CHAPTER SIX

Professor Allan Abbass: intensive short-term dynamic psychotherapy

DK: Can we start by your telling me what personal or professional experiences directed you into the profession of psychiatry and then into the practice of ISTDP?

AA: I started out in family medicine and emergency medicine. I had patients in my practice who had symptoms that I couldn't help with [Abbass, 2005]. People would come for medical complaints, but I couldn't actually figure out what was causing these problems using my standard medical training. So I ended up starting to talk to people more and I taught myself some elements of interpersonal therapy out of a book. I found it fruitful to talk more with these patients who would come with these complaints and with various anxieties and depression. It was around this time that I was talking to one of my senior colleagues who had had some exposure to ISTDP. I had no clue what it was, but he said that based on my interests, I would really be interested in it. I had always been a very self-reflective person, always interested in how the mind works, how my own mind worked, how past and present experiences have shaped me. I was doing a lot of self-reflection so when my colleague mentioned this form of therapy, I looked into it and I found out that I could train in this while I completed the second year of my family medical residency. My course advisers agreed that I could split the year and do this for half the year and do family practice to complete my residency for the other half of the year. That was how I got my initial exposure to ISTDP—in Montreal at McGill University.

DK: Were you actually taught by Habib Davanloo?

AA: Yes, for eight months of the year that I was there, Dr Davanloo was also there. He was doing live interviews all day on Monday and would come out and teach during treatment session breaks. Trial therapies were being conducted all day long; I watched videos, and there were a couple of days in the week where we would have a supervision group or live interviews, or watch someone's tape. I got to do some intake assessments, and I got to see cases and was provided supervision based on case videotape. Most of this training was provided by one of Dr Davanloo's senior trainees. That was my first exposure to psychotherapy training, in fact. I had not had any exposure to the more traditional psychoanalytic training so I didn't have anything to unlearn.

Thereafter, I attended core training with Dr Davanloo from most of 1991 to 2001. Core training was comprised of weeklong videotape-based immersion courses and three or four blocks per year of four days of group videotape supervision. Since then I've continued to attend the immersion courses nearly every year in Montreal.

DK: Was it somewhat of an advantage not having had previous, more traditional psychodynamic training?

AA: It's possible that made it easier for me to actually learn this method—the fact that I didn't have other theories in the way. ISTDP theory made a lot of sense to me, but the process of watching it on the videos was, at first, shocking to me because of the level of activity. I had trouble distinguishing between the therapist being active and focusing on emotions and actually criticising and attacking the patient. I couldn't separate those out at first. I wondered what he was doing to the patient because the therapist's activity was so pointed at what the person was doing. What I didn't understand then was the timing of the therapist's interventions and all the clarifying that goes on before you can actually challenge a person's behaviours. That part of the process was happening so efficiently in Dr Davanloo's work that it was hard to see until I got more exposure to it myself. At the end of each interview, the patient would be so appreciative, open, and released that I recognised that something important was going on. That's why I stuck through it and I kept going with the training. I was sitting there watching live interviews where he would be in another room doing these trial therapies for hours in the day. He would come out intermittently and talk about the process with us. This was a really intensive exposure for me, having had no other exposure to hang my hat on.

DK: It is really interesting for me to hear about your initial reaction to this form of therapy because quite a few therapists to whom I have spoken have had that same reaction—including myself—of being initially horrified about how the patient was being treated. Some of them got over it but others felt that they were not able to practise this type of therapy because it ran counter to their self-perception as a therapist.

AA: Yes, I know what you mean. When I was watching those videotapes, it was anxiety provoking, but I didn't even recognise that I was anxious because I thought he was attacking the patient. Sometimes I was laughing out loud in class and saying, "What are you doing in there?" When I started to recognise what was going on in the process, that's when I started to notice I was anxious and having feelings mobilised that were triggered by sitting there watching those interviews. I became aware that what was being activated by this exposure

to these intensive attachment exercises were my own attachment feelings. It is the therapeutic attachment that mobilises all the other attachment feelings and all the feelings about being hurt in attachments in the past and this is basically what the therapy is about. I got the benefit of that just with the training, with my own supervision, seeing my own patients, watching my own videos, challenging myself, consciously, actively not defending. It was quite an emotional time, a challenging time, a learning time. I think that that was necessary for me to learn, and also to stay with it. Now, if I had been frightened and afraid of the process, I definitely would have stopped. If I decided I didn't want to feel anxiety, I didn't want to feel emotions, then I would have dropped out of training. Just by letting myself become aware and start to feel emotions, I became aware quite early on that there was such a gap in medical education, the gap being that we weren't taught about emotion physiology, what emotions are, how they affect the body, what the impact is when they are blocked and obstructed. All we were taught is how to treat irritable bowel syndrome and panic with pills and some conversational approaches, but all these other medical symptoms, such as chest pain and musculoskeletal pain were taught mainly from the medical perspective, which, to me is non-effective.

Based on having a dramatic experience with my first case that had marked improvement over twenty sessions, I couldn't deny that this was a very important process for this person, and for me. On that basis, I decided to go back and do a psychiatry residency so that I could teach and research this therapy, and make sure that it got into the medical curriculum. It's really what's driven me over these past twenty-two years.

DK: Have you undertaken any personal therapy or analysis?

AA: I haven't had any therapy at all. I had previously had a couple of counselling sessions when I was in medical school in second or third year, where I met with a senior counsellor concerning the break-up of a relationship. I think I went two or three times, just to deal with the grief. I have never had exposure to psychotherapy otherwise as a patient, except through the process of the training itself. Every time I watched the video, I put myself mentally on both sides and watched every hour of every video. I spent at least three to four years doing this work with each video. Every hour I'd watch and go through it

and see what emotions were going on in me. Quite quickly, early on, what started to happen was when the patient would have breakthrough of feeling, I would also have a parallel experience. I'd be having a breakthrough of feeling and the patient would be having a breakthrough of feeling. So I got the therapeutic benefit out of all that, just by tuning into the patient and sticking to the process of engaging with him, not defending, being present and encouraging that person to be present with me and to feel emotions that were being activated by sitting with me, and then tying it altogether, and remembering that. So therapy with my patients was having a therapeutic effect on me; a lot of my colleagues reported the same experiences as me.

DK: You don't feel concerned about these breakthrough feelings or the effect they might have on your patients?

AA: When a therapist is really stuck and blocked in one place with the same thing happening patient to patient and it's not getting dislodged or cleared out by a supervision process, then he or she might have a trial therapy of a few sessions or more. I guess it goes against the theory that absolutely everyone has to have therapy, or has to have years of therapy, or has to go to treatment in order to be able to provide treatment. I'm one example, and I know others too, for whom it just wasn't required, and we can still provide high quality therapy.

DK: So you virtually learnt on the job from patients and through the supervisory process. I think more conservative psychoanalytic therapists would be concerned that this represents a significant departure from basic minimum requirements in more mainstream psychoanalytic training.

AA: I'm sure it is. I have had the same events happen that patients have described during my training and supervision. It was the same process. The stimulus was deciding to be present with the patient and to let things happen, not to avoid things.

DK: So you were feeling parallel experiences with the patient. For example, if the patient were having a breakthrough of grief, would you experience grief as well?

AA: Sometimes. I was more thinking of the complex emotions of rage and guilt, because grief would pass on its own without it being

in the room, although, sometimes, it would be. I would have some parallel emotion—a parallel experience for the patient's grief, and for the patient's terrible story. Some of these stories are horrendous—what people have gone through in their lives; I don't know how they make it through. This is part of grief, and sharing the patients' stories.

I was thinking of what we call repeated unlocking, where a patient comes in, defended, and feeling anxious, detached, and avoidant. So we encourage them; together we focus to bring the feelings to consciousness. They experience the complex feelings, they experience the positive feeling, and they experience the physical pathways of their rage. They're looking at an image of what that rage would like to do. They're looking at the image on the floor. At first, it starts off as if it's me on the floor, but as they continue to look it becomes someone else from the past. For example, one patient had a feeling of rage in her body. When I asked her what she wanted to do, she said that she wanted to take me and flip me over and throw me against the wall. So I am flipped against a wall and I asked her, "What do you see?" "I see a small Chinese man, and I don't know why." She's looking and she doesn't even know who he was. The next week, she came back and said, "I found out who that man was. That was my father when I was really small. That's the way he used to dress." She had seen him in this very tight suit, and he was very thin at the time. As he aged he got bigger and he didn't wear this type of suit any more—so he didn't look the same as he did now. However, the image she saw in the session was an image of her father from when she was an infant and was given away to care. This was a huge trauma experience. These images and experiences are what we call a major unlocking of the unconscious [Davanloo, 1995b].

