Is it me or the model or the patient? Learning ISTDP with East Asian patients

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Introduction

This article presents questions, provisional learnings, and reflections about the cultural aspects of working with East Asian patients when learning and practising Intensive Short Term Dynamic Psychotherapy (ISTDP) based on my supervision, peer discussion, and personal therapy.

It is universally acknowledged that ISTDP is extraordinarily challenging to learn and master. Having completed my core training with ISTDP-UK in 2020, "it's me" was and is a common and realistic acknowledgement when therapy is not progressing well. I noticed when I started a small independent practice in 2020, followed soon by the Coronavirus pandemic - sparking fierce attention on the mental health of East Asians - at least a third of my caseload comprised of East Asians. This was in stark contrast to over a decade of working in the National Health Service (NHS) in London - a diverse and multicultural city - where I had seen less than a handful of East Asian patients. Often, these patients tended to be my most challenging cases, engendering a sense of: *is it me or the model or the patient?*

Background

A few acknowledgements to set the context before I answer the question "Is it me or the model or the patient?" Firstly, although there has been prolific research on psychotherapy with East Asian clients, there appears to be little literature on ISTDP with a specific focus on this population. This is despite the rich clinical discussions and curiosity within the ISTDP community from my experience. Exceptions include Dr. Coughlin's case of a Chinese immigrant in "Maximising Effectiveness in Dynamic Psychotherapy" (2017) and Dr. ten Have-de Labije's presentation of individual and couples therapy with first-generation Koreans in Germany at the International Experiential Dynamic Therapy Association (IEDTA) Conference (2022). Examining the cultural aspects of applying ISTDP is still relatively in its infancy since Dr. Davanloo's development of the model whilst working in the public health care system in Canada. From brief impressions, ISTDP continues to be predominantly taught, practised, and researched in the West.

Secondly, in her TED talk, the Nigerian writer Chimamanda Ngozi Adichie (2009) states: "The problem with stereotypes is not that they are not true, but they are incomplete, they make one story become the only story". I would like to stress that when referring to "East Asian" patients and certain characteristics of this population throughout the rest of this article, I am not claiming an exclusive monopoly. These features can be found across all patients and us. It is a delicate tightrope to not swing too much the other way, where all cultural differences become minimised or erased, therefore missing the opportunity for a deeper appreciation of our differences. Although I have explicitly referred to ethnicity, not every East Asian patient will present in the same manner. Multiple characteristics – age, gender, sexuality, and acculturation - will intersect with one another in a unique way.

Lastly, omitted in the title but surmisable in my name is that I am also East Asian: a 1.5 generation Korean-British immigrant, mostly educated in the West, including as a Counselling Psychologist and ISTDP therapist. Some East Asian patients sought me as their therapist solely based on my ethnicity. They implicitly and explicitly communicated hope that a fellow East Asian will understand their cultural background without having to explain themselves and potentially be able to have therapy in their mother tongue. They sought empathic recognition of their dilemmas, coming from a collectivist culture but currently living in a Western society. In the clinical vignette presented, a more unconscious motivation for seeking an East Asian therapist is also suggested. Director Bong, who won the Oscar for Best Picture with *Parasite,* remarked in his acceptance speech: "What is personal is universal." Not everyone who practises ISTDP will work with East Asian patients throughout their career for various reasons; in the same way, I may never work with specific patient populations. However, I hope my sharing contributes to discussions around a deeper learning process.

CONFLICT OF INTEREST STATEMENT
None.

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My personal experience of ISTDP as an East Asian patient

In 2020, a question was posed to the EDT mailing list, which I found myself replying to. Rebecca Stein from New York, US, asked: "Has anyone found it difficult to use ISTDP with Asian Americans? Is there any research on culturally sensitive / informed ISTDP?" I had a profoundly transformative experience of having ISTDP as a patient with two therapists not from the same background as me. In the spirit of Director Bong, I felt that I had something to share that was personal, honest, and potentially helpful. When I joined the initial Zoom call with other international colleagues, the following is what I wanted to share from my own experiences of being on the other side of the ISTDP upright chair.

