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Intensive Short-Term Dynamic Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

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Contents

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ORIGINS AND DEVELOPMENT

Intensive Short-Term Dynamic Psychotherapy (ISTDP) was developed by Habib Davanloo (1980) as a technique to break through the patient's defensive barrier. The technique facilitates the examination of repressed memories and ideas in a fully experienced and integrated affective and cognitive framework. Davanloo based his ideas on the work of a number of psychoanalytic therapists. In this section we will examine the influence of some of the more important figures in the development of Intensive Short-Term Dynamic Psychotherapy.

Freud (1905/1953) in his early work used many of the techniques of brief psychotherapy. He was extremely active in attempting to confront and overcome the patient's resistance. He maintained a focus by concentrating on connections to a specific symptom. When Freud shifted from the cathartic method to free association, psychoanalysis became a long-term treatment, since maintenance of a focus is directly opposed to free association.

Sandor Ferenczi and Otto Rank (1925) in *The Development of Psychoanalysis*, commented on a number of ideas that became central to ISTDP. They believed that intellectual knowledge without affect serves as a resistance. Therefore, they stressed that the therapist must be active to evoke

the affect that was achieved with the cathartic method. Ferenczi and Rank took the position that change comes about through a combination of affect and intellectual understanding of the original conflict in the transference.

Franz Alexander and Thomas French continued the work of Ferenczi and Rank with their concept of the corrective emotional experience. They believed that the reliving of early conflicts within the transference allows the patient to experience "those emotional situations which are primarily unbearable and to deal with them in a manner different from the old" (1946, p. 67).

It is clear that these writers realized that an active transference approach, bringing together affective and cognitive elements, was critical in producing positive outcome.

In 1944, Lindemann reported on his work with survivors of the Coconut Grove fire and focused on acute and delayed grief, as well as pathological and normal mourning. Davanloo, building on the work of Lindemann, recognized the importance of pathological mourning and the necessity of dealing with it early in treatment if short-term dynamic psychotherapy was to be effective.

David Malan (1976) and Peter Sifneos (1979) were instrumental in developing highly focused brief psychotherapies using substantial work in the transference. Sifneos emphasized the use of confrontation and anxiety-

provoking questions to keep the level of tension relatively high in order to shorten therapy. Malan introduced the use of the triangles of conflict and person, which help define the field of inquiry so that a clear focus can be maintained. He also developed the idea of trial therapy to help establish a patient's suitability for brief dynamic psychotherapy.

Davanloo (1980), building on the work of these authors, developed Intensive Short-Term Dynamic Psychotherapy, which is highly confrontational and emphasizes affect. Davanloo pays special attention to the defensive layering of highly resistant patients using Wilhelm Reich's (1949) ideas about character resistance. During the evaluation interview he actively employs trial therapy techniques and attempts to achieve an affective breakthrough either in the patient-therapist relationship or in some other important relationship in the life of the patient. Davanloo believes that the breakthrough sets the stage for access to the patient's core conflicts and allows repressed memories to enter consciousness.

In the early 1980s our group at Beth Israel Medical Center in New York City became interested in pursuing Davanloo's approach and subjecting it to systematic research (Winston et al., 1989). Since we began the technique has evolved so that affect is not so heavily emphasized. Instead, the focus is both affective and cognitive, and an attempt is made to integrate the two (Laikin and Winston, 1990). In addition, with more resistant patients a cognitive

restructuring is often done in the initial phase of treatment so that patients with many ego syntonic symptoms can recognize their defenses and increase their capacity to experience affect. Then the initial phase of treatment is much less confrontational, enabling the therapist to build a therapeutic alliance that can withstand the defensive and characterological analysis that must take place.

SELECTION OF PATIENTS

Intensive Short-Term Dynamic Psychotherapy can be applied to a wide variety of outpatients. It is suitable for patients with personality disorders primarily of the *DSM III-R* Cluster C group, such as avoidant, dependent, obsessive-compulsive, and passive-aggressive, as well as the histrionic personality disorder from Cluster B. Davanloo suggests that this therapy can produce good results in patients suffering from longstanding neurosis or maladaptive personality patterns with either an oedipal or a loss focus or both.

Because cognitive restructuring techniques are emphasized some patients with more severe psychopathology and less integrated ego structure, such as those with borderline and narcissistic personality disorders, can benefit. Patients with this level of psychopathology will require substantially longer treatment.

Exclusion criteria for this therapy are the following: severe Axis I diagnosis, such as schizophrenia, bipolar disorder or severe major depression, organic mental disorder, significant suicidal impulses, and marked acting out behavior, as well as drug and alcohol abuse.

Evaluation of patients is performed during the initial interview and should include trial therapy (Malan, 1976; Davanloo, 1980). A significant portion of the evaluation interview should consist of an application of the techniques of ISTDP. If the patient can respond with increased motivation based on an affective experience accompanied by understanding or insight, suitability is established. However, if the patient develops overwhelming anxiety, fragmentation, identity confusion, paranoid ideas, or other signs of a fragile structure, the interviewer should stop challenging the patient and begin a more supportive approach.

THEORY OF CHANGE

The experience of feelings is central to change in Intensive Short-Term Dynamic Psychotherapy. Alexander and French wrote: "In the course of one interview the patient may react with violent anxiety, weeping, rage attacks, and all sorts of emotional upheavals together with an acute exacerbation of his symptoms—only to achieve a feeling of tremendous relief before the end of the interview. Such experiences, although curative in effect, are painful;

they might be described as benign traumata. . .” (1946, p. 66). Alexander spoke of the corrective emotional experience, which is a positive reenactment in therapy of past conflictual relationships. Employing differential therapeutics is essential, as there are two broad categories of patients (Okin, 1986): the less resistant group, patients who manifest little character pathology and readily experience their feelings, and the more highly resistant group, patients who possess rigid character structures. In the less resistant group, change is believed to occur as the therapist facilitates affective and cognitive experiencing of repressed conflictual feelings and urges, while clarifying the associated defenses, symptoms, and anxiety. Whenever resistance to experiencing feelings and impulses is manifested, it is clarified and confronted through a steady defense analysis (to be described later) until resolved. This constant pressure to experience feelings and urges with frequent challenge to resistance produces an intrapsychic crisis by exposing the self-destructiveness of longstanding ego syntonic character patterns. This crisis produces intense affects, which tap into a reservoir of unconscious thoughts, memories, and feelings and activate the unconscious therapeutic alliance. This dynamic flow speeds and compresses the psychoanalytic process.

