

A Naturalistic Study of Intensive Short-Term Dynamic Psychotherapy Trial Therapy

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The objective is to study the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) trial therapies. In a tertiary psychotherapy service, Brief Symptom Inventory (BSI), Inventory of Interpersonal Problems (IIP) medication use, and need for further treatment were evaluated before versus 1-month post trial therapy in a sequential series of 30 clients. Trial therapies were interviews with active focus on emotions and how they are experienced. The interviews resulted in statistically significant improvements on all BSI subscales and one of the IIP subscales. One-third of clients required no further treatment, seven stopped medications, and two returned to work following trial therapy. The ISTDP trial therapy appeared to be clinically effective and cost effective. Future research directions are discussed. [*Brief Treatment and Crisis Intervention* 8:164–170 (2008)]

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ISTDP was developed by Davanloo since the 1960s to address resistances that undermine or preclude effective engagement in dynamic psychotherapy (Davanloo, 2005). Case series data (Abbass, 2002a, 2002b, 2003, 2006; Davanloo, 2005) and randomized controlled trials (Abbass et al., in press; Baldoni et al., 1995; Hellerstein et al., 1998; Winston et al., 1994) with patients with personality disorders and somatoform disorders have demonstrated that benefits can be accrued and maintained in long-term follow-

up. Moreover, these studies have shown that patients tend to become rapidly engaged and remain engaged with a very low dropout rate when using this method.

ISTDP is known for its broad applicability, technical specificity, emotional focus, and for its use of video technology as the central teaching instrument. The method is broadly useful for the populations studied above who comprise up to 86% of psychiatric office referrals (Abbass, 2002b). In order to work with these populations, Davanloo (2001) developed a set of specifically timed and tailored emotion-focused interventions including “pressure” to mobilize emotions, “challenge” to defenses that arise, and recapitulation of the findings after emotional experiencing. Finally, people who have seen Davanloo’s videotape presentations can attest to the focus on the visceral experience of emotions and active work to block

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defenses against these experiences. The small group videotape training method he developed has now a growing empirical basis (Abbass, 2004), adding to the broadly held opinion that one needs self-review and direct videotape training to learn the method.

ISTDP begins with a specialized assessment interview called a "trial therapy." This interview is a comprehensive assessment that includes provision of a psychotherapeutic experience (Davanloo, 1988; Said, 1990). The trial therapy uses specific interventions to engage the client and to help him or her identify and break through their defenses en route to experiencing the feelings that originally lead to the defensive system's development. Response to this trial, as opposed to any specific diagnostic criteria, is now the primary inclusion criterion for ISTDP (Davanloo, 2005).

Although case reports and videotape case presentations have suggested that trial therapy provides benefit to clients, no formal evaluation of its effectiveness has ever been performed. This pilot study is thus the first to evaluate the outcomes of the ISTDP trial therapy.

Methods

Sample

Thirty clients were recruited from a tertiary psychotherapy service set in publicly funded university hospital in an urban centre of 350,000. In this service, ISTDP methods are routinely used to assess and treat primarily treatment resistant clients with personality disorders, anxiety, depression, and somatoform disorders. After an average of 6-month wait, consecutive clients referred by healthcare professionals for psychotherapeutic evaluation were included in this study if they had *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* anxiety, depressive, adjustment, personality, or somatoform disorders. Clients gave written and

verbal consent to complete self-report outcome measures, to have the interview video recorded, and to attend a follow-up interview. Clients were excluded if they had psychotic disorders, active suicidal ideation, bipolar disorder, substance dependence, or mental retardation.

