**Learning Issues DRAFT**

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**Overview**

Herein we will review the general issues involved with learning ISTDP and specific aspects of using the model at different phases in the central dynamic sequence, in relationship to different patient categories across the spectrum.

**General Learning Issues**

An important question to ask is “What is required of the therapist to be able to provide ISTDP treatment?” I will summarize the core requirements as follows:

1. Understanding metapsychology – First there is a requirement for the therapist to have a good indepth understanding of metapsychology of the unconscious. It is important to understand the metapsychological elements of the specific patient categories you are working with and also metapsychology in regards to the central dynamic sequence in the treatment process with these specific categories of patients. This is the equivalent of understanding anatomy prior to undertaking surgery.
2. Understanding the timing and types of interventions – Along this line it is important for the therapist to recognize the different types of key interventions including pressure challenge and head on collision, and the timing of these interventions. Mistimed interventions or incorrect interventions both can result in misalliance or a lack of treatment progress.
3. Ability to recognize unconscious anxiety and defenses – Along the same line it is critical that the ISTDP therapist can recognize and monitor unconscious anxiety in its different formats and recognize unconscious defenses and their major formats. This requires the therapist to be able to be conscious of and maintain consciousness of these unconscious processes.
4. Anxiety and emotion tolerance – The ISTDP therapist requires a good capacity to tolerate unconscious anxiety and also a capacity to tolerate the experience emotions without having any untoward effects. Thus, the therapist requires a certain amount of physical and mental health and emotional capacity in order to not have any adverse effects within him or herself and secondarily, the patient.
5. A clear corner of the unconscious – In order to be able to work effectively with another person it is necessary for the therapist to be able to see beyond their own self and own projective processes and to be able to see the patients for who they are independent of colourations of transference, anxiety and other resistances operating within the therapist.

**Specific Learning Issues With Regards To Phases of the Central Dynamic Sequence**

*Phase of Pressure*

There are several potential areas of difficulty that the therapist can run into in applying the phase of pressure. These include the following:

* 1. A lack of properly focused pressure – One of the most common difficulties people have in applying the ISTDP framework is providing pressure or efforts to reach through to the person stuck underneath the resistances. Examples of therapists behaviours that will result in a lack of pressure include excessive intellectualized inquiry, too slow of a pace, too much explaining and intellectualizing about the process, moving from zone to zone without any clear rationale and a lack of specificity and examination of incidents. Another type of variant difficulty is doing behaviour that would ordinarily be pressure but doing it in the wrong zone. For example, if the therapist presses to feelings when the person is in a highly resistant position rather than pressing to defenses then there would be a lack in rise of complex feelings and unconscious alliance. There is also a risk of misalliance in going in this direction.
  2. Pressure in the wrong zone – If the therapist preferentially starts to focus on anger or only positive feelings to the exclusive of the other complex feelings there will be a lack of rise in complex feelings. Essentially to do this is the same as invalidating the other parts of emotion that are being mobilized by this complex therapeutic process. The end result is facilitating of splitting, externalization idealization and devaluation. Thus, a primitive defense could be reinforced and confuse the therapist about what they are seeing in their office and in front of them
  3. Splitting – When the therapist selectively focuses on only one of the feelings in the complex transference feelings this blocks the rise in all of the other complex feelings. This prevents the mobilization of the unconscious therapeutic alliance and can lead to processes that have adverse effects on patients.

*Mobilization of the Unconscious*

At a rise in complex transference feelings it becomes time to start to clarify and challenge the resistances that are crystallizing in the transference. Some typical technical difficulties that can occur at this time include the following:

1. Lack of Clarification before challenge – If the therapist begins to challenge the resistances in the patient without clarifying what is being challenged there is a risk of misalliance where the person will feel themselves to be criticized rather than their defenses to be challenged. It is critical to have the separation between patient and defenses prior to challenge.
2. Premature challenge – Similar to the above if challenge is provided at too low of a rise in complex feelings then there is a lack of separation between the person and their defenses. There is also a lack of unconscious alliance that can work with you to work to understand and challenge the defenses. Thus, challenge should be reserved for when there is a high rise in complex feelings and a resistance is present in the room. Doing challenge at too low of a rise can result in a drop in the rise of complex feelings as there is a more dominant effect of negative emotions mobilized by challenge.
3. Challenge to resistances that are not present – It is critical that challenge be leveled against resistances that are actively operating at that moment in the therapeutic process. Thus, the therapist is challenging a defense such as passivity when the person is actually using another defense such as detachment. The end result is the flattening out of the process of a potential misalliance.
4. Delay in use of challenge – It is critical to bring clarification into challenge when the patient brings the defenses into the room. If there is a delay in the use of challenge or an absence of challenge in the inquiry at the time there will be no further rise in the complex feelings and alliance.
5. Missing the present in the transference – If the therapist does not notice the resistances rising in the room then there will be a lack of clarification in the challenge. It is critical for the therapist to monitor when they feel the patient pulling away and distancing with maneuvers such as breaking eye contact, slowing down, shifting, turning posture away and other observable patterns.
6. Dropping pressure – Pressure is the lifeline to the person stuck beneath the resistance. Thus, it is critical to maintain pressure and continue to press for the person to be present with you and engage with you in the therapeutic process. Thus, pressure should be constant throughout the phase of mobilization of the unconscious. A drop in pressure and switching over to pure challenge without maintaining pressure can also result in misalliance.

