

# Intensive Short-Term Dynamic Psychotherapy: A Review of the Treatment Method and Empirical Basis

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**Abstract.** Based on over forty years of videotaped case-based research, Habib Davanloo of McGill University, Canada, discovered some of the core ingredients that can enable direct and rapid access to the unconscious in *resistant*<sup>3</sup> patients, patients with functional disorders, and patients with *fragile character structure*. We will describe here some of the main research findings that culminated in his description of a central therapeutic process involved in the intensive short-term dynamic psychotherapy (ISTDP) model. We will also describe the evolution of the technique over the past thirty years and summarize the empirical base for Davanloo's ISTDP.

**Keywords:** short-term, psychodynamic, dynamic, psychotherapy, Davanloo

## Davanloo and the discovery of unlocking the unconscious

In an effort to accelerate dynamic psychotherapy, Davanloo began in the 1960s to use more active approaches to identify and handle resistances. He initially worked with low and moderate resistant patients who could be put in touch with avoided unconscious feelings through focal interviewing, active use of interpretation of defenses and interruption of defenses that came into play (Davanloo, 1980).

In the 1970's he began working with more resistant patients. He discovered that with patients who manifested primarily *resistance* in session, his efforts to mobilize the underlying feelings and help them to interrupt and challenge their own defenses brought about a rise in complex feelings. These complex feelings, which Davanloo called the *complex transference feelings* (CTF), included deep appreciation and positive feelings for the therapist but also irritation because of the interruption of the customary defenses. When the CTF were mobilized he observed a corresponding rise in *unconscious anxiety* and *unconscious defenses* that

were in observable and definable patterns. When he tried to interrupt these defenses, he noted the defenses were then observed to line themselves up tightly between the therapist and patient or *crystallize*. When this process happened the therapist could then challenge the defenses and turn the patient against his or her own defenses.

To enable this, Davanloo discovered, through videotape study, his technique of *head-on collision* (HOC) with the resistance to achieve a total blockade of all defenses. The HOC is a communication to the patient that reflects the reality of the patient's resistance and the process between the patient and therapist. Central elements of the HOC include pointing out the destructiveness of the resistances, the limitations of the therapist, and the potential in the patient to overcome the resistances.

Davanloo found that all this effort brought about an *intrapsychic crisis* in the patient. In this complex state of mind, the patient is both wedded to and at odds with his or her own customary defenses. Davanloo found this to be a powerful psychic state of readiness for change within patients, bringing with it an intense desire to seek freedom from self-destructive patterns.

When this took place the complex transference feelings were able to be experienced yielding an abrupt drop in unconscious anxiety and defense. Following the breakthrough and conscious experiencing of these complex transference feelings, Davanloo discovered the emergence of a powerful force in the patient that he called the *unconscious therapeutic alliance* (UTA). Davanloo's concept of the UTA refers to a healing force in the patient that goes to battle with resistance and shines

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<sup>3</sup> The definitions of words in italic are provided in the glossary of terms as Appendix A.

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the light on the underlying core structure through the production of mental images and vivid memories of unconscious content. When the UTA is dominant over the resistance, the unconscious is said to be *unlocked*: direct access to the unconscious has been achieved in a *partial* or *major* fashion.

Following these efforts to reduce the resistance, the underlying feelings were accessible and now able to be experienced and worked through. Within his case series, Davanloo demonstrated that more complex and resistant patients required more of these unlocking experiences. Such work appeared to bring lasting changes in the manifestations of unconscious anxiety and defenses in favour of emotional awareness and processing (Davanloo, 1980).

Davanloo coined this entire process the *central dynamic sequence* of unlocking the unconscious in resistant patients (Davanloo, 1990) since, the same events roughly in this order, were seen repeatedly across several hundred patients in Davanloo's original case series (Davanloo, 1990) and were replicated in large case series of others (Abbass, 2002a, 2002b).

#### **Development of psychoneurotic disorders: Attachment trauma**

According to Davanloo's research, the onset of neurosis, character neurosis and *fragile character structure* can be traced back to psychological trauma connected to the relationship with important attachment figures in the person's early life. Traumatization stems from interruption of the person's emotional attachment or longings for closeness that are composed of deeply positive feelings of love. This trauma can be a temporary, persistent or permanent disruption to the attachment bond, or other disturbances in the relationship. The result is damage to person's experience of closeness and subsequent ability to be close to others. This traumatization causes painful feelings of loss and can lead to a reactive response composed of guilt-laden rage towards the loved one.

The conflictual nature of this fusion of intense emotion brings rise to unconscious anxiety within the psychic system. Unconscious defense mechanisms function to reduce anxiety and block the emergence of these feelings into conscious awareness. This unconscious anxiety and defense form what are commonly recognized as psychiatric and medical symptom disturbance as well as personality disorders.

