Understanding Davanloo's intensive short-term dynamic psychotherapy: A guide for clinicians

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In 1975 Dr Habib Davanloo and colleagues in Montreal, Canada, hosted the First International Symposium on Short-Term Dynamic Psychotherapy. Two years earlier, in 1973, Davanloo first met Peter Sifneos, who was based at Harvard in Boston, at the Ninth International Congress of Psychotherapy held in Oslo. In 1962, Davanloo and colleagues had established the Short-Term Psychotherapy Program at Montreal General Hospital. Frustrated by the long waiting lists for psychotherapy and psychoanalysis, and the relatively small number of patients in treatment absorbing the limited resources of the psychiatric clinic, they were determined to find effective ways of delivering shorter treatments and better use of resources for more patients. According to Davanloo's accounts (Davanloo, 1978) they made progress in Montreal, and by 1974, twelve years into the project, had achieved a good volume of effective outcomes. However, Davanloo and his colleagues ploughed a relatively isolated furrow and he was not familiar with Sifneos' work, or the work of others who had also been pursuing similar projects.

In 1974 Sifneos introduced Davanloo to David Malan who was working at the Tavistock Clinic in London, and the three of them brought together a faculty of around twenty-five to lead the 1975 International Symposium on Short-Term Dynamic Psychotherapy mentioned above. The 1975 Symposium was followed by a second in 1976, and a third in 1977. All three symposia were well attended, and largely featured the work of Sifneos, Malan and Davanloo, illustrated with audio and video presentations. Momentum was established, and collaborations were born which extended over twenty years or more.

Peter Sifneos brought to these collaborations, amongst other things, the use of focus and optimal high anxiety as factors contributing to effective, short-term therapy (Sifneos, 1984). Sustaining a patient at a high level of anxiety had generally been held as a contraindicator in psychoanalytic therapy, and reducing anxiety had usually been considered appropriate. David Malan brought a number of different contributions to these collaborations. At the Tavistock Clinic Malan had conducted systematic research that entailed detailed case examination, and this approach was highly compatible with Davanloo's case review through video analysis (Malan, 1963, 1976a, 1976b). Through his work at the Tavistock Malan had also developed a model of understanding psychodynamic practice through what became known as the 'two triangles', the 'triangle of conflict' and the 'triangle of person' (Malan, 1979). These two triangles became central to formulation and focus in the practice of Intensive Short-Term Dynamic Psychotherapy (ISTDP). Additionally Malan's knowledge of attachment theory, gained from his close colleague John Bowl by at the Tavistock, and object relations theory which permeated culture at the Clinic, informed thinking between himself and Davanloo.

Davanloo, through his careful review of clinical video recordings, had come to a considered conclusion that a precise structure of ordered clinical interventions, including 'pressure' and 'challenge' properly applied, led to direct access to unconscious material often in a small number of treatment sessions. This structure of interventions became known as the 'central dynamic sequence' (CDS), and it became an influential feature of a developing ISTDP model (Davanloo, 1988). Amongst other things these collaborations led to the establishment of the 'International Journal of Short Term Psychotherapy' in 1986, changing its name to the 'International Journal of Intensive Short Term Dynamic Psychotherapy in 1998.

Malan became convinced that Davanloo had discovered effective ways in which to shorten psychodynamic and psychoanalytic treatments that overcame the limits of the largely interpretative approach utilised in his own project and workshops at the Tavistock Clinic. Malan effectively abandoned his own model to support Davanloo in developing what was to become known as ISTDP (Malan, 1986a, 1986b). A collaboration between Malan and Davanloo during the 1980s saw publication of a series of articles in their international journal, and the most important of these were then published as collected papers in 1990 (Davanloo, 1990). These articles document specific ingredients discovered and utilised in

this period to accelerate treatment, and developments identified to improve application to a broad range of patients. During the 1990s a further series of papers were published, and these arrived in a second volume of collected papers in 2000 (Davanloo, 2000). These were productive decades illuminating and opening up Davanloo's work and discoveries to a wide audience.

