Intensive Short-Term Dynamic Psychotherapy (ISTDP)

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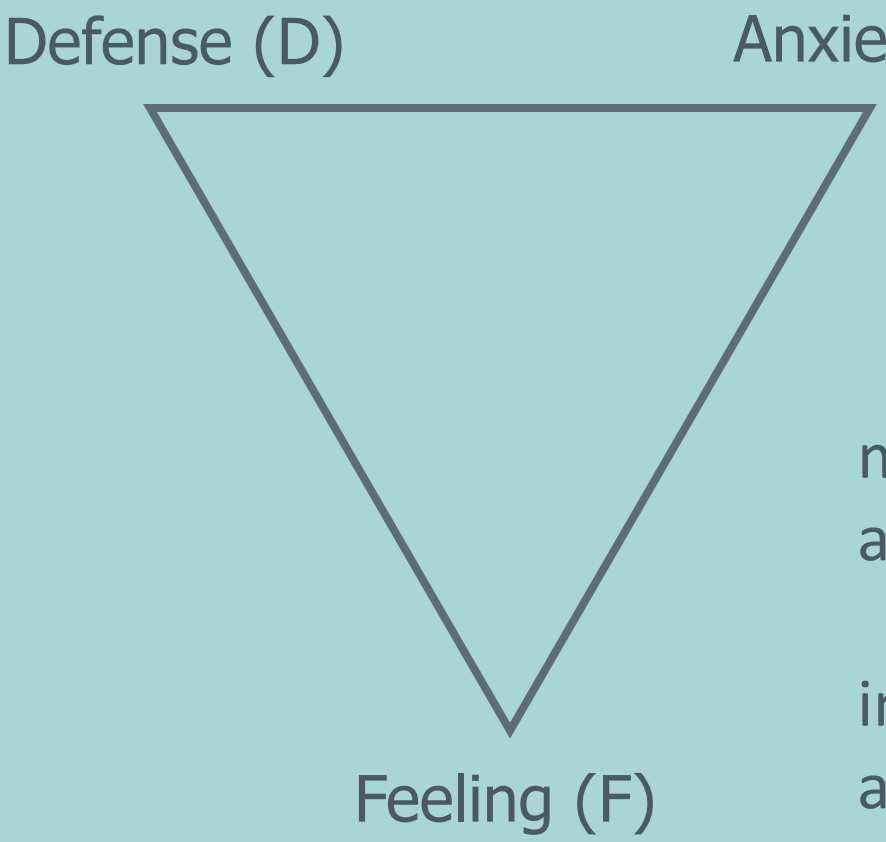
Review

(brief)

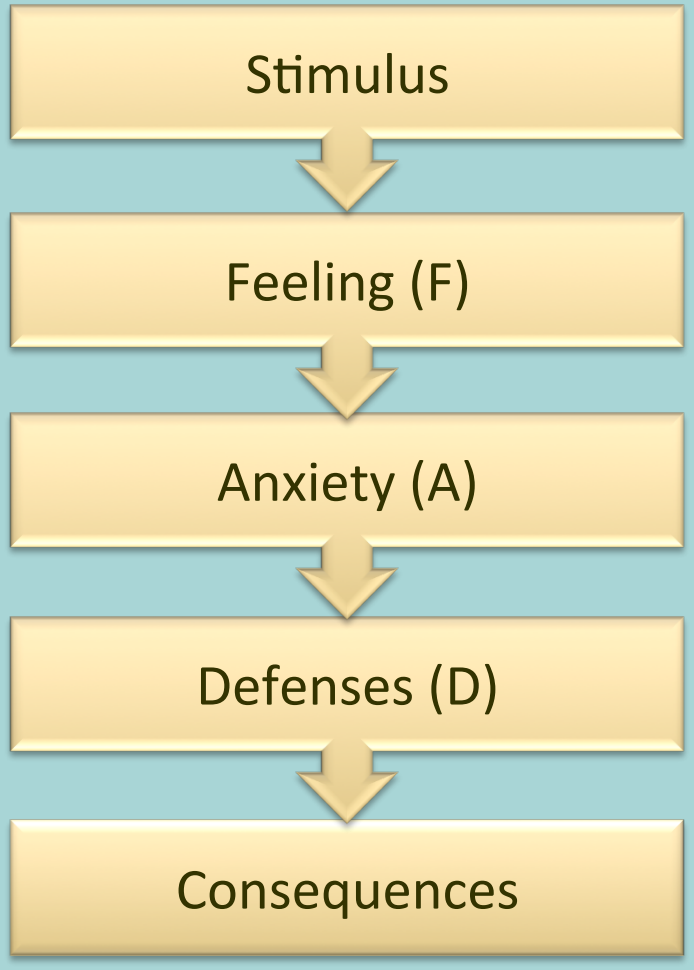
Triangle of Conflict



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")

Initiating Therapy

- What is the [internal] problem you would like us to work on together?
- Can you give me a specific example?

