

# AB-ISTDP Model of Treating Ego Fragility

AB



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**SENTIO CONFERENCE**

Warsaw. Poland April 16, 2026

# A Bit of ISTDP & My Personal History followed by....

- Metapsychology of Davanloo's Approach
- Research Finding
- Evolution of his Technique
- Fragility as a Separate Diagnostic Category on The Spectrum of Psychoneurosis
- Varieties of Cognitive Perceptual Disruption
- Metapsychology Summary of CDS
- Revision of Polyvagal Theory
- Technique of Attachment Based ISTDP
- Earned Secure Attachment
- Video Examples : Somatization; Dissociation

# In Therapy Forever? Enough Already

**M***Y therapist called me the wrong name. I poured out my heart; my doctor looked at his watch. My psychiatrist told me I had to keep seeing him or I would be lost.*

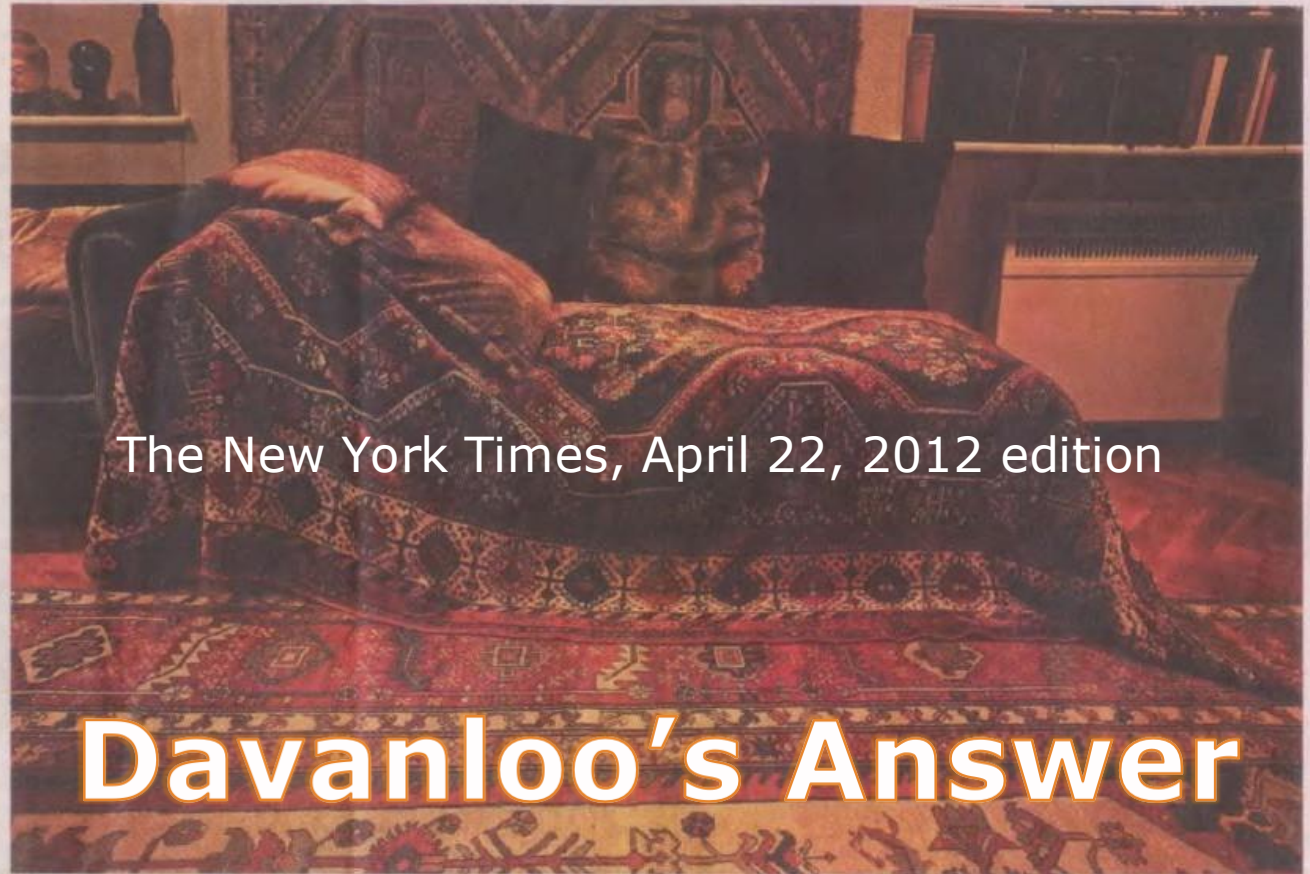
New patients tell me things like this all the time. And they tell me how former therapists sat, listened, nodded and offered little or no advice, for weeks, months, sometimes years. A patient recently told me that, after seeing her therapist for several years, she asked if he had any advice for her. The therapist said, "See you next week."

When I started practicing as a therapist 15 years ago, I thought complaints like this were anomalous. But I have come to a sobering conclusion over the years: ineffective therapy is disturbingly common.

Talk to friends, keep your ears open at a cafe, or read discussion boards online about length of time in therapy. I bet you'll find many people who have remained in therapy long beyond the time they thought it would take to solve their problems. According to a 2010 study published in the *American Journal of Psychiatry*, 42 percent of people in psychotherapy use 3 to 10 visits for treatment, while 1 in 9 have more than 20 sessions.

For this 11 percent, therapy can become a dead-end relationship. Research shows that, in many cases, the longer therapy lasts the less likely it is to be effective. Still, therapists are often reluctant to admit defeat.

A 2001 study published in the *Journal of Counseling Psychology* found that patients improved most dramatically between their seventh and tenth sessions. Another study, published in 2006 in the *Journal of Consulting and Clinical Psychology*, looked at nearly 2,000 people who underwent counseling for 1 to 12 sessions and found that while 88 percent improved after one session, the rate fell to 62 percent after 12. Yet, according to research conducted at the University of Pennsylvania, therapists who practice more traditional psycho-



The New York Times, April 22, 2012 edition

## Davanloo's Answer

ANNE LEBOVITZ. FROM "PIGRIMAGE" (RANDOM HOUSE, 2011)

are the top predicaments for which patients seek mental health treatment; schizophrenia is at the bottom of the list.

In my experience, most people seek therapeutic help for discrete, treatable issues: they are stuck in unfulfilling jobs or relationships, they can't reach their goals, are fearful of change and depressed as a result. It doesn't take years of therapy to get to the bottom of those kinds of problems. For some of my patients, it doesn't even take a whole session.

Therapy can — and should — focus

This approach may not be right for every patient, but the results described in the Finnish study are consistent with my experience.

If a patient comes to me and tells me she's been unhappy with her boyfriend for the past year, I don't ask, as some might, "How do you feel about that?" I already know how she feels about that. She just told me. She's unhappy. When she asks me what I think she should do, I don't respond with a return interrogatory. "What do you think you should do?" If she knew, she wouldn't ask me

Popular misconceptions reinforce the belief that therapy is about resting on a couch and talking about one's problems. So that's what patients often do. And just as often this leads to codependence. The therapist, of course, depends on the patient for money, and the patient depends on the therapist for emotional support. And, for many therapy patients, it is satisfying just to have someone listen, and they leave sessions feeling better.

But there's a difference between feeling good and changing your life. Feeling

The longer psychotherapy takes, the

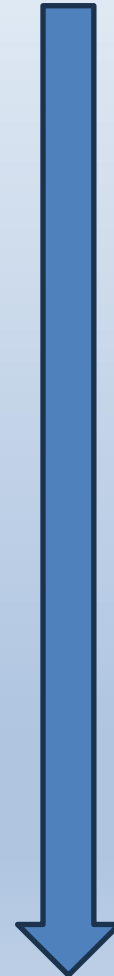
# Habib Davanloo, MD



- (born October 10, 1927) is a dynamic [psychotherapist](#) and psychiatric researcher who trained at a Harvard Fellowship and later worked in [Montreal](#), Quebec, Canada, who developed [Intensive short-term dynamic psychotherapy](#)(ISTDP).
- He was Professor of Psychiatry ( Emeritus) at [McGill University](#)<sup>[1][2]</sup> and founding editor of the *International Journal of Intensive Short-term Dynamic Psychotherapy*.
- Died November 2023 at age 97

# Neborsky – Davanloo Timeline

- 1978 UCSD Faculty Workshop
- 1980 UCSD Symposia Discussant (Mission Bay Sheraton)
- 1981 UCSD Symposia Discussant (Mission Bay Sheraton)
- 1982 UCSD Symposia Discussant (Mission Bay Sheraton)
- 1983 San Diego Institute Founded by Trunell and Neborsky
- 1983 Sponsored Community Symposia Discussant
- 1983 Appointed Assistant Editor International Journal STDP
- 1984 Two Extended La Jolla Workshops
- 1986 San Diego Institute Folds
- 1994 Lifespan Conference at UCLA
- 1994-97 First LA Training Group
- 1995 Supervision Group at my home
- 2000 Parting ways



# First Meeting

- I met Dr. Davanloo at UCSD in 1978 at a workshop he and David Malan led for the faculty. He had just held the 3rd annual scientific conference in his method in LA in 1977.
- Our chairman, Lewis Judd attended and invited him to stimulate the faculty in psychotherapy research
- The Department then sponsored five annual conferences where he and David Malan presented their videos .
- I was a discussant at each of those conferences

# My Early Training



- Dr Thomas Trunell and I started the San Diego Institute for ISTDP in the early 1980s and Dr Davanloo conducted our core training for 2 years in San Diego.
- We sponsored two large symposia for the community, 1983 \ 1984
- Two Intensive Workshops in La Jolla reviewing his work.
  - Summary Published in the Int J of Short Term Dynamic Psychotherapy 1984
- The San Diego Institute folded in late 1986.
- I attended his program one time in Montreal practiced my skills
- Individual supervision in Del Mar 1995

# Reunion

- I was asked by Dr Davanloo to discuss his video work at course sponsored by Dr Marion Solomon ( Lifespan Learning Institute) at UCLA in early 1990.
- After this conference Dr Davanloo asked me to start a Training Institute in LA. I agreed on the condition that he “supervise me on how to supervise his method.”
- This led to the establishment of the Los Angeles, San Francisco, and Western Canadian Institutes ( Vancouver / Calgary)

# My Observations

- Davanloo's method had three distinct phases of evolution
- 1960-1980
  - Phase 1: Pressure Challenge Head on Collision for All Comers
- 1980-2000
  - Phase 2: Discovery of the Fragile Patient and creation of the Graded Approach
- 2000-Present
  - Phase 3: Heavy Pressure and Emphasis on a Breakthrough the Transference

Despite parting in 2000 I remain grateful after all these years



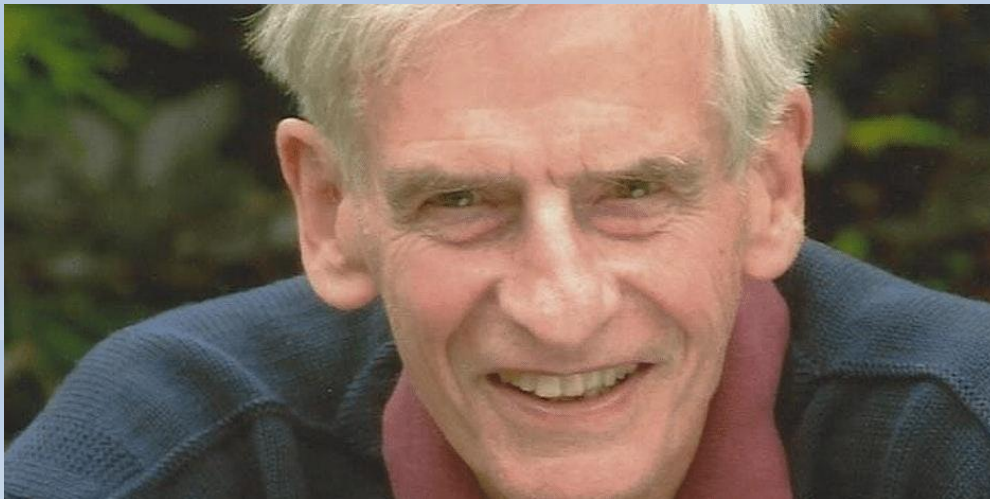
I was immersed in ISTDP training and joined IEDTA

# IEDTA Emerged as a parallel organization

- Milan, Italy, 2001 (Met Josette ten Have de Labije)
- Washington, DC, USA, 2003
- Los Angeles, CA, USA, 2005
- Aarhus, Denmark, 2007
  - Met Zofia Milska-Wrzosińska
- Vancouver, British Columbia, Canada, 2010
- Oxford, England, 2012

# David Malan's Contribution

- 11 years as research collaborator and theorist
- Ghost Author of Unlocking the Unconscious
- Sponsored two Oxford Conferences first in 2006
- Led to my eventually establishing ISTDP UK and ISTDP London
- Memorial Conference in London 2023
- <https://www.istdp.org.uk/david-malan-conference-booklet/>



# My Introduction of ISTDP to Poland

Met Zofia Milska-Wrzosińska In Aarhus IEDTA Conference 2007

Invited by her to teach at Laboratorium Psychoedukacji 2008 to 2018

First Two Day ISTDP Workshop at University of Warsaw 2008

On going seminars at Laboratorium in Warsaw thereafter

Seminars in Sopot and Gdansk 2017 with Sentio Institute

4th International Conference of the Polish Society for the Integration of Psychotherapy. Warsaw, June 2022.

