Intensive Short Term Dynamic Psychotherapy: An Introduction

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What causes suffering? Ever since the Buddha, hundreds of answers have been offered and over four hundred therapies! And each of these answers, whether maladaptive cognitions, maladaptive behaviors, unconscious conflict, dysregulated anxiety, etc. is an important piece of that 'puzzle' we call the human person. But as in the story of the blind men and the elephant, we must not mistake one piece of the puzzle with the entire picture.

That is why today many researchers are developing more complex and integrative models of psychotherapy that recognize the role of multiple dimensions such as development, unconscious conflict, cognitions, behavior, and the body. One such model is ISTDP which synthesizes multiple theoretical perspectives within an integrative theory of the mind, which translates directly into a theory of technique---a technique whose effectiveness has been demonstrated in over sixty research studies.

In life we inevitably experience conflicts with others. When conflicts occur, we experience feelings. These feelings, provided by evolution, tell us what we want and mobilize us to act on our desires. However, most patients seek therapy because they cannot channel their feelings into effective action. Instead, they become anxious and use defenses. These defenses create the presenting problems and symptoms from which our patients suffer.

So far, so good. Seems simple. But ISTDP defines each of these terms---feeling, anxiety, and defense---differently in response to recent research in ethology, biophysiology, and neuroscience. And these understandings result in techniques and approaches that can often lead to a more rapid and effective level of change.

Neuroscientists such as Antonio Damasio have shown us that feeling is only part of a larger non-conscious emotion system that we share with animals. This understanding radically changes the way we think about feelings, why they are unconscious, and why therapists need to work with them. Biophysiologists and neuroscientists have completely changed our understanding of anxiety too. ISTDP integrates those findings which results in a new and complex set of techniques for treating anxiety disorders and the resulting somatic symptoms. ISTDP also integrates findings from neuroscience, biophysiology, and psychoanalysis which change the ways we think about and work with defenses. When we recognize that defenses and character traits are forms of implicit memory not encoded in verbal declarative memory, we must shift from a purely cognitive to an integrative set of techniques to work with defenses experientially in the here and now in therapy.

This integration of theories and techniques gives ISTDP a unique understanding of the multiple unconscious processes operating in therapy. We can no longer think of it terms of only "the" repressed unconscious. Instead, that is only a tiny part of the spectrum of unconscious processes in the brain. Most of our unconscious processing is not and never has been encoded in verbal declarative memory and was never repressed. For instance, anxiety and defenses are usually unconscious but they are not part of the "repressed" unconscious which can be accessed through verbal interpretations. As a result, ISTDP clinicians use a number of non-interpretive techniques to work with unconscious processes that are encoded in motoric, implicit, and procedural memory.

ISTDP also has developed an integrative model of thinking about attention. Ever since Freud recognized the importance of an observing ego (1923), all therapists have understood the centrality of attention to the change process. Now neuroscience (Damasio 1999) shows us that our ability to pay attention to our bodily experience of emotion is the precondition for core consciousness. We must be able to pay attention to bodily experience moment to moment in order to develop self regulation (Schore, Stern). And this capacity for mindfulness---moment to moment attention to feeling, anxiety, and defense---is the central skill ISTDP develops in patients. Only through this kind of mindfulness can the patient see what triggers his anxiety and what defenses create his symptoms and presenting problems. Only through this understanding, can the patient know what to face and what to work on in therapy---moment by moment.

The maladaptive cognitions of cognitive therapy, the maladaptive behaviors of behavior therapy, the defense mechanisms of psychoanalytic theory, and the moving away from the moment (Buddhism) are all seen as defenses in ISTDP. Why? They distract our attention away from our inner life in this moment. ISTDP intersects with Buddhism in their shared finding that defenses cause suffering because they always function as a resistance to facing emotional reality in this moment. And like Buddhism, ISTDP holds that pain is inevitable in life. Every time we love, we will be hurt either by disappointments or through death. Pain is something we must bear; it cannot be removed, simply felt. But suffering, which is caused by our defenses, is something we can overcome in therapy.

