

Introduction

I am pleased to provide this volume to assist you in understanding and working with psychoneurotic and fragile patients groups. These populations are extremely common, representing the vast majority of treatment-resistant patients in mental health clinics and a large portion of those on chronic medications for psychological and physical symptom disorders.

For a range of reasons, these people suffer chronically and find themselves being bounced between parts of the medical and mental health systems at great cost to society. The long-term suffering is masked by short assessments, medical procedures, and referrals, so nobody but the patient himself and his family know about his chronic misery. He may end up in jail or institutionalized or he may suffer in silence in his own cave. After these patients had experienced years of childhood deprivation and abuse, the system often re-creates thwarted attachment efforts and adds to their burdens.

Finally, the patient has been referred to you. He brings trunkloads of misery, symptoms, and a spectrum of mechanisms by which he keeps a distance from you and he hurts himself. You can feel the heaviness as he hauls this luggage into your office. He is lucky to get to meet you, even if only for a few meetings. And the process begins.

How can you provide a compassionate, corrective experience to help remove some of his burden? How can you reach through to the person underneath, the person as he was meant to be before all this adversity?

In this volume we will review in detail the theoretical underpinnings and steps you can take to reach through to the person beneath the resistance. Through decades of case-based research we can outline specific treatment ingredients to assist you with this process.

The intensive short-term dynamic psychotherapy (ISTDP) framework centers on key common ingredients of interest in psychotherapy

today, including use of video for quality improvement, a rapid evaluative procedure, cognitive restructuring as needed, a high degree of emotional engagement, and a here-and-now focus, among others. Moreover, this framework includes novel processes such as monitoring unconscious signals in the body, rapid handling of defenses, the somatic experience of emotions, and the potent healing force: the *unconscious therapeutic alliance* (Davanloo 1987a). These common psychotherapy factors, coupled with unique components, are woven into a seamless fabric allowing you to work with an extremely broad range of clients. About forty published research studies show that ISTDP can be highly effective to the majority of psychiatric patients with benefits that persist in long-term follow-up (Abbass, Town, and Driessen 2012, 2013). It performs very well in treatment-resistant and complex populations (Winston et al. 1994; Abbass 2006; Abbass, Sheldon, et al. 2008; Abbass, Town, and Bernier 2013; Solbakken and Abbass 2014). Moreover, its specific ingredients, such as emotional experiencing and defense work, are related to treatment outcomes (Abbass 2002a; Town, Abbass, and Bernier 2013; Johansson, Town, and Abbass 2014). Now numerous studies show the treatment to be cost-effective, offsetting the excessive cost burden these patients place on medical, occupational, and social systems (Abbass and Katzman 2013; Abbass, Town, and Bernier 2013).

If you are new to this approach, I hope it will be understandable and the amount of new terminology tolerable. If you are coming from a cognitive behavioral therapy background, it may help to consider this as a unique exposure model with cognitive restructuring and response prevention in cases as needed: this exposure is to internal emotions and can lead to generalized benefits. If you are coming from other psychodynamic schools, I trust the core elements and processes will have enough familiarity to bridge to novel accelerating components of this approach: psychodynamic therapy going efficiently with rapid mobilization of the unconscious will have common therapy ingredients described herein regardless of the school of therapy.

I will introduce and describe specific intervention types that have different neurobiological and psychological effects. Interventions such as *bracing* and *recapping* are used to build capacities, while *clarification*, *challenge*, and *head-on collision* are used to interrupt defensive

behaviors. The mainstay intervention, *pressure*, is used to continually reach toward the person beneath the resistance and to encourage maximal treatment engagement and self-compassionate efforts. These interventions combined are a palette of tools you can use to help patients build psychic strength, gain relational capacity, bear difficult feelings, and extract themselves from long-held self-destructive patterns.

I have broken the book down into two main parts. The first reviews a new metapsychology of the unconscious derived from thousands of case studies and goes into great detail in the theoretical and technical basis of the approach. The second part focuses on the clinical application of this metapsychology. This part begins with the initial process, including psychodiagnostic evaluation, and moves into the process of mobilizing and working with the unconscious of patients from across the two spectra. The appendix reviews the current state of evidence for short-term psychodynamic psychotherapy and intensive short-term dynamic psychotherapy.

My hope is that this book will support you in your capacity to care for the people you will be privileged to meet. I also hope it will provide a supportive challenge to master your own self as a therapeutic instrument.

PART 1

A New Metapsychology of the Unconscious

Attachment Trauma and Transference

Imagine a mother and baby, face to face; the baby is having “whole body smiles” in response to a warm and equally responsive mother. You feel good seeing this. Why? Something good is happening: attachment, with all the biological and psychological benefits that result. A child who grows up with this uninterrupted parental bond will be able to relate to others without undue fear, anxiety, or defensiveness.

However, what happens if this bond is interrupted by a parent’s mental illness, death, abuse, or separation? This *attachment trauma* causes painful feelings. If the child can process the pain with a loved one, he will continue to develop normally and have close relationships later in life. If he is unable to process these feelings with a loved one, he will avoid his feelings and the relationships that trigger them. He will suffer from anxiety over closeness and intimacy.

The intense pain of loss may also mobilize rage directed at the lost, absent, or abusive parent. Unable to depend on his parent to help him process his feelings, the child, with his immature mind, must depend on his defenses instead. Because his conscious rageful thoughts cause suffering, eventually he buries them in his unconscious. But, believing his thoughts are the same as deeds, the child will live as if he had acted out his rage, as if he had damaged or murdered his parent. As a result, he has complex feelings of love, pain, rage, longing, and guilt about the rage buried in his mind. Now he fears to be close to his feelings or to the people that trigger them.

A child who shuts down his complex feelings can grow into an adolescent who experiences interpersonal avoidance, self-destructiveness, physical illness, depression, anxiety, or anorexia. The earlier the

trauma, the more severe the pain, rage, and guilt will be and, thus, the greater the defenses and self-destructiveness. (See chapter 3.) The link between these trauma and long-term difficulties has been observed in diverse research about adverse childhood events (Felitti et al. 1998).

If a parent cannot or does not respond to the child, the child's attachment longings will be frustrated. Children without secure attachment will suffer from patterns of pathology such as fragile character structure (Davanloo 1995a) and borderline personality organization (Kernberg 1976). They will suffer from the consequences of massive pain, rage, and guilt due to their attachment efforts being thwarted. They rely on primitive defenses including projection, splitting, and projective identification, leading to a poor ability to maintain an integrated self. Their unconscious anxiety manifests as mental confusion and a range of neurological symptoms, leading to poor anxiety tolerance.

TRANSFERENCE

The complex emotions related to attachment trauma are mobilized in a patient's current relationships, especially in psychotherapy. Why? You are a caring person, offering a potential attachment and expressing positive regard for your patient. You, looking into his eyes, remind him of his early attachments, interrupted attachments and failed attachment efforts.

