

Intensive Short-Term Dynamic Psychotherapy for Severe Behavioural Disorders: A Focus on Eating Disorders

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AD HOC Bulletin of Short-term Dynamic Psychotherapy: Practice and Theory. 2013, 17(1): 5-22

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Summary

In this article we provide a detailed outline of a method to evaluate and treat patients with severe behavioural disorders such as eating disorders and addictions. After reviewing 3 major categories of clients with these disorders, we outline a treatment approach based on Davanloo's ISTDP for patients with fragile character structure. This new metapsychology elucidated through extensive case-based research can help the therapist explain and handle the common problems observed when these clients give up various behavioural mechanisms. If the upsurge in emotions is not understood and handled, adverse effects and high rates of drop out can ensue: on the other hand using the ISTDP framework, these events can be turned into therapeutic events accelerating growth and healing processes. A detailed approach to capacity building in patients with fragile character structure is provided as these cases are very common and challenging to treat. This review is particularly applicable to those working in day programs and hospital based programs for behaviour disordered clients.

Introduction

Intensive Short-Term Dynamic Psychotherapy (ISTDP) can be applied with people with a broad range of self-destructive behavioural problems including substance abuse, gambling, compulsive sexual activity, poor impulse control, violence, temper tantrums, self-harm, risk-taking, and the spectrum of eating disorder related symptoms. In this paper we will have a particular focus on patients with Eating Disorders (EDs). We will define the different types of ED patients according to the metapsychology developed by Davanloo (1990, 2000). We will illustrate how unconscious mechanisms produce and perpetuate the self-destructive behaviours seen in these patients. Additionally, we will clarify how ISTDP may be an effective aid in working with these patients when behaviours are removed while psychopathological forces are still in operation. We will emphasise the technique as it applies to patients with severe fragile character structure/borderline organisation. We will also discuss unique treatment and therapist issues in working with behaviourally disordered patients.

The following material is derived from articles written by Davanloo and others, as well as from the work of the authors with patients in a variety of settings, including specialist ED services (Abbass & Kennedy, 1993).

The reader should note that this article must be taken in the context of the knowledge, skill level, and experience of the therapist: the rapid approach described herein should not be undertaken without adequate training and supports in place.

Empirical Support for Short-Term Psychodynamic Psychotherapy

Over the past 40 years a growing body of research has been conducted into the use of Short-Term Psychodynamic Psychotherapies (STPPs). Consequently, there is now good evidence to support the use of these approaches in treating patients from various psychiatric populations and with shorter duration and less costs compared to traditional longer-term psychoanalytic approaches. There are over 150 published outcome studies and 12 meta-analyses of STPPs showing, in general, large effect sizes that persist in follow-up for mixed - (Abbass, Hancock, Henderson, & Kisely, 2006; Leichsenring, Rabung, & Leibing, 2004), somatic - (Abbass, Kisley, & Kroenke, 2009), depressive - (Abbass & Driessen, 2010; Driessen, et al., 2010), and personality disordered patients (Abbass, Town, & Driessen, 2011; Town, Abbass, & Hardy, 2011).

In a recent meta-analysis of Davanloo's ISTDP, 21 studies (10 controlled, and 11 uncontrolled) were found reporting the effects of ISTDP in patients with mood, anxiety, personality, and somatic disorders. Robust pre- to post-treatment effect sizes were found ranging from 0.84 (interpersonal problems) to 1.51 (depression) (Abbass, Town, & Driessen, 2012) that were maintained in long-term follow-up. Based on post-treatment effect sizes, ISTDP was found to be significantly more efficacious than control conditions. Several studies included patients with personality disorders (PD) including three independent randomised controlled trials (RCTs), indicating that ISTDP is an empirically supported therapy for PD. Eight studies using various measures also suggested ISTDP was highly cost-effective.

Looking more specifically at the evidence for STPP and EDs, there are several published outcome studies. Dare et al. (2001) compared STPP with cognitive-analytic therapy, family therapy and routine treatment in the treatment of anorexia nervosa (AN) in adults. The STPP yielded significant symptomatic improvements and along with the family therapy, was significantly superior to the routine treatment.

Three studies have looked at the effectiveness of STPP treatment for adolescents with AN. Robin, Siegel and Moye (1995) and Robin, et al. (1999) compared behavioural family systems therapy (BFST) with ego-orientated individual therapy (EOIT) with both treatments found to be equally effective. Fitzpatrick, Moya, Hoste, Lock and le Grange (2010) manualised the EOIT model of STPP from that trial and re-named it Adolescent Focused Therapy (AFT). Lock, et al. (2010) compared the efficacy of AFT with Family Based Treatment (FBT) and found that both treatments led to considerable improvement and were similarly effective. Additionally, a small non-randomised study (Vilvisk & Vaglum, 1990) looked at the long-term follow-up of a group of adolescents who had received STPP for AN. Most of the young people in this study had a good outcome.

For the treatment of bulimia nervosa (BN), significant and stable improvements in BN, after STPP, have been demonstrated in studies conducted by Fairburn, et al. (1995), Fairburn, et al (1986) and Garner, et al. (1993). In the primary eating disorder specific measures (bulimic episodes, self-induced vomiting episodes), STPP was as effective as CBT. However, in an RCT conducted by Bachar, Latzer, Kreidler and Berry (1999), STPP was significantly superior to both a treatment as usual group (nutritional counselling) and cognitive therapy.

A small case series (Nowoweiski, Arthey, & Bosanac, 2011) using ISTDP with a mixed sample of patients with AN and BN yielded significant improvements in depression scores over a four-week day treatment program. Further, qualitative analysis revealed the patients expressed satisfaction with the component of their treatment that was most closely related to ISTDP.

Davanloo's New Metapsychology as it Relates to Patients with Eating Disorders

Spectra of ED patients suitable for ISTDP

Davanloo has described two spectra of suitable patients: the spectrum of psychoneurotic disorders and the spectrum of patients with fragile character structure (Davanloo, 1995, 2001). Broadly speaking and using ISTDP metapsychology, patients with 'severe' behavioural disorders can be classified into three groups: 1) *highly resistant character neurosis without repression*; 2) *highly resistant character neurosis with repression*; 3) *mild to moderate fragile character structure*; or, 4) *severe fragile character structure (borderline organisation)*.

Highly resistant patients have primitive murderous rage, guilt and grief in the unconscious leading to a self-destructive *punitive superego* system (Davanloo, 2001): they do not routinely use primitive defences nor do they experience cognitive disruption when anxious. Patients with fragile character structure had insecure attachments and repeated interruption of efforts to bond causing primitive rage with intense guilt and grief, leading to primitive defences and cognitive perceptual disruption when anxious.

