

Self Supervision

Hi, This is Jon Frederickson and welcome to the ISTDP Institute. Today our webinar is focusing on an important topic: how can we supervise our own work. Yes, it's great if you have an ISTDP supervisor but sometimes you don't. Sometimes there is a case you need help on before supervision. And sometimes you are just learning about ISTDP and don't have a supervisor yet. So what's a therapist to do?

Today we'll look at a primary way to do self-supervision and then we'll take a look at some of the most common errors that can interfere with your work.

Ideally, you have a videotape of the session you are concerned about. Of course you have heard that you should watch your videotapes. But what should we watch for? I remember watching my first videotapes and I would be just as confused after watching it as I had been before watching it. Why? I didn't know what to look for. I didn't know how to analyze the videotape. I didn't know how to assess whether my interventions had been helpful or not.

So let's start with a checklist that will help you sort out potential problems in a hurry:

- 1) is there an internal problem the patient has declared. A lot of times, the problem is right there. If you come from an approach where you just listened to what the patient said what comes to mind, this whole idea of getting an internal problem to work on is new. If there is no internal problem declared, then you can look at the tape and start to label the defenses the patient uses to avoid declaring an internal problem.

- 2) Has the patient declared her will to work on the problem? If not, look at the tape and label the defenses the patient uses to avoid declaring her will to look at the problem. If the patient declared his will on the tape, look to see whether
- 3) Has the patient declared a specific example of the problem? If not, look at the tape and label the defenses the patient uses to avoid declaring a specific example.
- 4) If all those elements of the checklist are in place, then we need to go the following series of steps to analyze your tape and figure out where the problems lie.

So here's **step one**. When watching a videotape, I encourage you to do a transcript. Then (here's the important step one), analyze each patient statement. Was it an expression of feeling, an example of excessive anxiety, or was it a defense?

Here's **step two**: now analyze each of your statements. Was your intervention asking for feeling, regulating anxiety, or helping the patient see and let go of a defense? If you are anything like I was when I was learning ISTDP, you will learn what I learned. I learned that a number of my interventions were NOT asking for feeling, regulating anxiety, or helping the patient see and let go of a defense. A number of my interventions were just reflections or intellectualizations. That was a big surprise to me.

Step three: compare the patient's responses and your interventions. When the patient expressed a feeling, did you explore it? If the patient's anxiety was too high, did you regulate it? When the patient used a defense, did you address the

defense? In other words, did your intervention address the patient's response? Often, we find a pattern in our work. We fail to explore a patient's feeling. Or we tend to intellectualize rather than address a defense. When you see your pattern, you can more easily be more focused in the next session. When you address a defense do you remember to ask the patient about the feeling? Always remember to do that one two punch. Reduce resistance and mobilize the unconscious. If you address only defense but don't ask about feelings, the patient will flatten out and the process will become cognitive. So always remember to ask about feelings after the patient sees and lets go of his defense.

Step four: when the patient uses a defense, how long do you wait to address it? Ideally, you address each defense as soon as it occurs. How many defenses do you let go by before you intervene? Could you intervene more quickly next time? The longer the patient uses a defense the longer he is able to repress feeling. As soon as you hear a defense you can intervene. Rather than listen to four more instances of self-attack, intervene as soon as you hear self-attack. Then the patient's symptoms will drop in session and you will have stopped a regression. Just the other day, a patient said on tape, "I think I'm stupid. It's clear I can't pass that test. I was such an idiot to even think I could go to college. And then I am so ugly no girl would want to go out with me." Four defenses in a row. Label each sentence the patient makes. If you are finding several defense sentences in a row, you have found a key area where you can become more effective. Up your speed, and interrupt after the first sentence involving self-attack. Remember: the more defenses that are unaddressed, the more the therapy will be blocked.