This process of activating emotions, anxiety, and defenses in the therapy relationship is *transference*. While transference does not represent the totality of all sources of emotional reactions in patients, it is the central focus of ISTDP and most forms of psychodynamic therapy.

As a matter of terminology, Habib Davanloo (1990) has also used the term transference to connote the therapy relationship itself. It is the *T* of the classic *Triangle of Person* (Malan 1979) where *C* is current people and *P* is past people (fig. 1.1).

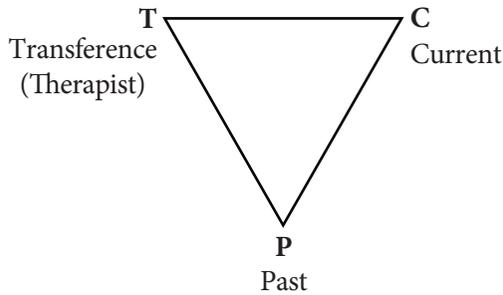


Figure 1.1 The triangle of person

COUNTERTRANSFERENCE

Otto Kernberg (1965) offers what is known as a totalistic definition of *countertransference* to account for all the feelings a therapist might experience with a patient. He proposes three kinds of countertransference that are all highly relevant to ISTDP:

- *Objective countertransference*: The patient evokes emotional reactions in the therapist that most people would have. For example, if the patient curses repeatedly, most therapists and others would be objectively irritated at such conduct.
- *Subjective countertransference*: The patient evokes feelings in the therapist that tell the therapist something about the patient's inner life. Kernberg (1965) describes two types of subjective countertransference:
 - *Concordant countertransference* where the therapist is identified with the patient's experience. This process, a product of empathic attunement, leads the therapist to feel something the patient is feeling. As a social species, we are able to sense other people's emotions and can experience the same visceral experience in some detail. For example, if you are the therapist, you may feel something in your stomach telling you the patient's anxiety is going into the smooth muscle of his stomach. You may feel a rise of heated rage in your chest, telling you that the patient's rage is coming to the surface.
 - *Complementary countertransference* occurs when the therapist feels the patient's feelings in the patient's transference

resistance. For example, the patient rejects you as he was rejected and you feel angry as the patient did when he was rejected in the past.

- *Neurotic countertransference*: The therapist has feelings toward the patient that are based on his own unresolved attachment trauma. Specifically, the past unresolved feelings in the therapist are activated while connecting with the patient and manifest in some combination of unconscious anxiety and defense.

These very useful cues help in understanding and working with the spectra of patients reviewed in upcoming chapters.

Attachment trauma is the central pathogenic force in a wide range of illnesses. Transference occurs when a patient's unresolved past feelings are activated in relation to the therapist and other current people. Objective countertransference occurs when the patient evokes feelings most people would have. Subjective countertransference occurs when the patient evokes feelings in the therapist that relate to the patient's inner life. Neurotic countertransference occurs when the therapist unconsciously transfers unresolved feelings onto the patient. Countertransference responses are helpful cues that can guide the therapist.

Unconscious Anxiety and Defenses

Attachment trauma–based unconscious pain, rage, and guilt trigger unconscious anxiety and unconscious defenses against that anxiety (fig. 2.1). This relationship is referred to as the *Triangle of Conflict* (Malan 1979). That is why we say that unconscious anxiety and defenses are *signals* of unconscious feelings.

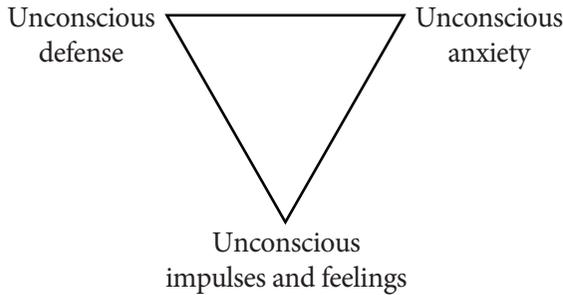


Figure 2.1 The triangle of conflict

Let's review the different patterns of unconscious anxiety and corresponding patterns of unconscious defense you will see.

STRIATED (VOLUNTARY) MUSCLE UNCONSCIOUS ANXIETY

The first pattern is *striated muscle unconscious anxiety* (Davanloo 2001; Abbass 2005). Striated muscle is the voluntary muscle of the body—muscle you can move on purpose. Anxiety in the striated muscle starts in the thumb and goes up the hand, arm, shoulder, and neck. Then it goes to the chest, abdomen, legs, and feet. This neurobiological process follows a progression up the side of the cerebral cortex. When

it is activated, you will see hand clenching and sighing respirations as the muscles of the chest and diaphragm contract and relax.

A person with anxiety in this pathway will have spasms, pains, and aches such as seen in fibromyalgia, headache, backache, neck pain, shoulder pain, chest pain, and abdominal wall pain. A person can experience hyperventilation with dizziness, tingling in the hands and feet, and a sense of shortness of breath as is seen with panic. Further, choking sensations, vocal problems, tics, and tremors can be caused or worsened by unconscious anxiety in the relevant striated muscle. A partial list of medical presentations related to striated muscle anxiety is shown in table 2.1.

Table 2.1 Striated-muscle-related medical presentations

Tension headaches	Chest pain
Jaw pain, teeth grinding	Shortness of breath
Choking sensations	Abdominal wall pain
Vocal and other tics	Leg pain
Neck pain	Cramps
Fibromyalgia	Tremors
Back pain	

Case Vignette: Striated Muscle Unconscious Anxiety

A man with fibromyalgia, with chronic pain related to stiff muscles, is sitting with hands firmly clenched while describing a conflict with his wife.

Therapist (Th): What kind of conflict was it? [*Pressure to be specific.*]

Patient (Pt): Um, well, problems with the neighbors. My wife's opinion was that I spent too much time arguing with this man, and she was probably right.

Th: So she brought this up again in the incident? [*Pressure to be specific.*]

Pt: Um-hmm.

Th: And how did you feel? [*Pressure to identify feelings.*]

Pt: Well, I'm getting tired of hearing about this.

Th: How do you feel toward her? [*Pressure to identify feelings.*]

Pt: [*Sighs deeply.*] Mad.

Th: Mad, like you mean angry? [*Clarification.*]

Pt: Angry, yeah.

Th: How do you experience the anger inside, physically inside your body? [*Pressure to experience rage.*]

Pt: I'm very, very tense.

Th: That's tension. That's anxiety. [*Clarification.*]

Pt: Anxiety, yeah.

Th: But how did you experience the anger toward her? [*Pressure to experience rage.*]

Pt: It's hard to explain.

Th: You became anxious, did you? [*Clarification.*]

Pt: Yeah, I became anxious.

Th: Do you become tense when you have anger, become anxious when you have anger inside? [*Clarification.*]

Pt: Yeah, and then I start to ignore her.

