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Chapter · January 2015

DOI: 10.1515/9783110471014-009

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## 7 Intensive Short-term Dynamic Psychotherapy (ISTDP)

Intensive Short-term Dynamic Psychotherapy (ISTDP) is one of a group of modern psychodynamic therapies that have been developed over the past 50 years. While firmly rooted in psychoanalytic theory, they are briefer than analytic treatments and require a more active stance from the therapist. ISTDP is closer to the instrumental<sup>3</sup> than the relational<sup>4</sup> view of therapy and nearer the intrapsychic than the interpersonal end of the spectrum.

Like other dynamic psychotherapies, ISTDP is based on the understanding that a patient's presenting difficulties are adaptations to anxiety or psychic pain caused by intrapsychic conflicts (Coughlin Della Selva, 2004; Frederickson, 2013; Ten Have-De Labije & Neborsky, 2012). It is *experiential*, in that half of the therapeutic task is to contact the patient's conflicted emotions as *here-and-now bodily experiences*, the second half being cognitive insight into how avoiding such experiences was the root cause of the patient's difficulties (Davanloo, 1990; Malan, 2000). The approach, developed by Davanloo (Davanloo, 1990, 2001, 2005), is based on Freudian theory, but applied through a set of techniques he claims remove the problems of therapeutic resistance. Malan (1980) suggests that ISTDP is the most significant step forward in psychodynamic psychotherapy since Freud, concluding that "Freud discovered the unconscious; Davanloo has discovered how to use it therapeutically" (p.23).

Put simply, intrapsychic conflicts are defined as defences against painful hidden feelings, which evoke anxiety<sup>5</sup> when approaching conscious awareness (Malan, 1979). Within ISTDP, 'hidden feelings' are summarised as the mixed emotions arising towards a caregiver when the attachment bond is ruptured: initial love and connection give way to protest and rage, then guilt about the rage, then grief and deep sadness about the loss of love.

Thus, the person is conflicted: one part of them wishes to contact and work through these anxiety-provoking attachment emotions, another acts to suppress them. The fundamental therapeutic task is to encourage the former as the path to therapeutic change, and help the patient disown the latter – the cognitive-behavioural patterns perpetuating their difficulties. It is a process of pressing toward emotion,

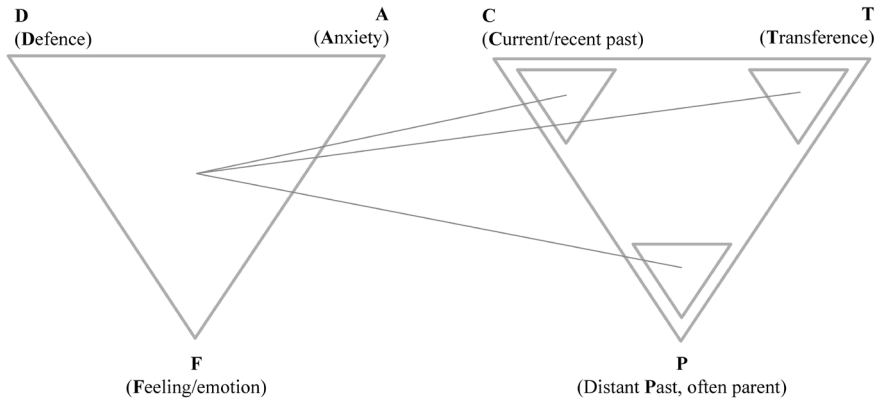
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<sup>3</sup> The notion that personal change occurs through specific techniques delivered on the basis of a good therapeutic relationship.

<sup>4</sup> The notion that personal change occurs through a good therapeutic relationship delivered via the medium of specific techniques.

<sup>5</sup> This utilises Freud's second theory of anxiety, where forbidden feelings and wishes stimulate a rise in anxiety; such anxiety acting as a signal for defences to be activated, which ward off the 'dangerous' emotions, and thus dampen anxiety (Erwin, 2002)

regulating the anxiety evoked, and blocking the maladaptive defences that hinder this process, summarised by Malan's triangle of conflict, which the Triangle of Person explains was formed in the past, and repeated in the patient's current life, as well as in the here-and-now of their relationship with their therapist (see Fig. 7.1, adapted from Malan, 1979).



**Figure 7.1:** Left: Triangle of Conflict, illustrating the conflict between defence, anxiety, and hidden feeling. Right: Triangle of Person, illustrating that conflicts formed in the distant past generalise to current or recent and transference relations

A hallmark of ISTDP is the precision with which emotions, anxiety, and defence are operationalised and worked with (Coughlin Della Selva, 2004). For an emotion to be experienced, it must be:

- labelled (e.g., guilt),
- felt as a physical sensation (e.g., sinking heavy feeling in chest/upper stomach), and
- its impulse explored in fantasy (acting to put the situation right).

Full experience often precipitates the next attachment emotion (e.g., anger leads to guilt, guilt to sadness, sadness to love).

Anxiety signals that such emotions are surfacing; and this experience is diagnostic of how quickly painful feelings can be worked through. If the therapist observes striated muscle activity, this signals that the patient can bear the emotions being activated, giving a 'green light' for further pressure. Smooth muscle activity or cognitive-perceptual disruption suggest easing off pressure toward feelings as this may be too anxiety-provoking for the patient (see Tab. 7.1).

**Table 7.1:** Pathways of anxiety (adapted from Coughlin Della Selva, 2004)

Striated Muscle Anxiety	Smooth Muscle Anxiety	Cognitive-Perceptual Disruption
Hand clenching	Bladder urgency	Drifting, dissociation, confusion
Tension in arms, neck, shoulders, and head	Gastrointestinal – IBS	Visual blurring/narrowing of visual field.
Sighing respiration	Vascular – migraine headache	Fainting, freezing, fugue states
Abdomen, legs, feet tense, and fidgeting	Bronchi – asthma	Hallucinations
	Localised or generalised pain	
	Auto-immune disorders	

Defences may be either tactical ways of avoiding interpersonal contact with the therapist, or more formal character structures (Coughlin Della Selva, 2004; Frederickson, 2013), as summarised in Table 7.2.