Based again on replicated videotape research, these patterns of unconscious anxiety can be directly diagnosed with both medical system and psychotherapeutic benefit (Abbass, 2005; Abbass, Campbell, Magee, & Tarzwell, 2009; Abbass, Sheldon, et al., 2008). These discharge pathways of *unconscious anxiety* include striated muscle tension (seen with hand clenching and sighing respirations proceeding to whole body tension), smooth muscle tension (affecting the gastrointestinal tract, vasculature and airways) and cognitive perceptual disruption (with mental confusion and in-

terruption of special senses such as vision, or loss of consciousness). Motor conversion is seen with an absence of striated muscle tension and focal or generalized weakness. Three main patterns of what Davanloo calls *major resistance* include isolation of affect, repression of affect, and projection/projective identification.

Davanloo observed a direct relationship between the intensity of pain/rage/guilt about the rage and the patterns of anxiety and resistance in cases treated. The greater the magnitude of repressed rage and guilt, the greater the likelihood of developing self-destructive system serving to protect others from the rage, direct it inwards, and punish the self at the same time. Simply put, the greater the intensity of underlying guilt, the more severe the associated anxiety, and the more pervasive and fundamental the defensive need to avoid experiencing these feelings. This *punitive superego* becomes interwoven within a person's character structure, interrupting emotional, interpersonal, occupational and physical health (Davanloo, 1987, 1988; see Figure 1).

#### **Spectra of patients suitable for intensive short-term dynamic psychotherapy**

Davanloo has described two defined spectra of patients suitable for intensive short-term dynamic psychotherapy (ISTDP; Abbass, 2002b; Davanloo, 2005; see Figure 1 for an overview).

The first is called *the spectrum of psychoneurotic disorders*. This spectrum goes from low to moderate to high resistance. The patients at the low end of the spectrum have only grief and arrive to therapy with a circumscribed focus of loss. They only have minor *tactical defenses*. The treatment is uniformly short, being less than five treatment sessions. Attachment trauma in these patients is loss due to death, parental divorce or some other event that disrupts family bonds and occurs usually after age six. These patients are rare in clinical samples being about one percent of outpatient psychiatric referrals in one study (Abbass, 2002b).

Moderate resistant patients are patients who have had greater and earlier attachment trauma resulting in murderous rage and guilt about the rage as well as grief in the unconscious. Such patients are somewhat aware of the nature of their difficulties and character defenses. There is the beginning of a self-punitive superego in this group of patients due to guilt about rage. These patients are good responders to 5-20 sessions of the original technique of Davanloo's method (1980). Abbass (2002b) reported that about one sixth of psychiatric outpatient samples consisted of moderate resistant patients.

Highly resistant patients have endured early severe trauma resulting in complex core pathology and the presence of unconscious primitive murderous rage and guilt about the rage. Trauma is earlier in development in this population. These patients have a punitive superego with drives to self-punish for the underlying guilt-laden rage. These patients require the