When patients have those experiences, I have had some parallel experience of my own—past emotions showing up in parallel. I use those feelings as a marker that the patient is experiencing emotions too. When I am experiencing my own feelings, they are really strong predictors that the patient was actually connected with their feelings. So it's really helpful. Now, today, I'm sitting with a patient and I will feel a parallel activation within me of rage, guilt, sadness—all these feelings arise in parallel with the patient's experience. But it doesn't connect to anything within me *per se*. These feelings are just tied to the patient's experience. I'm just picking up her emotions like a mirroring process. I'm just tuning in and I feel it with them. It's really helpful

because, first, they don't feel alone with their emotions. Second, it gives me confidence that they're actually feeling rather than just intellectualising about it, and talking about it, which we want to help them not do most of the time. They can intellectualise and talk about things, but the work is actually feeling the feelings, experiencing them, not just chatting about them. We're not just intellectualising and tying things together, but going through the next step of experiencing emotions—dealing with unresolved pain, rage, guilt about the rage, and then being kind to themselves and stopping the anxiety and defences from wrecking their lives any more. We want this to occur as efficiently as possible.

DK: Do you consider those parallel feelings that you have while working with a patient to be countertransference?

AA: Initially, I would call those feelings complex countertransference feelings. I was having a breakthrough of complex countertransference feelings, meaning that they were related to my own attachments, pain, rage, guilt about the rage, grief, loving feeling.[27] All these feelings were being mobilised by the process of engaging and working with the patients. However, in recent years when I'm talking with my patients, I'm usually having a parallel experience that has to do with empathic attunement, allowing me to resonate with their emotions. I don't consider this to be countertransference in the classical sense because these feelings are not linked to anything in my unconscious from the past. They are just an empathic experience with my patient, a mirroring event. For us, countertransference is used very rigidly to define transference of unconscious, unresolved emotions from the past to the present. Some therapists and models define countertransference as any feeling that comes up in the therapist. But we try to separate the two; one is related to unconscious feelings and secondary unconscious anxiety being triggered by the patient, and the other is not primarily linked to unconscious anxiety and feelings. Those feelings are related to tuning in to the patient. To engage a patient with intense therapeutic pressure and challenge will activate unresolved emotions in the therapist and can then produce anxiety and defence against these feelings, sabotaging treatment.

We're a herd species. When someone is alarmed, we all have our receptors on and we can all become alarmed at the same time. Thus,

mirroring and empathic attunement are normal responses. We need to clear up emotional obstructions in ourselves so that we can access this system therapeutically in order to be able to be present and identify and feel things with the patient. I can't tell you how many times I have been sitting with a patient and I feel some somatic anger coming into my body—a heated movement upward—and the patient is sitting there saying they're not feeling any anger. So I'd say, "If you felt anger, would you say so?" and they say, "No. I don't tell anyone." I would ask if there are any feelings of anger right now, and the patient says, "Yes, there is." I have to go and ask because I'm feeling it. You have to actually ask some people directly if they have a feeling because they won't offer it. I use my feelings as an indicator of what the patient is feeling. One of my patients said to me, "One thing about working with you that I have noticed, and it's important to me, is that I can never lie to you. I could never fool you because you always knew if there was a feeling happening or not!"

DK: Are you saying that you sometimes anticipate the feelings of patients and you use that to encourage them to express whatever it is they are experiencing?

AA: No, I would not call that anticipation because I'm not consciously doing that. It's just happening, I'm just feeling it. One patient, for example, was talking about her father calling her names. For a split second, I felt a shoot-up of anger in my body. But my patient was getting choked up and anxious. She missed the anger. I just said, "What did you feel the second you were talking about your father before you got all choked and anxious?" Then she backed up and felt the anger, and then her desire to choke her father. In that way, all the feelings became connected. In that example, I didn't anticipate the anger, but when I felt it, I realised that she must have felt it too, but it was so quickly covered up by the anxiety and by choking herself. It happened so fast that she didn't even see it. It was like a flash, like a flashbulb. It is in those flash moments that you can pick up the subtle passage of feeling that gets covered over really quickly—instantly repressed or projected outward. To do that, we've got to be comfortable and relaxed. We've got to be real and notice our own emotions and not be afraid of them.

Davanloo talks about having a clear corner of the unconscious mind so that you can see the patient for who they are without the

clutter of our past getting in the way and distorting the read. We can then engage with our patient distinct from our own past complex feelings and anxieties. Otherwise we are stuck, detached, anxious, or defending. The therapist can end up sabotaging the treatment process, being critical of the patient and not explaining what they're doing, getting misaligned.

DK: I can imagine that some therapists might have more difficulty than you have had in finding that clear space in the unconscious.

AA: Perhaps. If we look at the average of five trainee residents in psychiatry I've had over the past seventeen years, on average, there is one resident in each year who seems to be able to grasp the process efficiently with good anxiety tolerance, typically a warm, likable, sociable person. There are three who struggle with learning the method—they're blocked up to some extent. They can't see things too well, and they have some process to go through. The fifth is usually a fragile person, meaning their anxiety interrupts their cognitive–perceptual function. They can't see or hear or think when they start to engage a patient. They can't sit in the interview very well at all. So a longer process is required for them to get used to working in this way, to desensitise to their own anxiety, and start to be aware and start to feel emotion. There is an extra added training phase—a desensitisation phase—where the anxiety tolerance increases.

DK: Are these fragile trainees eventually able to become ISTDP therapists?

AA: They are if they persist in the training. But if a person has significant fragility, they're not going to be learning in the first months because they won't be able to remember any of it. It all disappears every week because the anxiety blocks it out. But if they persist, then by six months to a year of training, they start to be able to focus in the first fifteen to twenty minutes of the interview. Other than that, they don't get anything much done in the interview. It's very flat and intellectual. All they're really doing is trying to keep their own anxiety down, just trying to hold themselves together. They have got to get used to that; it's more about capacity building. For the three trainees in the middle, it's more about building awareness of emotion, understanding tactical defences [Davanloo, 1996a,b]. They're not as burdened by anxiety or defence. It is more about interrupting their

own defences, tuning into emotions, staying focused, using the interventions. The fifth person can actually sit in on the interview and apply elements of ISTDP almost immediately. So, on average, there are one-fifth of trainees with good capacity. This is from a pool of people the university has recruited far and wide, who are thought to have good interpersonal skills—that is, above average to start with.

DK: OK, so it is really quite difficult to identify people who are suitable for this kind of work. What ongoing training have you had beyond your training during your residency?

AA: I am continually training and learning case by case. Last year, I went to an immersion course. I go almost every year. In addition, I had supervision with Davanloo in blocks for several years to 2001. In the block training from 1991 upward, there were different foci for each training block. It all occurred on video [Abbass, 2004]—the teaching and the supervision. This allows us to look back and see what's going on, how we felt, to review it, to allow transmission of the information to other colleagues and learners. The video is the partner in the development and dissemination of Davanloo's method.

DK: The transparency with which ISTDP is practised and taught is in sharp contrast to the secrecy in which psychoanalysis is conducted. I wonder if I could turn your attention to the core skill set that you teach your residents undergoing ISTDP training?

AA: Sure. The first is ability to provide the central technical intervention, which is called pressure [Davanloo, 1999a], although the term is a misnomer. What we mean by this is encouraging our patients to be present with us, to identify emotions, and not to defend; to do something good for themselves. Pressure interventions include questions such as: "Can you tell me about your problems? Can you give a specific example? Can you tell me how you feel? How do you experience those feelings?" These questions support the therapeutic attachment and begin the process of building an unconscious therapeutic alliance in order to start to reach the person's defences. To do that, one has to be comfortable to be with another person, to be engaged and present with them, and to have emotions ourselves. Otherwise we won't do the pressure, we won't want the person to be open with us; we would want to keep them far away. For about one third of patients, all you require are pressure interventions.