Step five: make a list of the patient's defenses. Notice what kind they are (repressive, tactical, character, or regressive). If they are repressive and tactical, identify them and the price so the patient can let go of them to face her feeling. If you keep addressing a repressive defense and nothing happens, consider whether that repressive defense may actually be a character defense. For instance, "It's true he hit me but I think he was silly to do that." Repressive defense: "That is your thought, but if you don't cover the feeling with a thought, what is the feeling toward him." This intervention won't work. Why? Her intellectualization also serves as a character defense. That is, she dismisses herself and her feeling. "Is it silly that he hit you, or is that a way you dismiss yourself and your feelings?" Here we address her character defense of self-dismissal. If a repressive defense also functions as a character defense, address the dimension of character defense instead. If you address repressive defenses and there is no result, check to see if they are functioning as character defenses.

Also, notice what defense comes up the most. That is the pillar defense. Now you know which defense is most important for you to address in the next session.

Step six: let's suppose you have done all these steps and you are still puzzled. Did I do anything worthwhile? I'm sure you did, but it sounds like you may have trouble knowing what you did that worked. Watch the tape again. This time notice every time the patient sighs. The sigh is a sign of unconscious anxiety. Next, rewind the tape to find out what your intervention was that triggered the unconscious anxiety. That was a good intervention. Make a list of the interventions that triggered

anxiety. These interventions now tell you where you should be focusing. If an intervention works, keep using it and keep maintaining that focus.

Step seven: Okay. Let's suppose you didn't see any sighing. That can happen for many different reasons. Do not despair. We just need to do some psychodiagnosis. For instance, the patient may be an:

- 1) *Involuntary referral.* The patient does not want to do therapy or share his feelings, so no feeling rises to trigger anxiety. *Solution:* accept the patient's lack of desire. Point out that you have no right to do therapy with someone who does not want it. Leave the door open for him to return later when he is in a different stage of the change process (Miller and Rollnick 2002; Prochaska and Norcross 2007).
- 2) *Ambivalence.* The patient has one foot in and one foot out. He does not want to be involved, so no feelings or anxiety will rise. *Solution:* Explore his ambivalence. If he does not see how his defenses hurt him, he will not see how therapy could help him. Clarify causality to reach a consensus on what causes his presenting problems.

If he says he is doing therapy to obey someone else, this is a projection. Block this projection and clarify what is an internal problem for him until you reach consensus on the task.

If he projects his will onto you, deactivate that projection until he owns his desire for therapy.

If he understands the task, but does not believe he can do it, help him see the defense of underestimating himself.

- 3) *Organic or brain factors*: The patient may experience genuine confusion about the therapeutic process due to brain injury, below average intelligence, or physical illness and exhaustion. *Solution*: explain the therapeutic task clearly and simply for patients with below average intelligence to get a conscious therapeutic alliance. Do supportive psychotherapy while physically ill patients recover the strength to do an exploratory therapy.
- 4) *Discharge of anxiety into smooth muscles or cognitive/perceptual disruption*. These patients look superficially calm because their anxiety is discharged into smooth muscles and cognitive perceptual disruption instead of tension. *Solution*: regulate anxiety until it returns to the striated muscles.
- 5) *Discharge of anxiety through subtle tensing or hiding the tension consciously*. The patient can get rid of her anxiety by chewing gum, so it does not show up elsewhere in the body. *Solution*: ask the patient to take out the gum. Anxiety will appear in the body instead, becoming more obvious to the patient and more visible to the therapist. A patient who consciously hides anxiety will look stiff. His face will seem like a mask, lacking spontaneous expression. He immobilizes his body to avoid experiencing feelings in it.
- 6) *Characterological defenses hide unconscious transference feelings*: defiance, compliance, externalization, passivity, hopelessness, helplessness, high degrees of intellectualization, syntonic defenses, denial, and projection or projective identification. (See chapter on tactical and repressive defenses.) Rather than experience her anger, the patient can hide it under helplessness. Unaware of her anger, she feels no anxiety. *Solution*: help patients see their

defenses and turn against them. Feelings will rise, triggering anxiety in the body.