**Table 7.2:** Types of defence (adapted from Coughlin Della Selva, 2004)

Tactical Defences		Formal (Character) Defences	
Non-verbal	Verbal	Repressive	Regressive
Avoiding eye contact	Vagueness	Intellectualisation	Projection
Arms and legs crossed	Diversification	Rationalisation	Denial
Smiling and laughing	Sarcasm	Minimisation	Dissociation
Weepiness	Argumentative	Displacement	Acting out
Temper tantrums	Contradictory	Reaction formation	Somatisation
	Rate of speech		

Davanloo conceptualised the Central Dynamic Sequence (discussed further below) as a systematic method for how, in an idealised therapeutic scenario, the therapist can help the patient overcome their defensive processes in order to contact their hidden attachment emotions (Tab. 7.3, adapted from Abbass, Town, & Driessen, 2013; Davanloo, 1990, 2001, 2005).

**Table 7.3:** The Central Dynamic Sequence (adapted from Davanloo, 2001)

<b>1 Inquiry</b>	Asking about client’s inner emotional difficulties, history of the difficulties, severity, significant life events, goals; establish will to explore emotions.
<b>2 Establish triangle of person</b>	Focus on a specific example of when these difficulties were experienced; either in current life, transference relationship, or in past.

**Table 7.3:** The Central Dynamic Sequence (adapted from Davanloo, 2001) (continued)

<b>3</b>	<b>Working triangle of conflict</b>
	Encourage client's experience of feelings, block or restructure defences that prevent feelings from rising, regulate anxiety into striated pathway. Level of intensity rises to pressure, challenge, and head-on-collision as necessary.
<b>4</b>	<b>Breakthrough</b>
	Unconscious therapeutic alliance and patient's desire to experience emotions in transference, current, or past, overcomes the defensive parts of psyche that avoid emotion and perpetuate difficulties.
<b>5</b>	<b>De-repression</b>
	As the unconscious is unlocked, there is a de-repression of freely associated memories, meanings, and images that have dynamic significance.
<b>6</b>	<b>Interpretation</b>
	Cognitive linking together of de-repressed material into a coherent more conflict-free narrative, that better makes sense of the client's internal world. Focus on linking the triangle of person and conflict to build new insights.

## 7.1 Historical Origins

Davanloo's method, built on over 40 years of analysing videotaped sessions (Abbass et al., 2013), is immersed in Freudian theory, addressing the unconscious and feared 'taboo' emotions towards attachment figures, thus also owing a great debt to Attachment Theory (Bowlby, 1989). It echoes with the short-term, body-oriented work of Alexander and French (1946), Ferenczi and Rank (1925) and Gestalt therapy (Smith, 1976), and builds upon the short-term approach of Davanloo's mentor, Peter Sifneos (1987). David Malan has been instrumental in the history of short-term dynamic psychotherapies, and since the late 70s has been a great advocate for ISTDP (Gustafson, 1986). Now, Davanloo's work has inspired a broader range of Experiential Dynamic Therapies, in which many of his former students have blended his approach with their own. Examples include Accelerated Empathic Therapy (Fosha, 1992), Affect Phobia Therapy (McCullough et al., 2003), Experiential Short-Term Dynamic Therapy (Osimo, 2003), and Attachment-Based ISTDP (Ten Have-De Labije & Neborsky, 2012).

## 7.2 Unique Features

A first-time observer of ISTDP would see a number of distinctive features. Practically, there is an initial 2-3 hour 'trial therapy' session in which the therapist concentrates

on intervention and assesses the patient's response. Research indicates this as the best way to assess suitability for treatment (Gustafson, 1987), with factors such as diagnosis or severity of trauma having little predictive value. It is also likely that sessions are videotaped, for the therapist to review and reflect on. Qualitatively, there is an unerring, moment-by-moment focus on the patient's inner world – aspects which seek true expression and experience ranged against those parts that wish to hide from and avoid such deep contact with the 'true self.' The therapist's interventions are highly active and at first glance confrontative, as 'minimum respect' is shown to the defences that inhibit the patient's true self and perpetuate their suffering (Davanloo, 1990). Furthermore, attention is paid not just to the 'conscious alliance' of patient and therapist, but signals from the 'unconscious alliance' – such as the manner in which the patient delivers their words, double meanings, gestures, body language, signals of anxiety, physical symptoms etc. – that give the therapist clues to unconscious emotions (Davanloo, 1990, 2001). Altogether, the observer may begin to see how ISTDP is distinctive by blending elements from other approaches into a range of interventions that cohere around Davanloo's (2005) 'metapsychology of the unconscious'. Although this is underpinned by Freudian principles, Malan (2010) notes a sharp distinction between ISTDP and traditional analysis:

“Instead of allowing the client's defences to operate and then offering interpretations at a time when the client is receptive, an ISTDP practitioner seeks to help the client confront and disown their defences as they are activated, facilitating the here-and-now experiencing of the emotions which they repress.”

This difference, he reflects, is justified by the finding that defences are less impenetrable, and the therapeutic relationship far stronger, than first thought.

### 7.3 Empirical Evidence

The empirical base for ISTDP is still developing. Abbass, Town, and Driessen's (2013) review found 21 outcome studies pertaining to personality disorders, somatic disorders, depression and anxiety disorders, and mixed samples that reference Davanloo's method in their description of treatment. Of these studies, 13 (including 5 RCTs), met criteria for meta-analysis and used common outcome measurements. Effect sizes (Cohen's *d*) ranged from 0.84 for interpersonal problems to 1.51 for depression, and for the 5 studies with follow-up data (general psychopathology and interpersonal problems), these effects were maintained at follow-up ranging from six months to ten years. More widely, a 2014 Cochrane Review (Abbass et al., 2014), updating an earlier review (Abbass, Hancock, Henderson, & Kisely, 2006), included 33 studies of short-term psychodynamic psychotherapy (STPP) for 2173 randomised participants with common mental health disorders, in which problems with emotional regulation

were purported to play a causative role. Across general, somatic, anxiety, and depressive symptoms (plus interpersonal problems and social adjustment), there was significantly greater improvement in the short and medium term (with the exception of somatic symptoms in the short-term) relative to controls. Although effect sizes increased at long-term follow-up, some effects did not attain statistical significance. More specifically, post-hoc tests revealed that effect sizes were significantly greater for those studies using Malan/Davanloo's approach than other STPP methodologies. However, given the heterogeneity of samples, study types, and methodological limitations of the original research, the authors advise caution when interpreting these promising results.