DK: So this group of patients only require pressure to have an unlocking of the unconscious. Is that what you meant?

AA: Yes, these are low to moderately resistant patients, who have a relatively small amount of attachment trauma and subsequent emotions. But patients who are more traumatised, earlier in life, are highly resistant. These patients respond to the pressure efforts to help them open up by becoming tense, defensive, closed up, guarded, and blocked. Thus, instead of opening up they pull away. They don't know they're doing it. It's involuntary. So our task is to clarify what they're doing, which is hurting their own effort, and interfering with what we are trying to do together. We start to clarify that, so that they see the problem, and then challenge them not to defend.

Thus, we enter the phase of challenge, which is the second technical skill an ISTDP therapist needs to understand and be able to provide. In this phase, we challenge, collaboratively and collectively, the defences that are understood to be the problem. I might say, "Do you notice that you have detached, are avoiding me . . . now your eyes go away, you're closing up and slowing down? Do you notice that?" And then I say, "But if you do that, it's going to cut off what we're trying to do together. Do you know what I mean?" Then I say, "So if you don't go detached, if you don't hurt yourself that way . . ." Interestingly, challenge is very supportive for the person because it's done to help the person out. You're helping a person to do the best for themselves. So challenge is required for highly resistant patients, and in one of my studies, 55% were highly resistant. The remainder are either low to moderate resistant or fragile. Low resistant patients have only grief and they aren't locked. They just have grief and they just use minor defences to cover the grief. So, here is an example.

Patient: My father died when I was fourteen and I'm having trouble dealing with it.

AA: So the problem has to do with your father, pertaining to your father's death?

Patient: Well, it might be a little bit about that [using her defences]. I'm not sure.

AA: But when you came in you said you thought that it was about your father's death.

Patient: Well, I think it must be.

AA: OK. Tell me about your relationship with your father.

Patient: Well, I don't really remember my father.

AA: Do you mean you don't remember him? [minor defence]

Patient: [Gives an account of the day her father died]

AA: There's a lot of painful feeling in you right there, when you talk about this. [And then the grief just comes out].

That's the whole treatment, concluded in one session in this low resistant patient. There was no rage in the unconscious at all. There was no self-harming, self-destructive system, no personality problems, only some minor symptoms of adjustment disorder. Her defences were correspondingly minor diversionary tactics. These defences really serve to tell us that we are in the right place and to stay there: since they are directional arrows, they are almost part of the alliance!

Now, the moderately resistant patient has some rage and some guilt about the rage, and grief. For those patients, pressure is enough to break through the defences, bring up the complex feelings and open up the unconscious. These complex feelings are experienced and open the memory banks, which bring this clear imagery and recollection of the events that lead to the defences. It becomes an unlocking, without much else except pressure.

Highly resistant patients defend and put walls up in the room and that's when we need to bring challenge to interrupt, otherwise they just get more detached and the process goes dead. It becomes a stalemate. These are patients who could not be treated with more classical psychoanalysis or other forms of treatment because they are just too defended. This model of therapy was developed for precisely these highly resistant people.

Another category is high resistance with repression. In this group, when the emotions are activated they are instantly repressed, perhaps into the stomach, into depression, or into muscle weakness. Instead of the feelings coming up, they just go weak and sick in the body and become depressed and tired as a result of that instant repression. That group needs capacity building first. By this, we mean bringing structural changes at the level of unconscious anxiety and defence in order to change the anxiety discharge pathways and defensive pathways around: with this work, unconscious anxiety starts to operate in the

voluntary muscles versus the smooth muscle of the body. Defences shift from instant repression to ability to self-observe, intellectualise and isolate affect. Once this is achieved, they can start to feel safely. Davanloo called this the graded format, in which we alternate pressure with stopping and intellectually examining phenomena: this helps the person observe the process and learn to self-reflect. This shift brings a shift in the unconscious anxiety discharge pathway toward voluntary muscle tension. Other psychotherapy models also use similar elements with these populations, but we optimise them purposefully by watching the body anxiety patterns. We work right up to the emotional level beyond which they cannot manage the activation and are about to repress, then we intellectualise at that level. This process gradually increases the level of activation before repression takes over. This method is about as efficient as you can get to build capacity. This set of methods was discovered and developed from extensive videotape review, including retrospective review of successfully treated cases.

DK: Is this process of capacity building similar to Fonagy's concept of "mentalization"?

AA: Peter Fonagy and I discussed this at length once. We identified some parallels between mentalization and our capacity building approach. A conference comparing and contrasting the approaches would be welcome. For us, the ability to isolate affect and to observe it causes unconscious anxiety to go into the voluntary muscles, for example, causing hand clenching and sighing respirations. That gets the anxiety out of the bowel, out of the blood vessels, out of the rest of the body. It just makes the patient tense; then they can start to feel from that level. They're now ready to be able to tolerate the emotions at the unconscious level. That is the objective for us but not the end of the process: it is a first step to being capable of tolerating painful, anxiety-provoking, unresolved emotions.

The other group of patients are those who have fragile character structure and borderline organisation. They require intensive capacity building—which begins with helping them to develop psychic integration. We have to help them identify and understand their projections and projective identifications, and splitting defences. But the process is the same, moving anxiety, for the first time, into the voluntary muscles, and increasing self-reflection. I say "for the first time"

because it's usually a developmental problem where the patient never developed the ability to be anxious. It's always been split and projected out. When you block their projections, anxiety tends to come in the form of cognitive disruption—they start to have blurry vision, fuzzy-headedness, and drowsiness. When we work with these patients, there's no challenge. It's all pressure and then stopping and talking about it; observing it and intellectually examining it, tying it together, recapping and linking. So capacity building is another key technical skill the ISTDP therapist must know.

For the highly resistant patient, we have challenge and an intervention called head-on collision [Davanloo, 1999b], which is a complex form of challenge and high pressure. It is essentially a statement of the reality of the limits of what the therapist can do, the potential of the patient, the problem of the resistance, and a lot of encouragement for them to do something about it. Inevitably, if it's well timed, this will lead to a breakthrough to the unconscious.

DK: What are the essential differences between pressure and challenge?

AA: Pressure encourages the patient to do something good for himself, as opposed to saying, "don't do that". Pressure brings activation; the pressure is uplifting as it encourages a healthy action. Challenge is interrupting harmful behaviour. Here, the therapist says "don't". When we say "don't", we are activating different centres in the person's mind than when you say "do". Pressure results in activation and challenge results in inhibition. The key is the timing of the challenge. Based on tens of thousands of hours of videotape research—I've got over 2,000 cases—when the defences start to move into the room, when patients start to defend and detach and avoid and go away from us, that represents mobilisation and crystallisation of the anxiety and defences, which becomes an obstacle between us. This is the time to start to clarify and challenge the resistance. If we do it before then, it's theoretical or hypothetical and the patient feels persecuted because they don't understand it. This can result in a misalliance and prevents the rise in all the dynamic forces, including the unconscious therapeutic alliance. So timing is critical. If resistance isn't there, you don't want to talk about it. We wait until it shows up, and then clarify it and challenge it with the patient. Misunderstandings about timing occur typically at times when therapists become

confused about ISTDP and perceive it to be harmful. Misapplication results in drop-out or adverse events.

DK: When there is a misalliance and the patient retreats or goes back into resistance, do you acknowledge that it was a therapeutic error creating that misalliance or do you just go back a few steps and start again?

AA: It depends on what the source of misalliance is.

DK: Let's take, for example, mistiming the challenge as the source of misalliance.

AA: If we challenge prematurely, the patient will go flat, but it doesn't necessarily result in a misalliance. We might get an argument because we don't clarify what it is we were challenging, and the patient doesn't understand it, so we end up with a debate. In this situation, we just back up and clarify what it is we are talking about. We have to express to the patient, in actions, that we have the highest respect for the person, but the lowest regard for their self-harming resistances. If you can couple together a strong positive regard for the patient with a distinct lack of respect for behaviours that are harming a patient, then you can do this approach here, without getting too anxious about it. The therapist must be able to tolerate complex feelings—that is, be able to "love" and "hate" at the same moment and not act out. The therapist can feel those emotions and not defend and not get anxious and not get detached and not harm the other person. Thus, the therapist can hold these complex feelings together. That helps the patient to do the same, and that opens up the unconscious, bringing these complex feelings all up together. This was Davanloo's major discovery: namely, identifying the need for the actual experience of complex feelings in order to unlock the unconscious. What we don't want to do is split—criticise or idealise the patient. There is a therapeutic middle ground in which the therapist is working with the patient against his defences. Have I answered your question?

