Intensive Short-Term Dynamic Psychotherapy Trial Therapy

Effectiveness and Role of "Unlocking the Unconscious"

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Abstract: This study examined the effects of trial therapy interviews using intensive short-term dynamic psychotherapy with 500 mixed sample, tertiary center patients. Furthermore, we investigated whether the effect of trial therapy was larger for patients who had a major unlocking of the unconscious during the interview compared with those who did not. Outcome measures were the Brief Symptom Inventory (BSI) and the Inventory of Interpersonal Problems (IIP), measured at baseline and at 1-month follow-up. Significant outcome effects were observed for both the BSI and the IIP with small to moderate preeffect/posteffect sizes, Cohen's $d = 0.52$ and 0.23, respectively. Treatment effects were greater in patients who had a major unlocking of the unconscious compared with those who did not. The trial therapy interview appears to be beneficial, and its effects may relate to certain therapeutic processes. Further controlled research is warranted.

Key Words: Short-term psychotherapy, psychological assessment, psychodynamic, emotion

(*J Nerv Ment Dis* 2017;205: 453–457)

With the establishment of psychotherapy's effectiveness, public access to this treatment becomes more important. Some major factors restricting access to psychotherapy include limited availability of funds to pay for therapist hours in public clinics and reluctance of payers to fund psychotherapy beyond a limited number of sessions; hence, there exists a need for shortening therapy and intensifying its therapeutic benefits in these limited clinical hours.

Among the brief therapy methods, intensive short-term dynamic psychotherapy (ISTDP) (Abbass, 2015; Davanloo, 2000) is a broadly applied treatment of mixed psychiatric disorders with growing empirical support. This treatment model has been studied with case series research and randomized controlled trials and found to show large treatment effects for psychosomatic, depressed, anxious, personality-disordered, and mixed populations, which are maintained in follow-up (Abbass et al., 2012, 2013; Town and Driessen, 2013).

The ISTDP treatment begins with a single, extended, evaluative, and therapeutic session called a trial therapy. The trial therapy is used to assess how to best tailor treatment to an individual's needs based on key parameters of patient functioning: patterns of somatic anxiety, patterns of defense, capacity to identify complex feelings, and degree to which a person is identified with his defenses. It includes a treatment component to determine likelihood of response to a treatment course and has the potential to serve as a stand-alone therapeutic intervention. The trial therapy has been described and evaluated with case series and process research (Abbass et al., 2008a, 2008b) and found to be an active interview that reduces symptoms (Brief Symptom Inventory [BSI], $n = 30$, $p < 0.001$) and interpersonal problems (Inventory of Interpersonal Problems [IIP], $n = 30$, $p = 0.06$). It yielded superior symptom benefits compared with a nonrandomized control group that was provided standard psychiatric consultations (Abbass et al., 2009). Notably, in these previous studies, trial therapies were conducted by one experienced therapist, thereby limiting generalizability of the results.

Key processes linked to change during ISTDP have been recently reviewed (Abbass and Town, 2013), concluding that one therapeutic ingredient is considered to be the patient's actual experience of his or her true feelings about past and present individuals in a patient's life (Davanloo, 1990a). These feelings typically relate to adverse relational events, including nonsecure childhood attachments and attachment ruptures. When triggered in new relational situations (including the therapy relationship), such unprocessed feelings typically generate anxiety and secondary avoidant behaviors (*i.e.*, defenses), which lead to relational difficulties and/or symptom formation. Using videotape-based case research, Davanloo discovered a sequence of processes that appeared to give open access to these trauma-related feelings, providing a therapeutic opportunity to process and integrate them. He observed that providing therapeutic effort, encouraging the patient to be engaged, to not defend, and to feel emotions triggered in the interview, activated both complex feelings and an aspect of the therapeutic alliance that emanated from a nonconscious aspect of the patient's mind. This "unconscious therapeutic alliance" revealed itself by cognitive linkages to and mental imagery related to attachment trauma, a process that Davanloo refers to as "unlocking the unconscious" (Davanloo, 1995a, 1995b, 2001). This unconscious alliance was seen as being activated in different degrees along a continuum from low rise in feelings to major extended unlocking of the unconscious (Davanloo, 2000). In major unlocking of the unconscious, the mental imagery of a past person becomes transposed over the image of a current person in the midst of an intense emotional experience. For example, in examining complex feelings toward the therapist, the mental image of the therapist becomes the image of the blond-haired mother from the patient's childhood and corresponding to this is passage of grief, remorse, and loving feelings toward this past person. This major unlocking is felt to be a concomitant of a high level of emotional activation in the therapy process where the defenses against emotional closeness and the anxiety about feelings are overcome by the direct experience of the defended feelings (Davanloo, 1995b). A detailed description of this process and the empirical support for each of its phases has recently been published (Abbass and Town, 2013).

