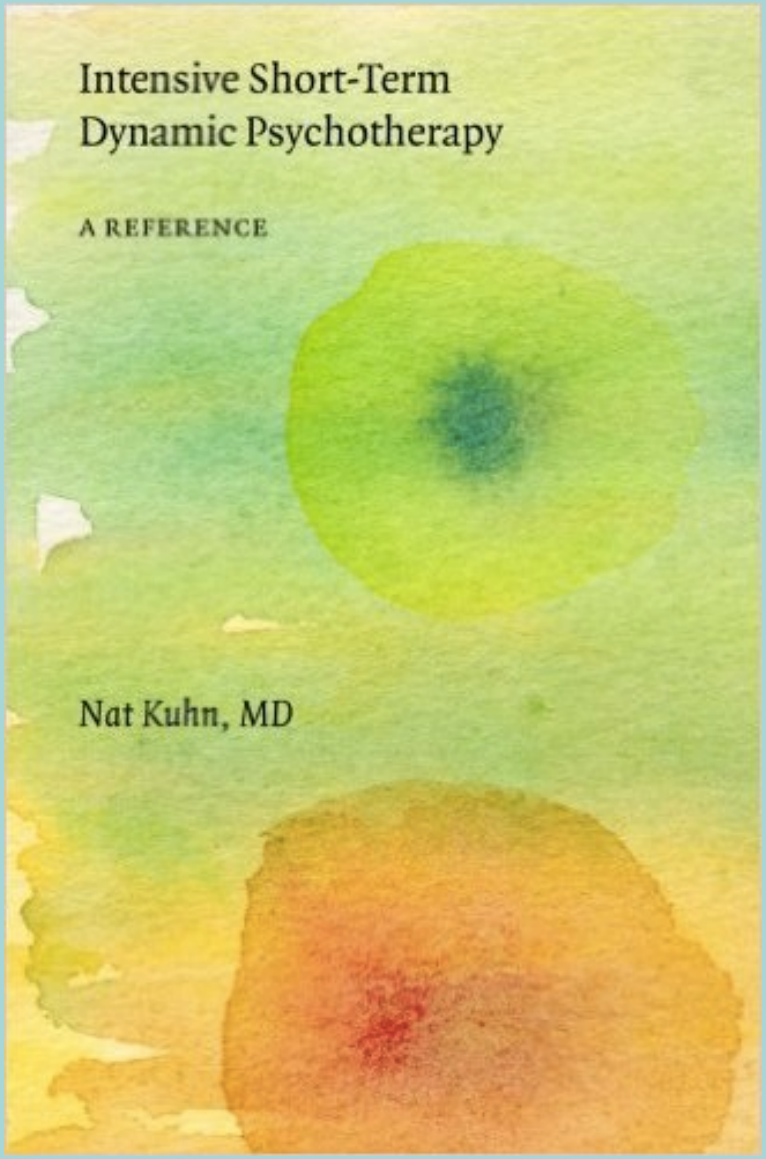
Books—II

- More elaborated, so more examples
- Also, easier to lose the forest for the trees
- Some terminological differences