Th: That's a mechanism you use to deal with the anger? [*Clarification.*]
But how do you experience the anger underneath? [*Pressure to experience rage.*]

Pt: Like I say, it's really hard to put a word on that. I get really mad, okay.

Th: So it's like rage, you mean.

Pt: It's like rage, yeah.

Th: How do you experience the rage? [*Pressure to experience rage.*]

Pt: [*Sighs deeply.*]

In this segment, focus or pressure on the patient to identify his feelings toward his wife activated unconscious anxiety in the striated muscle: rather than feel the feelings, he just became tense and sore in his body.

ISOLATION OF AFFECT

Was this man able to intellectually tell me how he felt toward his wife? When I said how did you feel toward her, what did he say? He said "Mad."

He is able to intellectually label his feeling, but does he experience the feeling in his body? No, he just becomes frozen with tension. Does he notice this? No. He can describe the intellectual label (anger) but not the physical experience of his feeling. This is called *isolation of*

affect. When the person can intellectualize and isolate his affect from his experience, anxiety is discharged into the striated muscle. This capacity is parallel to the ability to self-reflect through activation of the dorsolateral prefrontal cortex. Davanloo calls the groups of defenses against the experience of murderous rage *major resistances*. Isolation of affect is the first one.

Anxiety in the striated muscle is the best pattern to have, except in this patient's case the degree of chronic tension he had caused a lot of muscle pain. When he experienced the underlying rage and guilt, his tension and pain dropped rapidly.

SMOOTH MUSCLE UNCONSCIOUS ANXIETY

The second pathway of unconscious anxiety involves the *smooth muscle*. Smooth muscle is involuntary muscle over which a person has no control, located in the airways, bowel, and blood vessels. The muscle in the bladder is similar but is called *transitional muscle*. People with a lot of anxiety channeled to this muscle suffer from many somatic symptoms requiring referral to medical specialists. A partial list of these common presentations is shown in table 2.2.

Table 2.2 Smooth-muscle-related medical presentations

Medical specialty	Smooth-muscle-related condition
Cardiology	Hypertension, coronary spasm, flushing, hypotension with loss of consciousness
Respirology	Asthma, coughing, choking symptoms
Gastroenterology	Irritable bowel syndrome, gastroesophageal reflux disease, functional vomiting, unexplained abdominal pain
Urology	Bladder dysfunction, interstitial cystitis
Neurology	Migraine

If unconscious anxiety goes into smooth muscle when the therapist focuses on emotions, he will see no striated muscle tension. These patients seem relaxed because they don't exhibit visible muscle tension. Since they don't look anxious, they end up in medical settings rather than psychologists' offices. Patients with unconscious anxiety in this pathway frequently have two or more of the conditions listed: in our own large sample (Johansson, Town, and Abbass 2014), one half of the patients with migraine headaches also have irritable bowel syndrome.

Case Vignette: Smooth Muscle Unconscious Anxiety

A middle-aged woman with migraines and irritable bowel syndrome is sitting looking very calm with no visible muscle tension.

Th: Can you tell me an example of when you had a conflict so we can see how it affects your symptoms? [*Pressure to be specific, pressure to task.*]

Pt: If I ever get in a conflict with someone, I get a headache. [*Suggestion of link to complex feelings.*]

Th: Can you describe a specific time this happened? [*Pressure to be specific.*]

Pt: It happens with my husband sometimes.

Th: Can you tell me an example of when that happened? [*Pressure to identify feelings.*]

Pt: Yes, once when my husband had spent all our money on a trip and we had none left for our rent, I was so mad I yelled at him. A while later I got a headache and nausea.

Th: So you did the action of yelling, but how did you feel toward him? [*Clarification of action versus feeling, pressure to identify feelings.*]

Pt: I thought, "I'm not a good wife." [*No display of signals of striated muscle anxiety.*]

Th: You mean you became critical of yourself? [*Clarification.*]

Pt: Yes, I was. My stomach doesn't feel good right now.

Th: Can you tell me what you notice in your stomach? [*Intellectual review to reduce anxiety and isolate affect.*]

Pt: There are cramps here, like bloating coming on. [*Points to her middle abdomen.*]

Th: So when we talk about this situation of conflict and frustration, your stomach reacts. Is that what happened? [*Recap: feelings-anxiety.*]

Pt: Yes, it seems to.

Th: So is this a way that frustration with your husband goes, to your stomach or to a headache somehow? Because when you start to talk about your frustration toward him, your stomach reacts here and out there you got a headache. [*Repeat of recap.*]

Pt: Yes, it did.

Th: Can we examine that? How that happens here? [*Pressure to task and patient's will.*]

Pt: I would sure like to.

Monitoring of Response

The therapist observes that the patient looks completely relaxed with no striated muscle tension. This woman's anxiety is not discharged into the striated muscle but is being *repressed* into the smooth muscle in the gastrointestinal tract. In the actual event it appeared to produce a headache. The patient also has a tendency to self-criticize when she has anger with someone else, another typical finding in patients with *repression*. To confirm that anxiety is channeling to the smooth muscle and to ascertain the level of anxiety intolerance this patient has, the therapist repeats the process with another focus.

Th: Can you tell me what happens when we are here together? What feelings come up here with me as we talk together? [*Pressure to identify feelings.*]

Pt: Well, I don't know. [*Smiles but shows no visible tension.*]

Th: Let's see what feelings come up here generating this stomach effect. [*Repeat of pressure.*]

Pt: I . . . my stomach is reacting again. [*Again appears totally relaxed with no striated muscle response.*]

Th: So again when you speak of your feelings, your stomach reacts with cramps. [*Recapitulation, linking of feelings with anxiety.*]

Assessment

The therapist confirmed that this woman's unconscious anxiety was not discharged to the striated muscle but rather into the smooth muscle of her bowel. She had limited ability to isolate affect or intellectualize about her emotions. These findings show that rapid mobilization of unconscious feelings could worsen her gastrointestinal symptoms because her anxiety exceeded the threshold of her anxiety tolerance. Hence, before helping her to be able to tolerate her unconscious emotions, the therapist needs to build her anxiety tolerance through the *graded format of ISTDP* reviewed in chapter 15 (Davanloo 1995b, c; Whittemore 1996; Abbass and Bechard 2007).

REPRESSION

Was this woman able to identify which emotions she was feeling? No. She started to talk about when she was irritated but ended up

talking about where the feelings went—into the stomach. The emotions were *instantly repressed*. The feelings did not reach consciousness but instead were repressed into the body. Recent research suggests this process is mediated at least in part by the subgenual part of the anterior cingulate cortex. Depressed patients with overactivity in this region do not respond to cognitive therapy, cognitive behavioral therapy, or certain antidepressants (Abbass, Nowowieski, et al. 2014).