DK: You have partly answered it. I also wanted to know whether you would acknowledge a therapeutic error if you believed one had occurred.

AA: When an intervention is confusing or a patient took offence at something—depending on how they're expressing that—I'll just say

that really wasn't what I was intending to do. So, yes, I'll acknowledge that I wasn't intending to do it and that will bring back the anxiety and defences. They might come back to the next session and say, "You know, I'm really [sighs] . . . [they're all anxious], "something happened last session. I'm not sure I liked it" [sighs] . . . I'll say, "Can we look at how you felt with me? You're tense when you are talking about it. There is something happening. Can we look into it?" Thus, in this case, rather than apologise, the best move is to see what complex feelings are being mobilised as the patient is talking about it.

If they didn't have a positive feeling about what I did and truly felt it was something negative I did to them, then they wouldn't be anxious any more. They would not be tense. They would not be defending. They would be telling me that they didn't like it without any unconscious signals. When that's happening, I know that there's something that I messed up, missed, misunderstood, or just transmitted wrongly.

We have so many cultures and languages here in Canada, things can easily become misunderstood. You can be having a bad day, your intervention was mistimed or any combination of factors can produce a misalliance. The therapeutic decision the therapist makes is always based on unconscious signals. Unconscious anxiety in the voluntary muscles is a solid positive marker to keep going and focus on what's going on emotionally under the tension. It's important not to get hung up on words too much at that point, but just to go with the feelings. Many patients' defences centre around creating misalliances, debates, and arguments with others to keep a distance, so a patient simply saying the words "you did something wrong" does not necessarily mean much!

DK: What are the major diagnostic indicators you use to place people on the spectrum of resistance and fragility?

AA: This is a central skill set in ISTDP, namely, doing a psychodiagnostic evaluation of the anxiety and defensive patterns and levels in patients. I have already mentioned voluntary muscle tension. Then there is anxiety discharged in the smooth muscles like the bowel, airways, and blood vessels. This anxiety pathway goes with depression, irritable bowel, and migraine; the person flattens out. The third dimension is cognitive perceptual disruption where the person loses vision or it gets blurry, or they lose hearing, or feel numbness; they

can even black out or faint. With motor conversion, there is no tension in the voluntary muscles at all and muscles in one part of the body are weak.

Davanloo identified three types of major resistance. The first is isolation of affect, where the person intellectualises but does not feel anything. The second is repression, which goes with smooth muscle, conversion, and major depression. The emotions get repressed and they go into those body systems. The third is projection and projective identification. When projection is occurring, there is no unconscious anxiety, but when you interrupt it, these patients tend to go to cognitive disruption first. A person with striated (voluntary) muscle anxiety will often report fibromyalgia and pain in the body, as well as intellectualisation and emotional detachment. These tend to cluster. All of these factors are assessed in the first minutes of the first interview. We assess the level of resistance, the degree to which emotions are mobilised, and the degree to which the patient sees their defences. If you add these parameters together, it tells you which way to go. You can really make a decision based on a few algorithms.

DK: Do you see patients with simultaneous striated and smooth muscle tension?

AA: Not in the same second; there's a transitional period where they might have some smooth muscle firing but the striated muscle is relaxed. Research shows that people with irritable bowel and high blood pressure look more relaxed than normal controls, because they don't have voluntary muscle tension. Most patients have a threshold above which they have smooth muscle anxiety, although when it is at a lower level, they get voluntary muscle tension anxiety. So they can have fibromyalgia, a whole lot of pain in their body, but when they are coming to your office, they get diarrhoea just by getting out of the house. Once in the office, they have a migraine and look flat. They don't have any tone. Their stomach's cramping. When they're at home, they're relaxed but tense, that is, relatively calmer.

If a person with cognitive disruption comes into your office and they can't see well and they're confused and cloudy, when they're at home at night, they're scared someone's going to come in and attack them. They're really projecting a lot. They can't take a shower because they can't hear the sounds and they're scared. A different level of rise occurs when they're at home compared with when they're out. It

changes its manifestation also. Some people start with a low level where they can have striated muscle tension, then they have a higher rise and the anxiety goes into the smooth muscle. At an even higher level, they get cognitive disruption. So, on a bad day, they're really flustered and cloudy-headed; on a medium day, their stomach cramps and they feel a little sick. On a really good day, they're just tense. Tension is best because at least they're not in the bathroom feeling weak and vomiting.

The transcript you presented for comment reminds me of a patient of mine who had suffered depression for five years and was off work. He said, "My problem has to do with my childhood." He was tense with sighing respirations and was ruminating in an intellectual way. I said, "I see you are anxious. Can we look into what feelings you have coming in here?" He said, "Yeah. My childhood was difficult . . ." I said, "But right now, in here with me, do you notice that you're really tense? What is coming up here with me?" I didn't go into the childhood rumination. The guy had had therapy for years and he still wanted to talk about his childhood in a detached way. I opted to mobilise the unconscious to look at what was driving all this unconscious anxiety. So that's what we did for the first fifteen minutes. There was a nice breakthrough, with complex feelings with me. In the midst of the passage of feelings, including rage and guilt, he was seeing a visual image of the face of his father. He had five sessions and returned to work after being off work for so long. So, you can have a lot of conversations, but if they're all tensed up and defending against the emotions, there is little value in that because people are already able to intellectualise.

We're interested, as a dynamic psychotherapy, in helping our patients to feel their actual emotions, not just to know them, but to experience them. Feeling the emotions is the key. They must first have the capacity to tolerate emotions and then to feel emotions that cause anxiety and defence. That process helps the vast majority of patients with a broad range of problems—86% of referred psychiatric patients can benefit from this approach, that is, five of the six people coming into a psychiatrist's office in Canada were candidates for this approach.

DK: I was astounded when you told me that you have seen 2,000 patients in your career so far because a psychoanalyst would only see between seventy to 100 patients in a whole career.

AA: That's right. I remember calculating that. For example, Winnicott saw fewer than 100 patients in his whole career. By the time I finished my psychiatry residency, I had already treated as many patients as Winnicott, including some treatments that involved dealing with early life phase trauma. I don't understand what might be happening in psychoanalytic treatments that take so long unless the goals are other than to work through unresolved unconscious emotions. Like most of us, I have never viewed psychoanalytic treatment being conducted. I have only heard conversations or read about psychoanalysis. I don't know what it really looks like, unlike our treatments, which are all videotaped and visible to practitioners. I can't see the added value in all that many sessions, especially in Canada and other countries were the health dollar is so stretched.

DK: I guess it is free association and greater therapist passivity that together prolong psychoanalytic treatment?

AA: Dr Davanloo was very frustrated by the inactive stance in psychoanalysis and what he found to be the questionable effectiveness of it. He was trained as an analyst, so he had an insider perspective. He argued that therapists had to be more active to handle resistances and to turn patients against their defences. Also, he was concerned about the long waiting lists in Montreal in the public clinics for long psychoanalytic treatments. So, shorter therapies were born of necessity. He, and a few others including Peter Sifneos [1990], James Mann [1996], and David Malan [1976, 1979], worked in the 1960s and 1970s to develop their own methods. David Malan abandoned his own approach due to lack of includable patients and collaborated with Dr Davanloo for many years. Having said this, ISTDP for fragile and high resistant cases with repression is usually over 40 sessions so this is not truly "short-term", but still much shorter than for the same patients undergoing psychoanalysis.

DK: I noticed that Davanloo uses Malan's triangle of person and triangle of time as a conceptual basis for therapeutic intervention.

AA: Those triangles actually pre-date Malan [Ezriel, 1952; Menninger, 1958], but Malan emphasised them, brought them to prominence.