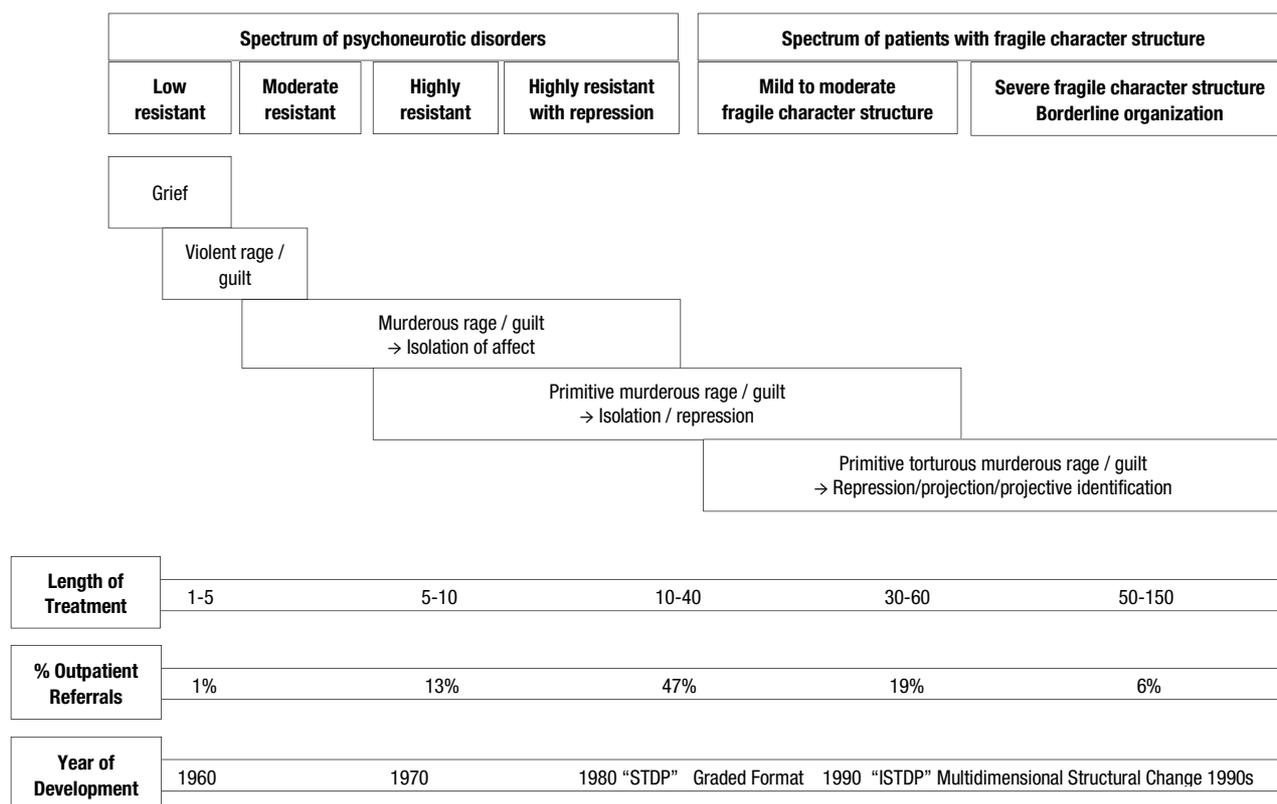


Figure 1. Patients suitable for ISTDP. STDP = Short-term dynamic psychotherapy, ISTDP = Intensive short-term dynamic psychotherapy.

fully developed technique of the ISTDP treatment (Davanloo, 2000) in order to overcome these extensive defenses. Some of these patients may have significant repression with depression and somatization: in this case a preparatory phase of *graded format* to build anxiety tolerance before accessing the unconscious (Davanloo, 1990; Whittmore, 1996). Treatment is longer in this group of patients being 20–40 one-hour sessions. This group of patients is quite common, being about half of outpatient psychiatric referrals in one study (Abbass, 2002b).

The *spectrum of patients with fragile character structure* includes patients with mild to moderate to severe fragile character structure. Patients with mild fragile character structure have moderate anxiety tolerance, however at a threshold, they will experience cognitive perceptual disruption, dissociation, and various neurological symptoms. They can experience loss of consciousness. At this level of rise in feeling they will tend to use projection and repression. This anxiety can be generally reduced within a few minutes however. Patients with moderate fragile character structure experience cognitive perceptual disruption at a low to moderate rise in unconscious anxiety. The unconscious anxiety takes longer to reduce, generally five to fifteen minutes. Patients with severe fragile character structure would typically meet criteria for dissociative disorder and borderline personality disorder. Patients with severe fragile character structure will experience cognitive perceptual disruption and projection at a

very low rise in anxiety. They may have projective identification and splitting as a prominent defensive system and may not have any unconscious anxiety whatsoever. Such patients run into major difficulties in their social, occupational and interpersonal functioning (Davanloo, 1995a). This entire group of fragile character structure patients was about 25 percent of outpatient psychiatric referred patients. (Abbass, 2002b). Fragile patients require some phase of bringing multidimensional structural change in unconscious anxiety and defense before accessing the unconscious. Such patients are typically either extremely anxious or using projective defenses during initial assessment interviews.

### Empirical support for Davanloo’s metapsychology

Various types of research have corroborated some of these findings that are unique contributions to our understanding of how the unconscious mind tends to operate: they constitute a “new metapsychology of the unconscious” (Davanloo, 2005).

### Therapist responses in ISTDP

The first distinguishable research category focuses on the quantification of therapist responses in ISTDP. Using graduate raters to code therapy transcripts, the application of ISTDP by different trained therapists has been studied across multiple research centers to

validate clinical guideline recommendations. Treatments conducted by a sample of twelve therapists participating in a controlled clinical trial of STDP (Winston, Laikin et al., 1991, 1994) were studied and the process characterized as active and involved marked by the frequent use of therapist confrontation (Joseph, 1988; Makyen, 1992; Salerno, Farber, McCullough, Winston, & Trujillo, 1992). This finding was subsequently replicated in a case series study of STDP (after Davanloo, 1980; see Town, McCullough & Hardy, 2011). A comparison of therapist responses in STDP, versus an insight orientated brief dynamic treatment, revealed a statistically higher frequency of therapist behaviors focused on addressing patient defenses in STDP across each phase of therapy (Winston, Winston, Wallner Samstag, & Muran, 1994). Bernardelli, De Stefano, and Stalikas (2002) described ISTDP as having a strategic and systematic focus on exploring and confronting self-defeating patterns. Abbass, Joffres, and Ogrodnick (2008) studied the composition of therapist responses that characterize ISTDP compared to standard psychiatric interviews. The preponderance of *pressure* interventions in ISTDP sessions, revealed concordance between Davanloo's manualized treatment description (Davanloo, 2005) and therapy as practised. A high frequency of sighing respirations in these interviews supports ISTDP theory (Davanloo, 1980, 1990, 2005) which posits that the mobilization of unconscious processes is evident through unconscious anxiety.