Presentation at Centrum 2022, 2025



SENTIO POLISH  
INSTITUTE  
OF ISTDP

POLISH INSTITUTE OF INTENSIVE  
SHORT - TERM DYNAMIC  
PSYCHOTHERAPY SENTIO

It is our great honour to invite for the first time in the Tricity, Poland

**Dr Robert Neborsky | USA**

psychiatrist, outstanding psychotherapist,  
supervisor and teacher of ISTDP

Dr Neborsky will lead the 1-day-workshop

**“Changing the Working Model  
of Attachment in ISTDP”**

This workshop will review the ground breaking research of Bowlby, Ainsworth, Main and Hesse in understanding the relationship between attachment experience and vulnerability to adult psychopathology. This research underlies the basis of the corrective emotional experience.

Videotapes of Dr Neborsky applying ISTDP to patients with neurotic and characterologic disorders will illustrate how sustainable change can be accomplished in a reasonable time frame. He will also present the treatment of a mother with disorganized attachment treated successfully, followed by the treatment of her son ten years later with an avoidant attachment style.

It will be a chance to watch the psychotherapeutic work of one of the most outstanding teachers of ISTDP in the world.

The training will be translated into Polish

DATE: **23rd May 2017**

TIME: **9.00-18.00**

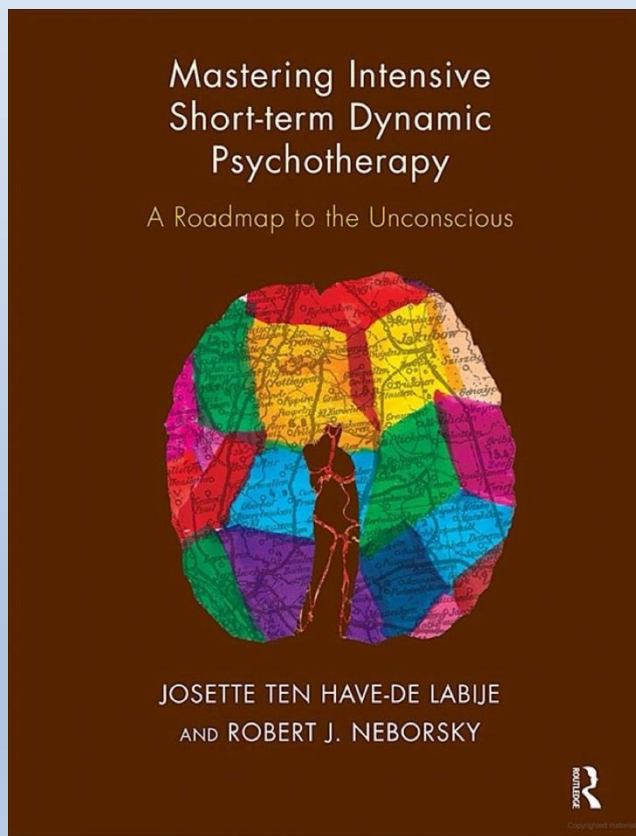
LOCATION: **Gdańsk**

COST  
OF THE TRAINING: **490 zł** registration before 15.04.2017  
**590 zł** registration after 15.04.2017

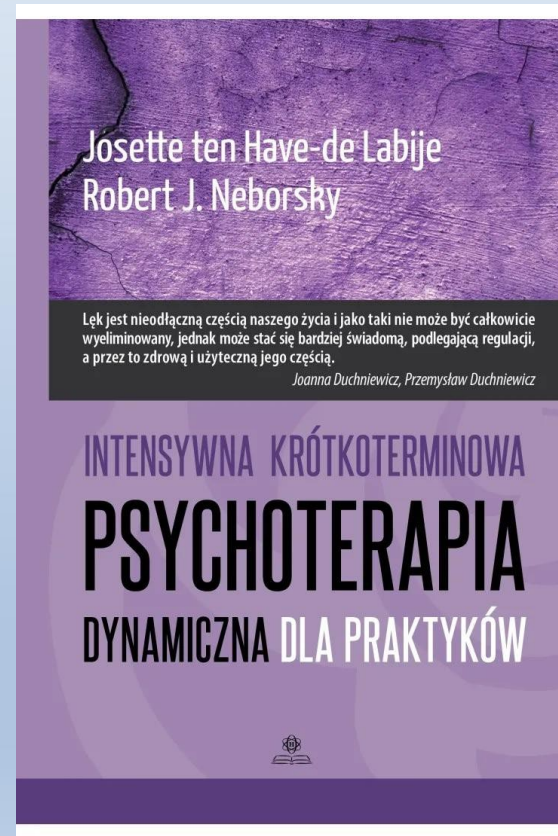
REGISTRATION FORM AND BANKING DETAILS AVAILABLE AT:  
[polskiinstytutistdp.pl/wydarzenia/trwala-zmiana-stylu-przywiazania](http://polskiinstytutistdp.pl/wydarzenia/trwala-zmiana-stylu-przywiazania)  
[www.polskiinstytutistdp.pl](http://www.polskiinstytutistdp.pl)

# Translated by Joanna and Przemysław Duchniewicz

2012

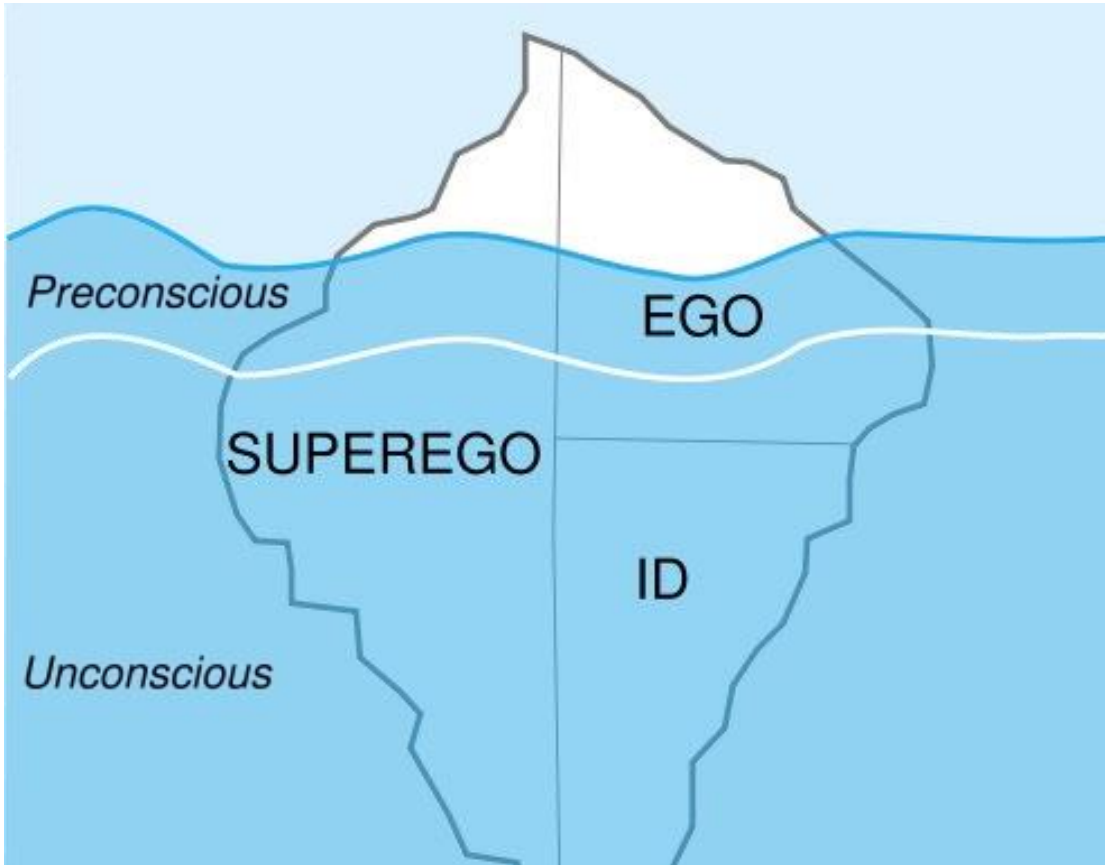


2025



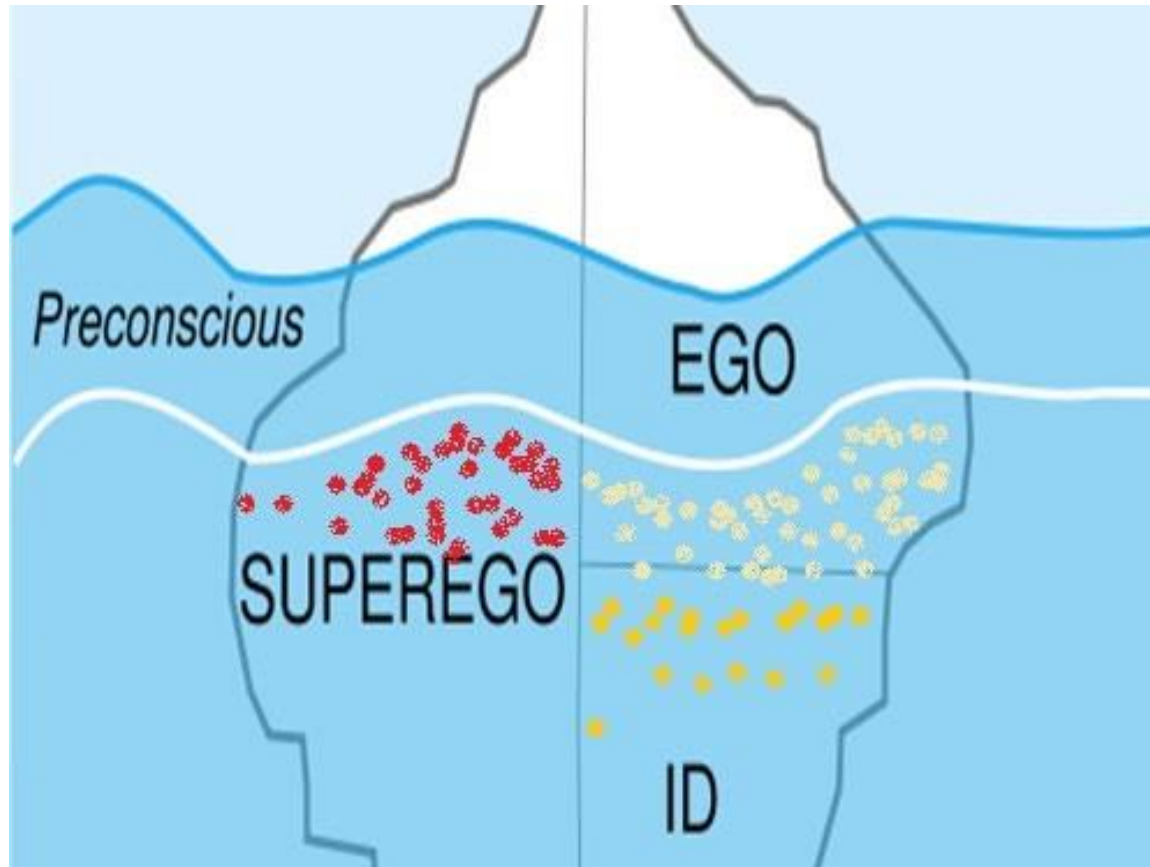


## THE METAPSYCHOLOGIC STRUCTURE OF ISTDP



- Circa 1895-1923
- An Analytical Therapy

## Topographic and Structural Models Superimposed



**Where analysis, ISTDP and AB/ISTDP aspire to reach on the Topographic and Structural models.**

# Davanloo's Technique like Freud's recognizes the problem of Resistance

- As far as the patient is concerned his sense of guilt is dumb; it does not tell him he is guilty; he does not feel guilty, he feels ill. This sense of guilt expresses itself as resistance to recovery which is extremely difficult to overcome.

