

Key Clinical Processes in Intensive Short-Term Dynamic Psychotherapy

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Davanloo's Intensive Short-term Dynamic Psychotherapy (ISTDP), while derived from traditional psychoanalytic theory, is a modified brief treatment with growing empirical support for its effectiveness with clients with psychoneurotic disorders and character pathology. This model describes key empirically derived processes that can bring ready access to unprocessed unconscious emotions that otherwise perpetuate widespread symptom and behavioral disorders. Herein we describe the metapsychological underpinnings, clinical application, and evidence for central interventions used in ISTDP through the use of a case example.

Keywords: short-term, psychodynamic, psychotherapy, emotion

Habib Davanloo developed an accelerated method of psychodynamic treatment called Intensive Short-term Dynamic Psychotherapy (ISTDP) during the past 40 years. The method has growing empirical support for a broad range of psychoneurotic and borderline disordered clients (Abbass, Town, & Driessen, 2012). In the 1970s, Davanloo began video-recording treatment sessions to discern key events that took place in cases where clients experienced global and persistent gains in follow-up. He then looked retrospectively at treatment videotapes and applied the same interventions prospectively across other case series and followed them up to test the durability of changes. Through this research, he noted a sequence of events that related to efficient and persistently effective work with resistant clients and called it the *central dynamic sequence of unlocking the unconscious*.¹ This series of events appear to enable *direct access to the unconscious* unresolved attachment-trauma-related emotions by helping the forces of the *unconscious therapeutic alliance* to dominate those of unconscious resistance (Davanloo, 2005). We will describe these key procedures and phenomena with vignettes from a first contact with a moderately resistant client.

Phase 1 and 2: Inquiry, Pressure, and Psychodiagnosis

Psychodiagnostic evaluation of the client is central to initiating and planning in ISTDP. This refers to assessing the formats of unconscious anxiety, the specific nature of the major resistances, and the degree of resistance (Abbass, Lovas, & Purdy, 2008; Davanloo, 2000).

Davanloo noted three main discharge pathways of unconscious anxiety and the process of motor conversion. The first, striated

(voluntary) muscle unconscious anxiety, is observable as hand clenching and sighing respirations: accompanying this pathway he noted clients primarily used what he called isolation of affect with intellectual awareness devoid of emotional experience. The second level is smooth (involuntary) muscle unconscious anxiety affecting the muscles of the gastrointestinal tract, blood vessels, and airways, resulting in problems such as migraines, irritable bowel syndrome, and hypertension: accompanying this pathway he noted instant repression of emotions and major depression where emotions were channeled directly into the body before reaching consciousness. The third level is cognitive perceptual disruption where the person experiences visual blurring, mental confusion, and hallucinations: these clients tend to use projection and projective identification as primary major defenses. Clients with motor conversion, with focal or global muscle weakness, also experience repression of emotions (Abbass et al., 2008; Davanloo, 2005).

To determine the pathways of unconscious anxiety and defense, *pressure*, or efforts encouraging the client to identify and experience underlying emotions and be present with the therapist, is applied. This *pressure* to emotionally engage mobilizes complex feelings related to past attachments, and this in turn mobilizes anxiety and defense in the office. From this psychodiagnostic data, the therapist can make his or her decision what way to proceed (see Figure 1). If the client has striated muscle tension and isolation of affect, a direct mobilization of the unconscious is warranted. If the client goes flat with repression, cognitive disruption or projective defenses, then a process to build capacity to tolerate unconscious anxiety is warranted before attempting to access the unconscious (Davanloo, 1990).

Vignette 1

This 54-year-old unemployed man with depression, choking panic attacks, and obsessive-compulsive personality disorder arrives to the first session with hand clenching and deep sighing

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¹ Theoretical concepts specific to Davanloo's (2005) ISTDP are italicized from here on to distinguish them from any colloquial meaning.

