Introduction to Experiential Dynamic Therapy

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Hyatt Regency Boston

What do our patients [and the world] need?

- Effective treatment
- Efficient treatment

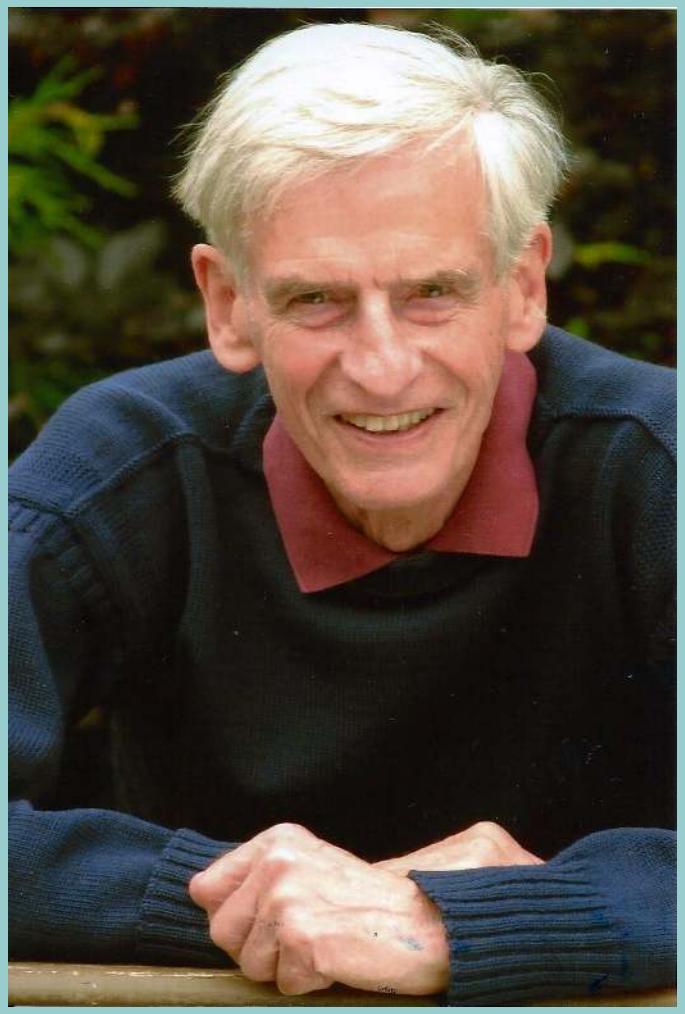
The history of EDT is very much bound up with the history of Short-Term Dynamic Psychotherapy (STDP).

"If you have an effective therapy, then short-term is better than long-term. And if you have an ineffective therapy, then short-term is better than long-term."

Development of STDP
[Short-Term Dynamic Psychotherapy]

- A number of Freud's cases were short-term, but treatments lengthened and Freud became increasingly pessimistic about intractable resistance
- 1920s: Ferenczi and Rank
- 1940s: Alexander & French
- 1960s & on: Balints & P. Ornstein, Davanloo (ISTDP), Luborsky (SEP), Malan, Mann, Sifneos (STAPP), Strupp & Binder (TLDP), Wolberg