Firstly, culture can be used as a defense. It can be used to defend against emotional closeness and having an equal collaborative relationship with one's therapist. It can also be used to defend against complex feelings in response to broken attachment bonds and take responsibility for one's self-defeating patterns. Of course, your environment shaped what defenses you developed that were adaptive at the time! That is true for everyone! So, what are you going to do about it? I found it powerful for my therapists to acknowledge my different cultural norms, validate real lived experiences of racism and discrimination, yet at the same time keep a tight focus on my internal problem and intrapsychic conflict. When I presented at the IEDTA Conference in 2022, one (non-East Asian) colleague asked whether I thought explicitly acknowledging the cultural context of the patient's difficulties would help. I suspect the effectiveness of this intervention will vary, depending on how it is delivered, timing, and for whose benefit. Most importantly, I believe demonstrating empathy and understanding of the cultural context of a patient's difficulties will be ineffective unless accompanied by pressure to clarify and intensify their intrapsychic conflict.

In addition, not unique to ISTDP, I experienced even deeper and fuller breakthroughs of complex feelings when using my mother tongue to articulate them. Psychotherapy research has repeatedly demonstrated that patients using their mother tongue significantly aids in accessing their emotions and encoded memories (Dewaele, 2008, 2010; Dewaele & Nakano, 2013; Pavlenko, 2006). Studies in multilingualism support this by finding greater emotionality embedded in the first language learnt compared to languages learnt later, such as from adolescence onwards, especially for expressions of love (Caldwell-Harris et al., 2010; Dewaele, 2008, 2010; Dewaele & Nakano, 2013; Harris, 2004; Pavlenko, 2006). One explanation is that the first language is usually learnt in a highly emotional context - with one's attachment figures - whereas languages learnt later may vary in the emotional context (Harris et al., 2006). My experience is that the patient's use of the mother tongue remains effective even though the therapist may not understand directly but via subsequent translations from the patient.

Following the lively initial Zoom meeting, seven colleagues from three different continents met online twelve times over the course of a year between 2020 and 2021. One of us presented a video recording each time working with an East Asian patient for peer supervision. Our discussions explored whether there are any principles to be mindful of or adaptations necessary when working with this population.

What I learnt from my patients, supervisors, and colleagues so far: It's still me.

Returning to the question of "is it me or the model or the patient?" it has been reassuring that adhering to the central tenets of ISTDP will safeguard the therapy with any patient. Drs Neborsky and ten Have-de Labije (2012) highlight the paramount importance of establishing and maintaining a healthy therapeutic alliance. This includes fostering an equal, collaborative relationship, agreeing upon a shared understanding of the problem, division of tasks between therapist and patient, short-, mid- and long-term goals of therapy, and particularly paying attention to separating the ego from the Punitive Super Ego (PSE). Similarly, Professor Abbass and Dr Town emphasize the importance of monitoring dyadic attunement and synchronicity between therapist and patient (personal correspondence, 2021). Asking and checking the patient's will and consent with the task specified avoids the pitfall of "stepping into the shoes" of a previous dysfunctional attachment figure and facilitates side-by-side working together. This is demonstrated by the following clinical vignette from 2021.

Clinical vignette: The Chinese daughter who would rather disappear

A second-generation Chinese patient in her early twenties wanted to get my help with her low mood, social anxiety and later disclosed episodes of binge eating. All sessions were conducted online during the pandemic. Her parents separated when she was a child; both are described to be highly emotionally volatile, lacking in warmth, and relentlessly critical. Her father can also be demanding and pressures the patient to

help with his business whilst she has a full-time job and lives in a separate city. Lastly, she grew up with an older brother with severe autism, who has been aggressive towards her physically and verbally, which was never acknowledged within the family. The following transcript is from session six - weekly sessions of fifty minutes - where the patient starts with what she has taken away from the last session. She reported seeing more clearly how dismissive she is towards herself and hypothesized that she "inherited" this from her mother. Upon my invitation, she gave a specific example of her mother tutting her and saying she should use two hands when putting on facial cream, not one, when visiting her last week. The patient described getting angry and shouting back; she explained to me that nothing she does is ever good enough for her mother.

Fifteen minutes into the session:

Therapist: How much do you feel connected with your angry feelings toward your mother right now?

Patient: (still composure, monotone, slow speech) They are still present right now, talking about it, it (small sigh), yeah, inside I feel frustrated (bigger sigh), erm, I just had a deep sigh

Therapist: Yeah, I saw that, a nice deep sigh

Patient: Yeah, I feel a bit tense (moves shoulders)

Therapist: Yeah, you are getting much more tense in the upper half of your body (patient nods). So how do you notice the angry feelings toward your mum underneath this nice deep sigh and the tension that's building in your body?