*The Phase of Head on Collision with Resistance*

When there is a high rise in the complex transference feelings it becomes critical to step up the level of challenge to match. It is at this time that head on collision becomes required. (Cross reference: Head On Collision section) Examples of difficulties with head on collision include the following:

1. Missing elements of head on collision – In providing head on collision it is critical to being in all the elements that are active in terms of the resistance, alliance and transference pattern of relating. For example, it is critical to deactivate the transference, undo the omnipotence in cases where there is present. If one provides a head on collision but does not undo the notion of omnipotence then the statement to the patient is really to say “You’re doing everything wrong and I know how to fix it for you.” The same kind of issues apply with other core elements of head on collisions.
2. Premature Head On Collision – Head on collision is a very powerful intervention. The timing of a major head on collision is when the resistance is well crystallized in the transference and when the unconscious alliance is mobilized to a significant degree. Doing a head on collision prior to this can drop the rise in complex feelings and drop the rise in the alliance. The reason for this is that it is a very heavy intervention requiring the power of the alliance and requiring the person to be strongly emotionally activated with complex feelings near to breakthrough. Prior to this there simply isn’t enough energy in the system to be able to benefit from a head on collision with an uplifting effect.
3. Wrong type of head on collision – As we talked about in the section on head on collision, there are different types of head on collision at different points in time and at different degrees in rise in the complex feelings. For example, to provide only a short range head on collision at a time when there is heavy crystallization of resistance in the transference there is unlikely to be much therapeutic benefit. Conversely to provide a major head on collision at a low rise in the transference or medium rise in transference can

also have a flattening out effect in the rise in the mobilization of the unconscious.

1. Bypassing the head on collision entirely – Patients with high resistance and with crystallization will require head on collision in order to break through to the unconscious. If the therapist for one reason or other failed to provide a head on collision the result is that the person is stuck with the resistance in place and with the alliance and unconscious complex feelings being frustrated.
2. Becoming supportive and dropping the pressure – When there is high mobilization of the unconscious complex feelings, resistance and alliance, it is critical to maintain pressure as described above. Again the pressure is the lifeline to the person stuck underneath the resistance thus, it is critical to maintain contact with the person when providing such a heavy intervention as head on collision.

*Passage of rage*

Common technical issues related to the passage of rage include the following:

1. Bypassing the rage in the transference – When the rage is trying to pass in the transference in relationship to the therapist it is critical that the therapist focus on the rage and help the person to experience it as it is being activated by our therapeutic work with the patient. Bypassing this would be a frustration for the patient and for the alliance.
2. Premature portraying – It is critical that the somatic pathway of rage be activated to some degree at least in order for the portraying of the rage to be fruitful. Otherwise portraying is simply an intellectual exercise that could even increase anxiety and resistance in the person. Examples of when this would happen is when there is a high rise in anxiety and resistance present while trying to portray. This refers to the problem of an inadequate mobilization of the complex transference feelings and somatic pathway of rage.
3. Somatic pathway not activated – It is critical that the somatic pathway of rage be activated versus the unconscious anxiety about this rage. Thus, one wants to wait until the striated muscle unconscious anxiety is dropped and there is a movement of heat and energy up through the upper body to the arms prior to portraying and focusing upon the content of what the rage is.
4. NOTE: - It is important to note that pressure to experience the rage will mobilize the complex transference feelings as well and can further facilitate the passage of and experiencing of the murderous rage. It is important to know however, when you are doing pressure to portray as a way to mobilize the unconscious as opposed to when you are doing pressure to portray as a means to help the person to talk about what you believe they are really experiencing. In other words, simply talking about the experience of the rage without the experience is much less therapeutic than actually feeling the feelings. You want to help the person to actually somatically this and all the other emotions.
5. Passage of guilt and love – When the rage passes as described above there is a sense of satisfaction that comes with this experience of this rage. It is important to help the person experience the satisfaction and the relief that comes from doing the action of the rage that they have just felt. This will facilitate the passage of the guilt and painful feeling. Some of the key ingredients toward assisting the passage of guilt and loving feelings and issues of what technical problems can come up include the following:
6. Avoiding the body – One technical problem that can come is that the patient has experienced an urge to murder somebody but the therapist somehow moves away and ignores the fact that there is a dead body on the floor in the office. Thus, the passage of guilt and a loving feeling there is thwarted. It is thus critical to stay with the eyes approach and touch and engage with the injured or dead loved one.
7. Detecting the passage of guilt – If the therapist misses that guilt is trying to pass he or she may inadvertently keep pressing for rage or go towards some other emotion and block off the passage of guilt. It is thus important to try and empathize with the patient and see what they are going through, what they are experiencing to try and put yourself in their shoes and to be able to sense within yourself when guilt and all other emotions are being experienced.
8. Interrupting the passage of guilt – In the same vein, when the guilt is passing, if the therapist does not recognize it or becomes anxious, he or she may start to talk or interrupt the passage of guilt. It is important to note that when there is a high degree of passage of guilt it is impossible to interrupt it from breaking through. But with a lot of ISTDP processes especially in the learning phase, there are partial passages of guilt which can easily be interrupted by distracting comments from the therapist.
9. Missing the loving feelings – In some cases when the rage is passed the person may begin to see or recall images of the loved one in positive moments. They may lay these images and emotions side by side with this dead body or damaged body as a means to experience the guilt about the rage. It is thus critical to recognize these loving feelings that are coming when these positive images show up and to facilitate the experience of a warmth and loving feeling to embrace. This will facilitate more deep passages of guilt about any rage.

*Learning Issues related to the UTA*

Some technical issues related to the unconscious therapeutic alliance are as follows:

1. Missing the UTA – (Cross reference section on UTA) It is common in the early phase of training to have difficulty recognizing the lower levels of the unconscious therapeutic alliance. If the therapist misses the unconscious therapeutic alliance such as in the form of negation or linkages or even imagery showing up then he or she may inadvertently bypass what the alliance is saying. It is important, thus to recognize the markers of negation, whispers from the alliance, linkages and imagery showing up in proportion to the degree that the complex transference feelings are being experienced.
2. Arguing with the UTA – If the therapist fails to recognize the UTA he or she may get into an argument and a debate with the UTA about where the process is. Thus, the alliance may be pulling the image of the mother from the past but somehow the therapist wants to focus on the father then this is a major technical problem. It is important to recognize the markers when the UTA is coming into force and follow it suspending our own prospectus about what may or may not or should or should not be there.
3. Ignoring the imagery – When a breakthrough of rage has happened and there is a damaged body on the floor it is critical for the therapist to go to the face and eyes and to wait for the alliance to produce linkages and images. The eyes or image of the damaged body may convert to someone in the past or else linkages may come. Thus, it is critical to press to see what this is and who this is that this rage has been directed towards and give the alliance some time. If one goes too fast, then the alliance will not have time to mobilize. It is critical, especially in the earlier breakthroughs with patients to give them time for the alliance to mobilize.
4. Pushing versus following the UTA – When the unconscious alliance is there and is mobilized on a low level it is critical not to start pressing and challenging and interrupt the flow of the unconscious alliance. Such events can happen if the therapist is anxious and defending in doing things that even can be provocative to the patient at the time when the alliance is about to bring some very painful or primitive material to the surface. The main solution to this is for the therapist to continue to monitor their own emotional reaction and their own unconscious and see if any imagery is showing up in their own minds causing such interruptions.

*Phase of Consolidation*

When providing recapitulation after passage of the complex feelings and dominance of the unconscious alliance some key technical issues are required.

1. The need for repeated recap – Based on Dr. Davanloo’s research and my own clinical experience, it is important to have repeated recapitulation tying together the corners of the triangle of conflict and the triangle of persons repeatedly. This is important for symptom reduction in patients with depression and panic for example. It is also important truly to educate the conscious alliance and strengthen its capacity to provide further dynamic exploration of the unconscious.
2. Missing elements in recapitulation – It is key to review all the elements of the complex underlying feelings. For example, forgetting to note and recall that there is guilt about the rage and that this rage and guilt have to do with complex feelings from the past can lead to acting out or regressive behaviour in the person’s current life. Thus it is important to bring as much as possible the entire picture of the person and their psychodynamics into the process when doing the phase of consolidation.
3. Maintaining pressure during recapitulation – It is critical to be constantly feeding the unconscious therapeutic alliance with pressure and again through cementing that bind between your unconscious and the unconscious of the patient. This is provided by pressure and constant encouragement of them to do their best, to battle resistance, to be present with you, to identify and work through very difficult emotions.