In this article we will not focus on ED patients with moderate resistance, who have a relatively mild set of trauma related feelings, usually from ages 5 to 8, as they are rarely seen on ED inpatient or day hospital treatment programs. Further, low resistant patients, who are quite healthy with some unresolved grief, do not experience ED or other severe behavioural disorders.

The following table provides an overview of ISTDP derived metapsychology of these three groups of ED patients.

Table 1 *Summary of ISTDP Metapsychology*

Category	Core Neurotic Structure	Anxiety Pathways	Major Resistances	Treatment Duration	Core Treatment Elements
High Resistance with or without prominent repression	Attachment trauma age 5 or less. Murderous or primitive murderous rage, guilt and grief.	Striated Muscle Smooth Muscle	Isolation of Affect Repression	10-40	Graded format when needed to override instant repression. Handling resistance, mobilization of the unconscious. Repeated unlocking with experiencing of murderous rage and guilt about rage. Rapid working through to termination.
Mild to Moderate Fragile Character Structure	Disorganized attachment plus trauma. Primitive torturous murderous rage, guilt, grief, intense craving of attachment.	Limited striated muscle Smooth Muscle Cognitive & Perceptual Disruption	Limited Isolation of affect Repression Projection, Splitting &, Projective Identification	20-100	Graded format to bring structural changes at level of unconscious anxiety and defence. Thereafter, repeated unlocking of the unconscious, working through and termination. Partial courses can be beneficial and range from 20-50 sessions.
Severe Fragile Character Structure (Borderline Organization)	Disorganized attachment plus trauma. Primitive torturous murderous rage, guilt, grief, intense craving of attachment.	Cognitive & Perceptual Disruption	Projection, Splitting & Projective Identification	100-150	Extensive phase of bringing multidimensional structural changes at level of psychic integration, unconscious anxiety and defence followed by repeated unlocking of the unconscious, prolonged phase of working through and termination.

Discharge pathways of unconscious anxiety and related resistance

Davanloo discovered, through extensive videotape research, three major discharge pathways of unconscious anxiety and the process of conversion (Abbass, Lovas, & Purdy, 2008; Davanloo, 2005). The first is *striated muscle unconscious anxiety*, a neurobiological pathway beginning with thumb tension, proceeding to hand tension, chest wall tension and tension progressing down the body: the main observations in patients with this pathway activated are hand clenching and sighing respirations. Accompanying this discharge pathway, Davanloo noted patients could intellectualise about emotions without experiencing them: he called this type of resistance '*isolation of affect*'. The second pathway he noted is *smooth muscle unconscious anxiety*, which affects the involuntary muscles of the gastrointestinal (GI) tract, blood vessels and airways, resulting in medical problems such as migraines, irritable bowel syndrome and hypertension. Accompanying this pathway of anxiety he noted '*repression*' of emotions and major depression: when this pathway is active the patient is not able to isolate affect and the striated muscles are not activated. The third pathway is *cognitive and perceptual disruption*, where the person experiences visual blurring, disturbance of hearing, along with mental confusion and a change in level of consciousness: patients with this anxiety pattern tend to use primitive defences of splitting, projection and projective identification. When CPD is active, the patient has no access to striated muscle tension and cannot isolate affect. Patients with motor conversion, characterised by muscle weakness, also have repression of emotions, an absence of striated muscle unconscious anxiety and an inability to isolate affect. The evaluation of discharge pathways of unconscious anxiety and resistance is central to psychodiagnostic evaluation in Davanloo's ISTDP.

Davanloo (2001) uses the term '*projective identification and symptom formation*' to describe the process where the patient identifies with the victim (attachment figure) of their violent fantasies and experiences psychosomatic symptoms that exactly match the injuries they unconsciously imagine inflicting (e.g., crushing chest pain in a patient who crushes the chest of his victim). The patient may also experience chronic pain and/or weakness in the areas of their body that they would use to inflict these injuries (e.g., weakness in the knees of a patient who stomps their victim to death), in an unconscious attempt to both punish the patient and protect others from their rage. Projective identification and symptom formation are strongly linked to psychopathology in these patients and is driven by unconscious guilt (Davanloo, 1987, 1988, 2001, 2005).

Through therapeutic *pressure* (focus) to identify emotions and experience these emotions, unconscious anxiety and defence patterns can be directly assessed. This can then lead to a treatment pathway as described in Figure 1 below.

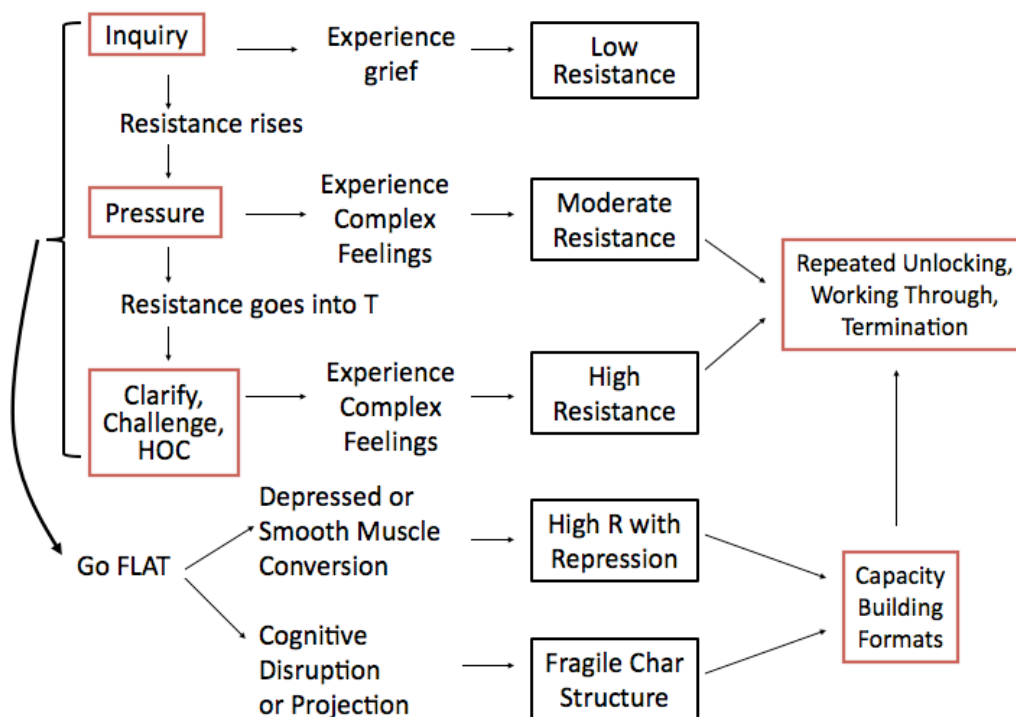


Figure 1. ISTDP Psychodiagnostic and Treatment Pathways.