Fostering change in the highly resistant group of patients with characterological rigidity requires an additional preliminary stage: restructuring of the defenses. In this group, it is believed, there is always

some—and usually extensive—inhibition, deflection, or regression from the appropriate experience and expression of feelings and impulses (in fact, the difficulty is seen as pathognomonic of character pathology). Change is initiated by systematically helping such individuals to identify and experience their feelings and impulses and differentiate defenses and anxiety. When this restructuring phase is accomplished, as indicated by the patient's access to feelings and impulses, more previously unconscious material will become available. For example, a woman who is chronically depressed recognizes the link between her depression and anger and then recounts previous incidents when she became depressed and now realizes that she was angry.

Once the therapeutic alliance is established, work centers on linking the points of the triangle of person—composed of transference, current people, and past people—with regard to impulses/feelings, defenses, and anxiety, the triangle of conflict (illustrated in figure 1, found in the following section). This constant experiencing and linking of conflicts is believed to rapidly resolve neurotic symptoms and interpersonal patterns. Another major agent of change is the frequent analysis of the transference relationship, especially for highly resistant patients, with whom the analysis of transference resistance leads to the restructuring of the triangle of conflict, and the subsequent recognition and experience of feelings and impulses. This central role of the transference reflects the position of psychoanalytic theorists such as Merton Gill (1982).

TECHNIQUE

Introduction

Intensive Short-Term Dynamic Psychotherapy (ISTDP) is a treatment that follows the principles of psychoanalytic therapy. The best test for suitability is the evaluation, or trial therapy, in which the techniques of ISTDP are applied and carefully monitored. The major innovations which speed and intensify treatment are the following:

1. High therapist activity level
2. Maintenance of focus
3. Early and extensive analysis of the transference
4. Analysis of character defenses to achieve a high level of affective and cognitive involvement at all times
5. Extensive linkage of the therapist-patient relationship (transference) with other significant relationships in the patient's life.

Sessions are weekly, face to face, fifty minutes long, with a maximum of forty sessions. Traditional psychoanalytic abstinence and neutrality are observed (Greenson, 1967). The therapist does not give direction, advice, or praise and does not gratify but rather explores personal inquiries by the

patient.

Evaluation

The evaluation or trial therapy plays a special role in ISTDP. As the term trial therapy implies, there is a testing of the specific innovative techniques of this therapy to determine whether a patient can respond favorably and benefit from ISTDP. The evaluation covers several phases. First is the survey, which is a superficial assessment of the current difficulties via the two triangles without getting prematurely entangled in challenging resistance. Next is the challenge, which has two parts: step 1, a low-pressure cognitive phase in which defenses are clarified, then step 2, a more intense phase of challenge and pressure to exhaust the patient's resistance. The result is clearer access to previously unconscious conflicts. This is followed by the interpretive phase, in which current and transference problems are clarified and then linked to their core genetic antecedents. These phases vary and depend on the patient's level of resistance.

The central dynamic sequence is Davanloo's schema for the evaluation of moderately to highly resistant patients. Davanloo points out, "Of course not all trial therapies consist exactly of this simple sequence. The phases tend to overlap . . . [with] a good deal of repetition . . . [and tend to] proceed in a spiral rather than a straight line. . . . [It is called] the central dynamic sequence . . .

[and should be] seen as a framework which the therapist can use as a guide" (1988, p. 100). The following list summarizes Davanloo's eight phases of the trial therapy.

1. Inquiry into current difficulties and initial identification of defenses.

2. Pressure leading to more resistance.

3. Clarification and confrontation of defenses and appeal to the patient to make defenses ego alien.

4. Challenge the transference resistance, which intensifies due to steps 1 through 3. Special attention is paid to self-defeating and selftorturing aspects of defense.

5. Emergence of mixed feelings in the transference, which signals the beginning of clearer access to the unconscious.

6. Analysis of transference around the triangle of conflict and linkage to other significant figures.

7. Completion of the diagnostic inquiry.

8. Connecting the core neurosis to current symptoms and character.

It is a mistake to rigidly apply this paradigm, since it varies from patient to patient. If the basic principles are applied in a heuristic manner to tracking and challenging resistance, a sequence will evolve that is appropriate to the

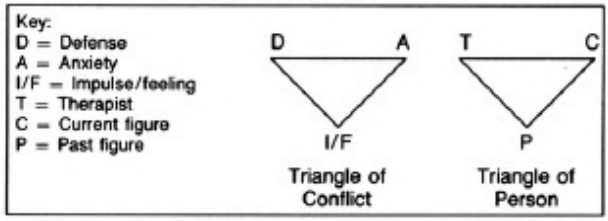
patient. This model is a good first approximation or initial guide. In our experience, there is a natural path that unfolds with each patient-therapist pair that cannot be anticipated. That is why we prefer our simpler, more flexible model, which covers the same issues.

Survey.

The evaluation opens with a survey. Current problems are elicited with minimal challenge. In this phase diagnosis, character structure, and defenses are assessed. This information is filtered through the triangle of conflict (Freud 1925-1926/1959) and the triangle of person (figure 1).

Figure 1

The Two Working Triangles



For example, a man complaining about being overlooked for a promotion by his boss declares he felt depressed (D):

Therapist: How did you feel (I/F) toward your boss (C)?

Patient: I was a little (D) annoyed (I/F).

Therapist: So, in the face of your annoyance (I/F) with your boss (C) you became depressed (D).

No challenge is made at this time to have the patient fully experience the impulse/feeling. The questioning is aimed at a clear, specific, psychodynamically informative account.

There are some circumstances in which the current problem survey is briefly deferred. If a patient presents a great deal of initial transference feeling, or is depressed, anxious, or in a crisis, these areas should be clinically reviewed before moving to the general survey. These precautions avoid stressing a fragile patient. If there are no contraindications, all the current areas of disturbance are delineated in the course of the survey. The current sexual life is explored, whether or not that is a source of complaint for the patient. The patient is challenged only if there is so much resistance that numerous efforts to get the current history fail. There is acknowledgment of resistance, such as, "You're smiling as we discuss your anger," but the resistance is not pursued at this time.

Challenge Step 1.

After the survey is completed, the challenge phase begins with the most troublesome current problem. This is the defense or character analysis, which

is a continuous process that occurs in two phases (McCullough, in press).