## 7.4 Critiques and limitations of ISTDP

Despite the above, empirical support for ISTDP is still limited. Although Davanloo's techniques have evolved to include more 'fragile' patient populations (Abbass et al., 2013; Whittemore, 1996), it is not recommended for those with poor impulse control or with active psychotic symptoms. However, suitability is largely judged on response to the initial trial therapy session. As an emotionally challenging approach, ISTDP demands great ability to tolerate intense emotion from both therapist and patient, and, for the therapist, awareness of counter-transference (Abbass, 2004). There is a danger of using specific ISTDP techniques without sufficient understanding, training, and supervision. To press on feelings when the patient is too anxious, or using regressive defences, can increase suffering. Applying specific factors too frequently, without paying sufficient attention to common factors, can also lead to misalliances (McCarthy, 2009). Furthermore, without reflective capacity, the abuse of therapist-patient power differentials and the devaluation/idealisation of the model or the therapist are potential risks; indeed, Gustafson (1986) caricatures Davanloo's approach as akin to 'revelatory religious experience' – the 'saviour therapist' offering the promise of transformative experience to the suffering patient. More broadly, debate about the validity and utility of psychoanalytic thought remains; however, this is now modified by new evidence in the field of neuroscience (Johnston & Malabou, 2013). Nevertheless, there is sound evidence for ISTDP's efficacy, consistent with trans-theoretical models, suggesting that intense emotional experience and cognitive re-appraisal are both necessary for therapeutic change (Ecker, Ticic, & Hulley, 2012).

## 7.5 Formulation in Action

The chronological narrative of Molly's history and current predicament meshes well with the developmental perspective of a psychodynamic theoretical frame. The account appears much more structured than the story that a client would normally

tell, but, reading through it, our mental process is similar to that of listening during an assessment – organising and reorganising material as it emerges, noticing gaps and ruptures in the narrative, and trying to get empathic access to her experience while monitoring our emotional reactions.

Starting with her current circumstances, the first thing we notice is Molly's relative dearth of intimate relationships (single, lives alone, one close friend whom she talks to once a week on the phone, use of social media, solitary hobbies). Her feelings towards her parents make us wonder whether she generally protects herself against demands she perceives as excessive (and might feel guilty about not being able to meet) by avoiding close contact. This leads to an initial dynamic hypothesis about withdrawal as an adaptation to (defence against) the anxiety arising from a conflict between a wish (to be close) and a feared reaction (to be taken advantage of). This preliminary understanding will be modified in light of subsequent information.

In considering her early personal history, we wonder about Molly's ambivalent feelings about her sister Ella. It must be difficult for her, due to her agonising conflict between love and anger, to feel reliant on someone of whom she is jealous, possibly envious. When she allows herself to do so, she fears she might be unable to contain her aggressive impulses and end up hurting someone she loves. Here we notice that our emotional engagement changes – something of her distress arrives in us, possibly helped by the direct quotes. Now we need to ask ourselves whether her experience resonates with our own. Having excluded that potential cause for our reaction, we are left with the hypothesis that we have been invited into a complementary countertransference, providing in our minds something that meets Molly's internal need.

Continuing, it seems that Molly learned a model of intimate relationships from her parents: where getting too close can be destructive and hostile feelings are best expressed at a distance. In their effort to modulate aggression, they may have controlled affection too, leading them to perceive Molly as overly emotional, and Molly experiencing home life as lacking warmth. We also would assume that her emotional demands might have stirred up her parents' mixed feelings, who would have defended themselves against their own ambivalence towards intimacy, first through criticism – to express their rage – and then guilty withdrawal to protect Molly from the consequences of their feelings. We also find ourselves speculating that Molly perceived an absence of unconditional acceptance from her parents, notably her mother. Maybe the best way she could secure love and attention was by being a self-reliant high achiever, and could only safely express her dependency needs when being physically unwell. Having little confidence that others would give her freely what she needed, being controlling and demanding would appear a reasonable – and sometimes successful – strategy.

From the account of her early adulthood it appears that Molly's adaptation of high achievement initially worked well, but that she developed another adaptation – social withdrawal – to cope with the anxieties about mixed feelings created by exposure to others. It is not clear why this might be so, but an initial hypothesis would be that she

can easily feel shamed; maybe something resonates with her experience of mother's disappointed looks. As being prone to shame is often linked with high self-criticism, we now wonder about early interpersonal experiences of being criticised that she may have taken on board. The intrusion on her sexual encounter with Jack would have served to sensitise her further to shame – because of her engaging in self-attack rather than healthy anger to express her hurt about the incident – and may have evoked her conflict regarding the potential destructiveness of intimate contact. It is possible that, when feeling vulnerable, she tried the familiar strategy of being demanding and controlling but was unsuccessful with Jack. This would have triggered more hurt and reactive anger about Jack's unavailability, leading to further self-attack and shame. This maladaptive process reinforces the idea that others shame her, rather than her shaming herself, recreating an old pattern we imagine to have originated in intimate moments with her parents. This would serve to further strengthen her embarrassment and fear of being ridiculed, to the point where social withdrawal appeared the only possible coping strategy.

The account of Molly's adulthood shows her adaptation of high achieving becoming less productive (working as a classroom assistant rather than a teacher) and increasingly undermined by her interpersonal withdrawal. In the relationship with Danny, her propensity for being seen as controlling and demanding now becomes clearer as a defence against the abandonment anxiety arising from a conflict between her wish to be close and special and her experience of being rejected, leading to intense mixed feelings toward him. As before, this unhelpful adaptation brings about the feared consequence, leading to her taking an overdose. We would understand this as a desperate attempt to avoid recognising her murderous feelings towards Danny by turning them against herself, in a final effort to protect the attachment.

