Intensive Short-term Dynamic Psychotherapy: Methods, Evidence, Indications and Limitations

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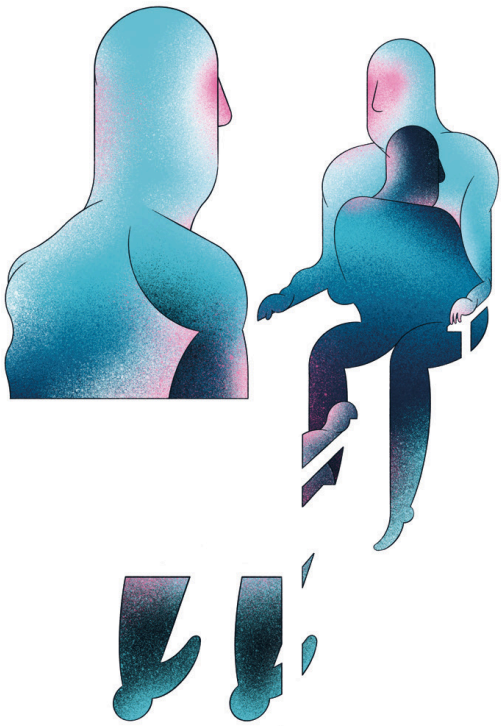

ACTIVE TREATMENT As this treatment is very active, it is open to perhaps an increased risk of adverse effects. This places demands on the therapist necessitating rigorous training, writes Allan Abbass.

In this article I will follow up the article by Camilla Bärthel Flaaten published in this journal and speak more broadly about intensive short-term dynamic psychotherapy (ISTDP). I wish to thank Flaaten for writing her article and raising a series of questions and concerns of importance to the practice of psychotherapy and to the practice of ISTDP specifically. I will write here about the general ISTDP working metapsychology of the unconscious and attachment trauma, the stance of the ISTDP therapist, types and timing of interventions, indications and contraindications for ISTDP, the evidence

base for ISTDP, training methods, the limits of the model and possible pitfalls/adverse effects of the method.

Metapsychological basis of ISTDP

Based on more than one thousand case studies using videotaped research (Davanloo, 1977; Abbass et al., 2015a), an in-depth understanding of patterns and processes deriving from unresolved attachment trauma has been developed. Interrupted attachments produce a series of feelings including at least grief. In most individuals who have had attachment trauma, the interruption is so painful that it induces rage that is guilt-laden and that becomes buried and avoided. Later relationships activate the attachment feelings including love, grief and any rage and guilt about the rage. When these feelings are mobilized at an unconscious level, they induce unconscious anxiety in specific demonstrable pathways and a series of matching unconscious defense patterns (Davanloo 2000; Abbass, 2015).

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Unconscious anxiety has specific observable patterns affecting voluntary muscle tension (tense muscles, sighing, muscle pain and spasms), smooth muscle (bowel, bladder, blood vessels), and cognitive-perceptual function (affecting vision, hearing, concentration, memory and level of consciousness). Some categories of unconscious defense include isolation of affect (intellectual awareness without feeling the emotions), repression of emotions, projection and other primitive defenses and resistances against emotional closeness. These specific patterns are related to emotions of different levels of intensity, typically occurring at different stages of child development. All of this has been studied and repeatedly observed on video-recorded cases throughout treatment courses, leaving us with a pathophysiology of attachment trauma, physiology of emotions and metapsychology of unconscious operations (Davanloo, 1977, 2000; Abbass, 2015).

Stance of the ISTDP therapist

When the therapist and patient form a therapeutic bond, with a shared goal that is agreed upon by both, unconscious, unprocessed complex feelings about attachments in the past are mobilized. These feelings then manifest as unconscious anxiety and subsequent unconscious defenses. Together, the therapist and patient identify unconscious defenses and unconscious anxiety and enable the patient to identify and process the feelings that are being activated by the attachment process with the therapist.

