Intensive Short-Term Dynamic Psychotherapy (ISTDP)

Class #1, 18 September 2016

Nat Kuhn, MD

www.natkuhn.com, nk@natkuhn.com, 617-489-9090

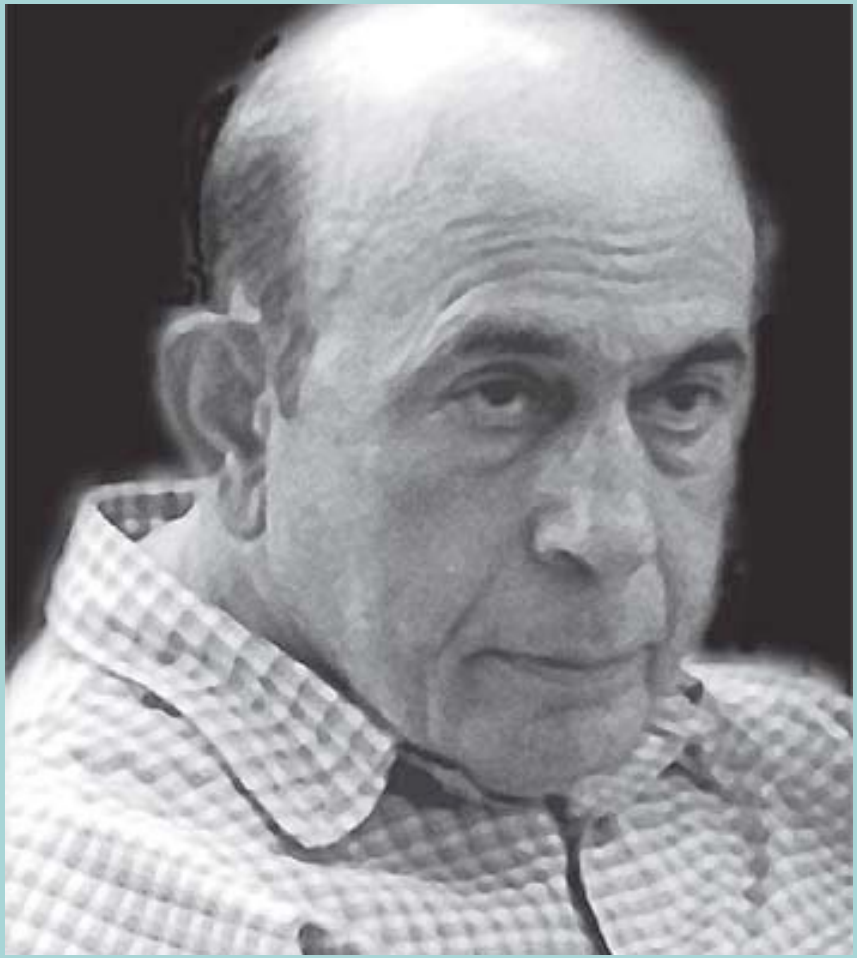
ISTDP Boston, www.istdpboston.net

William James College, 2016-2017

Introduction

(brief)

What—I



ISTDP (Intensive Short-Term Dynamic Psychotherapy) was developed by Habib Davanloo at McGill University in Montreal, starting in the 1960s and 70s

What—II

Davanloo was trained in psychoanalysis, and started with an interpretive approach similar to Alexander, Malan, Sifneos, etc. He concluded that (2005):

- These therapies are effective, but only because they "bypassed the major resistance by a process of selection" and that "this group of patients cannot be easily found"
- A purely interpretive approach is "quite inadequate" to deal with significant resistance
- "[B]ypassing the resistance is not the answer to the problem"

Resistance

"What happens in therapy is that people come in asking for help, and then the very next thing they do is they try to stop you helping them."