The first step is a cognitive familiarization of patients with their defenses in relation to feelings and anxiety (the triangle of conflict). The therapist applies steady low pressure to enable the patient to be specific, clear, emotionally involved, and able to declare and experience feelings. This first phase is managed in one of two ways, depending on the level of resistance of the patient. Patient resistance covers a continuous range, but for didactic purposes we delineate two groups—high resistance versus low resistance (see table 1). Patients with low resistance can differentiate the points of the triangle of conflict, have ego dystonic defenses and symptoms, show high motivation, present relatively simple focal problems, and relate well to the therapist. The predominant resistance is repression, often accompanied by guilt feelings, which also serve resistance. Because resistance in this group is low, the evaluative phase of therapy is generally brief.

TABLE 1

Patients' Resistance Characteristics

Low Resistance	Characteristic	High Resistance
Good	State of differentiation of triangle of conflict	Poor
High	Motivation	Low

Simple	Complexity of psychopathologic foci	Complex
Ego alien; fewer	Character defenses	Ego syntonic; more
Good	Interpersonal relatedness	Fair to poor

Note: In actuality, patients' resistance falls along a continuum.

In the moderately to highly resistant group, the first step is generally longer and plays a crucial part in preparing the groundwork for future interventions (Fosha, 1988). These types of patients are characterized by an inability to clearly describe and differentiate impulse/feeling, defense, and anxiety, and instead report vague depressive or anxietylike symptoms, migraine headaches, or gastrointestinal and other psychosomatic disorders. Many of their defenses and symptoms are ego syntonic; their motivation is poor and they have many infantile conflicts. They frequently present in a vague and poorly related manner. The bulk of their resistance is manifested as self-defeating interpersonal patterns that signify a harsh, punitive superego. Resistant patients frequently exhibit a lack of emotional involvement, which often signals early life deprivation, loss, and a sense of not being valued. They have erected emotional barriers to ward off closeness in order to avoid experiencing painful yearnings, losses, anxiety, and other dysphoric affects.

In contrast to the first group, which comprises excellent psychotherapy candidates, patients in this second group have frequently failed at several previous treatments and are the most difficult patients to treat. They need a longer first phase, known as cognitive restructuring of the triangle of conflict. This is the preinterpretive phase in which the triangle of conflict is delineated but interpretations of underlying dynamics are deferred. The marker that heralds the end of the cognitive pressure phase is the initial emergence and experience of feelings, frequently starting with annoyance toward the therapist for the relentless pressure directed at warded off affect and content. This annoyance is accompanied by sadness, pain, guilt, and longing. If step 2, consisting of challenge and pressure for intense affect, is applied prematurely to this group, misalliance often results. Too much anxiety is mobilized; or the patient, lacking the recognition of ego syntonic defenses or character armor, may feel attacked by the therapist.

Consider step 1 with such a patient.

> Therapist: So you became depressed (D) in the face of your annoyance (I/F) with the boss (C), but how did you experience the annoyance (I/F)? Depression (D) is not annoyance (I/F).

In this example the patient does not consciously experience annoyance. Instead depression is used defensively, which may be a characterological way of dealing with anger. The goal in ISTDP is to obtain fully experienced feeling based on three parameters: (a) physiological arousal, (b) motoric

manifestations of activation such as raised voice and body movement, and (c) cognitive acknowledgment of the inner urges in fantasy.

> Patient: Well, I walked out of there (D).
>
> Therapist: Walking out is avoidance (D) and distancing (D); that still doesn't tell us your inner experience of annoyance (I/F).

A less resistant patient soon starts to tell about the impulse/feeling. "I felt my blood rushing with adrenaline in my chest and arms." With this group, we move rapidly to step 2, since there is a clear understanding of the triangle of conflict. In the more resistant group, further work is necessary to restructure the ego's capacity to experience affects.

> Patient: I don't know how I experienced annoyance.
>
> Therapist: When you say "I don't know (D)" it is a declaration of helplessness (D) as we try to investigate your annoyance (I/F).
>
> Patient: I am helpless (D) a lot of the time.

This is an ego syntonic character defense with which the patient is identified. The therapist must continue steady low pressure, attempting to dissect out and undermine ego syntonic defenses.

> Therapist: So you remain helpless (D), and we still don't know how you experience annoyance (I/F).
>
> Patient: I feel my throat tighten (A) and butterflies (A) in my stomach.

Therapist: So you become anxious, your throat tightens and butterflies in your stomach. So we see that in the face of your annoyance (I/F) you become anxious (A), but that still doesn't describe how you experience your annoyance.

The therapist steadily differentiates the triangle of conflict and helps the patient distinguish defenses and anxiety from the impulses/feelings. Again, in step 1 the pressure is relatively low. After some work on the first focus (feelings toward the therapist) the same affective focus will be investigated toward another person with the focus maintained on the original impulse/feeling in relation to this new person. Through a series of such analyses of the triangle of conflict with different figures, a progressively higher level of affective experience is achieved, with maladaptive defenses becoming ego alien. When the patient is no longer using regressive defenses such as depression, helplessness, somatization, detachment, uninvolvement, and so on, step 2 is commenced and heavier pressure is brought to bear on the remaining resistance.

A special technique of ISTDP called portraiting or imagery is often employed. The patient is asked to visualize a scene in great detail, such as the actual or fantasied death bed scene of a parent or, as in the preceding example, a conflict with the boss, with appropriate affective involvement. This technique begins in step 1 and is used in all phases of ISTDP when a specific incident or fantasy is being focused on. Resistance to specificity, clarity, and emotional involvement is challenged. This visualization technique facilitates

full cognitive involvement along with physiological and motoric expression. The technique helps intensify emerging feelings such as anger, sadness, grief, closeness, and sexuality.

A comparison of ISTDP with learning theory-based therapies (McCullough, in press) is warranted. ISTDP uses techniques such as flooding (Boudewyns & Shipley, 1983) and Implosion Therapy (Stamfl & Levis, 1967). In ISTDP patients are prevented from avoiding painful stimuli (flooding) and are asked to let their feelings go and essentially construct an image or fantasy around the particular feeling (Implosion Therapy or exposure treatment). The flooding model applies more to less resistant patients who can immediately experience affect, whereas a systematic desensitization model parallels the restructuring process with highly resistant patients.

Challenge Step 2.