**Learning Issues Across the Spectra of Suitable Patients: See Reaching Through Resistance Chapter Sections for more details on this!**

In this section I will describe some of the common technical issues and learning issues related to different patient categories. The first one is the low resistant patient. Low resistant patients only arrive with tactical defenses. They do not have any major resistances and they do not crystallize their defenses in the room. Thus, the job of the therapist is to recognize that the therapeutic alliance is already in place and follow it rather than to overread the resistance. The most common technical problem that happens with these patients is overreading the defenses and even going to challenge when it is not required. This can produce a misalliance. These patients however are quite healthy and will be irritated and communicate this to the therapist to help them correct themselves. Thereafter, the therapist just needs to follow the therapeutic alliance and help the patient to focus in on emerging grief. Tactical defenses are basically arrows pointing the way to the avoided grief.

*Moderately Resistant Patients*

Because there is more intense rage and guilt in the unconscious in these patients, one problem that can happen is therapist anxiety and defenses making an intellectualized and emotional detachment process. Otherwise a lack of clear psychodiagnosis may lead to confusion about the process and a lack of directed pressure and as required, challenge. Premature challenge can take place with these patients. This may or may not be due to therapist anxiety or checked confusion about what the level of resistance is or whether the resistance is crystallized in the transference or not. A dropping of pressure at a high rise in complex transference feelings can produce problems in these cases thwarting a breakthrough in the unconscious. Because these patients are significantly resistant, rage, guilt and grief may pass on a partial level and may go undetected by the therapist. If this happens then they will miss the mobilization of the unconscious therapeutic alliance and may even go to an argument with the unconscious alliance. Another issue is a lack of recapitulation and review of the process after breakthrough.

*Highly Resistant*

With the highly resistant patient, the patient may come very confused about their own problems and it is often difficult to know where to focus. In these cases it is a requirement to search for the resistance. The therapist may be confused about this process or may make assumptions leading to confusion in the patient and even misalliance. These patients often may externalize and ventilate leading to some confusion about where the therapist should focus. Another area of confusion is misreading regressions and phenomenon for passage of emotions. Highly resistant patients are anxious and can often have explosive discharge or other regressive phenomenon that may look like emotions but which are actually defensive operations. Another common problem with the highly resistant patient is the issue of timing and pressure versus clarification versus challenge and head on collision. Premature head on collision can be very problematic with highly resistant patients leading to abrupt misalliance and premature drop out. Conversely, a lack of challenge when it is required also leads to a stilted process and a lack of treatment effect.

Countertransference in the various forms described in Chapter XREF) can be a major problem working with highly resistant and fragile character structure patients. The risk of unrecognized countertransference is that the therapist can become punitive, challenge prematurely or challenge defenses that are not present in a way to criticize the patient.

In these moments in time the transference may be activated: the therapist may be in the shoes of a punitive parent or neglecting parent or some other form of punitive character of the person’s past thus, it is critical to recognize when this is happening and deactivate the transference.

High Resistance With Repression

Some common problems here in addition to the ones described with highly resistant patients are as follows: If the therapist misses the process is above threshold the patient can become fatigued due to major repression of emotions. Thus, it is critical to be monitoring the striated muscle anxiety and the capacity to isolate affect to be sure the process is below threshold. Conversely, if there is too low of a rise in the complex transference feelings, there is an inadequate amount of exposure to the emotions and there will be a delay in capacity building. Thus, it is critical to monitor the rise in complex feelings and to be near to thresholds. Often when the complex feelings are passing the process may look atypical relative to when feelings break through defenses. When the emotions break through in patients with major repression they are essentially breaking through a repressive barrier as opposed to breaking through resistances. Thus, the therapist may miss the complex transference feelings that are actually being experienced.

Another issue may be a lack of recapping. It is critical to do extensive recapitulation and review to cement the capacity to see the process and to isolate the affect.

Fragile Patients

There are multiple technical problems and learning issues with regards to the fragile patients. First, an important skill set is to be able to recognize how much psychic integration is required. The patient who is primarily using splitting and projective identification may require extensive phases of psychic integration otherwise the process can end up reinforcing splitting and lead to adverse psychosocial effects outside of sessions. Likewise, missing when the process is above thresholds can be a significant problem. The patient may become afraid of the process or go flat with repression or both. Again, it is important to have an adequate rise in complex feelings so that there is a good dose of exposure. This will lead to the development of psychological structures and capacity including isolation of affect and striated muscle anxiety.