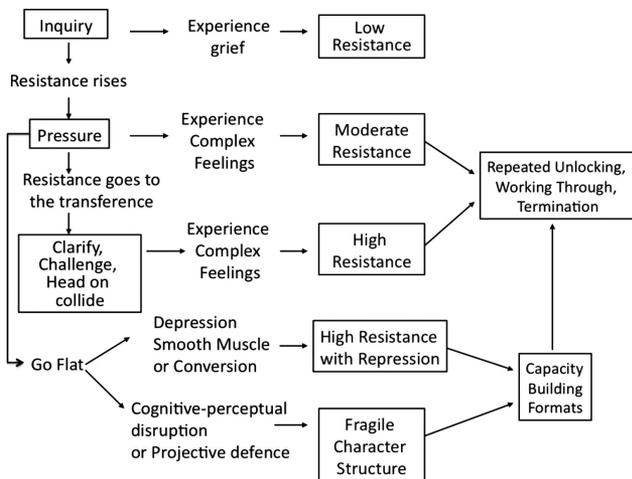


Figure 1. Psychodiagnosis and treatment planning.

respirations.² We start at the beginning of the trial therapy (first interview).

T: Can you tell me what difficulties you are experiencing?

C: (hands are clenching, he takes a sigh and speaks in a highly ruminative and detached fashion) I come from a dysfunctional family . . . my father was alcoholic . . . my family immigrated.

T: What difficulty are you coming in for now?

C: Right now I'm suffering from depression and anxiety.

T: Right now I notice you are anxious. Do you notice you are anxious now? (Beginning a dialogue with the unconscious).

C: Yes, I'm tense. (Smiles, hands clench, and he sighs).

T: Can we look into what feelings are driving this anxiety here with me? (Pressure).

C: (Deep sigh, smile, and hands clench).

Commentary: This client responded strictly with striated muscle anxiety (tension in intercostal muscles: sighing respiration), intellectualized (isolation of affect) and tactical defenses (cover smile) suggesting a direct move to mobilize the unconscious is warranted (see Figure 1).

Empirical Support for Phase of Pressure and Psychodiagnosis

The concept of an accurate psychodiagnostic evaluation in ISTDP theory is analogous to the core principle of focal adherence in brief dynamic therapies. Using standardized methods for formulating the nature of a client's core dynamic conflict, significant associations have been shown in multiple studies between the correspondence of therapist interventions to a focal dynamic issue and both treatment outcome and process (e.g., Barber, Crits-Christoph, & Luborsky, 1996). Process studies on the use of interpretations in brief dynamic therapy and their accuracy show a relationship to positive outcome (e.g., Crits-Christoph, Cooper, & Luborsky, 1988). The ISTDP concept of establishing an accurate psychodiagnostic at the earliest opportunity finds some support from Messer, Tishby, and Spillman's (1992) finding that focal adherence is most important in the early and midtreatment phases. This replicated process-outcome finding therefore emphasizes

both the need for an accurate assessment of focality alongside an awareness of client capacity to tolerate unconscious anxiety.

Phases 3 and 4: Clarification and Challenge

In addition to psychodiagnosis, the goal of pressure is to mobilize *complex transference feelings* and secondary resistance against these feelings so the person can see and overcome the resistance. These *complex transference feelings* include appreciation for the therapist's efforts and irritation toward the therapist due to implicit and explicit disregard for habitual defenses: these complex feelings hearken back to attachments and the complex feelings related to attachment trauma. Signs that the resistance is crystallizing in the therapy relationship are nonverbal detachment such as breaks in eye contact, slowing down, and closing of posture. It is at this time that clarification of the negative impact of the resistance is both fruitful and necessary. Thereafter, the resistance can be collaboratively challenged.

Vignette Continues (Minute 3)

T: Do you notice now that you are going away from me and slowing down? (Clarification).

C: (sighs, hands still clenching, hesitating between words and going slowly) Yes . . . I hope uh, to, uh, impress you in some way, uh . . .

T: So can we try to see what feelings drive this anxiety and detachment here? (Pressure).

C: Yes but I don't know how to answer it (sigh). I'm daring to hope . . . I feel shaky.

T: Besides anxious, what feelings are stirring up here with me? (Pressure).

C: I'm quite tense . . . I think you are someone who . . .

T: How are you feeling here with me? What is at the root of this? (Interruption of rumination, pressure).

C: I think that you are a person who may have the . . .

T: So that is a thought. (Clarification).

C: Yes it is . . .

T: But what are the feelings . . . (Pressure)

C: I have a sinking feeling and a mass in my guts (anxiety and suppression of emotions).

T: But what about the feelings you are shutting down. (Pressure).

C: I'm feeling hopeful. I'm daring to hope this will work but afraid you will turn me away. (Anticipation seen with rise in complex transference feelings).

T: So what do you feel? (Pressure).