The intensive challenge to transference resistance is believed to be the key to therapeutic success with highly resistant patients in ISTDP (Been & Sklar, 1985). Step 2 is a more intense challenge and pressuring of the resistance. In this phase the therapist is highly active, rapidly challenging and exhausting successive layers of defense. This constant pressure helps crystallize the resistance.

The pressure comes through a series of steps, including challenge and

pressure to the defenses and finally the "head-on collision" (Worchel, 1986), an appeal for the patient to give up the defenses. This appeal points out the self-destructive and self-defeating nature of the defensive barrier, the need to fail and suffer as well as to defeat the therapist by defeating oneself (highlighting superego resistance). These motivational statements are made when the resistance is nearly exhausted, as evidenced by a high level of physiological and motoric arousal. Resistance such as the avoidance of pain and the instinctual attachment to early objects must frequently be challenged as well.

The constant pressure builds up a mixture of feelings toward the therapist and includes anger at having defenses immobilized, a wish for closeness, and a painful sense of what has been lost in other intimate relationships. Davanloo (1980) believes the experience of this complex of mixed feelings toward the therapist with a high level of intensity unlocks access to unconscious material toward current and past significant others. These feelings surge to the surface, and additional defenses are mobilized to prevent the affective outpouring. As the affect emerges, the unconscious therapeutic alliance (Langs, 1978) surfaces. These are the forces in the patient battling the resistance and craving intimacy and satisfaction in life. These forces assist the patient in discarding previously ego syntonic defenses as their self-defeating nature becomes obvious. At this juncture, the therapist is challenging in two ways. One is pressing for the experience of feelings (I/F)

and the second is challenging the massive barrier of defenses the patient has erected, a barrier that blocks his or her ability to be intimate with people, the "wall" (Davanloo, 1986).

Resistance is conceptualized on two levels. First is the already mentioned micro level, composed of various defenses: obsessional, regressive, tactical, nonverbal, and transference resistance (see table 2).

These defenses combine to form a barrier or wall against emotional closeness, the macro level. After these individual defenses have been identified, they are reframed as elements of the barrier against intimacy. This is a powerful intervention that heightens the intrapsychic conflict and helps make the defenses dystonic.

TABLE 2

Types of Defenses and Resistance

Obsessive	Regressive	Tactical	Nonverbal	Transference
Intellectualization	Compliance/Defiance	"I suppose"	Body posture	Resistance against closeness
Undoing	Weepiness	"Perhaps"		
Reaction	Passive-Aggressive		Eye	

formation			contact	
Sarcasm	Projection	Verbal maneuvers to distance patients from their feelings	Vocal quality	Resistance against rage
Isolation of affect	Somatization		Fidgeting	
	Dissociation /denial		Tics	
	Acting out		Clenching of fists, jaws Sighing	

The concept of unlocking the unconscious applies to the moderately to highly resistant group of patients whose rigid defenses and character style allow extremely limited fluidity for their affects, feelings, and fantasies. This unlocking occurs on two levels. First is the increased ability to experience and tolerate affects, known as restructuring the triangle of conflict. Feelings are no longer reflexively channeled to symptoms (depression, anxiety, psychosomatic symptoms) or defenses. Instead the patient consciously acknowledges and tolerates the affect. A good analogy is comparing a lightning rod and a capacitor. As soon as the charge hits a lightning rod (here, defenses and symptoms) it is discharged. On the other hand, a capacitor

accumulates and stores charge, introducing a time delay. The reflexive cycle of symptoms and defenses is broken and a measured (delayed) response is made. The charge or urge is brought under the auspices of conscious awareness and control. This is the highest state of maturation and integration. Simultaneously with this enlarged capacity comes a new awareness that past symptoms and defenses were used in early life to ward off strong feelings and impulses toward ambivalently experienced relationships. It now becomes clear that past behaviors such as obsequiousness or helplessness were defenses against rage and pain (T-C-P linkage). Affectively intense memories can now emerge and will reveal the genetic core conflicts through the process of clarifying and experiencing the points of the triangle of conflict in relation to the three points of the triangle of person. This emergence of painful, conflicted early memories is the second part of the unlocking. A complete past history is not obtained at this time, only a past history that spontaneously emerges in regard to the current difficulty. A complete systematic past history is obtained after the current areas of disturbance are completely surveyed. However, it must be understood that whenever significant resistance emerges the therapist should return to resistance/defense analysis.

Interpretation.

After the triangle of conflict is understood and experienced, the

interpretive phase of the evaluation begins: the linkage between I/F, D, and A is repeatedly made in regard to T, C, and P. Next the inventory of the current areas of difficulty is returned to and completed, including current sexual functioning. A medical history to rule out significant contributing illness is obtained. Then a systematic survey of early life is undertaken, including relationships with parents, siblings, and other significant early figures; sexual development; and academic and social functioning. This is again a dynamic inquiry based upon the two triangles. When a significant relationship is examined, triangular involvement is explored. Particular attention is paid to identify and link early dynamic constellations that resonate with current conflicts. Depending on the time available and complexity, a partial understanding, consisting of some of the early relationships, or a complete understanding, based on working with and experiencing conflicts with all early figures, is obtained. The best evidence that a patient's problems are appropriate for and will respond to ISTDP is a successful trial therapy. There are three indications of success in trial therapy:

1. Obtaining at least one T-C-P linkage during the evaluation in a fully experienced affective and cognitive framework.

2. Seeing a change in the patient's functioning or the use of more adaptive defenses in the next sessions.

3. Observing the appearance of memories or dreams related to the patient's core conflicts.

To summarize, the evaluation is the true test for treatability with ISTDP and the period during which the techniques are initially tested. The proper fine tuning of technique to the individual patient is empirically discovered by progressively increasing the level of pressure in the preinterpretive phase and monitoring the patient's ability to respond, anxiety level, and defensive style. The therapist should always be ready to moderate the pressure if the patient manifests too much anxiety or fragility in response to the challenge. In a successful evaluation, a patient reports immediate symptom attenuation or relief and shows an alteration in his or her character defense pattern.

In Beth Israel's research protocol, the evaluation is limited to two two-hour sessions. In nonresearch settings the evaluation may run as long as three to four hours, over one session or more as needed.

Therapeutic Contract.