The Relationship between Suffering and What We do in Therapy

Patients come to therapy because they suffer from symptoms and presenting problems. To end this suffering, we must find out what causes it. So we ask the patient what problems he is seeking our help for. Then we explore a specific situation where his problem occurs. By exploring, we find out what feeling he avoids due to anxiety and the defenses that cause his suffering. Now we can help the patient see what he must do in therapy: 1) see and turn against defenses that create the presenting problems and symptoms; 2) face rather than avoid what makes him anxious; and 3) feel his previously avoided feelings. If he can face and feel his feelings, he doesn't have to suffer from anxiety and symptoms instead. He can channel his feelings into adaptive action rather than use maladaptive defenses.

"But aren't defenses good for us?" you ask. Some can be adaptive. But patients come to us because they are using maladaptive defenses that cause their suffering. Defenses create the presenting problems and symptoms for which patients seek our help.

But if defenses are harmful, why do we use them? Most patients have been hurt in past relationships. But therapy invites a close relationship. Our invitation triggers feeling, anxiety, and defenses in the patient. In our studies of session videotapes we notice patients can use as many as five defenses per minute! And with three hundred defenses an hour all day long, it should be no surprise that patients suffer from the symptoms and presenting problems created by those defenses.

So, how do we help the patient in ISTDP? Every intervention invites a more secure autonomous relationship with the patient. The next second the patient has a feeling. The second after that, the patient gets anxious in her body. The second after that, the patient uses a defense. Every time the patient uses a defense, her symptom or presenting problem will increase.

But this is cause for hope. If we can interrupt every defense that hurts the patient and help the patient see and turn against her defenses, her symptoms will diminish and disappear. So the therapist must systematically point out each defense, help the patient to see it, help her see the price of the defense, and turn against it so she can face what she has avoided.

But you may ask, "Aren't you interrupting the patient? What about free association?" We never interrupt the patient. We interrupt the defenses that hurt the patient. As long as patients talk freely about their feelings, we listen carefully. But, when patients use defenses to avoid feeling, we interrupt their defenses so they can experience their feelings instead. The ISTDP therapist actively addresses any defense that prevents the patient from having a deeper connection with herself and causes her suffering.

In ISTDP, defense interruption is viewed as an act of compassion toward the patient. Accepting defenses in the session collaborates with destructiveness. One day a patient had not shown up for her session. I wondered if she might be in the hallway. I went out there and sure enough, there she was, sitting on the floor, cutting her wrist with an Exacto knife while watching the blood drip onto a pile of napkins on the floor. I did not just watch her defense---the cutting of her wrist. I took the knife away from her. Every defense of self attack, self dismissal, or self neglect is a cut to the soul. And if these defenses are not blocked the patient may die the death of a thousand cuts.

The Triangle of Conflict as a Guide to Focusing Effectively

How do we help patients see their defenses, turn against them, and face feelings they have always avoided? The man who developed this method, Habib Davanloo, realized something very important; every patient statement is an expression of either feeling, anxiety, or defense. If you know what is going on, you know what to do. If the patient expresses feeling, we encourage feeling. If the patient is too anxious, we help the patient to regulate his anxiety then explore feeling. If the patient uses a defense, we help the patient to see and turn against the defense then explore feeling.

After each patient statement, the therapist asks: is this feeling, anxiety, or defense (the elements that constitute the triangle of conflict)? Once this is determined, the therapist knows how to proceed. If it is feeling, help the patient to maintain the focus on feeling. If it is not, help the patient to see the "detour" to anxiety and defense which has just taken place so that he can return to a focus on feeling.

Feelings

Our brains non-consciously assess the environment all the time. After all, if a mammal does not keep assessing the environment it can become dinner! Once the brain assesses the environment, it non-consciously mobilizes the body. This non-conscious activation of the body is called emotion. Emotions organize animal behavior. The dog that is happy runs up to you and licks your face. The dog that is scared barks at you and attacks. In just the same way, emotions organize human behavior. But we have something animals don't have: an awareness of this bodily activation of emotion. This awareness of our bodily activation is what we call feeling (Damasio 1999).

Animals just feel what they feel. So why do feelings become the engine for conflicts in humans? Emotions are the primary way in which infants communicate with their caretakers for the first two years of life. The survival of infants depends on the security of their caretaker's attachment to them. So if a child's feelings trigger anxiety or anger in these caretakers, the child's brain appraises this as dangerous to its survival. In response, infants and children use defenses to hide their feelings in order to preserve the attachment.

