Intensive Short-Term Dynamic Psychotherapy (ISTDP)

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Termination

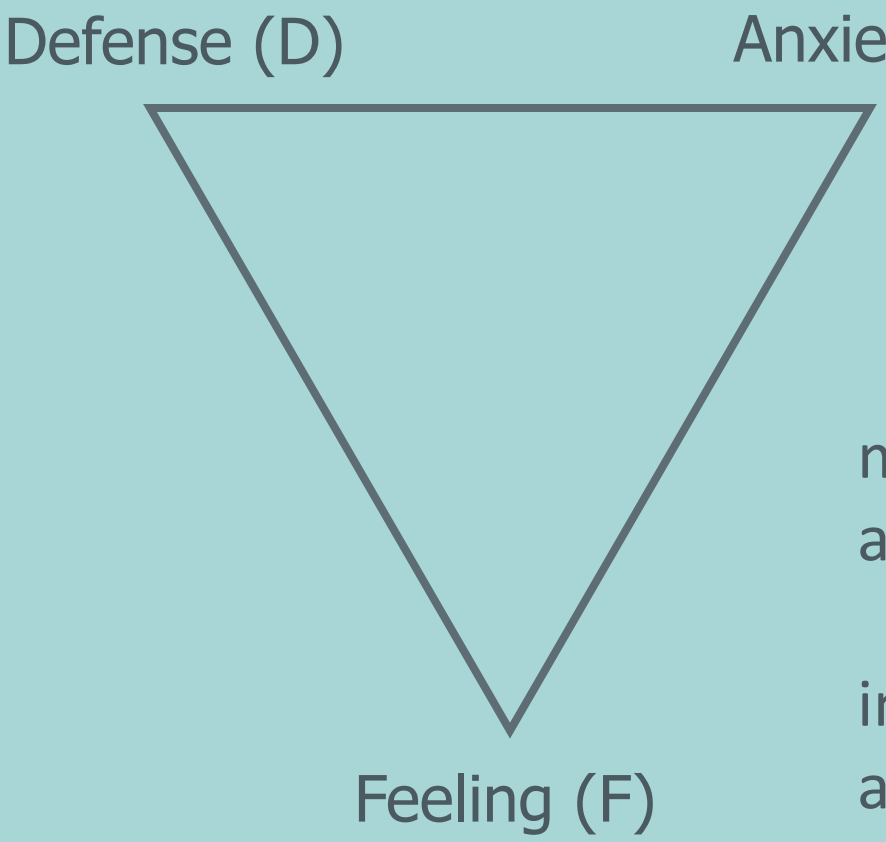
- Patients often turn to termination spontaneously
- Problems do not need to be resolved, but the patient should be able to carry the work forward
- Review presenting problems, and the state of patient's symptoms, social, and occupational functioning compared to arrival
- What helped and how?
- What remains to be done
- Feelings about termination and toward therapist, **including positive feelings**
- Celebration of success, acknowledgment of failures

Video

Review

(getting less brief)