* Red boxes indicate therapist intervention and processes. Black boxes indicate position on the Spectra. 'HOC' is *head on collision*. 'Resistance goes into T' refers to when the defences crystallise in the therapy relationship.

Psychopathology and ISTDP Treatment of ED Patients

We will now describe the core patient features and treatment approaches related to the four categories of ED patients.

1. Highly Resistant patients without major repression

From clinical experience, one third to one half of inpatient and day program ED patients have high resistance. Approximately one half of these are highly resistant without prominent active repression. These patients have anxiety that is primarily in striated muscle and they may have somatic pain complaints and anxiety disorders along with their ED symptoms. These patients have repressed primitive murderous rage with unconscious guilt of an intensity that can produce major depression and suicidality. When they are asymptomatic they have major character resistance with secondary relationship problems. They may use illicit substances (or prescription medication) as a defence against their anxiety and in such cases there is a redistribution of psychopathology.

In this category, the ED symptoms serve a masochistic function, satisfying a need to self-punish, due to repressed guilt about rage towards attachment figures. Their ED symptoms are defences against the experience of anxiety, painful feelings and rage. However, ED symptoms can become a medical syndrome and then the picture becomes clouded by secondary biological factors, which must be resolved to proceed in therapy. These patients have suffering distributed over all spheres of life and personal functioning: relationships, occupational function, enjoyment, self-esteem and insight are interrupted.

Highly resistant patients have major problems with emotional closeness and intimacy. Emotional closeness is anxiety provoking because it stirs up the unresolved feelings from past attachment trauma. Thus, during adolescent development, with possibilities of starting intimate relationships and separating from parents, underlying attachment related emotions are mobilised, resulting in ED behaviours. The symptoms then thwart separation and new attachment while suppressing the stirred up feelings and anxiety.

The unresolved load of guilt in the unconscious demands punishment and explains the 'economical' symptom substitution seen when a patient recovers from one symptom only to adopt another. For example, characterological issues or substance abuse may become more prominent when ED symptoms decrease and vice versa. This also explains the suicidality that is common in this group: there is constant need to pay for the unconscious murder of loved ones. In this population, successful resolution of psychopathology is contingent on helping the patient experience and work through the reactive rage and guilt about that rage; as well as to help them deal with the pain of the loss related to the original bonds. Therefore, when working with the highly resistant patient group, several aspects of ISTDP metapsychology must be borne in mind.

1. Monitoring Unconscious Anxiety

It is essential to continually monitor both the level and manifestations of unconscious anxiety in all ED patients. When you challenge a patient's defences, which in these cases mean challenging the patient's ED behaviours, it will mobilise feelings toward the therapist. Davanloo (1995) notes that the first layer of feelings activated by this process is usually anger with the therapist for not allowing them to use their customary defences. In the patient's unconscious, this links with all the past situations that have made them angry. However, alongside the anger lies a quite opposite feeling of warm appreciation that another human being is going to such lengths to sweep aside the facade and to get close to their true self. Davanloo calls these feelings the *complex transference feelings* (CTF). The CTF mobilise all emotions related to attachment and interruption of attachment and subsequently unconscious anxiety and defence are mobilised in treatment sessions.

2. Defense Restructuring

The ability to recognise and manage the patient's defences is an essential skill for therapists working with patients with severe behaviour disorders. The therapist must focus on each defence as it is mobilised to the frontline of the patient's defensive system. Patients must be helped to see these defences, understand how their defences operate and the costs of these defences in their lives. It is only when a patient is able to see their defences and the problems that their defences are causing, that the patient is able to decide to relinquish these defences. Then he or she can align with the therapist against the defences and together, they can begin to examine the origin of the patient's trauma. Ultimately, to get to the unconscious feelings, all layers of defence must be overcome.

It must be emphasised that the approach has to be tailored to defences as they are operating at each moment in the interview with the therapist: these are not cookbook approaches that apply to every patient with a certain defensive style. Rather, the therapist must work with the resistances present and how they are manifesting at that moment.

As most patients with EDs enter treatment unaware of their defences and the harm these defences cause, to the defences are referred to as being *syntonic*. Syntonic defences exist when the patient is so identified with their defences he or she does not see them. They may see themselves as the "perfectionist" or the "stubborn" person, as they do not see the damage they cause by continuously pushing people away and self-abusing via these mechanisms. Pressure to feelings and/or challenge to syntonic defences will create problems such as misalliance and potentially depression or other self-destructive defences. These defences first need to be made *dystonic* by helping the patient see the defences and how they prevent an open relationship with the therapist and thus, how they are self-defeating mechanisms. This process leads to the experience of grief over having the defences and distancing people in the past.

In the context of ISTDP treatment, *pressure, clarification and challenge* to the resistances are the main interventions employed. *Head on collision* with resistance is required when the highly resistant patient brings his or her defences into the therapy relationship or 'the transference' in such a way as to directly sabotage the process. This statement of reality has multiple functions including deactivation of defiance, undoing projective identification, and undoing the notion of the omnipotent therapist (Davanloo, 1999a, 1999b, 1999c).

3. Unlocking the Unconscious

The above noted pressure and work on defences mobilise CTF leading to the conscious experience of the CTF. When this neurobiological, somatic experience of rage, guilt and grief takes place, the unconscious anxiety and defences are broken through and this leads to a

dominance of the forces of the *unconscious therapeutic alliance* (UTA) over the resistance. Davanloo refers to the experience of the CTF as the triggering mechanism for unlocking the unconscious (see Figure 2).

The UTA is the innate healing force in the patient that helps carry the unconscious feelings into conscious experience for the patient by producing images of the unconscious and clear linkages to past attachment trauma. The UTA is considered the most important therapeutic force in the patient and is seen as more important than the conscious therapeutic alliance (CTA), particularly in patients who are constantly experiencing an unconscious need to self-sabotage.

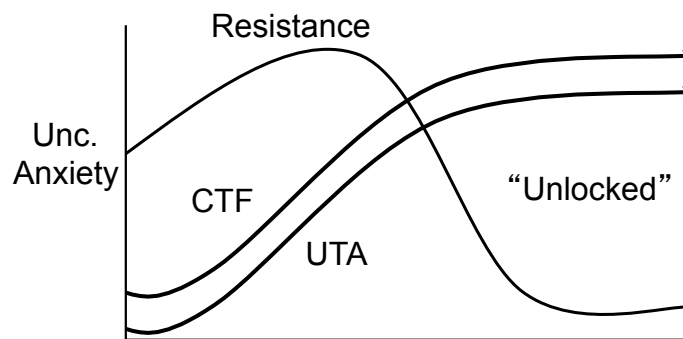


Figure 2. Unlocking the unconscious: Unremitting format (Davanloo, 1995).