The associations between unlocking the unconscious and the outcome of the entire ISTDP treatment courses have been examined in recent years. Studies reported greater symptom reduction, interpersonal problem improvement, improvement in work function, reduction in psychotropic medication use, and medical service cost reduction among patients experiencing major unlocking of the unconscious relative to those that did not (Abbass, 2002; Johansson et al., 2014; Town et al., 2013). These studies also found that gains associated with unlocking were independent of the level or nature of patient resistance (Johansson et al., 2014; Town et al., 2013).

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ISSN: 0022-3018/17/20506–0453
DOI: 10.1097/NMD.0000000000000684

To extend existing research, we examined responses to 500 consecutive trial therapies conducted by a range of therapists. We hypothesized that the trial therapy would yield significant clinical benefits and that outcome effects would be greater in those who had a major unlocking of the unconscious compared with those who did not.

METHODS

Setting and Participants

This study was conducted at an urban, university, and hospital-based tertiary psychotherapy service. Referrals were from medical specialties, the emergency department, mental health services including specialty psychiatric services, and family physicians. The sample for this study was from a large-scale cost study of patients treated over 9 years by all trainees and therapists on the service (Abbass et al., 2015). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, diagnoses were derived from clinical interviews and tabulated on an intake form. Patients were included if they had a trial therapy and completed at least one self-report outcome measure. They were excluded if they had substance dependence, organic brain syndrome, psychosis, or severe personality disorder with psychosocial instability precluding engagement.

As a standard procedure on this academic clinical service, all sessions were video recorded when possible for self-review, supervision, and quality assurance. In some cases, trial therapies were also observed live through closed circuit television. Participants signed a written consent for video recording and gave verbal informed consent to complete self-report measures as part of standard care on this service. Upon data entry, names were replaced by codes to maintain participant confidentiality. The video recordings were routinely rated for adherence, presence of major unlocking the unconscious, and level of resistance (see later details). This study was approved by the local hospital ethics review board and registered in ClinicalTrials.gov as identifier number NCT01924715.

Intervention and Therapists

All participants received a trial therapy of ISTDP conducted on one visit lasting up to 3 hours (Abbass et al., 2008a, 2008b). This specialized evaluative procedure helps determine the relative contribution of emotional factors to somatic and psychiatric presentations and includes therapeutic elements where emotions related to trauma are examined and processed where possible. ISTDP has tailored formats to overcome high levels of defensiveness in the forms of emotional avoidance and damaging behavioral patterns with tailored interventions, including clarification, challenge, and "head on collision with resistance" (Davanloo, 2000). For patients with self-regulation deficits, including prominent dissociation, primitive defenses, depression, smooth muscle–related anxiety (such as irritable bowel syndrome), or conversion disorder, the session focuses on building capacity to recognize and reflect upon body responses related to anxiety and feeling states (Davanloo, 1990b, 2005). Once these reflective capacities are sufficiently developed, the focus is on experiencing and processing the underlying impulses and feelings. Emotional experiences are followed by extensive, collaborative recapitulation to link together feelings-anxiety-defense and past-current-therapeutic relationships: This interpretive work after emotional activation is believed to improve anxiety tolerance, improve reflective capacity, and fuel the therapeutic alliance (Davanloo, 1990a). Medical, psychiatric, and personal histories are gathered.

