

Intensive Short-Term Dynamic Psychotherapy in the Private Practice of Psychiatry

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CME EDUCATIONAL OBJECTIVES

1. Understand the potential benefits of combined psychotherapy and medication management.
2. Appreciate subtleties in conducting these two processes simultaneously.
3. Develop a further understanding of the intensive short-term dynamic psychotherapy (ISTDP) model.

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Intensive short-term dynamic psychotherapy (ISTDP) is based on the psychoanalytic theory of unconscious conflict but departs from standard psychodynamic therapy in a number of significant ways. This highly active form of treatment is designed to mobilize intense feelings, regulate anxiety,

and overcome defense and resistance. It has a growing body of evidence of clinical effectiveness across a wide range of patients and has demonstrated significant cost savings.¹ This article explores unique elements of ISTDP, as well as practical issues that arise when ISTDP is introduced into a psychiatrist's

practice. It will offer examples of how ISTDP can positively impact an outpatient practice where psychotherapy and medications are integrated. ISTDP's unique approach to assessment and diagnosis will be described and compared to the standard psychiatric evaluation. Additionally, the relationship between

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ISTDP and medication treatment is explored.

The article is written from the perspective of a psychiatrist who practiced long-term psychodynamic therapy for 20 years before being introduced to ISTDP. Learning ISTDP can lead to profound changes in the conceptualization of cases and patient interactions, which can result in marked improvement in patient outcomes and satisfaction. By adopting the ISTDP approach, it is possible to reconnect with the enthusiasm and optimism that characterizes one's early exposure to dynamic psychotherapy.

UNIQUE ASPECTS OF ISTDP

In the early 1970s, Habib Davanloo, MD, began developing ISTDP in a systematic manner by videotaping therapy sessions and intensively studying the therapy process. He focused on the problem of resistance, and developed novel interventions to break through this barrier and facilitate the direct, visceral experience of previously avoided emotions. Subsequently, Davanloo required that his supervisees videotape their work as an essential component of learning ISTDP. Because ISTDP emphasizes the processing of moment-to-moment interactions as well as observation of nonverbal signals of emotion, videotape allows a supervisor to view the process directly, unfiltered by the therapist's subjectivity and unconscious.

Introducing the video camera into treatment is usually uncomfortable for a psychotherapist who has not used this tool. Revealing our videotaped work to a supervisor — and ourselves — requires the therapist to tolerate vulnerability, but is an invaluable way to hone one's skills. Having a wise and supportive supervisor has helped relieve my fears about having my work judged. Although I was initially concerned as to whether my patients would give consent to be videotaped, the majority have done so. I inform patients about my practice of videotaping during

the initial phone contact so that they have time to decide whether they are comfortable being taped. The patient should be informed that they will need to sign a videotape consent form when they arrive for the trial session (see Figure).

Although most patients express no interest in watching their videotapes, some request copies for review between sessions. This can help reinforce what was experienced in the session and enhance continuity between sessions. I was particularly struck by the value of videotape while working with a patient who found it very difficult to connect with his anger. In one session, while feeling anger toward his mother, his hands clenched into fists. When I pointed this out, he vigorously denied that this had happened. He agreed to our reviewing the tape and was astounded to see his hands making fists. Then, for the first time, he was able to acknowledge the powerful rage he had been carrying inside and subsequently referred to the importance of having observed his anger on tape.

WHERE TO BEGIN A SESSION

A psychiatrist who does both psychotherapy and medication management must decide how to begin each session. Should the session begin or end with a review of medications? The first minutes of a session allow me to collect important information: What is the first spontaneous communication? Does the patient share an emotionally impactful experience, or does he divert away from important material? Does he reveal unconscious anxiety? Does he arrive with defenses in the forefront? Does he passively wait for me to initiate the session? I usually hold the medication review until the end of the session because the opening moments, when not influenced by questions from the psychiatrist, are so valuable.