Initially, defenses are an adaptive mechanism for preserving a relationship. But they become habitual mechanisms that automatically kick in whenever feelings arise in any relationship. Defenses that were adaptive in past relationships turn out to be maladaptive in current relationships. They solved a problem in the past, but they create the presenting problems of today. Hence, we must help patients turn against these habitual, automatic defenses that began in infancy and developed throughout childhood so that they can face their feelings instead. In this way they can regain the freedom to feel, to be intimate with others,

and to channel their emotions into healthy adaptive actions. That's why in ISTDP we focus on feelings.

Primary feelings include anger, sadness, fear, joy, and surprise. But to be "in touch" with your feelings, to "feel" them in your body you need three elements:

1) A cognitive label: "I am sad."
2) Awareness of physiological arousal: heaviness in the chest and tears.
3) The motoric impulse: crying.

Let's look at another feeling.

1) A cognitive label: "I am angry."
2) Awareness of physiological arousal: sensation of heat rising from the solar plexus.
3) The motoric impulse: hands clenched and arms are raised.

When patients can experience these three elements, they have full access to their feelings. However, most patients do not have this full access because their defenses interfere. To help patients recognize what they feel, we must help them see the defenses they use to avoid paying attention to and experiencing their feelings.

Anxiety

Having talked about feelings, we now move to the second corner of the triangle of conflict: anxiety. When we talk about anxiety in ISTDP, we do not refer to it as a cognitive thought such as fear of loss. This is not a form of anxiety. It is a stimulus that can trigger anxiety.

In ISTDP we understand anxiety as a bio-physiological pattern of activation in the body. We have inherited through evolution a fear system from mammals. When we become anxious our somatic and autonomic nervous systems become activated. Our somatic nervous system is comprised of your skeletal or striated muscles, the ones we can move voluntarily. So when we get anxious our muscles become tense and prepared for action. At the same time our autonomic nervous system gets activated. Our autonomic nervous system is comprised of two branches: the sympathetic and parasympathetic nervous systems. If our sympathetic branch gets activated our heart races, our breathing rate increases, and our blood pressure goes up. If our parasympathetic branch gets activated our heart rate drops, our breathing rate drops, and blood pressure goes down. So what does this mean for therapy?

Davanloo (2000) discovered three basic unconscious pathways for anxiety discharge in the body. When patients get anxious, their anxiety can be discharged into striated muscles,

smooth muscles, or cognitive perceptual disruption. And each of these pathways of anxiety discharge has important implications for how to do therapy.

Patients who experience their anxiety in the striated muscles become tense in the session and sigh when you ask about emotionally important material. These patients are usually aware of their and anxiety and know what triggers it. These patients can tolerate a high rise of feeling.

On the other hand, some patients suffer from anxiety that is discharged into the smooth muscles. They suffer from migraine headaches, upset stomach, and diarrhea. Or patients may experience anxiety discharged into cognitive perceptual disruption. When they become anxious patients whose anxiety is discharged in this pathway become dizzy, have blurry vision or ringing in the ears, dissociate, or lose track of their thoughts. Patients whose anxiety is discharged into the smooth muscles or cognitive perceptual disruption require anxiety regulation before we explore their feelings.

To assess patients' anxiety we must explore their feelings in therapy. Exploring feeling in the session triggers anxiety in the body so we can observe where in the body the patient's anxiety is discharged. That lets us know what her capacity for affect tolerance is and how we need to tailor the therapy to fit her needs. Patients whose anxiety is discharged into smooth muscles or cognitive perceptual disruption can tolerate less intensity of feeling. As a result, they require more work on anxiety regulation and building their capacity to observe and tolerate the experience of their feelings and anxiety.

By this stage in the history of psychotherapy, we know that different patients have different capacities requiring different forms of treatment. ISTDP has developed several different kinds of treatment for moderate resistant, high resistant, fragile, depressed, and somatizing patients. Each of these groups requires tailored treatments based on the patients' affect tolerance, pattern of unconscious anxiety discharge, type of defenses used, resistances, and self-observing capacity. But to know which treatment format to offer, you first need to be able to make these assessments.