At the conclusion of the session, a treatment plan is offered, which may include follow-up with referral sources, a follow-up meeting 1 month later, or a recommendation to recontact on an as needed basis. Patients who were to be seen in a 1 month follow-up typically had little to no therapy contact between the meetings in part because of the 3- to 4-week delay in consultation letters reaching the referral sources.

Therapists were licensed health professionals and mental health professional trainees in ISTDP. Treatment fidelity was augmented through weekly video recording–based courses, weekly small video–based group supervision by an experienced supervisor (Abbass, 2004), and provision of technical literature on the model (Davanloo, 2000). Adherence ratings using a 4-point scale developed for a clinical trial in ISTDP (Abbass et al., 2008a, 2008b) were phased in during the period of this study.

Measures

Outcome

Self-report measures used include BSI (Derogatis and Melisaratos, 1983) and IIP (Horowitz et al., 1988). These well-validated measures were used at baseline on the day of the trial therapy and again at follow-up. Follow-up interviews were typically conducted 1 month after the trial therapy.

Presence of Major Unlocking

The supervisor determined the presence of major unlocking based on direct live observation of interviews or video recordings. A preliminary study of reliability of ratings of degree of unlocking from 30 video vignettes was performed with three raters and yielded adequate inter-rater agreement (κ of 0.66 or greater). One of these raters was the supervisor in this current study, considered an expert in the treatment model. To investigate whether having a major unlocking of the unconscious during the trial therapy correlated with greater treatment effects compared with those without, we used a binary variable (*i.e.*, unlocking, coded 1 = "did have a major unlocking of the unconscious during trial therapy," 0 = "did not have a major unlocking of the unconscious during therapy") to capture this process.

Resistance

Based on case series data from several hundred patients, Davanloo (1990a) established two operationally defined spectra of patients based on the observed nature of in-session use of defenses (resistance) and anxiety discharge patterns. A patient is considered to have "fragile character structure" when primitive defenses and cognitive perceptual disruption are prominent features: members of this group have prominent dissociation and paranoid tendencies. In contrast, "psychoneurotic spectrum" patients are those whose have other forms of defense and whose anxiety affects voluntary and involuntary muscles in the body. Both these spectra range from mild to severe with each having specific features identifiable in the trial therapy (Davanloo, 2000). Previous research has found differing treatment responses and durations between these different patient categories (Abbass, 2002; Abbass et al., 2008a, 2008b; Johansson et al., 2014), providing further validation of the concept of two spectra. Hence, for this study, we controlled for the type of resistance by including a binary variable that described this (*i.e.*, resistance, coded 0 = "psychoneurotic spectrum," 1 = "fragile character structure"). Coding of treatment resistance was likewise conducted by the experienced ISTDP supervisor during live observation or videotape-based review of the trial therapy. These ratings were blind in that they were conducted before knowing the follow-up patient ratings on self-report scales.

Statistical Analyses

The study had an open design, and no control group was used. Statistical analyses were therefore carried out within a linear mixed-effect framework (Singer and Willett, 2003) that focused both on the within-group effects of treatment on outcome (effect of time) and on whether having a major unlocking of the unconscious during the trial

therapy was associated with effects on the outcome measures. First, unconditional models were estimated for both BSI and the IIP to examine the average change rate from pretrial to posttrial therapy. These models were estimated with random intercepts and time (coded 0 for baseline and 1 for posttrial therapy assessment) entered as a fixed effect. Second, conditional models were estimated to examine whether the rate of change in BSI and IIP differed as a function of having a major unlocking of the unconscious during the trial therapy. Thus, unlocking was entered as a fixed effect predictor as well as in interaction with time. In addition, the type of treatment resistance was included as a control in the conditional model based on previous research showing baseline and outcome differences between these two groups.