4. Treatment Phases in the Highly Resistant Patient

Following the first unlocking of the unconscious, the process moves to a phase of repeated unlocking of the unconscious with the goals of removing the pathogenic guilt about rage. This is followed by working through and a relatively brief phase of termination. Typically, this can all take place over approximately 40 sessions, though a shorter course of treatment can also yield sustained benefits in conjunction with time limited, day hospital and inpatient program admissions.

Highly resistant patients without repression are candidates for the unremitting format of unlocking the unconscious as described above: pressure, challenge, head on collision and direct experience of the CTF leading to dominance of the UTA (see Figure 1 above).

II. High resistance with repression

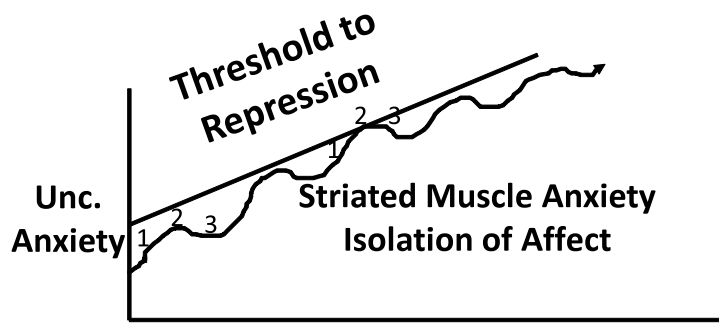
In contrast to the highly resistant patient without major repression, *highly resistant patients with repression*, have lower capacity to tolerate anxiety and will become flat at a low rise in CTF. Patients in this group have access to smooth muscle discharge of unconscious anxiety. Their deficits are related to an absence of ability to self reflect and isolate affect. This

parameter may be assessed from cues in the history, but the best assessment is what is seen in the interview when situations of anxiety are explored. Since this capacity fluctuates day to day, it must be continually assessed and treatment interventions titrated to match. Specifically, when treating patients with EDs, organic factors such as starvation lower a person's emotional capacity. This is why in many specialist ED clinics, patients can be seen to improve in their ability to access striated muscle anxiety and isolation of affect over a course of refeeding. The current capacity of the patient dictates the rate of rise in CTF that a person may tolerate.

Instant repression occurs in these patients because the rise in CTF brings a rise in the unconscious rage, which is prevented from reaching consciousness, and is instead internalised into physical symptoms. This is seen in the patient going flat, going weak and becoming depressive. In response to this reaction, this group of patients may experience a desire to binge or have urges to self-harm due to the residual guilt that has been mobilised by the triggering of unconscious rage.

Functional somatic disturbances caused by smooth muscle anxiety and conversion can be noted in the patient's history but are diagnosed through observation. When these mechanisms are in operation, there is a relative absence of striated muscle anxiety, since the unconscious feelings are being channelled into the functional disturbance. The mechanism of symptom formation is the instant repression of rage and guilt. Full syndromes, such as major conversion reactions, may also occur when there is a rise in unconscious feeling that lingers over hours or days without reaching consciousness (Abbass, et al., 2008).

The treatment approach for patients with instant repression is the *graded format of ISTDP*. The graded format involves cycles of pressure alternating with recapitulation. This work changes all anxiety into striated muscle and all defence into isolation of affect. This is critically important with symptoms such as conversion where the patient may have major untoward reactions if pressure is applied without restructuring first. This highlights the need to monitor the patient's unconscious anxiety, as the therapist needs to see a rise in striated muscle anxiety in order to continue pressure. If the therapist does not see a rise in striated muscle anxiety, it is likely that instant repression is in place (Abbass & Bechard, 2007; Davanloo, 1990). This mechanism must be fully restructured by gradually bringing the CTF into conscious awareness in a stepwise fashion with very close monitoring for repression, as shown in Figure 3.



1. Pressure to feelings or to defences
2. Rise in complex transference feelings and anxiety
3. Intellectual recap to bring isolation of affect

Figure 3. The graded format of ISTDP.

At each level of rise in the CTF, *isolation of affect* must be brought in to replace repression in order to augment anxiety tolerance. This helps prepare the way for a safe and smooth unlocking of the unconscious (see Figure 4). A single unlocking of the unconscious can permanently weaken the repressive mechanism, as the patient has faced some of the feelings they have feared without hurting anyone.

The treatment process after bringing these structural changes is similar to that of the highly resistant patient, with repeated unlocking, working through and termination.

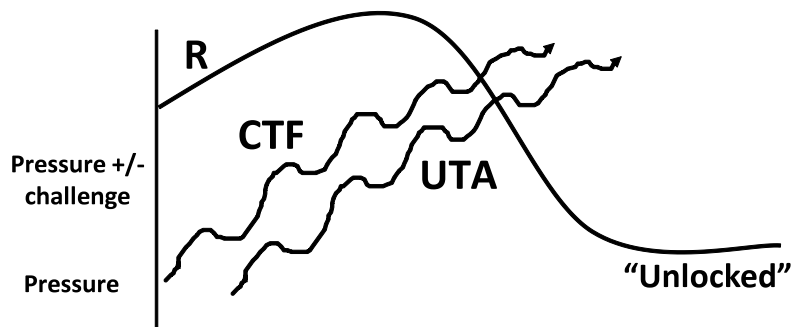


Figure 4. CTF and UTA when using the graded format of ISTDP.

In inpatient and day hospital ED programs, monitoring rise in CTF, repression and application of capacity building formats of ISTDP, are powerful skills that help prevent symptom substitution and other untoward effects from the rapid arrest of ED behaviours.

III. Mild to moderate fragile character structure

From our clinical experience, approximately one quarter of patients requiring inpatient and day hospital ED treatment can be categorised as having mild to moderate fragile character structure. The underlying intense emotions are similar to the above group except the early bonds were not secure. This deficit, coupled with thwarted efforts to attach thereafter, results in massive rage, guilt and self-destructive systems. To make this worse, these patients have fewer, if any, compensatory relationships through which to internalise higher level defences like isolation of affect. Interestingly, clinical case research has shown that any positive affectionate bond in life will prevent the development of fragility or borderline organisation: in many cases, this first bond is with a therapist.

The repressed feelings are so intense that they produce massive anxiety with cognitive and perceptual disruption (CPD) and primitive defences. Corresponding to this, they have limited access to isolation of affect. CPD is in some instances a defence against homicidal or suicidal impulses. These patients often have problems with impulse control and substance abuse. They have a narrow repertoire of more primitive defences such as projection, projective identification and splitting. They also tend towards significant repression with poor memories. For example, at the end of a therapy session, mild to moderately fragile patients may not remember what happened 20 minutes earlier.

The ED symptoms in these patients have the dual functions of self-maintenance/protection and self-sabotage. These patients typically become disorganised on inpatient wards when their ED symptoms are removed. They will have a drive to find other defences to reduce their anxiety and may succumb to major regressions such as self-injury, substance abuse, paranoia, temper tantrums, depression or somatisation. They may also learn new ED behaviours from other group members, such as new ways to purge, to simultaneously manage their anxiety and to self-sabotage.