DK: OK. Are the triangles a major focus for you when you are working with your patients? Do you make those links?

AA: About one-sixth of my therapeutic activity is linking. In the first session, it is a little higher at 19% [Abbass, Joffres, & Ogrodniczuk, 2008]. I use the triangles to tie together the feelings, anxiety, and defences, from the past and current relationships and the therapeutic relationship. We help patients see the tie-in between past and present and we recap a session using the two triangles. This forms a psychological structure. It probably wires up some neurons to link past–present and opens up some gateways between past–present emotions that are triggered with the therapist. Many patients come in and don't even know they have linkages. Unconsciously, it doesn't exist or it's not activating. They actually require help to make those linkages. These are central elements. This is one of the common factors across psychoanalysis and psychotherapy; making the unconscious conscious is another common theme. We're just as interested, obviously, in unconscious processes as are other psychoanalytic therapists. The differences are found in the level of activity. In the study of the first session, we found that there were almost a hundred interventions an hour. That is ten times the number of interventions some other models employ.

DK: There are clearly some commonalities between ISTDP and psychoanalysis. I wonder if you could discuss these a little more and also highlight the differences between the two approaches.

AA: The majority of all interventions are reaching for the person stuck underneath the anxiety and defences. We consider this effort, as expressed by pressure interventions, to be a central key. They have to know we really want them to be present with their horrendous stories and emotions. The only way we can communicate that is by reaching to them with pressure, with interventions. It's not enough to say, "I really want to know you and I want to know your terrible stories." We've got to show it by our actions. Our actions are really actively trying to encourage the person to be present with us. So the level of activity and the central focus on emotional experiencing is what distinguishes ISTDP from some other models. Psychoanalytical therapies have these same foci when the process is going efficiently. But we actively make those things happen; we don't wait for the patient to get there before we intervene.

DK: I notice also that there is much less focus on history taking in ISTDP. I recall Winnicott saying that psychoanalysis can be viewed as

one very lengthy history taking. You often don't have too much detail at the point where you get the breakthrough of feeling about the key people in the patient's life. Even then, there is no pursuit of an almost forensic history taking that occurs in other therapies.

AA: ISTDP with resistant patients is all about process, which means opening the unconscious and helping the patient feel the emotions and work through them. Up to that point in time, we don't care about content. Content-based review can itself become a resistance and delay access to the unconscious in resistant cases. In more fragile cases and those with repression, there is more history taking and developing of the whole narrative as part of building psychic integration and structure to be able to access the unconscious safely.

DK: You have this aspect in common with intersubjective/experiential/phenomenological psychoanalysis. Their two key concepts are experience and context. I think you are actually saying the same thing.

AA: Yes, it is all about process and what is happening in the room right now. We work purposely to establish the unconscious therapeutic alliance; this is the alliance that's buried in the unconscious that allows the patient to bring the images and the linkages and all the core content clearly into the present. We aim to help get this unconscious alliance dominating over resistance; getting the memory banks to fire, to move beyond the frontal inhibitory systems in the brain. We want to activate the emotional centres and emotional memory systems to fire up louder, or at higher volume, whatever it needs to do, to go beyond the inhibitory system. Until that happens, that's all we're focused on. We don't care what words are said, largely. This may sound like a terrible thing to say. Sometimes we get patients who want to beat around the bush for ten sessions or 100 sessions—the patient's life is passing and we will interrupt this rumination for his or her own sake. Likely the patient has already previously done that for hundreds of hours and it didn't go anywhere, so we are not going to allow that situation to repeat itself. If a patient comes in and tells me his father is really nasty and starts to go into detail with ranting about his father, I will cut across that and say, "Right now, you are anxious; can we look at that?" Then we start to get a breakthrough of the complex feelings. The rage is coming and then he is looking at the image on the floor—the damaged body there. I say, "Looking down there, what do you

see?" You would think he would see his father, but no, he sees his mother. On the surface, he thought it was all about his father, but actually in the unconscious at that point it was about his mother. Often, feelings towards one parent are defended against by ruminating defensively about the other parent. For example, the patient was angry with his father because his mother died and his father became a drinker and virtually abandoned him, but the feelings related to his mother dying were avoided. So when we achieved the breakthrough, it was all about his mother, and he couldn't believe he had those feelings about her. That changed everything for him. His annoyance with his father was conscious and was defensive, too. This is why we're more interested in establishing the unconscious therapeutic alliance and not getting hung up on the ruminations of the resistance in anxious resistant patients. Thereafter, the content becomes central; the patient starts speaking eloquently, even poetically about his life, with imagery and emotion. That's because the resistance has really been, to some degree, either reduced or removed by the process.

DK: So you are saying that once you reduce the resistance, relevant parts of the personal history follows, such as, for example, in the case you just described, you learnt that the patient's mother died and his father fell apart emotionally, leaving the patient as a boy abandoned by both parents.

AA: That's right. I don't need to know the person's childhood. When the alliance is established, they will tell me what's going on, and I follow them. All I need to know is how to help them to be with me. When that happens, the emotions emerge and everything else I just follow and underscore and recapitulate. If defences return, I'm back on process again. I'm back to helping them be back with me, to beat down their defences. Then I am following again, following the alliance, underscoring and so on.

DK: I imagine that this process would be especially important in resistant patients because they will not respond until work has been done on reducing their resistance.

AA: Yes, that's right. Here is a big difference between ISTDP and psychoanalysis. Interpretation in resistant patients is actually contraindicated. We use pressure, and challenge and head-on collision. An "interpretation" is only given after breakthrough. In the case

of graded work, we make "interpretive linkings". Some people would call that interpretation. In the highly resistant patient, that is a waste of time from the perspective of this model. That's why at least some varieties of classical psychoanalysis won't work with these patients.

DK: What do you think makes interpretation ineffective?

AA: In resistant patients, it doesn't add anything. Moreover, it supports intellectualisation and increases defensiveness. Thus, it can even compound and prolong treatment.

DK: Presumably because they are not experiencing the emotion in the present with you?

AA: No, and the other thing that happens is you risk the development of a transference neurosis.

DK: Davanloo, unlike many current forms of psychoanalytic practice, discourages any form of regressive behaviour in ISTDP, including intense dependent and erotic transferences, explosive affective discharge, or the use of regressive defences. What is anti-therapeutic about these phenomena, given that ISTDP theory states that there is a direct relationship between the intensity of murderous rage and guilt and the degree of resistance that must be overcome?

AA: Why add a neurosis to a person who already has neurosis? We define transference neurosis as a build-up of feelings with the therapist, thereby making the feelings towards the therapist part of the problem, part of the neurosis. We want to avoid that altogether, and we do, by bringing the feelings out that are mobilised towards us. We help patients to feel the feelings as soon as they are evident so that there's no build-up of feelings towards us—no ambivalence, no destructive or sexual feelings—because we actively keep all that out of the way. That's a big part of some psychoanalytic processes—develop the neurosis and then analyse it, but Davanloo and I see transference neurosis as a really destructive force. You must remember I have not had an analysis or psychoanalytic training and have been trained and work through the lens of Davanloo, so this is my bias.

DK: Nevertheless, ISTDP is still a psychoanalytic therapy because it is centrally concerned with experiencing emotion in a relationship in the here and now, and there is a fundamental focus on the

unconscious and resistance. The cognitive–behaviour therapies are not focused on any of those three elements—the unconscious, the therapeutic relationship, and resistance. A focus on non-verbal (body) behaviour is central to ISTDP and is used to identify the type of somatisation that is occurring during the session (striated or smooth muscle tension, cognitive–perceptual disruption, and conversion reactions) and the degree of fragility in the personality.

AA: Yes. We are interested in the signalling system of the unconscious, which indicates whether or not unconscious anxiety is being experienced in striated muscle tension. We look for that because, if it is there, we can go directly to the feelings. The neurobiological pathway of striated muscle unconscious anxiety goes up the sensorimotor strip of the cortex, starting with thumb tension and hand clenching and then up towards the neck and face. It also goes down to the muscles between the ribs, the diaphragm, abdomen, legs and feet. In a seated person, the main indicators are hand clenching and sighing. The person doesn't notice their hand clenching or their sighing; they don't notice they're hyperventilating. They can have some discomfort from the muscles getting tight, but don't notice it because it is unconscious anxiety. When we see that, it's a green light to go right to the feelings that are there in the room and that are being mobilised.

