Intensive Short-Term Dynamic Psychotherapy (ISTDP)

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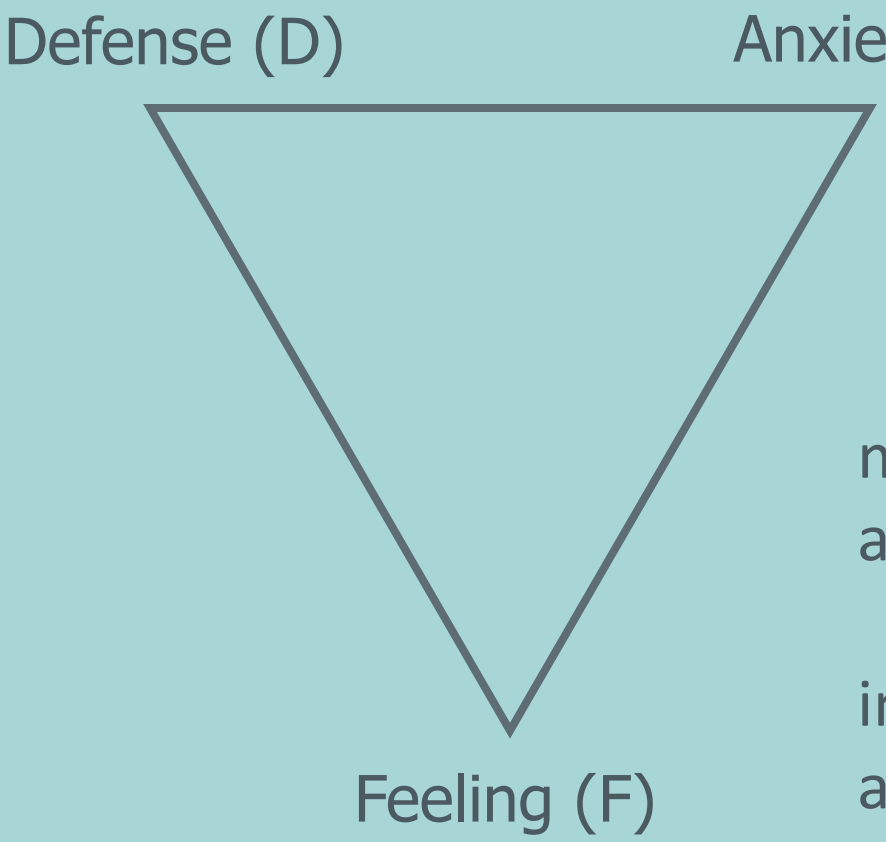
Review

(getting less brief)

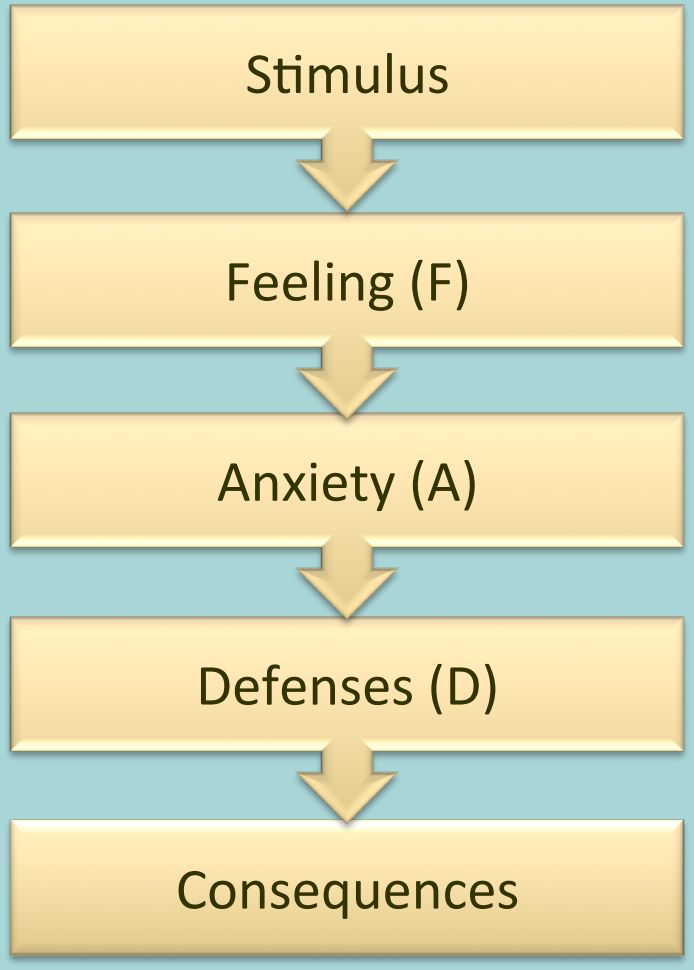
Triangle of Conflict



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")