So far, we notice two gaps in Molly's narrative: The absence of her father and the lack of any expression of rage. Maybe her idealisation of Danny links to her early experience of father not having fulfilled his required role of being desirable but containing the desire – either by being absent or by not providing safe boundaries. Ella seems the one person whom Molly feels safe to argue with. In her absence, she is turning her hostility towards herself, leading to her hospitalisation. The ward staff's split attitudes towards her possibly reflect her abandonment conflict – they either react against her frantic efforts to belong, or relate to her loneliness.

Molly's time with her parents, after being discharged from hospital, clarifies her use of achievement to secure parental approval. This can now be understood as an adaptation (reaction formation) to the anxiety arising from her anger at excessive demands, both from others and from herself. It serves her well for a time, allowing her to succeed at work and be content at home, but breaks down in the face of interpersonal conflict, possibly mirroring the dynamic between herself and Ella.

Molly's initial attempts to resolve her problems – replacing interpersonal contact with internal dialogue and trying to control her appetites – are unsuccessful. Her

childhood success in eliciting care from the family doctor possibly facilitates seeking help from her current GP, resulting in her referral for psychological therapy.

The initial consultation shows an unexpected readiness to move towards change. She appears emotionally engaged, willing to express anger (at her therapist, her parents, and herself), and openly demonstrates her conflict between wanting to be needy and self-reliant at the same time. It is possible that she uses her defence of high achieving (being a good patient) to cope with her anxiety about being looked at critically by the therapist. We expect that subsequent sessions with an ISTDP therapist would stimulate her defence of withdrawal.

The important disclosures in the subsequent sessions confirm and sharpen up the preliminary hypotheses. The experience of sexual abuse would have confirmed her sense that being close to someone makes her vulnerable to being exploited and hurt, possibly exacerbating her sense of intimacy as being potentially destructive, and reminding her of her own destructive feelings towards others that need to be kept locked down at all costs.

At this point we can think of two conflict formulations, each relating to an aspect of Molly's current predicament:

1. Her desire to be close and taken care of, which is activated when others are getting close to her, is in conflict with her experience of being taken advantage of. She protects herself and others against the anxiety-provoking feelings consequent to being hurt in the past by withdrawal or acting out.
2. Her wish to be special to another is in conflict with her experience of being critically evaluated and conditionally loved. She protects herself and others from the intense mixed feelings connected to previous rejections by striving hard to achieve. When she fails in this, she protects herself and others even further against the rage about her needs not being met, by trying harder to please and, when this fails, by turning her anger against herself.
3. We can see how her repeated adaptive reactions have developed into a 'character defence' – a habitual way of responding to perceived threats (see Table 7.2). It is maintained by 'cyclical maladaptive patterns' (Strupp & Binder, 1984), where her expectations of others lead her to dysfunctional interpersonal interactions that serve to confirm and strengthen her negative expectations. We would expect these patterns to be enacted with her therapist.

### 7.5.1 Initial Formulation Diagram

Our initial formulation is diagrammatically represented in Figure 7.2. It serves as a preliminary guide to intervention, as shown in the right-hand column, but will be updated and modified as we observe how Molly reacts in sessions.

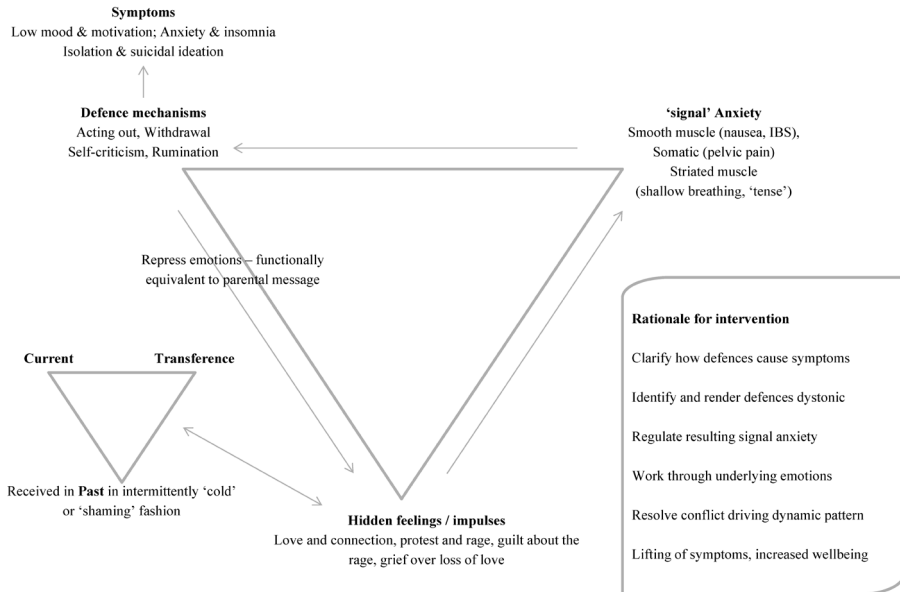


Figure 7.2: Initial formulation

### 7.5.2 Intervention Objectives

From an ISTDP perspective, we understand that the patient's symptoms and presenting problems are the inevitable result of excessive reliance on defences against anxiety-provoking feelings. While these defences often had an adaptive function in the past, their automatic and habitual use undermines the patient's current functioning. Without awareness of the feelings triggering the anxiety and driving the defences, the patient is 'driving blind' and is no longer making conscious choices. Therefore, the therapeutic task involves helping patients face and experience, rather than avoid, their conflictual feelings about the present and the past, as rapidly as possible and to the greatest degree that they can bear (Davanloo, 1990). Davanloo's research suggests that the visceral experience of anxiety-provoking feelings, in the here and now, serves as a trigger, *unlocking the unconscious*<sup>6</sup> and revealing the core of the patient's conflicts (Davanloo, 1990, 2001, 2005). In this way, the unresolved feelings from the past become clear and are available for re-evaluation. Patient and therapist can then

<sup>6</sup> Theoretical concepts specific to Davanloo's ISTDP (1990, 2001, 2005) will be italicised from here on to distinguish them from any colloquial meaning. Definitions of key concepts are provided as a glossary in Table 7.4

discover the true nature of the underlying cause of the patient's distress and resolve it at the source. Once these conflicts are consciously understood and their relationship to the patient's symptoms and suffering clarified, a process of working through and resolution of the presenting problems can take place. During this process, it is essential that patients gain insight into their own inner dynamics – in particular, the ways in which their inner conflicts (Triangle of Conflict; Fig. 7.1) are repeated in their interpersonal relationships (Triangle of Person; Fig. 7.1).

