This issue:

Intensive Short-Term Dynamic Psychotherapy

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Guest Editors

Almost from the start, analytically oriented therapists have sought to make treatment as effective, transformational, and efficient as possible. Freud was the first short-term dynamic psychotherapist, with most of his therapies lasting 6 months or less. Throughout history, as therapies lengthened to years and even decades, there has been a call to return to more-focused interventions. Ferenzi and Rank,[1] as well as Alexander and French[2] all called for shorter, more-effective therapies that dealt actively with the phenomenon of resistance and focused more on emotions than cognitive interpretations. During the 1960s and 1970s, there was another wave of interest and research into the effectiveness of short-term dynamic therapies, including the studies of Mann,[3] Malan,[4,5] Sifneos,[6] and Davanloo.[7,8]

Early research on the viability of short-term dynamic psychotherapy indicated that length of treatment was not a significant factor in determining outcome.[2,4] The idea that more treatment would lead to deeper and better results was refuted. Instead, the research revealed that a particular constellation of factors was responsible for therapeutic success.[4] The therapist variables included: the ability to view the patient's current crisis as the most recent manifestation of a core conflict, with origins in the past; the skill (and courage) to deal directly with negative transference feelings and high levels of resistance; and the persistent focus on feelings, rather than thoughts and interpretations. If the patient was able to respond to these interventions in an emotionally meaningful way within the first four sessions, the prognosis for a positive response to short-term dynamic psychotherapy was excellent.[4] Despite encouraging findings regarding the effectiveness of short-term dynamic psychotherapy, no new techniques were developed. Instead, most in the field have relied on strict selection criteria[6] or a narrow therapeutic focus,[3] even though Malan's findings[4] revealed that many of the most dramatic results were obtained with patients who had multiple problems of long standing.

THE METHOD

Intensive short-term dynamic psychotherapy[7-10] (ISTDP) has been the exception in the field. Although based strictly on psychoanalytic theory and psychodynamic principals, the therapeutic approach has radically departed from standard practice in many ways. Instead of using strict selection criteria, only patients with cognitive impairment, acute psychosis, or active drug addiction are eliminated from consideration. Rather than relying on history or descriptive diagnoses to determine suitability for treatment, response to intervention is employed as the primary diagnostic tool in ISTDP. In other words, patients are exposed to the active ingredients of the method so that their capacity to respond to therapeutic intervention is assessed in real-time. Research suggests that more than 80% of all patients seeking therapy are able to respond to this treatment method.[11] A naturalistic study examining the effectiveness of this type of active evaluation, in contrast to a standard psychiatric interview, suggests that it is highly effective.[12] In fact, one-third of all patients who took part in this type of initial interview were symptom-free at their 6-week follow-up and required no additional treatment.

THEORETICAL UNDERPINNINGS

ISTDP is based on Freud's second theory of anxiety, namely that anxiety is a danger signal, warning the ego of the possibility of trauma. In this case, trauma has been defined as "separation from, or loss of, a loved object or

a loss of its love."[13] Our basic feelings and emotions, from love and grief to rage and guilt, have all been selected throughout evolution to facilitate the emotional bond between loved ones. When caregivers fail to adequately attune to their children, or important emotional bonds are ruptured or abused, intensely mixed feelings are generated. "That such a separation or loss would constitute trauma is readily explained by the infant and child's prolonged state of mental and physical helplessness and utter dependence on caretakers for survival and well-being."[9] When the desire to love and be loved is thwarted or neglected, deep pain and grief are experienced. Rage toward the loved one who is causing that pain is also activated. The experience of such intense and often murderous rage toward a loved and needed parent gives rise to anxiety and guilt that is often overwhelming and is rendered unconscious. Although defending against these feelings reduces conscious anxiety and guilt and may help to preserve the bond with parents, it also exacts a toll over time. Put very simply, presenting problems are viewed as the inevitable result of the patient's excessive reliance on defenses against anxiety-provoking feelings, wishes, and impulses.