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, which lead to avoidance (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
- The complex feelings from early childhood are "locked" in deep layers of the unconscious; the therapist needs to help mobilize these feelings and bring them toward the surface where they can be observed and experienced
- Deeply buried feelings can trigger e.g. self-destructiveness with no evident stimulus or anxiety

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 mobilize 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” (e.g. intellectualizing, being vague, changing the subject, looking away) 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)

“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

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; Abbass says, “[Sigh]… that’s the ‘consent’ that I am looking for.”

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..."

“Spectrum of Resistance”

low moderate high

- Davanloo (2000) described a “spectrum of psychoneurotic disorders,” with less resistant patients to the left and more resistant patients to the right
- Five categories: extreme left, mid-left, mid-spectrum, mid-right, extreme right
- “Psychodiagnosis” involves, among other things, understanding where the patient lies on various spectra
- Abbass (2007) described a psychodiagnostic “algorithm,” which I am following here, based on three categories: low-, moderate- and high-resistance

Rise in the Transference

- Low rise: not much anxiety or defense
  - inquiry, pressure; avoid clarification/challenge
- Mid-rise: some signaling of anxiety and tactical defenses
  - resistance "going into the transference," some crystallization, e.g. patient may break eye contact
  - pressure; add clarification and at most mild challenge
- High rise: high tension, heavy crystallization, evidence of "intrapsychic crisis" with patient battling own defenses
  - "an extremely complex state within the patient, one in which he both wishes to cling to his resistance ever more strongly and at the same time begins to turn against it" (Davanloo, 2000)
  - resistance is "in the transference"
  - pressure, challenge, "head-on collision"

Inquiry

- “What is the problem you would like us to work on together?”
- “Can you give me a specific example?”
- Inquiry should generally not include extensive history-taking, which can encourage intellectualization and “history as told by the resistance”
- Abbass takes history at the beginning only if he sees no clear signaling, no clear defenses, and anxiety is not above threshold; he sometimes dispenses with identifying a problem if the patient enters with prominent anxiety

Internal Problem

- In ISTDP, patient and therapist must focus on an *internal problem*
- Complaining and externalizing are defenses and are countertherapeutic
- “Is there something I can help *you* with that would make this situation better?”
- The patient must be there of their own free will

Psychodiagnosis—I

- For patients who enter at low rise, when therapist starts with inquiry and pressure they will signal and start with tactical defenses
- In social situations, tactical defenses are usually sufficient to deter further inquiry
- When the therapist persists with pressure, two things can happen*:
  - breakthrough of unconscious feelings at low rise → patient is low resistance (1% or less); grief and tactical defenses only.
  - resistance starts to go "into the transference" (mid-rise) avoiding feelings but also avoiding closeness with the therapist
  - some tactical defenses are abandoned and other "greatest hits" get fortified