Defenses

Having addressed feelings and anxiety, we now move to the third corner of the triangle of conflict: defenses. Defenses are the strategies patients use to keep the thoughts, feelings, and impulses that trigger anxiety out of awareness. In ISTDP we group defenses into different categories.

Repressive defenses repress feelings so the patient will not be aware of them. They include intellectualization, rationalization, minimization, displacement, and reaction formation.

Regressive defenses involve some regression in the patient's capacity to see reality. These defenses include splitting, projection, somatization, externalization, acting out, and discharge.

Character defenses are based on identifications with punitive figures in the past. So I might dismiss my feelings as I was dismissed by my father, or I might ignore my feelings like my mother did, or I might treat myself as I don't matter like someone treated me. In character defenses, I do to myself what someone did to me in the past.

Tactical defenses repress feeling but, more importantly, they function as tactics to keep the therapist at a distance. They are interpersonal defenses. For instance, if you ask me what I would like help with, I might respond with the tactical defense of vagueness: "I'm not sure it's a specific problem. It may not be a problem at all. Maybe it's just a mid-life crisis. Not a problem at all." My vagueness serves as a tactic to keep you at a distance. It is my way of resisting you, preventing you from having a closer relationship to me. Tactical defenses include sarcasm, changing topics, arguing, avoiding eye contact, crossing one's arms and legs, or laughing off comments.

The type of defense tells you how to intervene, what type of patient you are working with, and how great their capacity for self observation is. ISTDP has developed a number of non-interpretive techniques to help patients observe their defenses, recognize the price and function of the defenses, and to turn against the defenses. ISTDP has also developed specialized techniques to help patients who present with higher level defenses, regressive defenses, resistance, or a transference resistance.

With this brief outline of the basic concepts and goal of treatment, let's take a look at the sequence of interventions we use in ISTDP to help patients become free of their defenses. This is known as the central dynamic sequence.

How do We Help the Patient? The Central Dynamic Sequence

Inquiry

Declaration of an Internal Problem

We begin therapy by asking the patient what her internal problem is for which she wants our help. Then we ask about the patient's difficulties, their origin and their history. Of course, the patient's answers will tell us what her basic conflicts are and her ability to deal with them. We never explore problems of other people the patient mentions. In ISTDP we explore the patient's conflicts between her feelings, anxiety, and defenses as they occur in the

situations where she has problems.

Declaration of Patient's Will

Once the patient has declared an internal emotional problem to work on in therapy we check to make sure the patient wants to be in therapy. A patient may claim he does not want to be there but is required to be in therapy by his boss, his wife, his doctor, or the parole board. But in ISTDP we take the position that we have no right to treat a patient who is merely complying with the will of others. If it is not his will to do therapy, we have no right to ask him to do so.

Declaration of a Specific Example

Once we have surveyed the patient's problems and the patient declares his will to engage in therapy, we ask for a specific example of where her problem occurs. Interestingly, patients often use defenses at this point. Rather than give a specific example, the patient might become vague and say, "I'm not sure there's a specific example really. It's more of an in general kind of problem." In response, the ISTDP therapist addresses the defense of vagueness and maintains the focus on a specific example. The therapist might say, "What you are saying is vague. It's important that you be specific so we can be sure to help you. Could you give us a specific example of where this problem occurs for you?"

Invitation to Feeling

Once the patient has said it is his will to do therapy and has given us a specific example we can begin the next phase in the central dynamic sequence: inviting feeling. We explore the specific example where the patient's problem occurs.

Clarify the Stimulus to Feeling: What Happened?

As we do so we try to figure out what happened in this example that triggered the patient's feelings. Did he suffer a loss? Did someone reject or insult him? Often defenses will emerge when we try to clarify what the stimulus was that triggered the patient's feeling.

Inviting Feeling

Once we clarify what happened we ask the patient what he feels. "What is the feeling over your daughter's death?" "What is the feeling toward your boss for rejecting your proposal?" As we ask about her feelings the patient can respond in one of three ways. She may respond with feeling. She might become anxious instead. Or she might use a defense to avoid her feeling. Most patients do not respond with feeling. Instead, they avoid their feelings by responding with anxiety or defense. In ISTDP we do not follow these detours to anxiety and defense. Instead, we identify each of these detours and then invite the patient to return to the

focus on his feeling. Maintaining this consistent focus in the midst of the patient's detours is one of the most important skills for therapists to learn.

