

**Bringing Character Changes with Davanloo's Intensive Short-term Dynamic Psychotherapy. In Press AD HOC Bulletin of Short-term Dynamic Psychotherapy
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Summary:

Davanloo has discovered and operationalized a means of direct assessment of character structure, including both discharge pathways of unconscious anxiety and specific manifestations of defenses. This psychodiagnostic process provides a roadmap to the unconscious buried feelings which generate the anxiety and defenses. This roadmap tells the therapist how much of which interventions are required to bring sufficient structural changes in unconscious anxiety and defenses to enable smooth, direct access to the unconscious. In following the map, changes in character structure begin to take place and are thereafter cemented by repeated unlocking of the unconscious and working through the underlying feelings. In this article, this process of psychodiagnostic evaluation, and the graded format of bringing structural changes will be overviewed and illustrated by vignettes from a course of treatment.

Specific Manifestations of Character Pathology

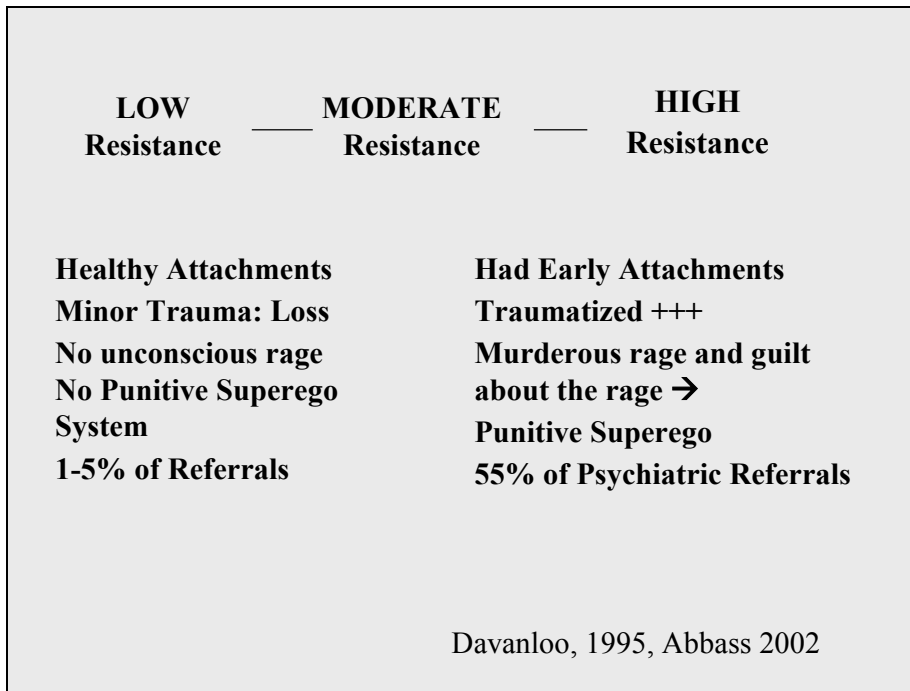
Davanloo has described 2 spectra of patients suitable for his technique of Intensive Short-term Dynamic Psychotherapy (ISTDP): the Spectrum of Psychoneurotic Disorders, and the Spectrum of Patients with Fragile Character Structure (Davanloo, 1995).

On the Spectrum of Psychoneurotic Disorders, patients at the left side have only unresolved grief and no character pathology. They have no major defenses and have no punitive superego structure as they do not have repressed rage and guilt about the rage (Davanloo, 1995). They do use tactical defenses such as vagueness or indefinite terminology ("maybe", "kind of", etc.).

As one proceeds across this spectrum the amount of trauma experienced and subsequent pain, rage and guilt increase. At the far right are patients who have experienced attachment at some point in their lives but these attachments have been broken by one or more traumatic events. The cascade of feelings about these ruptured bonds is the engine to these patient's difficulties. They have a punitive superego structure (Davanloo, 1995) and significant character pathology. They are, as a group, poorly motivated, lacking in insight, and highly resistant (Davanloo, 1990 e). Many of these patients use the major defense of

isolation of affect, associated with discharge of unconscious anxiety into the striated muscle pathway. These patients were the initial highly resistant patients Davanloo was able to successfully treat in the 1970's using the early version of his technique (Davanloo, 1980, 1995). He found that 23% of general psychiatric patients were able to be treated by this model (Davanloo, 2005). See Figure 1.

Figure 1 Spectrum of Psychoneurotic Disorders



Patients at the right end of this spectrum can also have access to repression as a primary major defense, associated with the discharge of unconscious anxiety into the autonomic nervous system, including the smooth muscle pathway. This results in a patient population suffering from such difficulties as chronic somatization and depression in addition to major relationship problems and self defeating behavior patterns (Davanloo, 1990 b), (Davanloo, 1990 c). These patients do not have solid defenses and have relatively less access to tactical defenses. Rather than to defend directly, they tend to go flat under pressure. In order to treat this group of patients, Davanloo developed a special modification of his treatment method which we will focus on in this paper. Through the use of this modification he was able to treat over 35% of general psychiatry patients (Davanloo, 2005). In total, the Spectrum of Psychoneurotic Disorders is about 65% of psychiatric office referrals. (Abbass, 2002)