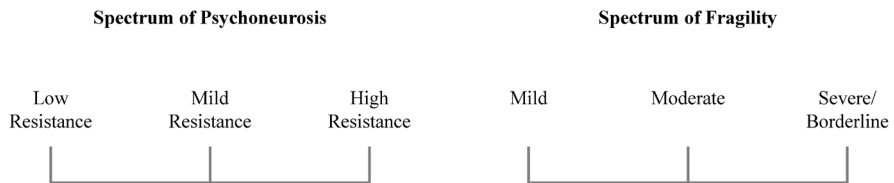
The interventions used in ISTDP are designed to create in-session mobilisation of emotional processes that lead to a rise in *complex transference feelings* (CTF). The specific mechanisms that lead to this rise are thought to be the simultaneous increases in *treatment resistance*, *unconscious anxiety*, *therapeutic alliance*, and the experience of feelings (Davanloo, 2005; Johansson, Town, & Abbass, 2014). Taken together, these mechanisms represent the unique approach of ISTDP and, importantly, its theoretical roots directly underpin them; they have been empirically validated and have been found to maximise therapeutic effectiveness. A patient's rise in CTF indicates that a painful unconscious conflict can be brought to the surface. Our job as therapists is to identify and intensify this conflict in order to get to the buried feelings underneath. The feelings being mobilised (CTF), together with the therapeutic alliance, represent one of two key forces seen to be fundamental in accessing unresolved attachment emotions; Davanloo (1987) termed this the *Unconscious Therapeutic Alliance* (UTA). The UTA is the healing force within the patient that wants to obtain emotional freedom and brings forth important dynamic information that both the patient and therapist can use to get to the core emotional conflicts driving the problems. However, as the UTA and CTF rise, there is an opposing force termed *Unconscious Resistance*, which is triggered by unconscious anxiety. This can be understood as any unconscious defence that operates in the therapy relationship to keep painful, attachment based, anxiety-provoking feelings out of awareness. If this force remains, it begins to *resist* the therapeutic task and prolong the patient's suffering. Therefore, a key part of this approach is to actively weaken the resistance in order to allow the attachment-based feelings to rise, leading to an *unlocking of the unconscious*.

### 7.5.3 Potential Problems

In order to assess the unique problems that each patient seeks help for, a *psychodiagnostic evaluation* is undertaken. This *dynamic* process is guided by the patient's response to each therapeutic intervention, and highlights the feelings that the patient is in conflict with, their unconscious anxiety channels, the defences that create the symptoms, and the patient's self-observing capacity (Frederickson, 2013). Based on the severity of response across these domains, Davanloo (1990, 2005) defined two spectra of patients suitable for ISTDP. The first is called the *Spectrum of Psychoneurotic Disorders* and the second is the *Spectrum of Fragility* (see Fig. 7.3).

The position on the spectra indicates the ease with which a breakthrough to the unconscious can be achieved and the different types of interventions that may be required (e.g. *pressure, challenge, head-on collision, and/or cognitive recapitulation*). Davanloo (1990, 2005) observed through his empirical research a strong relationship between a patient's attachment traumas, the intensity of reactive pain, rage, guilt about the rage, and their patterns of anxiety and resistance. In essence, the greater the magnitude of these conflicted feelings, the more severe the anxiety, and the more entrenched the defences to avoid experiencing these feelings (Abbass et al., 2013). Those placed on the first spectrum tend to have had less severe attachment trauma, yet display more treatment resistance due to their ability to defend against feelings. They have more access to striated anxiety, and use more mature defences such as repression. Those placed on the latter spectrum tend to have had more insecure attachments, making it harder for them to defend against their feelings, so their anxiety becomes dysregulated and is often channelled into non-striated pathways, with the use of more primitive defences such as acting out.

It is only following a detailed psychodiagnosis that the nature of the therapeutic task can be fully realised, and the core elements of the treatment process tailored, to ensure the therapeutic objectives are achieved as efficiently and effectively as possible.



**Figure 7.3:** Spectra of Psychoneurosis and Fragility (Adapted from Abbass, Town, & Driessen, 2013)

#### 7.5.4 Indicators for the Achievement of Intervention Objective

Put simply, ISTDP aims to replace symptoms and pathological defences with healthier adaptations that benefit the patient (Malan & Coughlin Della Selva, 2007). In order to achieve this, Davanloo outlined the Central Dynamic Sequence, which, broadly speaking, is designed to create an intrapsychic crisis where the dominance of the patient's healing forces over those of the resistance leads to an *unlocking of the unconscious*. During an *unlocking*, the patient experiences intense complex feelings towards the therapist or other current figure. This experience is linked to feelings towards past figures and emotion-laden memories about painful feelings, situations, and events from the past, such as adverse childhood experiences. At this point,

clear links, memories and images associated with core attachment and other related traumas become accessible (Town, Abbass, & Bernier, 2013). During this process, unconscious anxiety and defences are significantly reduced in favour of emotional awareness and processing, enabling the working through and healing of previously unresolved emotions in a new, healthy, and mature way (Davanloo, 1980). One may surmise that the event of *unlocking of the unconscious* sets the stage for psychotherapeutic change during ISTDP, and recent research suggests this to be the case (Johansson et al., 2014; Town et al., 2013).

### 7.5.5 Effectiveness

Davanloo (1990) stated that he believed the therapeutic effects found within ISTDP were “uniquely effective” and that those effects were produced by “specific rather than non-specific factors”. As discussed, the effectiveness of ISTDP is determined by the patient’s response to the specific interventions employed throughout the Central Dynamic Sequence. This sequence has been empirically associated with persistently effective outcomes across a range of disorders (Abbass et al., 2013; Davanloo, 2005). Immediate changes are often most noticeable in the *unlocking* and the *working through* stages, with longer term change found in follow-up interviews over months and years (Abbass, 2002a, 2002b; Coughlin Della Selva, 2006; Davanloo, 1990).