But things went quiet. Apart from an article in 2001 (Davanloo, 2001) and a book chapter in 2005 (Davanloo, 2005), which largely summarise previous work, we have seen little or nothing further from Davanloo himself. Not that things have been quiet in the ISTDP world in general, outside of Davanloo's group. There are those who trained with Davanloo, and have developed expertise and practice in ISTDP, who have written widely about the model (Abbass, 2015; Coughlin Della Selva, 1996/2006; Frederickson, 2013; Malan & Coughlin Della Selva, 2006; McCullough et al., 2003; Ten Have de Labije & Neborsky, 2012). Research has underlined the potential, effectiveness and efficacy of ISTDP, most notably from Allan Abbass and colleagues in Halifax, Nova Scotia (Abbass, 2015; Abbass, Town, & Driessen, 2012 ; Town, Abbass, & Hardy, 2011; Town, Abbass, Stride, & Bernier, 2017).

However, we now have a significant publication from Dr Catherine Hickey, significant particularly because she has worked closely at the centre of Davanloo's group in Montreal for twelve years during the period when publications have been all but absent. This is an insider's view. Dr Hickey starts her new book in chapter one by reviewing Davanloo's discoveries which we have previously seen published. This is a nice, concise summary of theory, which is known as 'Davanloo's metapsychology of the unconscious', his clinical procedures, and their practical application. Hickey tells us about Davanloo's understanding of transference and resistance, and the relationship between the two. We hear about the 'unconscious therapeutic alliance' (UTA) as an adjunct to transference and resistance. Davanloo's understanding of psychodiagnosis through his spectra of disorders and pathology, and the discharge patterns of anxiety, are well explained. Additionally we find an account of Davanloo's CDS, and the various forms of direct access to the unconscious as a result of application of the CDS. Here, Hickey reminds us about the importance of video technology in capturing clinical sessions for review and microanalysis, and in uncovering important clinical processes.

Having laid a foundation in Davanloo's previous work Hickey provides us an overview of two areas of Davanloo's work during the silent years of the last two decades. Firstly Hickey, in chapter two, describes the 'Montreal closed circuit training programme' which began its life, we are told, in 2007. Here, we learn that trainee therapists attend blocks of five days of intensive training, perhaps three to five times a year. During these blocks participants take on roles as interviewer and interviewee for a session. Sessions are watched live and video recorded, and Davanloo gives formative feedback both live and in review of the recordings. Whilst these sessions and feedback allow for therapist development in clinical technique they also appear to provide opportunity for personal intrapsychic development and insight. Those who can remember or are aware of humanistic developments from the 1970s in reciprocal counselling, co-counselling, personal growth seminars, peer development communities, and psychodrama workshops will no doubt find familiarities. Hickey acknowledges that the training programme has attracted criticism, just as these examples have in other settings, but she counters this criticism with an enthusiastic account of benefits. Her review of the training programme leads her towards consideration of competency-based medical education, and her perspectives on this are given more attention in the penultimate chapter of the book, chapter twenty-four.

Having described details about the closed circuit training programme, Hickey unfolds in chapter three, five new aspects of Davanloo's thinking which she tells us have previously been undocumented, and which help us to understand how clinical practice has evolved in this group since 2000. Under the heading of 'Fusion', the first of the five new areas of thinking, Hickey tells us that this term is used to delineate a phenomenon in which a patient's unconscious emotions are not differentiated as separate entities, but that their neurobiological pathways or columns are bound or 'fused' together. Davanloo apparently comes to this through his understanding of Bowlby's work and attachment theory, and he works to an assumption that 'fused' pathways are a product of developmental trauma in early attachments. According to Hickey, for Davanloo the most significant 'fusion' occurs between the pathways of rage and guilt, and 'fusion' in these pathways gives rise to complex unconscious, pathogenic consequences. It is difficult in the limited space afforded to Hickey to see how Davanloo arrived at this directly from Bowlby's attachment theory. However, this approach to emotion and attachment theory seems a long way from mainstream thinking (Barrett, 2017; Fonagy & Target, 2007). Fonagy and others have taken

attachment theory, along with reflective function and mentalisation, and given us detailed conceptual and clinical frameworks for understanding and working with the effects of developmental failure and trauma which take account of capacity for differentiating aspects of mind, including emotional states and regulation. In other ways Neborsky has applied rigour to an application of attachment theory to ISTDP in his development of Attachment Based ISTDP (AB-ISTDP) (Ten Have de Labije & Neborsky, 2012).