For perhaps a majority of patients, depending on the clinical setting, the process requires a supportive component designed to build self-reflective capacity, anxiety tolerance and ability to recognize emotions. This process includes what is called the graded format, in which complex feelings and subsequent unconscious anxiety are mobilized and reflected upon. This work changes the anxiety pattern from the smooth muscle or cognitive-perceptual field to voluntary muscle (Davanloo, 2000, Abbass, 2015). With these changes, the patient can then tolerate and begin to experience the underlying past feelings underpinning the anxiety.

For such challenging work to be therapeutic, the process needs to be completely voluntary, clear and understood by both parties. Any tendency of the patient to passively comply with the therapist must be recognized and addressed as a treatment-defeating mechanism. The process requires positive

regard back-and-forth between both people, even while complex feelings are mobilized within them. In other words, a solid team is required, with aspects of conscious therapeutic alliance and all the other common psychotherapy factors that have been well established through diverse research. From this space, a collaborative examination of feelings, anxiety and defenses may occur safely and comfortably.

Therapeutic interventions: activity versus hostility

The types of intervention that flow from this therapeutic bond include exploratory processes, clarification of avoidant patterns/defenses, challenge to defenses and further elaborations of these interventions. Linking of various phenomena, recapitulation, anxiety regulating methods and methods to facilitate emotional experiencing are also important elements (Davanloo, 2000; Abbass and Town, 2013; Abbass, 2015).

The timing of these interventions is extremely important. If clarification and challenge are done when those defenses are not present, the patient may perceive himself to be under attack. If the defenses are not adequately clarified before challenging them, the patient will feel himself to be under attack. Suffice to say, each intervention should augment the therapeutic bond, including conscious and unconscious aspects of the alliance. To ensure this, each intervention should be met with a combination of verbal and nonverbal responses that demonstrate that the intervention was both understood and helped the patient move in a healthy direction toward greater self-caring, self-understanding and forgiveness of self and others.

The process is tailored to the patient's unconscious anxiety and defense formats. In tertiary clinics where ISTDP is used (Abbass et al., 2015a), the vast majority of patients have low anxiety tolerance and thus receive a supportive, capacity-building format of the treatment to begin with. In this supportive or graded format, there is little to no challenge to defenses, rather the main focus is placed on building reflective capacity and improving anxiety tolerance.

The process is trans-diagnostic

Viewing video-recorded work where patients experience intense anxiety-provoking and painful feelings about past abuse can initially appear to be hostile to first-time viewers. This may occur more easily when one has seen only a short presentation with intense emotional processes. This perception was the same for me in 1990 when I was first exposed to this method (Kenny, 2013). I thought that the patient rather than the patient's defenses were under attack. It was not until I saw the patient become very open, go through very painful feelings of lost bonds, express deep gratitude to the therapist and have robust therapeutic benefits that I had to question my own tendency to avoid the depth of my feelings and those of my patients. Through the past 30 years of work, I have become convinced that, all too often, psychiatrists and psychologists are not encouraged to face their own feelings and destructive avoidant tendencies and those of their patients, to the detriment of both; this is, in my view, a form of passive hostility and neglect which we as a field and as teachers need to address.

Indications and contraindications

ISTDP has been used and studied for a broad range of clinical presentations, including the full spectrum of common mental disorders (Abbass, 2015), and has also been used as an adjunct in severe mental disorders (Abbass, 2016; Abbass et al., 2019) and addiction (Frederickson et al., 2020).

Having said this, the single ultimate indication for treatment is a response to a trial of therapy. The trial therapy determines the treatment pathway, suitability for treatment and potential concerns, establishes causative factors, and enables an overview of the person's problems. The trial therapy itself has an evidence base for being clinically effective and cost-effective (Abbass et al., 2008, 2017, 2018). It is from this assessment that a decision is made on whether or not to proceed with treatment with the therapist and patient as a team. In other words, no single diagnosis or problem is set as an absolute indication for this treatment.

Categories of patients who may benefit from the treatment include patients with dissociative elements, borderline personality features, unresolved grief, non-bipolar depression, the spectrum of somatic conditions linked to smooth muscle anxiety or with varying degrees of habitual avoidance of closeness and intimacy driven by unconscious tension. There are more detailed and unique psychodiagnostic findings occurring in two categories, including the spectrum of psychoneurotic disorders and the spectrum of fragile character structure. Patients with fragile character structure may take longer to treat, ranging from 20 sessions to two years or more depending on the severity of fragility and treatment goals; hence the treatment is not always short-term.