In each session, the ISTDP therapist attempts to create an intense engagement to help the patient experience avoided feelings. A productive session

CONSENT TO VIDEOTAPE	
I, _____, authorize David Wolff, M.D. to videotape my psychotherapy sessions with him as an integral part of my consultation and psychotherapy. I understand that Dr. Wolff is committed to studying the process of treatment in order to make psychotherapy more effective and efficient. I understand that the use of my videotapes is limited and may occur only in accordance with the highest ethical standards of professional confidentiality for California mental health practitioners.	
Viewing of my videotapes is strictly limited to the following:	
(1) analysis by Dr. Wolff to optimize the quality of my care	
(2) use by Dr. Wolff for the purpose of professional supervision about my treatment	
I understand that my name will never be disclosed and that the tapes will be used solely for the purposes described above. I further understand that the tapes are not part of my permanent medical record and that Dr. Wolff will erase each tape after it has been used for its intended purpose.	
_____	_____
Signature	Date

Figure. Example of a consent to videotape form for private practice.

builds in intensity as feelings rise closer to consciousness. If a patient is on a stable medication regimen, allowing the therapy process to proceed uninterrupted is indicated. If medications are being actively adjusted to address acute symptoms or side effects, then I make sure to end the therapy portion of the session with enough time to discuss medication.

DIFFERENCES IN DIAGNOSTIC ASSESSMENT

The standard psychiatric evaluation, lasting 60 to 90 minutes, involves gathering information about a patient's subjective experience and objective behaviors to arrive at *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnoses.² A treatment plan is then created based on clinical data relevant to these diagnoses. While *DSM* diagnoses can help guide decisions about medication treatment, they have proven less helpful when it comes to assessing a patient's capacity to benefit from dynamic psychotherapy. The ISTDP therapist takes a different approach to the evaluation process. The first 2- to 3-hour session in ISTDP, known as a trial therapy, is a dynamic assessment of both potential and pathology, based upon information obtained by putting pressure on a patient's psychological system and carefully observing his response. This is akin to an

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internist administering a cardiac stress test or palpating a tender abdomen to elicit information that cannot be obtained by history or observation alone.

In ISTDP, pressure refers to the following types of intervention:

1. Inviting the patient to form an honest, collaborative relationship with the therapist.
2. Pointing out the ways the patient avoids closeness.
3. Focusing on the patient's true feelings about the present and the past.
4. Blocking defensive avoidance of feelings and impulses.^{3,4}

An ISTDP therapist carefully observes the patient's verbal and nonverbal responses to these interventions to obtain crucial information about the patient's ego strength, including the capacity for self-reflection, the ability to see and turn against destructive defenses, the degree of resistance, and the ability to regulate anxiety. Based on this information, the therapist assesses the patient's suitability for ISTDP and determines if medication is indicated.⁵

CASE

A 35-year-old male had a history of dysthymia previously treated with psychotherapy but not medication. He was highly motivated and showed no defenses against closeness. With ISTDP therapy, he came to understand that he was not able to experience anger and instead would become depressed and self-critical. The patient was able to connect with the physical experience of anger, as well as the violent impulses associated with it. This work was valuable, and the patient became more assertive in situations where he had previously been passive and accommodating. However, despite the ISTDP sessions, the patient remained quite vulnerable to repeated cycles of depression. We agreed on a trial of a selective serotonin reuptake inhibitor (SSRI) antidepressant and the response was robust. The frequency and

duration of depressed mood dropped markedly and, with his mood improved, the patient was better able to address additional longstanding problems in his relationship. This led him to ultimately break up with his partner, something he had been unable to consider when depression was contributing to a pattern

The ISTDP therapist believes that the most effective way to help relieve anxiety is for the patient to have a direct visceral experience of avoided feelings.

of excessive dependency. The patient made a good adjustment to being single and was able to successfully taper off his medication after a year of stable mood.

In this case, once ISTDP built a foundation of self-awareness and fostered important change in certain areas, adjunctive treatment with medication was necessary to address persistent symptoms that were limiting further progress. A psychiatrist doing ISTDP needs to ask whether the patient is showing progress from session to session toward his desired goals. If there is no progress, or a point where progress stalls, it is necessary to examine the many factors that could account for this, including the need to consider a trial of medication. With any intervention, we want to objectively evaluate the patient's response and not allow undue time to pass without improvement. This encourages us to keep an open mind to the possibility that the treatment we are using might not be optimal and to be flexible enough to consider alternative approaches.