- 7) *Repression of feelings*: depression, conversion, or suicidal plans. The defense of turning anger on the self can make the signaling of striated muscles drop. *Solution*: help the patient see and turn against the defense. Feeling and anxiety will rise.
- 8) *Errors in technique*: no unconscious anxiety will rise if the therapist: a) does not focus on feeling consistently enough; b) focuses on defenses or feelings which are not present; or c) challenges the defenses before the patient has differentiated herself from them. In this last instance, the patient will feel attacked. This misalliance will trigger conscious anger, but not unconscious anxiety.
- 9) *Activation of the transference resistance*. For instance, if a patient develops an oppositional transference resistance, and the therapist argues with her, this interactional defense will repress feelings, and the patient will feel no anxiety. If the patient adopts a passive, helpless stance, and the therapist acts out the active role of the “helper”, the patient will feel no anxiety. When the therapist enacts the transference resistance, no unconscious anxiety will rise. *Solution*: deactivate the transference resistance.
- 10) *Over-medication*. Patients on many medications or illegal substances appear emotionally flat. These patients show no tension, fidgeting, or shifting in the chair. If a patient appears emotionally flat, ask if he is taking any psychotropic or pain medications. *Solution*: consult with the psychiatrist to

reduce medications. This sometimes helps patients become aware of their anxiety and feelings.

Let's suppose you are on top of the triangle of conflict. You are clear about it. You are correctly addressing defenses against feeling and nothing is happening! I just saw a case like that the other day. The supervisee presented a patient. The supervisee addressed the patient's defense of intellectualization. Then he addressed the patient's defense of self-attack. Then he addressed how the patient detached from feelings. One after another, he did a beautiful job addressing the patient's defenses against feeling. Yet we saw no unconscious signaling of anxiety. Why? A few minutes into the tape the patient mentioned he was having a reaction to the therapist. It turned out that the patient's problem was not defenses against feeling. His problem was that he was warding off contact with the therapist.

The therapist needed to shift from addressing the patient's defenses against feeling to the patient's transference resistance, the way the patient was relating to the therapist. This is one of the most frequent problems we run into. For instance, after several minutes of defense work, if nothing is happening you can shift your focus in defense work. Here is how you address intellectualization as a defense against feeling: "That is your thought, but your thought is not a feeling. If you don't cover your feeling with a thought, what is the feeling toward your boss?" If the patient keeps using those defenses and remains distant, shift focus to the transference resistance. "That is your thought, but your thought is not a feeling. Do you notice how this wall of thoughts is coming up between us? What is the feeling

toward me that makes you put up this wall of words?" So in this step, ask yourself: is the patient avoiding sharing feelings, or is the patient avoiding contact with me? If the patient is avoiding contact with you, focus on the relationship between the two of you. Point out how the patient is maintaining some distance and start asking about the feelings toward you that lead the patient to use a barrier.

Psychodiagnosis of Anxiety: Common Mistakes

Sometimes we make mistakes when assessing anxiety:

- 1) When a patient exhibits some striated muscle tension, therapists sometimes fail to assess all the anxiety pathways. In fact, some patients will experience anxiety in striated and smooth muscles or in all three pathways. Careful assessment of anxiety will help the therapist not work over the patient's threshold of anxiety tolerance.
- 2) When working with a patient who appears limp and calm, therapists sometimes assume the patient has no anxiety. As a result, they miss symptoms of smooth muscle discharge or cognitive perceptual disruption, which are not visible.
- 3) When working with a patient who appears limp and calm, therapists sometimes assume the patient has smooth muscle discharge or cognitive/perceptual disruption. If the therapist avoids focusing on unconscious feeling or relinquishing defenses, no unconscious anxiety will rise.

- 4) When a patient is able to observe her anxiety, some therapists rush ahead without assessing whether the patient can pay attention to and regulate her anxiety. A patient may observe her anxiety but then ignore it, preventing anxiety regulation. Until the patient turns against the defense of ignoring her feelings and anxiety, inviting feeling will fail. A patient cannot face and experience her feelings if she ignores her anxiety and feelings.
- 5) Some therapists pursue feeling when anxiety goes into the smooth muscles or cognitive/perceptual disruption. This results in stomachaches, headaches, increasing depression, dissociation, and projection. Now the patient suffers from excessive anxiety. *The therapeutic goal is not to face feelings while paralyzed with anxiety, but to experience one's feelings deeply while anxiety goes into the striated muscles.*