The therapeutic contract grows out of the findings of the evaluation. In a successful evaluation, an affective/cognitive breakthrough occurs, with T-C-P linkages subsequently established for some or all of the patient's current and core issues. This usually leads to emotional relief and an increased motivation to work on the problems. The therapist asks whether the patient wishes to explore current and early life conflicts and their linkage, as was done in the evaluation. If the patient agrees, a summary is made of the findings, again

focused on the two triangles, as well as on dyadic and triadic dynamic and characterological issues highlighted in the evaluation. The therapist states that these are the problems to be faced and sets the meeting time and financial arrangements. The patient is told that the maximum number of sessions is forty. There may be fewer, depending on the patient's characterological complexity and level of resistance.

Treatment

The techniques used in the treatment phase are similar to those of the evaluation. Treatment continues to be organized around the two triangles, with high therapist activity, ongoing challenge of significant resistance, and maintenance of focus with special attention to the analysis of transference resistance.

The patient is told at the start of the first postevaluation session that treatment proceeds best if each session is started with whatever comes to mind. This opening is called the adaptive context (Langs, 1978) and is composed of elements of the two triangles in a psychodynamic matrix. This context is thought to reflect the aspect of the core conflict that is emerging from repression into consciousness, with its associated resistances. When the therapist understands the adaptive context, including the interpersonal and the dynamic (triangular, dyadic), the understanding is summarized and

feelings are inquired into. Resistance is then challenged as previously, but with the added knowledge obtained in the evaluation of the patient's character structure, defensive operations, and underlying conflicts. Again, the goal is full affective/cognitive involvement. Once this is obtained in the C or T, a linkage is sought in the P. This is the process of elucidating the core conflicts and working them through. In a treatment that is progressing well, the amount and intensity of resistance and challenge tend to decrease as the sessions progress. The use of the transference analysis also diminishes as therapy progresses. There are upsurges of resistance, which require more challenge when particular conflicts are reached. The principle, as in other psychoanalytic treatments, is that the transference is a tool to handle resistance and is addressed when necessary toward this end. Triangulation is also introduced and explored. For example, if work is done in regard to the mother, the father's role should be inquired into; if a patient describes an intimate scene, feelings toward the intruding therapist should subsequently be explored.

Certain issues must be addressed early in treatment. One of these issues is pathological mourning; this must be handled early on because the repressed ambivalent feelings and resistances put a massive drain on the patient's energy to work in treatment, much as a severe depression does.

Pathological mourning must be activated and worked through before

more intensive dynamic exploration can be successfully undertaken. In moving to activate the pathological mourning into acute grief (Winston & Goldin, 1985), the typical defense analysis is necessary to facilitate the experiencing of ambivalent feelings. Pathological mourning should be briefly activated in the evaluation, but a broad survey is still the goal. The pathological mourning is then more systematically addressed in the early sessions.

From the evaluation's elucidation of the current problems stated by the patient, together with the characterological difficulties identified and linked to the clarified core conflicts, it becomes clear what issues need to be addressed in the treatment phase. If the evaluation is incomplete, elucidating only part of the core dynamics, the first few sessions should be used to complete the survey of core genetic conflicts. It is believed that a more thorough evaluation leads to a significantly shorter treatment. The treatment plan is focused on these early life issues, which should correspond to current symptoms and character patterns.

Termination

The end of treatment can be natural and simple in cases in which the original problems were uncomplicated oedipal issues. In such cases a patient will appear for a session and report many areas of change and improvement.

Subsequent review shows no residual problems. Termination is set for the next session and feelings toward the therapist and about saying goodbye are investigated, with associated feelings and memories explored.

In more complicated treatments, especially where loss has been a major focus, termination will continue the working through of feelings about other losses. In these patients, three to five sessions are allotted at the end to focus on a thorough experience of the “death" of the therapy and other unresolved grief. Frequently, losses not discussed earlier in treatment will now emerge—for example, a grandparent who had a special relationship with the patient. In this group, it is the therapist's job to be sure the mourning process is not avoided, or the gains from treatment may be significantly diminished to defend against painful feelings.

TRAINING OF THERAPISTS

Intensive Short-Term Dynamic Psychotherapy calls for rigorous individual and group training of at least two years for therapists experienced in psychoanalytic psychotherapy. This training consists of one hour of individual videotaped supervision for each hour of treatment, as well as a weekly one-and-a-half-hour group supervision to follow various types of patients through the course of treatment. We have extended this training to psychiatry residents and psychology interns. All training is based on a

manual. There is a concomitant didactic course on theory and technique.

CASE EXAMPLE

The following case demonstrates some phases of ISTDP treatment. The evaluation phase is emphasized due to its central importance in ISTDP. The dialogue comes from transcribed videotaped sessions.

The patient was a fifty-year-old divorced woman who was unemployed but had supported herself and her son, who was then nine, for many years. She sought treatment because she wanted more pleasure out of life, was lonely, overworked, and chronically depressed and weepy. She had a sporadic relationship with an older man, who was impotent and gambled. He was unreliable, sarcastic, and insensitive to her needs. She had an antagonistic relationship with her ex-husband, her son's father, who was also unreliable and self-centered, and who contributed little financially to the rearing of their child. There were few women and no men in her life whom she considered as friends or supports. Her relationship with her older sister, who lived a comfortable, financially secure married life, was poor.

Her relationship with her son was loving, but she feared she might die and abandon him. Her father died suddenly when she was nine years old, which was a devastating loss for her. Recently, she did have a benign tumor removed from her neck, and she suffered from hypertension, as well as

overwork, but her health was generally good.

The evaluation was the second of two evaluations by different interviewers. We use this format as a training experience in interviewing, as well as to obtain a more complete picture of the patient. The patient reacted to being asked to repeat what her problems were by rolling her eyes and laughing. The therapist chose to ignore her immediate reaction and to attempt to get the current problems mapped out first. This effort failed, as the patient remained vague and circumstantial for the first few minutes and then mentioned again, "Last week I said exactly the same thing." At this point, the therapist decided the warded off feelings and thoughts toward the interviewer for having to repeat her story were blocking the process and decided to defer the survey of current difficulties until this resistance was addressed.

After a few minutes of vague complaints the session continued.

> Therapist: I noticed that you smiled (D) when I mentioned that we'd start from scratch. . . . What is your reaction (I/F) to that?
>
> Patient: Well, obviously it's a repetition . . .
>
> Therapist: Right, you mentioned that, a repetition, let's see how you feel (I/F) about having to go through it again because I notice you're smiling (D) a lot when you start to mention repetition. Do you notice that? (*The therapist is starting to work in the triangle of conflict, linking I/F to D.*)
>
> Patient: Yeah, I'm aware of that. I understand the manner in which the program

works (D). I guess I'm kind of interested in going beyond that, however, I recognize that . . .