Because many patients did not return for a second visit (*i.e.*, postdata was missing), we used maximum likelihood estimation to make use of all available data. This form of estimation provides unbiased estimates under the less restrictive assumption of data missing at random (Mallinckrodt et al., 2001), which allows the probability of data being missing to be dependent on both outcome variables (e.g., symptom level as measured by the BSI and the IIP) and predictors (Little and Rubin, 2002). Within-group effect sizes (Cohen's *d*) were calculated using observed means and standard deviations, controlling for precorrelations/postcorrelations (Borenstein et al., 2011). The primary α level was set to 0.05 because of the exploratory nature of the study (Bender and Lange, 2001). All calculations were performed using SPSS version 21 (SPSS, Inc, Chicago, IL).

To evaluate whether there were different rates of unlocking on the two spectra of resistance, we conducted post hoc analyses, using a χ^2 test, between the two spectra and those with versus without major unlocking. Because fragile patients tend to require capacity building efforts before being able to tolerate an unlocking, we expect them to have lower rates of major unlocking. Similarly, we compared rates of unlocking with trial therapies that were rated at or above the adherence cutoff of 3 of 4 versus those who did not reach this cutoff. Adherence ratings were only available for 34% ($n = 170$) of these patients because this rating had been phased in during the study interval so this was not included as a variable in the modeling noted earlier.

RESULTS

Sample and Therapists

Five hundred sequential patients who had a trial therapy and completed baseline measures were included. Female patients comprised 305 (61.0%) and male patients were 195 (39.0%). They averaged 40.9 years of age (SD, 13.0 years). The most common diagnoses were a somatoform disorder (59.8%), personality disorder (48.2%), major depression (38.4%), and generalized anxiety disorder (30.5%). In regard to psychodiagnostic categories, 71.6% were placed on the spectrum of psychoneurotic disorders and 27.4% had a fragile character structure (1.0% had missing values). In follow-up an average of 1 month later, 269 and 237 completed the BSI and IIP, respectively.

A total of 15 therapists provided 500 trial therapies. Eight were residents or fellows in psychiatry, two were psychologists, and one each was a psychiatrist, a family physician, a behavioral nurse specialist, an occupational therapist, and a social worker. Adherence ratings were available for 170 of the trial therapies and averaged 3.2 (SD, 0.83) on a 4-point scale with 3 as the adherent cutoff, suggesting adequate adherence to the ISTDP model.

Baseline Status and Effects of Time

Observed means (SD) before and after for the BSI were 1.63 (0.76) and 1.34 (0.78), respectively, and for the IIP were 1.53 (0.66) and 1.39 (0.73), respectively. Results from the unconditional model revealed significant effects of time on both the BSI and the IIP (Table 1), with estimated rates of change as −0.26 and −0.15 for the BSI and the IIP, respectively (negative estimates indicating a symptom reduction over time). Preeffect/posteffect sizes were moderate for the BSI (Cohen's $d = 0.52$) and small for the IIP ($d = 0.23$).

Effect of Unlocking

Of the 500 included participants, 120 (24.6%) had major unlocking of the unconscious during the trial therapy session. Data on unlocking were missing for 13 patients (2.6% of sample). There was no significant baseline difference between those with major unlocking and those without on both the BSI (mean difference = 0.020, SE = 0.077, $t(485) = 0.273$, $p = 0.785$) and the IIP (mean difference = −0.055, SE = 0.075, $t(451) = -0.733$, $p = 0.465$). Results for the final conditional models revealed that those with major unlocking had greater improvement on both the BSI and the IIP between pretrial and posttrial. The additional effect of unlocking was estimated at −0.14 for the BSI, which trended (*i.e.*, $p < 0.10$) toward significance ($p = 0.07$), whereas the estimate for IIP was significant at −0.18 (Table 1). Preeffect/posteffect sizes for patients with major unlocking were large for the BSI ($d = 0.91$) and moderate for IIP ($d = 0.53$), respectively. These effects are illustrated in Figure 1.