The treatment tasks here are more complex, with the need to build higher-level defences and higher levels of anxiety tolerance. This restructuring process requires the graded format as described above, which may then be followed by repeated unlocking of the unconscious to enable the patient to experience the repressed rage, guilt about that rage and grief associated with attachment trauma. The unconscious rage in these patients is primitive and voluminous,

necessitating more sessions followed by an extended working through to termination. Shorter treatment courses can be helpful in reducing symptoms, but typically ISTDP treatment is over 40 sessions and up to 100 with more prolonged phases of working through and termination.

IV. Severe fragile character structure

Approximately one-third of patients requiring specialist treatment for EDs have severe *fragile character structure* or what is more commonly called *borderline organisation*. Although this is not necessarily Borderline Personality Disorder (BPD), patients with severe fragility typically do meet criteria for BPD. This is a primary disorder of self-functioning compounded by severe *superego pathology*. These patients have experienced massive emotional trauma in their early attachment relationships, hence they have enormous repressed rage and guilt about the rage. They have lifelong primitive defences including temper tantrums, explosive discharge of the affect, poor impulse control, projection, double and multiple projective identification, drifting, drowsiness, dissociation, and disruption of their cognitive and perceptual function with hallucinatory experiences (Davanloo, 2001). They tend to have extremely high levels of fear and distress and are prone to substance abuse and addiction. They have major projection and secondary defiance (e.g., projecting that the therapist is controlling and then defying him or her). They may have spontaneous breakthroughs of rage that are not connected to any unconscious issue. Self-harm, including cutting, is more common here compared with the patients described above. There is a more prominent lack of development of an integrated self in these patients and there is significant projection with splitting as a primary defence against experiencing anxiety. This has a defensive component and is due to a lack of development. They have little to no access to isolation of affect and their behavioural problems may be understood as due to interactions with projected aspects of the split parts of the self. These mechanisms create severe interpersonal problems, including countertransference responses in therapists.

These patients may experience brief psychotic states that will often be fully repressed. This renders the patient unable to report events as they have very heavy use of instant repression, giving them poor memories. This may be evident in reports of time lapses and other features of dissociation.

With these patients, removal of the ED symptoms may induce more severe symptoms, including psychotic regressions, terrified states and the need to use substances. The ED symptoms are sometimes the most adaptive defensive system that these patients are able to manifest so their rapid removal may activate more primitive defences due to the inability to tolerate the intense emotions surfacing.

ISTDP Treatment of Severe Fragile Character Structure

In each of the above-described groups of patients, there has been a decreasingly adaptive defensive structure, from high resistance through to mild-to-moderate fragile character structure. However, these defensive structures have enabled each of these groups of patients to maintain some, albeit increasingly limited, internal sense of themselves. Patients with severe fragile character structure have virtually no internal structure and therefore, almost no sense of themselves as a person. Due to heavy reliance on projective defences and splitting, there may be no unconscious anxiety. These patients require a global restructuring of unconscious anxiety, defences and feelings: they require the creation of an internal self-reflective capacity through which the patient is able to develop an integrated sense of what is occurring within themselves. Specifically, they need to gain access to isolation of affect and striated muscle discharge of anxiety (Davanloo, 2001). Thus, these patients require an extensive phase of multidimensional structural change prior to unlocking the unconscious: thereafter repeated unlocking, extensive working through and termination may take place (refer Table 2 and Figure 5).

Table 2

Phases of Therapy with Patients with Severe Character Fragile Structure

Phase	Task
1. Structural Integration	Multidimensional structural work to create an integrated patient
2. Graded Format	Multidimensional structural work to build capacity to tolerate anxiety
3. Repeated unlocking	Experience of repressed pain, rage, guilt and craving of attachment
4. Working Through	Mobilisation and experience of residual grief, rage, guilt, consolidation
5. Termination	Closure of the therapy relationship with working through of remaining grief

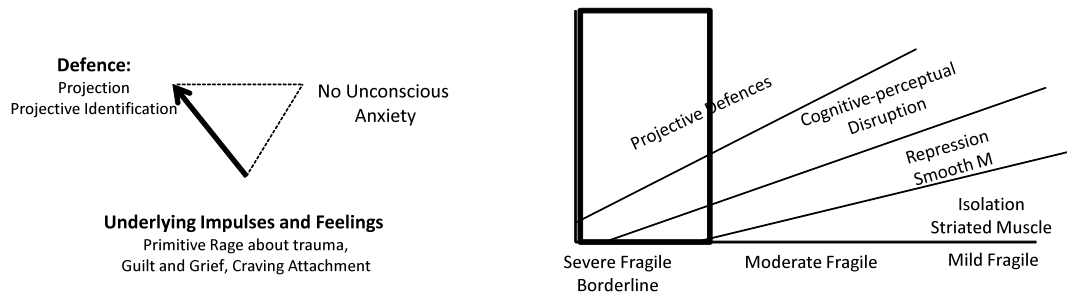


Figure 5. Self-structure of patients with borderline organisation prior to multidimensional structural change.

Phase 1: Psychic Integration

This group of patients typically have splitting of the psyche. In this extremely primitive defensive system there are multiple fragments of personality, all simultaneously engaging in different (but often overlapping) projective processes. The ‘presenting’ personality (the patient) is frequently internally bombarded with these multiple, simultaneous split parts as they try to engage with the therapist. Regardless of the degree of the split, all pieces must be brought together and integrated into one patient, as the therapist needs to have one patient to work with in order to build emotional capacities.

The early phase of treatment for this group entails bringing higher-level defences of isolation of affect to replace projection and projective identification. Not addressing projection may lead to regression, worsening of ED symptoms or acting out. This restructuring of defences and anxiety brings a restructuring of unconscious feelings. Specifically, this means a decrease in the rate of rise in the intense underlying emotions, with cortical, self-observing centres of the brain firing to capture what would otherwise be a flood of intense affect. This phase of treatment (i.e., the restructuring phase) can take over 20 one-hour sessions and must be achieved prior to moving to the stage of repeated unlocking of the unconscious.

During this phase of multidimensional structural integration, ‘guarding the transference’ is very important. The therapist must be vigilant in ensuring they are not cast into the shoes of the punitive or critical attachment figure. The therapeutic relationship must be kept clear of this with any trace of feelings towards the therapist being brought out and examined. Bypassing or

missing such these feelings may bring regressive defences, self-harm and/or exacerbation of the patient's symptoms.

Distorted perceptions of the therapist and the therapeutic relationship are two of many factors making this work complex. To overcome projective defences and to help the patient begin to manifest striated muscle anxiety, an examination of how the patient sees others and themselves is undertaken. This process is aimed at bringing about structural integration of the patient's split views of themselves and others. It has some typical stages that will now be described.