IMPORTANCE OF EMOTIONAL REGULATION

Treatment with medication and all psychotherapies are an attempt to help

patients regulate their emotions. Barlow et al⁶ offered a unifying theory of emotional disorders, stating that "Emotion regulation and dysregulation seem to play an important role in the maintenance of emotional disorders and become our target for treatment." They continued that "Individuals concerned about the expression and experience of their emotions may attempt maladaptive emotion regulation strategies such as suppression and avoidance, hiding or ignoring them, with unintended consequences." Medications are considered successful when they help regulate emotions, but in this paradigm, the patient is playing a passive role in the treatment. They are not engaged in a process that will allow them to gain mastery over their emotional experiences and their symptoms often recur if the medication is withdrawn.

Because ISTDP regards anxiety as a signal of unconscious feelings, the ISTDP therapist believes that the most effective way to help relieve anxiety and associated symptoms is for the patient to have a direct visceral experience of avoided feelings. Because anxiety is unavoidable if there is to be growth, the ISTDP therapist wants to keep the patient's anxiety in an optimal range. If anxiety is too high, leading to cognitive disruption or somatic symptoms, the therapist helps the patient regulate their anxiety in the session to build up their capacity to tolerate feelings. In patients who defend with repression and emotional detachment, anxiety is too low and it is then necessary to apply pressure to raise the patient's anxiety and bring feelings closer to the surface. In such cases, medication can hinder a patient's ability to successfully address emotional issues.

Psychiatric medication can lead to a reduced experience of emotion, either as an intended therapeutic effect or as the result of side effects. A study by Opbroek et al⁷ found that, compared

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to controls, patients on medication reported significantly less ability to cry; to care about others' feelings; and to feel sadness, creativity, or anger. Similarly, in a study by Price et al⁸ of patients taking SSRIs, most described a reduction in the intensity of all emotions. This applied to both positive emotions such as excitement, joy, and love, as well as negative feelings of sadness, anger, and disappointment. Many described feeling emotionally detached and disconnected from themselves and others. Although most described the blunting of emotions as beneficial early in their treatment, many ultimately came to regard it as an unwanted side effect.⁸

CASE

A 32-year-old male came to see me for ongoing medication management of a generalized anxiety disorder. He was taking an SSRI that he described as very helpful in reducing his anxiety. I continued this medication and saw him for infrequent medication management appointments to review his progress. During one such appointment, we discussed a pattern of self-defeating and passive-aggressive behaviors that he had never previously addressed in psychotherapy. From that brief visit, the patient began to see some of his dynamic issues in a new way that motivated him to begin a course of ISTDP with me. The first few sessions revealed how detached he was from all feelings. Understanding that the SSRI could be contributing to his lack of access to feelings, he agreed to taper off of it. This decision spoke to his commitment to face emotions fully in order to get free from the harmful consequences of longstanding character defenses. Off the medication, with greater access to emotions, the ongoing ISTDP treatment has helped him understand anxiety as a signal of feelings that are getting triggered by specific, current experiences. He is now motivated to face these feelings rather than resort to habitual (and

now dystonic) defenses. He and his wife have begun seeing a marital therapist, which has led him to see how much he maintains an emotional and physical distance from his wife.

CASE

A 49-year-old single male, never married, was referred for consultation. The patient had been hospitalized 5 years previously and diagnosed with a manic episode. Based on the diagnosis of bipolar disorder, he was taking two mood stabilizers and a benzodiazepine, prescribed by a psychiatrist that he saw every few months. He also saw a psychotherapist weekly but did not find either of these treatments helpful. A 90-minute psychiatric evaluation session with me failed to reveal a history of a mood disorder. Rather, he appeared to have an anxiety disorder that led him to go to the emergency room 5 years prior at a time when his anxiety had peaked. He was admitted and his rapid speech, agitation, and insomnia were interpreted as manic symptoms. I informed the patient that I could not see justification for either the bipolar disorder diagnosis or his current medication regimen. What did stand out from our meeting were the following factors: high levels of unregulated anxiety, a clear pattern of compulsively giving to others, resenting family and friends for not appreciating his generosity, neglecting himself, a conflicted relationship with his father, and the absence of a successful long-term relationship. I suggested that we meet for ISTDP therapy sessions to address these issues.