Repression is the second category of major resistance. Repression is an unconscious process where emotions are shunted away from consciousness. This is different than *suppression*, where the patient consciously avoids emotions.

COGNITIVE-PERCEPTUAL DISRUPTION

Cognitive-perceptual disruption occurs when unconscious anxiety interrupts a person's special senses and ability to think. Some of the many manifestations of this anxiety pathway include interruption of vision or hearing with what is better known as *sensory conversion*. A person can transiently go completely blind or deaf. The mind goes blank and the person can even lose consciousness with a fainting attack or a pseudoseizure type of event. The person can hallucinate when anxious: thus, he may actually experience transient psychotic phenomena. These patients end up seeing the neurologist and having special tests like magnetic resonance imaging scans, and some patients are misdiagnosed as having psychosis. A partial list of clinical presentations of cognitive-perceptual disruption is in table 2.3.

Table 2.3 Cognitive-perceptual-disruption-related medical presentations

Visual blurring, visual loss, tunnel vision
Hearing impairment or loss
Memory loss, mental confusion
Loss of consciousness
Pseudoseizure
Dissociation
Hallucination in all five senses

If a person has significant anxiety in the form of cognitive-perceptual disruption and the therapist focuses on unconscious feelings, this patient will become mentally confused or develop some of these other phenomena.

Case Vignette: Cognitive-Perceptual Disruption

A man with paranoid personality disorder arrived in a treatment session rubbing his eyes but with absolutely no visible striated muscle anxiety.

Pt: You'll have to excuse me a little today; I'm a little foggy.

Th: Foggy? [*Clarification of the experience.*]

Pt: Yeah.

Th: Is your thinking kind of foggy, cloudy? [*Clarification of the experience.*]

Pt: Foggy and cloudy.

Th: How's your vision? [*Clarification of the experience.*]

Pt: Cloudy.

Th: Is it tunnel vision, or is it like looking through a screen? [*Clarification of the experience.*]

Pt: More tunnel vision.

Th: More like it's hard to see the outside of your visual field, but you can see straight ahead in the room. [*Clarification of the experience.*]

Pt: Yeah.

Th: When did that start? [*Pressure to be specific.*]

Pt: Um, two, maybe two days ago relatively . . . like I just noticed it this morning.

Th: So this is what we looked at as anxiety, right? [*Pressure to remember previously learned material.*]

Pt: Yeah.

Th: And the last two days, all day? [*Clarification of the experience.*]

Pt: Actually more or less just today when I woke up.

Th: Okay, so why are you anxious right now? [*Pressure to identify causes.*]

Pt: Is it anxiety?

Th: That's what we figured when we've met before. [*Pressure to remember previously learned material.*]

Pt: It's more of a completely stoned type of feeling.

Th: It's a disconnection kind of thing. Disconnected from what's going on. [*Clarification.*]

Pt: Yeah.

Th: And any thoughts about why you're anxious this morning? [*Pressure to identify causes.*]

Pt: I don't think it has anything to do with coming here.

Th: You don't think it has anything to do with coming in?

Pt: Not to do with coming to see you, no.

Th: You weren't anxious about it?

Pt: No, I don't think so.

Th: How do we account for that anxiety then? How are you accounting for it? [*Pressure to identify causes.*]

Pt: I've got school tomorrow and I was thinking about school last night.

Th: Why today though? [*Pressure to identify causes.*]

Pt: Um, I don't know. You're right, cause it's kind of subsiding!

Th: It's just come down now?

Pt: Yeah.

In this vignette, the patient has no anxiety in the striated muscle. Could he tell the therapist about the emotions? No. He wasn't conscious of his feelings or even his anxiety. This is why we call it *unconscious* anxiety. Since they are unaware of their feelings or anxiety, these patients often seek medical attention for these somatic symptoms.

PROJECTION, PROJECTIVE IDENTIFICATION, AND SPLITTING

In the early sessions, this patient projected his rage onto others and then feared them. By this treatment session, he had ceased projecting and was exploring his own feelings and the anxiety they triggered. As he trusted me and faced his feelings, anxiety began in the form of cognitive-perceptual disruption. Projection is a major defense against cognitive-perceptual disruption. By projecting his anger onto others, he did not have to experience unconscious anxiety over the intense rage within himself but he instead suffered conscious fear and rage about the rage he expected from others.

Like projection, projective identification goes with cognitive-perceptual disruption. Projective identification in this frame is the projection of aspects of oneself, such as the abuser, the neglecter, or the critic. These projected parts may produce a concordant (we are both critics) or complementary reaction in others (you are controlling so I will defy you).

Splitting refers to holding one-dimensional views of people and events to preclude any complex feelings and anxiety. Examples of splitting include idealization and devaluation of the self or others.

Patients with dissociative and psychotic disorder diagnoses, at times, have these manifestations of unconscious anxiety and defense. (See chapters 16–17.)

MOTOR CONVERSION

Another somatic pattern related to unconscious feelings and impulses is motor conversion. When motor conversion is active, instead of striated muscle tensing up, the patient goes weak and flat, losing power in one or more muscle groups. For example, the patient may lose the ability to move his arms, legs, or vocal cords. Sometimes, as in the case of tremor, the patient experiences excess tension alternating with weakness in rapid cycles.

When the patient's anxiety goes into conversion, he looks relaxed because he has no striated muscle tone. This is the well-known phenomenon of “la belle indifference” where the person appears relieved despite paralysis. The patient is neither anxious nor defensive because the anxiety and defense both are converted into weakness.

To clarify, many neurologists also refer to striated muscle symptoms of unconscious anxiety as conversion, but the mechanism is obviously different. Patients with anxiety in the striated muscle rarely show la belle indifference; patients with motor conversion usually do. Patients with anxiety in the striated muscle will show signaling of a rise of unconscious feeling and anxiety; patients with motor conversion do not. Patients with anxiety in the striated muscle will be tense and strong; patients with motor conversion will show no tension and lots of weakness. Patients with anxiety in the striated muscle will use tactical defenses and isolation of affect; patients with motor conversion will show few defenses since all the feelings and anxiety are repressed,

manifesting as weakness. Obviously, the treatment of these two categories of conversion will differ greatly.

Case Vignette: Motor Conversion

A man with episodic weakness with falling and becoming at times paralyzed for hours or days comes to the office by wheelchair. He is having a great deal of weakness and spasms and moving from side to side in the chair as if he could fall out.

Th: I understand you saw the neurologist about some problems and he suggested that we meet. What are the difficulties that you're experiencing at this point in time? [*Pressure to be specific.*]

Pt: [*Display of large-amplitude upper body spasms.*]

Th: You're experiencing physical symptoms right now? [*Clarification of symptoms, encouragement to self-reflect.*]

Pt: Yes.