—Dr. David Pollens, as quoted in "Therapy Wars: the Revenge of Freud," by Oliver Burkeman, The Guardian 7 Jan 2016

What—III

- Instead, Davanloo attempted “a direct approach to the whole complex system of resistance”
- “If activity is steadily and relentlessly increased in step with increasing resistance, does there come a point at which resistance breaks down without the patient becoming flooded with more feelings than can be tolerated?”
- Yes, provided that “transference is also handled with a similar degree of activity” (2005)
- Over the decades, Davanloo refined and broadened his technique. Abbass (2002) reports that it is appropriate for 86% of referrals in a general psychiatry practice

Who

- Habib Davanloo
- David Malan

- Allan Abbass
- Jon Frederickson

- Leigh McCullough (APT), Diana Fosha (AEDP), Jeffrey Magnavita
- Young, Safran & Muran…

The Big Picture

A Brief Digression on “Theory”

- My own experience with theory, especially psychody-namic theory during training: there were many competing theories, each of which kind of made sense, but no sense of how you might validate or falsify any one theory
- My experience with ISTDP theory (“metapsychology”) is that its constructs take on a palpable reality as you gain experience with the therapy
- I am not asking you (and I do not ask patients) to “buy” the theory, just to bear it in mind, in an open-minded way

Attachment Trauma:
The Origin of Neurotic Psychopathology

In all but the rare "low resistance" patients there is a sequence of:

- Attachment bond (positive, loving feelings)
- Attachment trauma: loss, abuse, neglect
- Pain
- Rage (typically at least murderous rage)
- Guilt (intense, due to combination of rage and love)
- Self-punishment (punitive superego)

In ISTDP, the mixture of positive and negative feelings is referred to as "complex feelings." The complex feelings toward early attachment figures are sometimes referred to as the "core neurotic organization."

Attachment Trauma—II

- These complex feelings are intense and generate intense anxiety
- Anxiety leads to avoidance; this avoidance takes many forms, known as **defenses**
- Above all others, the feelings—and often the anxiety—are kept out of conscious awareness ("unconscious"), under a "repression barrier"; this is "repression" in its broadest sense

Defenses Cause Presenting Problems

For example:

- Relationships stir up the complex feelings toward early attachment figures (transference); people avoid or sabotage relationships
- People turn anger against themselves, resulting in excessive self-criticism, depression, etc.
- Anxiety can become symptomatic; instead of being a signal of a problem, it becomes its own focus
- People engage in a stunning amount of self-defeating, self-sabotaging behavior (e.g., repetition compulsion)

How to Resolve Problems

- Help people **experience** their unconscious feelings, which lowers their anxiety
- To do this, people have to stop avoiding their feelings; that is, they need to put aside or **give up their defenses**
- Giving up the defenses will result in a temporary *increase* in anxiety
- Doing that needs to involve a level of **willingness**

Then Why is it So Hard?

- Defenses are unconscious
- Anxiety is often unconscious; and even if it is conscious the trigger is unconscious, provoking *rationalization*
- In other words, defenses are active in the therapy itself; that is, **resistance**
- In other words, there are defenses holding the defenses in place; resistance is a robust, self-perpetuating system
- For therapy to be effective, the therapist must deal with resistance
- This problem is in no way limited to dynamic psycho-therapy (see Aviram et al, JCCP 9/16 pp. 783-794)