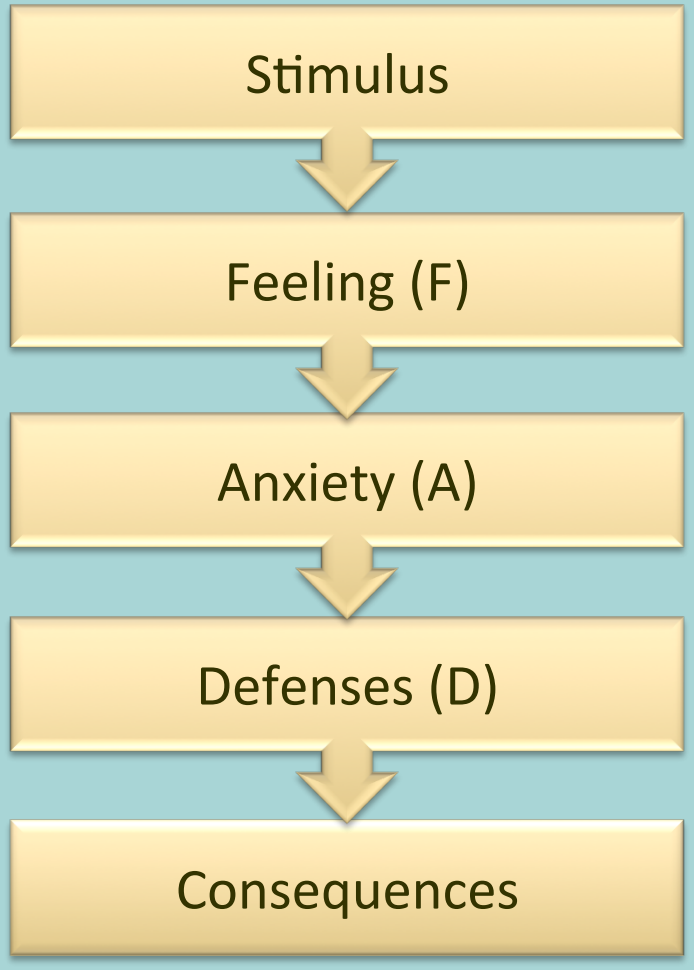
Triangle of Conflict



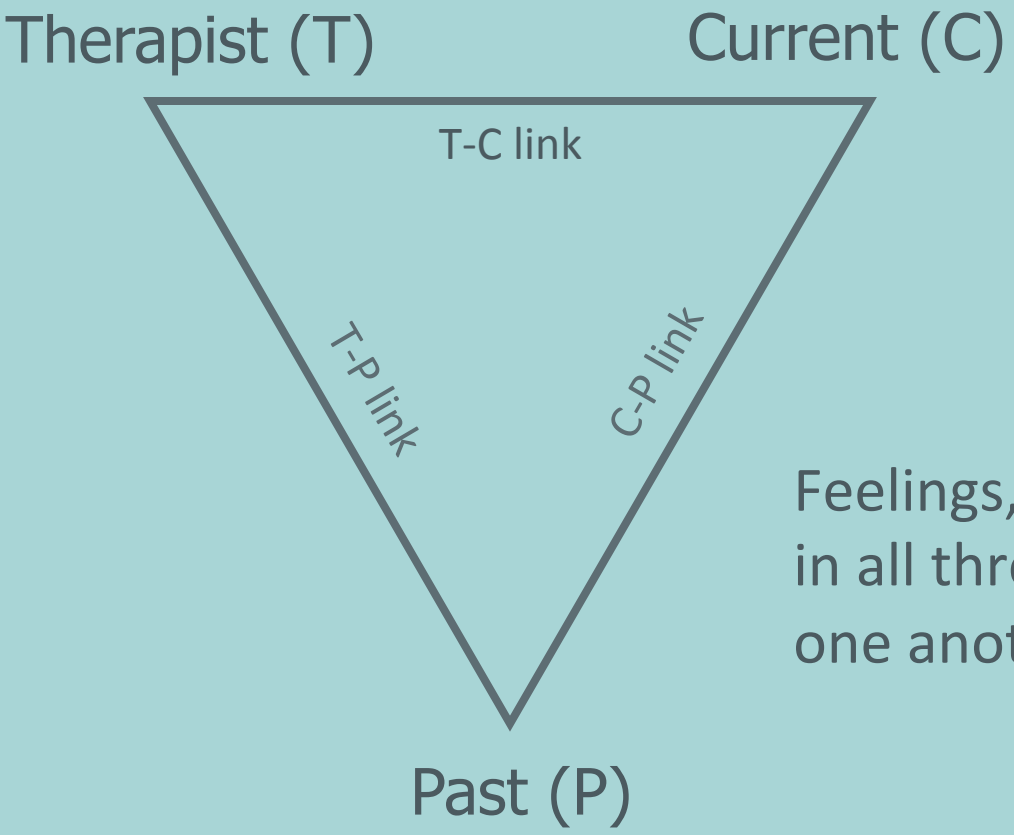
Anxiety over conflicted mental content leads patients to avoid by deploying Defenses

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

“Causality”



Triangle of Person



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

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")