Patient: (small sigh, eyes blink, head tilts slightly) How do I know?

Therapist: How do you notice the angry feelings toward your mum underneath the nice sigh and the tension?

Patient: (bigger sigh, slowly looks upwards then downwards, chews lip, pause) I just feel like, when I talk about her in this situation, that frustration will always come up

Therapist: Sure, so how do you notice the anger towards her inside you coming up right now underneath all this tension and nice deep sighs that you are doing (patient sighs, moves imperceptibly backwards) if you just allow yourself to connect with it?

Patient: (Eye contact with Th, monotone) So how do I feel towards her?

Therapist: How do you notice the anger inside you towards her?

Patient: I, I, I just, I feel it in my body, in my chest (sighs, raises a hand to touch her chest)

Therapist: (emphatically) Yeah, yeah, what do you notice? So the anger is inside your chest right now would you say, or somewhere else in your body when you say you feel it?

Patient: (first change in pitch, emphatically) Yeah, like my chest, I don't know if it feels like tighter or, or like, warmer (repeatedly tapping chest with hand)

Therapist: Uhuh, like heat?

Patient: Yeah, like I feel a surge in something here (pointing to chest)

Therapist: A surge in energy and power?

Patient: (again emphatic tone) Yeah, almost as if I feel these emotions with my heart.

Therapist: Uhuh, you feel something around your heart, a bit of heat to your anger, a surge of power, OK, (Pt rests head on closed hand, looks downwards) So if you allow yourself to connect up with your understandable feelings of anger towards your mum (Pt sighs) and if could just travel how does the anger want to come out towards your mum in your body?

Patient: (sighs) Erm, vocally, I just wanna shout.

Therapist: Sure, (Th repeats memory, Pt nods), shouting is not the same as feeling angry, when you feel angry, you have heat, a nice surge of power, a rise in energy, then you go a bit tense, then you have to do this nice breath out, shouting is more like getting rid of the tension rather than feeling your anger, because you're losing your impulse control in that moment, would you agree? (differentiating Feelings-Anxiety-Defense) (Pt nods and sighs)

The patient agrees and offers another example of where she did not deal with her feelings toward her mother. She drinks water in response to her increasing anxiety symptoms of dry mouth and throat as she starts turning against her syntonic defenses.

Therapist: You feel angry towards her because you've had an experience with her that nothing you do is ever good enough for her, she will always offer some kind of criticism (Pt nods) so shall we just pay very careful, attentive attention to your angry feelings toward her? (asking for Pt's consent and will) (Pt sighs) I understand that she doesn't, doesn't mean that you don't have to, ignore your angry feelings either and dismiss them (separating ego from PSE) or you go flat, you go depressed and go what's the point of anything anymore (Pt nods imperceptibly, looks down) that's what you do with your anger, you either lose control and verbally spit it out which is no longer feeling angry (Pt sighs, small nods)

The patient agrees with this and adds how draining it is for her to react in these ways. The therapist validates that this is a steep price to pay for defending against her anger.

Therapist: Do you want us to stay here and see how we can help you get to the bottom of your angry feelings

toward your mum without detaching or deflating or going into just verbally losing impulse control but it doesn't make any difference to you? (again asking for Pt's will and consent)

Patient: (sighs, small nods, looking at Th, monotone) yeah, I'd like to continue.

The patient offers another example from the past week where her broken attachment longings emerge more clearly: experiencing dismissal by her mother when seeking closeness with her.

Patient: (looking down, sighs) Yeah, it just annoys me.

Therapist: So how much anger do you feel right now towards your mother in your body as you remember her saying "what are you doing?" (Pt looking away, biting lip)

Patient: (same monotone) Moderate, my arms are crossed (looks down at her arms, sighs) Yeah, medium, I feel a bit frustrated (laughs)

Therapist: Sure, who do you feel frustrated towards right now in this moment?

Patient: My mum.