If the patient goes on a detour to anxiety we label her anxiety and then return to the focus on feeling. If the patient goes on a detour to defense we have to help her see the defense and its price, turn against it, and return to focusing on her feeling. If patients continue to detour to anxiety and defense they won't arrive at their destination: a deep feeling connection with themselves, with their desires, with others, reality, and life itself.

Defense Work

As soon as we invite the patient to reveal her feelings defenses arise. Each time she uses a defense we point it out and help her see the price of using the defense, actively addressing any defense that could cause suffering to the patient. And then, each time, we invite her to return to the focus on her feeling.

Th: "What is the feeling toward your husband for saying he wanted to have sex with someone else?"

Pt: "I thought it was rude." [*Defense of intellectualization. She describes his statement rather than her feeling*.]

Th: "It was. But if we don't cover the feeling with this thought, what is the feeling toward him?"

Pt: "I think he is angry with me." [*Projection: the patient speculates about someone else's feeling rather than revealing her own*.]

Th: "We can only speculate about his feeling but we could get absolutely clear about yours. If we don't speculate about him, what is your feeling toward him for saying he wants sex with someone else?"

Pt: "I feel detached." [*Defense*]

Th: "But detached is not your feeling. Detaching is how you deal with your feeling. You detach. If you don't detach, what is your feeling toward him?"

As you can see, the therapist helps the patient each time she uses a defense. Our goal is to help the patient face and experience the feelings she usually avoids. To do that we carefully help the patient see each defense she uses. Then we help her see the price of her defenses: they create her symptoms and presenting problems. Then we help the patient turn against her defenses. If she still has trouble turning against her defenses we confront them.

But some patients who eventually see their defenses do not turn against them. Why? They think their defenses help them.

Pt: "I think detaching helps me deal with my husband."

To help the patient turn against her defenses, we must show her how her defenses create her presenting problems and symptoms. Ideally the patient can make this connection if we ask her a question about the impact of her defenses.

Th: "But if you keep detaching and avoiding your feelings here with me, what impact will that have on our work?"

Pt: "I won't get anywhere."

Breakthrough to Feelings

When the patient relinquishes her defenses, she begins to experience feelings which she has always avoided. These feelings are usually toward family figures with whom the patient had a troubled relationship. Sometimes the feelings are toward people who abused the patient. Either way, the patient faces deep, previously avoided feelings in an emotional breakthrough to feeling.

With the breakthrough to feeling the patient experiences a wave of mixed feelings toward earlier figures in her life. Now she experiences the emotional connections between her past and the problems she suffers today. Through these experiential insights her life begins to make sense in a new feeling way. And we can explore her past emotionally, meaningfully without her defenses being in the way.

Consolidation

Most therapies use interpretation to bring unconscious material to the surface. But interpretation can reinforce the patient's intellectualization and rationalization. So in ISTDP we interpret only after the breakthrough to the unconscious so interpretations, emotionally experienced, will lead to genuine integration.

The relief of experiencing previously avoided feelings and the deeper understanding that they bring motivate the patient to seek a deeper connection to her inner life. Now her task is clear: to help her turn against her defenses, face what she fears, and to experience her feelings as deeply as possible in order to get to the bottom of her difficulties. And in doing this we help the patient channel those feelings into adaptive actions so she can achieve her goals in life.

By helping the patient turn against her defenses we help her have compassion for herself and her longings---which her defenses defeated. At the same time, by helping the patient turn against her defenses we demonstrate our compassion for her and her right to reclaim her life. In a letter to the existentialist psychiatrist Ludwig Binswanger, Freud once wrote that "psychoanalysis is a cure through love." Through our constant attention to the patient's inner life and by blocking the defenses that strangle it, ISTDP also is also a cure through love. Through our constant moment to moment attention to the patient's feelings we actively demonstrate our concern for her right to be free from those inhibiting defenses that have perpetuated her suffering. For, as Frieda Fromm-Reichmann said, "To redeem one person is to redeem the world."