On the Spectrum of Patients with Fragile Character Structure, patients have major character pathology with a history of severe trauma, an absence of healthy attachments, increased violent behavior and victimization. They have longer occupational disabilities, use more medications for longer periods and are more difficult to treat, requiring longer courses of therapy (Davanloo, 1995), (Abbass, 2002). They make up about 20% of psychiatric office referrals (Abbass, 2002). Overall, these patients have primary major defenses of projection and repression. These patients have access to varying degrees of unconscious anxiety in the form of cognitive and perceptual disruption, such as drifting, visual blurring or tunnel vision and dissociation (Davanloo, 1980), (Davanloo, 1995) . At the mild end of this spectrum, the patient experiences transient cognitive disruption at a higher level of anxiety, while the severely fragile patient experiences this at very low levels of anxiety and can remain in this state for a much longer period of time. With application of new advances in his technique to bring Multidimensional Structural Changes, 52% of general psychiatric patients and 86% of psychiatry practice referrals are now candidates for ISTDP (Davanloo, 2005, Abbass, 2002).

Overview of Bringing Character Changes with Davanloo's ISTDP

In brief, bringing character changes means reducing or removing resistances against experiencing emotions and resistances against emotional closeness. In other words, the patient must develop the ability to be intimate and experience feelings without it triggering a pathogenic reaction. In this therapeutic process, self-destructiveness is converted into self-caring. Davanloo has described that this process can be directly accomplished by helping the patient to see the resistances, overcome the resistances and experience the underlying feelings about the trauma of the past. In brief, the steps to accomplish this are as follows:

- Inquiry
- Psychodiagnostic evaluation
- Preparatory phase
- Repeated unlocking of the unconscious
- Working through
- Termination.

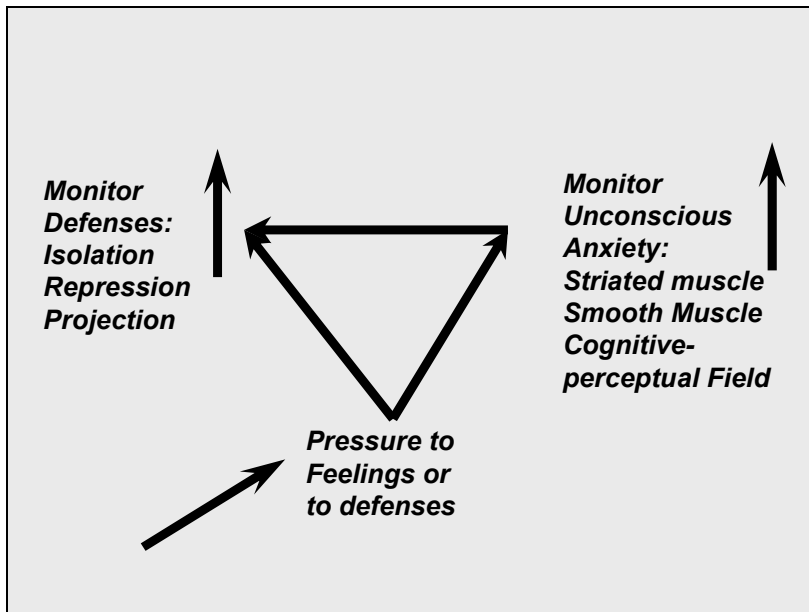
In this review, we will focus on the psychodiagnostic findings and preparatory phase as seen in the early treatment of a young man with chronic depression, severe irritable bowel syndrome, agoraphobia with panic and chronic self-destructive behavior including chronic suicidal ideation.

Davanloo's Psychodiagnostic Evaluation

Davanloo has described a specific process used to evaluate the patient's anxiety discharge pathways and nature of his or her resistance. The process involves using "pressure" which

mobilizes complex feelings toward the therapist. These “complex transference feelings” (CTF) include both appreciation and irritation at the therapist’s intention to both understand the patient’s underlying emotional problems and to work to free the patient from their difficulties (Davanloo, 1990 e). These complex feelings mobilize unresolved unconscious complex feelings from past relationships which generate unconscious anxiety and defenses against this anxiety. One can then see the degree and types of unconscious anxiety and the nature and degree of the resistances. Thus, this process allows a direct examination of the patient’s psychic and character structure (Davanloo, 1990 e). See Figure 2