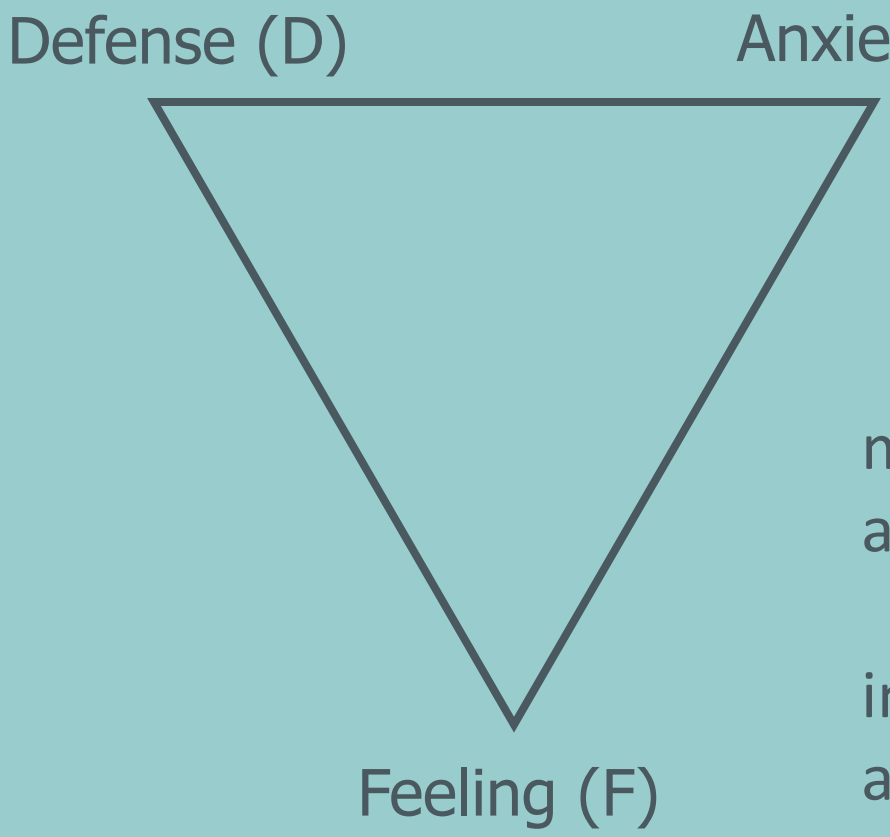
David Malan



Clinician and researcher at the Tavistock Clinic in London

Author of “Individual Psychotherapy and the Science of Psychodynamics” (1979, 1995), a classic of purely interpretive STDP