During these stages, key processes associated with change are observed, including: de-repression of memories, experiencing and gaining insight into painful emotions, and consciously modulating feelings. These outcomes are thought to weaken unconscious associations and connections, and have been consistently associated with measures of physical and emotional health (Coughlin Della Selva, 2004; Town et al., 2013). As patients become more conscious of their feelings and behaviours, without undue anxiety or defensive processes getting in the way, there is an increase in psychological flexibility and the opportunity for adaptive choices to be made. This, in turn, makes way for major therapeutic benefit, including: symptom relief, character change, improved relationships, and emotional freedom. Coughlin Della Selva (2004, p. 171) highlighted that the depth and stability of any changes are put to the test when a patient faces a conflictual situation and demonstrates the following:

- a. reduced anxiety
- b. reduced reliance on defensive processes
- c. increased emotional activation and affective expression
- d. cognitive and emotional insights into the relationship between the Triangle of Conflict and the Triangle of Person
- e. a sense of hope and mastery that overrides feelings of helplessness
- f. increased adaptive capacity indicating psychological growth

As the original problems the patient sought help for are resolved, these outcomes can be observed as occurring automatically in response to situations inside and outside of therapy. When this happens, it suggests that transformational change has been achieved, whereby new learning has replaced old implicit associations, leading to deep, profound, and lasting change (Ecker et al., 2012).

### 7.5.6 Practical Interventions

The initial phases of Molly's ISTDP assessment would involve establishing an intrapsychic focus and enquiring into the nature of the problems she is experiencing. Gaining an internal focus is crucial; without it no psychotherapy can take place. The enquiry phase would consider, in detail, the most recent precipitant to Molly's problems, as this is likely to generate important information regarding the nature of her inner conflicts (Malan & Coughlin Della Selva, 2007). From the outset, the therapist is active and creates an atmosphere of emotional engagement, which constitutes the start of the phase of *pressure* (Davanloo, 1990).

*Pressure* is a series of tailored interventions that serve to bring the visceral experience of feelings, patterns of defences, and/or anxiety to light (Abbass, Joffres, & Ogrodniczuk, 2008). In the early stages, we put *pressure* on the patient to be specific, to examine their internal world, and to engage with the therapist in this endeavour. Doing so activates the attachment system and thus each area of the Triangle of Conflict. As signals of unconscious anxiety or defence emerge, they are carefully assessed and this determines how the therapist should proceed; if Molly responds with striated anxiety we examine the defences she has been using and link these defences to her presenting problems. We help her see how her defences have been hurting her and encourage her to relinquish them in order to *unlock* her true feelings. If Molly responds in ways that indicate fragility in her character structure, our interventions would focus on building her ego adaptive capacity by oscillating the interventions of *pressure* and *cognitive recapitulation*. This process is designed to bring multidimensional psychic and cognitive integration, as well as structural changes, so that Molly's capacity to withstand her unconscious anxiety and the painful feelings underneath is increased before any *unlocking* can take place (Davanloo, 1990, 2005).

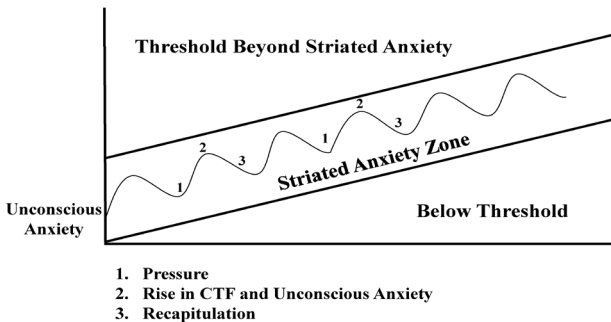
### 7.5.7 Techniques

In order to identify what technical interventions one might need to apply, the first major task is to determine Molly's discharge pattern of anxiety. As we have not had the opportunity to assess Molly's response to intervention, we are not able to undertake an accurate *psychodiagnostic evaluation*. However, for the purposes of this chapter,

we can consider the information we have been given and speculate how we might proceed.

Molly has been complaining of nausea and has a recent diagnosis of idiopathic pelvic pain and Irritable Bowel Syndrome (IBS); in response to situations at work, Molly has also reported experiencing ‘butterflies’ in her stomach and needing the toilet more often. These functional and somatic symptoms can indicate a pattern of unconscious anxiety that is channelled into the smooth muscles (Abbass, 2005). We also have evidence that instead of experiencing feelings, Molly tends to either act out or internalise them, for instance by taking an overdose of painkillers, becoming tearful when discussing her situation at work, expressing anger through confrontation, criticism, temper tantrums, and internalising anger through heavy self-criticism and self-blame. These defences would be considered regressive and self-punishing. We are also made aware of several interpersonal interactions, which have culminated in the unhelpful and maladaptive response of withdrawal. Collectively, this information suggests that Molly’s presentation is complex, with low tolerance across a number of domains, including: anxiety tolerance, emotional tolerance, and tolerance for emotional closeness and intimacy.

Consequently, a stepwise approach is indicated, and this would be applied through the graded format of ISTDP (Coughlin Della Selva, 2006). In the graded format, cycles of *pressure* (1) are followed by a rise in *CTF* and *Unconscious Anxiety* (2). When the anxiety approaches the threshold beyond *striated*, *pressure* is reduced and *recapitulation* of the process is performed (see Fig. 7.4).



**Figure 7.4:** The graded format of ISTDP (adapted from Abbass & Bechard, 2007)

As soon as anxiety returns to a tolerable state (striated zone), gentle *pressure* is applied again; whenever anxiety is too high, “depressurizing” techniques are employed once more (Coughlin Della Selva, 2004). Each round should involve a slight increase in intensity, thus building, in a graded fashion, Molly’s ability to tolerate her anxiety,

feelings, and impulses directly. Consolidating insights into her internal dynamics is achieved by repeated cognitive analysis of the process. Once Molly's discharge pathway of anxiety has fully shifted to the striated muscle system, higher levels of *pressure* and challenge as per the standard format of ISTDP can be applied (Davanloo, 1990). The process of recapitulation reduces regressive processes, creates more mature defences, and thus "changes character" (Abbass & Bechard, 2007, p. 18). If this systematic analysis is not done, Davanloo (1990) notes that defences can re-establish themselves and symptom reduction is slower.