DK: How are you with people who are crying?

AA: If it is due to grief, I will try to facilitate that very painful feeling, or I'd say nothing because it's already being felt. I don't need to say anything. For example, if a person just had a feeling of rage pass and they can see the loving eyes of the father that they just murdered, and all this painful guilt is emerging, we would facilitate that or say nothing and let it be felt.

But if it's self-directed anger, that is, being angry at oneself—we call this a regressive defence that manifests in choking themselves, being harshly self-critical and crying due to neck tension. Then we actually will focus on the feelings that are being mobilised because it means there are some feelings that were triggered with us that turned inward. So we try to uncover the feelings that were triggered with us first before the patient turned the anger in on him- or herself. In this situation, we apply pressure. So, how we respond to crying depends on the meaning of the crying.

Guilt has its own somatic pathway and so does grief. These are different emotional somatic pathways. We have been teaching emotion physiology in our new medical curriculum for a number of years to all the medical students, and the medical and surgery residents at our university too. We want a literate medical system, doctors who can understand the emotional effects on the body and how to pick these things up. We want our doctors to be more self-aware.

DK: Can you say a bit more about these different pathways for the different emotions?

AA: Yeah. The somatic pathway of rage starts in the bottom of the body, feet and lower body, with heat, energy, or a fireball moving upward. It moves upward and as it does, it displaces any tension and anxiety all the way up as it passes up. So the tension stops when the heat and anger come up. It goes up to the neck, down the arms to the hands with an urge to clench and express aggression, and in some people it then goes to the jaw, with an urge to bite. So rage moves from the lower spinal levels upward.

Unconscious anxiety moves from the top spinal levels downward. It starts in the middle of the neck and goes south. The emotions are going north, upward, and pushing outward the unconscious anxiety all the way up. That's the somatic pathway of rage. There is an urge and some thoughts about aggression. It has a wave that comes and goes like a sine wave.

The somatic pathway of guilt involves upper body constriction and pain when the person experiences remorse looking at the dead person. It's guilt about rage and often is accompanied by the pain of grief as well. It has a wave that comes and goes—a solid wave. During the middle of it, the person can't talk. There is too much pain and they're immersed in it.

Grief is not so much a solid wave. It's not as painful in the same physical sense as guilt is. It comes and goes, and the core content is loss; there are also loving feelings and feelings to attach. There is also a moving warmth in the body, mid-body, chest and an urge to embrace or reach toward a person.

These things are physiologic events but we don't talk about or think of them that way. I think psychology has missed this in almost all textbooks. The literature there is confused because they usually

confuse rage with anxiety, the behaviour, the defence, and the body experience. When you look at books on emotion, it's confusing.

When you understand emotion the way Davanloo does and work with the emotions in this way, you get directly to childhood issues and all the painful feelings and trauma. Before then, the anxiety and defence cover all the feelings up, and that's why people appear in your office.

DK: Do you draw on Steven Porges' polyvagal theory to understand these physiological pathways of the emotions that you have just described? The polyvagal theory [Porges, 2001, 2007] explains how an increasingly complex neural system developed in order to regulate the different neurobehavioural states needed to deal with environmental challenges. Porges argued that the physiological states underlying all survival-related behaviours are associated with one of three neural regulation pathways or circuits. The three circuits and their associated behavioural strategies are the freeze response or "playing dead", which is the most primitive circuit, the fight/flight response, and the communication/social engagement circuit. The theory states that under increasing levels of threat, people move to circuits that have an older evolutionary history. I have read some papers on ISTDP that refer to Porges' theory with respect to these neuro-emotional pathways that you have just described. This leads me into my next question.

I work with musicians with severe music performance anxiety. These musicians often report bizarre experiences; for example, when they start to play their instruments under conditions of social threat, they report that their limbs feel as if they do not belong to them, or they'll look at the music but feel unable to read it. Others report "explosions going off" in their brains and so on. How would you understand such symptomatology?

AA: You are describing a person with fragile character structure that is associated with depersonalisation, derealisation, and dissociation under the burden of the anxiety. For musicians, it is likely connected to the assessment people are going to make of their performance. It has to do with being scrutinised, which is related to the trigger of a trauma response that mobilises a lot of painful feeling—rage, and guilt about the rage. Usually it's very heavy rage, and that leads to cognitive perceptual disruption. They don't notice these feelings. If you have a

session or two or three or four with these people, it makes a huge difference. They become able to look at a crowd and smile. Before that, they're scared, robotic or frozen. They would have prepared for the performance mechanically and then go do it and don't think about it. But that strategy doesn't make the best performers, obviously. They're not in it, even though they can play it. Performers need and want to be in it, connected to themselves, able to bring a feeling of joy to the performance instead of feeling terrified about it.

DK: Yes, the emotions are extremely intense. Many musicians have told me that going out on stage to perform is akin to torture. They actually use the word "torture".

AA: For fragile patients, their unconscious rage actually has a torturing quality; it's intense to the point that they not only want to punish somebody, they want to make the person suffer a torturing experience, for which they feel very guilty. So when they try to reach to that feeling, they get all cloudy and can't see straight, and get dizzy and drowsy until you help them acquire the capacity to face it. It's a hell of an experience for them because it's strong rage, so there's a lot of guilt in it. That's why they're disorganised. You can build up the anxiety tolerance though. Fragile character structure is a result of trauma in infancy, inside the first two years of life, plus a lack of compensatory relationships to develop more adaptive defences.

DK: Do you space the sessions differently for people with fragility compared with other, less damaged patients? For example, would you see them more often than once a week?

AA: It's generally once a week, and it's usually for an hour. If it's every two weeks, I'll make it an hour and a half. If, for some reason, a person can only come monthly, I might make it three hours. There's another thing called block therapy, where a person will come for, say, sixteen hours of treatment over a few days. That's usually for people flying in from a distance. We give them sixteen sessions in a few days and they are able to have sometimes ten or more unlockings, which has a huge effect on them.

DK: And that doesn't vary with the level of pathology?

AA: No, not usually. When I first started to do this work, my sessions were longer. I just had them longer on purpose. I wanted to

make sure I had time with the patient and had time to do what we could do. I was having about two hour sessions. But everything's gone shorter over time. As far as a trial therapy, I average about ninety minutes. When I first started out, I would leave a whole afternoon and take several hours to do a trial therapy. Now, it's more efficient. However, sometimes, people need a series of sessions before you can tell if they are likely to benefit or not, because patients often have a broad range of problems to deal with. Some have bona fide medical conditions; others live in really bad social situations. Serious medical or social problems can interrupt therapeutic efforts.

DK: In very fragile patients whom you're only seeing once a week, would there be a risk of major attachment crises occurring between sessions?

AA: Even with fragile patients, it is very rare for them to go into crisis between sessions. We just don't see it. Once we get the ball rolling with a good trial therapy, the patient feels contained between sessions. I don't get the phone calls, desperation emails; that is very rare. The therapy has a containing effect on patients from the outset. The person is doing hard work in the session, and they're the first to tell you, this is hard. If the person has been projecting his or her whole life and blaming everybody else, and you're sitting there helping them stop doing that, that's hard. So they know it's hard work, but it gives them something to chew on in between sessions, and they feel like it's going in the right direction. So their hope goes up and they're acting out goes down. I have heard of only a very few suicides that have happened in relation to this form of therapy, and typically those people were not attending therapy at the time of the suicide and had major psychological problems, including histories of psychosis and repeated suicide attempts.

DK: What might undermine the success of a therapy in the absence of these complications?

AA: Misalliance or technical problems. There's a rate of non-response though. If we're going to have a non-outcome, we're going to find out quickly because we start off with a trial therapy. If a person's not going to respond or there's some issue that's going to prevent treatment from being effective, we're going to discover that at the outset. So rather than embark on a long treatment and hope it's

going to eventually get somewhere, we do a trial therapy, which is a very strong predictor of outcome. I do not accept a person and say I'm going to treat them for years. Trial therapy will indicate the odds of a successful therapy. It also gives the patient an opportunity to assess whether they are interested. Simply put, it is not for everyone and everyone is not suitable for it.