Resistance was significant as a fixed effect for both BSI and IIP, suggesting that patients belonging to the fragile group had more symptoms at baseline. Post hoc analyses also found that fragile patients were less likely to have a major unlocking in the trial therapy compared with nonfragile patients ($\chi^2(1) = 14.943$, $p < 0.001$). Despite these two findings, when tested as a predictor of change within the statistical model, resistance did not interact with time; thus, the impact of resistance on

TABLE 1. Linear Mixed Effects Models Estimating Change in BSI and IIP From Baseline to Follow-up After Trial Therapy

		BSI		IIP	
Fixed Effects		**Unconditional Model**	**Conditional Model**	**Unconditional Model**	**Conditional Model**
Initial status	Intercept	1.63[a]	1.51[a]	1.52[a]	1.45[a]
	Unlocking		0.05		0.08
	Resistance		0.37[a]		0.16[b]
Rate of change	Intercept	−0.26[a]	−0.20[a]	−0.15[a]	−0.10[b]
	Unlocking		−0.14[c]		−0.18[b]
	Resistance		−0.06		0.05

[a] $p < 0.01$.
[b] $p < 0.05$.
[c] $p = 0.07$.

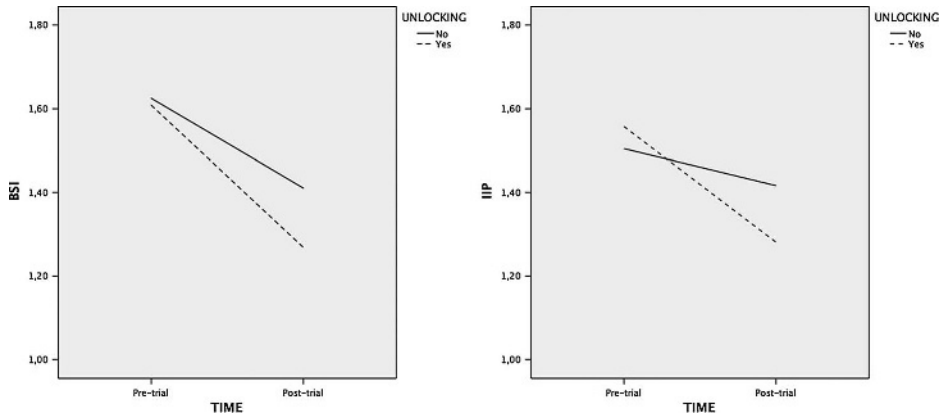

FIGURE 1. Mean predicted values on BSI and IIP for patients with or without unlocking during the trial therapy.

outcomes did not differ between those with major unlocking and those without.

In those with major unlocking, 96.7% met the clinical cutoff (3 of 4 or greater) for adherent, whereas only 45.7% without unlocking met this cutoff, a statistically significant difference ($\chi^2 = 25.9$, $p < 0.05$).

Backchecks on Missing Data

Although the analytic method we used incorporates adjustments for missing data, we also performed backchecks. We found no significant differences between psychoneurotic (missing $n = 162/358$) and fragile patients (missing $n = 67/137$) in terms of missing data on the BSI ($\chi^2 = 0.532$, $df = 1$, $p = 0.482$) and IIP ($\chi^2 = 0.779$, $df = 1$, $p = 0.420$). Intake score did not differ significantly between patients with complete or missing data on BSI (mean difference = −0.99, $df = 498$, $t = 1.453$, $p = 0.147$) or IIP (mean difference = −1.00, $df = 498$, $t = 1.467$, $p = 0.143$). Finally, the model estimates for completers only did not differ significantly from the entire group of patients as reported in Table 1.

DISCUSSION

Within limitations we will describe later, this study suggests that the trial therapy model may be beneficial for diverse, tertiary-referred patient groups. Because this was a study of a range of therapists, it extends previous research suggesting that the trial therapy was effective (Abbass et al., 2008a, 2008b) and superior to general psychiatric intake interviews (Abbass et al., 2009) in the hands of a single therapist. Significant improvements were self-reported on both symptom and interpersonal problem measures. Moreover, the effects seen in the group with major unlocking were moderate to large and occurred in not just a few patients but in one quarter of these tertiary patients.

