Santa Clara Valley Chapter
CALIFORNIA ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS

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INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY (ISTDP) EXPLAINED

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We are focusing this issue, in part, on modern psychodynamic therapies. We are very interested in your work in intensive short-term dynamic psychotherapy (ISTDP). Can you tell us more about this modality? What does “short-term” mean?

ISTDP is an experiential therapy that helps the patient face the feelings they avoid by regulating their anxiety moment-to-moment, and helping them see and turn against defenses that are maladaptive. Through this process the therapist helps patients observe and develop compassion for their inner life and relinquish habits of self-rejection. Although based on psychodynamic theory, ISTDP integrates techniques from multiple approaches, including cognitive, behavioral, somatic, Gestalt, and mindfulness therapies.

Short-term means that this approach generates more impactful results in a shorter span of time than most other therapies. ISTDP is an evidence- based approach that demonstrates greater efficacy in treatment outcomes than even more popular therapies, such as CBT.

What specific aspects of this way of working make this a psychodynamic therapy?

Admin view

Psychodynamic means working with conflicting forces from the unconscious. Clients enter therapy for a variety of reasons, such as relationship difficulties, anxiety, depression, procrastination, lack of self confidence, problems with self-assertion, low motivation etc. However, patients are often unaware of the specific forces that may be causing their difficulties. For example, because they have been hurt through neglect, abuse, dismissal or being pressed into service of taking care of an impaired parent, patients developed coping strategies both adaptive and maladaptive to protect those early insecure relationships and manage themselves.

We often meet with patients when the strategies that they put into operation, automatically and unconsciously, no longer work for them. Our hardwiring evolved to unconsciously detect safety and danger in our relationships. That's how we learned to survive! When patients perceive threat, mostly unconsciously, they deploy all of the strategies that they learned to protect themselves growing up. Of course, they don't see those strategies. As we invite the patient to form a close relationship with us, in order to help them with their presenting difficulties, the invitation to closeness registers as an unconscious threat, and the patient puts into operation all of the ways they learned how to survive. They show us, in the present, the precise history and nature of their suffering. Through moment-to-moment tracking of anxiety pathways and defensive habits that interfere with closeness and reaching their treatment goals, the patient gradually learns how to see themselves more accurately, regulate their anxiety and turn on their defensive structure that has created their suffering. When this happens, feelings spontaneously arise, which, when unfettered by anxiety and defense, facilitate deep healing. This process often brings unconscious memories to surface that can be addressed in the present and resolved.

Could you give us a short fictional case example, with a problem someone might bring in and what the work would look like with that client?

A middle-age married man with two teenage children came to see me for therapy when he lost his job, became depressed, and his wife threatened to leave the marriage. The man thought that having been in a job that he didn't like was causing his difficulties, and that if he had a new job, it would solve his problems. While getting a new job might improve his circumstances and possibly his mood, what the man did not see was how his passivity and detachment were causing the problems in his marriage, getting him depressed and were critical variables that contributed to him being fired. Of course, unaware, the client presented his passive, detached stance with me in therapy. He also did not see how operating from a detached, passive position covered his inner feelings and vitality, which would help free him from a deadly cycle of turning on himself.

The critical tasks of therapy were helping the man reframe the problem as not the job outside of him, but rather observing the defenses operating inside him as causing his difficulties, experiencing his will for his own well-being and turning on these defenses. Once the patient turned on his own defenses, this led to a spontaneous rise in grief/sadness that he had been hurting himself for years by putting these defenses into operation in all of his important relationships and blocking closeness with himself and his wife. The client's ability to bear his sadness about his own self-harm was a crucial variable in the healing that took place.

What kinds of clients is this therapy most suitable for?

Clients who suffer from mood disorders such as anxiety and depression, difficulties with motivation, self-assertion, procrastination, addiction, trauma histories, underemployment, conflicts at work or with family members, and character disorders, such as chronic passivity.

Admin view

Are there clients or populations with whom you decide not to use ISTDP and if so why?

Clients who do not want to work in therapy and see therapy as only a place to chat and vent would not benefit from ISTDP. ISTDP therapy is not a therapy that happens to the patient; rather, it is a co-created enterprise between the therapist and client, both putting their full effort towards the client's stated goals.

ISTDP would also not be suitable for patients who are actively suicidal, homicidal, or engaging in domestic violence. We also modify approaches within ISTDP to account for particular client characteristics such as severe fragility.

How does this modality work with African American clients, Asian American clients and other clients of non-European descent?

This therapy was originally conceived and developed by an M.D. of non-European decent, Habib Davanloo. It is currently practiced worldwide, including North America, Europe, Asia, and the Middle East.

Are there issues that come up or adjustments that you make in order to meet your clients where they are?

Yes, for instance, for clients who suffer with severe anxiety there is a *graded approach* to ISTDP where we help clients using specific interventions that help build their self-observing capacity and increase their anxiety tolerance.

My understanding is that this a very directive approach, where the therapist is more highly directive of sessions. I find that interesting since my impression of more traditional psychodynamic therapy is very much allowing the client to freely associate and bring up what comes into their head in the moment. Can you talk about this? And what does "directive" look like in ISTDP?