Th: What are you experiencing in your body, at this point, right now? What is it that you observe from inside? [*Pressure to self-reflect.*]

Pt: Uh, well, I'm coherent. [*Self-reflection with a clear head.*]

Th: Um-hmm, what is it that you're noticing in your body? [*Encouragement to self-reflect.*]

Pt: Okay. [*Self-reflection.*]

Th: Are you aware of being anxious? [*Encouragement to self-reflect.*]

Pt: No, I'm not anxious.

Th: Do you notice muscle tension? [*Encouragement to self-reflect.*]

Pt: You mean as far as being tense coming into the building?

Th: Muscle tension within your body. [*Encouragement to self-reflect.*]

Pt: Oh yeah, I know that's there.

Th: Why is that there right now when you're coming here to see me; what's causing that? What feelings are driving that tension in the body? [*Pressure to identify feelings.*]

Response to Focused Process

After seven minutes of focusing on the bodily experiences and what underlying emotions he had, the patient becomes much more relaxed and the spasms stop. He has no sighing and hand clenching, suggesting the emotional forces are manifesting as conversion. He begins

to focus on conflict with his new wife that predated these symptoms, which began one year prior.

Pt: My wife likes to have things a certain way, and sometimes she goes off yelling and cursing.

Th: Um-hmm.

Pt: And it really pisses me off.

Th: So this was a certain time when you were home and that happened? [*Pressure to be specific.*]

Pt: I could hear her walking around the hallway swearing.

Th: How did you feel toward her? [*Pressure to identify feelings.*]

Pt: Very angry!

Th: How does that feel in your body when you think about that—in your body? [*Pressure to experience rage.*]

Pt: In my body. [*Self-reflection.*]

Th: Thinking about it now, what are you noticing that tells you that you feel very angry inside? [*Pressure to experience rage.*]

Pt: Gosh! [*Self-reflection; draws a large sigh.*]

Conversion to Striated Muscle Anxiety

This patient's sigh is a marker of a shift from conversion to the striated muscle anxiety pathway. This transition is a direct product of focused pressure to mobilize his unconscious emotions, coupled with efforts for him to observe his body and isolate affect. When he started to isolate affect, the emotional forces shifted from conversion to striated muscle anxiety. From this state he went on to experience some complex feelings about his wife, including a small amount of somatic anger and guilt. These feelings with his wife became linked to complex feelings about his mother from past verbal abuse. His mother is now a nice, older woman: the conflict with his wife has mobilized this unresolved rage and guilt.

At the end of the session, the patient is quite strong in all his limbs and walks out with no need for his cane or wheelchair. What took place is the process of replacing motor conversion with emotional experience. We explored feeling gradually to change the pathway of anxiety discharge from motor conversion into the striated muscle. Chapter 15 describes this “graded format” in great detail, but the principle is

this: if the therapist helps the patient isolate affect, unconscious anxiety shifts to the striated muscle.

MAJOR RESISTANCE OF GUILT

A fourth category of major resistance is resistance of guilt or the punitive superego (punishing conscience), a force that Davanloo calls the *perpetrator of the unconscious* (Davanloo 1987b, 1988, 2005). This resistance of guilt refers to a built-in need to defeat and sabotage the treatment process to avoid the experience of unconscious impulses and feelings. This resistance is driven by intense guilt about murderous and primitive rage toward loved ones and is seen in highly resistant and fragile patients. Unconscious guilt drives an overbuilt conscience that punishes the patient for his complex feelings: the patient harms himself to avoid guilt over his wish to harm others. The result is damage to relationships, reduced insight into oneself, loss of productivity and limited enjoyment of life. Anytime the therapist approaches the patient's complex feelings, the resistance of the superego will interrupt the session. This resistance is a formidable foe to the therapy process, requiring extensive efforts to turn the patient against it; it is the essence of treatment resistance in psychiatric conditions. The patient cannot let himself succeed in the bond with the therapist due to massive guilt about rage toward loved ones. In response, use well-timed pressure, challenge, and head-on collision to overcome this powerful resistance. (See chapter 15.)

SUMMARY: MAJOR DEFENSES AND SOMATIC PATTERNS

Thus, we see specific somatic patterns of unconscious anxiety and the defense of motor conversion. These four patterns (striated muscle, smooth muscle, cognitive-perceptual disruption, and conversion) correspond to patterns of major resistance. Recognition of these patterns can directly inform how to proceed with psychotherapy. (See table 2.4.) Some patients have different anxiety pathways predominant at different times, so we will review interventions used to manage each of these.

Table 2.4 Corresponding somatic and resistance patterns

Somatic pattern	Corresponding resistance
Striated (voluntary) muscle	Isolation of affect
Smooth muscle	Repression
Motor conversion	Repression
Cognitive-perceptual disruption	Projection, projective identification, splitting, repression
Any of the above patterns	Resistance of guilt (punitive superego)

TACTICAL DEFENSES

In contrast to major defenses, tactical defenses are loosely held and easily penetrated or bypassed—they are satellites around the major defenses or can constitute the entire set of defenses a patient uses (Davanloo 1996a, b). Rather than a dichotomy, these defenses are on a continuum from tactical to major defenses. (See fig. 2.2.)

Tactical defense

More apparent
Dystonic
Loosely held
Easily handled



Major defense

Less apparent
Syntonic
Tightly held
Difficult to handle

Figure 2.2 Continuum of tactical to major defenses

Several types of tactical defenses exist, including the following:

Cover words: using words to hide one's true feelings

Cover words for anger: "It bugged me" or "I'm annoyed."

Confusion as a tactical defense: "I'm confused."

Cover words for murderous rage: "I'm frustrated."

Cover words for emotional closeness: "I'm embarrassed."

Covers words like silly or dumb: "It was a silly situation to be in."

Defensive weeping: using regressive defenses

Blanket statements: saying for example "I was completely overwhelmed."

Use of jargon: making statement such as "I was full of existential angst."

Indirect speech: stating for example "I was probably mad."

Rumination: rambling nonspecifically without a focus or target

Vagueness: responding to a question with a vague statement

Rationalization: explaining the reason for a feeling rather than the feeling itself

Intellectualization: giving a description devoid of emotional experience

Generalization: being nonspecific

Diversification: avoiding the focus

Not remembering: suppressing and ignoring emotions

Denial: not acknowledging what one is actually experiencing or doing

Externalization: blaming others for internal problems

Obsessional indecisiveness: not committing to specifics about problems or emotions

Stubbornness, defiance: exhibiting oppositional conduct

Tangents: avoiding specific focus on feelings or problems

Somatization: describing symptoms rather than actual feelings

Talking to avoid the experience of feelings: continuing to speak so feelings are not felt

Body movement as defense against feelings: avoiding eye contact for example

Passive compliance: going along with the therapist

To determine whether a defense is a tactical defense versus part of the major resistance, the therapist should interrupt or ignore it and see whether it goes away. If the defense keeps coming back, it is likely part of the tightly maintained major resistances against murderous rage.