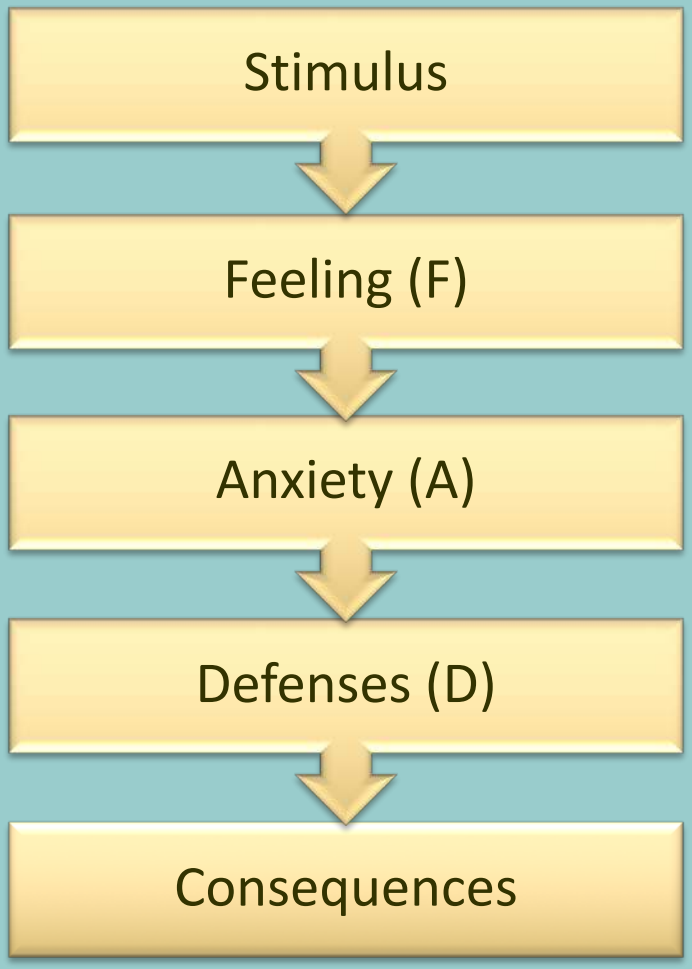
Triangle of Conflict



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

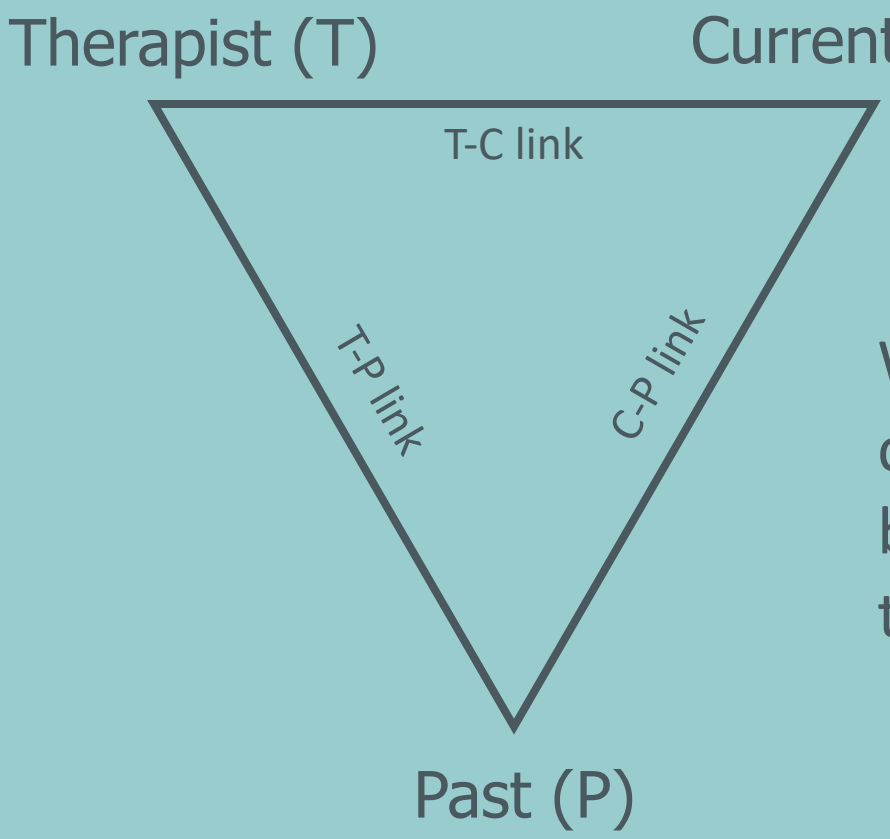
Experiencing the conflicted impulses/feelings can lower anxiety and reduce avoidance

“Causality”



Triangle of Person

[Menninger, “Triangle of Insight”]



We are always alert to connections and parallels between the corners of the triangle of person

What makes psychotherapy long?

[or, “If it’s so simple, why isn’t it simple?”]

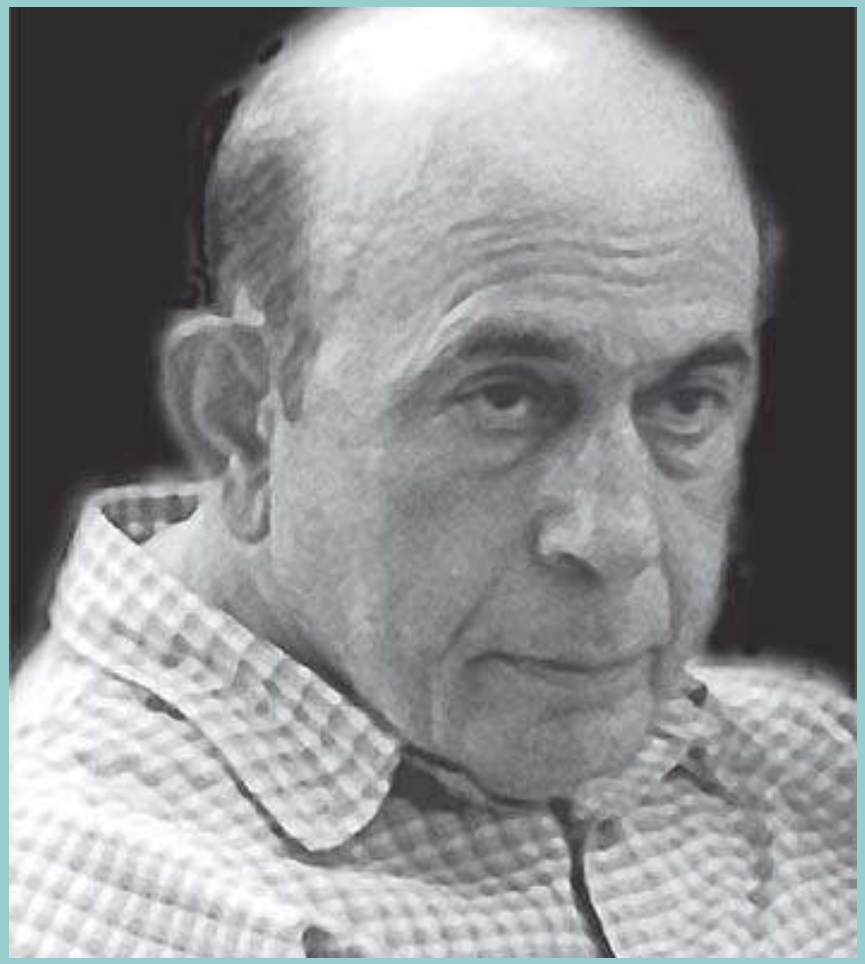
Psychotherapy gets long because of ***resistance***:

“the use of defenses in the therapeutic situation.”