Therapist: So, intellectually (D) you know how the program works, but let's see what you're feeling (I/F) about having to go through it again.

Patient: O K, I'm bored (D) but I'll repeat it . . .

Therapist: Well, bored is not really feeling, it's detachment (D), isn't it? But what's your feeling (I/F) about having to repeat . . . ?

Patient: My feeling, um . . .

Therapist: . . . you like it?

Patient: Not particularly, no, well somewhere around September of last year I was told that I'd have to have surgery for a growth in my neck (D) . . . (*The patient attempts to change the focus.*)

Therapist: The surgery in your neck is obviously important, but before we move to that you were mentioning the boredom and having to repeat, and I was trying to look at what your feeling is about that.

The therapist asked for the patient's feelings toward him about having to repeat the story. The patient rapidly resorted to a variety of defensive maneuvers—rationalizing, smiling, boredom, changing the topic, and compliance, rather than declaring her feelings. The therapist began differentiating the triangle of conflict by pointing out these defenses and labeling them "not feelings." The therapist's first task was to determine the patient's ability to declare and experience her feelings, and from this determine whether restructuring would be necessary (placing her in the less

resistant or more resistant group). The interview continues:

Patient: My feeling is I guess that I've been living with a lot of history for a long time, very close up front and, um . . .

Therapist: I notice you're having a lot of trouble looking at me (D) as you start to talk about this and again you smile (D).

Patient: I don't consider myself an evasive person (D), I really don't . . .

Therapist: . . . but you bring up the word evasive now.

Patient: Well, one who does not or isn't capable of eye contact is usually removing themselves from something. I don't think I'm particularly . . . (*The patient's defense of breaking eye contact, a form of distancing, is not ego syntonic since she identifies it herself.*)

Therapist: But isn't that how you are right now with me?

Patient: O K.

Therapist: You notice that about yourself, right now?

Patient: O K, I accept that. I just think that, you know, for two hours . . . *(The use of rationalization is ego syntonic and needs more low pressure work as described in step 1.*)

Therapist: The issue is that you have some reaction about repeating. You say you're bored (D), but that's a detached state, not a feeling, you see? What do you feel (I/F) about having to go through it again here with me?

Patient: I don't know, maybe you're touching on something. I thought about that a lot, after last week's meeting, I'm not sure, other than real feelings of sadness at times. I'm not sure that I have a lot of handles on feelings and I think maybe that's because—how can I phrase it?—Right, because the feelings came up about, you know, what was I feeling and I said to myself, in

thinking about it, what are my feelings? I'm not sure I can identify them.

Therapist: O K, so they're all very vague (D). Isn't that what you're . . .

Patient: I don't know (D) that it's all very vague or . . .

Therapist: But you say you don't know (D).

Patient: . . . or an unconscious effort on my part to detach myself from feelings.

Therapist: Well, for whatever reason, right now as we try to look at your feelings you are very vague (D), whether the reasons are conscious or unconscious, you see that here with me you're vague?

Patient: Yes.

Therapist: Because there is a lot of talking about feelings, intellectualizing (D), but you don't declare how you feel (I/F) about having to repeat yourself. You mention that you thought about it after last week's session and I asked you if you liked that.

Patient: O K, I'm thinking, I'm thinking what can be gleaned (D) . . .

Therapist: Yes, but you see you go on to rationalize (D) a lot.

Patient: O K.

Therapist: You see what I'm saying about rationalizing (D).

Patient: O K, so I guess that's what I'm doing, I really don't want to address feelings and maybe that's true.

Therapist: O K, so let's look at that because this is a major obstacle that we have to address, because what is our job here? You see, what's your goal? It's to get some understanding about your feeling life.

Patient: That's true, and that's probably one of the main motivations of being here.

Therapist: Right, and then right from the start you don't want to look at your feelings, you see that? That's going to be very self-defeating if that's the direction you go in, you see, if part of you doesn't want to look at your feelings.

(*The therapist believes the defenses are now less ego syntonic and increases the pressure by a motivational statement addressed to the patient's self-defeating tendency [superego resistance].)*

Patient: I'm . . . probably aware of that and maybe that's why I'm sitting here in . . .

Therapist: O K, so let's look at this because you're saying there's part of you that doesn't want to look at feelings, that wants to rationalize?

Patient: I don't know that I don't want to look at feelings, or I really don't know (D) . . .

Therapist: You see, you begin rationalizing again (D).

Patient: Why?

Therapist: You give excuses—"I don't know if I want to look at feelings or I don't"—but I'm saying do you see this is a problem, right now for us, that as soon as we try to look at your feelings . . .

Patient: Yeah . . .

Therapist: . . . you start to rationalize (D) and you avoid (D) the issue. You're being an evasive person, in your own words, and again you're smiling (D) when I point out your evasiveness.

Patient: Smiling as opposed to crying.

Therapist: Do you feel like crying (I/F) right now?

Patient: No.

Therapist: But, you see, the issue is that you don't like having to repeat. Is that right?

Patient: That's true.

Therapist: So, how do you feel (I/F) toward me for having to repeat?

Patient: I don't know, I guess there would be (D) a degree of annoyance (I/F).

Therapist: "there would be"—you make it questionable, "there would be" (D), you see?

Patient: Yes.

Therapist: Because again you're smiling (D). Isn't that striking to you, the smile when you say you're annoyed (I/F)? I mean, isn't that the opposite of annoyance, a smile?

Patient: I would say that I have a difficult time expressing anger (I/F) or . . .

Therapist: Well, I see that now.

Patient: . . . or dealing with anger (I/F) . . . um . . .

Therapist: So, this is a major issue that we have to look at, because what we see right away is you're being an evasive person, as you put it, that you put on a facade of a smile when you're feeling angry with me, do you see that? (*The therapist is starting to address the patient 's characterological style of distancing, the wall, which is composed of all the defenses.*)

Patient: With you or probably with most people . . .

Therapist: Uh-huh, so, then, it's not just a problem here between us; this is how you are on the outside, too.

Patient: I would have to . . . I think so, I think so.

Therapist: So, then, this is a major problem that we need to look into, right, if you're going to put on a facade when we're trying to take a look at the emotional difficulties in your life.

Patient: I don't think . . . I can tell you right off the bat that I don't think I'm going to walk through that door and suddenly be a different person than I am . . . um . . .