If at any point you find that you are not clear on the internal problem you and the patient are working on, it needs to be addressed

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

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); which mobilize Anxiety (A); which mobilizes
- Defenses (D), also known as resistance (R)
- Together these “twin factors of transference and resistance” mobilize the unconscious therapeutic alliance (UTA), according to Davanloo

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 (identification)	Character/Transference Resistance
Punish/sabotage self	Superego Resistance (SER)/Punitive Superego (PSE)

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

Single Defenses vs Defensive Systems

- Individual defenses often respond well to clarification and, when necessary, challenge
- However, when defenses function together as a "system," patients will simply rotate another defense to the front, often eventually going in circles; in this case the entire system must be clarified
  - Example: many patients will alternate between blaming themselves (self-attack), but will switch to blaming others (externalization) when this is pointed out. At that point it is necessary to clarify the overall "blame system": "It seems like you blame yourself, and then you get sick of being blamed all the time, so you blame other people, but that doesn't really make sense, so you switch back to blaming yourself, over and over. Does that seem accurate?"

“Tactical” vs “Major” Defenses

- “Tactical defenses” are specific *defensive behaviors*—things patients “do” in the session; this is the most zoomed-in, granular view of defenses
- “Major defenses” are defense *mechanisms*, e.g. intellectualization, projection, identification with the aggressor, reaction formation. They are broader, and more difficult to assess moment-to-moment
- Davanloo emphasizes that this is a continuum, e.g. intellectualization may be purely tactical and easily brushed aside, or it may be the mainstay of the patient’s defensive system

Zoom Lens on Defenses

- As mentioned above, tactical defenses are the most "zoomed-in," granular level of defenses
- At the most "zoomed-out" level, the anxiety pathways roughly correspond to predominant major defenses:
  - Striated muscle: "isolation of affect" (obsessional defenses); the adaptive version of isolation of affect is self-observing capacity, "the ability to think *while feeling*."
  - Smooth muscle: "repression" (includes depressive self-attack, somatization)
  - CPD: repression, plus primitive defenses (e.g., projection with loss of reality testing, projective identification, denial)

Categories of Tactical Defenses

- Equivocating: vagueness, indecisiveness, diversion, circumstantiality, trailing off, cover words
- Intellectual: rumination, rationalization, hypothetical ideas, generalization, black-and-white thinking, externalization
- Affective: weepiness, irritability
- Relational: stubbornness, sarcasm, devaluation
- Somatic/behavioral: smiling, laughing, chuckling, talking, slouching

The purpose of this slide is to suggest something of the range of tactical defenses; please allow me to discourage you from obsessively memorizing it.

Dealing with Tactical Defenses

- Recognizing and dealing with tactical defenses needs to be fairly reflexive
- When a tactical defense first appears, typically the best way to deal with it is to ignore it, e.g. by repeating a question
- Focus only on defenses that are actively getting in the way: the “front of the system”

“Front of the System”

The “front of the system” refers to the predominant aspect of the patient’s presentation at any given moment in therapy

- With genuine feeling at the front of the system, the therapist’s job is to facilitate the experience of the feeling, often just by staying out of the way
- With anxiety at the front of the system, the therapist’s job is to acquaint the patient with the anxiety, and help to regulate it
- With defenses, there is typically one defense or group of defenses “at the front”

Defenses Start to Organize

- Patients relinquish some defenses more readily than others; some may evaporate simply by repeating a question
- With continued pressure, defenses become organized, starting to line up in “layers”
- Focusing on defenses that are not in the front of the system is not helpful; clarification and challenge are only useful when defenses are getting in the way
- With appropriate clarification and challenge, the front layer will become “exhausted” and the patient will rotate in the next layer

Defenses Start to Organize

As defenses organize, patients:

- fall back on a habitual, tried-and-true set of “character defenses” that they use in many relationships
- distance themselves not just from feelings (resistance to experiencing feelings, REF) but from the therapist’s attempts to connect with them (REC, resistance to emotional closeness); that is, defenses start to “crystallize in the transference,” with increased avoidance of eye contact, and rumination

Help the Patient Turn Against the Defenses

- When defenses appear repeatedly in a way that directly impedes the progress of the therapy, the therapist needs to start clarifying them so that the patient can "turn against the defenses"
- Clarification is essential: to turn against the defenses, the patient needs to see that they are doing them, and see that the defenses are a problem
- Challenging a defense without sufficient clarification gets in the way of effective therapy
- The more tenaciously a patient continues to return to a defense, the more vigorous the therapist needs to be in dealing with it

Syntonicity

Defenses experienced as universal, inevitable, protective, or part of "who I am," are said to be *syntonic.* With syntonicity:

- The patient is "identified with the defense"
- You must help "separate the patient from the defense"
- Challenging a syntonic defense:
  - is experienced as an attack on the self, rather than as an attempt to be helpful;
  - generates anger without appreciation;
  - leads to fall of rather than rise in CTF; and
  - generally does not lead to signaling
- You *will* see signaling as the patient starts to separate from the defense

Misalliance

Premature or excessive challenge can lead to “misalliance,” a situation in which the patient is angry at the therapist without a corresponding presence of conscious or unconscious positive feeling.

- Misalliance prevents therapeutic progress and frequently leads to dropout
- Abbass: “The patient should never actually be angry at you”
- If the patient is getting angry at you but not signaling, take a step back

Questions for Dealing with Defenses

- "Do you see that you are [doing this]?"
- "Is [it] helping you or hurting you?"
  - Clarifying the costs of the defense is the key conscious step in separating the patient from the defense
- "What are the feelings that come up when you see that you are hurting yourself in this way?"
  - Experiencing sadness over the losses due to the defense is the key unconscious step in separating the patient from the defense
- "Would you like to see what we can do about this together?"
  - "Let's see what we're going to do about…"
  - "What are you going to do about..."