“What happens in therapy is that people come in asking for help, and then the very next thing they do is they try to stop you helping them.”

—Dr. David Pollens, as quoted in “Therapy Wars: the Revenge of Freud,” by Oliver Burkeman, The Guardian 7 Jan 2016

Habib Davanloo



Davanloo had psychoanalytic training, and started with an interpretive approach similar to Malan, et al. He concluded that:

- a purely interpretive approach is “quite inadequate” to deal with significant resistance
- other STDPs bypass major resistance through narrow selection criteria

Davanloo: Active Therapist

"If activity is steadily and relentlessly increased in step with increasing resistance, does there come a point at which resistance breaks down without the patient becoming flooded with more feelings than can be tolerated? The first pilot project clearly demonstrated that the answer to this question is positive, but only if the second complicating factor, transference, is also handled with a similar degree of activity."

Key Interventions

The vigorousness of the intervention is always calibrated to the patient's capacity and degree of mobilization

- Pressure: encouragement to face something avoided
  - "What are you feeling?"
- 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"

Experiential Dynamic Therapy

Many people trained with Davanloo in the 1980s and 90s, learning his Intensive Short-Term Dynamic Psychotherapy (ISTDP), and carrying the work forward:

- ISTDP: Allan Abbass, Kees Cornelissen, Patricia Coughlin, Jon Frederickson, Allen Kalpin, Josette ten-Have de Labije, Robert Neborsky
- Diana Fosha (Accelerated Experiential Dynamic Psychotherapy, AEDP)
- Leigh McCullough (Affect Phobia Therapy, APT)
- Ferruccio Osimo, Michael Alpert, Jeffrey Magnavita, etc.

Many of these people were involved in founding the IEDTA, and in its early days.

Psychodynamic Conflict as Affect Phobia

- Feelings trigger anxiety
- Defenses are phobic avoidance/escape behaviors
- Experiencing the feeling:
  - lowers anxiety acutely
  - breaks the conditioned link between feeling and anxiety
- Experiencing the feeling while blocking defenses can be seen as exposure and response prevention
- For exposure to be effective, it needs to be long enough for the anxiety to go down

Feeling

- Feeling—or “Impulse/Feeling (I/F)”—refers to underlying feeling (frequently unconscious)
- Awareness of feeling includes naming, physiological experience, awareness of impulse
  - Irritation, anger, rage (assertion, violence)
  - Sadness, grief (acknowledge loss, prepare to replace)
  - Guilt (acknowledge wrong, repair, avoid repetition)
  - Emotional pain, distress
  - Positive: love/tenderness, joy, excitement

Unconscious Anxiety

According to Davanloo, 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, light-headedness, tunnel vision, dissociation ("red light")

Approaching a conflict-laden area leads to signaling (sighing), unless the patient is over threshold or defenses have entirely shut down the anxiety

Self-Care Learning EDT

Watching EDT video, some of it quite graphic, mobilizes our own feelings toward early attachment figures.

This can have a therapeutic effect, but it can also push viewers over threshold.

It is key to be compassionate with yourself, and start by regulating your own anxiety.

"I'm going to need some kind of signal from you."

[New Yorker Caption Contest, 9/13/16]