A common misperception about ISTDP is that this therapy is a directive or confrontational approach. In reality, ISTDP tries to help patients become aware of what they want and desire, so that their desire directs the therapy, and their defenses do not misdirect it away from the patient's goals. In this active approach, both the therapist and client are fully engaged in helping the client solve their presenting difficulties and reach their goals. Both the therapist and the client have respective tasks to help the client attain their goals. The engine of this therapy is the patient's will and innate healing force for their own health and well-being. This therapy facilitates an environment where the native force for health within the patient can naturally emerge. An active therapist and a passive client will not generate results. Only when both parties are fully active, are positive results possible.

I tend to be less comfortable being more directive in sessions. Does that mean that ISTDP would not be as appropriate for me as a therapist?

Admin view

Unfortunately, defenses are usually directing the patient's life and creating the symptoms and presenting problems. So, as an act of compassion, we help the patient to see and turn against their own defenses, so that the patient's desires can direct the therapy. The patient's will must direct the therapy, not the therapist. So the therapist is following the specific unconscious signals of the patient, so that the patient can direct him/herself.

Or, is that something that one learns to become better at as you learn ISTDP?

There are many different skills and competencies in ISTDP that therapists learn over time. ISTDP offers a variety of workshops, supervision, immersions and longer training programs that help therapists build new skills to be more effective with their clients.

What do you love most about working in this way with clients?

I love being active with clients, learning about how our brains function, and acquiring a set of concrete skills that make me more effective as a clinician. I especially love not only helping patients reduce their symptoms; this is the only therapy that I am aware of that creates genuine character change.

Who influenced you to learn ISTDP?

I was first introduced to ISTDP by attending a seminar in 2006 on Attachment Theory with Mary Main and Eric Hess. One of the co-presenters was Robert Neborsky, M.D., president of the California Society for ISTDP. He delivered a fascinating lecture and presented a video of a patient he had seen over time, which showed true character change. What I saw unfolding on the videotape simply took my breath away. I knew I wanted to find out more about this approach. After attending a few other workshops on ISTDP, in 2008, I enrolled in a 3-year core-training program with Robert Neborsky, M.D. and Josette Ten Have De Labije, PsyD.

In 2010, during my 3rd year of core training, I attended a workshop with Jon Frederickson, MSW, founder of the ISTDP institute. The concepts that Frederickson presented were so clear and compelling, I knew immediately that I wanted to learn more from him. So, I reached out to Frederickson for individual case consultation, which has now spanned over 10 years! I have continued to take many advanced trainings with Jon Frederickson and with other well-known ISTDP teachers including Allan Abbass, M.D., Patricia Coughlin, PhD and John Rathauser, PhD.

You actually teach and mentor other therapists in learning ISTDP, is that right?

Yes, and I absolutely love that part of my work! I attended a 3-year teacher/supervisor training in ISTDP from 2011 – 2014 with Patricia Coughlin, PhD. I am currently pursuing an additional 3-year training program as an ISTDP trainer and supervisor with Jon Frederickson. Frederickson and I are currently co-facilitating a 3-year core-training program for trainees in Alberta, Canada. The group has now entered its 3rd year. I am very fortunate to mentor and supervise licensed marriage and family therapists, social workers, psychologists and psychiatrists learning ISTDP from all over the U.S. and in Canada.

Admin view

Can you talk more about your work teaching and mentoring others?

What is central in teaching and supervising is to meet each therapist exactly where they are in their personal and professional development, and to amplify their innate wish to learn and become their best self. It's important to cultivate the strengths of each therapist as well as help them understand and compassionately learn from mistakes. A key principle in ISTDP therapy is that we are always guided by response to intervention. And doing therapy, of course, is not like balancing a ledger. The entire person of the therapist is involved; and the person of the therapist meets the humanity of the client. So it is the crucial combination of integrating specific skills and developing the best qualities of our character that make therapy work successfully. ISTDP teaching and supervision builds on both.

What are the biggest struggles you see your students having with this way of working?

A couple of things come to mind. One common difficulty is not trusting the native healing force within each client. When we don't trust our client's innate capacity for health, we end up doing more under the erroneous assumption that we can heal the client. A typical way this plays out in therapy, is that a passive client can make an active therapist work harder. When this occurs, the natural healing force, which we call in ISTDP the unconscious therapeutic alliance (UTA), will not arise in the client. So, doing less is often more and yields better results.

Some therapists early in training may hesitate showing their work because the supervisor will see their mistakes. ISTDP is, in part, learned through working from the student's videotape of their work with patients. The videotape is valuable because it points to the specific areas where the therapist may need additional support from the supervisor. Mistakes are viewed as a normal and even essential part of the learning process, and the therapist/trainee slowly begins to grow their own self-compassion muscle by learning and benefiting from their mistakes.

Anything else you'd like to share that I didn't specifically ask?

Even learning some of the basic skills in ISTDP will help improve therapists' treatment outcomes.

*Diane maintains a private practice in Northern CA and has taught yoga at yoga studios in the Bay Area and at corporations. Diane has also taught workshops on ISTDP at Stanford University Vaden Counseling Center, at Stanford University Law School, and for the Northern California Professional Association of ISTDP. Her website is **www.byster.com**.*

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