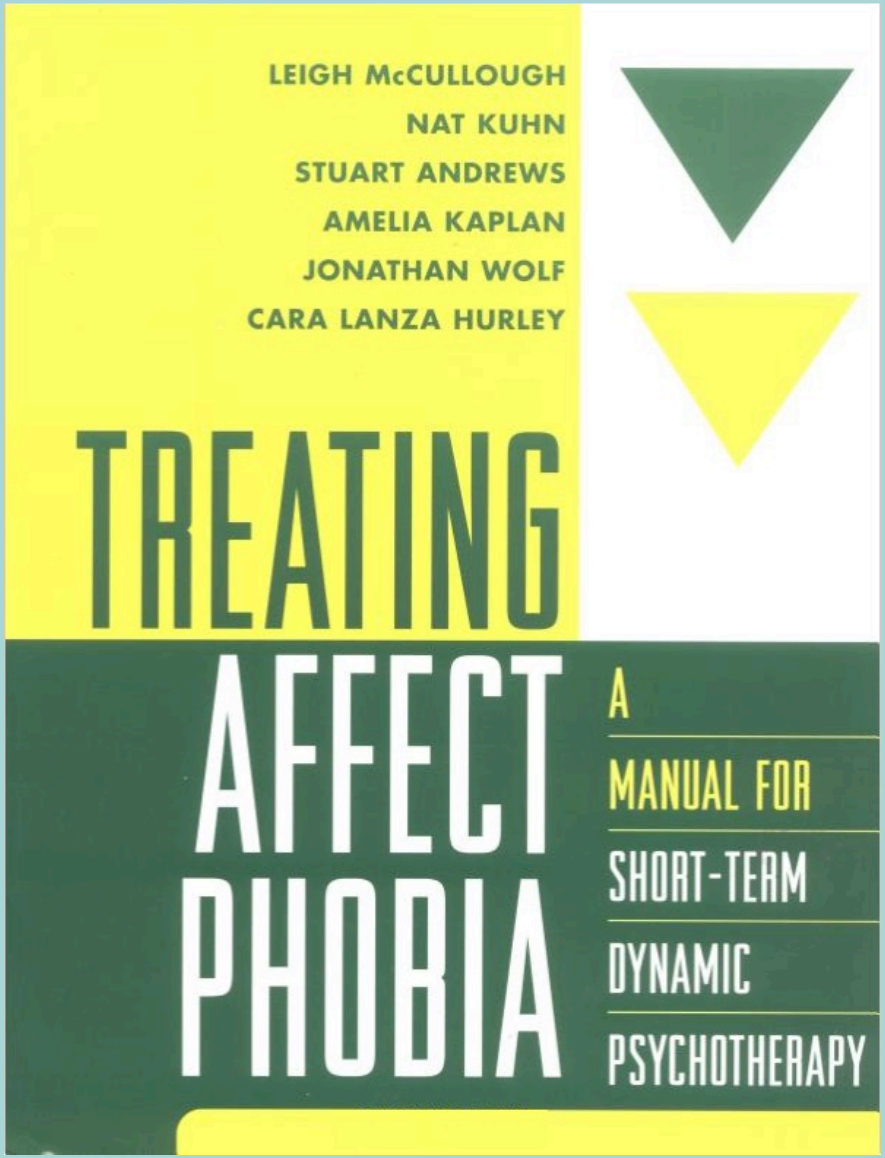
Books—III

- Definitions of terms—there are quite a few
- In-depth discussions of discrete topics
- Clinical examples
- Specific page references to Davanloo's writings
- Highlights terminological differences between various authors
- I tried to write the book I wish I'd had starting out



Books—IV

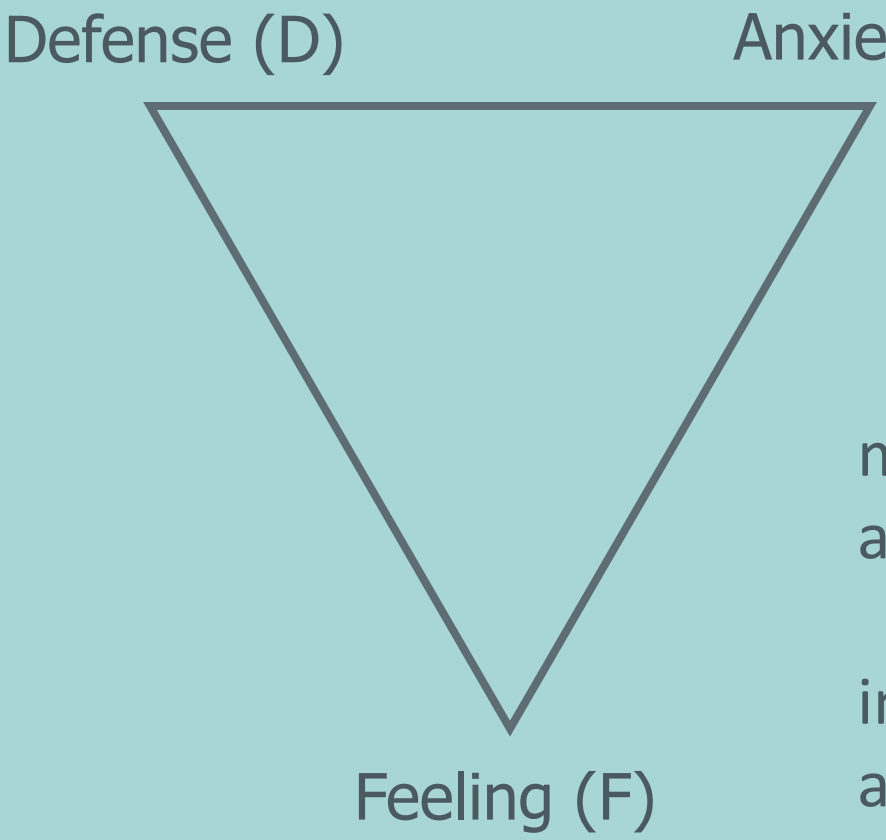
- A good place to start, especially for beginning therapists
- Good coverage of the two triangles
- Exercises
- *But,* in the Affect Phobia model:
  - anxiety is more cognitive
  - guilt is grouped with Anxiety rather than Feeling