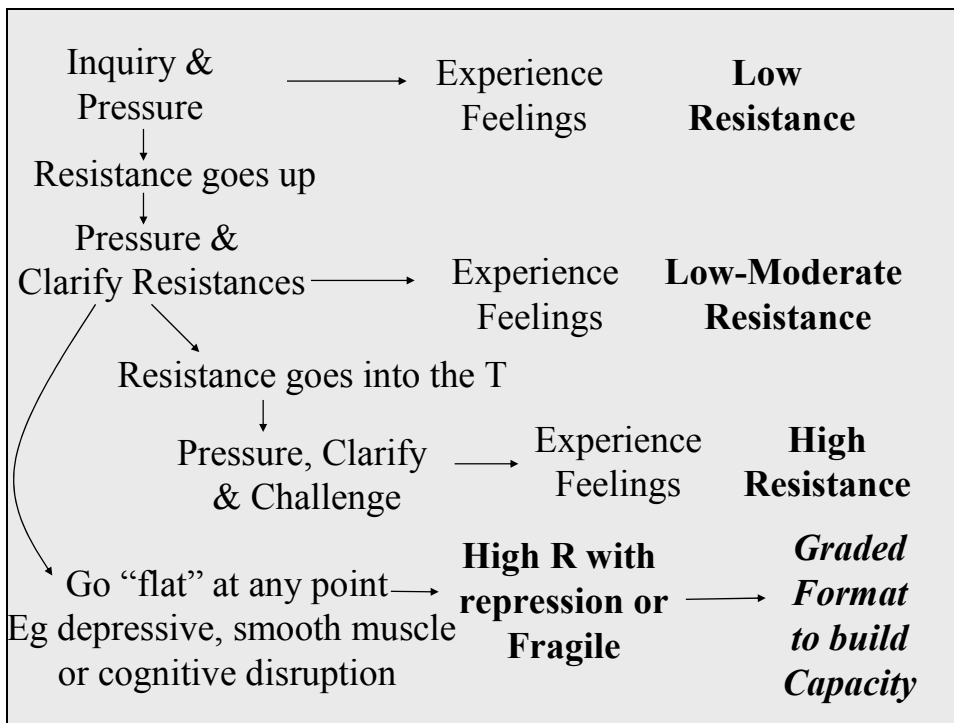
Figure 2 Psychodiagnosis



There are several specific types of interventions which constitute pressure including structuring the interview, focusing on the specific problems with specific examples, focusing on avoided feelings and focusing on the experience of the feelings. Pressure will at times be to the patient’s will, to the therapeutic task, to an equal collaboration and to be present and open with one’s feelings (Davanloo, 2000).

The results of this pressure and holding on defenses are a direct examination, rather than a speculation, about the patient’s anxiety tolerance and defenses. This specificity is required to determine the most effective treatment approach for this particular patient. Examples of the possible patterns of response, the implications of the patterns and treatment approaches are in Figure 3.

Figure 3: Psychodiagnostic Algorithm



Brief Case History

The patient is a 30 year old man who is single after being “dumped” in a humiliating fashion by his fiancée 4 years prior. He was on long-term disability for 4 years, on antidepressants and anxiolytics. He did not make it to the initial interview because he was too anxious to leave his house, afraid he would have uncontrolled diarrhea. He was often housebound with this same fear. He would not drive due to fear of diarrhea if he was stuck in traffic.

Initial Psychodiagnostic Evaluation

The patient looked physically very calm in this interview, despite having missed the first session. The interview began and he described chronic depression, suicidal ideation without active planning, panic attacks, generalized anxiety and social isolation.

Th: Can you tell me about a time you experienced this diarrhea. (Pressure to be specific, structuring the interview)

Pt: It comes out of the blue. There is no warning. (Suggests he does not see emotional linkage)

Th: Can you describe a specific time this happened so we can see how that works? (Pressure to be specific)

Pt: It happened when I missed the first session.

Th: Can you tell me about that? How did you feel when you missed the session? (Pressure to feeling)

Pt: I called you then got cramps and later diarrhea.

Th: When you called me how did you feel? (Pressure to feeling)

Pt: I thought I was an idiot for missing it.

Th: You mean you were angry... but at who? (more Pressure to feeling)

Pt: I was and am an idiot.

Th: So you mean angry at yourself? Is that what happens at times? (Clarifying defense)

Pt: Yes, I guess it does.

Th: Because in your approach to tell me about that you became angry at yourself? (repeat Clarifying defense)

Pt: Yes I did.

Th: Can we look into that? How that happens here? (Pressure to task and patient's will)

Pt: Sure, I think we have to.

Th: hears gurgling sounds. But patient looks completely relaxed with no striated muscle tension. This is suggestive that the anxiety in this man is not directing to the striated muscle and is rather being repressed into the smooth muscle of the GI tract: the patient looks "relaxed" but the GI tract is in spasm.

Th: What is happening now?

Pt: Heartburn. (points to his chest)

Th: Did you just get heartburn? Anything else?

Pt: I can hear my stomach gurgling.

Th: So you can hear it gurgling. Is this what happens sometimes when you have strong feelings and anger, that you get heartburn and cramps? (Recapitulation, linking feelings with anxiety)

Pt: Yes it must be.

Th: Because in your approach to talking about anger you got heartburn and cramps here. So is that where the anger goes? (repeat Recapitulation)

Pt: Must be, because it just happened!

This is suggestive evidence that repression of emotions takes place to the smooth muscle. To confirm this finding and to ascertain the level of anxiety intolerance he had, the process is repeated with another focus.

Th: Can you tell me about another time that this happened. (Pressure)

Pt: Yes when my I'm angry with my brother I don't say anything, I ignore him.