Therapist: You mean, in other words, there's going to be a part of you that's going to hang on to the facade.

Patient: There's no doubt in my mind that I . . .

Therapist: O K, let's look at that. Would you say you have a tendency to be a stubborn (D) person?

(As one defense is given up, a new one comes more clearly into view. In this case it is stubbornness. Notice too that the therapist maintains the pace by interrupting the patient when she starts to rationalize.)

Patient: I would say probably (D).

Therapist: Probably (D), I mean is it . . .

Patient: Yeah, I would think so . . .

Therapist: So, in other words, the stubborn (D) side of you can hang on to this facade and procrastinate (D)?

Patient: The stubborn (D) side of me has been cultivated, I think, as a tool for me to live . . . um . . . and be able to survive.

Therapist: O K, so then this is another critical issue that we have to look at, you see, because I'm saying to you that it's important for us to look at your honest thoughts and feelings.

Patient: I absolutely agree with you. *(This statement indicates that the therapeutic alliance is improving.)*

Therapist: You see, but right away the idea is that you're not going to be able to let that down, that you're not going to be able to let that facade down for a long time. You know, you're looking sad (I/F) right now, you're looking really sad.

Patient: You're right. (*The patient turns down her head as she starts crying.)*

Therapist: But you don't want me to see that either. You see how you need to keep distance (D), right here with me now? That you don't want me near your feelings.

Patient: It's true.

Therapist: Let's see what it is that brought the sadness (I/F) to you.

Patient: I'm amazed that I'm crying.

Therapist: What's in your thoughts along with the sadness? *(These tears are the first breakthrough of feelings.)*

Patient: I guess I have always tried very hard to put a lid on feelings, on my feelings, because I was never . . . um . . . or rarely able to express them without being blown away.

Therapist: How do you mean?

Patient: From very early on . . .

Therapist: Right now are you fighting it, if you're honest with yourself. I mean, is part of you trying to keep a distance even as you experience a lot of pain?

Patient: No, I'm just trying very hard to maintain my composure.

Therapist: This is what I mean. Part of you wants to keep the lid on, even now, isn't that the case?

Patient: Um . . .

Therapist: Because I see you struggling. I mean, obviously there's tremendous feeling (I/F) in you right now and you're starting to talk about a lot of painful issues from the past but even as we, together, try to understand your difficulties part of you wants to keep the distance (D), keep the barriers and not let me into your intimate thoughts and feelings.

(As feelings emerge, there is an effort to suppress them; the therapist must clear this residual resistance.)

Patient: I would guess that's probably true, it's conflict of being frightened of revealing what I'm really feeling because my experience has not been a terrific one when I've done that.

Therapist: So, there's a lot of fear about closeness and openness.

Patient: Absolutely true, there's no question in my mind that I . . . and not only is that true but I think I've chosen people who have been important. . . have played important roles in my life . . . um . . . who are incapable of hearing or dealing with feelings, and I don't think that's an accident, I think that I definitely made a conscious effort, whatever the design was I just filled in the tapestry.

Therapist: So, then the question is how that's going to be here with me, you see,

because I'm the one now who wants to get to know your intimate thoughts and your intimate feelings.

Patient: I don't think it's going to be easy, I really don't, but then I say to myself I really want to do it, and generally when I am determined to do something I do it! . . .

Am . . . I am ready to make changes. I don't think those changes are going to be easy or painless, but I've come to a stage in my life where I really believe it's time that, um . . . (*The patient is declaring a high level of motivation.)*

Therapist: O K, well, then, let's look. You started to tell me about your surgery, a lump in your neck that you mentioned earlier.

This transcript reflects the first fifteen to twenty minutes of the evaluation session. The patient displayed both ego alien defenses such as breaking eye contact, a form of distancing that she immediately acknowledged as a problem, and ego syntonic defenses such as rationalization. Her rationalizing required repeated highlighting by the therapist so that her feelings toward him about repeating her story could be clarified. This combination of ego syntonic and alien defenses places the patient in the moderate resistance range. She also had psychosomatic symptoms, which indicate higher resistance. Other defenses became clear as well, especially stubbornness. As evidence of a good therapeutic alliance appeared, indicated by the patient's linking her avoiding eye contact and evasiveness, and her agreeing that one goal in therapy would be to understand her feelings, a challenge to her self-defeating behavior (superego resistance) was initiated. It became clear that part of the patient's problems

were her characterological difficulties, especially various forms of distancing. She agreed that she used her facade with everyone (T-C linkage). Then a wave of sadness and crying emerged, which the patient attempted to control. This was the first breakthrough of more intense feelings. Although anger was the initial topic, sadness about her loneliness and lifelong struggle surfaced. This is typical in moderately to highly resistant patients. The breakthrough of sad feelings results in a high level of motivation. The patient declared: "I really want to do it, and generally when I am determined to do something I do it!"

This part of the interview lasted twenty minutes. The evaluation then continued to survey her current problems. It became clear that she was angry with her ex-husband. As an effort was made to look at this anger, resistance increased. Finally, the patient recalled an incident when she actually attacked him. This attack was determined to be an isolated event, indicating that the patient did not have an impulse control problem. She described her rage as a "bolt of lightning" exploding in her chest, accompanied by the urge to lash out at him. Her voice was raised and her upper body was animated. She was asked, "What if you did let it all out in fantasy?" She struggled against this idea, again resorting to stubbornness. Finally, she admitted really wanting to hurt him by punching his face. In actuality, she had sat on his chest and punched his arms, avoiding more vulnerable targets. As the therapist pressed for more fantasy, the patient spontaneously declared her hatred of her mother and how she would have liked to lash out at her. As she described her

violent feelings toward her mother, she was shaken by a wave of nausea. This was followed by tears of depression and hopelessness. More restructuring work was done around the triangle of conflict in regard to these violent feelings and the accompanying depression and anxiety.

Throughout the evaluation, the three parameters of feeling (motoric, physiological, and fantasy) were being assessed. As this was done, the therapist indicated that lashing out verbally or physically is not recommended and actually may be a form of defense.