Review

(brief)

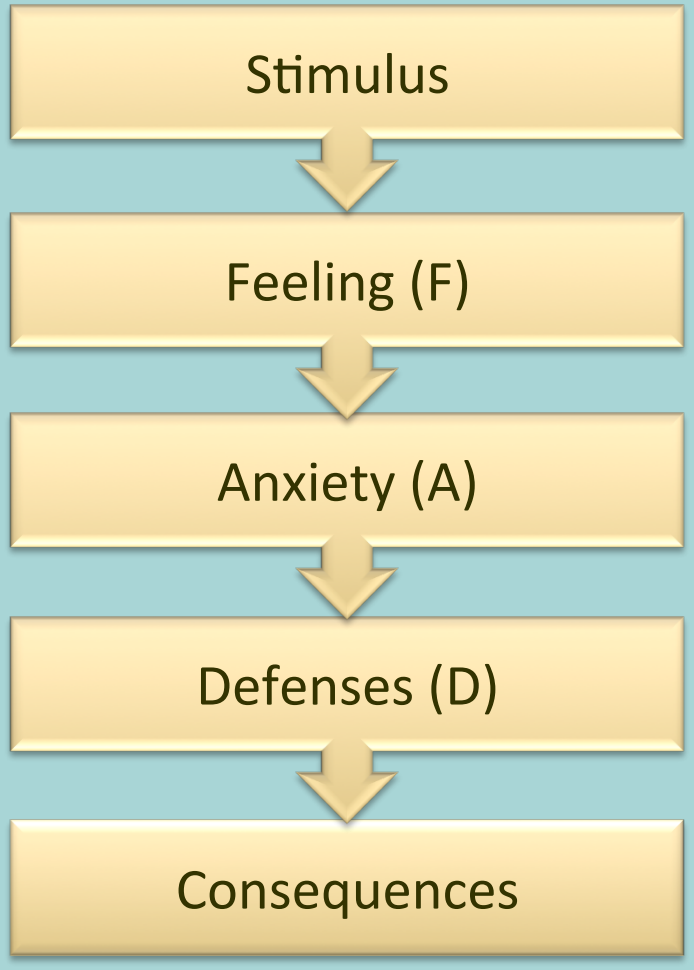
Triangle of Conflict



Anxiety over conflicted mental content leads patients to avoid by deploying Defenses

Experiencing the conflicted impulses/feelings can lower anxiety and reduce avoidance

“Causality”



Anxiety

- Anxiety refers to *unconscious anxiety* not to cognitions (worry)
- Anxiety **signaling** is the "dowsing rod" of ISTDP
- Unconscious anxiety can be manifested through three pathways. Anxiety can hit a "threshold" and move down the list to another pathway:
  - Striated (voluntary, skeletal) muscle: hand wringing, sighing, yawning, muscle tone (signaling, "green light")
  - Smooth (involuntary, visceral) muscle: nausea, IBS, heartburn, migraine ("red light")
  - Cognitive-Perceptual Disruption (CPD): fogginess, tunnel vision, dissociation ("red light")

Key Interventions

The vigorousness of the intervention is always calibrated to the rise in CTF and the patient's capacity

- Pressure: encouragement to face something avoided
  - "Do something good for yourself"
- Clarification: encouragement to understand defenses
  - "Do you see that you are _____?"
  - Recap = more extended clarification (including two triangles)
- Challenge: encouragement to relinquish defenses
  - "Don't _____."
  - "You can _____, but then you will not reach your goal."
  - Culminates in "head-on collision," to shift balance to UTA vs R

“Triple Factors”

The therapist’s attempts to help the patient, including forming a relationship, mobilize:

- Complex (positive and negative) feelings, which mobilized feelings toward early attachment figures (complex transference feelings, CTF)
- Anxiety (A)
- Defenses (D), also known as resistance (R)
- The unconscious therapeutic alliance (UTA)

Response to Intervention

In response to an intervention, the patient will:

- Feel: help deepen the experience of feeling (often by doing nothing)
- Defend: continue with pressure/clarification/challenge
- Go flat (smooth muscle anxiety, CPD, depression, motor conversion): build capacity (graded format)
- Respond from the UTA: take note, possibly shift focus