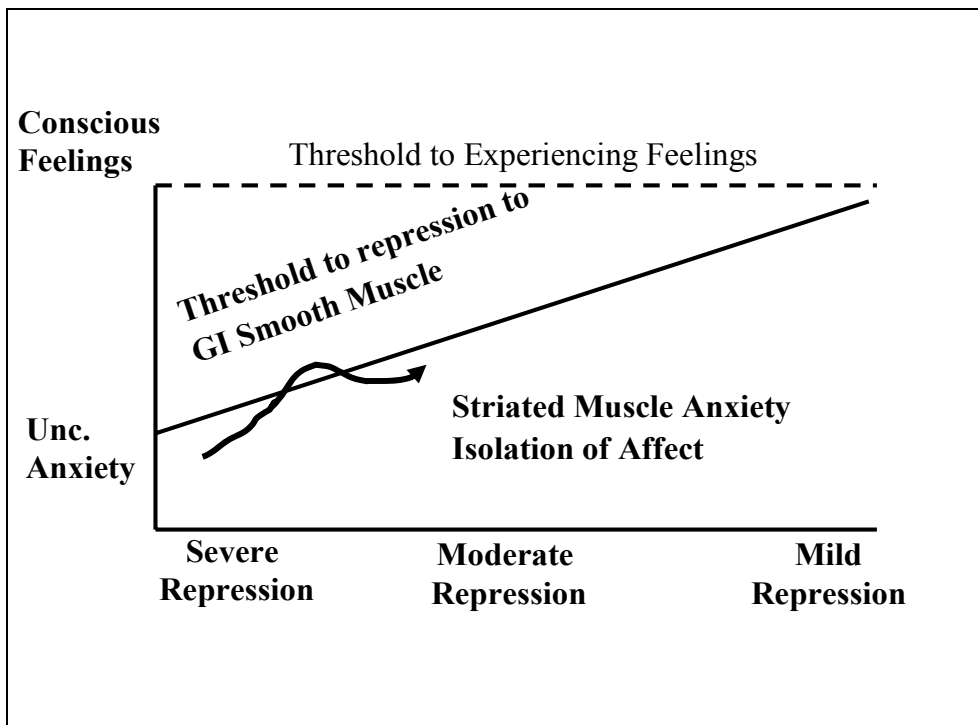
Th: Can you tell me about a time that happened? (repeat Pressure)

Pt: Yes just the other day he did something to irritate me... and that is coming back again.... the heartburn. (Again, the patient is totally relaxed with no striated muscle response.)

Th: So again when you speak of anger, your stomach reacts with acid and cramps. (Recapitulation, linking feelings with anxiety)

Thus, we confirmed that this man had poor anxiety tolerance because there was no evidence of discharge of unconscious anxiety to the striated muscle system. Rather, it appeared that any unconscious anxiety discharged into the smooth muscle of his bowel. He thus had little corresponding ability to isolate affect or intellectualize about his emotions. As we can see in Figure 4, this finding tells the therapist that a direct effort to mobilize the unconscious would likely result in a worsening of his GI symptoms as the threshold to repression was passed. Hence, the process calls for application of the Graded Format of ISTDP (Davanloo, 1990 b), (Davanloo, 1990 c).

Figure 4: Psychodiagnostic evaluation of a patient with smooth muscle unconscious anxiety. After Davanloo, (1990 b, c).



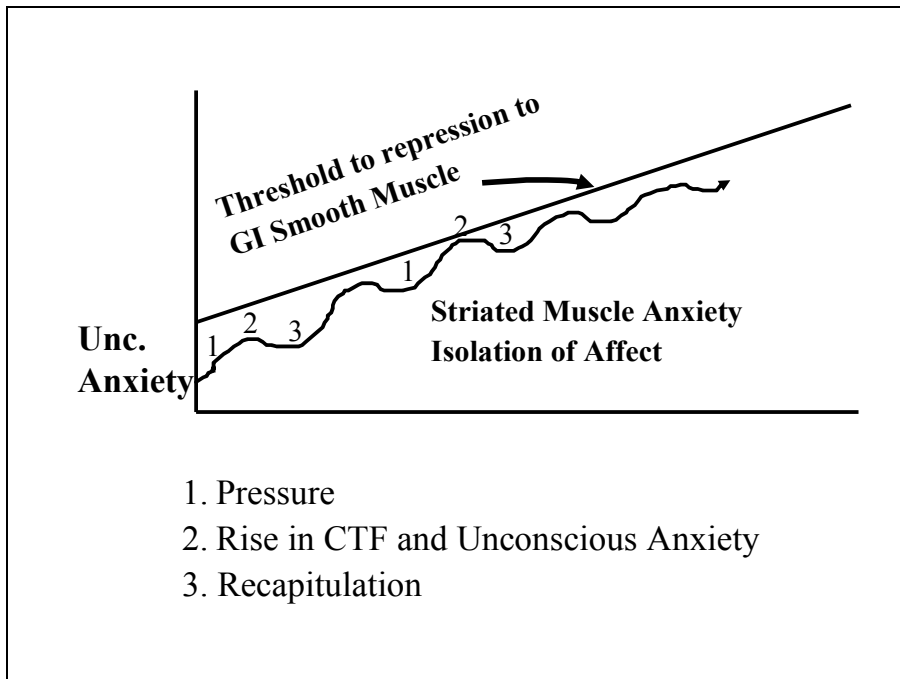
It will be helpful for the reader to be aware of the association between the 3 types of major resistance and discharge pathways of anxiety. In brief, striated anxiety discharge is generally associated with isolation of affect. Smooth muscle discharge is associated with repression. Finally, cognitive disruption is generally associated with repression and projection. The overall goal of this work is to build the patient's capacity to tolerate anxiety, redirecting the discharge pathways of anxiety from cognitive disruption and smooth muscle into the striated pathway, with an associated shift of the patient's major resistances from projection and repression to isolation of affect. Once a patient's discharge pathway of anxiety has shifted to the striated muscle system, the therapist is able to confidently apply higher levels of pressure and challenge as per the standard, unremitting format of ISTDP (Davanloo, 1990 b).