Freud, 1923

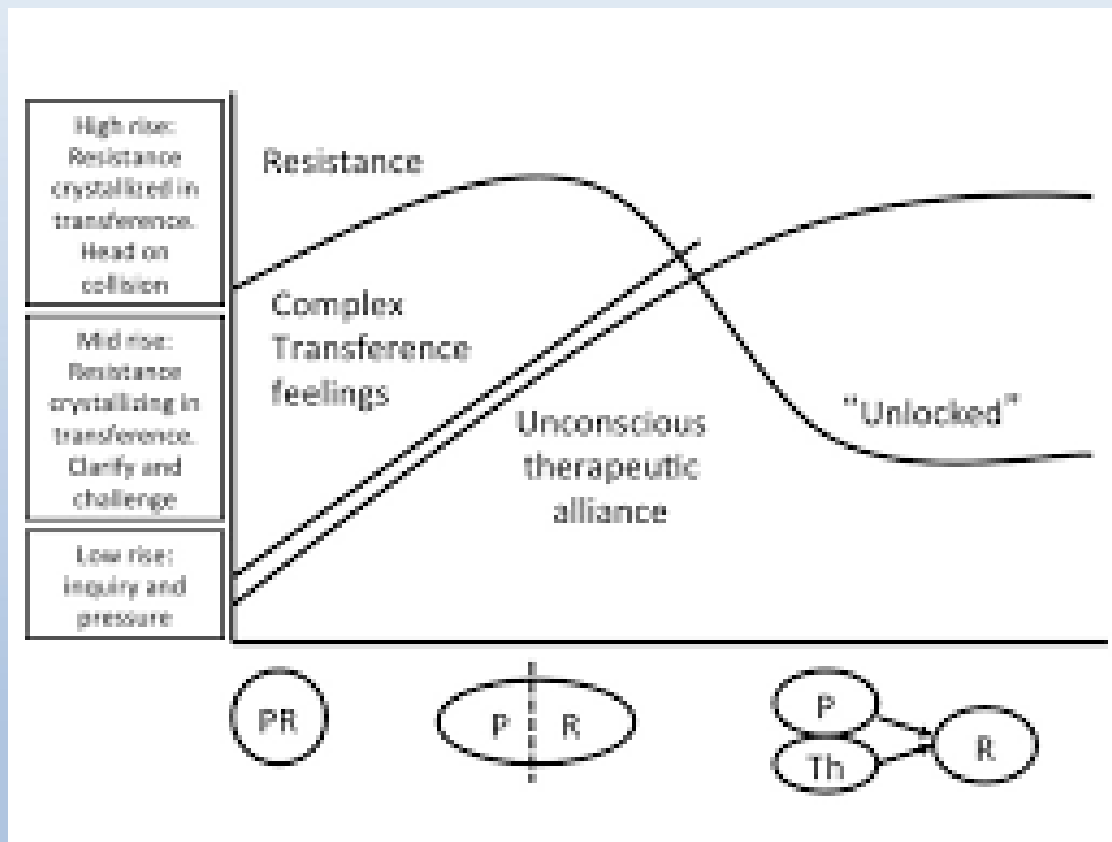
# ISTDP

## Qualitative Basis

- 1960-2000's: Case Series with Follow-up. Davanloo's Large Case Series (628) and qualitative videotaped research. Results were never published.
- "I believe that dynamic psychotherapy can be not merely effective but uniquely effective, that therapeutic effects are produced by specific factors rather than nonspecific factors, and that the essential factor is the patient's actual experience of their true feelings about the present and the past". (Unlocking the Unconscious, 1990)

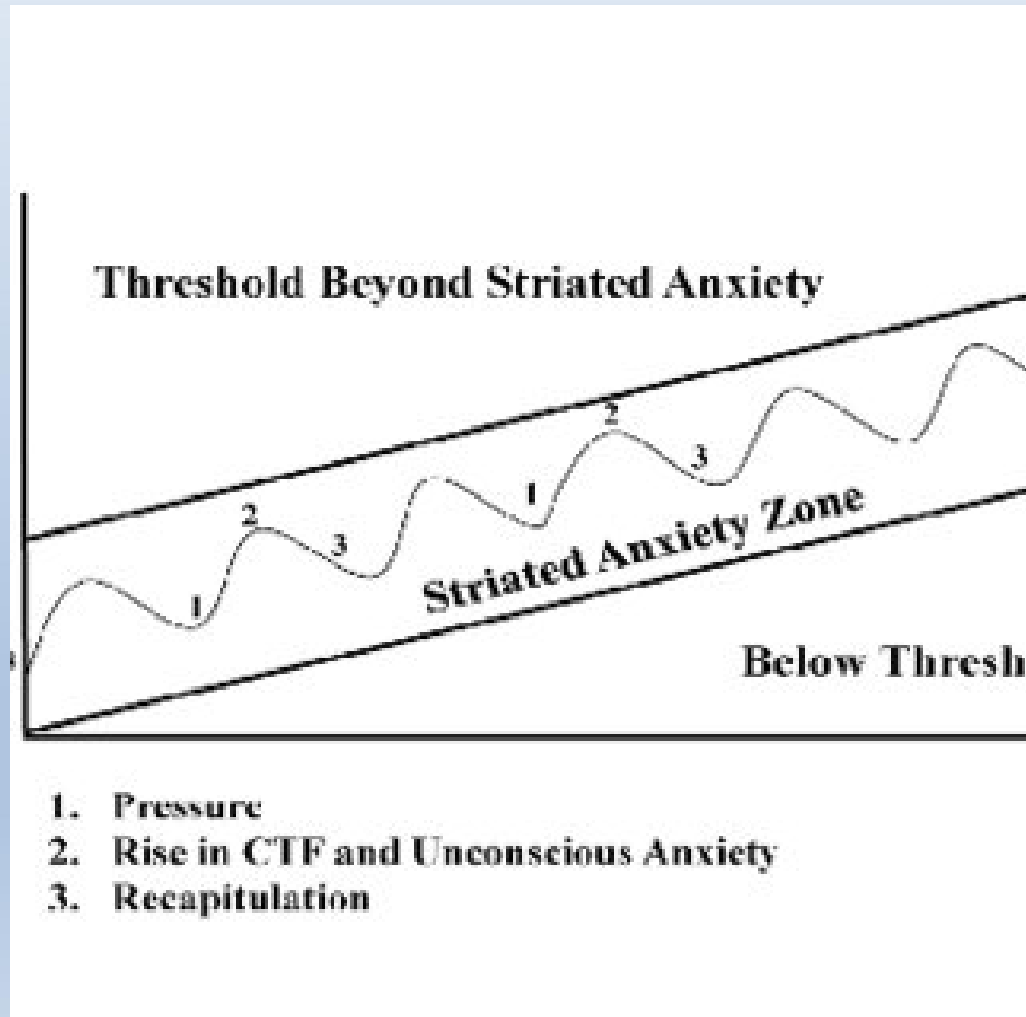


# Phase 1



## Phase 2 1980-2000

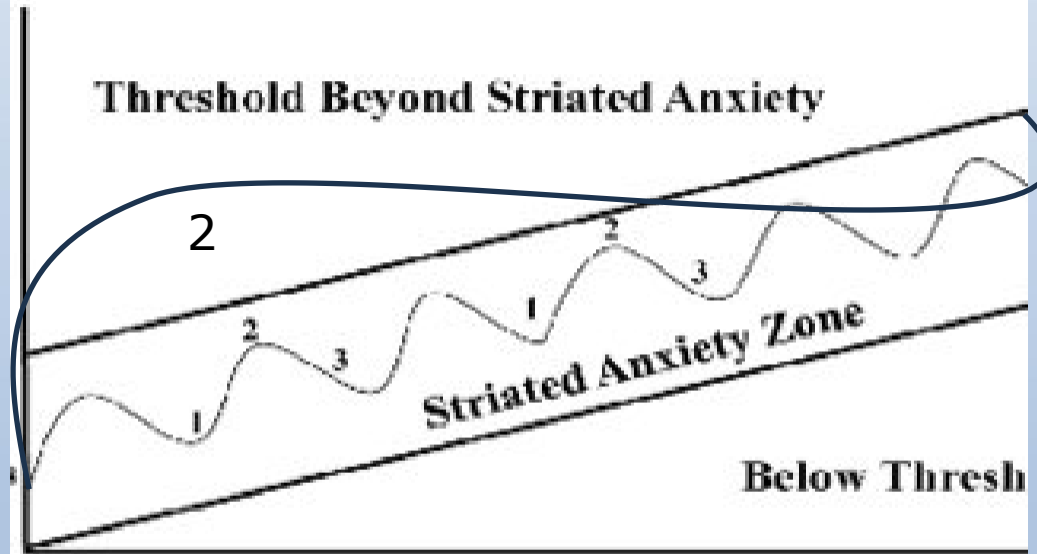
# Discovers and adapts Technique to Address The Fragile Ego



# Phase 2 1980-2000

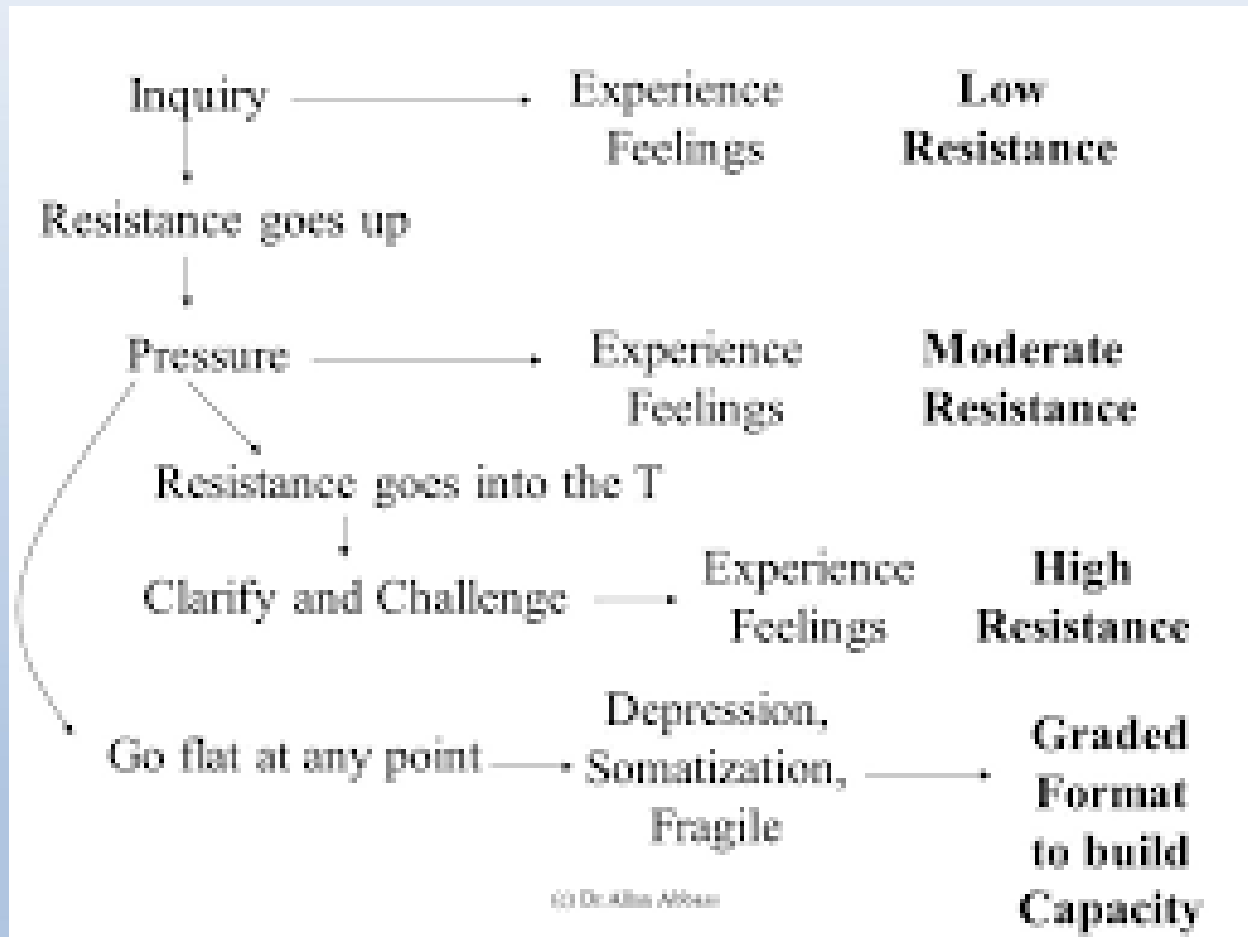
## Discovers and adapts Technique to Address The Fragile Ego