Graded Format

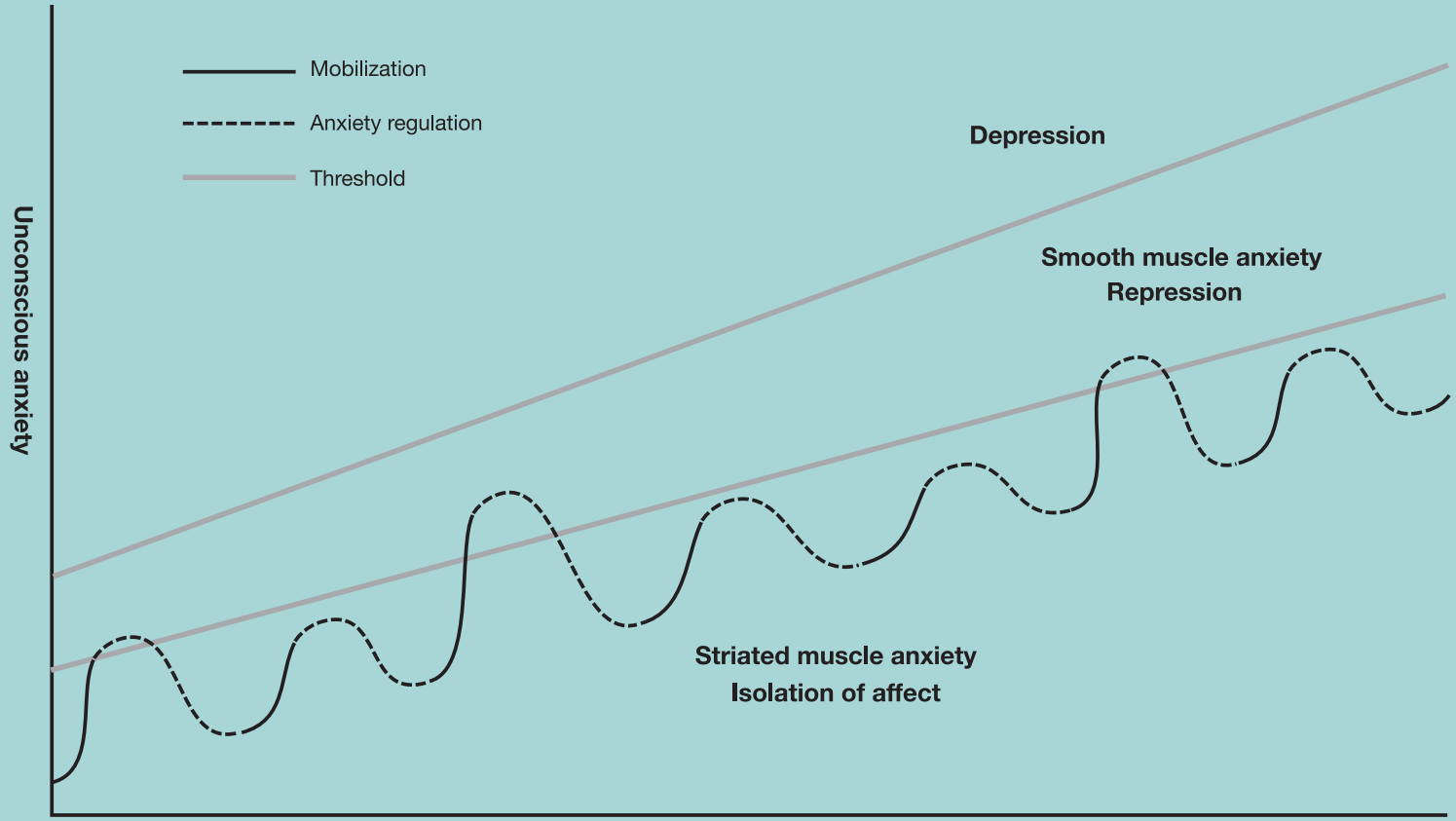
Davanloo developed the “graded format” of ISTDP (or “restructuring technique”) for patients without sufficient capacity for the standard format, i.e. who go over threshold or resort to primitive/dangerous defenses.

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

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

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."

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

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

Effects of Interventions

These interventions "mobilize the unconscious"—both constructive and destructive:

- complex feelings toward the therapist, which mobilize complex feelings toward early attachment figures (CTF)
- anxiety, and therefore defenses (resistance)
- unconscious therapeutic alliance (UTA)

All of these are necessary for effective ISTDP. The therapist's task is to help mobilize these forces in order to precipitate an "intrapsychic crisis" and to then help the patient tip the balance toward the constructive (alliance).

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"

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.