C: I've never come to grips with what we call feelings and I tend to suppress them and go to my head! (Showing more insight suggesting the unconscious therapeutic alliance is activating).

T: So how much has this been damaging you? (Clarification). Why do you do this to yourself? (Rhetorical question to the unconscious).

C: It cripples me totally.

T: So if you don't detach or think (challenge) lets see how you feel here beneath this anxiety. (Pressure).

² This includes excerpts from a trial therapy but identifiers and details are changed to ensure anonymity.

C: I'm starting to feel angry! (Complex feelings of appreciation and anger are present).

Empirical Support for the Role of Clarification and Challenge

Microprocess analysis of therapist–client responses in ISTDP reveals evidence for these specific therapist interventions. [Makynen \(1992\)](#) showed that the cumulative effect of repeated confrontation interventions early in treatment was associated with reduced client defense later in therapy. Furthermore, the greater attention the ISTDP therapist pays to address defense in early treatment phases, the greater likelihood of reduced defenses later in therapy ([Winston, Winston, Wallner Samstag, & Muran, 1994](#)). When sequential therapist–client responses were examined, the techniques of active confrontation to client feelings and defenses against feeling preceded the highest levels of client emotional arousal ([Town, Hardy, McCullough, & Stride, 2012](#)).

Phase 5: Unlocking the Unconscious

Davanloo discovered what he refers to as the triggering mechanism to unlock the unconscious, namely the direct experience of the *complex transference feelings*. For this to take place with resistant clients, he highlighted the need to continue to *pressure* and *challenge* the defenses until the actual somatic experience of these emotions was taking place. The somatic pathway of rage was reported in clients as an upward movement of heat or energy moving from the bottom of the body upward to the chest and up to the neck and finally down the arms to the hands with an urge to grab or do some sort of violence. The somatic pathway of guilt about rage was experienced as waves of upper body constriction and remorse while looking at the mental image of a dead loved one for example. Grief by comparison is a softer experience without physical pain: the cognitive content of grief is around loss rather than on remorse.

The repeated observation, and perhaps his most important, was that when the client somatically experienced these complex emotions, unconscious anxiety about these feelings dropped dramatically and abruptly: when the anxiety dropped, the resistance subsequently reduced markedly or was removed. It was in this relaxed and open state of mind that the client experienced visual images and clear memories of traumatizing events: this therapeutic force in the client brought open access and Davanloo called it the *unconscious therapeutic alliance* ([Davanloo, 1987](#)).

Vignette Continues: Minute 8:00

T: Let's see how you physically experience the anger in your body. (Pressure).

C: Energy moving up and down my arms (moves arms expressively).

T: How do you experience that anger compared to the anxiety? (Pressure).

C: Anger, I feel it rising up from here and it wants to get out! (moves his hands upward).

Commentary: Now unconscious anxiety in the form of tension has dropped and motoric, cognitive, and somatic concomitants of rage are present. Now the therapist examines the impulse.

T: How physically does it want to go in terms of thoughts (pressure) if you don't protect me from it and if you don't cripple it? (Challenge).

C: I feel like doing something.

T: Lets see what this thing is (pressure) *if you don't cripple yourself now.* (Challenge).

C: I feel like I want to reach up and strangle you. (Hands rise in expressive fashion)

T: And then what . . . (Pressure).

C: It holds on your neck.

T: Then what happens to me? (Pressure).

C: Then you will probably die. You are gasping and turning blue . . . and then I feel relief . . . but then tremendous guilt . . .

Commentary: Process here is slower with pauses between statements and he is immersed in mental imagery.

T: Can we look at what you see in your hands. (Pressure).

C: Your face is relaxed and your eyes are staring at me saying "why did you do this to me?"

T: "Why did you do this to me" (clarification). *What do you say to the eyes?* (Pressure).

C: I say it is nothing personal . . . I have this stuff in me and it had to get out!

T: What do the eyes look like? (Pressure).

C: They are bloodshot . . . blue.

T: How do you feel when you see the blue eyes? (pressure) *Who has those blue eyes?*

C: My father.

T: What do you do with your father's dead body?

C: I cradle his head and say "I'm sorry . . . I'm so sorry" (some passage of guilt).