Standard Format vs Graded Format

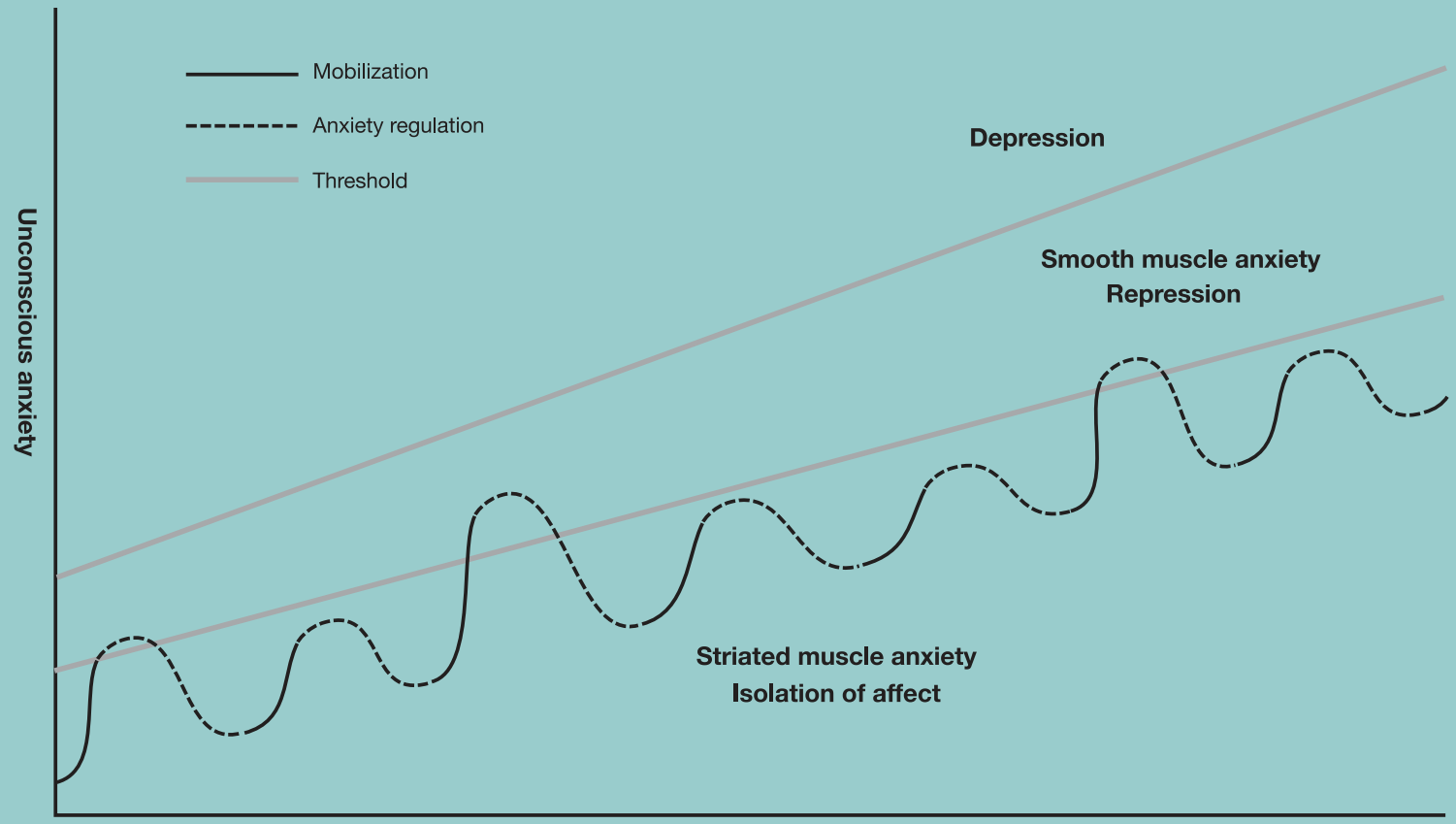
- Davanloo's initial "unrelenting" approach to resistance works well for patients with sufficient *capacity* to tolerate a breakthrough of unconscious feeling, leading to *unlocking* of, and *direct access* to the unconscious.
- This "standard format" of ISTDP involves both a deep experience of affect and insight ("the ability to think *while feeling*").
- Not all patients are able to tolerate this approach.
- For patients without sufficient capacity (e.g. those who go "over threshold"), Davanloo developed the "graded format."

Graded Format

The graded format involves alternating periods of:

- Mobilization (pressure, clarification, challenge), until:
  - –anxiety threshold is reached
  - –destructive defense [e.g., depressive collapse]
  - –primitive defense [e.g. projection]
- Capacity-building:
  - –Self-observing capacity: recapping
  - –Anxiety tolerance:
    - •Recapping
    - •Exploring somatic manifestations of anxiety
    - •Changing station on the triangle of person
  - –Mobilization can resume when patient is thinking clearly (“isolating affect”) and below threshold (sighing)

Schematic: Graded Format



Kuhn (2014), “ISTDP: A Reference,” following Abbass (2007)

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
- Guilt (intense, due to combination of rage and love)
- Self-punishment (Punitive Super-Ego, PSE)

Because of their intense, conflictual, anxiety-provoking nature, these *complex* (i.e., mixed) *feelings* are "locked" in the unconscious under a *repression barrier*.

The Effects of Attachment Trauma

- Unconscious guilt causes patients to treat themselves as if they were in some sense truly guilty of murder (*punitive superego*)
  - They avoid closeness to "protect" others
  - They act in self-punishing, self-sabotaging ways (repetition compulsion)
- Self-sabotaging defenses are active in the therapy itself, helping to explain the tenacity of resistance
- Relationships, especially ones like the therapy relationship which brings up complex feelings, will start to *mobilize* the complex feelings toward early attachment figures (*complex transference feelings*, CTF)

Resolving Attachment Trauma

- Complex feelings toward early attachment figures generate unconscious anxiety which trigger defenses, which result in presenting problems
- Experiencing rather than avoiding these complex feelings lowers anxiety, so defenses are not triggered and problems resolve.