When **exceeding** threshold use *ISTDP Mindfulness* and/or Re-routing technique to Sympathetic Outflow to restore Threshold



1. Pressure
2. Rise in CTF and Unconscious Anxiety
3. Recapitulation

# Phase 3: 2000 -Present





# WHERE IS FRAGILITY ON THE SPECTRUM OF PSYCHONEUROSIS?

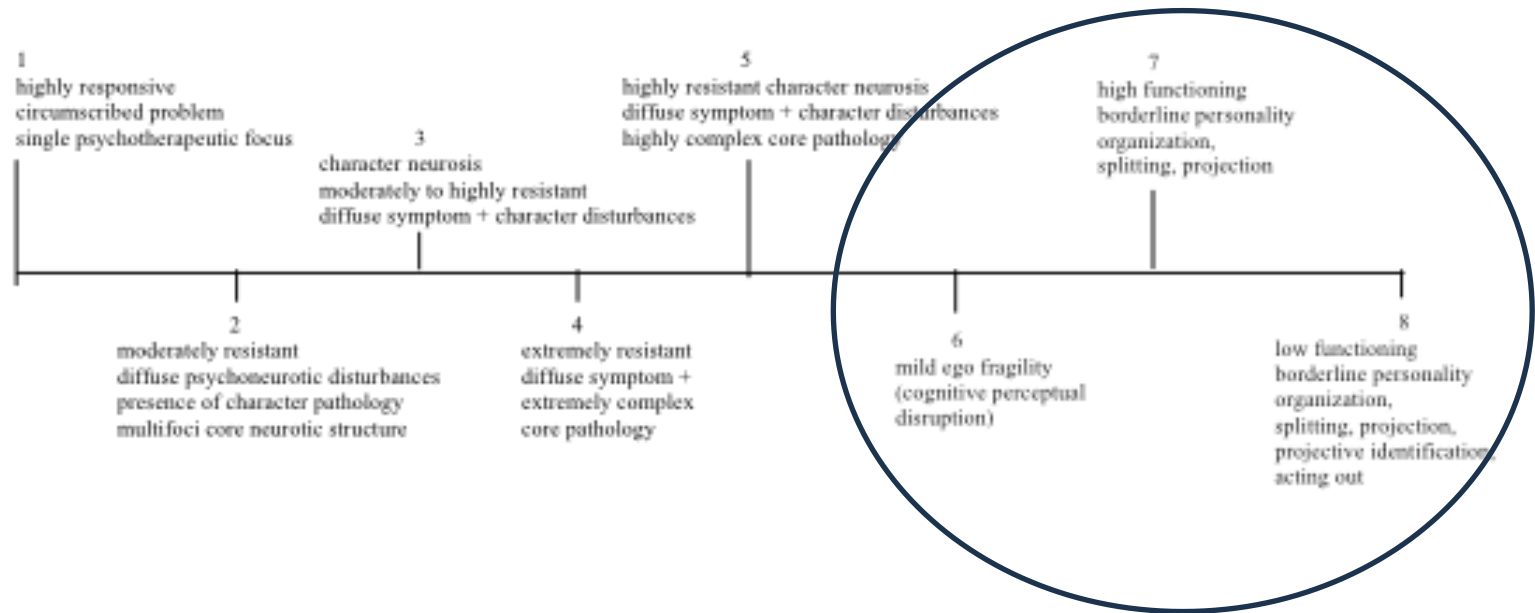
Defense quality, ego adaptive capacity  
and “**resistance style**” defines  
psychodiagnosis

# Spectrum of Psychoneurosis

American J of Psychotherapy Vol 67 No 1, March 2013

Neborsky et al

**Figure 1. The Spectrum of Psychoneurotic Disorders (Adapted from Davanloo, 1995)**

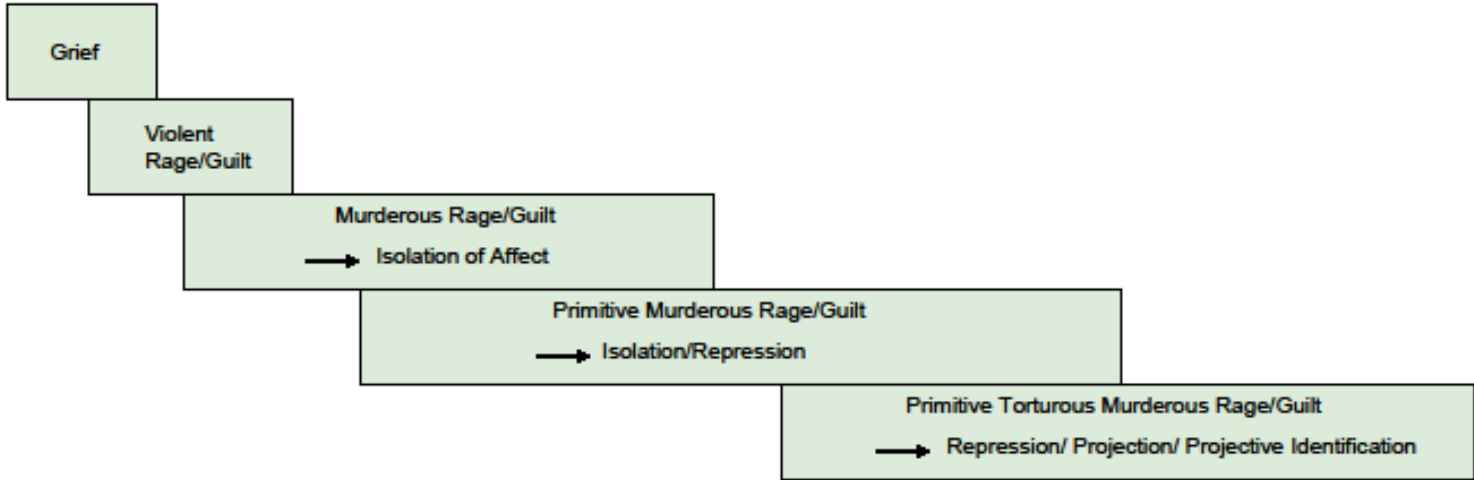


## Spectrum of Psychoneurotic Disorders

Low Resistant	Moderate Resistance	Highly Resistant	Highly Resistant with Repression
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## Spectrum of Patients with Fragile Character Structure

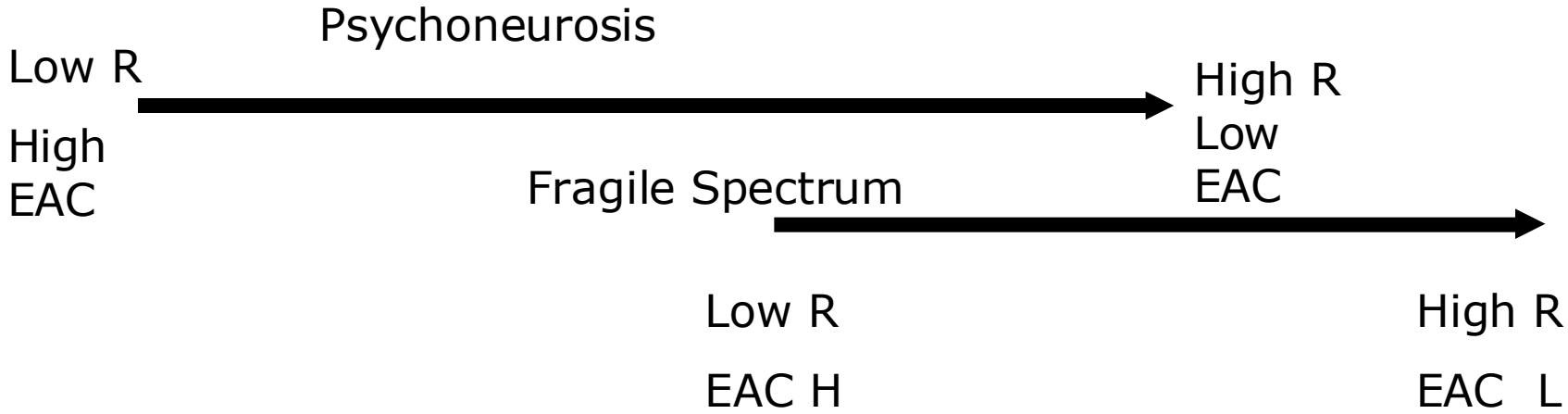
Mild to Moderate Fragile Character Structure	Severe Fragile Character Structure - Borderline Organization
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Length of Treatment	1-5	5-10	10-40	30-60	50-150
% Outpatient Referrals	1%	13%	47%	19%	6%
Year of Development	1960	1970	1980 "STDP" Graded Format	1990 "ISTDP" Multidimensional Structural Change	1990's

\*\* Patients suitable for ISTDP. STDP = Short-term dynamic psychotherapy, ISTDP=Intensive short-term dynamic psychotherapy