There are many ways to handle tactical defenses including clarifying, pressuring, ignoring, blocking, and challenging (Davanloo 2005). In general, tactical defenses can be ignored so long as there is continued rise in unconscious signals and access to feelings. If the patient keeps using a tactical defense, it is more a part of major resistance and it will need to be clarified and challenged directly.

Low resistance patients use only tactical defenses. *Moderately resistant patients* use both tactical and major defenses. *Highly resistant patients* with repression and *fragile character structure patients* may lack tactical defenses, so they succumb to major defenses of repression and projection.

There are four main formats of somatic manifestation of activated unconscious emotions and corresponding categories of major resistance. Many forms of tactical defenses may exist separately or be more or less part of major resistance. Tactical and major defenses are on a continuum. These defenses are all signals of activated unconscious impulses and feelings.

Spectra of Suitable Patients

This chapter reviews the categories of patients suitable for ISTDP (Davanloo 1995b, 2001). These categories of patients relate to the degree and nature of defense and anxiety. (See fig. 3.1.)

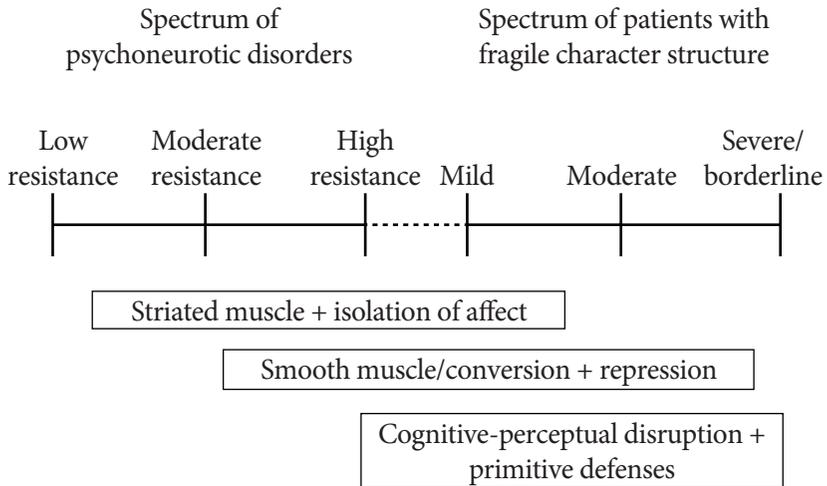


Figure 3.1 Spectra of patients suitable for ISTDP

These categories also relate to the intensity of underlying unprocessed feelings and impulses, which in turn relates to the age of trauma. (See fig. 3.2.)

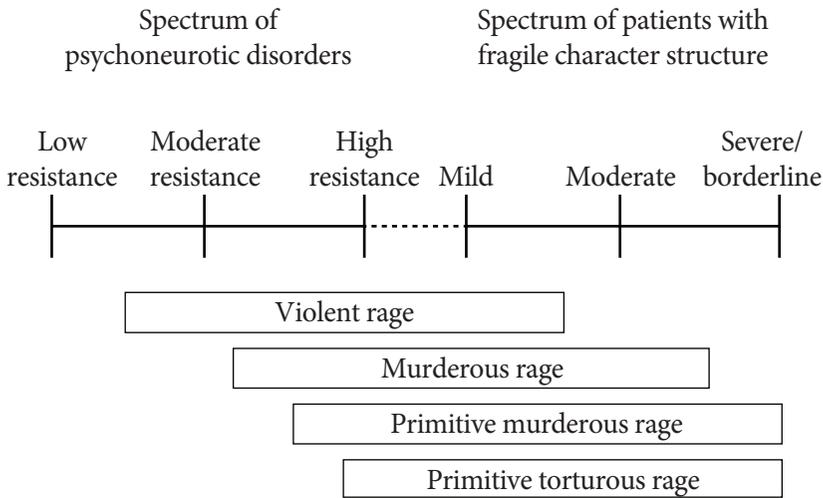


Figure 3.2 Underlying guilt-laden aggressive impulses

SPECTRUM OF PSYCHONEUROTIC DISORDERS

The first of two spectra is the spectrum of psychoneurotic disorders (Davanloo 1995a). This spectrum goes from low to moderate to high resistance.

Low resistance patients are highly responsive with a single focus of loss with unresolved grief. These losses have typically occurred after the age of seven. These patients present with only minor tactical defenses; they do not have unconscious rage and guilt so they have no major resistance. (See chapter 12.)

Moderately resistant patients present a moderate degree of symptom and character problems. They have experienced attachment trauma, usually after age five, resulting in unprocessed pain, murderous rage, guilt about this rage, and grief. Unconscious anxiety is discharged to the striated muscle, and the primary major defense is isolation of affect, although they can also experience some repression. These patients have some insight into the problems and defenses, but are moderately impaired socially and functionally due to resistances against emotional closeness and habitual character defenses. (See chapter 13.)

On the right side of the spectrum, highly resistant patients have complex symptoms and character problems. These patients have

endured trauma early in life typically starting before age four, resulting in layers of intense grief, rage, and guilt about the rage. They also have layers of guilt and grief due to losses resulting from the defenses. These feelings tend to be fused together and hard to experience separately. If the rage has a sexualized component (e.g., urge to rape) it is highly fused with primitive rage and guilt. Highly resistant patients have a punitive superego due to buried primitive murderous rage and guilt about the rage. They use *syntonic* character defenses, meaning they do not see their defenses as problematic. These patients also have *resistances against emotional closeness*. Repression and isolation of affect are typical major resistances. They can be extremely detached or defensive, or they can suffer from self-destructive behavior disorders. They can also suffer from severe symptom disturbances. Friends, family, and health professionals have usually given up trying to reach through to these patients.

SPECTRUM OF PATIENTS WITH FRAGILE CHARACTER STRUCTURE

The next spectrum comprises patients with fragile character structure (Davanloo 1995a). They comprise one-quarter of psychiatric private office referrals (Abbass 2002a). These patients have intense, unconscious, primitive murderous rage, primitive torturous rage, guilt, and grief related to figures in the past who failed to consolidate or heal ruptured bonds with the patient. The major resistances of fragile patients are primarily primitive defenses such as projection, projective identification, splitting, and repression. Unconscious anxiety occurs as cognitive and perceptual disruption in the forms of mental confusion, dissociation, fainting, or hallucination. They have much dysfunction and often land in jail or the hospital because of physical injury. They cannot tolerate their own emotions, so they need preparatory work to help them build capacity before they can face underlying feelings.

At the mild end of this spectrum are fragile patients who experience these primitive phenomena only at a high level of anxiety; these patients can tolerate a moderate amount of anxiety. At the severe end of the spectrum are patients with borderline personality structure who use projection and projective identification at a very low level of

anxiety. Moderately fragile patients fall between these two extremes. (See chapters 16–17.)