Preparation of the Patient for Unlocking the Unconscious: The Graded Format of ISTDP

Davanloo has described a method to build capacity to tolerate unconscious anxiety in patients for whom the standard format would be overwhelming and likely to exacerbate symptoms. The above vignettes illustrate this graded format in action. A key feature of individuals like this patient is their inability to distinguish between feelings, anxiety and defenses (Davanloo, 1990 b, c). Accordingly, a process is required that brings the ability to self-observe and think about emotions, overcoming the repression of affect and enabling the patient to differentiate between feeling, anxiety and defense. That is, isolation of affect and self-monitoring are brought to replace repression and somatization of affect.

As we can see in figure 5, there is a specific process to follow in the graded format, quite distinct from the unremitting pressure, challenge, and head-on collision of the standard format of ISTDP. In the graded format, cycles of pressure are followed by a rise in CTF and unconscious anxiety. When the anxiety approaches the threshold to repression, then the pressure is reduced and recapitulation of the process is performed, clarifying the link between emotion, anxiety, and defense, as well as the link between the patient's past and present life experiences and the transference (Davanloo, 1990 b, c).

Figure 5: The Graded Format



Technical Issues while employing the Graded Format:

In the following Sections we will review some technical issues which come into play when using the Graded Format.

1. When to Raise Pressure

When the therapy process is unfocused and detached, with little rise in complex feelings, there is a need to raise the pressure. Without this pressure and rise in complex feelings, anxiety tolerance will not improve, simply because there is no exposure to the accompanying anxiety taking place. In other words, the work of therapy at this phase is experiencing and tolerating the unconscious anxiety associated with complex unconscious feelings. In addition, without pressure to activate the unconscious forces, there is a risk that therapy will drift endlessly. Another risk of inadequate pressure is that the therapist may

become concerned that the patient has lower anxiety tolerance than they really do. This may lead the therapist to tread far too cautiously and extend the patient's suffering.

2. How to Raise Pressure

Davanloo has described a broad range of ways to use pressure. In a nutshell, any efforts you make to encourage the patient to be present with you in the room, with his or her feelings, to experience these feelings and to do battle against defenses constitutes pressure. The patient experiences your efforts as encouragement, but at the same time is irritated by the encouragement, because you are implying that change must occur, even if it is clearly for his or her own benefit.

3. Where to Place Pressure

Simply put, we need to focus where the patient's primary system of defense is positioned. The complexity of this for the therapist is recognizing what is the "front" of the defensive system and where it interfaces with the therapist and process. For example, in the vignette above, when the patient was beating himself up verbally, the focus was on self-directed anger. When he developed audible GI cramps, the focus was on repression of emotions and conversion to smooth muscle. If he goes flat and depressed, then the focus would be on repression to the state of depression. Each time, the therapist is aiming to replace these regressive phenomena with isolation of affect and self-observing capacity.

4. When to Lower Pressure

How then does one know when the pressure is too high and must be reduced? Referring to Figure 5, when one is above the threshold, one must move to reduce the anxiety or risk worsening of the patient's symptoms. What are the signals when one is above the threshold? Specifically, there will be a lack of striated muscle anxiety and isolation of affect: the discharge pathway of anxiety will shift to smooth muscle or possibly cognitive disruption. The patient will not be aware that emotions were just repressed, but instead he or she will regress into depression, weepiness or somatization (e.g. weakness, fatigue, pain, numbness, etc.).

5. How to Lower Pressure

The above vignette also illustrated methods to lower pressure. First, the focus on underlying feelings was stopped for the moment. Second, the process was reviewed in partnership with the patient, clarifying what had just occurred and linking feelings to the anxiety and defenses observed in those moments. This helps him to see that there were feelings, but he was not able to experience them as they were shifted into other pathways. Third, the focus was shifted to another "station", from the transference to his current life, asking for specific examples of a similar process occurring at other times. Alternation between T and C is common in the graded format with primary emphasis on the moment to moment monitoring of the process in the office. Fourth, asking the patient to describe the physical and mental experience of the anxiety promotes the patient's budding ability to isolate affect and to better learn to observe and describe his internal physical cues.

6. How to Manage Extreme Anxiety

What about when you are focusing on some area and the patient's anxiety goes high above their capacity to tolerate it? For example, what if the patient experiences cognitive disruption with mental confusion, visual blurring, and intense fear or panic? This event calls for direct efforts to immediately reduce anxiety or the risk is misalliance and a high rate of drop out. The techniques noted above in point #5 describe some maneuvers that can use to reduce this anxiety. In addition one should consider the following:

- a. Take an assertive and active stance: Being silent makes the anxiety go higher in general. Silence allows the patient to project on to you some aspect of their internal conflict, for example mentally placing you in the shoes of a past abusive figure and interacting with you as though you were that figure.
- b. If the patient is hyperventilating, tell the patient to stop breathing. The patient, unaware of this will breathe him or herself into a confused state if you do not bring awareness to this process.
- c. Focus on the process and feelings that were mobilized in the transference. This may seem paradoxical, but bringing rise in the CTF can, and usually does drop the level of anxiety. After all, the high anxiety there was mobilized partly because of what you had been doing or not doing in the office. Going to the "T" is your statement that you are not afraid of these feelings, even if they are experienced in relationship to you.
- d. Keep talking and be present yourself. If the patient is confused, they will not hear you well and may not even see you well. Let the patient ground him or herself with your help. Patients will tell you that during these times they just focused on your voice or your face and used that to calm down.
- e. Repeat yourself and recapitulate liberally afterward. Repeat the insights gained because the patient will tend to repress and forget what was being learned. Recapping repeatedly will reduce the tendency to become so anxious the next time.
- f. Ask the patient to co-monitor and to tell you when they are near such a threshold again. Thus, you both have your eyes on all the parameters, thresholds, anxiety levels etc. This is good general principle for ISTDP: collaboration toward developing a "copilot" in therapy.
- g. You will know it is safe to move on again when you start seeing signals of striated muscle anxiety (tension, sighing respirations, etc.)