### In-session events in ISTDP

Programmatic study of the therapeutic process in Davanloo's (1980) standard treatment model began in the 1980's at Beth Israel Medical Centre (BIMC). First, patients' responses to therapists' use of transference interpretations were studied in line with the psychotherapy field's then interest in the role of interpretative interventions. Contrary to expectation, transference interpretations were more likely to elicit an immediate defensive response from patients rather than an insight based affective response (Porter, 1987). A follow-up study found evidence suggesting that the likelihood of patient defense was in fact reduced however, when therapists used triangle of conflict references and confrontation preceding an interpretation of transference material (Joseph, 1988). Next, therapists' confrontation interventions were studied, revealing an increase in patient defense following single confrontations (Salerno, 1992). These findings supported Davanloo's observation that attempts to make resistant patients aware of unconscious processes are typically met with defense due to underlying anxiety. Next, researchers sought to explore the impact of sustained pressure and confrontative therapist activity to the resistance in line with Davanloo's recommendations. Sixty-four sessions taken from sixteen patients were analyzed and the cumulative effects of repeated confrontation in the early

phase of treatment were found to be effective in reducing patients' defenses (Makynen et al., 1992). The opposite patient response was seen following neutral clarification interventions by the therapists. Makynen et al. (1992) interpreted these results as confirmatory evidence of Davanloo's theory that repeated confrontation can be an effective technique for the dissolution of immediate patient resistance. However, contrary to ISTDP theory, the studies from the BIMC laboratory (Makynen et al., 1992; Salerno, 1992) did not find evidence linking single or repeated therapist confrontations to an emergence of patient affective responses. These studies failed, however, to examine responses on a statement-to-statement basis and patient affect was coded solely on the presence or absence of affect. Informed by these observations, using the same system for coding therapist responses, Town, Hardy, McCullough, and Stride (2011) examined the association between therapist interventions and the intensity of immediate patient emotional arousal in STDP (after Davanloo, 1980). The findings offered validation for Davanloo's technique of active confrontation: therapist confrontative interventions drawing attention specifically to patients' impulse, feelings and defenses were found to precede the highest levels of emotional arousal (Town et al., 2011). The final process study from the BIMC STDP program studied the relationship between patient defensive behavior and therapist responses addressing defense (Winston, Winston, et al., 1994). Large correlations between patient defense and therapist interventions addressing defense were interpreted as evidence of adherent STDP activity: therapists respond to defense with increased activity targeting the resistance (Davanloo, 1980). To test the theoretical assumption that active confrontation to emerging defense is therapeutic, researchers predicted diminished defensiveness in subsequent quartiles of treatment. The results show that the greater the frequency of therapist activity addressing patient defense in quartiles 1 and 2, the greater the decrease in subsequent patient defensive behaviors in quartile 3 (Winston, Winston, et al., 1994). Although STDP therapists were actively intervening throughout treatment, the difference in patient behavior was only significant later in therapy. This study thus appears to support Davanloo's (1980) theoretical rationale for high activity level with attention to patient's defensive behavior in order to tackle resistance.

### Correlating in-session events and outcome

In line with Davanloo's clinical observations and teachings, the final collection of studies identified underlines the direct relationship between specific coordinated treatment events and treatment outcome observable through videotape analysis. McCullough et al. (1991) found that transference interpretations followed by patient affect were positively correlated to good outcome. Using the same dataset, a second study found a relationship between improved outcomes and