# Patients are classified by level of resistance and ego adaptive capacity

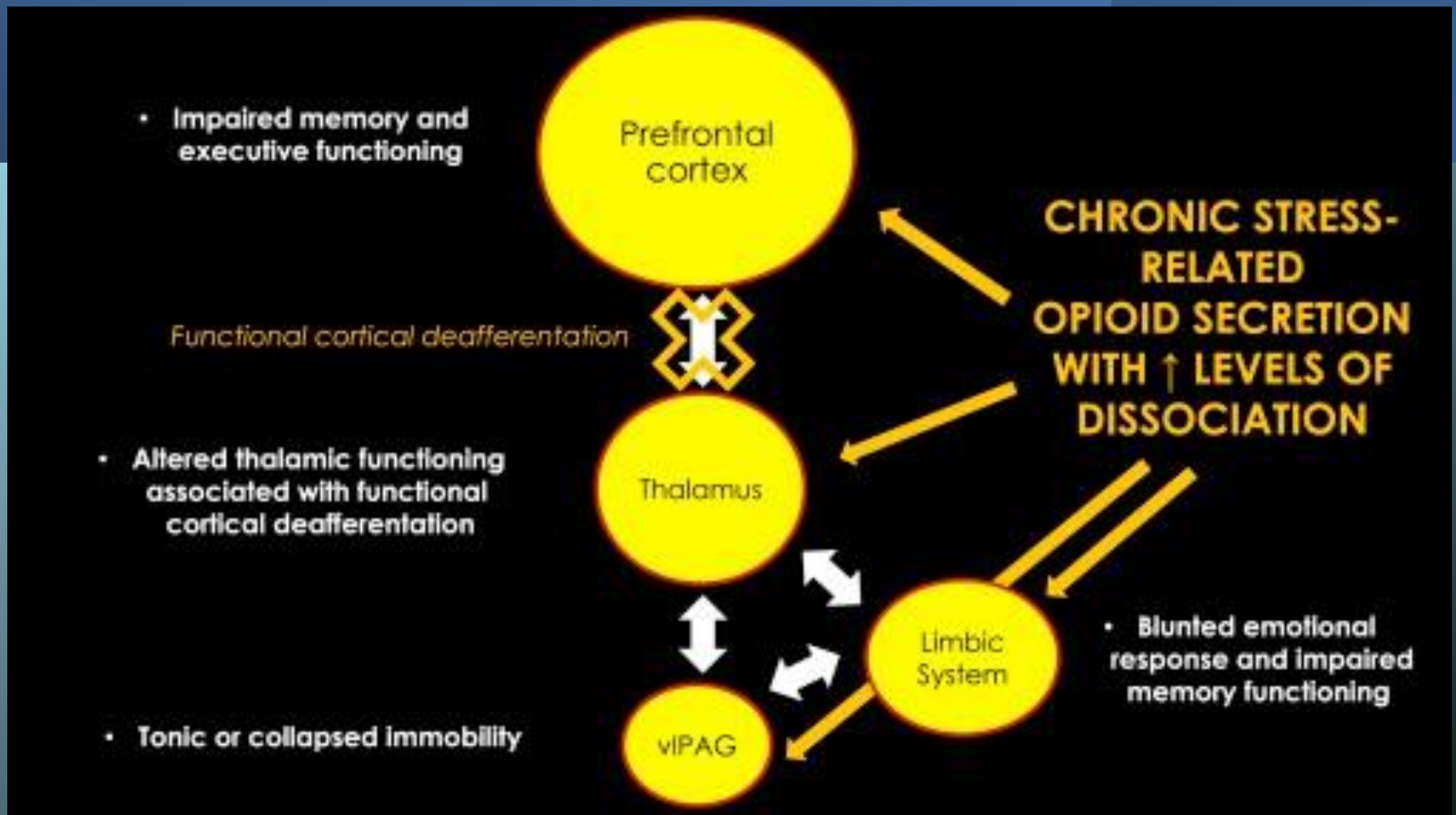




# FRAGILE SPECTRUM

## Types of Cognitive Perceptual Disruption (CPT)

# DISSOCIATION



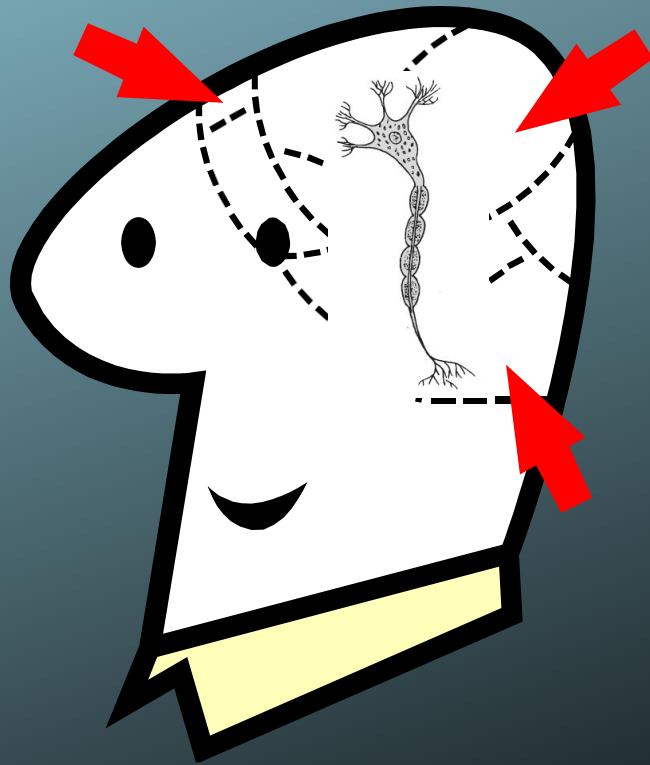
# Disorganization

Coherence of Narrative is lost from conflicting emotions



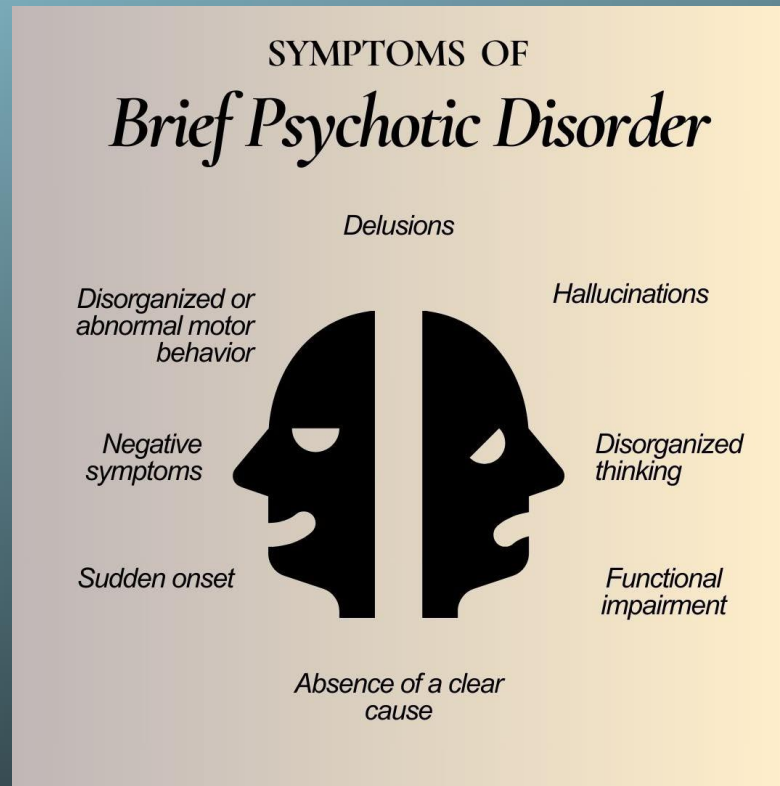
# Dizziness: Vestibular Overactivation

Excessive parasympathetic Activity Affecting Vestibular Apparatus



# Psychosis

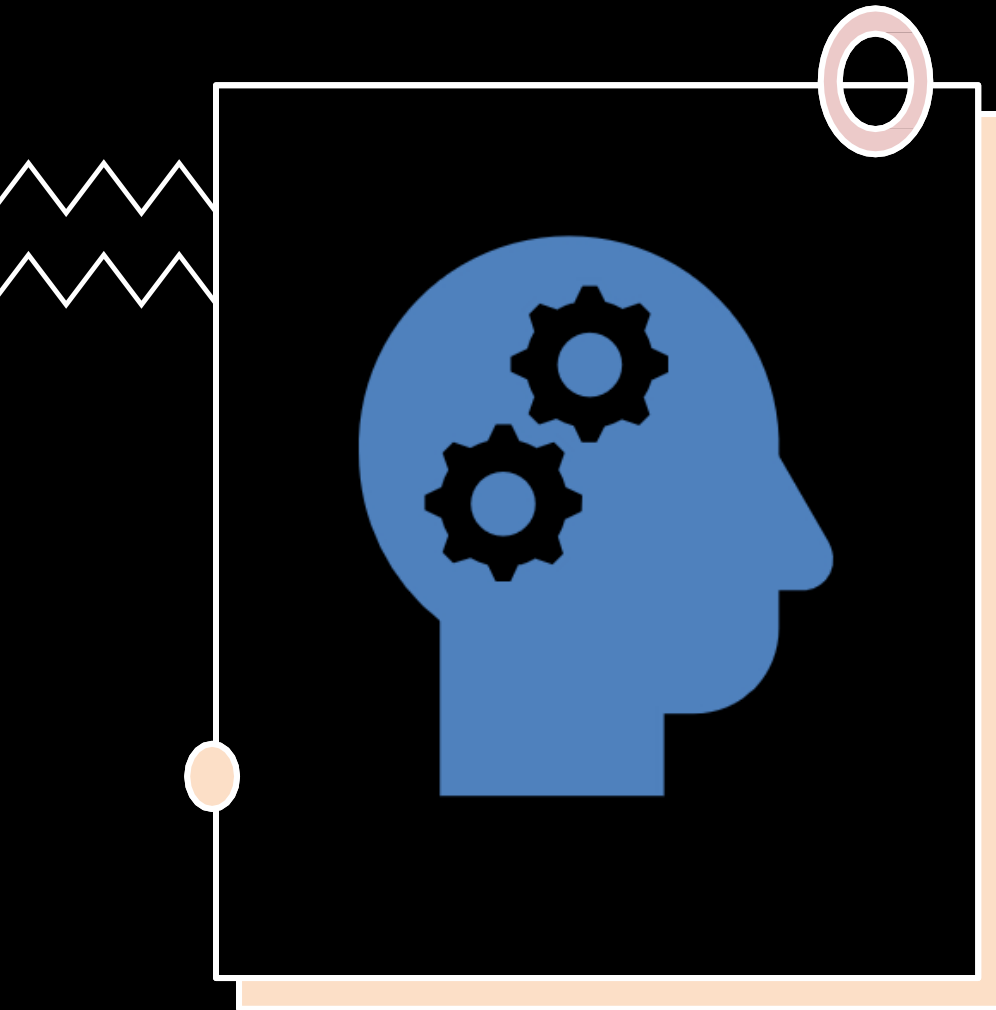
Perception of Reality is Lost



# Acting Out

Behavioral Control is Lost





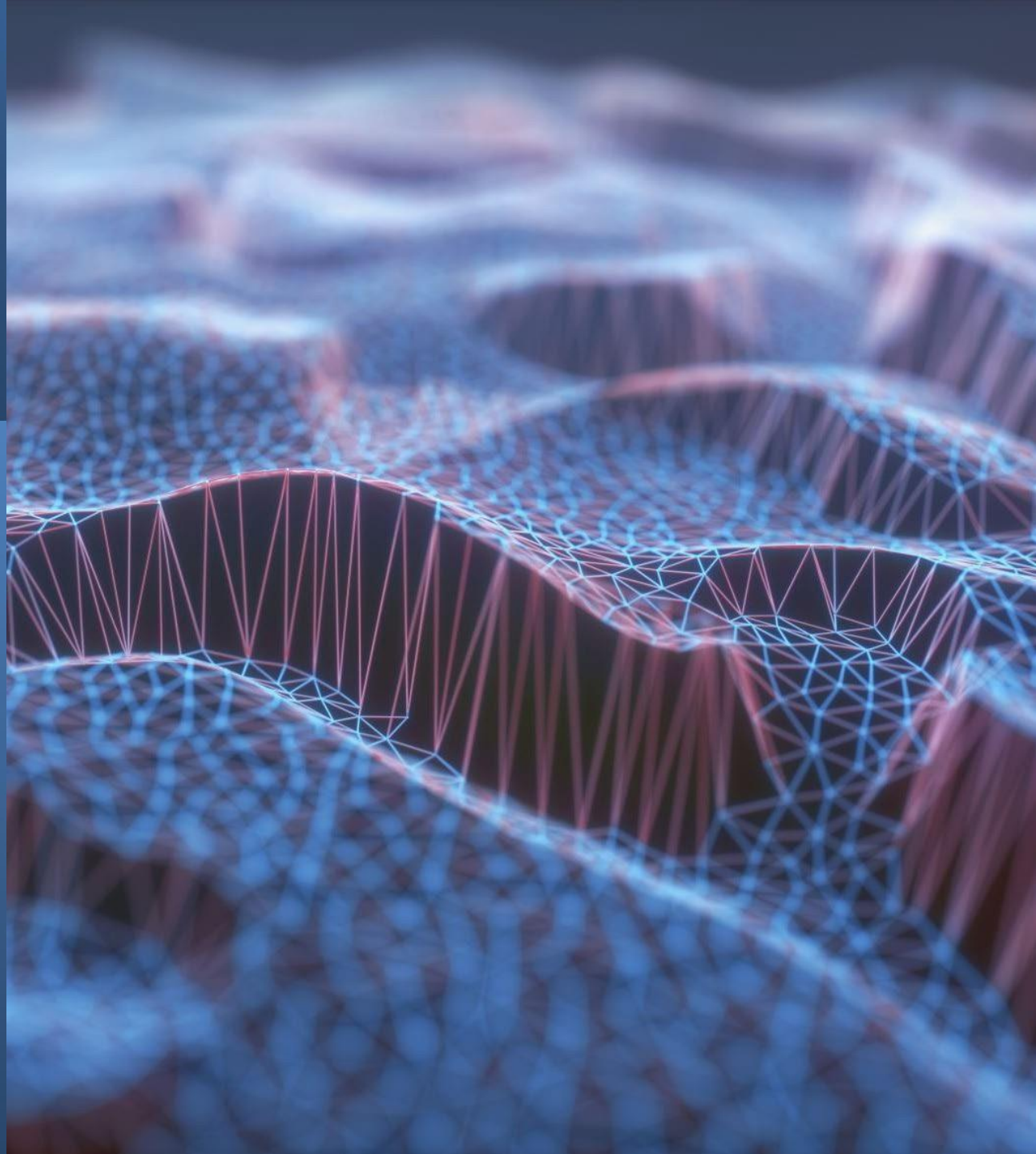
# METAPSYCHOLOGY OF THE UNCONSCIOUS

Attachment Based ISTDP



Topographic and  
Structural Model

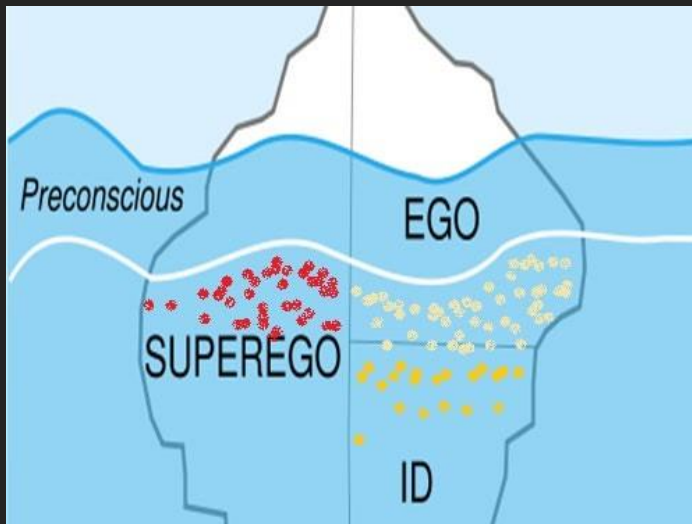
**CONSCIOUS  
VERSUS  
UNCONSCIOUS**



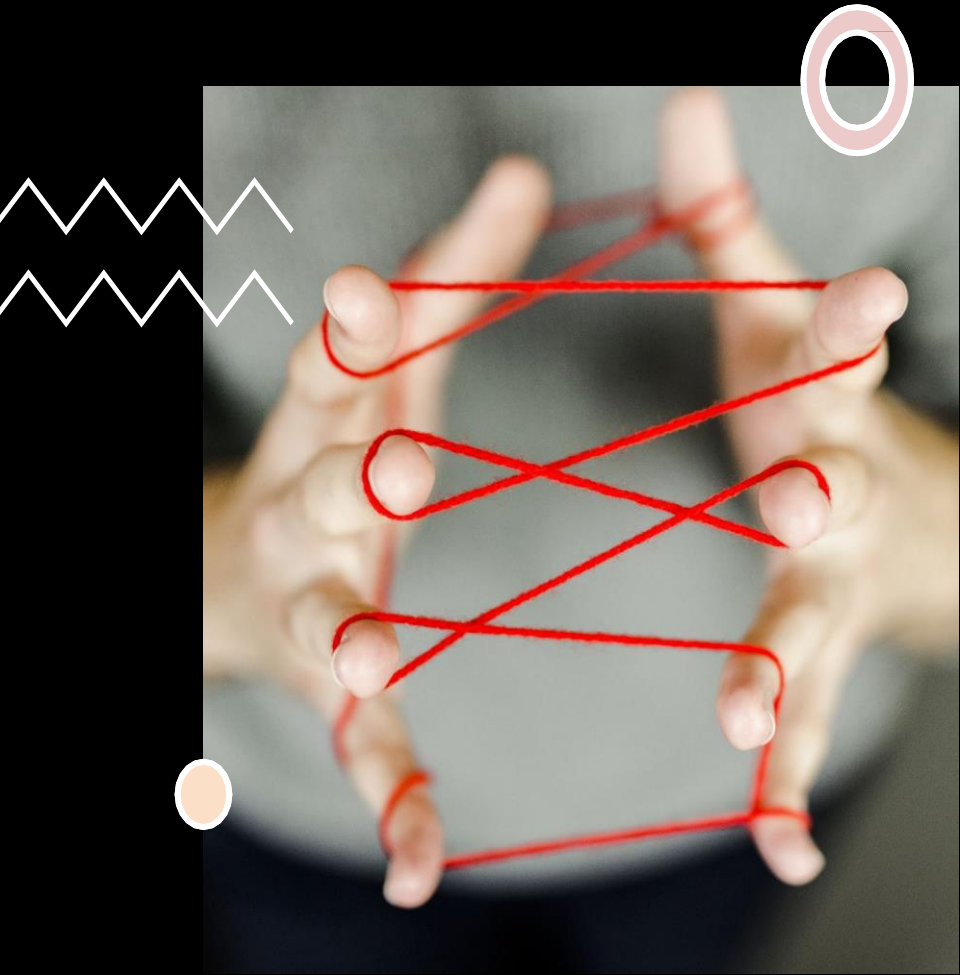


## Topographic and Structural Models Superimposed

- Circa 1895-1923
- An Analytical Therapy



**Where analysis,  
ISTDP and  
AB/ISTDP aspire to  
reach on the  
Topographic and  
Structural models.**



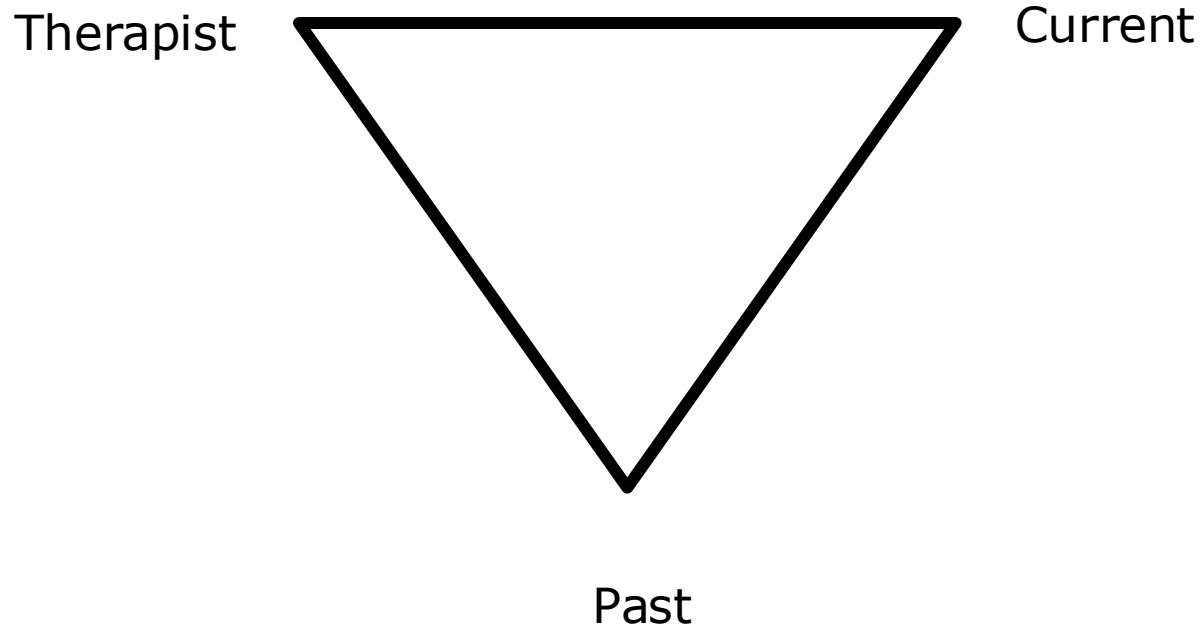
# THE PRACTICE OF AB/ISTDP UTILIZES

## The Two Triangles

The ISTDP therapist teaches the patient to look at themselves through the triangles of conflict and persons with a healthy **observing ego** and **attentive ego**.

It utilizes a specific form of here and now Mindfulness, tracking the activity Moment to Moment of ...

# Triangle of Persons

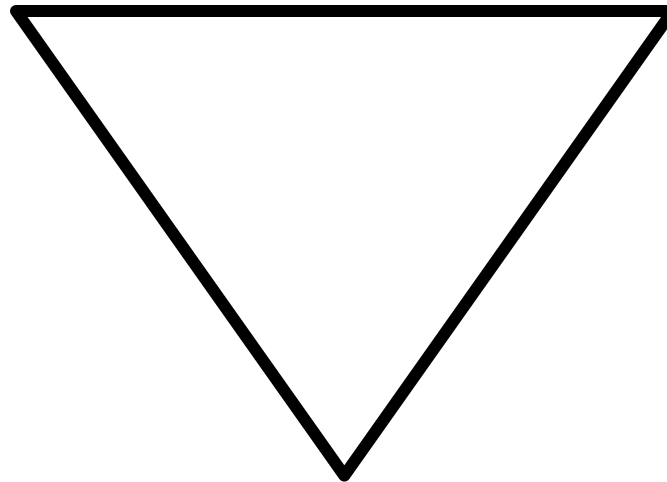


The Practice of ISTDP  
After Menninger, Malan, Davanloo

# Triangle of Conflict

## ***Unconscious Defense***

Stimulus/Response



## ***Unconscious Anxiety***

Striated Muscle

Smooth Muscle

Somatic

Cognitive-perceptual

## ***Unconscious Feeling***

Pain, Rage, Guilt, Grief, Love

The Practice of ISTDP  