7. Managing Major Regressive Defenses

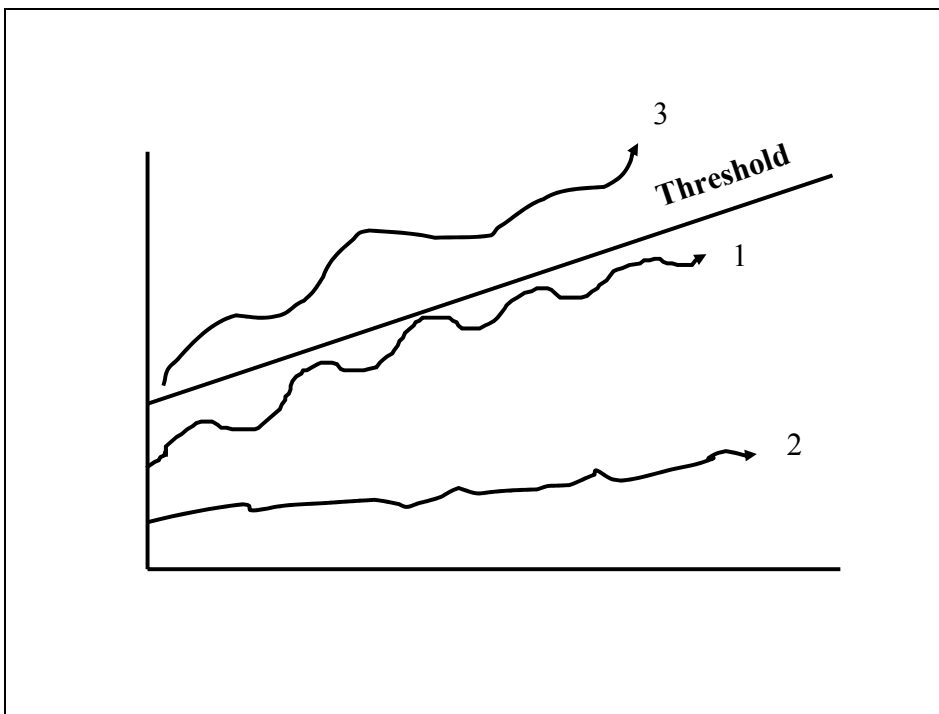
What about the patient who tends to tantrum, goes to major tears, hits him or her self, yells or has other major regressive phenomena? These phenomena are relationship and alliance destroying behaviors which must be avoided or at least stopped as soon as possible. The exact intervention depends on the cause. If they are due to too much muscle tension, then anxiety reducing interventions described in point #5 are helpful. If due to projection, then the best approach may be directly examining the way the patient perceives you, and exploring where that perception came from: this weakens the projection and replaces it by isolation of affect and self-observation. If due to regressive defenses and a mix of

repression then bringing rise in the CTF will help as noted in point #6. If it is due to the patient's habitual character defenses, then one must acquaint the patient with the behaviors and help them see the consequences: this may result in breakthroughs of grief when they see the damage the defenses have done to all relationships they have tried to form.

8. Optimization of the Dosage (Figure 6)

The degree of rise in anxiety, like behavioral exposure, has an optimal dosage that the patient can bear, work at, and master without untoward effects. This makes them want to climb that hill further with your help. From the perspective of ISTDP, the optimal place to be is near the threshold (1) working within this therapeutic window. If the rise is too low, then the process of bringing changes in anxiety tolerance will be unnecessarily slow (2). If too high and often above the threshold then the alliance can suffer as the dynamic forces pour into depression, somatization or cognitive disruption. (3)

Figure 6. Optimization of Graded Format



Vignettes from the 4th 1 hour session

Th: So when you are coming you were anxious and had some reflux symptoms? (Pressure)

Pt: Yes I was thinking about this anger thing and was upset with my brother the other day.
(has a partial sigh = some striated anxiety)

Th: So there was some strong feelings you came to speak about and your stomach reacted. Do you have any cramps or heartburn now? (Recapitulation, link feelings with anxiety)

Pt: No not now. (hands are somewhat clenched = striated)

Th: Can we look into the feelings you have coming in today? (Pressure)

Pt: I was at his place and we were talking about growing up. He seemed to think it was pretty rosy and I felt annoyed at him.

Th: How do you experience your anger? (Pressure)

Pt: I got nauseated and had diarrhea after. (No longer has any striated signals)

Th: So the anger again went to your stomach? (Recapitulation, link feelings with anxiety). Why didn't you get to feel the anger? What were you afraid of? (Pressure)

Pt: I don't know (Burping) I'm getting cramps again now. (points to abdomen = smooth muscle anxiety)

Th: So right now the anger we focus on goes to cramps. Is that process happening again? (Recapitulation, link anger and anxiety)

Pt: Yes

Th: So when we focus on the feelings now, the emotions go to your stomach rather than being felt (repeat Recapitulation). Can we look at how you are feeling here with me when we speak? (Pressure).