Zoom Lens on Defenses

The “zoomed-in” view is tactical defenses: specific individual defensive behaviors which take place in the session.

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”

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

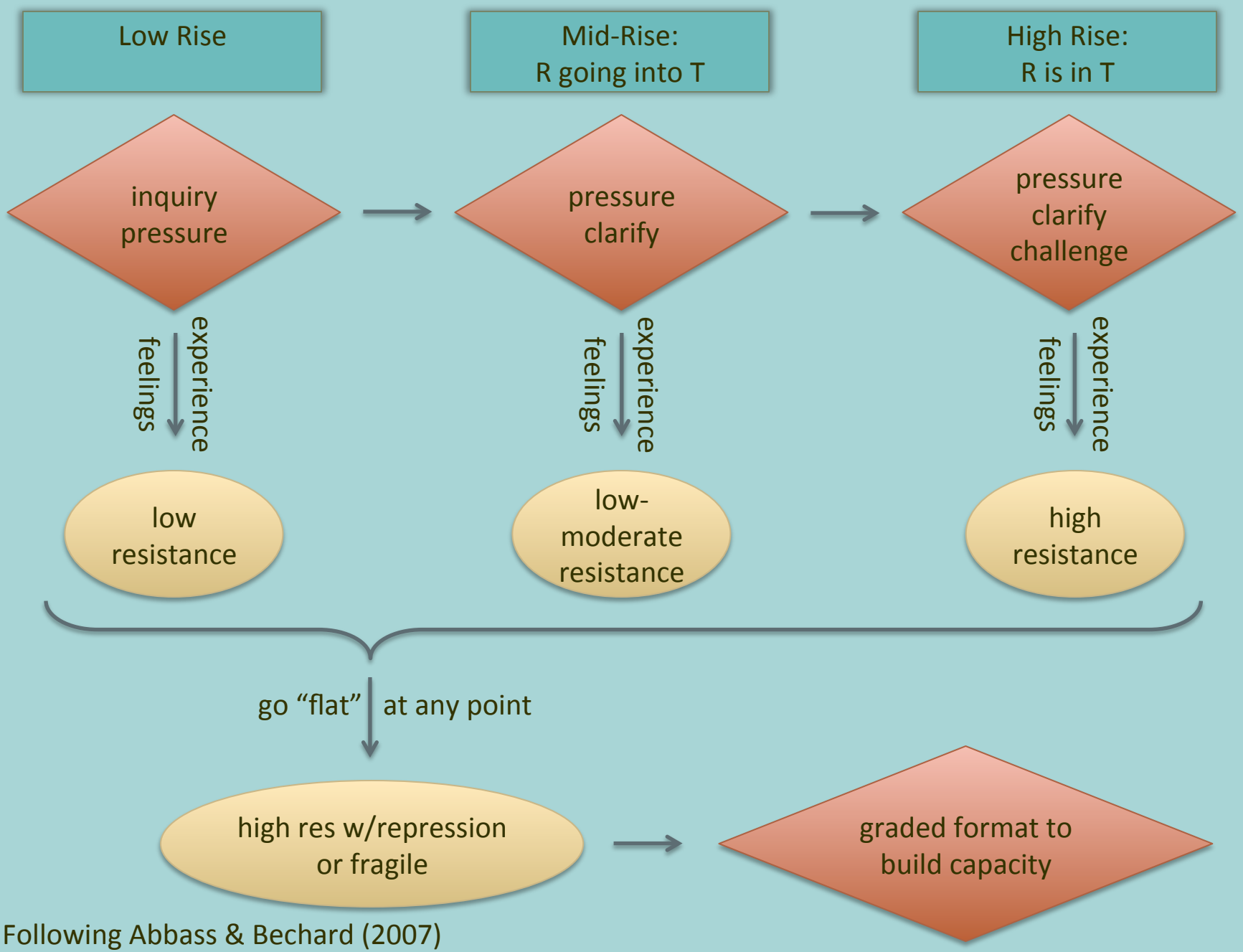
Defenses experienced as universal, inevitable, protective, or part of "who I am," are said to be *syntonic.* With syntonicity:

- 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
- Signaling generally starts as the patient starts to separate from the defense

“Spectrum of Resistance”