We Bring Ourselves to the Therapy

- Doing therapy triggers the therapist's ToC: F, A, D
- Doing therapy mobilizes unconscious feeling in the therapist (ToP)
- Watching video does the same
- The therapist has counter-transference, counter-resistance, and a therapist UTA
  - Countertransference may refer simply to feelings that arise in the therapist during therapy, or to feelings related to the therapists unresolved complex feelings
- Your anxiety may go up threshold
- Do what we encourage in patients: nonjudgmental self-acceptance and compassion; you are the instrument

Graded Format

In the Beginning…

…Davanloo created the "standard format" of ISTDP:

- "unremitting" approach to the patient's resistance→
- breakthrough of complex transference feelings→
- unlocking or "direct access" to the unconscious

This works well for patients who have "[ego-adaptive] capacity":

- able to tolerate the associated anxiety (i.e. striated)
- do not resort to highly destructive defenses, e.g. depression, violence, yelling, self-injury, severe drug use, primitive ("big-p") projection

Threshold

However, perhaps half of patients have an anxiety "threshold," above which they:

- have smooth muscle anxiety;
- get cognitive-perceptual disruption; or
- resort to highly destructive defenses

In this situation, there needs to be a phase of capacity-building, using the "graded format."

Capacity can be thought of as "the ability to think *while feeling*."

Graded Format

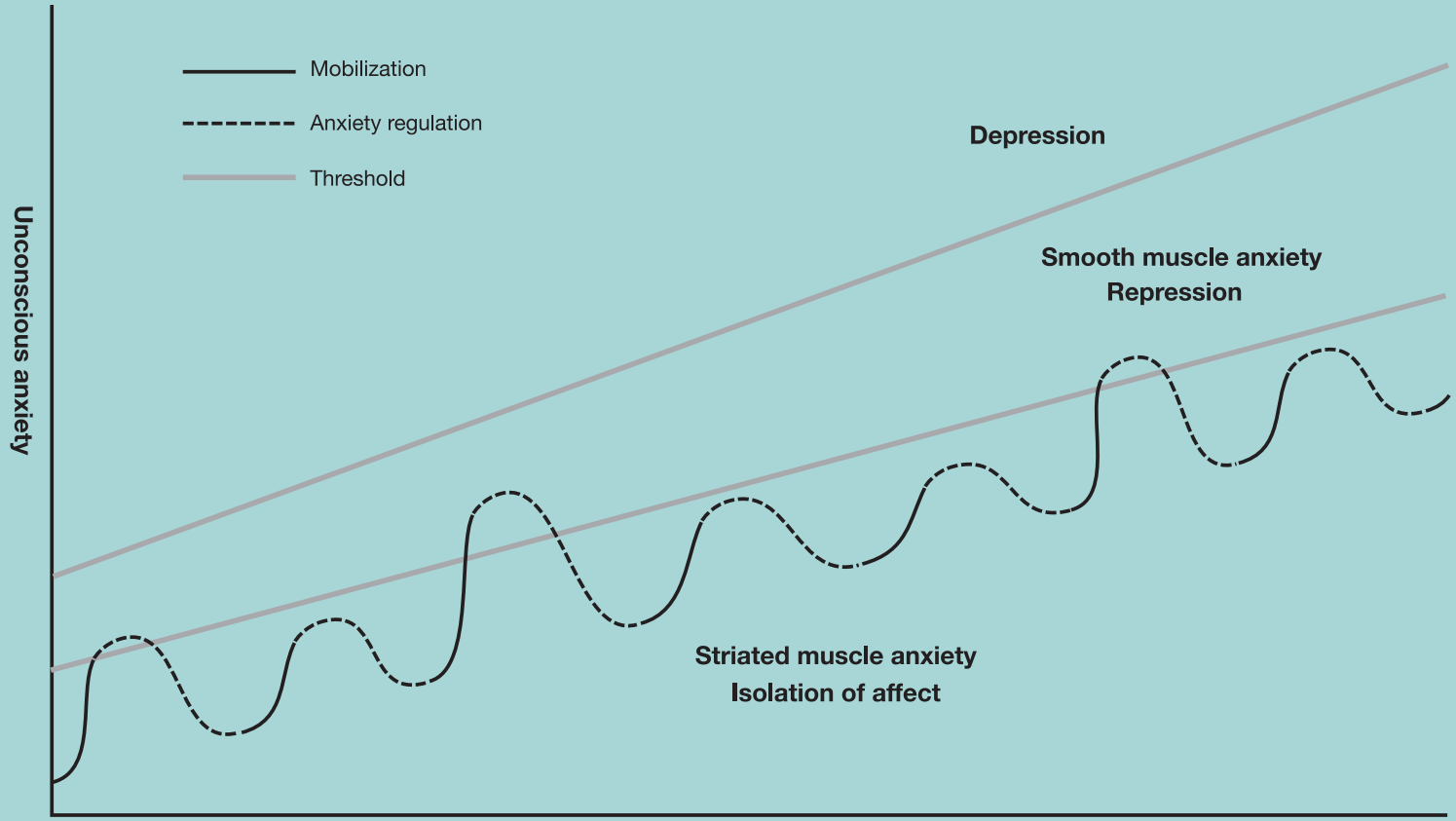
Davanloo developed the “graded format” of ISTDP (or “restructuring technique”) for patients without sufficient capacity for the standard format.