Pt: With you? I don't have any feelings with you. I feel irritated at myself. My stomach still feels bad. (Not showing any striated signal; referring to smooth muscle anxiety)

Th: So again when the emotions rise, anger turns inward on yourself. As if shutting down the anger, to hold it inward and keep it from any one else. (Recapitulation) How would you feel had you been angry in some way with your brother or here with me? (Pressure - this is primarily an intellectual question but alludes to the reason he uses repression: fear of and guilt about doing harm)

Pt: It would feel pretty bad. He has had a pretty tough time for the past 5 years since Mom died and his marriage was in trouble too. He has the same thing I do with the bowel and anxiety. (Empathic response, albeit intellectual)

Th: So there is positive feelings as well. Is this why the anger turns inward on your self? To protect him....(Recapitulation, link complex feelings with defense)

Pt: To beat up me... I feel always like I should be punished for some reason...or that someone will punish me.

Th: This is very important. So you have love at the base, but anger as well. When the anger comes, it is shut down into depression, anxiety, and some kind of guilt system? Like as if you had harmed someone you care about...(Recapitulation, link complex feelings with anxiety and defense – connecting 3 points on the triangle of conflict)

Pt: ...so direct it at myself? (helping out with the Recapitulation)

Th: Do you think?

Pt: Seems that way to me. It makes sense but I don't want that anymore. (Looks stronger, calmer and has striated signals back with better body tone, hands clench)

Th: Let's see what we can do about it (Pressure).

Pt: What do I do? (Resistance: some passivity and regressive trend)

Th: Let's see. Are you waiting for me? (Pressure)

Pt: I'm not sure what to do. (some tension, sigh)

Th: How do you feel toward me right now? (Pressure)

Pt: Frustrated.

Th: How do you feel this frustration inside? (Pressure)

Pt: I don't. It is toward me really.

Th: So back at you again. Back to the mixed feelings again? Lets see how we can address that, to stop it. Because the feelings go in a few directions...to your stomach, to anxiety, to depression, to avoidance and to a passive position. All back on your self... as if to protect the other person (Recapitulation and Pressure).

Pt: That is what I'm doing, and I don't like it really....

One can see by this point in the session, some lifting of the depressive process, more energy, less smooth muscle discharge, and some access to striated muscle anxiety and

isolation of affect. These are typical early symptom responses seen by about the fourth hour of therapy when the process is going well. And this is often to the pleasant surprise of physicians and specialists who have been seeing the patient look the same, with the same health complaints for years despite the best of traditional medical care. Looking at Figure 5, the patient is now in the section of moderate capacity to tolerate anxiety and moderate tendencies towards repression, still with the potential to have GI smooth muscle and depressive responses but at a higher threshold than before. That is, he can tolerate a higher level of pressure and associated complex feelings without going over threshold. This moves him closer to being able to experience his emotions, the ultimate goal of the process. The patient can now begin to think and talk about his emotions without exacerbation of his symptoms.

Evidence of character changes in the early phase of treatment

With application of the graded format, structural changes in unconscious anxiety and defenses take place. Instead of losing track of feelings with repression and GI symptoms, he becomes able to stay aware of the emotions (i.e. to isolate affect) and unconscious anxiety becomes experienced as striated muscle tension. Once the tendencies towards repression and smooth muscle anxiety discharge have been blocked, the process then becomes more and more akin to the direct or unremitting process of ISTDP, mobilizing the unconscious feelings with unlockings of the unconscious. The patient becomes able to tolerate enough rise in CTF to have the first dominance of the Unconscious Therapeutic Alliance over the resistances, a process Davanloo has called first breakthrough or a minor form of partial unlocking of the unconscious (Davanloo, 1990 f).

Vignettes from the 8th 1 hour session

Pt: I have been feeling better... the diarrhea has stopped for a few weeks now, but I've been noticing I don't like my sister-in-law very much. (Striated anxiety: Hands are clenching and he has a sigh)

Th: Can you tell me more about that? First why your diarrhea has stopped (Pressure).

Pt: I'm not sure exactly (Sighs) but something is different. I am thinking about the feelings more and not letting them get to me... the anger and anxiety thing we talk about.

Th: Can we look into what happened with your sister in law? A specific situation you noticed (Pressure to be specific).

Pt: Yes, my nephew John's gerbil died and she wanted to flush it down the toilet... my nephew was so upset and crying.

Th: How did you feel? (Pressure)

Pt: I told her to be sensitive and consider the effects on John... and she did. (Sighs again)

Th: She had a good response to that? (Pressure)

Pt: Yes she did actually. She was surprised I said anything and she thanked me for it later. What I said was measured and calm. I was a bit surprised! (Proud and smiling)

Th: So you felt good about that and good with her too? (Clarification and Pressure to positive feelings)

Pt: Yes but when she was saying that it tore my heart out and I felt enraged. (Sighs and emergence of next component of CTF)

Th: How do you physically experience the rage when you think of it now? (Pressure to experience emotion)

Pt: It just... (moves hands from lower abdomen to upper body in sweeping motion, indicating somatic pathway of rage is beginning to activate)

Th: How does that feel now? (repeat Pressure to experience emotion)

Pt: Its in my gut and chest.... moving up.....a heat. (Tension is now dropped and patient is energized with some degree of somatic pathway of rage activated)

Th: How does that feel? (repeat Pressure to experience emotion)

Pt: Like I want to poke, to point.(gestures in a strong fashion)

Th: How does it want to go if it is not stoppable? (Pressure)

Pt: It wants to zap out like a laser beam. (Forceful and expressive) And it would zap her into the wall.