Trial Therapy Procedure

Trial therapy (Davanloo, 1988) commences by identifying the client's problems. Specific examples of problems are examined in detail. When signals of anxiety or defenses emerge in the session, the emotions underlying these signals are brought into focus through the use of pressure. Pressure is a series of tailored interventions that serve to bring the visceral experience of feelings and patterns of defenses to light. The therapist clarifies the nature and impact of defenses as they emerge in the process. The therapist and client collaborate on undoing the defensive behaviors blocking the emotions as they present in the office. This process of challenge to defenses, in partnership with the client suffering under the defenses, mobilizes complex transference feelings. These feelings, including appreciation, anger, and guilt about anger toward the therapist, activate complex feelings related to attachments in the past. These complex feelings trigger both a drop in anxiety and defenses and rise in the "unconscious therapeutic alliance." This aspect of the therapeutic alliance brings unconscious emotions and associated images to consciousness and is stimulated by the therapist's efforts to access underlying emotions (Davanloo, 2001). Thereafter, dynamic exploration with the experience of emotion related to past trauma, completion of the history, linking of past and present phenomena, and psychotherapeutic planning then take place. The pace of the interview is dictated by the client's capacity to engage in the process, using a more gradual or "graded" format when the client has low

capacity to tolerate emotions (Davanloo, 1987). This graded format prevents vulnerable clients from becoming overwhelmed with the emotions mobilized. In the present study, the average duration of the trial therapy session was 84 min (range 60–180 min, depending on the complexity of the client’s problems).

At the end of the interview, clients were asked to return for a follow-up interview 1 month later to assess their responses and to decide collaboratively regarding the need for and type of follow-up. The follow-up sessions occurred an average of 5.5 (*SD* 0.2) weeks after the trial therapy session. The client did not have any contact with the therapist between these two sessions.

Measures

After each of the two sessions, clients completed the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) and the Inventory of Interpersonal Problems (IIP)-64 item version (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), which are self-report measures of symptoms and interpersonal disturbance, respectively. Both these are standardized, validated rating scales that have specific definitions of caseness and normative data. The percentage meeting case criteria, requiring medications, and working was noted before and after the session.

Statistical Analysis

Baseline characteristics were compared before and after the trial therapy using paired-samples *t*-test for continuous variables and McNemar’s chi-square for categorical variables. Alpha was set at 0.05 (two tailed).

Results

Sample

The sample consisted of young- to middle-age adults who had high rates of long-term psycho-

TABLE 1. Prevalence and Distribution of Baseline Variables

Variable	
N	30
Age (years)	36
Female (%)	37
Married (%)	63
Employed (%)	47
Duration off work (weeks)	88
University degree (%)	43
Using psychotropic medications (%)	67
Average duration on medications (months)	33
<i>DSM-IV diagnoses</i>	
Axis I (<i>N</i> , %)	
Major Depressive Disorder	14 (47)
Panic Disorder	10 (33)
Dysthymic Disorder	10 (33)
Somatoform Disorder NOS	9 (30)
Generalized Anxiety Disorder	7 (23)
Any Axis I Diagnosis	30 (100)
Axis II (<i>N</i> , %)	
Personality Disorder NOS Cluster C	7 (23)
Obsessive Compulsive PD	5 (17)
Avoidant PD	4 (13)
Personality Disorder NOS Clusters B and C	4 (13)
Any Axis II Diagnosis	26 (87)

Note. NOS = not otherwise specified; PD = personality disorder.

tropic medication use, interpersonal dysfunction, and disability. They were referred by family physicians (22), psychiatrists or other mental health professionals (5), and specialist physicians (3). All clients had a *DSM-IV* Axis I disorder, whereas 26 met criteria for a personality disorder (see Table 1). This is a typical sample of clients seen on this tertiary service.