Identifying how others are seen in relationship and fantasy

Examining projections is a critical treatment component with this group. This can be done through conversation with the patient. For example, asking them to describe how they perceive people in their life will yield volumes of information about typical splits and projective identifications. For patients who express major projective fears, such as being attacked at night, one may ask, "Imagine you're alone at night and there is an attacker coming, what do you imagine the attacker would be like and what are you afraid he would do?" This process helps to desensitise these patients to their own unconscious sadistic material. In reviewing this material, we generally find that ED patients have two or more opposing ways of identifying people:

Part A: identified with thin people: hostile, driven, pretty, restricting, purging,
independent, critical and loathing of fat people

Part B: identified with fat people: passive, bingeing, dependent, lazy, laid back, critical
and hateful of thin people

Identifying how the patient sees him or herself and therefore relates to others

At times, patients may identify more readily with the "thin" type person, whereas at other times they may identify with the "fat" type person. That is, they hold both views of themselves and shift in their behaviours as a result of the dominant view that they hold of themselves at any given time. Therefore, it is necessary to explore the split-self identifications, both of which are aspects of the patient that they split off and project onto others. This helps to undo the projective components, as many patients will identify themselves with both of the opposing views that they hold about other people: bringing this to their awareness can begin to undo the projective process. This component of metapsychology helps explain why many ED patients alternate between restrictive behaviours and purging behaviours.

Patient and therapist then explore if there are parallels between the above two points

Once the patient understands that he or she sees him or herself and others in two opposing ways, the therapist may explore with the patient whether the way they see others is the same as how they see themselves (i.e., either the “thin” type: hostile/driven/critical of fat, or the “fat” type: passive/bingeing/dependent). This allows the patient to begin to understand that “What I see out there is really me”. In understanding this, projection and projective identifications are gradually overcome through a process of intellectual awareness: thereafter, many of the ED behavioural disturbances which are fuelled by these distortions begin to remit. This realisation gives rise to grief in the patient, as they begin to see the damage their primitive defences have caused.

First experiences of unconscious anxiety

With these primitive defences reduced, unconscious anxiety will manifest for the first time. Initially, this anxiety is usually experienced as CPD, with drifting and transient dissociation. By restructuring the projective defences, patients are better able to contain themselves: relationships start to improve as the patient begins to use their anxiety to help self-regulate for the first time instead of projecting that others are attacking/critical. For example, the patient will drift and fall asleep with rise in unconscious anxiety as opposed to self attack or attack others under the burden of projection. The patient’s capacity to overcome projective defences is built through self-observing during graded exposure to their internal perceptions. Thus, the result of Phase 1 is the creation of an integrated patient with cognitive perceptual disruption and some growing capacity to self reflect. It is important to note that some patients will also experience some smooth muscle unconscious anxiety for a period of time while on the way to higher anxiety tolerance: when the anxiety is in the smooth muscle, the cognitive perceptual field is clear, so this is a better pathway to have than CPD (see Figure 6).

The preparatory work done to this point provides a foundation, an internal structure, for the patient. It helps to develop capacity to be anxious and begin to tolerate this anxiety. It helps them to begin to develop a more mature defensive system.

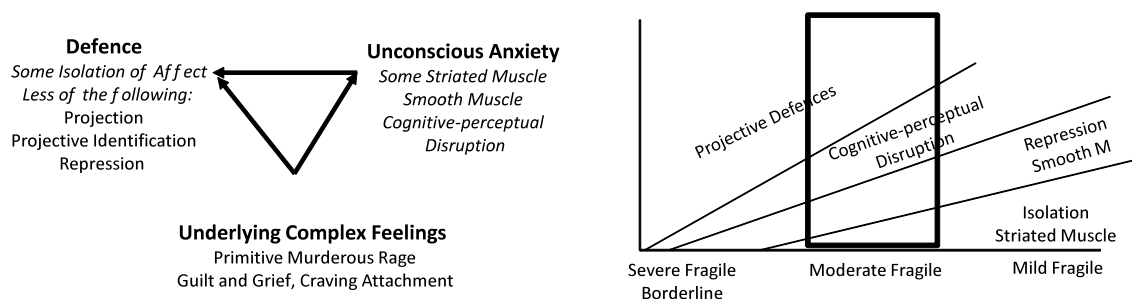


Figure 6. Self-structure of patients with borderline organization during the process of undergoing multidimensional structural change.

Therapist activity in Phase 1

This is complex psychotherapeutic work requiring knowledge of and comfort with this level of psychopathology. Certain technical recommendations apply to working with this population.

- 1) The therapist should be active, engaged and distinct from what is being projected onto them.
- 2) The process should be focused on to the specific task at hand (e.g., to help the patient understand their difficulties, to help them explore themselves and to help examine their thoughts).
- 3) The patient should be made aware of what the process and tasks are, what the risks and benefits of doing the work are, and decide to be a willing partner toward that goal. This must be clarified repeatedly.
- 4) Therapist should frequently change 'stations'. Focussing in one particular area, or on one topic, for too long will often bring too much rise in anxiety for the patient to tolerate and take the patient over threshold and into projection.
- 5) Therapists need to be reasonably certain that the patient will benefit and have no untoward effect from this therapy. If there is no evidence of gains and suitability for this type of treatment (through the use of video review, consultation and supervision) then the approach should not be used.
- 6) Therapist should contribute ample intellectual reviews of the links between phenomena to foster self-reflective capacity. This must be done repeatedly.
- 7) Therapist should not wait for projections to fix on them and then to analyse them. This is avoided, as the therapist is an ally always aiming to be distinct from any projective identification that may tend to occur. The projections are examined in the current situations from the start with an eye out for when they coalesce in the treatment relationship.
- 8) The therapist's position should be to validate all aspects of the patient's experience, not to take a side with or against any of the split parts. The therapist's role is only to examine and acquaint the patient with the split aspects of the self. To label one part as good or bad is a split on the part of the therapist and may result in misalliance. Neither side is the resistance; rather the split itself is the manifestation of the resistance. This mirroring of all aspects of the patient is required to bring psychic integration.

Phase 2: Graded Format: Bringing further structural changes

The previous work has helped the patient to block instant repression, self-destructiveness, projection and projective identification leaving a patient with anxiety manifesting primarily as CPD (i.e., drifting, dissociation, hallucination and drowsiness) and smooth muscle discharge. From here, the therapist and patient can now move to bring structural changes in the patient's unconscious anxiety towards striated muscle anxiety. Therefore, in order to restructure the patient's fragility, a graded exposure to a rise in CTF and anxiety as described in the section on Mild to Moderate Fragile Character Structure is now required.