a reduction in patient defenses and increased affect responses over the course of treatment (Taurke et al., 1990). Winston, Winston, et al. (1994) reported several significant correlations between increased frequency in therapist responses addressing defense and improved patient outcomes. This offered some further indication that therapists need to be consistently active in confronting patient defense (Winston, Winston, et al., 1994). While limited by the correlational nature of the study designs, the results of these two studies offer some support for the theory that necessary ingredients of change in ISTDP include actively addressing patient defense, focus on the exploration of dynamic patterns as they emerge in the transference, experiencing underlying feelings, and reduction in patient defenses. More recently, evidence from both large sample research (Abbass, 2002b; Abbass, Joffres, Ogrodniczuk, & Hilsenroth, 2008) and micro-process analysis (Salvadori, 2010) provide further confirmatory findings. In an analysis of patient symptom change in a large naturalistic study across mixed disorders, Abbass (2002b) found that the peak degree of rise and experiencing of complex transference feelings predicted outcome and differences in cost effectiveness of treatment. This finding was then replicated across  $N = 300$  trial therapy sessions: significant correlations were found between peak degree of rise in the transference and interpersonal change and symptom-based change (Abbass, Joffres et al., 2008). Using a single case series replication design to study ingredients of change, Salvadori (2010) further illustrated the relationship between emotional mobilization and symptomatic and interpersonal change in ISTDP. Although the study designs are limited by their correlational nature, these findings add data to emerging evidence linking emotional focus/mobilization and outcome in brief dynamic therapies (Diener, Hilsenroth, & Weinberger, 2007). Tentative findings from the process analysis of two successful ISTDP treatments for patients with major depressive disorder suggested that patient acquisition of insight into defensive functioning may also be associated to symptom improvement between sessions. Paserpskytė (2012) found that both patient insight and degree of emotional experiencing were significant predictors of outcome. New, published data, offers preliminary evidence which suggests that treatment outcome in ISTDP may be better explained by the occurrence of a major unlocking of the unconscious during therapy rather than purely emotional mobilization per se (Town, Abbass, & Bernier, 2013). Having previously established a causal relationship between treatment and outcome in a naturalistic sample of 89 patients (Abbass, 2002a), further analysis found that patients experiencing at least one major unlocking reported significantly improved change scores on self-report measures of depression, anxiety, general psychiatric symptoms and interpersonal functioning. Furthermore, in the 12-month period post ISTDP, the average healthcare costs incurred by these patients was significantly less com-

pared to those without a major unlocking during therapy (Town et al., 2013). While validating the central supposition of ISTDP, that dominance of healing forces over those of resistance enables access and processing of underlying emotions, this research may also offer tantalizing clues for developing a better understanding around the process-outcome relationship in ISTDP.

### Summary of ISTDP efficacy research

Since Davanloo first presented his method in the 1970's, 21 outcome studies have been conducted referencing Davanloo's textbooks or technical articles in its treatment description. These are described below as are the results of a recently conducted meta-analysis of a subset of these studies (Abbass, Town, & Driesen, 2012).

**Mixed samples.** Four studies have reported on the efficacy of ISTDP in mixed diagnosed samples. In his initial case series, Davanloo (1980, 2005) reported that 83% of 172 mixed psychiatric patients responded to ISTDP. Symptomatic and personality changes were observed following pre-post assessment and gains were maintained at long-term follow-up (2–9 years). Secondly, Abbass (2002b) reported on a mixed sample of 166 patients. Eighty-six and 65% of patients treated no longer met clinical case criteria on measures for general psychopathology and interpersonal functioning. In a third study using a mixed, naturalistic sample, Abbass (2002a) found large effect sizes on self-report measures for symptom distress and interpersonal difficulties in 89 patients treated with ISTDP. Finally, Abbass (2004a, 2004b) reported that self-reported patient symptom distress improved significantly to below the clinical threshold at termination in a sample of treatments provided by psychiatry resident trainees under videotape supervision, although patient-rated interpersonal problems did not improve significantly.

**Personality disorders.** Most of the ISTDP efficacy research relating to a specific diagnostic category has been focused on the treatment of personality disorders (PD). Three RCTs been conducted in this area (Abbass, Sheldon, Gyra, & Kalpin, 2008; Winston, Laikin et al., 1994; Hellerstein et al., 1998). Both Hellerstein and colleagues (1998) and Winston, Laikin et al (1994) included small samples of patients ( $n = 15–25$ ) that were largely diagnosed with cluster C and PD not otherwise specified (NOS) and used Davanloo's early technique (Davanloo, 1980). Both studies reported a significant decrease in symptomatology following ISTDP, but no significant global rating differences when compared with alternative brief psychotherapies. On subscales analysis of a sample of this study group, ISTDP brought greater reduction in SCL-90 Depression, SCL-90 Psychoticism and Social Adjustment Scale Social and Leisure ratings while an alternative brief model brought greater reductions in SCL-90 Anxiety and Phobic Anxiety (Winston et al., 1991). Abbass, Sheldon, et al. (2008) treated a sample of PD

patients including some with borderline, paranoid and narcissistic personality disorder, with experienced therapists using Davanloo's updated technique (Davanloo, 2000). ISTDP resulted in significantly more improvement on symptom, interpersonal and functional measures in comparison to patients in the minimal contact control group. The control group accrued comparable gains when delayed ISTDP was provided and treatment gains were maintained in long-term (2.1 year) follow-up.

In addition to these three RCTs, Cornelissen and Verheul (2002) reported case-series data from a unique residential treatment program for personality disorder involving individual ISTDP sessions alongside other therapies. Patients' self-reported quality of interpersonal relationships improved at discharge, and increased at 1 year and long-term follow-up (3-years). In an extended naturalistic sample of all patients completing this program, large treatment effects were found on general psychopathology and general functioning measures at termination and long-term follow-up (10 years; Cornelissen, Smeets, Willemsen, Busschbach, & Verheul, in prep.). Four further published studies describe ISTDP treatments in samples composed of large percentages of patients with PD, with three naturalistic studies all reporting significant gains after ISTDP (Abbass, 2002b, 2006; Callahan, 2000) and one reporting significant larger reductions in general psychopathology and interpersonal functioning measures after a ISTDP trial therapy interview than after a standard intake assessment (Abbass, Joffres, & Ogrodniczuk, 2008).