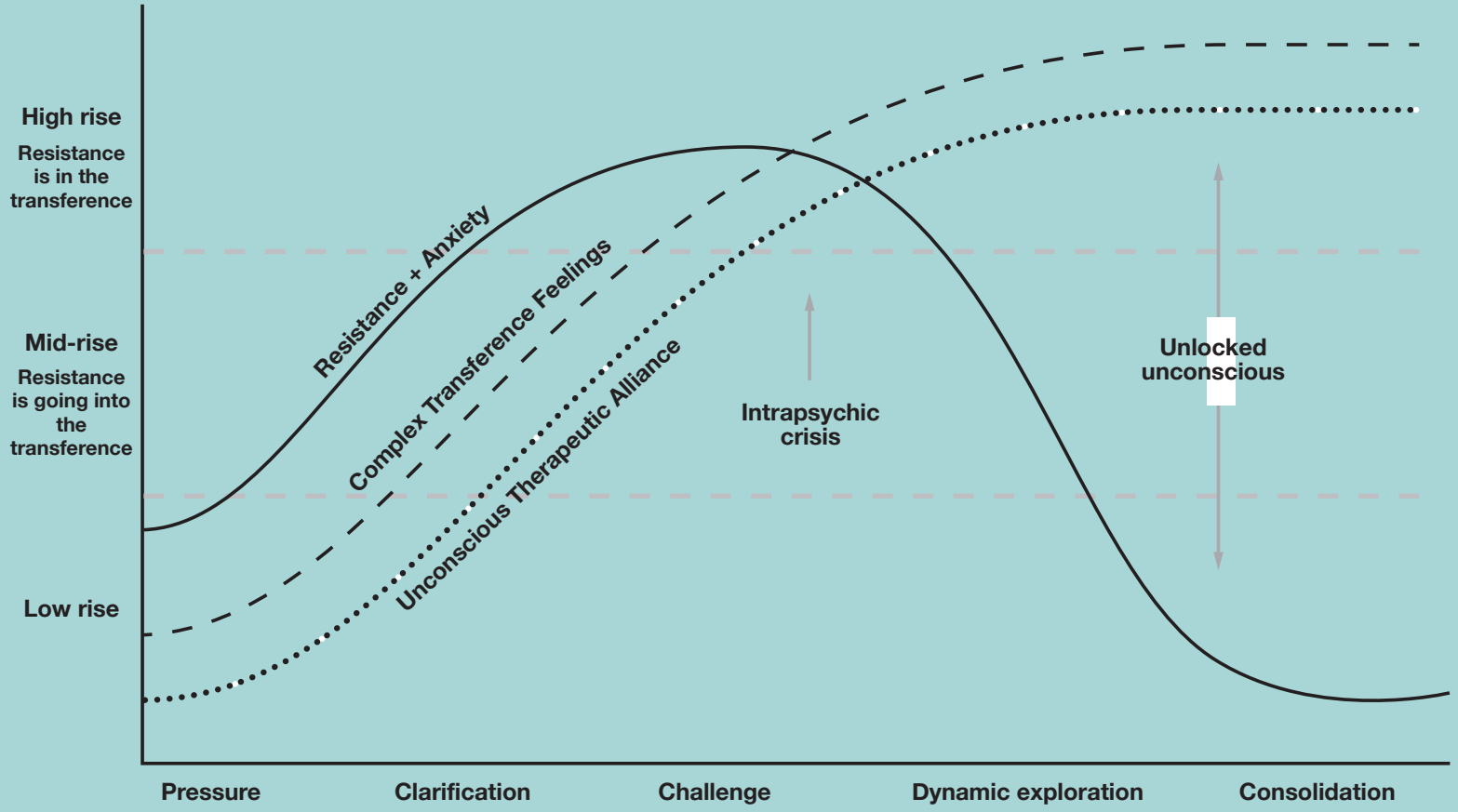
low moderate high

- 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



Following Abbass & Bechard (2007)

Therapeutic Mechanism



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The Unlocked Unconscious

- When the UTA is mobilized and resistance is low, the UTA guides the therapy process to meaningful images, memories, and insights; the therapists job is mainly to sit back, and sometimes underscore
- Experiencing feelings is not the therapeutic mechanism of ISTDP; it is a means to an end: unlocking the unconscious
- When resistance is low, insight leads to lasting change
- Unlockings can be subtle, but a small unlocking is often worth more than a big breakthrough without an unlocking

Five Factors to Monitor

- What is the discharge pathway of unconscious anxiety: striated, smooth muscle, or CPD?
- Are there anxiety thresholds; if so how high are they?
- What is the active major defense pattern: isolation of affect? repression? projection? superego resistance?
- To what extent are defenses syntonic vs dystonic?
- What is the psychodiagnostic category: low, moderate, high resistance? high resistance with repression? fragile?