DK: How do you manage those people whom you find unsuitable for this approach?

AA: If after five or ten sessions we see a non-response, we would either do a consultation or consider termination. If we don't see any signals of unconscious issues emerging, we can't discern any activation of the unconscious, if there is a complicated social setting, substance dependence, or a psychotic process operating, we refer them for other appropriate treatment.

DK: How do people respond when you tell them that you think the best course of action is to refer them somewhere else?

AA: It's virtually always a mutual decision. We discuss it with the patient before acting.

DK: So there is a group of patients for whom this therapy is contra-indicated?

AA: Yes. We have had an occasional patient, for example, with delusional disorder, who becomes fixated on having this treatment because they saw it in the newspaper. So we try. But really the person is psychotic and we really can't do a lot there. We're not seeing any unconscious signal. There's no internal process. Either the person is externalising or their problems are actually all external and we can't treat external problems with this approach. There's no psychodynamic treatment for external problems: external problems require an entirely different response—a socially based strategic response, like getting them into secure accommodation or out of a situation in which they are being abused or harassed. These external problems need to be addressed first before unconscious issues would be accessible.

DK: What is your approach to treating patients who present with a long medication history of psychotropic drugs?

AA: About 95% of people come to therapy in our service on psychotropic medications. We stop the medication most of the time. Over my career as a psychiatrist, for every pill I've prescribed, I've stopped twenty.

DK: I imagine that you are not popular with big Pharma [laughs].

AA: There are some well-meaning drug companies and reps who want to help patients and will fund education in the psychotherapies. They want to help their company also, but they know medication is not enough. They know that other treatments are needed. We are completing a study [Abbass, Kisely, & Rasic, n.d.] showing a $10,000 cost reduction per patient after an average of seven sessions of ISTDP treatment by reducing hospitalisations and physician costs. In the three year follow-up, costs reduced by $10,000 per patient compared with the previous three years.

DK: That's quite astounding. The fact that you are able to treat so many more people than the more traditional psychotherapies makes it much more cost and time effective. What are your thoughts about the age of the patient? Is there an upper and/or lower limit?

AA: I have worked with patients as young as twelve years old; I have a colleague who has worked with even younger children. ISTDP can be effective with young people if they can work like an adult and have some striated muscle unconscious anxiety. We should also consider family therapy when younger people present for therapy. I like Minuchin's work [Minuchin, 1974]—this form of family therapy has some elements in common with ISTDP.

As for the upper age limit, I've worked with people in their seventies and eighties. We typically do a short course of therapy, usually less than ten sessions, for an adjustment issue, even though they may have long-standing issues and possibly character issues.

DK: Do you see decreased responsiveness in this older age group—the "can't teach an old dog new tricks" issue?

AA: No, on the contrary. Therapy seems to help them out quite a bit. In fact, one of our studies showed that this older age group had greater medical service cost reduction compared with younger populations [Abbass, Kisely, & Rasic, n.d.].

DK: Many studies internationally show that the bulk of the medical costs for any one person occur in the proximal years before death, so there is greater potential to reduce these costs because of the initially higher medical costs in this age group.

AA: That's right, but we are seeing this cost reduction, sustained in long-term follow-up, as the patients become even older.

DK: ISTDP grew out of classical Freudian psychoanalysis. There are both commonalities, for example, mobilising the positive transference (Davanloo's unconscious therapeutic alliance) and removing the major resistances, and differences between Freudian psychoanalysis and ISTDP. For example, ISTDP does not use the couch, free association or a "passive" therapist. Can we look at each of these? I gather that everyone sits up for ISTDP.

AA: Yes, that's right. We want to use chairs with arms, so that we can follow the rise of striated muscle anxiety and to be face-to-face, squared up to maximise eye contact. Eye contact is important in terms of early attachment because the early bond is through the eyes, so we are really interested in having eye contact.

DK: We have touched on free association, which is the cornerstone of classical psychoanalysis, but do you have any other comments on it here?

AA: We don't use free association and I believe that in many or most cases, it sets the stage for a victory of the resistance, through delaying therapeutic ingredients. Our goal is to mobilise the unconscious therapeutic alliance and access the pathogenic emotions as rapidly as the patient can bear. To do this we actively work on the resistance in order to reach to the patient stuck underneath the resistance.

DK: Because the ISTDP therapist is so active, silence occurs less frequently in ISTDP compared with other therapies that use silence as a therapeutic tool. How does ISTDP view the function of silence? Is there a place for silence in ISTDP?

AA: Yes. There is a place for silence. When a person sits there passively, I might go silent as a way to use pressure to encourage the patient to become more active. So I'll sit and wait, thereby exerting pressure. This is one situation, by the way, where an "analytic" stance may be quite effective.

DK: Do you acknowledge or deal with oedipal issues?

AA: Sexualised attachment with the opposite sexed parent doesn't form any pathology on its own, but rage with a sexual component carries with it huge guilt. It's part of the rage and guilt system, but that's not the Oedipus complex. That's sexualised rage—raping or sexual violence is part of rage. Sexualised rage is not the same as an affectionate sexual feeling. There's case-based evidence for the oedipal theory in specific cases as a major pathogenic force. I have not observed it in any of my cases, nor has Davanloo. I've heard of patients actually correcting the therapist when he tried to suggest an oedipal triangle at one point.

DK: As did little Hans, Freud's famous case that purportedly proved the Oedipus complex, when his father suggested an oedipal dynamic [laughs].

AA: The reality is that the patient is likely to want to murder the same sex parent because that parent interrupted the relationship with their opposite sex parent. For example, if a father keeps thwarting the efforts of his son to attach with his mother, the boy is going to start to feel jealousy and rage toward his father, and then guilt about the rage towards his father.

DK: And a similar process would occur with a daughter?

AA: Yes.

DK: Do you have a position on therapist self-disclosure?

AA: Self-disclosure doesn't really come up much. It might happen if a person just tosses out a question. For example, if I'm focusing on the feelings of children, the patient might say, "Do you have kids?" and I'll just say yes. Then they go on. We don't make a big to do about it. I don't want to interrupt things by getting hung up on a simple question.

DK: What about touching patients?

AA: I don't do any touching; it's not in the realm. I might shake hands after a session if the patient offers a hand but I don't offer a hand. I don't put a hand on their shoulder or offer a hand as a gesture of comfort, although I know that some colleagues do.

DK: What is your attitude towards gift giving?

AA: As far as gift giving, tokens that reflect the collaboration that we had are really nice. Because our treatments are typically short, we don't have to deal with some of the issues that arise in the more prolonged therapies in which strong attachment bonds form with the therapist.

DK: How are dreams worked with in ISTDP, if at all?

AA: In 1992, I remember saying to Dr Davanloo that most of my patients don't bring dreams to their sessions. I asked him why. He said, "That's because they don't need to bring dreams because you're unlocking the unconscious [Davanloo, 1996c] each time they come and the content is coming through in the day time in the session. They're dreaming while they're awake." So we refer to the unconscious alliance that patients form with the therapist as dreaming while awake. They are seeing dream-like images coming up in the session. Even between sessions, some patients report looking in the mirror at their teeth and seeing fangs. When they look at their hands, they see hair like a wolf. Then they look out to their swimming pool and there's the mutilated body of their mother floating around in the pool. This is the unconscious alliance. This is dreaming while awake. So we don't get into dreams *per se*; we don't need to. One exception is during the capacity building phase in patients with low anxiety tolerance or fragile character structure. In this setting, dreams are used as vehicles to build capacity to tolerate complex emotions and anxiety.

DK OK. What factors constitute the essential mechanisms of change in ISTDP. This question is related to termination, so we will tackle them together. Davanloo [2005] states that termination can be considered when the patient is symptom free, shows multi-dimensional structural character change and that the "pathogenic organization of the unconscious has been totally removed" (p. 46). How do you achieve these outcomes?