According to Hickey, the second of five new aspects of Davanloo's thinking is with regard to 'transference neurosis'. This is apparently rejected by Davanloo as having no therapeutic value, as it has to be fair by the majority of leading figures in the field of short-term psychodynamic psychotherapy (STPP) including Malan and Sifneos, In Hickey's consideration Freud is roundly criticised for seemingly promoting it, although we might think that Freud was doing his best with what he had at the time he was working. However, Davanloo's lack of tolerance for the development of transference neurosis in the therapeutic relationship, his progress in understanding and working with the 'Transference Component of Resistance' (TCR) and the UTA, are no doubt impressive.

A third new aspect of Davanloo's thinking brought to us here concerns 'Intergenerational transmission of neurosis'. Although we may be familiar with intergenerational transmission in the context of a range of other psychosocial concepts, apparently Davanloo has a particular and discrete perspective to convey. Hickey tells us that Davanloo has identified an early developmental phenomenon in which a child is 'turned against' a family member, often a parent, by another family member, often the other parent or a grandparent. According to Davanloo this 'turning against' produces a tenacious neurosis, and rage and guilt towards the perpetrator of the division. Hence, 'turning against', it is suggested, creates a complex intrapsychic, unconscious conflict which is repeated when the child becomes a parent.

Perhaps the most important new aspect of thinking, and the fourth brought to us by Hickey, is Davanloo's conceptualisation and application of 'multidimensional unconscious structural changes' (MUSC). As Hickey has described previously, a major aim and cornerstone of Davanloo's theory and practice is direct access to the unconscious, which he calls 'unlocking the unconscious', and an ability to work directly with core pathological structure within the unconscious. As Hickey writes, this direct access to the unconscious

is a phase of psychic integration, and this at the very least implies that the work involves restructuring the core pathological structure. This appears to reflect Davanloo's statements in the 1980s, and confirmed by Malan's observations, that it is during a period of unlocking that major structural change occurs. However, also in the 1980's, Davanloo started to use the term 'restructuring' to describe an effect of necessary interventions before unlocking occurs with patients experiencing more severe and complex pathology (Davanloo, 1987). According to Davanloo this involves a phase of restructuring ego defences, and is necessary in order to develop sufficient ego capacity to tolerate a phase of unlocking. A phase of restructuring became known as the 'graded format' because of a titration of intervention against the patient's anxiety and affect tolerance (Davanloo, 1987; Whittemore, 1996).

A phase of graded format, considered by Davanloo to be restructuring of defences, is epitomised in two parts. Fundamental to this phase of work is an understanding that a patient can be unaware of, and have little concern about, unconscious defences and destructive patterns to which they give rise, and which are causing the problems that have brought them to therapy. In this state, defences are considered syntonic. Initially, in the graded format, work is undertaken to help a patient to observe and differentiate aspects of their internal world as indicated on Malan's triangle of conflict; 'impulse/affect' from 'anxiety', 'anxiety' from 'defence', and 'defence' from 'impulse/affect'. A main focus of this phase of work is to ensure that the patient can properly recognise and understand their defences as a significant component of their problems.

In a second phase of the graded format, drawing on observing and differentiating work, the patient is helped to turn against their defences, and to ally with the therapist in making the defences dystonic rather than syntonic. Once defences are dystonic the patient and the therapist can work together to challenge the defences without alienation and rupture in the therapeutic relationship. As work in the 1980s progressed there was considerable debate about whether this can really be called restructuring in the same way that the effects of direct access to the unconscious might be. Interestingly we now learn from Hickey that Davanloo continues to call this work restructuring, and he has conceptualised MUSC encompassing restructuring across all phases of treatment. We also learn it seems that the term 'graded' has disappeared from Davanloo's vocabulary, even though in the wider world of ISTDP the graded format has been

further developed and become an essential component of working with patients experiencing severe and complex pathology. Indeed some developments in the graded format have greatly expanded a therapeutic repertoire for building capacity, and some have gone beyond use ideas of restructuring (Abbass, 2015; Frederickson, 2013; McCullough et al., 2003).