In addition to the negative consequences of defensive functioning,[14,15] the concomitant lack of awareness of anxiety and emotions prevent their optimal regulation. A good deal of research now suggests that many psychiatric disorders may be, at least in part, disorders of emotional awareness and regulation.[16] Consequently, therapeutic interventions that can foster the awareness, regulation, and integration of strong emotions should be effective in remediating symptoms and facilitating emotional health and well-being.[17]

THERAPEUTIC TASK

Since the defensive avoidance of anxiety-laden feelings is viewed as the major cause of psychopathology, the therapeutic task involves identifying and then removing the defenses in favor of facing and viscerally experiencing the feelings that have been chronically avoided. Since defenses work by reducing anxiety and keeping threatening thoughts, feelings, memories, and impulses out of conscious awareness, patients can be quite reluctant to abandon them. In most cases, these defenses have had some adaptive value in the past. However, when defenses are relied on excessively, they often cause the very problems that patients need our help to overcome. Great therapeutic skill is required to deal effectively with the defenses and resistances that interfere with the therapeutic relationship and perpetuate the patient's suffering.

PSYCHODIAGNOSTIC PROCEDURE

ISTDP begins with a highly focused and detailed approach to inquiry, examining the nature and history of the patient's difficulties in a phenomenological manner. The patient's current problems provide the starting point for inquiry. This process increases the likelihood that therapist and patient will come to consensus regarding the nature of the problem and the therapeutic goals, both of which are highly associated with the establishment of a strong therapeutic alliance.[18] It also allows for an examination and understanding of the factors involved in precipitating the patient's symptoms.

Once the survey of difficulties has been obtained, the therapist zeros in on a recent example of the chief complaint. The patient is encouraged to be an active participant in the process from the outset and is invited to provide detailed information about his experience. Any hesitation to form a collaborative alliance with the therapist is identified as it appears. Then, the patient is encouraged and directed to identify and experience his true feelings toward the significant others involved in the example being explored. Whereas many therapies focus on some aspect of emotion, say the cognitive awareness or somatic experience of feelings, ISTDP is a method of treatment that facilitates the direct and multifocal experience of feelings, including the cognitive, emotional, somatic, and interpersonal components of affect. In so doing, the patient's ability to tolerate, understand, and integrate previously disavowed emotions is enhanced. It also appears that the direct and visceral experience of anxiety-laden feelings and impulses leads reliably to an opening or unlocking of unconscious memories, allowing patient and therapist to get directly to the core of their difficulties.[7,17] The subsequent de-repression of memories, dreams, and associations sheds light on the development of the patient's core conflicts and creates an opportunity for their rapid resolution. The developmental history pertinent to the presenting complaints takes place once this opening has been created.

Since anxiety about, and defenses against, the experience of mixed feelings will become a resistance in the treatment, the identification of both is vital for rapid and effective treatment. ISTDP was designed to deal directly

with these forces from the inception of treatment, which may be one of the factors responsible for high levels of success, especially with patients who have proved resistant to other forms of therapy.[19,20] The therapist's active and persistent effort to connect emotionally with patients activates the unconscious attachment system and rapidly mobilizes the complex feelings toward others that have been previously avoided. In this way, even chronic conflicts come alive in the therapeutic relationship and are available for revision.

Throughout the process, anxiety is monitored and used as both a guide and measure of safety. Often, therapists move in to reduce anxiety far too rapidly, inadvertently depressurizing the very process that can lead to healing. Since anxiety is the signal that threatening feelings and impulses are being activated, it is our sign to move in, not out, of focus on the conflict stimulating the anxiety. Assessing and regulating anxiety in such a way that it remains at an optimal level is the key to a safe and successful process. If anxiety is too high, causing physical symptoms or cognitive-perceptual disruption, downregulation is indicated. Helping the patient think about feelings or "mentalize," rather than becoming symptomatic, is a vital step in building capacity.[21] Conversely, if defenses are in place and anxiety is too low, progress will be greatly compromised. Focus and pressure to experience feelings is required in order to increase anxiety to an optimal level in such cases. The constant monitoring of anxiety allows therapists to tailor their interventions to the current needs and capacities of each patient.