At the beginning of the next session, he told me that he felt like I had come to know him better in 90 minutes than did his prior psychiatrist of 5 years. This was an opportunity to explore his feelings toward that psychiatrist, whom he felt had failed to understand him and whose treatment was ineffective. Initially, he offered positive statements

about the doctor and got anxious as I blocked this defensive response. With difficulty, the patient began to identify and then experience his anger and rage toward him. Although he was anxious about facing the violent impulses that were getting activated, he was able to visualize his impulses toward the doctor, an ISTDP technique often used to help a patient experience feelings fully and gain access to their unconscious. To the patient's surprise, the week following the session was characterized by freedom from anxiety and his best sleep in years. We worked together to rapidly get him off the two mood stabilizers and begin a process of tapering him from the benzodiazepine that he had been on for more than 15 years.

BEFORE AND AFTER

As a psychiatrist who had been practicing dynamic therapy for 20 years before shifting to the study and practice of ISTDP, I went through a challenging period of transition. There is a marked difference in the approach of an ISTDP therapist from that of a more traditional psychodynamic therapist. I found it helpful to let my patients know that I was using a new approach to their treatment to help them make sense of the changes in how we interacted. For example, I began to interrupt them when they were speaking away from their feelings or diverting the conversation. I blocked their attempts to externalize their problems or analyze others. Patients struggled with a mixture of irritation/anger toward me for applying pressure, as well as gratitude that I was not willing to let them undermine our efforts to help them gain freedom from their suffering. It took concerted effort on my part, along with the encouragement of my supervisor, to convey clearly to my patients my readiness to face all of their feelings toward me, including anger and rage, and use the experience for maximum therapeutic effect.

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CASE

I worked with a patient for 10 years in a weekly dynamic therapy that he found helpful. He developed insight into how he devalued himself while pleasing others, avoided conflict, and lacked the capacity for healthy self-assertion. Therapy helped him cope with the end of his marriage and his coming out as a gay man. Many years later he contacted me wanting to work on the problem of his not being true to himself. With my new ISTDP perspective, I was struck by the patient's almost complete inability to identify and experience his feelings. When he would describe a conflict with someone, he could not answer the question: "What feelings do you have toward ____?" The only feeling he could identify was anxiety, which functioned as a blanket covering all other feelings. Facing his anger toward me, which the ISTDP therapy process generated, proved to be the most helpful to him in accessing his feelings without the automatic repression that had previously operated. He then faced the fact that he had been avoiding areas of conflict in his current relationship and was accepting less intimacy than he wanted. He resolved to speak truthfully with his partner, which

he recognized as a necessary step in his growth. When he finished therapy after 9 months of intensive work, he felt transformed by the experience in a way that surpassed the previous work that we had done.

CONCLUSION

Integrating ISTDP into our work as psychiatrists presents interesting challenges. We always need to assess the relative contributions of biological and psychological vulnerabilities so that our treatments are optimal. It is the response to our interventions that guides the therapy process. By carefully monitoring a patient's moment-to-moment experience in the session, we learn when it is optimal to press for the experience of feelings, when to help with anxiety regulation, and when to do the work of identifying and challenging destructive defenses. Videotaping sessions is a powerful and necessary tool to help therapists learn how to be effective as ISTDP therapists. As psychiatrists, we need to regularly consider the question of whether medication is aiding the psychotherapy process or limiting its effectiveness. Careful clinical judgment that involves an ongoing evaluation process

is crucial to the successful integration of medications and therapy, ensuring that they work together in a synergistic manner. Our goal is to relieve suffering, which is best achieved by a flexible approach guided by theory and tailored to each unique patient.

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