ANY FEELING CAN BE USED AS A DEFENSE

- Differentiating defensive affect from “true” affect is a key EDT skill; therapists need to help patients make this same differentiation
  - True sadness/grief vs helpless/hopeless/regressive weepiness
  - True guilt vs self-attack/shame
  - Explosive discharge of anger, triggered by anxiety

Tactical Defenses & Character Defenses

- *Tactical defenses* are ones that you can witness in the course of a therapy session, e.g., vagueness, intellectualization, sarcasm.
- *Character defenses* are habitual ways of dealing with the world, such as externalization/blame, self-attack, self-neglect, passivity, etc.
- These occur on a continuum: most patients intellectualize on occasion, but for some it is part of their character style, making an impenetrable wall against the therapist.
- Character defenses tend to be *syntonic*, i.e., viewed as a natural part of the self. Challenging syntonic defenses can lead to *misalliance*—negative feelings toward the therapist, rather than complex feelings.

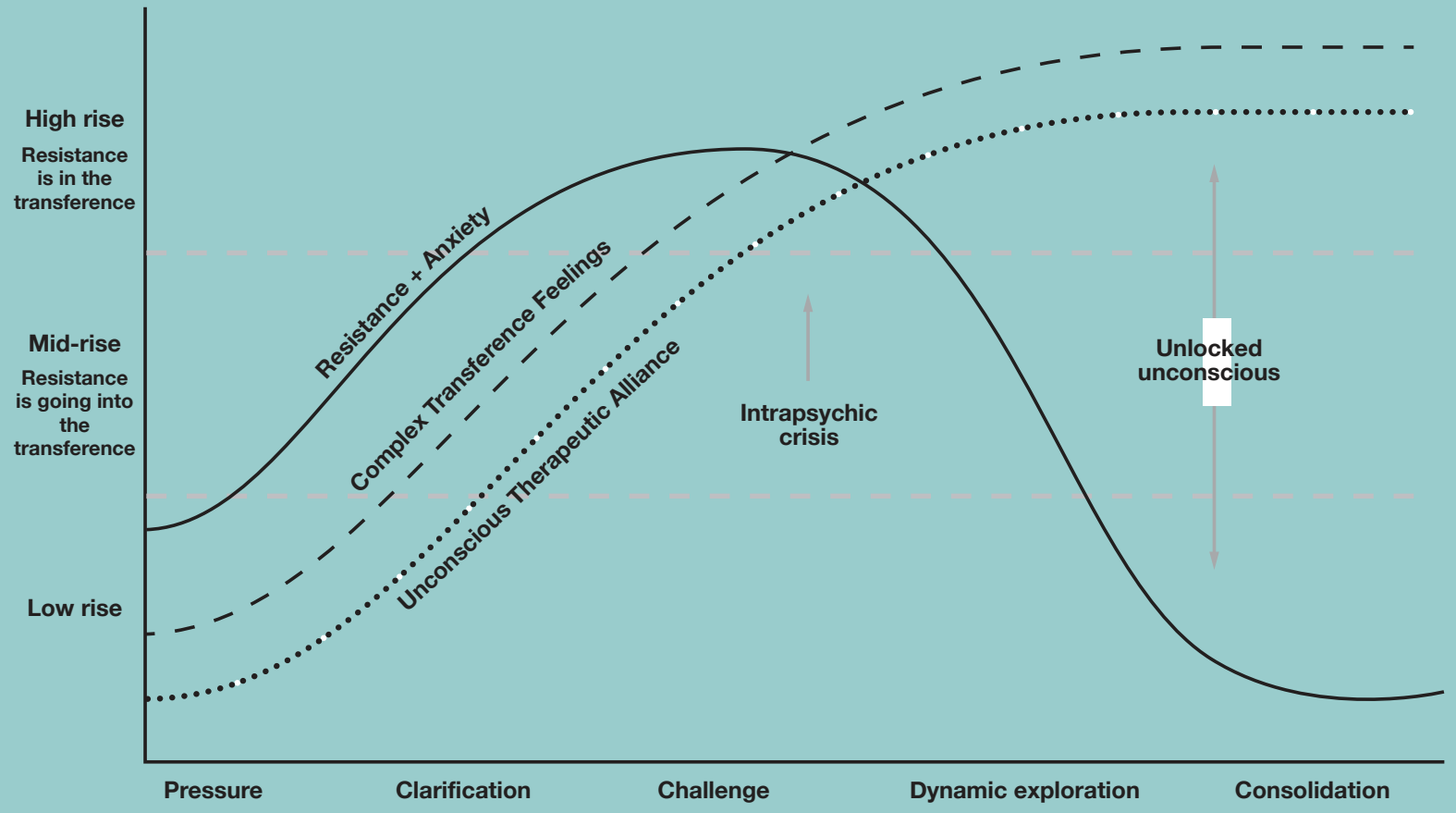
What Happens in Therapy

- Approaching avoided feelings or other material raises anxiety, and triggers defenses
- The therapist's persistence and caring mobilize *complex feelings* toward the T (i.e., mixed positive and negative)
- These resonate with and mobilize feelings toward early attachment figures (complex transference feelings, CTF)
- These raise anxiety more, and trigger more defenses
- "Twin factors of resistance and transference [feelings]"

Unconscious Therapeutic Alliance (UTA)

- A force within the patient that works toward healing and freedom
- Brings avoided material into therapy, often by linking
- Initially the UTA is heavily dominated by the resistance
- The UTA is mobilized in proportion to the complex transference feelings (CTF)
- Our job is to mobilize the UTA and (mostly) get out of the way, so it can do the therapy
- ISTDP strives to “bring the resistance into the room.” We like to see anxiety and defenses, they are signals that we are on the right track: mobilization of CTF, and hence UTA

Therapeutic Mechanism



Kuhn (2014), "ISTDP: A Reference," following Abbass (2007)

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

Head-On Collision