Interventions and Responses

Five randomly selected (blinded selection of already randomized case numbers) trial therapies were studied in detail by the therapist and an independent, trained clinician–therapist. The therapist was active using 165.5 interventions per hour. Pressure was the most common intervention occurring at an average of 97 times per

TABLE 2. Pre- and Post-BSI Subscale Scores

Mean (SD) subscale	Mean (SD)		Pre-post difference	p Value ^a
	Pre	Post		
Somatization	1.31 (0.83)	0.94 (0.75)	-0.37	0.003
Obsessive compulsive	2.15 (1.15)	1.62 (1.06)	-0.53	0.002
Interpersonal sensitivity	2.03 (1.18)	1.43 (1.21)	-0.59	<0.0001
Depression	1.74 (0.90)	1.17(1.00)	-0.58	<0.0001
Anxiety	1.90 (0.80)	1.25 (0.67)	-0.65	<0.0001
Hostility	1.69 (0.89)	1.05 (0.67)	-0.64	<0.0001
Phobic anxiety	1.31 (1.22)	0.88 (0.91)	-0.43	0.002
Paranoid ideation	1.79 (1.00)	1.25 (0.83)	-0.53	0.0004
Psychoticism	1.49 (0.85)	1.06 (0.90)	-0.43	0.006
Global rating (GSI)	1.69 (0.75)	1.17 (0.75)	-0.52	<0.0001
Case criterion (%)	63	20	-43	0.0003

^aPaired *t*-test or McNemar's chi-square.

hour (58.6% of all activity). This was followed by reviewing the linkages seen between past and present, feelings, anxiety, and defenses at an average of 29 per hour (18.6%), clarification and challenge of defenses at an average of 23 per hour (13.8%), and inquiry into problem areas (5.4%) and dynamic exploration at an average of 5 per hour (3.0%).

In response to these interventions, clients initially evidenced anxiety visible as muscle tension (Abelson, 2001; Davanloo, 1987) with 20.0 sighing respirations per hour. Expressed emotions were frequent, as evidenced by 16.4 expressions per hour of feelings including anger (11.0), guilt or grief (4.2), and positive feelings (1.2) in relation to recent and past key people. These experiences were followed by a marked drop or cessation of sighing respirations, suggesting anxiety reduction.

Client Outcomes

The global score and all subscale scores from the BSI were significantly reduced following trial therapy (see Table 2), indicating reduced symptomatic distress. Thirteen clients (43%) no longer met case criteria after the trial ther-

apy. Table 3 shows that there was statistically significant improvement in the domineering/controlling subscale of the IIP, whereas the overly accommodating subscale and global rating of the IIP just failed to meet statistical significance ($p = .06$). Thus, clients became less controlling of others, as well as less passive. Two clients (6.7%) no longer met IIP case criteria following trial therapy.

Ten (33%) clients requested no further treatment in the follow-up interview after the trial therapy. In each case, the therapist supported the client's decision, agreeing that further treatment was not necessary. The global BSI score for these 10 clients went from an average of 1.37 to 0.89 ($p < .01$), and the average IIP rating went from 1.47 to 1.07 ($p < .05$) after the trial therapy, indicating movement toward the normal ranges on both measures. Seven of these 10 went from meeting case criteria on the BSI to no longer meeting case criteria. Four of these 10 moved from meeting to no longer meeting case criteria on the IIP.

During the period between trial therapy and the follow-up interview, 7 (35%) of the 20 clients who were on (11 different) medications were able to cease their use of medications.

TABLE 3. Pre- and Post-Interpersonal Problem Inventory Subscale Scores

Subscale	Mean (SD)		Pre-post difference	p Value ^a
	Pre	Post		
Domineering/controlling	1.63 (0.79)	1.24 (0.70)	-0.39	0.008
Self-centered/vindictive	1.86 (1.25)	1.45 (0.71)	-0.40	0.12
Cold/distant	1.54 (0.67)	1.46 (1.14)	-0.08	0.70
Socially inhibited	1.65 (0.78)	1.59 (1.13)	-0.06	0.73
Nonassertive	1.24 (0.66)	1.08 (0.62)	-0.16	0.24
Overly accommodating	1.53 (0.69)	1.28 (0.68)	-0.26	0.06
Self-sacrificing	1.38 (0.63)	1.23 (0.66)	-0.15	0.19
Intrusive/needy	1.56 (0.76)	1.33 (0.77)	-0.23	0.14
Global score	1.55 (0.67)	1.33 (0.69)	-0.22	0.06
Case criterion (%)	73	65	-8	0.67

^aPaired *t*-test or McNemar's chi-square. Case percentages may vary due to missing data.