After Ezreil, Malan, Davanloo

**Defenses  
are to be  
observed by  
therapist  
and patient  
as well as  
evaluated  
for their  
cost to the  
ego**

- Conscious versus Unconscious
- Immature ( Level II) versus Mature ( Level IV)
- Pathological (level I) versus Neurotic (Level III)
- Front door versus Cellar door
- Adaptive versus Maladaptive
- Syntonic versus Dystonic

- Level I –IV is Valliant's Schema

# AB-ISTDP Mindfulness Practice

- **Observing Ego**
  1. Identifying a defense
  2. Identifying pathway of anxiety
    - a. Sympathetic
    - b. Parasympathetic activation
    - c. Cognitive Perceptual Disruption
  3. Pathway of Core Emotion
- **Attentive Ego**
  1. Actively intervening to re-route anxiety from parasympathic pathway to sympathetic Pathway
  2. Recognizing sympathetic suppresses core emotion from consciousness
  3. Intervening to regulate sympathetic anxiety with the goal of feeling core emotion *with love, care, and precision*

## ***AB/ISTDP MINDFULNESS***

### **OBSERVING THE PATHWAYS OF UNCONSCIOUS ANXIETY VERSUS THAT OF EMOTION**

“Core Emotion” versus “Anxious”

Sympathetic : Regulated versus *Unregulated*

Parasympathetic: Adaptive versus *Overused*

# The Pathways of Anxiety and Core Emotion



See [WWW.ISTDP.COM](http://WWW.ISTDP.COM) for these Flash Holograms

# Summary of Unconscious Anxiety Pathways

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## Sympathetic

Dry mouth, throat, eyes

Sweating armpits

Sweating palms

Cold hands

Blushing

Increased heart rate

Shivering

## Parasympathetic

Lightheadedness

Dizziness

Sleepiness

Fainting

Constipation

Diarrhea

Urge to urinate

Nausea

HCL secretion stomach

Tearing\*

## Cognitive

Processes :

Incoherent, delayed, or accelerated

Content:

Disturbed orientation toward time, place, or person

Perception:

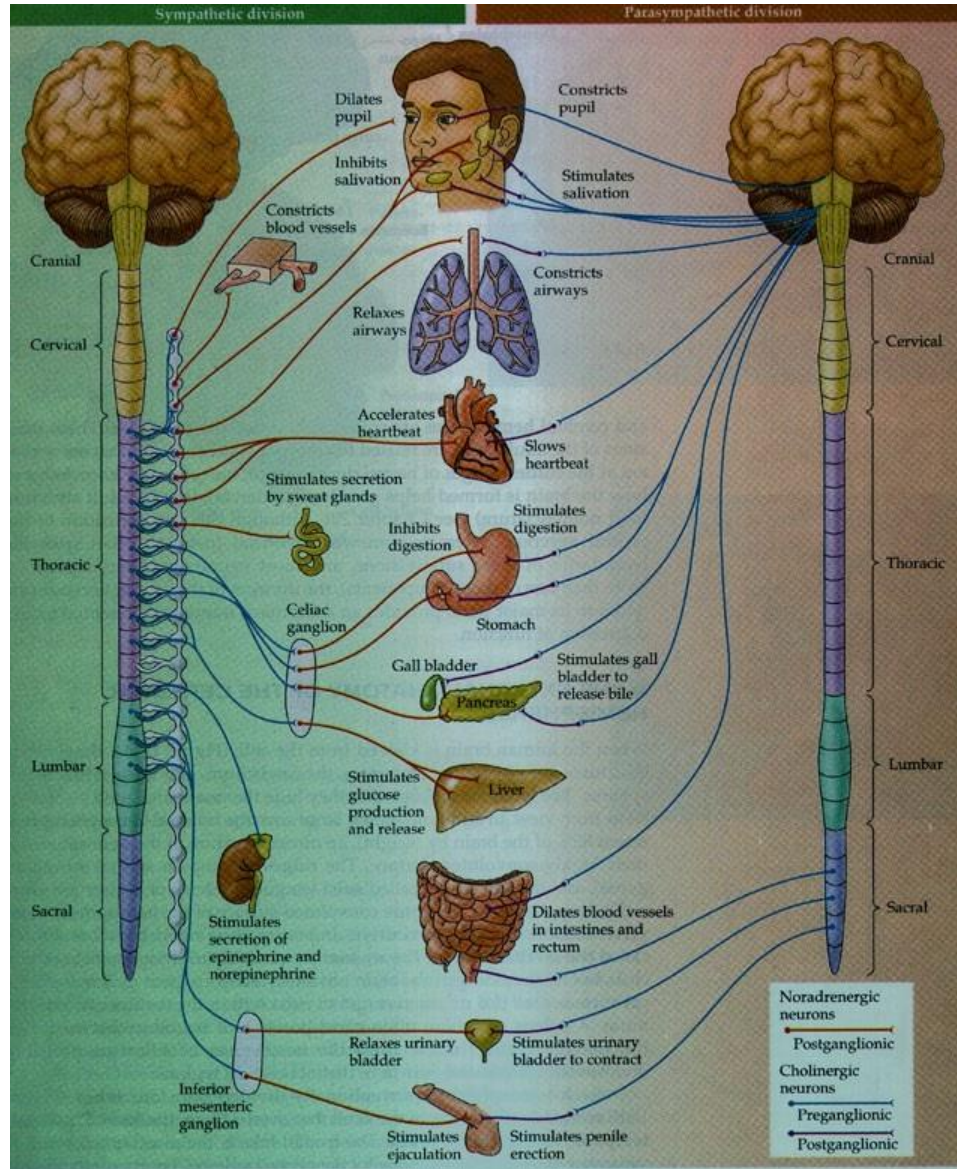
Acuity of visual/auditory perception

Tunnel vision

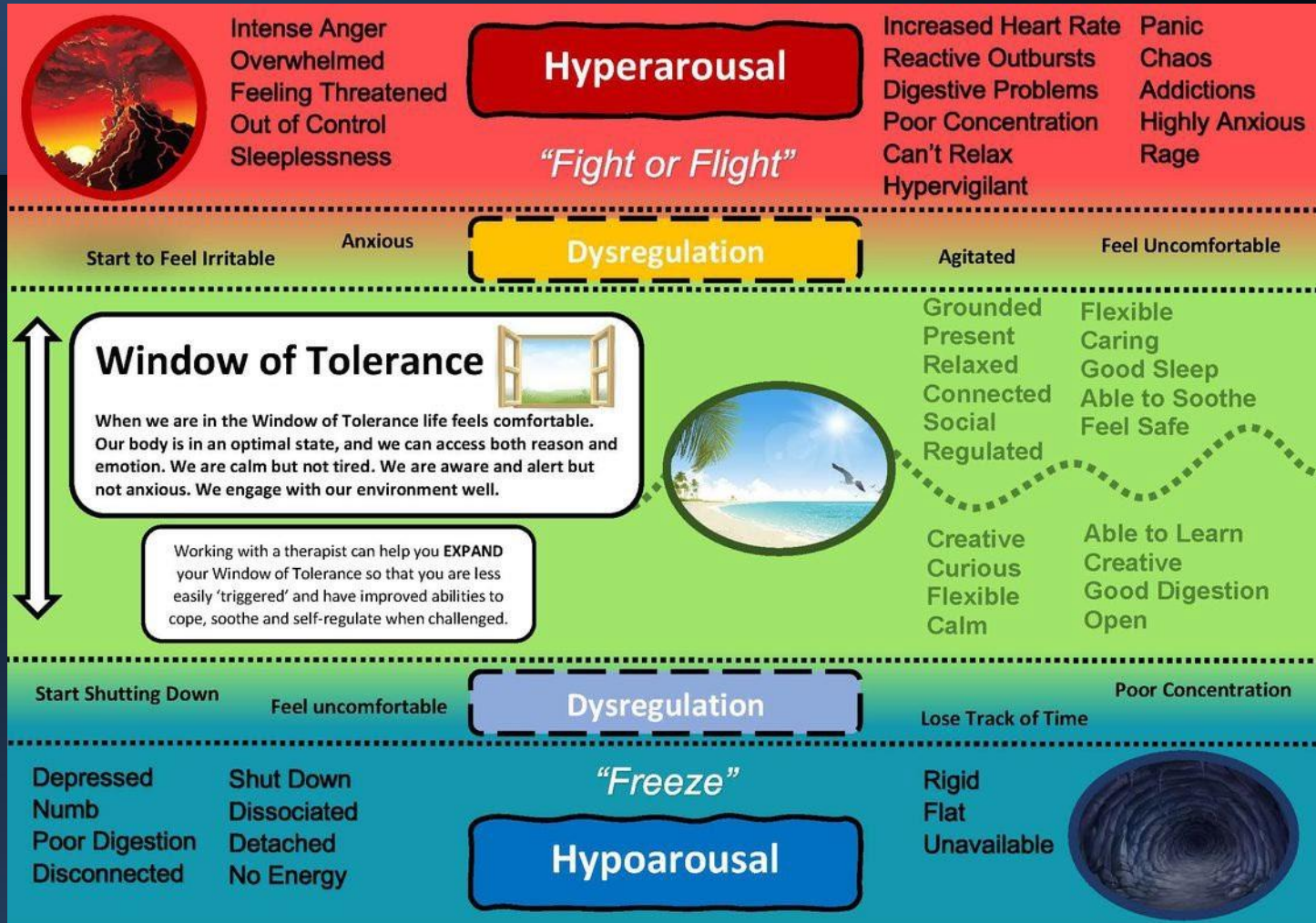
Tinnitus

Hallucinations, dissociation

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# Fight, Flight, Freeze\* or “Sham Death”

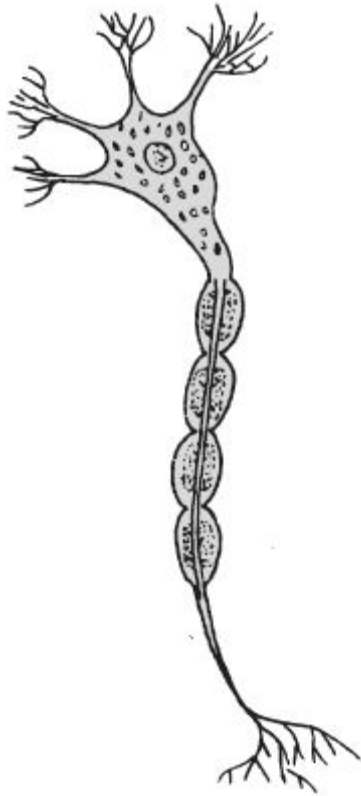


Polyvagal  
Theory  
“Freeze” is a  
confusing term  
Some people  
“freeze with  
fear”  
Shut down is  
more accurate



# Underuse of the Pre- Frontal Cortex Results in

## Chronic Parasympathetic Over Activation



Lightheadedness

Dizziness

Sleepiness

Fainting, Bradycardia, POTS

Constipation

Diarrhea

Urge to urinate

Nausea

HCL secretion stomach/ ulcers

Tearing\*

and Depression

**Acetylcholine\***

# Parasympathetic Nuclei

Nucleus	Function	Vagal Fiber Type	Porges' Polyvagal Theory
Dorsal Motor Nucleus	Controls parasympathetic motor functions for organs below the diaphragm (e.g., gut motility and glandular secretions).	General Visceral Efferent	Associated with the older dorsal vagal complex, responsible for the primitive "freeze" response.
Nucleus Ambiguus	Controls muscles for swallowing and vocalization. Provides parasympathetic motor fibers to the heart.	Special Visceral Efferent and General Visceral Efferent	Associated with the newer ventral vagal complex, regulating social engagement and calming responses.
Nucleus of the Solitary Tract (NTS)	The main sensory relay for visceral information from internal organs. Integrates data on heart rate, blood pressure, and digestion.	General Visceral Afferent and Special Visceral Afferent (Taste)	Processes the sensory feedback that helps determine which state (ventral, sympathetic, or dorsal vagal) the nervous system should engage in.
Spinal Trigeminal Nucleus	Processes pain, temperature, and touch from the head and ear.	General Somatic Afferent	Not a primary component of Porges' theory, but its sensory input adds to the complex array of information received by the brainstem.

# Key Parasympathetic Nuclei

- **Dorsal Vagal Complex:** This pathway originates in the dorsal motor nucleus of the vagus nerve. According to the theory, this evolutionarily older, unmyelinated pathway is responsible for the primitive "freeze" or immobilization response to extreme danger. It sends motor fibers to organs below the diaphragm. "Sham Death"
- **Ventral Vagal Complex:** This newer, myelinated pathway originates in the nucleus ambiguus. It is unique to mammals and regulates the muscles of the face and head, allowing for social engagement and calming. It sends motor fibers to organs above the diaphragm, including the heart. The mediator of "positive transference."

# Acetylcholine



- Acetylcholine is the brain's most prolific (80%) neurotransmitter.
- A decrease results in either mania or cognitive impairment
  - Excessive amounts result in depression

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# Anxiety Regulation in ISTDP

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- Through Precise Observing the AB/ISTDP therapist activates
  - The observing ego
    - The Left orbito-frontal gyrus
    - The lateral right orbito-frontal gyrus
  - The attentive ego
    - The medial right orbital-frontal gyrus
    - Increases Cortical-limbic connectivity
- *The patient then will either regulate anxiety on their own behalf or defend!*

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In a Fragile patient  
anxiety is first carefully  
induced via pressure to  
feel and then its  
regulated by accurate  
observation via the PFC

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- AB/ISTDP therapist activates
  - The observing ego
    - The Left orbito-frontal gyrus
    - The lateral right orbito-frontal gyrus
    - Observes I/F- A-D
  - The attentive ego
    - The medial right orbital-frontal gyrus
    - Increases Cortical-limbic connectivity
    - Soothes the disruptive state with empathy
- *The patient then will then regulate anxiety and improve ego adaptive capacity*

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In a Fragile patient anxiety may present with *overactivity* of the vagal system and utilize the Dorsal Vagal Nucleus causing fatigue, exhaustion, and POTS\* like symptoms

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- AB/ISTDP therapist activates
  - The observing ego
  - The attentive ego
- Encouraging the patient to re-route the anxiety from the parasympathetic system to the sympathetic system where it can be regulated with mindfulness and emotional experiencing.

\* Postural Orthostatic Tachycardia Syndrome



“Neurons that **fire together**, wire together.”

– Donald Hebb

Exercising the observing and attentive ego stimulates rapid neuroplasticity and Synaptogenesis enhancing capacity to tolerate conflictual feelings.

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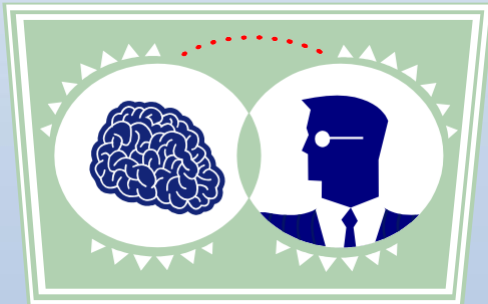
# ISTDP Technique

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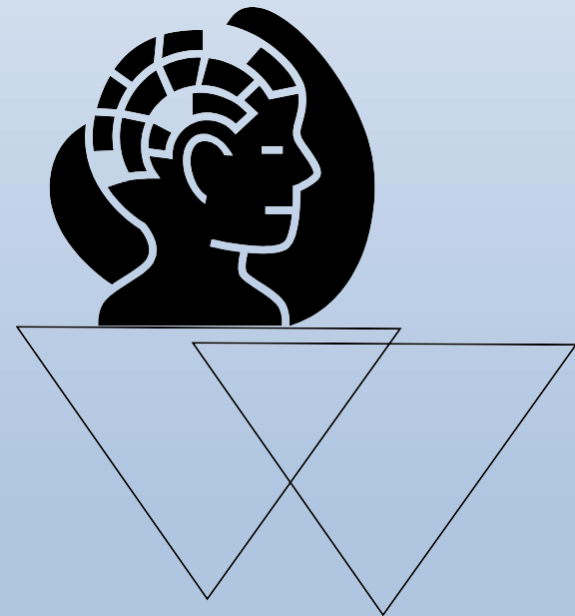
- Focuses on the Brain
  - Structure of Language and Patterns of Speech
  - Narrative
  - Relationships
  - Phenomenology of Emotions
    - Unconscious Anxiety (autonomic ns)
      - Tension
      - Sympathetic
      - Parasympathetic
      - Cognitive
- Uses ...