- The “most potent form of challenge,” with the goal of shift the balance to the UTA dominating the resistance. It is **not** a collision between patient and therapist.
- It can involve:
  - the defenses and their functions
  - the costs of the defenses, especially in terms of presenting problems
  - stressing the patient’s will and keeping the responsibility with the patient
  - “deactivating the transference” or “stepping out of the shoes of the parent”
  - “honest statement of reality”: success, failure, and the limitations of the therapist

Portrayal

- ISTDP, APT, and some other EDTs use “portrayal of the impulse”—imaginal exposure—to deepen affective experiencing
- You will doubtless see many portrayals of murderous rage at this conference
- The conclusion that “ISTDP is about rage” is hard to avoid, but also incorrect
- ISTDP is about *complex feelings,* but if we had to single out one, it would be guilt

Transference Resistance

- An “invitation to a sick relationship” (“transference”) which the therapist must turn down, e.g.:
  - omnipotent therapist, helpless/dependent patient
  - active therapist, passive/detached/uninvolved patient
  - prescriptive therapist, defiant/compliant patient
- A healthy therapeutic relationship is:
  - collaborative
  - eye-to-eye, equal, rather than one-up-one-down
  - patient working from the inside, therapist from the outside
  - therapist as “hired co-investigator”

Response to Intervention

In ISTDP, your next intervention is always guided by the patient's response to your last intervention

- Feeling: encourage (often by doing nothing)
- Anxiety: regulate, if over threshold
- Defense (or anxiety under threshold): continue with pressure, and clarification/challenge as indicated
- Communication from unconscious: note, and perhaps explore

Central Dynamic Sequence (CDS)

While stressing that sessions do not develop in such a linear way, Davanloo delineated phases of the trial therapy and other sessions:

- Inquiry
- Pressure
- Challenge
- Transference resistance
- Unlocking
- Systematic analysis of the transference
- Dynamic exploration of the unconscious
- Consolidation

Rise in the Transference

The addition of clarification and challenge to pressure is guided by the mobilization of CTF or "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, start to ruminate, etc.
  - 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"