Even though there are randomized controlled trials, case series and case reports for the full spectrum of common mental disorders, DSM-5-type diagnoses do not determine the unique dyadic process of treatment. The process is transdiagnostic, focusing on specific parameters of conscious and unconscious processes to tailor the treatment to each patient.

There are few absolute contraindications to having a trial therapy. If the person has active substance use and is coming to the session intoxicated, then medical withdrawal or specialized programs using ISTDP methods and drug counseling may be required. If a person has active psychosis or active mania, then he would typically require stabilization of some sort. Furthermore, ISTDP is used as a supportive adjunct in these populations. Active inflammatory bowel disease and some other active autoimmune syndromes may be at risk of worsening in treatment due to anxiety and to the stress of the process itself.

One contraindication to this method, however, is centrally important: if a person does not have an internal set of difficulties that relate to problems with unconscious, unprocessed feelings related to attachment trauma, this treatment is not appropriate. This is not a treatment for external problems, nor for social problems per se on its own. If a patient and therapist do not see direct evidence of unconscious, unresolved emotions visible as unconscious anxiety and defense, then this treatment is contraindicated and other options should be considered.

Evidence base for ISTDP

Short-term psychodynamic psychotherapy methods have been subjected to over 250 randomized controlled trials (Lilliengren, 2021). ISTDP and related derived methods – under the umbrella of experiential dynamic therapies – have been subjected to about 50 randomized controlled trials and many case-series studies. These randomized trials cover the spectrum of anxiety disorders, depression, personality disorders, addiction and somatic symptom disorders. A review of some of these studies in 2016 (Lilliengren et al., 2016) found that the method collectively outperforms other bona fide treatments. At the time of that study there was an inadequate number of studies to assess whether it outperformed any specific individual treatments like cognitive behavioral therapy. It did outperform supportive therapy. The authors found this treatment to have a low dropout rate of 16.3 %. In a recent meta-analysis of short-term dynamic therapies for somatic symptom disorders, a small series of RCT

studies pointed to superior effects from ISTDP compared with CBT in chronic pain samples (Abbass et al., 2020).

At least 25 studies have measured the cost effectiveness of this treatment (Abbass and Katzman, 2013, Abbass et al., 2013a, 2015a and b, 2018, 2019). This evidence points to large and persistent reductions in doctor, hospital and emergency use. There is also evidence of reductions in medication. Other studies point to reduced disability costs. In one study of a chronic welfare population, the government saved three quarters of a million Canadian dollars by helping people return to work.

A large number of studies of these treatments have been conducted on complex and refractory treatment populations (Abbass, 2016 Town et al., 2017). In a high-quality RCT, ISTDP outperformed community mental health treatment (medication and mostly CBT) as usual for treatment-resistant depression, and had the highest published remission rate of any treatment in follow-up (40 %) (Town et al., 2017, 2020). Another study done in Drammen, Norway found that refractory patients benefitted in comparison to waitlist controls and had reduced costs, and that in follow-up, patients also had a high rate of remission on self-reported measures. An RCT found ISTDP for addictions to outperform drug counselling (Frederickson et al., 2019). This ability to assist patients who are complex, highly resistant and who do not respond to other approaches may be the most important contribution of this method to psychological care (Solbakken and Abbass, 2014, 2015, 2016).

The treatment has also been studied for refractory patients with severe mental disorders. As an adjunct to patients with psychotic disorders and bipolar disorders, there is some preliminary data for cost-effectiveness and clinical benefits that persisted in follow-up (Abbass et al., 2015b, 2019). One study of inpatient psychiatry showed reduced use of electroconvulsive therapy that offset the cost of the psychologist (Abbass et al., 2013a).