THE THERAPEUTIC STANCE

The ISTDP therapist is not neutral but takes a stand for the health and capacity of the patient while blocking defensive avoidance and destructive behaviors that undermine treatment and perpetuate suffering. This method of treatment includes techniques designed to mobilize the patient's will, develop a collaborative alliance, challenge defenses, facilitate the direct experience of previously avoided feelings, and develop an atmosphere of intimacy and trust between patient and therapist.[22]

Recent research on memory reconsolidation validates this method of accessing implicit emotional memories and transforming them in such a way that they are fundamentally changed.[22,25] This research suggests that the "brain is always capable of unlocking and dissolving emotional learnings,"[22] if exposed to a certain set of circumstances, all of which are integrated into the paradigm of intensive short-term dynamic psychotherapy. It seems that the "reactivation of a consolidated memory can return to a labile, sensitive state — in which it can be modified, strengthened, changed, or even erased."[22,25] The process of reactivation and reconsolidation of previously implicit emotional memories often appears to be life-changing.[22] In order to achieve such ends, the emotions evoked in situations that typically activate symptoms must be reactivated in the treatment situation. It is not enough to talk about feelings, they must be viscerally experienced in order for the memories associated with these feelings to be evoked. Once these feelings and memories are reactivated, conscious, and present in the here and now, they are in a destabilized state and available for reworking. It is essential that some sort of disconfirming experience with the therapist take place during this period of time for the transformation to occur.[22] This finding seems to substantiate the work of Alexander and French[2] regarding the central importance of the corrective emotional experience.

SUMMARY

In this special edition of Psychiatric Annals, readers will be introduced to the theory and technique of intensive short-term dynamic psychotherapy. A variety of researchers and practitioners will detail their personal experience learning ISTDP and integrating it into their own psychiatric practice, as well as presenting the data on clinical and cost-effectiveness across a wide spectrum of patients. References to the use of ISTDP across settings will also be included. An original article describing a treatment program for patients in a specially designed ISTDP residential program in Norway is presented. The cost-effectiveness of this modality will be delineated. Finally, the unique aspects of teaching and training practitioners in the application of ISTDP, along with some preliminary data on the efficacy and cost-effectiveness of this training for psychiatric residents is presented.

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about the guest editors

Jeffrey W. Katzman, MD, is a professor and Vice Chair of Education and Academic Affairs for the Department of Psychiatry at the University of New Mexico School of Medicine. In this role, he administers educational programs for medical students, residents, and faculty in the department and assists in the facilitation of educational activities for the community. He is also a leader in psychotherapy training for psychiatry residents in the department. Dr. Katzman began working with leaders in the area of intensive short-term dynamic psychotherapy 3 years ago and currently uses this model when in the psychiatric emergency room, resident clinics, and in his own practice.

Prior to his current work, Dr. Katzman was the Chief of Psychiatry and Director of Behavioral Health Care for the New Mexico VA Health Care System for nearly 10 years, where he created and administered multiple programs for veterans. He earned his MD at UC San Diego, and finished his residency training at UCLA.

Patricia Coughlin, PhD, is a clinical psychologist with more than 30 years of experience in the practice of dynamic psychotherapy. In the past 20 years, her focus has been on the writing, teaching, and practice of intensive short-term dynamic psychotherapy. Having trained with Habib Davanloo, MD, the originator of this model, she has gone on to write articles, chapters, and books on the theory, technique, and research support for the model. In addition to teaching psychiatric residents at Northwestern University School of Medicine, Albany Medical College, Thomas Jefferson School of Medicine, and the University of New Mexico School of Medicine, she teaches and trains mental health professionals internationally.

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