The outcome parallels those of other studies of ultra brief psychodynamic therapy. Using a three-session model, Barkham et al. (1999) reported large sustained gains in clients with subsyndromal depression. Despland et al. (2005) reported moderate and significant symptom reduction and social adjustment gains after a five-session model of psychodynamic therapy was provided to self-referred psychiatry outpatients. Aafjes-van Doorn et al. (2014) used a single-session model with secondary care patients and reported large, significant gains on the Clinical Outcomes in Routine Evaluation Outcome Measure and trends to improvement on the BSI. However, they did not find significant interpersonal problem gains in a smaller sampled study, and they also did not find that outcomes varied with a measure of emotional activation.

The observation that fragile patients had lower unlocking rates matches the clinical observations that these patients have lower emotional capacities and require interventions to build anxiety tolerance before being able to experience unlocking. Nonetheless, previous research has found both groups to benefit equally from major unlocking when the patient is able to achieve this event (Johansson et al., 2014; Town et al., 2013). Once again, here we did not find differences between the groups when unlocking is controlled for, meaning that the unlocking event has similar effects across groups regardless of the type of resistance.

These findings suggest that unlocking may be beneficial when it can be facilitated across patient populations regardless of symptom or interpersonal problem burden. There may be other patient subcategories within the larger sample of this study design that may be more or less likely to experience unlocking. For example, patients with active major depression, conversion disorder, and somatization who were categorized as having psychoneurotic disorders (not fragile character structure) may also have had a lower rate of major unlocking in the trial therapy because of the need to build emotional capacity over multiple therapy sessions ahead of tolerating the unlocking itself (Davanloo, 2000). Nonetheless, the finding that unlocking is beneficial when it occurs in both patient groups, and regardless of the baseline symptom and interpersonal loads, indicates that the process of facilitating an unlocking appears to be an independent therapeutic event.

The methodological limitations of this study suggest that these promising findings should be interpreted with caution. First, there were missing data points because many patients only had one session, necessitating the analytic methods we used. Further patients with only one interview were of more than one category (e.g., those recommended to return if need be versus those referred to resources in their own jurisdiction), presenting a possible confound. Second, the ratings of spectrum and unlocking were completed by a single instructor, opening the possibility of bias in evaluating these parameters; these ratings were however completed before viewing patient outcome measures, thus, preserving this component of blindness. Third and related to this, rise and resistance levels were rated at the same tape review leaving the possibility that these measurements influenced one another. Fourth, even though there were no baseline differences between those who had major unlocking versus those who did not, it is possible that unlocking was a product of some other unique patient characteristics not measured by this study that predispose to better outcomes; hence, major unlocking may have been a product of unmeasured patient factors. Fifth, although typically patients did not have treatment sessions between the trial and follow-up interviews, it is possible that those few who did have some treatment sessions derived benefits that could confound results. Finally, this study lacked a control condition to account for the effects of time passage and the generic effects of an assessment interview. Examining the outcomes of those with and without major unlocking, however, may be considered a type of control comparison where all patients had interviews but observed emotional events differed qualitatively.

Among its strengths, this study reflected real-world practice conditions by using a range of therapists and a broad spectrum of

sequentially referred patients. Because this is a tertiary clinical service, patients referred had typically failed to respond adequately to previous medication and psychotherapy efforts. Thus, this interview approach may be a reasonable option as a treatment assessment tool in public outpatient mental health clinics and tertiary psychotherapy services.

CONCLUSIONS

The ISTDP trial therapy method may be clinically useful for a range of psychiatric clients. These findings further support the concept that the process of unlocking the unconscious may be a candidate therapeutic ingredient in psychotherapy (Davanloo, 1990a). Future research should include the use of a randomized comparison condition to control for the effects of time passage. It should also further examine predictors of response by operationalizing degree of resistance as a dimensional variable such that the nature of patient resistance and fragility can be more sensitively explored.

DISCLOSURE

This research was supported by the Nova Scotia Department of Health and Wellness, The Dalhousie University Department of Psychiatry, and The Mental Health Foundation of Nova Scotia.

The authors declare no conflict of interest.

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