# Interventions are Organized Around Two Equally Important Therapeutic Interactions

- Separating Ego from Superego



- Exploring the Triangles of Conflict and Persons



## Primary Therapeutic Task in ISTDP: Separate Ego from Superego\*

- Patients with high super-ego pathology need a phase of de-identification with their punitive ways of treating themselves
- They experience sadness (*compassion for self*) ( or grief over self suffering) for their unnecessary suffering and understand the mechanism of producing their suffering and/ or anger at the unneeded suffering.
- This increases
  - Motivation and Ego Adaptive Capacity

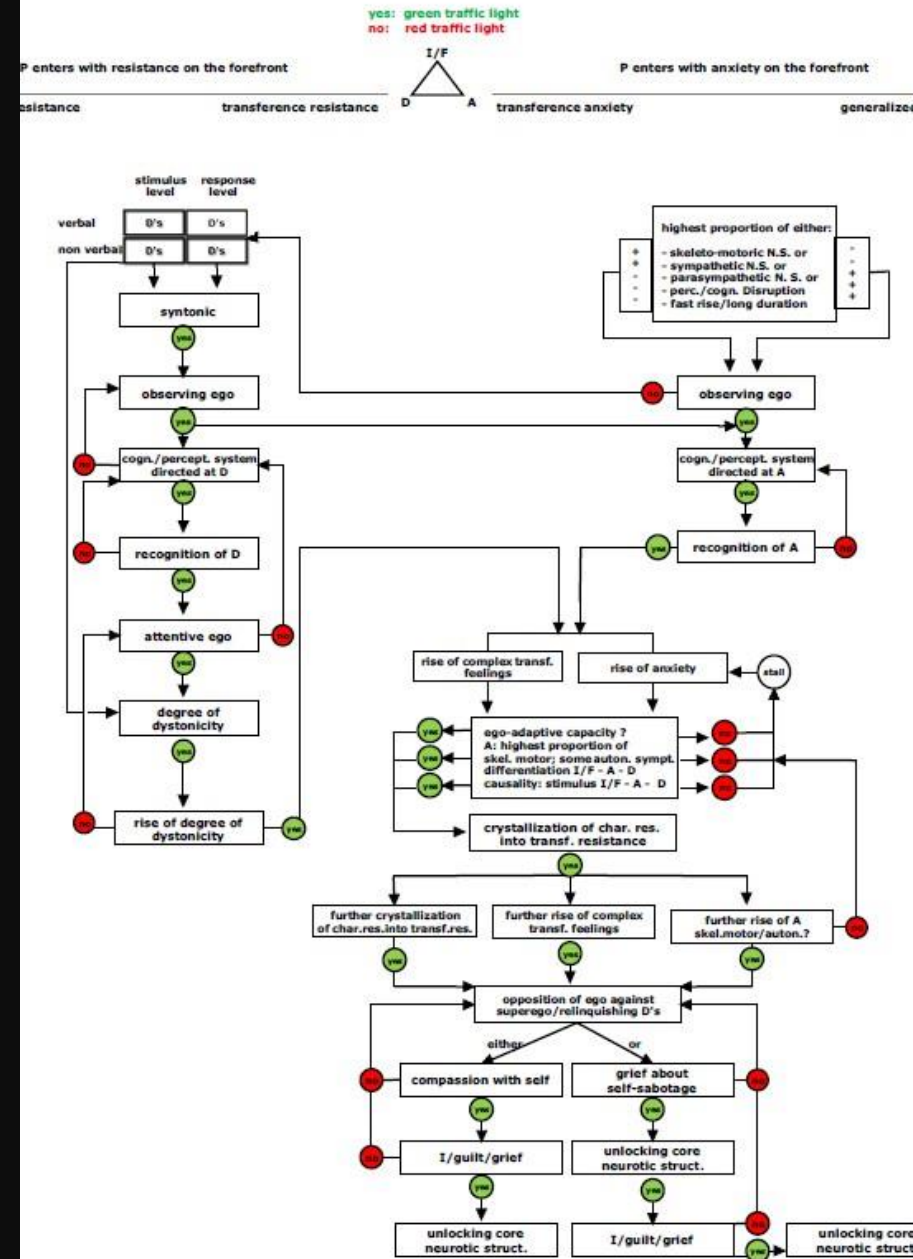
\* After ten Have de-Labije “ Whose Intra Psychic Crisis”

# A Precise Central Dynamic Sequence

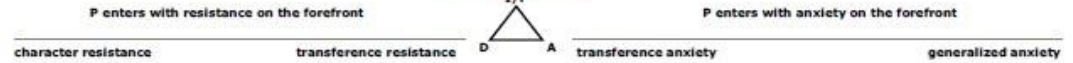
- Originally described by Malan and Davanloo elucidated by ten Have-de Labije
- An Attempt to overcome interpretation ( cog intervention)
  - *Believed by them to be most efficient way to access Unconscious Mind*
- Involves sequential interventions in a structured therapy

# The Central Dynamic Sequence of Davanloo

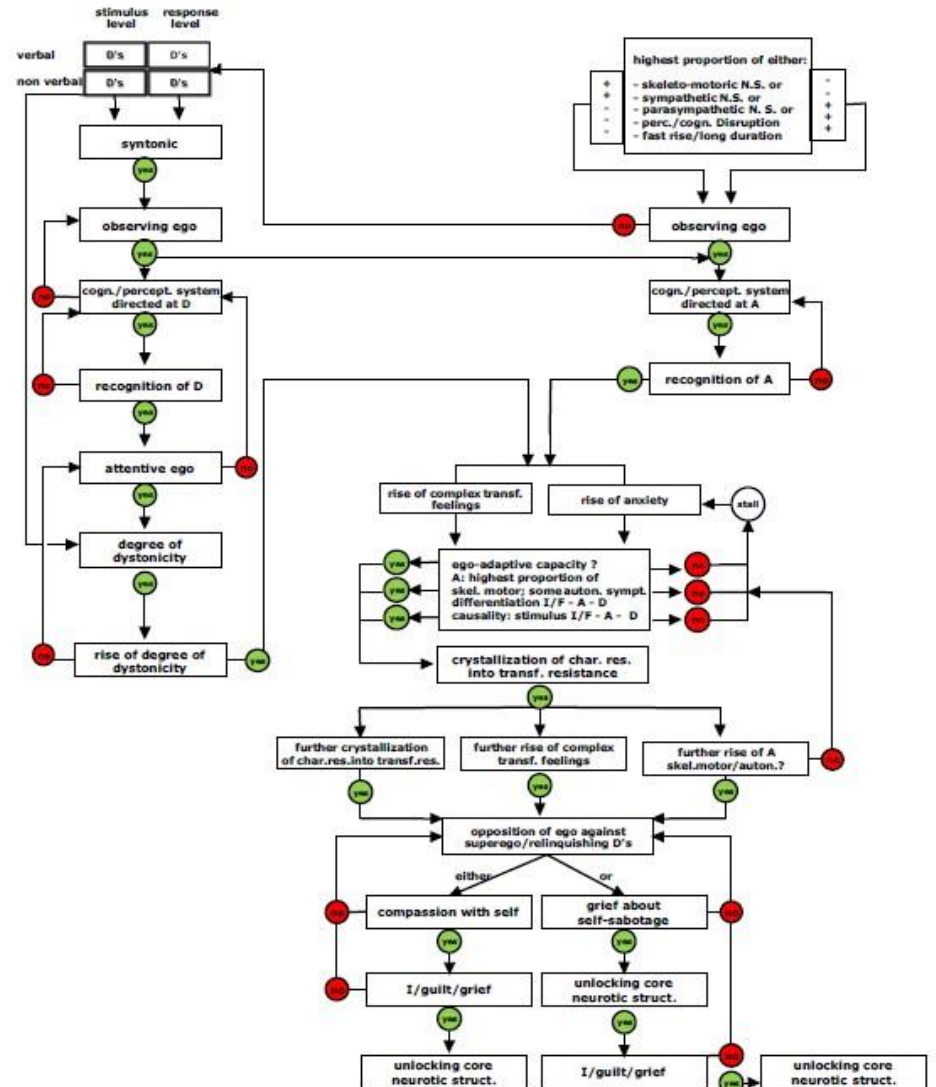
- An efficient therapeutic sequence of interventions to lead to the pathogenic core of unconscious conflict
- Mastering this sequence is the key to effective ISTDP



yes: green traffic light  
no: red traffic light



# Traffic Lights



# Summary of the Central Dynamic Sequence\*

- Inquiry
- Undoing PSE projections if present
  - Confrontation, Identification, Clarification of defenses
  - Regulation of Anxiety
- Turning of Ego Against the Superego (*Intra- psychic crisis*)
  - Mobilization of aggressive impulse against the aggressor
  - Breakthrough into Cs of Rage Guilt Grief Love
- Restructuring the Ego
  - Distinguish the Corners of the Triangles of Conflict
- Pressure to experience feelings in the Therapeutic relationship
  - GRIEF OVER NEUROTIC SUFFERING
- Exposure of core neurotic conflict
- TCP links
- Recapitulation
- Treatment planning

- \*Varies according to ISTDP clinician

**Central  
Dynamic  
Sequence**

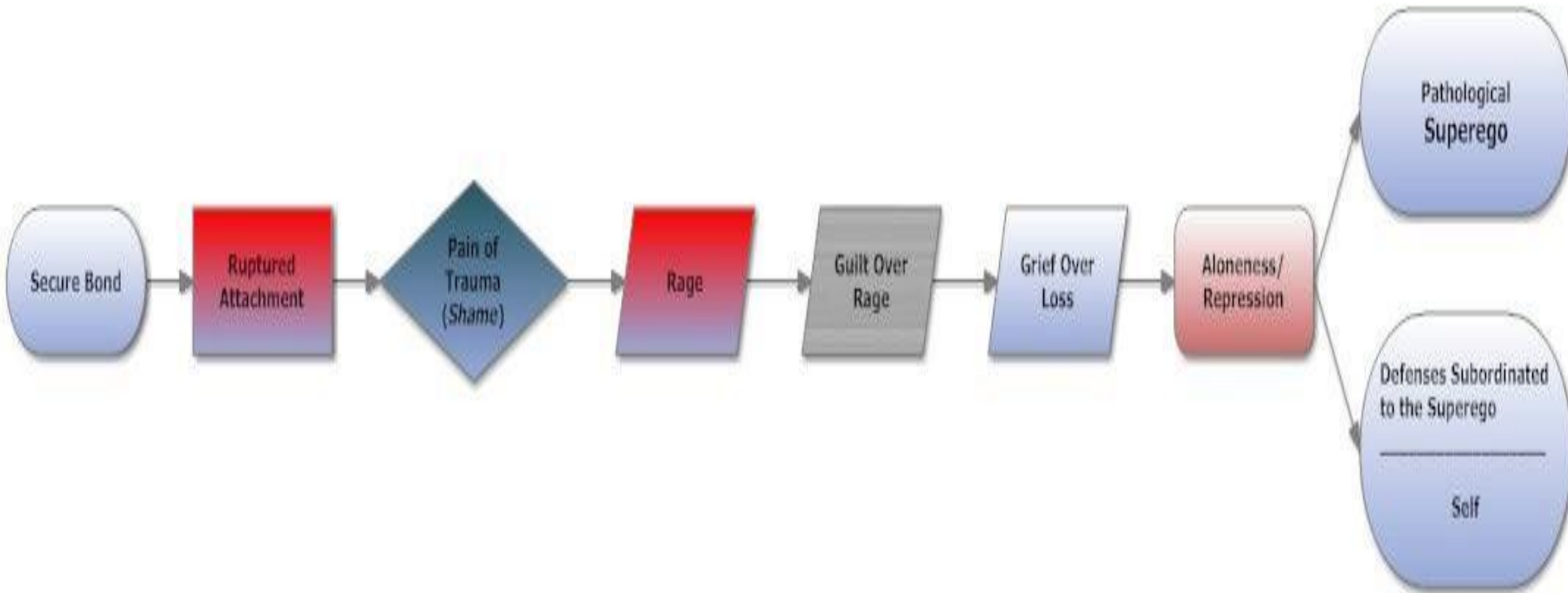
**Exposure of  
core neurotic  
conflict**

The patient's current difficulties are revealed from their developmental genesis yet felt in the here and now



This results in emotional insight and facilitates resolution of residual resistance and increased Working Alliance and development of an Unconscious Therapeutic Alliance

# PATHOGENESIS OF PSYCHONEUROSIS



# Developmental Origin of the Punitive Superego

Conscious      Unconscious

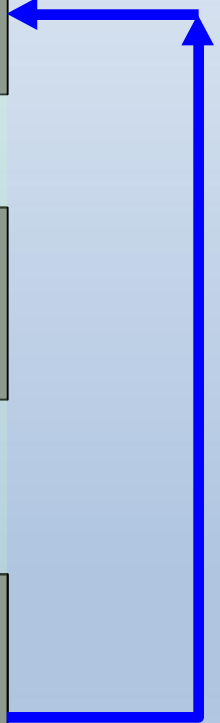
**SUPEREGO**  
**Punishment**

**EGO**  
**Pain**

**ID**  
**Rage, Guilt, Grief, Love**

*Trauma*

PARENTAL  
BOND





- **The Pathological Superego is deposed and is replaced with a loving, mindful, compassionate superego. The attachment style is less avoidant, ambivalent, or disorganized than before treatment.**




Characteristics of  
the Healthy  
Superego  
is created  
through

An Earned Secure  
Attachment  
Main and Hesse

- Praises realistically (healthy pride)
- Values and encourages knowing one's feelings (earned secure)
- Encourages autonomy and free choice (earned secure)
- Empathizes with disappointment and failure
- Encourages facing and understanding one's failure, to then take constructive action





The Medical Magical Mystery Tour: Fragility with  
Somatization.  
(Part 1 Initial Interview: rebuilding Fragile ego  
Part 2 Working Through)

PRODUCTION \_\_\_\_\_

DIRECTOR \_\_\_\_\_

CAMERA \_\_\_\_\_

SCENE \_\_\_\_\_



- **Restoring Healthy Attachment**
- **Mind, Body and Spirit**
- **With *ABISTDP***



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