As a result of pressure interventions, clarification, identification, and confrontation of defenses and turning them dystonic, the patient experiences Complex Transference Feelings (ctf) toward the therapist. This is indicated by the patient's increasing tactical defenses such as looking away, crossing her arms, and laughing. With high resistance patients, at mid to high rise, a breakthrough in the transference may be indicated in the standard format of ISTDP. I may have asked her, "What feelings are coming up here with me?" Helping her experience both gratitude and irritation towards me to facilitate a successful breakthrough and transfer of image to a past attachment figure would constitute "unlocking of the unconscious" (Davanloo, 1995). CTF is felt when the patient experiences me treating her as important and worthy to investigate her emotions precisely, yet at the same time inviting and challenging her to turn against her defenses. After all, Dr Neborsky quipped in supervision (2021) that it is easier for East Asian patients to kill me as their surrogate attachment figure than a non-East Asian therapist! This unconscious motivation for East Asian clients to seek an East Asian therapist suggests transference reactions may have started before our meeting.

Therapist: OK how do you notice it in your body in the way that it wants to come out if you direct it towards her, how does the angry energy inside you want to come out if you direct it towards her (Pt looking away) if you don't block it off, and if you don't dismiss it, and if you don't go flat?

Patient: Probably (looking away) well shouting isn't, you said shouting isn't

Therapist: Yeah if you put the impulse back into your body so I know you are tempted to shout but if you don't go into just verbally getting rid of the tension, how does the energy want to come out through your body? (Pt looking down, a clenched fist rises in view of the camera, she looks at it and puts her hand back out of view of the camera, sighs, looks down) How does the anger wanna come out towards your mum that you notice inside you? (Pt sighs, purses lips then looks away then down)

Patient: Mmm, my hands are in fists.

Therapist: Mmhm, so you are making your fists like this? (Th raises clenched fists into view of camera)

Patient: Yeah (Pt raises her own clenched fist, then releases the fist, stares at her open hand before dropping it back on the table).

Therapist: Yeah, ok, so how much power is there in your fists and in your arms right now? (Pt sighs, closes eyes, rests head on hand that clenches into a fist)

Patient: (Pt lifts head from clenched fist and stares at it) Quite a lot, I just want to squeeze.

Therapist: Yeah, like a really tight fist like this? (The therapist shows her own clenched fist into camera view). There is a lot of power in there?

Patient: Yeah I've got a stress ball in my other hand (shows me on camera, Pt smiles, sighs)

Therapist: So how does the anger want to come out towards your mum through your fists?

Patient: (looks away) It doesn't, it just stays in me, like I wouldn't, I wouldn't want to hit her (laughs, looks down) (negation defense) I just keep it in my hands and then I would just disappear.

Therapist: That seems like a poor trade off. You and I aren't saying you are going to do any of this in real life, that once you act it out, that's no longer anger, that's just losing impulse control, (speech gradually accelerates) you and I are just paying attention to how you notice your angry feelings when you feel them inside you so you don't have to turn into your mum and dismiss yourself and your feelings in the same way she did (Pt crosses her arms, tilts head) so you don't have to go into feeling deflated, demotivated, into negative thinking...

Here, there has been a drop in the patient's will, resulting in her moving towards a compliant-defiant position to a now demanding and critical therapist. A more effective intervention at this point to increase the patient's intrapsychic conflict would have been:

Therapist: Which do you listen to, the voice in your head that says don't hit her or the honest feelings in your body including anger that wants to hit her? All I'm inviting you to do is feel and see the picture in your mind of what the impulse wants to do, but the choice is yours. You can continue telling me that you don't want to hit her, go into asking why questions that you will not get an answer to, and continue to punish yourself with this negative view of the world and yourself. Or, if you want, you can look at what your body wants to do with me right now with attentiveness, care and precision together.

It's partly Me but can the Model also come closer to our East Asian patients?

"The key to the patient's unconscious is in the patient, not in the textbook." Dr ten Have-de Labije (personal correspondence, 2021).

I believe Dr. ten Have-de Labije was underlining the importance of never losing sight of the patient: without deeply understanding our patients, there can be no therapeutic success. So, who are our East Asian patients? Psychotherapy originates from a Judeo-Christian framework. There is prolific discussion and research on working with patients who are not from this culture. Confucianism, Buddhism, and Taoism are the three most prominent philosophical ideologies that have shaped the worldview of East Asians. Confucianism governs the structure of the social system and moral standards dictating how one socialises: what are one's roles in the larger social context and appropriate moral behaviours. Teachings of Buddhism and Taoism primarily offer ways of coping and support, impacting more how one navigates the stresses and demands of daily life. Below is a table that highlights the key principles of each.