Therapeutic Window

There is a 'therapeutic window' of rise in CTF that severely fragile patients will be able to work within while doing this graded work. If the level of CTF is too low, it may prolong treatment. If the level of CTF is too high, projection will dominate and the therapist and other patients in group programs will be seen as attackers or abusers. Initially, the therapeutic window is small and staying under the threshold to projection and repression is difficult. As the patient develops an intellectual understanding of their defensive processes, the therapeutic window expands, and it continues to enlarge as each of the above stages is completed.

Undoing instant repression of CTF

Much of the work above undoes projective defences and mobilizes CTF: this may, however, trigger instant repression and other destructive mechanisms if the CTF are not examined and experienced to the patient's capacity. Restructuring of these defences is accomplished by examining situations that mobilise mixed feelings and trigger repression. This enables the patient to understand how anger gets turned inward to depression, self-harm, anxiety and somatisation. This sequential understanding overcomes instant repression by bringing intellectual defences, including isolation of affect. This should be done using the graded format to build a higher capacity to tolerate CTF without untoward effects (see Figure 7).

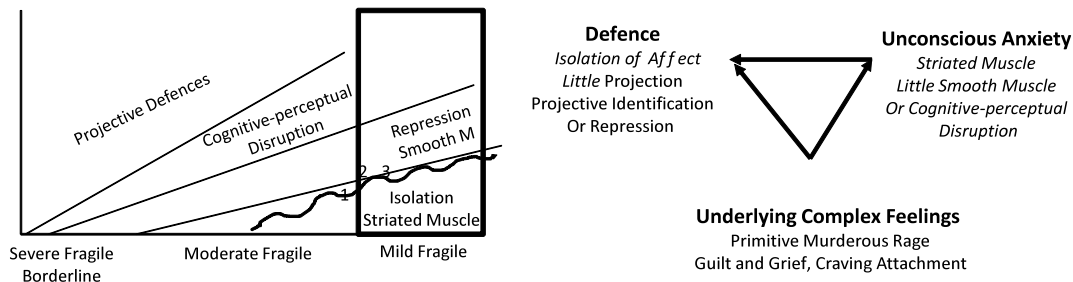


Figure 7 Graded format with patients with fragile character structure

This part of the process is designed to help turn the patient against any remaining self-destructiveness. If this is a product of projection the therapist continues to identify and weaken these mechanisms by examining the link between the mixed feelings and self-destructive behaviors. This work could not be done while the defences of major fragmentation and projective identification were still operating but now the patient has some capacity to self reflect and challenge the mechanisms. If this had been done too early or too directly, projection would fix on the therapist as an abuser or villain with loss of therapeutic alliance and further acting out. Under these circumstances, the patient may become compliant with the therapist only to worsen in other ways, such as becoming more depressed or self-destructive. This is one explanation for why many ED patients restore weight while admitted to hospital only to subsequently lose any weight gains on discharge.

Initial development of the unconscious therapeutic alliance

From the moment the therapist begins to work on the projections, the UTA is being mobilised parallel to the level of rise in the CTF. Therefore, the degree of hope in the patient rises, acting out is reduced, symptoms begin to remit, functioning begins to improve and the patient can begin to see light at the end of the tunnel. The overall effect of this approach is summarised in Table 3 below:

Table 3

Development of the Therapeutic Alliance with Patients with Severe Fragile Character Structure

During Phases 1 and 2: Conscious and early Unconscious Therapeutic Alliance develops

- 1) Acting out is reduced
- 2) Patient is cautiously hopeful and less depressed
- 3) Primitive defences are reduced: the best defences they have come forward
e.g., In ED patients: body image improves, urges to restrict diminish, etc.

- 4) Avoidant behaviours are reversed without a primary behavioural focus
- 5) Conscious anxiety is kept low
- 6) Somatisation and regressive weepiness or tantrums are blocked
- 7) Defiance/compliance with the therapist is not prominent

Later Phases: Unconscious Therapeutic Alliance Dominates

- 1) Statements of clear insight into internal dynamics
- 2) Clear linkages to traumatic events
- 3) Flashbacks with visual imagery related to traumatic events
- 4) Mental images of the primitive emotions in the unconscious emerge

Phase 3: First Breakthroughs and Unlockings

When unlocking of the unconscious in patients with fragile character structure occurs, it first comes in the form of grief-laden unconscious feelings about the enormous negative impact of the projective defensive system on their lives. These first breakthroughs will bring grief related to past losses and trauma. Later partial unlockings progress with some experience of rage with some guilt and grief. These are followed by passages of major unlocking of rage and guilt about the rage when anxiety tolerance is higher.

As these patients move forward in therapy to repeated unlocking of the unconscious, they may have transient pseudo-hallucinatory or illusionary experiences as a product of the UTA. For example, they may experience further body image distortions, such as seeing themselves in the mirror as appearing like a wild animal. This is because the unconscious rage in fragile patients is very intense and primitive, matching in every way the severity of the trauma. They may have, at the more intense layers of their unconscious, urges to maul and consume family members' or abusers' bodies and to vomit them out. Conceptually, at the core of the severe fragile character structure patient there is a primitive murderous rage with not only an urge to murder, but to also torture their traumatizers. This causes massive guilt in the patient's unconscious, since they also had a wish for a positive bond with these family members or people as well. Additionally, the grief of the trauma is very intense, since they have been massively traumatised.

Phases 4 and 5 Working Through and Termination

The phases of working through and termination are extensive and prolonged with severely fragile patients. The treatment itself can be one to three, or more, years in total so the therapy bond is significant and a great loss to the patient. This loss brings all unresolved grief and losses to the surface, along with primitive rage and guilt. Thus, the prospect of eventual

termination of a successful partnership serves as a catalyst that keeps mobilising rage, guilt and grief for the patient to experience and process with the therapist.

Issues Relevant to Specialty Eating Disorder Programs

The suicidal patient

In dynamic terms, the point at which a patient is having suicidal ideation may be a time of opportunity to treat the patient with ISTDP, as it is a time when they are closest to unconscious rage and guilt. This is because the driving force for suicidal ideation is a rise in unconscious rage, which results in unconscious guilt being triggered. In essence, the patient's impulse to kill him or herself is driven by a wish to protect the people they love from the unconscious murderous rage and a need to punish themselves for having this rage. During this period, the patient may not be excessively using repression or other defences. It may be a golden opportunity to gain a major breakthrough into the unconscious rage, guilt and grief. This may be a way to make a gain out of what looks like a disastrous situation. However, thresholds to projection and instant repression must still be monitored and the graded format applied as required.