Over the first several sessions, more work was done on restructuring the patient's ability to tolerate rage and intimacy. Many violent memories and dreams surfaced. Her violent fantasies toward her ex-husband and her mother were linked. She remembered that after her father's death, she had to share her mother's bed. Every night she would fall out of bed trying to remain far from her mother, who was very critical and jealous of her close relationship with her dead father. The mother blamed her for her father's death ("you loved him to death") and constantly repeated how she wanted to abort the patient, but the father had stopped her. During the fourth session, the patient had an urge to dismember and chop up her ex-husband, which she related to cutting up chickens as a young girl and finally linked to violent feelings toward her mother. Around the seventh session, her mother actually died. Although she had been estranged from her mother for years, she was

able to attend the funeral. To her surprise, she cried at the funeral.

After the tenth session, the patient stopped complaining of being depressed and was no longer weepy. As the treatment progressed she obtained a suitable job and reported feeling much lighter and more alive. In a moving session in the midphase of treatment, she described a date with an abusive man. Once she heard how sarcastic and abusive he was, she informed him she would not tolerate abuse and ended the date. Later that session, she described new empathy for her mother, who slaved to raise her, and anger at her father for being self-centered and abusive toward her mother. With great pain and tears, she acknowledged how painful it must have been for her mother to receive the father's abuse and then see him cuddle his little princess. No wonder her mother hated her. This was a major shift, since her father had always been idolized. She now linked the abusive men in her life with her father.

As the treatment moved toward termination, the patient was ambivalent, feeling she was not ready. Nearing the end mobilized anger and sadness toward the therapist. These feelings were linked to mixed feelings about other prematurely lost people, her father and mother.

At the six-month follow-up, the patient reported maintaining all her previous gains. She no longer suffered from depression and had an

appropriate job. She was much closer to her son, her sister, and several friends. The patient achieved significant characterological improvement and symptom resolution.

EMPIRICAL SUPPORT

Davanloo (1978, 1979, 1980) has performed three clinical studies on ISTDP. His patients were seen for an average of twenty sessions. They included patients with neurosis and longstanding personality disorders. Baseline and outcome assessments were performed by independent evaluators. Forty percent of patients had follow-ups of five to seven years. Davanloo reported substantial clinical gains, which were maintained at termination and long-term follow-up.

The efficacy of ISTDP has been examined in a more systematic study (Winston et al., 1991). ISTDP was compared with Brief Adaptive Psychotherapy (BAP) and a waiting list control group. Patients with longstanding personality disorders, including avoidant, dependent, histrionic, obsessive-compulsive, passive-aggressive, and mixed personality disorders, were treated by experienced therapists. Both therapies (ISTDP and BAP) showed significant improvement on target complaints, SCL-90, and the Social Adjustment Scale, compared with waiting list control subjects (see table 3). Effect sizes for ISTDP ranged from .80 to 1.35. The two therapy groups were

similar in overall outcome but showed differences on the anxiety and depression subscales of the SCL-90. ISTDP was significantly better on the depression subscale, while BAP patients were more improved on the anxiety subscales. In addition, findings at midphase (Trujillo & McCullough, 1985) indicated that ISTDP patients had more symptoms, including anxiety, than on admission. These findings may indicate that ISTDP is effective at mobilizing affects (particularly anxiety) that may take some time to work through.

We examined a number of therapist and process variables in ISTDP and BAP using a coding system developed for videotaped psychotherapy sessions (McCullough et al., 1985). ISTDP therapists are very active, intervening at the rate of approximately 2 interventions a minute. In a session there are an average of 12.7 patient-therapist interventions and 27.3 interventions related to current and past figures (see table 4). Since ISTDP is twice as active as BAP, many therapist interventions occur more frequently in ISTDP than in BAP. However, it is clear that ISTDP uses more affective and verbal probes (22.9 [11.1 percent] versus 5.9 [5.7 percent]) while BAP has relatively more questions and cognitive probes (22.8 [21.9 percent] versus 27.6 [13.4 percent]). These process results indicate that ISTDP has more of an affective focus than does BAP, while both therapies actively use the transference and have an interpersonal focus.

TABLE 3

Admission and Termination Means and Effect Sizes for Global Outcomes across Groups

	BAP (N = 17)	STDP (N = 15)	Controls (N = 17)	Analysis of Convarience
*Target Complaint I**				
Admission	10.47	10.08	11.69	F = 12.46
Termination	6.67	5.91	10.25	P = .0001
Effect size	1.23	1.35	.46	SD = 3.10
*SCL-90 Global Score**				
Admission	44.55	43.77	47.38	F = 4.84
Termination	36.27	36.62	44.06	P = .01
Effect size	1.11	.96	.45	SD = 7.45
*Social Adjustment Scale**				
Admission	2.06	2.13	2.15	F = 6.68
Termination	1.74	1.76	2.18	P = .003

Effect size	.70	.80	-.07	SD = .45

Note: Effect size was computed by subtracting the termination mean from the admission mean and dividing by the standard deviation of the combined control and experimental groups.

*The scores of the two groups given therapy were significantly different at termination from those of the control group ($p < 0.05$, Duncan Multiple Range Test).

In another process study using patients treated with either ISTDP or BAP, we were unable to find single therapist or patient variables that correlated with outcome (McCullough et al., in press). However, when variables were examined in context (patient response to a therapist intervention) we found a significant contribution of transference interpretation followed by patient affect to improvement at outcome. Furthermore, Taurke, Flegenheimer, McCullough, Winston, & Pollack (1990) demonstrated that two patient variables (the ratio of patient affect to patient defense) were significantly correlated with outcome in our pooled sample of ISTDP and BAP patients.

CONCLUSION

ISTDP appears to be an effective treatment. It has a significant range of application, which is being broadened as modifications are added. There are unique technical aspects, which require extensive and systematic training. ISTDP is believed to be a sound training model as well (Laikin, 1990). We are

committed to ongoing research to further define elements of technique and patient selection.

TABLE 4

Average Frequencies of Occurrence per Session of Therapist Behaviors in the Two Treatment Groups

Behavior	BAP	STDP	t	P
Questions and cognitive probes	22.8	27.6	1.31	ns
Affective and nonverbal probes	5.9	22.9	5.95	.0002
Clarification	16.5	27.0	1.33	.0012
Confrontation	13.8	30.8	5.19	.0002
Addressing defensive behavior	15.0	34.5	1.19	.0005
Addressing anxiety	3.3	3.8	.76	ns
Addressing warded off impulses	4.8	12.6	3.4	.004
Patient-Therapist interventions	8.3	12.7	1.69	.11 (ns)
Intervention related to current and past figures	11.5	27.3	3.67	.004

Advice/support	3.1	3.6	.50	ns
Total therapist activity	104.0	206.0		

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