TABLE 1. DESCRIPTION OF CONFUCIAN, BUDDHIST & TAOIST PRINCIPLES (LIN ET AL., 2021)

IDEOLOGY / TENET	DESCRIPTION
Confucianism	
Propriety Pressure	Needing to uphold appropriate behaviours and actions in public because of social pressure
Interpersonal harmony	Avoiding conflicts by withholding 'negative' emotions or being agreeable with others
Conforming to social norms	Recognising and adhering to social norms and expectations
Relational hierarchy	Respecting and valuing perspectives of elders / authorities
Self-cultivation	Striving to cultivate the best of self
Buddhism	
Not self	Not focusing on the idea of 'I' or self
Interconnectedness	Realising one is part of a greater whole
Taoism	
Acceptance	Accepting all things as they are
Tranquillity	Remaining calm and still throughout daily life

Discussion

When understanding the Confucian principles of Relational Hierarchy and Interpersonal Harmony, it becomes even more pertinent with East Asian patients to check their will and consent. Resistance against emotional closeness or having an equal partnership with the therapist can be culturally sanctified or encouraged by a hierarchical societal structure. My patient was not used to being asked about her feelings, opinions, and wishes, especially by elders or authority figures. East Asian patients may habitually adopt a passive position in response to seeing themselves as lower in the hierarchy than the therapist and perceive the therapy as purely a didactic relationship rather than one involving emotional closeness. When building on mid to high rise with resistance at the forefront in ISTDP, the therapist's speech may pick up the pace, or the tone becomes more clipped as another way of adding pressure to the interventions.

In contrast, for some East Asian patients, the opposite may be more mobilising. In the clinical vignette, the patient responds with sustained rise when I match her pace, leaving the pauses, keeping the tone curious and not using significantly more words than her. This may be counterintuitively mobilising by not stepping into the shoes of an authoritarian figure, who treats her in a pressuring manner. If I am not careful with maintaining a healthy working alliance whilst doing pressure interventions, I can easily flip in her mind to a demanding and critical authority figure, whom she has no choice but to either comply or defy.

The same Confucian principles also may contribute to challenges for East Asian patients to acknowledge their CTF with the therapist right here, right now in the session, even when palpably felt in the body. My patient opts to stay in the current example of investigating her feelings toward her mother instead of toward me. East Asian patients may be experts in masking their CTF with a pleasing, compliant and agreeable stance. Hypervigilance to how CTF is masked via these defenses, as well as to any drop in patient's will or loss of healthy working alliance, is crucial. I have experienced and heard anecdotes where therapists are surprised to receive a polite therapy termination email from the patient, thanking them for all their help: the most quietly defiant act some East Asian patients may resort to.

As well as toward the therapist, it can be heretical for East Asian patients to acknowledge and feel their complex feelings toward their Past and Current persons such as family members in a culture that is heavy on filial piety and gratitude. As the patient experienced a higher rise of feelings in her body, any ownership and feeling of the impulse of wanting to hit her mother will be moral turpitude to her superego: how dare she feel and exhibit any aggression to her ancestors! Patients may choose loyalty to their internal objects over therapists if the therapist's interventions are not precise. At worst, patients may perceive the therapist's interventions to be coercing them to adopt individualistic Western values and betray their collectivist ones, which not even East Asian therapists can avoid by virtue of their ethnicity. For example, in the West, there may be value in feeling one's complex feelings in response to broken attachment bonds then constructively asserting oneself. On the other hand, East Asian cultures may choose to value prioritising the collective according to their Buddhist value of Interconnectedness.

Another way Buddhist principles, especially "Not Self", may present itself is for intergenerational attachment traumas to not explicitly be named and acknowledged. This is not an exclusive phenomenon to the East Asian population. My first East Asian patient in independent practice was a first-generation Chinese immigrant who did not perceive herself to have experienced emotional neglect. She described her parents were physically and emotionally absent throughout her life because they were busy working and caring for elderly family members. Rather than focusing on her complex feelings in response to her unmet attachment longings, she berated herself for not helping her family even more. My ill-timed and leading questions to get her to see her experiences in a different light only increased the risk of misalliance. Profound emotional neglect may also manifest in East Asian patients approaching therapy in a studious manner: writing notes, requesting psychoeducation around "what are emotions", or asking for homework. This may be formulated as a defense of intellectualisation. At the same time, it may contain a genuine desire for the emotional closeness that they have not had and reflect a clumsy attempt to collaborate with their therapist using the only ways they know how (Dr Louis, personal correspondence, 2022).