Psychodiagnosis—II

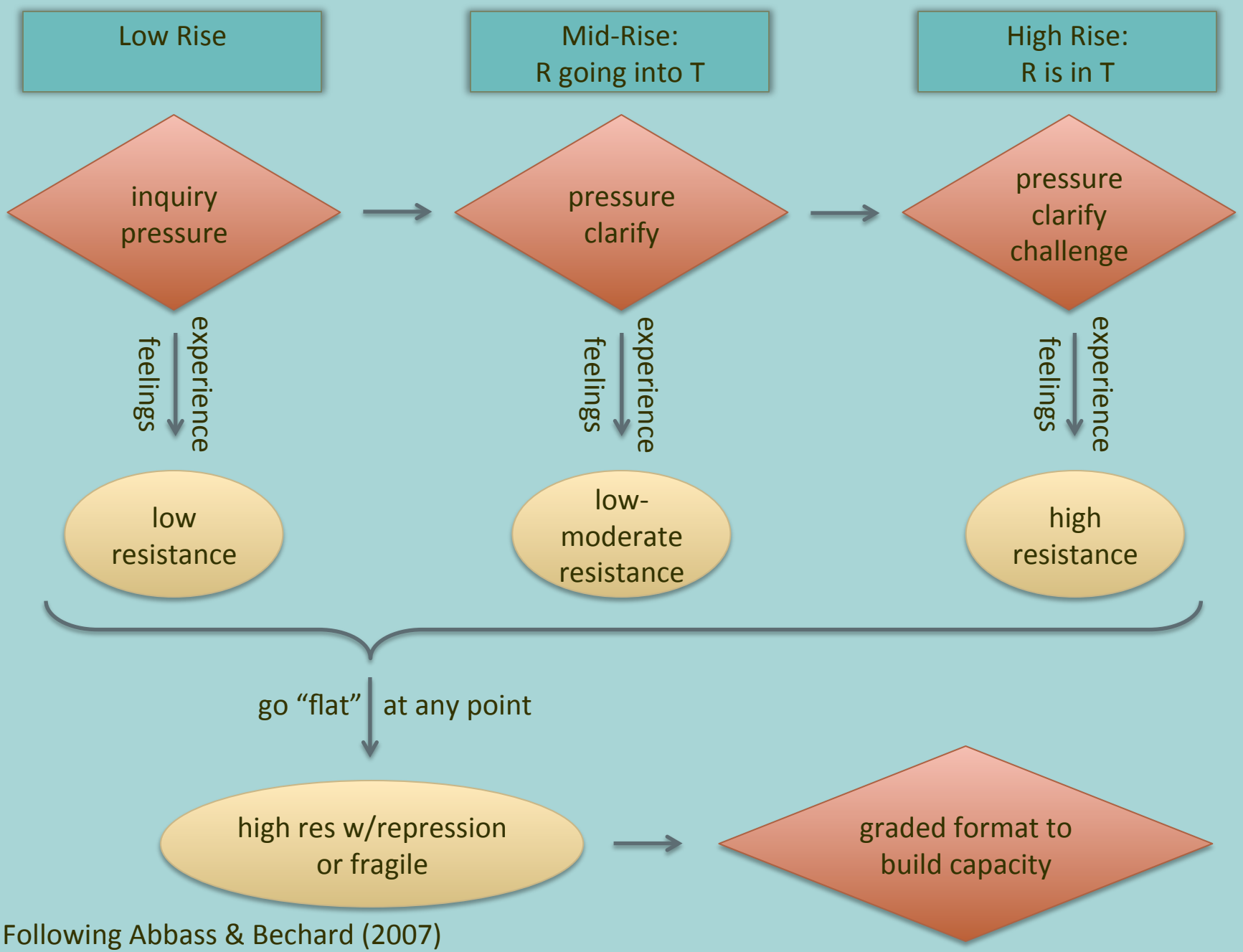
- When the therapist persists with pressure and adds clarification and mild challenge, two things can happen*:
  - breakthrough of unconscious feelings at mid-rise → patient is moderate resistance; or
  - high rise: “resistance [becomes] tangibly crystallized between therapist and patient, i.e., the patient is not merely trying to avoid his painful feelings—which no doubt he does all the time—but is specifically and repeatedly resisting the therapist’s attempts to reach them in the interview situation” (Davanloo, 2000)
  - signs of crystallization: increased avoidance of eye contact, slowed speech, internal rumination

Psychodiagnosis—III

- If feelings break through when the therapist persists with pressure and adds systematic challenge including head-on collision, patient is high resistance
- Focus on the “front of the system,” i.e., the active defense in the moment; when one defense is exhausted, another will rotate to the front

*Psychodiagnosis—IV

- If the patient goes “flat” (cognitive-perceptual disruption or “repression”: smooth muscle anxiety, depression, conversion) at any point, patient is either fragile or has “high resistance with repression,” and needs the graded format to build capacity
- Fragile patients will have a predominance of cognitive-perceptual disruption and primitive defenses such as big-p projection, projective identification, splitting, dissociation



Following Abbass & Bechard (2007)

“Spectrum of Fragility”

low moderate high

- Davanloo: “spectrum of patients with fragile character structure”
- The less anxiety that patients can tolerate before going flat or resorting to primitive defenses, the further to the right they are
- Abbass et al (2013) equate high fragility with borderline personality organization (Kernberg) but not BPD; these patients require a preparatory phase of “structural integration” before the graded format, to bring together “parts”
- Various attempts have been made to combine the spectra, not entirely convincingly in my opinion