### 7.5.8 Fit of Techniques With Theoretical Approach, Formulation, and Intervention Objectives

Molly's unique adaptations to her past emotional environment are described through the Triangle of Conflict, with specific reference to the type of anxiety and defences she presents with; this then guides our intervention efforts. The technical interventions used, based on attachment and psychodynamic theory, are designed to stimulate the attachment system in order to get to the root of her presenting problems. The interventions of *pressure* and *recapitulation* are tailored to preparing the way for Molly to be able to tolerate the intensity of her unconscious feelings and the core conflicts that have been driving her suffering. As Molly begins to understand her feelings are reactive to interpersonal situations, she will see how her unresolved feelings towards others in the current and past are being enacted time and time again, in an automatic and unconscious fashion. As her unconscious is exposed to rage, and guilt about the rage, due to the overt and covert traumas of emotional coldness, dismissal, and criticism, she will then be able to experience the pain and grief about these situations and the losses they represent. Working through these reactive emotional stages should give way to previously forbidden feelings of love, longing, and connection that are at the core of the attachment system. As this process is repeated, and more of Molly's unconscious is brought into conscious awareness, her brain will begin to create autobiographical coherence, and in doing so, enable her to resolve her inner conflicts now, as an adult, with all of her current capacity.

Once Molly understands her key conflicts around closeness and intimacy, and how she has been defending herself from these, she will have the opportunity for new adaptive choices that align with her true values and her true self. This process should clear the way for her to experience major therapeutic benefit across multiple domains of functioning.

In summary, our initial formulation is a starting point for making sense of Molly's predicament. Much of the important information that will help us and her to a better understanding will emerge over the course of therapy, in response to interventions that are grounded in psychodynamic theory, but also guided by close observation of her moment-to-moment reaction.

Table 7.4: Glossary of key terms

Term	Definition	Examples
<b>Central Dynamic Sequence</b>	Empirically derived series of therapeutic processes as described in Table 7.3	N/A
<b>Cognitive Recapitulation</b>	Clarifying statement often used to reduce <i>pressure</i> and build capacity by cognitively linking emotions, anxiety and defence in the here and now.	“So we can see that when you just spoke about your anger, you turned it inwards onto you and then you experienced stomach cramps. Is this where your anger goes?”
<b>Complex Transference Feelings</b>	Combination of mixed feelings simultaneously experienced towards the therapist, which link to unresolved emotions about past attachment traumas.	Mixed feelings towards the therapist include: positive appreciation and irritation. Unresolved emotions from the past include: love, pain, rage, guilt and grief.
<b>Treatment Resistance</b>	Any (often unconscious) defence that operates to block and resist: the experience of mixed feelings emotional closeness with the therapist the therapeutic endeavour	Passivity, ambivalence, compliance, defiance, detachment, denial.
<b>Pressure</b>	Focused efforts to encourage the patient to emotionally engage with themselves and with the therapist.	“What emotion are you experiencing right now in your body? “How do you feel towards me when I ask you that question?”
<b>Challenge</b>	Once the patient can see their defences, they are encouraged to not use them and to face their feelings instead	“Now that you’re aware of detaching from me, yet your body is taking some deep sighs, could we look at the feelings coming up towards me if you don’t detach?”
<b>Head-on-collision</b>	Clarification and challenge of treatment resistant defences with an emphasis on the consequences of the defence and an encouragement to overcome it collaboratively.	“Now that you can see how denying your true experience prevents us from getting to know what you really feel and stops me from helping you, can we have a look at the emotions you are having right now so we can face reality together, otherwise you continue to remain alone with these experiences?”

**Table 7.4:** Glossary of key terms (continued)

<b>Unlocking of the unconscious</b>	The psychic state in which a patient's healthy desire to heal and reveal their hidden thoughts, feelings and impulses overcomes the part that wants to keep them stuck and suffering.	N/A
<b>Working through</b>	A process of making cognitive and experiential links, building conscious narratives and amplifying the therapeutic process.	"So now we can see that the anger you had towards me was linked to intense rage and guilt towards your Father who hurt you by leaving the family home. These feelings led to a deep sense of grief and a longing to be close to him again, all of which is very painful to process, but it has been driving your avoidance of intimate relationships now and leading to your loneliness and anxiety about closeness. Can you see that, too?"

Anna Tickle & Michael Rennoldson

## 7.6 ISTDP Formulation: Critical Commentary

We approach this critique of the ISTDP formulation from a systemic position. The systemic assumptions we draw upon include:

- Therapeutic practice is enhanced when it adopts a 'circular' understanding of causation.
- Attention needs to be paid to the social, economic, and cultural context of clients.
- The role of formulation, or hypothesising, is principally to catalyse change in a system, rather than accurately describe the origins of psychological distress.
- Therapists should pay particular attention to the potential hazards of their work, and avoid inadvertently contributing to oppressive practice.

Our critique highlights general points of overlap and difference between ISTDP and systemic practice. At first glance the two respective conceptual systems (or at least the language used to describe them) are very different. We are struck in particular by the mechanical aspects of the ISTDP view of the psychosocial world, as well as by its confident use of the language of dysfunction. Metaphors from the physical world abound: anxiety is assessed for its 'striation'; 'pressure' is applied until particular thresholds are crossed; repressed feelings are 'unlocked'. Whilst these ideas undoubtedly have

utility for some clients, we also anticipate potential hazards arising from this mechanical viewpoint. We would consider this one amongst many ways of describing the social and psychological worlds with no special claim to truth.

Formulation within systemic practice focuses on the present and the social context of the person, whereas ISTDP is concerned with a person's intrapsychic world and its origins in early relationships. However, there are also points of connection. Both approaches draw upon the insights of attachment theory to bridge the social and intrapsychic worlds. Both also appear to hold recurring patterns of relationships as being of central importance in the difficulties that bring clients to therapy.

### 7.6.1 Formulation Content

The two conflict formulations highlight apparently repeating patterns in Molly's relationships. However, on closer reading we found little 'circularity', in the sense of explaining the contribution and interaction of all parts of a system. Instead the formulations focus on *Molly's* behaviour, feelings, and indeed 'failures' of the strategies she has tried to use. It could be argued that the 'success' or 'failure' of strategies can only arise in the context of particular responses by others.