The Small Picture

David Malan

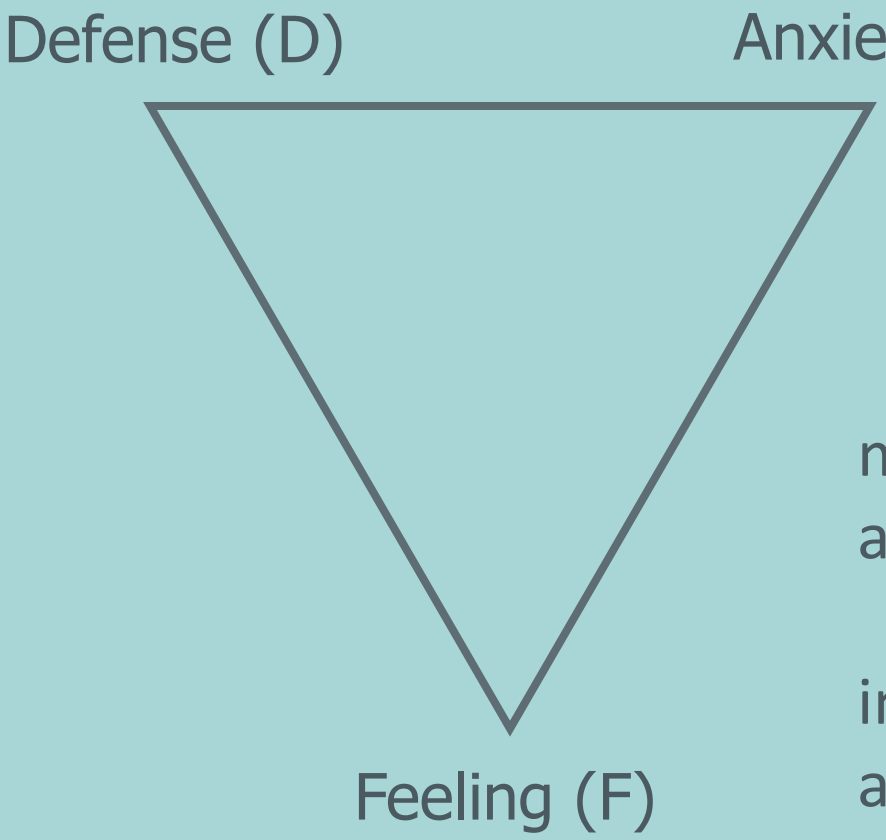
Clinician and researcher at the Tavistock Clinic in London

Author of “Individual Psychotherapy and the Science of Psychodynamics” (1979, 1995), a classic of purely interpretive Short-Term Dynamic Psychotherapy (STDP)

Malan's Two Triangles

- The "universal technique of psychodynamic psychotherapy"
- *Defenses* and *Anxiety* block the experience of conflicted *Impulses* and *Feelings*
- The Triangle of Conflict depicts this process in a simple, graphical way that can be used for overall psychodynamic formulation and for fine-grain *moment-to-moment* tracking during a session
- The Triangle of Person captures the interpersonal situations in which conflicts play out, and the links between them

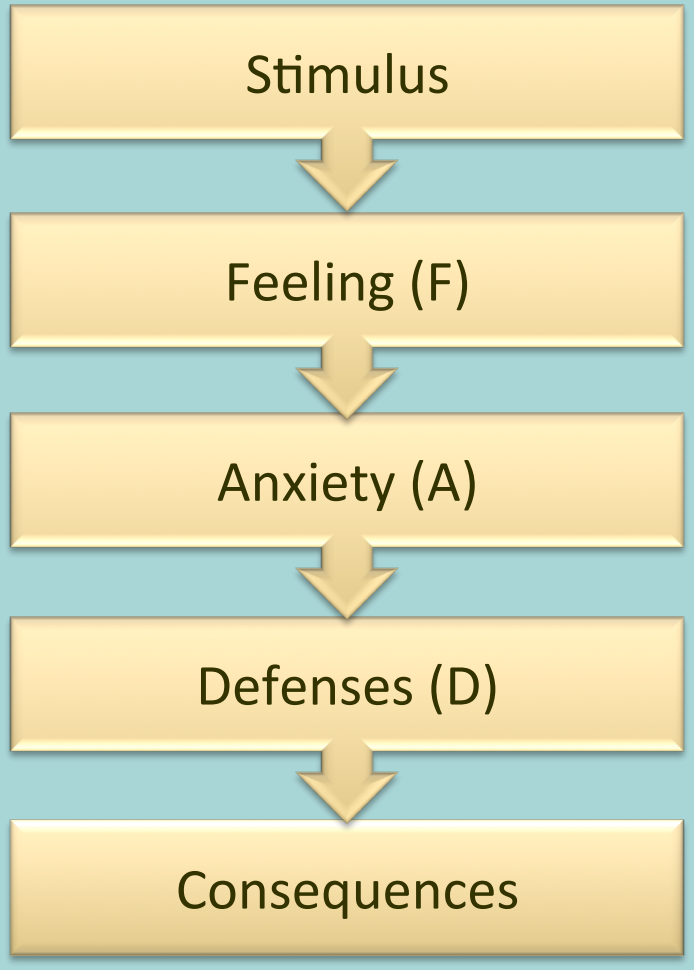
Triangle of Conflict



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

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

“Causality”