Th: Then what happens? (Pressure)

Pt: Then she is stopped.... And I feel bad. (tears form in his eyes)

Th: It's a very painful feeling... (resonating with his emotion)

Pt: Yes. (weeps quietly)

It is important to note that at this point, anxiety and resistance are temporarily absent. Because of this, pressure and challenge are not indicated at this point. It is the therapist's

job to simply highlight and acknowledge the painful aspect of this emotion, and to not interrupt the process by talking. After the wave of guilt passed it is time again to recap.

Th: So in that moment there were strong complex feelings all at once. You identified with John and his loss and this mobilized sadness and a degree of rage with a body experience in it. But this rage had guilt attached to it.

Pt: Yes. But I didn't get diarrhea or cramps that time, and I said something, and it worked out well really.

Th: Yes, you were conscious of the feelings but didn't get to quite experience them until now. And when you did feel them, the anxiety and tension dropped and the feelings were felt. But they were mixed and strong. Before, it would have been to the washroom and a panic, maybe becoming more depressed, but for sure not talking about it (recap, linking anxiety/feeling/defense).

Pt: That is for sure.

Th: But we have a question about these feelings. Do you have any thoughts what this all meant to you and why you felt so strongly.

Pt: I do (wells up with wave of sadness and tears)..... My Mom (Therapeutic Alliance brings link to a past figure with whom there is unresolved emotion).

Th: There is a very painful feeling..... (resonating and highlighting)

Pt: (weeping) My father and mother divorced when I was 5 years old. All I remember after that was how I was not allowed to talk about my father and rarely got to see him. My mother wouldn't allow it. It was like he died.

Th: Or like she killed him?

Pt: More like that.

Th: There is a lot of painful feeling there.

Pt: (More grief comes).

In the opening minutes of the session we see a common response in patients with while being treated with ISTDP. The therapy is bringing changes at an unconscious but not at a conscious level. Patients will often report feeling better, having more awareness of emotion, but not being able to explain why things are better or exactly what has changed. The therapist, however, can see the changes in unconscious anxiety discharge pathways and defense.

In the partial unlocking, of which this is an example, there is no transfer of the image to the figure with whom the patient has unresolved feeling. Rather, there is a link to that person that the patient often seems surprised themselves to be realizing in the moment. It is then possible to explore feelings around the original figure. In this example it was also possible to have some understanding of why this incident was linked to his mother: his empathy for his nephew, when his nephew's mother was taking something away from her son, refusing to acknowledge any right the son had to grieve or have feelings over the broken bond. This then triggered the patient's feelings about his experience with his own mother and the broken bond with his father. By him addressing the situation, and being calm enough to do so, he also had a sort of interpersonal breakthrough for himself.

After this unlocking, it is essential to have an extended phase of consolidation, laying out for the patient the links between anxiety, feeling and defense, in the past, present and transference. This is a systematic and repetitive process, reviewing the same information over and over until one is sure to the patient has been able to incorporate the process into his own understanding of himself. This consolidation weakens repression and cements isolation of affect: thus it "changes character". If the systematic analysis is not done, Davanloo (1990 b, 1990 c) notes that the defenses can reestablish themselves and symptom reduction is slower.

Conclusions

For the many patients who have access to repression and projection as major resistances, the standard, unremitting format of ISTDP is contraindicated. This format is only safe to use when the patient's major resistance is in the form of isolation of affect with striated anxiety discharge. For patients with major repression, the use of the unremitting technique, rather than leading to a breakthrough in the unconscious, can trigger repression and a potentially serious exacerbation of their symptoms (Davanloo, 1990 b), (Davanloo, 1990 d).

However, with the use of the graded format, characterized by cycles of pressure and recapping, learning at the rise in the transference feelings takes place. This leads to a restructuring of unconscious anxiety pathways and defenses, building the patient's capacity to withstand the impact of their unconscious emotions. After each recap, the therapist returns to pressure at a higher level. The therapist constantly monitors the patient's unconscious signaling system to inform his next intervention (Davanloo, 1990 b), (Davanloo, 1990 c). Challenge has little role in the graded format because, by definition, patients requiring grading are not able to crystallize their defenses in the transference. Without this crystallization there is no indication for challenge (Davanloo, 1990 b), (Davanloo, 1990 c).

The point of this phase of treatment is not unlocking the unconscious, but rather preparing the way for the patient to be able to tolerate the intensity of his unconscious feelings. With this work, the patient becomes able to experience some level of emotion, differentiate it from anxiety, and understand the defense mechanisms used to avoid the emotions. Anxiety starts to be discharged in striated muscle and the patient can now isolate affect at a high rise in complex feelings. Is at this point that we state the defensive system has been restructured, and the patient is able to tolerate the standard, unremitting technique of ISTDP. Even though this is a preparatory phase, it does however result in symptom reduction and demonstrable changes in character structure.

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Intensive Short-Term Dynamic Psychotherapy (ISTDP), as developed by Habib Davanloo, is an intensive emotion-focused psychodynamic therapy with an explicit focus on handling resistance in treatment. A core assumption in ISTDP is that psychotherapeutic effects are dependent on in-session emotional processing in the form of rise in complex transference feelings that occurs when treatment resistance is challenged.

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