As described above, the treatment assessment which is called a trial therapy brings about significant symptom reduction on average and shows evidence of cost-effectiveness (Abbass et al., 2008, 2017, 2018)

Beyond these outcome research studies, around 20 process studies of ISTDP and related methods have been conducted (Abbass et al., 2013b;Town et al., 2019). Studies point to a very high rate of therapist interventions in this treatment. Other studies found that sequential work on defenses predicts emotional experiencing and that emotional experiencing predicts improvement on the outcome measures. Specifically, the process of unlocking the unconscious is related to interpersonal and symptom gains as well as to healthcare use reduction in follow-up. Emotional processing, and in specific the experience of anger, also helps patients in treatment (Town et al., 2019, Town et al., in press). Some studies assessing mechanisms of change were recently reviewed (Hoviatdoost et al., 2020).

Many of all these studies were conducted by our group here in Canada. However, many were conducted independently by other groups around the world. There are studies in which I was a co-author but did not provide the treatment or direct clinical supervision but rather supported the research design and/or publication.

Limits of this research

It is important to note that the results of all this research point to an evidence-based and efficient treatment that appears to be cost-effective and broadly applicable in clinical samples. However, there are nonresponse rates in every study, and dropouts in virtually all of them. I documented my first six years of cases and found that about 80 % of patients had gains on outcome measures and did not

return for treatment in a passive follow-up period (Abbass, 2002). However, 20 %, or one in five, did not make gains, dropped out, or returned for further treatment. This figure of 80 % is similar to what Davanloo reported (83 %) in his first large case series (Davanloo, 1977). The obvious conclusion here is that this treatment is not a panacea, but at the same time appears to be beneficial and well tolerated for a significant majority of people who undertake the treatment.

Training

As this treatment is very active, it is open to perhaps an increased risk of adverse effects. Even though the dropout rates are relatively low with ISTDP, the high level of activity places demands on the therapist necessitating rigorous training. First, trainees are expected to attend immersion courses where details of processes are reviewed with the use of case videos. Second, trainees undergo video-recorded group supervision. Third, trainees are expected to make a case study of all of their cases to evaluate suitability. Fourth, people are expected to self-review to check clinical response and to continually improve treatment skills. Fifth, trainees are expected to self-examine and become aware of their own emotions, even while treatment for the therapist is neither expected nor generally required. Literature is provided and there are some self-report guides for self-supervision as well. In this training, idealization of the method and the trainers is actively discouraged as a barrier to learning and self-development (Abbass, 2004).

In studies of therapists in training, the treatment has been demonstrated to be effective in both anxiety disorder samples and mixed samples (Rocco et al., 2021; Abbass, 2004; Abbass et al., 2013c). The number of hours of training also seems to correlate with improved cost-effectiveness. In our largest study of 890 patients, over 50 trainees contributed outcome data. These therapists were psychologists, psychiatrists, family doctors, psychiatry residents, social workers and behavioral nurse specialists (Abbass et al., 2015a).

Possible pitfalls and adverse effects

Even with the above safeguards, and with detailed guidance and training, adverse effects can and do sometimes occur. We recently published a paper on how rupture is managed and how misalliance is avoided actively within the ISTDP frame (Abbass and Town, 2021).

There are multiple factors that may interrupt the treatment alliance and produce adverse effects. First, therapist countertransference responses, anxiety and defenses can interrupt the treatment alliance. Second, mistiming or misapplication of interventions can lead to misalliance or other adverse effects. Third, failure to establish a conscious therapeutic alliance and shared task can result in adverse effects or no treatment benefit. Fourth, failure to recognize and manage a person's defenses with which the patient is not well acquainted can result in a range of difficulties including misalliance or a passively compliant process without benefit. Finally, failure to recognize any biological, social, familial or other factors in symptom causation can lead to partial response or negative effects, depending on the factors.

Summary and conclusions

While ISTDP is not a panacea, it is a treatment that is clinically useful in diverse psychological and psychiatric samples. It appears to work by improving emotion regulation, by facilitating emotional

experiencing and building insight which, combined, can help to heal attachment trauma. It is quite an active treatment which helps people overcome unconscious habitual avoidant patterns that became galvanized during interpersonal trauma in childhood. It has significant applicability but is also limited to clinical utility in people with attachment trauma and unconscious emotional problems. As an active approach, there is risk of misalliance, and this risk should be offset by training, video-recorded self-review, peer support and ongoing education around challenging populations.

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