AA: The first mechanism of change is building capacity to tolerate anxiety. That has a good effect on its own; it helps to build the capacity to achieve breakthrough to the unconscious. If the patient can tolerate a high rise in emotion without defending and without getting sick, this will bring about change and symptom reduction. However, breaking through to the unconscious rage and guilt and experiencing

the guilt and the rage will bring character change. It brings a softening of the interpersonal space. They're not afraid of killing anybody. They're not on a guilt trip interrupting all their relationships. That's an important change agent in this approach. That's when you see interpersonal problems changing and this improvement in interpersonal relationships strongly correlates with cost and service use reduction. To be clear about "total removal", in the real world, we do many partial courses in which the depths of pain, rage, and guilt are not fully worked through in highly resistant and fragile cases. In moderate and low resistant cases, the bulk of the unconscious is examined and worked through.

DK: Davanloo states that many patients have experienced major trauma early in life, which is associated with primitive, unconscious, murderous rage, guilt, and grief in relation to early attachment figures and that these factors give rise to major resistance and major character disturbances. What advice does ISTDP offer with respect to child rearing practices to help prevent such disturbances?

AA: If parents project on to the child, that will agitate the child, so when we treat a parent, we're treating their child too. How many times do you see children improve when you treat their mother and father? For example, a mother comes in complaining, "My child's in a terrible shape. He's got ADHD, conduct disorder and obsessive compulsive disorder. He's on all these pills." Then you treat the mother, and they say, "Oh, what's happened? My son's got better, doing so much better in school, is so much easier to manage." We haven't treated the child but we have reduced the parent's projection on to the child and when we can do that, it takes the burden off the child and the parent can then be more attuned to the child.

DK: What about our world which is continually in crisis and conflict?

AA: I'd say the commonest threats are projective processes and herd mentality that comes out in people who feel attacked, and who react as a herd and declare the other side an enemy. It becomes herd versus herd, and the projection sticks there; it becomes a way of reducing anxiety for people who have neurosis. In some conflict situations, people experience less anxiety and depression because they have an external threat to deal with.

It is a similar dynamic in abusive relationships. A person in an abusive relationship is under constant threat. They don't have many symptoms; they're just externally burdened. They maybe tired and afraid, but when the victim gets out of that relationship, they collapse with severe depression and self-destructiveness, and suicide becomes a risk. We think things should improve after getting out of an abusive relationship but they don't because the person is imploding. They have always had the rage and guilt within themselves, and it is triggered by their abusive husbands. When a person no longer has an external abuser, the internal abuser kicks in. The aim of therapy is to help them deal with the underlying feelings. This is a very common scenario, this repetition compulsion in people like this. We understand it as a self-punishing superego system, which is also built to protect others. The superego has a positive function, but it is also self-constricting, so there's a negative function there as well.

DK: How do you interact with a person who comes in complaining of existential angst, of meaningless, of the futility of a life that is finite?

AA: If I see someone coming in with that presentation, they are usually tense and ruminating. I make a decision about how to proceed on the basis of unconscious signals, of unconscious anxiety and defence. If I see that, and if someone comes in vague and ruminating about the world, I might say, "What's happening when you come in here to meet with me because you're talking about these things, but I'm not really getting a sense of who you are. I'm hearing your theories and these thoughts going round, but who are you in there?" Then I will start pressing for them to be present with me. Then the tension will come and then the defences will come, and then we'll be in the process of opening up the unconscious. Usually there are some unresolved issues that are getting triggered by the phase of life. Different life stages bring different challenges. This implies an emotional process with losses, so these types of patients will come for a meeting or two, or a handful of meetings, to sort out whatever is being triggered by that phase of their life.

For a person who becomes obsessed and ruminates about the meaning of existence, I think it is a process of uncovering the unconscious meaning of what's going on. I am just going to focus on the feelings that are there under the anxiety and see if they can really be present with me in order to sort out what it is that's making them

worried and tense and anxious. Soon, the symptoms and worries and phobias will start melting down. In patients who are highly resistant, we are uninterested in content until the unconscious therapeutic alliance is activated. In low resistant patients, the content is already there; they are already open, but those people are really rare in the clinical world. I've only seen six or seven out of approximately 2,500 patients. I haven't even seen ten low resistant patients with no rage in the unconscious. That's probably because I'm a psychiatrist and it's harder to get to me. But there are people out there who have no buried rage. They just have grief related to specific losses and my role is to help them feel the grief. It doesn't take much since they only have minor defences. However, for the highly resistant patient, where there is rage and guilt, it takes much more work.

DK: How does ISTDP understand fundamentalism? For example, there was an incident in Denmark in which Muslims rioted because a cartoon depicted the prophet Mohammed in a disrespectful light. We had a similar incident in Australia in which a riot broke out as a result of a video clip that was posted on the Internet being interpreted as an insult to the prophet. In that demonstration there were children as young as three years old who had been given placards to hold in the street that said, "Behead all infidels who insult the prophet, Mohammed."

AA: I think many religious structures can become an element of resistance. Also, within these structures can also be elements of alliance. The world's major religions support positive regard for others. If you think about it, what is it that prevents people from doing that with each other and having a high regard for each other, and furthering the development of one another? The answer is resistance. It's like jealousy. If a person is developing and someone doesn't want them to develop, they feel jealous about it and want to thwart the efforts of the person who wants to develop. Parents can do it with their children, but so can neighbouring communities or countries. If one country has more money or resources, this can produce envy in their neighbours and lead to attempts to undermine them in some way. The same thing can happen within different religions. Simplistically, this type of behaviour can be understood as a defensive structure, which also contains elements of alliance (the herd mentality). Societies and cultures shape both health and pathology of all its members.

Underlying all the structures of culture, though, are just hurt people, with their emotional pain, rage, and guilt that stimulate unconscious anxiety and defences. That part can be cleaned up. It's harder to address the social problems, financial imbalances, the problems of politics, governments, religious differences; these are tough problems to tackle.

DK: Yet, some people override the herd mentality or collectivism which are so important to the survival of social groups—the idea that what is good for one is good for all—and become what is described in mainstream psychiatry as antisocial personalities or sociopaths, those who disregard and violate the rights of others.

AA: If a person enters the world with positive self-regard, he is able to access his own emotions and understanding of other people. These capacities provide the potential for that person to make a useful contribution in the world. They have no need to blame or attack others. Davanloo defines mental health as good anxiety tolerance—the ability to tolerate ambivalence, to tolerate mixed feelings, to see multiple perspectives without splitting, without turning anger inward and getting sick, or outward and blaming and attacking. It's a simple definition, and we have efficient, specific ways to turn a long course of treatment into a short course of treatment with the first goal being to build this capacity.

I would like to meet some of those people you are referring to and talk. I have worked with offenders or former offenders. I had one guy who was carrying a gun for the whole treatment. He told me at the end of therapy and I'm glad I didn't know. This guy said to me, "I have an antisocial personality disorder; I don't think you're going to be able to help me." Then he started heaving a lot of sighs and started to work. This guy had completely adapted to his environment and it became understandable as to why he had become a gangster. If you knew this guy's story, you would understand that it was the only way he could have survived. So we got a process going; he had unconscious anxiety. He was not a sociopath; he was not a guy without a conscience. In fact, he had too much conscience. So he could be helped. He will do less harm when he feels better about himself. This other man sexually assaulted a child. We focused on how he felt with this child during the assault. He reported a massive, murderous rage mobilising towards this child. Instead of murdering the child, he

abused him. But when he had murdered the child in his head and he felt the rage, he was looking at the image and saw the eyes of his father. The guilt started pouring out. Every one of the children whom he assaulted was his father. Instead of murdering his father, he abused children, in an attempt to prevent himself from committing murder, but he was burying his feelings. He was also self-destructing to avoid perpetrating more harm. He was transferring his feelings from his father on to the children whom he abused.

DK: If we distil your key message, I think it would be that herd behaviours and the response to the environment you have described all have similar roots within the unconscious experience of individual members of a social group, and until these are understood and addressed, we cannot expect to see positive changes in our world of conflict and strife. Would this be an accurate summary of your position?

AA: I think that among several psychosocial factors, unconscious rage and guilt drive much of the self-destructive and other-destructive conduct we see in the world today. I've seen many people go from harming to helping others when they have better anxiety tolerance and a better regard for themselves through working through underlying rage and guilt. It is obvious to me that this is a key factor. The good news is it can happen through psychodynamic psychotherapy and need not take years or tens of thousands of dollars in the vast majority of cases.