On the other hand, some East Asians may have caregivers who can be formulated as being narcissistic: perceiving their children to be an extension of themselves or existing only to gratify their wishes. Parents who were described as hyper-controlling and dictating how patients live their lives were defended by patients as being ultimately loving and wanting the best for them. For example, another Chinese patient of mine reported how her mother dictated her career, partner, and appearance, including hairstyle into her thirties. Her mother even had the patient's name changed after she became an adult. It took careful inquiry to begin exploring that my patient may have a separate mind from her mother, and a longing for her differences in opinions, wishes, and desires to be respected by her mother.

Furthermore, the Taoist principle of Tranquillity may underlie how my patient in the clinical vignette presented with

very little signalling: minimal changes to her facial expression, posture, tone, volume, and rate of speech. For her, fidgeting or admitting to using a stress ball can be a dramatic display of anxiety. Her striated anxiety pathway is only indicated by her muscle tone and sighs alongside a conscious working alliance. The same principle may also apply to expressions of core feelings; Salvador et al. (2023) found evidence that there is variability in emotional expression across cultures.

Given the formidable PSEs East Asian patients can develop, separating their ego from PSE can be tricky but crucial. Otherwise, interventions from the therapist can quickly trigger shame, feeling criticised, and risk a misalliance. This is in response to even the most basic level interventions, such as feeding back observations of their anxiety symptoms or pointing out their defenses in an empathetic manner. This makes it more challenging to establish a working alliance. PSEs can also dictate the goals of therapy. One Chinese patient emailed me wanting therapy to not let the unexpected bereavement of her father get in the way of making partner at her law firm. What I found undeniably helpful was a shift in my own stance. Rather than rushing for feelings, I had learned to cultivate patience with myself and my patients, including appreciating all aspects of them and their conflict. It helped to hold due respect for their attachment traumas and all the ways they reveal themselves but remaining ironclad about the meta-psychology and interventions that I am offering.

Final reflections

"The hardest patients are those with the same defenses as the therapist." Dr ten Have-de Labije (personal correspondence, 2021).

It has always been a complex emotional experience to recognise my own blind spots when practising ISTDP. I too have syntonic defenses, normalise my PSE, and have not internalised what it is like to have a truly equal, collaborative relationship with emotional closeness. When pointing out her constellation of defenses that culminated in ignoring her physical symptoms of anxiety, one Chinese patient agreed wholeheartedly. She described wilful self-neglect in the service of being able to work long and gruelling hours. She shared this with a degree of pride and superiority to colleagues who had limits. Prior to the session, I had been feeling smug that I persevered through the working day despite feeling mildly unwell. As I listened to my patient, I noticed recognition, resonance and empathy of the unhealthy part that can exist in both of us. Not only did I feel frustration towards her defenses and PSE but also hopefulness and excitement that I may help her enjoy her healthy ambition and drive without confusing it with emotional self-neglect. This strengthened my resolve to replace her PSE with a healthy ego that she had not had an opportunity to experience previously.

Building upon my previous ISTDP therapy, I found ongoing supervision and learning with brilliant and humane teachers, peers, and friends invaluable in shining a spotlight on these blind spots. For example, it is entirely possible for the clinical vignette presented to have been supervised without any reference to the cultural backgrounds of both my patient and me. It proved to be an enormously helpful, complete, and integrating experience when Dr Neborsky did incorporate these cultural aspects alongside ISTDP meta-psychology. Not until I had seen myself side by side with an East Asian patient on that Zoom screen, being specifically appealed to as an East Asian therapist, had I examined deeply our shared millennia of cultural heritage and the impact on my ISTDP practice. In conclusion, the answer to the question "Is it me or the model or the patient?" whenever I find myself struggling working with East Asian clients offering ISTDP, is, unsurprisingly, all three. There is always room for my clinical development: mastery over delivery and timing of interventions, separating ego from PSE, or recognising my own PSE. This does not negate that understanding our East Asian patients deeply may help highlight where more attention and precision is required in the application of ISTDP to effectively unlock their unconscious. With the expanding practice of ISTDP reaching Africa, India and China, it certainly feels like a fruitful time for us to explore the cultural aspects of learning, practicing and teaching ISTDP.

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