Feeling

- Feeling—or "Impulse/Feeling (I/F)"—refers to underlying feeling (frequently unconscious)
- Awareness of feeling includes naming, physiological experience, awareness of impulse
  - Irritation, anger, rage (assertion, violence)
  - Sadness, grief (acknowledge loss, prepare to replace)
  - Guilt (acknowledge wrong, repair, avoid repetition)
  - Emotional pain, distress
  - Positive: love/tenderness, joy, excitement

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")

"I'm going to need some kind of signal from you."

[New Yorker Caption Contest, 9/13/16]

Defense—I

- Defenses can be adaptive, e.g. anticipation and suppression
- We are concerned almost exclusively with *maladaptive* defenses
- Almost every symptom is a maladaptive defense
- Defenses are “escape behaviors” that lower unconscious anxiety
- Conversely, when a patient stops using a defense, anxiety goes up; defense and anxiety “trade off”

Defense—II

- In moment-to-moment formulation it is frequently more helpful to think of defensive *behaviors* ("tactical defenses") rather than defense *mechanisms* ("major defenses")
- ***ANY FEELING CAN BE USED AS A DEFENSE:*** e.g., weepiness can be depressive reaction or cover anger; anger can be used to avoid emotional closeness; angry outbursts can defend against the *feeling* of anger; shame can be used to defend against guilt
- Distinguishing defensive affect from "true" affect is a key ISTDP skill

Experiencing

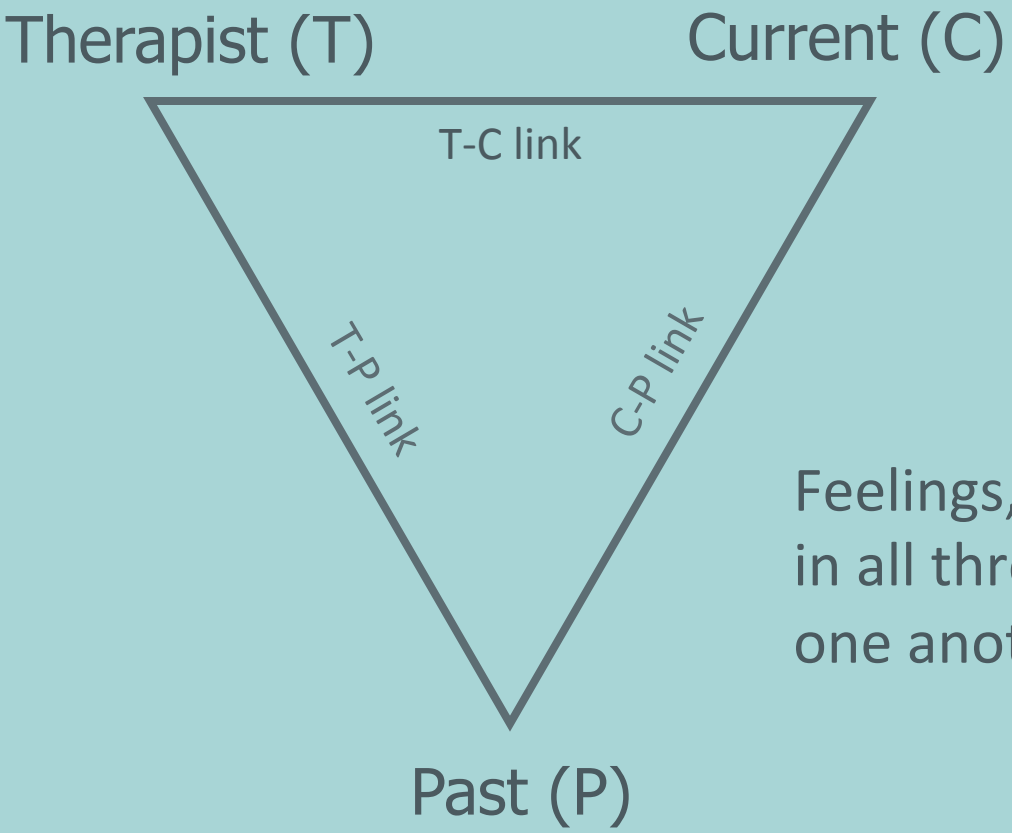
- The key to successful therapy is breaking the chain of causality: stimulus→F→A→D→problems. The "weak link" is the anxiety response to feeling
- The way to break that link is exposure (and response prevention)
- Successful exposure involves the *physiological experience of affect*, which needs to be prolonged enough for anxiety to go down
- Thinking and talking about affect is **not** experiencing it, it is frequently an avoidance; intellectualization is a defense