CONTRAINDICATIONS TO ISTDP TRIAL THERAPY

In general, relatively few absolute contraindications exist to having an ISTDP trial therapy. Because the model includes close monitoring of patient response and techniques to bring down anxiety, it is generally a safe procedure, even with patients with more severe mental disorders. However, the following relative contraindications are worth noting.

First, patients with active *mania* should not be provided a trial therapy: there is significant likelihood of increased symptomatology. Likewise, patients with *unstable psychotic* symptoms should not be offered a trial therapy until stabilized. Even then, psychosis is a contraindication to this model in the hands of most therapists with even a moderate degree of experience. Patients with active *ulcerative colitis*, *Crohn's disease*, *multiple sclerosis*, and *rheumatoid arthritis* should be treated with great caution when using this approach as any increase in anxiety caused by treatment could exacerbate these autoimmune disease processes.

Active *substance dependence* is a relative contraindication to this treatment. Patients who come to sessions intoxicated or who are unable to function without alcohol in their systems may require medical detoxification and a period of abstinence prior to being able to benefit significantly from this treatment. Patients using marijuana daily can undergo a trial therapy without any significant difficulties or concerns about withdrawal.

Patients who are actively *suicidal* can have a trial therapy so long as they can (in the therapist's opinion) make an honest commitment to not act on these impulses in the service of trying treatment. If any doubt exists about willingness or ability to make this commitment, the patient should be assessed for more intense care including hospitalization, medications, and emergency services.

CAUTION REGARDING THE USE OF INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY

Even with the safeguards built into this treatment approach, therapists should work within their level of skill, confidence, and knowledge. This guideline is a basic matter for all regulated therapists and is at the core of professional ethics codes. An anxious therapist is more likely to induce misalliance and adverse effects. Thus, therapists should only work with more complicated patients, including patients with repression, depression, conversion, and cognitive disruption, under supervision or with close scrutiny through video-recording and some sort of peer review process. Being in over one's head can result in adverse effects in both therapist and patient (Abbass 2004).

The majority of patients seeking psychiatric services fall into two broad spectra of patients suitable for ISTDP. Patients with fragile character structure have had deficient early attachments plus trauma, resulting in cognitive-perceptual disruption and primitive defenses. Patients with psychoneurotic disorders had more secure attachments and do not routinely employ these primitive defenses. A cautious approach is warranted in applying the model in certain cases.

Complex Transference Feelings and the Unconscious Therapeutic Alliance

In all but the low resistance patients, direct access to the unconscious can be achieved through the mobilization and direct experience of the *complex transference feelings*, a process that effectively reduces *resistance* and activates the healing force within the patient that Davanloo (1987a) called the *unconscious therapeutic alliance*.

TRIPLE FACTORS

Davanloo (2005) discovered the key relationship between the complex transference feelings, unconscious therapeutic alliance, and resistance. These complex feelings toward the therapist resonate with pain, rage, and guilt about the rage from past attachment trauma. When these unconscious complex feelings are activated with the therapist, unconscious anxiety and defenses (resistance) are mobilized. The direct experience of the complex feelings overrides the anxiety and defenses. Through this process, the unconscious therapeutic alliance rises in proportion. This entire process is referred to as *unlocking the unconscious* (Davanloo 1995d).

COMPLEX TRANSFERENCE FEELINGS

Complex transference feelings are mobilized when the therapist reaches to the person who is stuck underneath the defenses. Trying to connect to the person and helping him battle his defenses evokes complex feelings, which include warm feelings or appreciation coupled with irritation and anger toward the therapist. The anger will have an

element of guilt attached to it because of the positive feelings toward the therapist. The degree to which these complex feelings are experienced is in direct proportion to both the removal of resistance and the dominance of the unconscious therapeutic alliance.

Simply put, the degree to which a person can experience love, rage, and guilt combined equals the degree to which the unconscious therapeutic alliance can be activated. This capacity to tolerate ambivalence is the central key to ISTDP and needs to be optimized. Without this capacity, the unconscious will stay shut, and emotions will stay buried.

This same capacity must be present in the therapist: he must be able to simultaneously feel *both continuous positive regard for the patient and disdain for the resistances* that hurt the patient.

Together, the patient and the therapist can safely tolerate only as much rage as they can experience love at the same time: combined, these experiences enable the experience and working through of guilt, the central pathogenic force in all but low resistance patients. If the therapist or patient cannot tolerate this ambivalence, the process will become split with elements of idealization and devaluation resulting in either limited treatment effects or adverse events (Abbass 2004).

UNCONSCIOUS THERAPEUTIC ALLIANCE

The therapeutic alliance is composed of conscious and unconscious components. Conscious therapeutic alliance refers to rapport, shared objectives, shared therapy effort, and other ingredients of an effective collaborative process. A conscious therapeutic alliance is inadequate to bring up unconscious material for processing in all but lower resistance patients; another more powerful force is required to battle higher degrees of resistance.

Davanloo's major discovery is that of the unconscious therapeutic alliance (Davanloo 1987a). When working with highly resistant patients and mobilizing the unconscious, Davanloo observed that the patients were experiencing visual imagery in the form of damaged or dead bodies of attachment figures or other disturbing images. He discovered this was a manifestation of a dynamic force in the patient working to bring unconscious feelings and impulses to consciousness to be healed. He called this force the *unconscious* therapeutic alliance

since it was not functioning volitionally, and it operated differently than conscious components of therapeutic alliance.

When the unconscious therapeutic alliance is working at a high level, visual imagery of the unconscious is indeed experienced within and between the treatment sessions. However, it is more common for the unconscious therapeutic alliance to only be mobilized to a partial level so that these more dramatic or obvious manifestations are absent. For help in recognizing these lower level manifestations of unconscious therapeutic alliance, figure 4.1 describes a *spectrum of the unconscious therapeutic alliance* (Abbass 2012). The therapist’s goal is to recognize when the unconscious therapeutic alliance is developing and work with the alliance rather than disagree with the alliance or become frightened by what it produces.

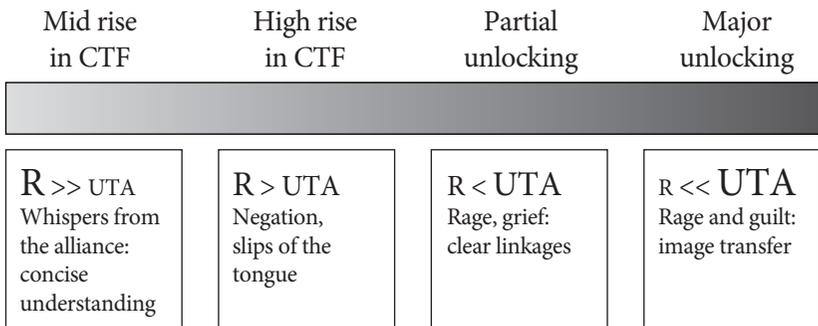


Figure 4.1 Spectrum of unconscious therapeutic alliance
 R: resistance, UTA: unconscious therapeutic alliance,
 CTF: complex transference feelings

Whispers from the Alliance

I refer to the very first signs of the unconscious therapeutic alliance as *whispers from the alliance*—these occur when the patient offers short statements reflecting concise understanding of her difficulties and inner obstacles to treatment. She speaks softly but with deep meaning. Whispers from the alliance occur at a mid rise in the complex transference feelings: they are the first communications from the unconscious therapeutic alliance. At this stage, the unconscious therapeutic alliance is mobilized but mostly overpowered by the resistance and anxiety.