A final new aspect of Davanloo's thinking brought to us by Hickey concerns what Davanloo has called the 'neurobiological pathway of memory'. Apparently Davanloo has assimilated an understanding of the neurological pathways of emotion, particularly rage, guilt and grief, with the neurological pathways of memory. This is brought together with Davanloo's concept of TCR, when pathways of emotion are mobilised towards the therapist, which in turn mobilise pathways of memory. This appears to be something of an integrating idea which comes together in the phases of 'multidimensional unconscious structural changes' (MUSC).

The final chapter of the book, chapter twenty-five, is a contribution by Dr Robert Tarzwell, a psychiatrist who conducts research in functional brain imaging in psychiatric disorders, and who has undertaken training with Davanloo. In this chapter Dr Tarzwell reviews some aspects of research in psychotherapy, a current understanding of brain function, and the development of brain imaging and its application with psychotherapy research. From this review Dr Carswell considers possible interactions of ISTDP with brain function, and proposes a research agenda to examine how neuroimaging might contribute to an understanding of this interaction. Dr Tarzwell is candid in acknowledging that current knowledge and research in this area is limited and in an early stage of development. However, he presents some interesting theoretical considerations and conceptual hypotheses.

Remaining chapters in the book, chapters four to twenty-three, present in-depth reviews of clinical vignettes, with extended transcripts from video, recordings of ISTDP treatment sessions. These chapters helpfully illustrate applications of the new aspects of Davanloo's thinking described previously. Hickey's writing in these chapters is fluent and easy to follow, and the considerable depth of detail included here is important in understanding and drawing us into Davanloo's work.

It is possible to consider that a silence which fell on Davanloo and his group in the last two decades, following such a creative and productive output in the

previous two decades, has been broken by Dr Hickey. This is a significant step. It can appear that the silence reflected a form of isolation, indeed perhaps even insulation, which we might consider similar to the first decade of Davanloo's work in the 60s and 70s. It is perhaps a surprise that developments in the wider world of psychoanalytic and psychodynamic theory and practice that may have influence are not apparent in this book, and in Davanloo's more recent developments. Object relations theory, and particularly developments in Kernberg's group with structural object relations and transference focused psychotherapy (TFP) (Clarkin, Yeomans, & Kernberg, 2015; Kernberg, 1979), would seem to have a significant interaction with Davanloo's understanding of metapsychology and practice. Similarly Fonagy's work with attachment theory, and with mentalisation and mentalisation-based treatments, would seem to speak to Davaloo's approach to the effects of trauma and building of ego capacity (Fonagy, 2001; Fonagy & Bateman, 2006; Fonagy & Target, 2006).

Dr Hickey shows an enthusiasm and commitment to Davanloo and ISTDP which is admirable and infectious. Some may interpret this, at least in part, as displaying a degree of idealisation, particularly in her repeated injunction that training with Davanloo is the only way to properly master ISTDP. However, we owe her a debt in opening up the developments, to which she has been party, to a wider audience, and in enabling us to learn from these. We can consider this to be an important book in the progression of STPP, and ISTDP in particular.

Notes on contributor

Stephen Buller has had a lead role in the development and delivery of psychotherapy in the UK for more than 35 years, more recently as the service lead and a senior clinical specialist in NHS psychotherapy services in Derbyshire. He is the director and senior consultant for the Psychotherapy Foundation, an organisation working to promote, support and develop the use of safe and effective treatments in evidence based psychotherapy, and the proper and sound governance of these treatments. He is also the director and lead consultant at Cathexis Psychotherapy, a social enterprise for the delivery of evidence-based practice, education and training in evidence-based psychotherapy. Steve has extensive training and experience across a range of psychotherapeutic models,

working with individuals, families, and groups in a variety of settings. His work is predominantly based in psychoanalytic and psychodynamic models, and for more than 30 years he has had a significant commitment to development, training, supervision, and research in short-term psychodynamic psychotherapy (STPP) largely influenced by the ISTDP model. As a registered mental health professional and a registered psychotherapist, Steve has occupied key roles in professional organisations at a local and national level. He has been a member and vice-chair of the Ethics Committee of UKCP (United Kingdom Council for Psychotherapy), a council member and Chair of Ethics for the Universities Psychotherapy and Counselling Association (UPCA) and a member of the executive committee of the Universities Training College (UTC), a division of the United Kingdom Council for Psychotherapy (UKCP).

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