* Functions of Defense/Resistance

Defense	Resistance
Avoid feeling (triangle of conflict, "cellar door")	Resistance to Experiencing Feeling (REF)
Avoid closeness ("front door")	Resistance to Emotional Closeness (REC)
Enact a pathological relationship with self or other	Character/Transference Resistance
Punish/sabotage self	Superego Resistance (Punitive Superego, PSE)

Low-resistance patients have only REF; as resistance increases, defenses function less in isolation and more as part of integrated systems.

Triangle of Person



Feelings, anxiety, and defense occur in all three contexts, and they **link** to one another

Video

(yay!)

Attachment Trauma and the ToC

- Patients carry the complex feelings toward early attachment figures (complex transference feelings, CTF) around with them at all times.
- The CTF may generate a constant level of background anxiety and a constant process of avoidance of feeling and closeness, and of self-punishment; defenses keep the CTF "locked" in the unconscious.
- Unconscious guilt triggers unconscious anxiety, and self-punishment can be seen as a defense: "if I just punish myself enough, I don't have to actually feel guilty."

Implications for Therapy—I

- Experiencing *all* of the complex feelings toward the attachment figures results in decreased anxiety, and decreased use of destructive defenses
- No destructive defenses → no neurotic problems
- When patients experience previously unconscious guilt, they no longer need to avoid it, and therefore no longer need to punish themselves.

Implications for Therapy—II

- **But**: defenses are active in the therapy itself, i.e. *resistance.*
- Experiencing feelings reduces defenses, but defenses keep patients from experiencing feelings
- To experience feelings, patients need to relinquish their defenses
- To dismantle the resistance, it needs to be brought "into the room" where the patient can see and turn against it
- Most other therapies try to circumvent the resistance

Implications for Therapy—III

- To relinquish their defenses, patients must:
  - be aware of using their defenses
  - see that their defenses are hurting them
  - choose not to use them
  - be able and willing to bear the increased anxiety that results from not using them
- ISTDP involves a mix of experiencing and insight
  - Insight cannot be purely intellectual (state-dependent learning)
- ISTDP is not "about rage," or even "about feelings"
  - Dealing with any impediments to an emotionally close, collaborative working relationship of equals (Abbass: "Can you feel your feelings *here with me*?")
  - Resistance works against such a relationship, as well

Therapy Mobilizes Complex Feelings…

- The therapist's attempts to be helpful mobilize complex feelings toward the therapist, (a) because therapy involves emotional closeness
- (b) There are positive feelings, due to the therapist's persistence in working for the patient's good, and daring to question the status quo
- (c) There are negative feelings, due to the therapist's persistence in working for the patient's good, and daring to question the status quo

…Which Mobilize CTF

- The complex feelings toward the therapist mobilize complex transference feelings (CTF), i.e., complex feelings toward early attachment figures
- As a result, the therapist's attempts to help mobilize:
  - anxiety (A), often in the form of signaling (e.g. sighing)
  - defenses (D), which get in the way of therapy i.e. resistance (R)
- Davanloo noted that the process of therapy mobilizes the "twin factors" of "transference [CTF] and resistance"