One patient who always felt herself a victim declares with a small voice something that summarized her difficulty.

Pt: I've been getting in my own way.

A chronically self-punitive man says the following:

Pt: Maybe I am not such a bad person.

A highly resistant man simply makes a statement about his feelings:

Pt: I bottle them up!

These communications are markers of a mobilized unconscious: a shifting in favor of alliance over resistance.

Negation and Slips

The next level of unconscious therapeutic alliance appears in the form of negation and slips of the tongue, as originally described by Freud. Negation simultaneously reveals and denies the unconscious wishes. Negation occurs at a high rise in the complex transference feelings where the unconscious therapeutic alliance is growing but still somewhat weaker than the resistance.

One man at a high rise in complex feelings makes a declaration:

Pt: I never hit anybody in my life.

And three seconds later he adds to his statement.

Pt: I did but I missed him and hit the wall! Yeah! I broke my hand.

A middle-aged man declares the following after a partial passage of complex feelings.

Pt: I can't think of a specific time and day I felt angry with my father.

Th: You can't think of one?

Pt: Yes, I can! On my seventh birthday he was drinking and fell over right on the table.

A young man with depression has this to say at a high rise in complex feelings.

Pt: I never wanted to kill anyone.

Th: You mean you wanted to kill people?

Pt: Yes, I did!

As you see, at this level of rise in complex transference feelings and unconscious therapeutic alliance, the patient is nearly ready to declare feelings he had not previously been clearly aware of.

Linkages

The next level of unconscious therapeutic alliance occurs in the form of crystal-clear linkages the patient makes between his past and current complex feelings. These linkages occur during a first breakthrough or partial unlocking of the unconscious after the patient experiences some components of the complex transference feelings. The unconscious therapeutic alliance, now higher than the resistance, can direct us to the underlying complex feelings.

A middle-aged woman after experiencing violent rage and guilt about the rage toward the therapist declared:

Pt: No. No. I feel terrible to have thought of hitting you . . . I remember my mother did that to me once. I think I could have killed her that day.

A young man after passage of violent rage and guilt toward the therapist declared:

Pt: I just remember my father did something to me. My sister and I were arguing, and he put me in the basement in the dark. I was so furious about that.

Transfer of Images

At the next level, the unconscious therapeutic alliance results in the transfer of visual imagery. When the person experiences murderous rage and guilt in the therapeutic relationship, the visual imagery will transfer to the person in the past where those feelings belong. When murderous rage breaks through to the therapist for example, the image of the therapist might convert into the blond-haired, blue-eyed mother from the past. Then the patient will feel guilt and other emotions toward her mother. This process is a *major unlocking of the unconscious*. The experience of the rage clears out the anxiety and drops the resistance; then the unconscious therapeutic alliance dominates the weakened resistance. When the unconscious is thus mobilized, patients often see powerful imagery during and between sessions. Davanloo called this process *dreaming while awake* (Davanloo 2005).

Here is an example of dreaming while awake: After a session one patient saw an image of her mother's dead body floating in the harbor. As she kept walking along the waterside, her mother's dead body

floated beside her all the way home. The same image kept rising up across her visual field “like a slide” until this patient had a major passage of guilt about the rage toward the mother.

WORKING WITH THE UNCONSCIOUS THERAPEUTIC ALLIANCE

The forthcoming chapters contain many case vignettes illustrating how to work with the mobilized unconscious therapeutic alliance. A few of the central themes to note are as follows:

- *Recognize the unconscious therapeutic alliance at its lower levels:* The first step is detection of the unconscious therapeutic alliance so you don’t accidentally counter and obstruct it. Then you will go to a mode of listening for what the unconscious therapeutic alliance is saying versus working to mobilize it. One not uncommon technical issue in new learners is missing the unconscious therapeutic alliance and challenging it rather than following it. In one example the therapist kept challenging the patient’s unconscious therapeutic alliance that was bringing a clear incident from the past with the father: the therapist kept pressing to feelings in the transference, thereby blocking access to the unconscious.
- *Follow it! You are now the copilot:* When the unconscious therapeutic alliance is mobilized, your job is to follow it, help the patient maximize his emotional experiences, and recap what is learned with the unconscious therapeutic alliance. You have done the job of mobilizing this powerful force; now the task is for a partnership of two copilots to fly over regions of the unconscious that need examining and experiencing.
- *Educate it—recapitulate:* After you complete segments of emotionally focused work, recapitulate what is learned in great detail to bolster the unconscious therapeutic alliance. To recapitulate, actively link all the information together in terms of feelings-anxiety-defense and all people, past and present. Make this a shared process with the patient, and be sure each piece is correct by verifying it with her. This linking work fuels the unconscious therapeutic alliance, which is then empowered with a deeper understanding of psychodynamics and the treatment

pathway. This understanding allows you and the patient to collaboratively paint the portrait of the person's overall self. Cases in chapters 13–17 illustrate the techniques and functions of recapitulation.

- *Maintain it:* If anxiety and resistance overtake the unconscious therapeutic alliance, your job is to repower the unconscious therapeutic alliance through pressure, challenge, and head-on collision to reactivate the complex transference feelings and unconscious therapeutic alliance. If the unconscious therapeutic alliance is weak, the patient will try to move the process into the transference, as if it is a gas station, for more fuel.

UNCONSCIOUS THERAPEUTIC ALLIANCE VERSUS PSYCHOSIS

Signs of the unconscious therapeutic alliance can be mistaken for a psychotic breakdown or major cognitive disturbance. In fact, a patient whose unconscious therapeutic alliance is mobilized is doing well in her life. She is generally working, functioning, relating well to others, and experiencing decreased symptoms. In contrast to a psychotic breakdown, signals of the unconscious therapeutic alliance have clear dynamic links that, when worked through, lead to the experience of the complex feelings and therapeutic effects.

The complex transference feelings include deep appreciation and irritation toward the therapist for his efforts to reach through the patient's resistance. The unconscious therapeutic alliance is seen along a spectrum from low levels to a position of dominance over the resistance when it shines light on the unconscious impulses and feelings to allow healing. The unconscious therapeutic alliance is mobilized in direct proportion to the complex transference feelings: reaching through resistance brings the unconscious therapeutic alliance into force.