Empirical Support for Unlocking the Unconscious

There are several lines of research supporting the theoretical premise of a clinical association between emotional mobilization and positive psychotherapeutic change in dynamic psychotherapy. First, the meta-analysis by [Diener, Hilsenroth, and Weinberger \(2007\)](#) found a significant relationship between client emotional experiencing and outcome across 10 independent psychodynamic psychotherapy studies. In ISTDP specifically, emotional mobilization, categorized by degree of *unlocking of the unconscious*, was positively correlated with improvements on both self-reported symptoms and interpersonal problems after an ISTDP trial therapy interview ([Abbass, Joffres, & Ogrodniczuk, 2008](#)). A second study directly compared treatment effects between clients who had at least one *major unlocking* of the unconscious during a course of ISTDP versus a group of clients without a *major unlocking* during therapy: *major unlocking* was associated with greater improvements on measures of symptom and interpersonal functioning and more substantial medical system cost reductions ([Town, Abbass, & Bernier, in press](#)).

Phases 6 and 8 Recapitulation and Consolidation

Recapitulation of the process after the passage of emotions is a critical feature of this approach. Moreover, in intellectualized resistant patients, this interpretive process is restricted to after the unconscious is mobilized. The objective of this work is a thorough linking of unconscious feelings, anxiety, and defense in respect to

past and present figures. This collaborative review cements the conscious understanding of the linkages between phenomena but also strengthens the *unconscious alliance* and weakens the resistance (Davanloo, 2005).

Vignette Continues (1 hr 3 min)

The remainder of the session was focused on the experience of pain, rage, and guilt related to both parents and his wife, all of whom he had detached from.

T: So it's a painful feeling when you see this system. It's just pain and rage in there.

C: Oh yes. Yet at the same time I'm seeing a way to connect into it and release it somehow . . . so it's not building up in me all the time (understanding transference and treatment process).

T: There is a painful feeling to see your mother suffering (from his rage) and to see that she suffered due to your suffering (from his anxiety and depression).

C: Oh Yes. When I see her face (image from unconscious therapeutic alliance) now she is getting younger now: she was a beautiful woman with dreams (emergence of sadness).

T: You put yourself as the target of the rage to protect her and punish yourself. (Interpretation).

C: Exactly . . . tremendous regret . . . how could we hurt each other so?

Few Minutes Later

C: It gets me . . . depressed and anxious . . . and weak in my arms . . . I've always been afraid if provoked that I would kill . . .

T: . . . as if you would get aggressive and kill so you shut off your body and all your emotions . . . (Interpretation).

C: . . . yes, I direct it at myself.

T: So this is all a system to cover up the original pain? Then you have rage and guilt to deal with. So you suffer that way as if you killed everyone. (Interpretation) Does this seem accurate?

C: That's exactly what has been going on. When you asked me how I felt with you I could see parts of me battling each other! (Smiling, brighter, and proud of insights into his dynamics).

Empirical Basis for Phases 6 and 8

Indirect empirical support for recapitulation stems from a recent single-case series design study examining the treatment process in more and less successful courses of ISTDP for depression. Trained raters judged the degree of client insight in the segments of each therapy session that immediately followed the peak instance of client emotional arousal (Pasperskyte, 2012). Insight emerged as an independent predictor of outcome: therapist recapitulation of in-session emotion processes to facilitate client insight may have a therapeutic benefit. Further, validation of the importance of recapitulation and consolidation following breakthrough of conflicted affect associated with problematic experiences is evident in its emphasis in pantheoretical process models of therapeutic change [e.g., the assimilation model, (Stiles, 2002)]. Informed by this conceptual framework, Detert, Llewelyn, Hardy, Barkham, and Stiles (2006) demonstrated that assimilated client insight into core problems was statistically associated with symptom improvement in brief psychodynamic treatment.

Conclusion

ISTDP technique is composed of specific, tailored, and well-timed emotionally focused psychodynamic interventions derived from extensive videotape research. By using the signals of unconscious anxiety and defense, direct communication to the unconscious of the patient from initial contact can enable rapid psychodiagnosis and treatment planning. *Pressure* to engage, *challenge* to resistances that interrupt the process, and ushering through *complex transference feelings* can lead to direct access to unresolved unconscious emotions. Extensive and repeated recapitulation of what is learned strengthens the alliance and weakens the resistance. Through these processes, the *unconscious therapeutic alliance* can bring the emotions forth and allow healing of longstanding pathogenic rage, guilt, and painful feelings.

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