**Somatic disorders.** Six studies reported on the effectiveness of ISTDP in the treatment of somatic disorders. In an RCT for urethral syndrome and pelvic pain, Baldoni, Baldaro, and Trombino (1995) reported significant improvement in urinary symptoms and pelvic pain in the ISTDP condition when compared to a medication treatment control. Another RCT concerning immune factors in a student population, reported statistically significant changes in the levels of blood associated immune cell counts in the ISTDP group relative to a verbal disclosure control group (Ghorbani, Dadsetan, Ejei, & Motiyan, 2000). In addition, four naturalistic studies reported that ISTDP was effective in reducing somatic symptoms with psychogenic movement disorder (Hinson, Weinstein, Bernard, Leurgans, & Goetz, 2006) chronic back pain (Hawkins, 2003), recurrent headaches (Abbass, Lovas, & Purdy, 2008), and medically unexplained symptoms in frequent attendees at emergency departments (Abbass et al., 2009).

**Mood and anxiety disorders.** Finally, three studies focused on the efficacy of ISTDP in the treatment of mood and anxiety disorders. First, Wiborg and Dahl (1996) compared ISTDP combined with clomipramine versus clomipramine alone for panic disorder in an RCT and found that all patients receiving the ISTDP combined treatment were free of panic attacks at termination, with 80% remaining symptom free at

18 month follow-up. When clomipramine was discontinued, the relapse rate was high and significantly greater in those who were not provided ISTDP. Secondly, Abbass (2006) studied ISTDP efficacy in ten patients with treatment resistant depression and reported large effects on depressive symptom measures and interpersonal problems, which were maintained at 6-month follow-up. Thirdly, Abbass (2002c) reported that five sessions of modified format of ISTDP based on enhancing emotional awareness resulted in reductions on measures of general psychopathology and interpersonal functioning for four patients with stable bipolar disorder, with general psychopathology measures entering the non-clinical range.

**Meta-analytic findings.** Based on this empirical literature, Abbass, Town, and Driessen (2012) identified 13 studies using common outcomes measurement and meeting selection criteria for meta-analysis. Table 1 summarizes these studies. Effect sizes were calculated for general psychopathology, depression, anxiety and interpersonal functioning outcome measures. Pre- to post-treatment effect sizes (Cohen's  $d$ ) were found to be ranging from .84 (interpersonal problems) to 1.51 (depression), indicating large improvements on all outcome measures. Post treatment to follow-up effect sizes were found to be non-significant for general psychopathology and interpersonal problems, indicating that gains were maintained at follow-up for these outcome measures (effect size could not be calculated for other outcome measures due to lack of data). Based on post-treatment effect sizes, ISTDP was significantly more effective than control conditions in a group of three studies ( $d = 1.18$ ; general psychopathology measures). A further sub-analysis found the more recent version of ISTDP ( $d = 1.37$ , 1990 and later) to yield greater effects than studies using the earlier version of Davanloo's methods ( $d = .58$ ,  $p < .05$ , before 1990). These findings support the effectiveness of ISTDP, but this result should be interpreted with some caution given the wide variation in studies and patient samples that were aggregated for the meta-analysis and the methodological limitations of the body of literature included (Abbass et al., 2012).

**Cost-effectiveness.** Eight published studies provided cost-effectiveness data (Abbass, 2002a, 2003, 2006; Abbass et al., 2010; Abbass, Lovas, et al., 2008; Abbass, Sheldon, et al., 2008; Cornelissen, Smeets, Willemsen, Busschbach, & Verheul, in prep.; Cornelissen & Verheul, 2002). A very short course of ISTDP for medically unexplained symptoms resulted in a net \$ 504 cost reduction per patient (Abbass et al., 2010) while controls had a non-significant cost increase. Reduced hospital and mental health service use was reported in two naturalistic studies ( $N = 89$ ; Abbass, 2002a;  $N = 93$ ; Cornelissen & Verheul, 2002): in the first, an 85% reduction in hospital services and 33% drop in physician costs was evidenced, and further costs savings were accrued over 3-year follow-up (Abbass, 2002a). In the second (Cornelissen & Verheul, 2002), there was a significant reduction in both hospital

Table 1. Study characteristics and outcome data included in meta-analysis (Abbass, Town, and Driessen, 2012)