Unconscious Therapeutic Alliance (UTA)—I

- The counterpart of the destructive resistance is the constructive *unconscious therapeutic alliance* (UTA), a force working to help the therapy succeed
- Davanloo discovered that CTF mobilizes not just resistance, but also the UTA ("triple factors" = CTF + R + UTA)
- When patients enter therapy, the destructive part is "in charge" (R dominates UTA); the purpose of therapy is to help put the constructive part in charge (UTA dominates R; constructive dominates destructive)

Unconscious Therapeutic Alliance (UTA)—II

- The UTA is active in therapy with:
  - associations that "pop into [the patient's] head"—it's not always defensive avoidance!
  - memories
  - images
  - dreams
  - transfers

Interventions and Responses

A fundamental principal of ISTDP is that your next intervention is guided by the patient's response to the last intervention

Most interventions have both a diagnostic and therapeutic function

Content is less important than in many other therapies

Goal of interventions before "unlocking": safely bring about rise in anxiety, resistance, CTF, and UTA ("rise in the transference")

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

Pressure—I

Any intervention which encourages the patient to help themselves by facing something which they are avoiding is a form of pressure. Examples include:

- Pressure to Feeling: “What are you feeling?”
- Pressure to Closeness: focus on emotional openness and presence
- Pressure to Task: maintaining focus on goals
- Pressure to Consciousness: focus on awareness
- Pressure to Will: focus on patient’s choices
- Pressure to Partnership: focus on therapeutic relationship as “eye-to-eye” rather than “one-up/one-down”

Pressure—II

- Pressure is the mainstay of pre-unlocking ISTDP
- Knowing where to put pressure takes experience
- In a “tight system,” pressure is like pumping up a beach ball. Each pressure will generate a *signal*, either a sigh (striated anxiety) or a specific defensive behavior (tactical defense).

Clarification

- Generally used in conjunction with defenses, but also used in terms of anxiety, feeling, will, causality, etc.
- Pointing out defense: “Do you notice that you….?”
- Function of the defense:
  - avoid feeling
  - avoid closeness;
  - enact a pathological relationship with self or other;
  - self-punishment
- Costs of the defense, especially as relates to the presenting problems

Challenge

- An implicit or explicit suggestion that the patient not use a defense
- Occurs on a spectrum from very mild (clarification contains an element of challenge) to “head-on collision,” timed depending on the rise in CTF
- Patients perceive challenge to syntonic defenses as criticism and attack, since syntonic defenses are viewed as part of the self
- Premature challenge can cause “misalliance,” a rise in irritation and anger without a corresponding rise in positive feeling, which at best slows treatment

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

More Video

(yay!)

Learning ISTDP

- ISTDP is amazing therapy
- It is not easy to learn
- You do not need to do "all of it" to find it helpful
- Learning ISTDP is similar to being an ISTDP patient:
  - it is a journey with ups and downs
  - it brings up our own anxiety, defenses, and unconscious feeling
  - it will stretch you and involve significant personal growth
  - having compassion for yourself is crucial
  - ultimately, you need to find your *own* way (both in input and output)
- The ISTDP world seems prone to idealization and devaluation

Personal Note from Nat re: “Short-Term”

- I do not care about short-term therapy
- I care about effective therapy
- If you have an effective therapy, short-term is preferable to long-term
- If you have an ineffective therapy, short-term is preferable to long-term
- If you are trying to make your therapy more effective, short-term is preferable to long-term
- Short-term = as rapid as possible to bring meaningful change
- Focus on efficacy first, and then on efficiency

MCA (Most Common Acronyms)

- CPD: cognitive-perceptual disruption
- CTF: complex transference feelings
- D, A, F: Defense, Anxiety, Feeling (Triangle of Conflict)
- PSE: punitive superego
- R: resistance
- T, C, P: Therapist/Transference, Current, Past (Triangle of Person)
- TCR: transference component of the resistance
- UTA: unconscious therapeutic alliance