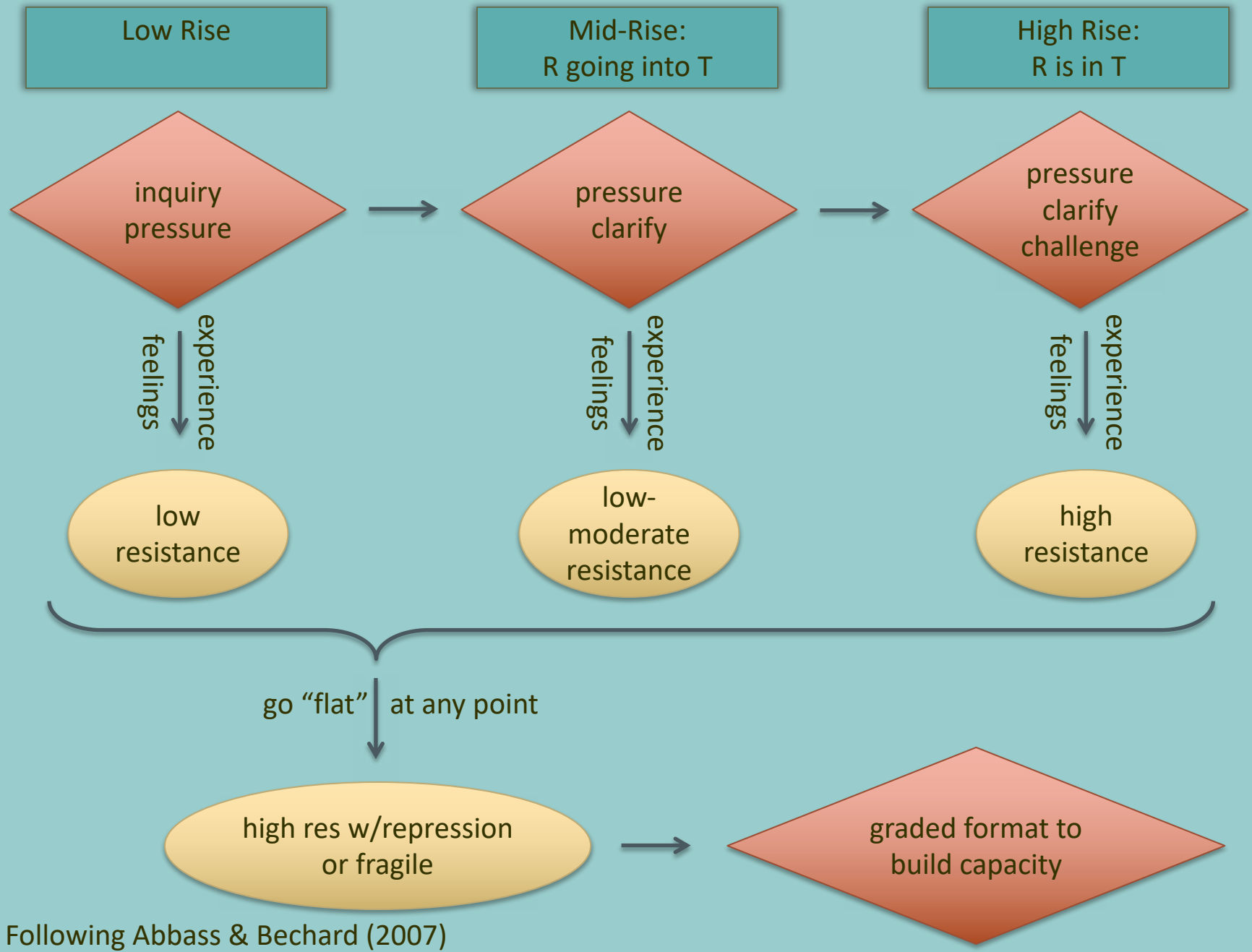
Phases of Treatment

- Trial therapy (usually 2-3 hours)
- Repeated unlockings
- Working through (more focus on grief, with pockets of rage and guilt)
- Termination

Spectrum of Psychoneurotic Disorders

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,” based on three categories: low-, moderate- and high-resistance



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”

Dealing with Syntonicity

Syntonic defenses need to be made dystonic before chal-lenging them a systematic way: “separating the patient from the defense” or “turning the patient against the defenses”

- “Do you see that you are [doing this]?”
- “Is it helping you or hurting you?” (cost of the defenses)
- “Do you want to continue doing it, or to stop?”
- “What are the feelings that come up when you see that [this] has hurt you?”

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)
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, often with multiple functions.

Defensive systems must be clarified and challenged as such. For example: alternating between blaming self and blaming others.

Defenses and Anxiety Pathways

The pathways of unconscious anxiety are roughly associated with categories of defenses

Anxiety Pathway	Defenses
Striated muscle	Intellectualization, “Isolation of Affect”
Smooth muscle	Repression: depressive collapse, some somatization/ conversion
Cognitive-Perceptual Disruption (CPD)	Repression *and* primitive defenses such as projection with loss of reality testing

How to Start Therapy

- What is the problem you would like us to work on together?
- Can you give me a specific example?
- Need to identify an *internal problem* that the patient
  - wants to work on
  - with you
  - now

Projection: Big-P vs Small-p

- “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.
- “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 who project is for advanced practitioners.

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: “I’m not angry at you [T], you’re angry at me.”
  - Will: “I know you want me to…”
  - Superego: “You are judging [criticizing, etc.] me.”

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