Study	Study type	N	Condition	ISTD method	ISTDP format (Nse)	Assessment moments	Diagnosis	ISTDP pre-post ES ( $d$ ) <sup>†</sup>	ISTDP post-follow-up ES ( $d$ ) <sup>†</sup>	ISTDP vs control post-treatment ES ( $d$ ) <sup>†</sup>
Winston et al. (1994)	RCT	25 30 26	ISTDP BAP Waitlist	Davanloo (1980)	IND	Pre, post, 1.5 year follow-up	Personality disorder	0.84		0.61
Baldoni et al. (1995)	RCT	13 23	ISTDP CAU	Davanloo (1980)	IND (12-16)	4 year follow-up	Urethral syndrome & pelvic pain	1.73	-0.66	1.41
Hellerstein et al. (1998)	RCT	25 24	ISTDP BSP	Davanloo (1980)	IND (29)	Pre, post, 6 months follow-up	Personality disorder	0.27	0.05	
Callahan (2000)	Open	6	ISTDP	Davanloo (1990)	IND (60)	Pre, post	Mixed	4.92		
Abbass (2002a, b)	N-RT	166 17	ISTDP Waitlist	Davanloo (1990)	IND (14.9)	Pre, post waitlist	Mixed	1.17		1.27
Abbass (2002c)	Open	4	ISTDP	Davanloo (2000) Modified	IND (5)	Pre, post	Bipolar I disorder	1.91		
Hawkins (2003)	Open	47	ISTDP	Davanloo (1986)	GRP (8)	Pre, post	Chronic back pain	0.10		
Abbass (2004)	Open	56	ISTDP	Davanloo (1990/2000)	IND (8.9)	Pre, post	Mixed common mental disorders	0.68		
Abbass (2006)	Open	10	ISTDP	Davanloo (1987)	IND (13.6)	Pre, post, 6 months follow-up	Treatment resistant depression	2.16	0.26	
Hinson et al. (2006)	Open	10	ISTDP	Davanloo (1980)	IND (12)	Pre, post	Psychogenic movement disorders	1.66		
Abbass et al. (2008)	RCT	27 13*	ISTDP Minimal contact control	Davanloo (2000)	IND (27.7)	Pre, post, 2 year follow-up	Personality disorder	1.95	-0.03	1.04
Abbass et al. (2009)	N-RT	50 27	ISTDP CAU	Davanloo (2000)	IND (3.8)	Pre, post	Medically unexplained symptoms	0.58		
Cornelissen et al. (2002, in preparation)	Open	155	R-ISTDP	Davanloo (1980/1990)	IND (6 months)	Pre, post, 1-10 year follow-up	Personality disorder	1.07	-0.40	

Note. <sup>†</sup> The effect sizes in this column are averaging different general psychopathology, depression, anxiety and interpersonal functioning outcome measures. \* 27 patients total with 13 patients starting in waitlist then crossed over to ISTDP. ISTDP = Intensive short-term dynamic psychotherapy. BAP = Brief adaptive psychotherapy. CAU = Care as usual. BSP = Brief supportive psychotherapy. R-ISTDP = Residential ISTDP. GRP = Group therapy. IND = Individual. N = Number of participants. N-RT = Non-randomized clinical trial. Nse = Number of sessions in the ISTDP condition. Open = Open study (no comparison condition). RCT = Randomized clinical trial.

admissions and mental health appointments. Five studies reported reduced medication usage of 35% to 81.5% (Abbass, 2002a, 2006; Abbass, Lovas, et al., 2008; Abbass, Sheldon, et al., 2008). Significant reductions in medication usage were found in ISTDP treated groups versus waiting-list controls (Abbass, Sheldon, et al., 2008) and a treatment as usual group (Abbass, 2002b). Large savings from reduced disability claims were reported (Abbass, 2002a, 2006; Abbass, Lovas, et al., 2008; Abbass, Sheldon, et al., 2008) and the proportions returning to work in five studies (Abbass, 2002a, 2006; Abbass, Lovas, et al., 2008; Abbass, Sheldon, et al., 2008; Cornelissen & Verheul, 2002) were 94%, 80%, 82%, 100% and 32.9% respectively.

### Educational implications

Since the 1960s, Davanloo audio- and then video-recorded all of his sessions, which supported the technical developments described herein and education of others. Systematic use of video technology in ISTDP is central to verifying adherence, enhancing self-reflection and improving treatment quality. It enables single case and case series research and Davanloo has lauded it as an invaluable tool in his own discoveries, many of which were found on retrospective videotape review then replicated prospectively.

ISTDP training routinely includes small group, case-based video supervision of treatment process and content: the many benefits of this method have been previously reviewed (Abbass, 2004a). Closed-circuit training in which live observation and therapist feedback is offered is provided in some training programs. The use of audio-video symposia involving presentations of actual case material (e.g., Davanloo, 1979-2011) is also central to the dissemination of the method. This open system of case scrutiny by students and learners makes case review a laboratory of clinical study and quality improvement. Shame and anxiety are overcome fairly readily as this openness is just part of the training culture.