(Abbass, 2015)

Collaborative Working Relationship

- Therapist:
  - "hired co-investigator," always working on the patient's behalf
- Patient:
  - full participant, needs to have will engaged
- Resistance leads the patient to sabotage this by enacting a dysfunctional relationship
- This relationship goes by the name of "the transference," because it involves aspects of early attachment relationships, e.g. a patient who responded to a punitive parent with a high degree of compliance may perceive the therapist and others as punitive and react with a similar compliance

Transference Resistance

- Frederickson: “an invitation to a sick relationship”
  - omnipotent therapist
  - helpless patient
  - dependent patient
  - passive detached, uninvolved patient
  - defiant patient (and/or its flip side, compliance)
  - highly self-critical patient
- Transference resistance involves projection of and/or identification with various aspects of early attachment figures

Be Counterprojective

- Davanloo: therapist must “step out of the shoes of the parent”
- Therapist can reinforce “expert (omnipotent) position,” whether through lack of understanding or “counter-resistance”
  - I don’t know
  - What do you think?
  - Don’t just go along with this because I’m saying it…
  - You’re the expert on you
  - I have the sense that...
- Defiance should be dealt with prophylactically, by periodically confirming patient’s will (“mini-consents”)
  - Shall we look at this?
  - …if you want to

The Search for the Resistance

- Transference resistance is “the silent killer of therapy,” in that it often does not involve signaling; a patient who is passively waiting for an omnipotent therapist to magically solve their problems will be able to maintain good eye contact without signaling
- If a patient is not above threshold and other causes of lack of signaling are unlikely, ask specifically about transference resistance:
  - I wonder if you are kind of waiting passively for me…
  - Could it be that a part of you is stubbornly clinging to...
- Signaling will provide an accurate answer; the patient’s verbal answer may or may not

(Conscious) Therapeutic Alliance

- The conscious alliance doesn't get as much attention as the UTA in ISTDP
- Given the therapist's higher level of activity in ISTDP, the CTA is at least as important as in other therapies
- Bordin (1979) outlined three aspects of the "therapeutic alliance" or working alliance:
  - Goals: set by the patient
  - Tasks: explore obstacles to goals, and if possible remove them
  - Bond: collaborative working relationship
- Resistance interferes with each of these

Goals

- Must be set by the patient
  - Not spouse, referring doctor, court, school
  - Not therapist
- Must be “internal problem”
- (Non-)example: “I want to feel my feelings”
- “How is that a problem for you?”

Tasks

- Explore and, if possible, remove obstacles to goals
- Patient:
  - Self-observation/mindfulness, especially Feelings, Anxiety, Defenses
  - Face things rather than avoid
  - Take action outside of therapy to improve things
  - “Love, Care, and Precision”
- Therapist:
  - Help patient remove internal obstacles to goals, to the extent possible

Projection

Projection

- Originally referred to attributing disavowed feelings to another
- In ISTDP, often used in a broader (Kleinian) sense of attributing some disavowed part of the self to another
- In particular:
  - Feelings: T is angry at patient ("I'm not angry at you, you're angry at me")
  - Will: T wants to look at something
  - Superego: T is judging patient

Big-P vs Small-p 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. Pts will often look afraid, and talk about "fear" rather than "anxiety."
- "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 with big-P projection 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 mother, triggering anxiety

Working with Projection

- Anger at projections will generally not lead to signaling, because it is a defense, and is not associated with complex feelings
- "I'm angry at you for judging me, for trying to hurt me."
- Fear of projections generally cannot be regulated in the usual ways
- Instead, projections must be "deactivated," which is surprisingly cognitive
  - "What is it that tells you I am angry at you [judging you, etc.]?"
  - Explore the evidence in a curious, nonjudgmental way
- When a big-P projection is deactivated, pt will typically go into CPD

More Video