Assuming the causation of Molly's problems lies in early parental and sibling relationships is highly linear, and risks what might be described as a teleological error. Molly's life is read as the almost inevitable playing out of early unconscious conflict. This risks neglecting the contribution of more recent or current contexts and failing to account for exceptions to the problem. For example, within the formulation, the experience of sexual abuse is interpreted as confirming or exacerbating a pre-existing conflict. However, it seems equally plausible that sexual abuse might have been completely at odds with Molly's previous experience, shattering her assumptive world (Janoff-Bulman, 1985). From a systemic perspective, the placement of causation in early relationships seems arbitrary.

The intrapsychic location of difficulties could have some benefits for some clients. It could offer Molly a sense that change is within her reach and control, as opposed to relying on others who may not buy into the process of therapeutic change. That said, it would have to be balanced against the potential for Molly to feel blamed for her difficulties. There may also be broader risks of using therapy only to reduce the distress and change the individual behaviour of victims of sexual abuse, rather than also addressing social aspects such as acknowledgement, accountability, and justice.

More broadly, the ISTDP formulation pays little attention to Molly's social and cultural context. This reflects the limited information available in the case material, but is probably also a product of the intense focus upon Molly's intrapsychic experience. For example the putative self-protective function of striving hard to achieve, identified in the second conflict formulation, may have equally significant meaning in Molly's experience of gender, social class, education, and family history.

### 7.6.2 Role of Formulation

The impression given is that formulation plays a relatively modest role in directing the therapy. More important are the technical assessments and procedures of the therapy, which rely on information gleaned from the client's behaviour within the therapy room. This is a similarity with a systemic approach. Both favour the use of therapeutic technique according to therapist judgement within the session, rather than following a sequence of interventions that could be mandated by a formulation. However, there are clear differences too. Within a systemic approach, formulation ideas may be discussed 'as if' they are true, but their real purpose is to stimulate change within a system. It would concern us if an ISTDP formulation is intended to be treated as a set of truthful propositions about what is really going on for a person. This raises questions of what follows for the client if the formulation turns out to be false, and what degree of confidence we can have in the ontology and discovery procedures underpinning ISTDP.

### 7.6.3 Client Experience

The question of how clients experience ISTDP seems not to have been addressed within research. What can be easily found online if querying the client experience of ISTDP is an article from VICE magazine that suggests the experience 'has a weird edge to it, like a psychological fight club run out of a church basement' (Keefe, 2013). The confrontational approach aims to create change within sessions at the time when the individual's defences are 'activated'. This has some similarity to the use of 'enactment' within structural family therapy, in which the therapist allows the family to engage in spontaneous transactions and then suggests alternatives (Minuchin & Fishman, 1981). Allowing therapists to use confrontational techniques whilst maintaining a belief in their own privileged access to the truth of a person's life might risk at least a poor experience of therapy, if not adverse outcomes (Masson, 1988). Family therapy has not always taken this sufficiently seriously (Reimers & Treacher, 1995), we hope the ISTDP community will.

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## 7.7 Author Response

The 'systemic' assumptions guiding this commentary are rather commonplace: Sure, context is important, formulations need to be action-oriented, therapists should avoid being oppressive, and circular understandings often help (though they do not necessarily enhance practice). All this is fairly unremarkable; the commentary's

misunderstandings are far more informative: Mistaking ‘striated anxiety’ for a metaphor, rather than a description of the neurophysiology of emotion, points to one of the defining features of ISTDP (and by implication to one of the shortcomings of the systemic view) that we may not have sufficiently emphasised in our chapter – like other psychodynamic approaches it is an embodied therapy. From Freud’s model of psychosexual stages, empathising with the infant’s somatic experience (see Mitchell, 1974), via Reich’s ‘character armour’ and Winnicott’s ‘psycho-somatic integration’, to modern trauma therapy, the visceral aspects of experiencing have continually been privileged over the verbal/cognitive ones. Insight, however cleverly constructed and contextually aware, is held to be useless without its emotional and physical substrate. The client’s moment-to-moment sensory experience, rather than any mechanical view of intrapsychic structures, is the ISTDP therapist’s guide to intervention. In this sense, clearly “the ‘success’ or ‘failure’ of strategies can only arise in the context of particular responses by others”, as the commentary postulates.

Another misunderstanding concerns circularity. The systemic position’s aversion to linear accounts is strangely at odds with its emphasis on narrative. The Aristotelian structure of a story having a beginning, a middle, and a (preliminary) end makes intuitive sense to many clients; it directly meshes with their experience of life and may give them hope that their own future storylines can be rewritten from the position they are currently inhabiting. On that basis, circular formulations, such as ‘repetition compulsion’, ‘cyclical psychodynamics’ (Wachtel, 2014), or ‘active phantasies’ (Symington, 1984), then help to make sense of interpersonal maintenance cycles – the very opposite of a “teleological error”, assuming an “inevitable playing out of early unconscious conflict”. The client’s encounter with the therapist constitutes the setting where such circular patterns can be experienced directly – rather than intellectually apprehended – and potentially modified or replaced.

A similar misapprehension relates to the role of formulations. Whether based on Malan triangles or on developmental sequences, ISTDP formulations are working hypotheses that have to be modified, revised, substantially changed, or even discarded in light of each individual client’s reactions. Such understandings are of necessity specific, transitory, and incomplete. Their validity is supported or challenged by the client’s physical and emotional response, rather than by their fit with a preconceived blueprint. Yes, theory is important, though primarily by helping therapists to keep their bearings and continue thinking while under pressure.

Finally, we are firmly in agreement with the need to obtain accounts of clients’ experiences of ISTDP from sources other than therapists’ case studies. Good qualitative research is indeed required to provide these, so that we are not taken in by a journalist’s second-hand pastiche masquerading as an authentic client voice, such as the one rendered by Keefe (2013), referred to above.

**Acknowledgement:** The authors wish to thank Dr Patricia Coughlin Della Selva for her comments on a draft of the manuscript.

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