Moreover, two clients were able to resume work, after an average of 15.0 weeks off work.

In the period subsequent to the trial therapies and 1-month follow-up interviews, the remaining 20 clients had an average of 12.8 (range 2–84, *SD* 18) treatment sessions to reach mean BSI Global Severity Index (GSI) ratings of 0.59 (*SD* 0.6, $p < .001$) and IIP ratings of 0.92 (*SD* 0.6, $p < .001$), both in the normal ranges.

Discussion

The ISTDP trial therapy is an interview method that identifies and focuses on emotional drivers of current symptoms and behavior problems. The most common intervention used was pressure; hence, the primary focus was on engaging the client and encouraging him or her to focus on and undo barriers to closeness and emotional experiences in the present. As Davanloo (2005) has described, when the process goes well, the unconscious component of the therapeutic alliance is activated and reveals links to times when emotional barriers and fear of closeness and intimacy actually began. Previously avoided emotions are experienced, and some

degree of healing can then take place. This can then facilitate engagement from this first contact.

Within the limitations of this study's naturalistic design, converging data suggest this intervention was beneficial for these clients. First, given that only 5.5 weeks passed between the initial assessment and follow-up, it is unlikely that time passage alone produced the improvement, especially because these clients had several years of difficulties. Because they were spaced over a several month period, it is unlikely that temporal variables (such as season change) could account for the improvements. BSI ratings showed significant and major improvements on all subscales and 43% of those meeting case criteria no longer did in follow-up. The facts that one-third of the clients did not require more sessions in follow-up, that several were able to stop medications, and that two were able to return to work further suggest the trial therapy was beneficial. The IIP global rating just failed to improve to a statistically significant degree, although the one subscale that did significantly improve, (domineering/controlling) is one that is theoretically more difficult to change (Horowitz et al., 1988). Clearly,

more sessions were required for most of these clients to bring significant interpersonal and symptomatic change, but this process appears to have helped alleviate distress and restore function from this first contact.

The relative brevity of this interview suggests that it is a cost-effective consultation format. Moreover, the cost of the interview may be quickly offset through medication reduction and reduced disability payments (Abbass, 2002a, 2003). These results are important given long waits for publicly funded psychotherapy services.

These results compare favorably with other studies of short psychodynamic treatment methods. Despland et al. (2005) also found significant symptom reduction using a 2 + 1 session method and noted that 27% no longer met case criteria on the SCL-90 GSI compared to 68% no longer meeting these criteria in our study.

The limitations of this study, however, highlight the need to further study the trial therapy in order to test its clinical efficacy. First, there was no comparison group to control for the effects of attention or therapeutic ingredients other than purported emotion-focused work. Second, these interviews were all conducted by a therapist experienced in ISTDP methods, so the results may not be generalizable. Trial therapies with less experienced clinicians may well be longer in duration (Davanloo, 2005). Third, clients did not have structured diagnostic assessments to confirm specific diagnoses. Finally, clients who did not require additional services were not followed up formally in the long-term, so we cannot say if these gains were maintained.

Thus, future research will require a randomized control group, trained therapists, standardized diagnostic assessments, and formal long-term follow-up of those who appear not to need more sessions. A suitable control is the standard intake assessment provided by

therapists, which are often as long as or longer than this interview method. Such a study should include a formal cost-benefit analysis.

In conclusion, the ISTDP trial therapy appeared to be beneficial for this series of clients presenting for tertiary psychotherapy services. This method requires further study to determine if it is superior to existing assessment approaches. In the absence of such research, clinical experience has rendered this our assessment method of choice for suitable, willing clients.

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