After formal training, therapists frequently report the helpfulness of continuing peer and self-review of tapes within their routine practice. This can help to reduce isolation, stagnation in growth and burnout that can happen in private psychological practice.

### Discussion

Thus, through thousands of hours and 40 years of videotape-based case study, Davanloo has afforded the field a comprehensive brief therapy model with new contributions to the metapsychology of the unconscious. While limited in depth and number, publications on process-outcome research have gone a distance toward corroborating some of Davanloo's findings and metapsychological theories.

A moderate amount of outcome research supports the application of ISTDP across a very broad range of psychiatric and somatic disorders. With regard to spe-

cific diagnostic groups, most research has been conducted in the treatment of personality disorders, where ISTDP generally results in improvements in multiple areas of functioning (symptomatic, interpersonal and functional) that are maintained in follow-up. An important strength of this body of literature is the diversity of centers, type of therapists, and patient populations that have tested ISTDP: these all support the potential generalized utility of this method.

However, various methodological limitations are apparent in this body of research as well, with many studies including small sample sizes and lacking comparison conditions, random assignment of patients to conditions, blind outcome assessors, and intention to treat analyses. Furthermore, therapist experience and measurement of treatment adherence were variable. These limitations must be taken into account when interpreting the studies' results: further rigorous study ISTDP in specific patient populations and compared to other treatment methods is warranted.

The beneficial effects of an open learning framework in cultivating a healthy educational environment to facilitate advanced psychotherapy skill acquisition bears underscoring. Our experience in applying the videotape workshop and supervision format has been quite positive now for almost two decades. An open learning process with linkages to outside therapists and therapy groups is essential to enabling implementation of a lasting program of this intensity within the university setting (Abbass, 2004b).

### Conclusions

Thus, ISTDP is a systematic set of approaches to treat a very broad range of complex and resistant patients. While methodological limitations exist, others after Davanloo have published a modest amount of qualitative and quantitative research that supports his basic concepts and furthers the evidence for efficacy and cost-effectiveness of the method. The brevity, breadth of focus and the existence of a potent trial therapy model add to the clinical utility of ISTDP.

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### Appendix A: Glossary of terms

- Central dynamic sequence.** Typical flow of processes that enable mobilization and dominance of the unconscious therapeutic alliance over the resistance.
- Complex transference feelings.** Mixed emotions directed toward the therapist which link to complex emotions related to past interrupted attachments.
- Crystallization of resistances.** When defenses organize themselves as a barrier between the patient and therapist, interrupting the collective in-session task.
- Fragile character structure.** A personality structure with poor capacity to integrate complex emotions: at a rise in feelings he or she has a threshold at which he or she will cognitively disrupt or use primitive defenses (e.g., projection, projective identification, splitting).
- Graded format.** A procedure to build anxiety tolerance through cycles of mobilization of complex feelings and intellectual recapitulation about the process.
- Head on collision.** Comprehensive clarification and challenge to resistances in the therapy relationship coupled with encouragement to overcome the resistances.
- Intrapsychic crisis.** The psychic state in which the patient's resistances are in opposition to healthy drives emerging within him or herself.
- Major resistance.** Defenses against the experience of murderous rage and guilt about the rage.
- Multidimensional structural changes.** An integrative, construction process to (1) Build capacity to experience and tolerate anxiety, (2) Experience and tolerate emotions, (3) Reduce reliance on regressive defenses and increase ability to isolate affect, and 4. Recognize the linkages between past and present feelings, anxiety and defenses.
- Pressure efforts.** Efforts to focus the patient toward emotionally laden, avoided content areas or efforts to focus the patient to be emotionally engaged in the therapy session.
- Punitive Superego.** A propensity to self-punish in relation to having unconscious guilt-laden rage toward loved ones.
- Resistance defenses.** Resistance operating in the therapy relationship.
- Spectrum of psychoneurotic disorders.** A spectrum comprised of neurotic patients who do not manifest primary cognitive perceptual disruption and related primitive defenses.
- Spectrum of patients with fragile character structure.** A spectrum of patients who manifest cognitive perceptual disruption, projection, projective identification and other primitive defenses.
- Tactical defenses.** Minor defences that abate with minor efforts such as bypassing, blocking or countering.
- Unconscious anxiety.** Anxiety signaling underlying mixed attachment related feelings out of the person's awareness. The three primary manifestations are striated muscle tension, smooth muscle tension and cognitive perceptual disruption.
- Unconscious defenses.** Defense mechanisms operating at a level outside of a person's awareness to avoid painful attachment related feelings and associated unconscious anxiety.
- Unconscious therapeutic alliance.** Healing force within resistant patients that manifests as visual imagery and clear linkages to unconscious core content.
- Unlocking the unconscious.** The psychic state in which the unconscious therapeutic alliance is dominant over the resistance.

Received January 16, 2012

Revision received June 30, 2012

Accepted July 31, 2012