The graded format involves alternating periods of:

- mobilization (pressure, etc.), until an anxiety threshold is reached
- capacity-building through recapping and other anxiety-regulating techniques.

As patients develop capacity, the work starts to resemble the standard format.

Schematic: Graded Format



Kuhn (2014), “ISTDP: A Reference,” following Abbass (2007)

Building Capacity—I

When anxiety goes above threshold or you see repression or primitive defenses, switch to capacity building. Lower (but do not eliminate) pressure, and do one or more of the following:

- Intellectualize (recap, "go around the triangles"), to build self-observing capacity
- Explore the anxiety in the body (tension, deep breaths)
- Change "station" on the triangle of person: T to C, or vice versa; C to C; generally not to P

Building Capacity—II

- How long does it take for the anxiety to go below threshold? “It takes as long as it takes”
  - The patient may go below threshold before you respond
  - It may take the rest of the session
- When building capacity, reduce but do not remove pressure, e.g. by changing to an unrelated topic
- Removing pressure entirely will actually *increase* anxiety

Recapping

- Recapping builds self-observing capacity and lowers anxiety
- Is the patient able to:
  - observe feelings, anxiety, defenses?
  - understand causality (stimulus→F→A→D→problems)?
  - see defenses as something separate from themselves, potentially under their control?
  - do these things with compassion rather than self-judgment, i.e. without resorting to self-attacking defenses?

Video

(finally!)

Somatic Symptom Disorders

- Many somatic symptoms are manifestations of unconscious anxiety
- Somatic symptom disorders:
  - drive enormous healthcare expenditures
  - drive medical providers crazy

Following Abbass (2015)

Striated Muscle Anxiety: Symptoms

- Tension headaches
- Back pain
- Bruxism, jaw pain (TMJ)
- Neck pain, chest pain, leg pain
- Fibromyalgia
- Cramps
- Tics, including vocal tics
- Choking sensations
- Tremor

Following Abbass (2015)

Smooth Muscle Anxiety: Symptoms

- Neurological: migraine
- Gastrointestinal: IBS, GERD, functional vomiting, abdominal pain
- Urological: bladder dysfunction, interstitial cystitis
- Respiratory: asthma, cough, choking symptoms
- Cardiovascular: hypertension, flushing, hypotension with loss of consciousness, coronary artery spasm

Following Abbass (2015)

Cognitive-Perceptual Disruption: Symptoms

- Blurry vision, tunnel vision, blindness
- Hearing impairment or loss
- Tinnitus (“ringing in the ears”)
- Vertigo (“room spinning,” “head spinning”)
- Confusion
- Memory loss
- Dissociation
- Non-epileptic seizures
- Loss of consciousness
- Hallucinations in all five sense

Following Abbass (2015)

Medically Unexplained Symptoms (MUS)

- Significant improvement is possible in a small number (say 4-6) sessions, especially in smooth-muscle and CPD symptoms
- Abbass (Can. J Emer. Med. 2009, 11(6), pp. 529-534):
  - 50-patient case series from ED: somatization, anxiety, chest pain, abdominal pain, headache NYD (not yet diagnosed)
  - Assessment interview, average of 3.8 sessions
  - 232 visits in year prior, 72 in following year
  - Significant improvement on BSI: 1.21 to 0.86

Projection

- “Big-p”: loss of reality testing, “projection as a regressive defense,” borderline. Often used exclusively in this sense. Patients believe that the therapist wants to hurt them, e.g.
- “Small-p”: intact reality testing, “projection as a repressive defense,” neurotic.
- Recognizing big-p projection is important, because pressure and challenge lead to bad outcomes, and standard anxiety regulation is not effective. Projections must be “deactivated.” Dealing with patients who project is for advanced practitioners.

Projection vs Transference [Feelings]

- Projection: when I look at you I see my father's (or my own) judgment, and I get angry (or afraid). No signaling.
- Transference: as I allow myself to get close to you, the mix of positive and negative feelings I have toward you resonates with and mobilizes the mix of positive and negative feelings I have toward my father, triggering anxiety. Signaling.