The patient who is in projection and defiance

Commonly, in many specialist ED day treatment and inpatient programs, patients move to a projective and defiant stance. This is understandable since the treatment has removed their customary defence (i.e., the ED symptoms) so they have a secondary rise in unconscious feelings and anxiety. When this happens, one may restructure the projection by bringing in higher-level defences as described above. Once the projection is undone, the defiance disappears and there is a new emergence of therapeutic alliance, as the patient has been understood. Further, the therapist may move to unlock the unconscious and move to the affective origins of the defence: this would have a significant impact on the state of unconscious anxiety and defence in the patient. However, being punitive or accepting the role of the projection and then pressuring a person in this state will increase the projection and defiance. This can become a counter-transferential self-defeat.

Psychosis-like phenomena

A major concern in working with patients with severe fragility is they sometimes appear worse before they get better. These patients have a major repressive layer and once this layer is overcome and restructured they may then have an increase in anxiety, which may manifest as CPD, pseudo-hallucinations or true hallucinations. This is a positive sign that tells the therapist that part of the restructuring is done and repression is being overcome. At this time, some members of the team may be tempted to use medications to stop this process. The problem with this is the potential for a drop in the CTF and UTA due to prescribing medication. Instead, the therapist should aim to go on to the next level of restructuring, which is to bring higher-

level defences and a higher anxiety tolerance. The central approach to this is to cognitively explore the hallucinatory material, which are essentially projections: this helps to bring higher-level defences and anxiety discharge pathways into operation.

Prevention of secondary symptom development

At times, the patient may be left 'hanging' with a rise in the CTF. This phenomenon can easily occur in inpatient programs where patients' eating is being monitored. Having one's eating and meals monitored typically brings a rise in unconscious feelings and anxiety. However, due to the treatment structure in these environments, these emotions may not be addressed. Therefore, the CTF remain in the preconscious zone of the patient and do not come to be consciously experienced. This prevents the patient from understanding what is going on within him- or herself on an emotional level. As a result, the patient has a rise in unconscious anxiety that lingers until a secondary symptom pathway opens up, such as depression, substance use, psychosomatic illness, self-harm or a return of ED symptoms.

This phenomenon is visible with patients looking for answers from the treatment team as to what is occurring within them and having high levels of unconscious anxiety. The treatment for this rise in CTF is to bring the feelings to conscious experience via the process described above. A single unlocking of the unconscious can bring a decrease in all the symptoms and character defences and will help answer for the patient, "What do I feel?". Most importantly, it will help ensure that the 'defence removal' does not result in untoward reactions such as self-harm, or the other problems typically seen and described above.

Differentiating unconscious feelings from anxiety and defences

With rapid removal of the ED symptoms, we often see the regressed, self-loathing, self-harming, or suicide-preoccupied patient. This state is generally not consciously associated with pain of loss or guilt about past rage, but is usually linked to how the patient sees him- or herself (e.g., "I'm a total loser", "I'm hopeless" or "I don't deserve to be here"). That is not to say they do not have guilt and grief in their unconscious, but this is a state of regressive defence versus true feeling. This may be mistakenly labelled as a 'feeling' and the patient is encouraged to experience it (i.e., "*to feel the feeling*"). The patient is experiencing something, usually anxiety and it is painful, but, to encourage them to 'feel' it is to encourage a regressive defence versus to look at what the anxiety is about and what they are doing to themselves with this anxiety. This misunderstanding may mobilise unconscious feelings towards the therapist, which may be converted into more regression. This speaks to the common misperception that tears necessarily mean a therapeutic event has occurred. These regressions should be managed in the same way as the spontaneous repression described above: the unconscious feelings should be brought to consciousness to overcome this regression.

Institutional defiance

It is common for patients with severe psychopathology to have had repeated admissions to inpatient and day treatment facilities, and to have had multiple treatment failures within those facilities. This creates, within the patient, a limited perception of the effectiveness of treatment and of how much is required from the patient to be 'in' treatment. Often, such patients agree to another admission with no clear goals and little motivation to do the work required to recover. Consciously or unconsciously, they expect treatment will fail and that they will again be discharged and abandoned. This creates resistance and unconscious defiance in the patient, as the treating therapist stands in the shoes of every therapist who has gone before them and also in the shoes of the attachment figures that failed the patient in the earliest phases of life (von Korff, 1998).

Once in treatment, the patient may become indifferent to him- or herself and treatment, or even hopeless. This institutional defiance must be overcome prior to work on symptom removal or character change can begin. Thus, the initial process with the patient must first be to engage his or her will to be an active participant in an internally focused therapy. Day to day treatment interventions must include simultaneous focus on the treatment goals and the patients will to collaborate toward achieving these goals. Thus, the work requires ongoing deactivation of defiance.

Team Splitting: Getting and staying on the same "page"

With fragile patients, the intensity of underlying emotions sets the stage for splitting between staff members in programs. For example, half of the staff may feel the patient is a helpless victim of abuse and needs to be protected while the other half may see her as a psychopathic predator that brings many of her problems upon herself. Another example is splits between formulations, where one therapist feels the issue is about thinking patterns (leaning toward a cognitive approach) while another is only interested in emotions (taking a psychodynamic perspective). In these scenarios, the patient is not getting a whole validation for his or her split parts and this can have adverse effects on the patient and the team. Regular team meetings to find common grounds and therapeutic foci are thus the necessary hallmark of successfully functioning teams (Abbass & Kennedy, 1993; O'Kelly & Azim, 1993; Stewart & Williamson, 2004).

Conclusion

In this article, we have described how the metapsychology and techniques of ISTDP can be used to understand and treat a wide range of patients who suffer from severe behavioural disorders, such as severe eating disorders. In doing so, we have described techniques to help bring

structural integration in patients suffering from a lack of psychic integration. We have described the phases of treatment that need to be followed to bring about an increase in the anxiety tolerance and to bring about defensive restructuring in order to begin the work of gradually helping the patient face his or her own dynamic forces.

Once the phases of multidimensional unconscious restructuring are completed, the therapist can then begin to use the graded format of ISTDP to help acquaint the patient with his or her unconscious feelings. In this way, the signalling system of the unconscious will provide the therapist with the necessary information about how to travel the road towards the unconscious. This road is now without the major structural damage that previously prevented such a journey. Where the graded format is 'paving the royal road to the unconscious', the process above is constructing a road that previously did not exist.

We also reviewed some cautionary notes and interventions to help prevent regression in these cases. Such regression is inevitable due to rapid removal of behavioural mechanisms before psychic integration and anxiety tolerance are present. We also noted some issues that are crucial for team functioning and the avoidance of splitting.

Although we have described how these techniques can be applied to patients with severe eating disorder pathology, these techniques can be applied to patients suffering from a broad range of severe behavioural difficulties commonly seen in inpatient hospital programs, day programs and prisons. However, working with these patient groups requires constant attention by the therapist to avoid the potholes associated with projection, splitting and projective identification, as well as any biomedical complications associated with those behavioural disturbances.

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