

HAVING READ:
“SHORT-TERM THERAPY FOR LONG-TERM CHANGE”
(SOLOMON & NEBORSKY, 2003)

CONVERGENCE AND DIVERGENCES IN SHORT-TERM THERAPY:
SOME THOUGHTS ON “SHORT-TERM THERAPY FOR LONG-TERM
CHANGE”

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Summary

The Areas of Convergence

In 1918, as Freud stood before the Fifth International Psycho-Analytical Congress in Budapest, there must have been some anticipation among the audience about how he would address the challenges that threatened the unity of the psychoanalytic movement. The past several years had seen the public defections of Alfred Adler, Wilhelm Stekel, and Carl Jung. Freud was already the great man, having published *Interpretation of Dreams*, *Three Essays on the Theory of Sexuality*, and the *Origin and Development of Psychoanalysis*, and he could have used his forum in Budapest to demand psychoanalytic orthodoxy. Instead, he opened his address with the following words: “As you know, we have never prided ourselves on the completeness and finality of our knowledge and capacity. We are just as ready now as we were earlier to admit the imperfections of our understanding, to learn new things and to alter our methods in any way that can improve them.” (Freud, 1919)

The STDP psychotherapists presented in this book - Lee McCullough, Robert Neborsky, David Malan, and Michael Alpert - are setting about a similar task. Each of them has worked directly with ISTDP's founder, Habib Davanloo. Each has reevaluated what ISTDP does, and how to go about doing it better. Ultimately, each has developed his or her own form of an STDP. Given the fact of a common genesis, areas of convergence of purpose and techniques among these practitioners are to be expected. By reading *Short-Term Therapy for Long-Term Change*, their other writings, and a transcript of a conference in La Jolla, California, in 2000, one can see where the significant convergences occur.

First, they are united in believing that, In Malan's words, “purely interpretive psychotherapy, whether short-term or long-term, had been carried to its limits and found inadequate.” (According to Malan, research proved conclusively that only 20 percent of patients treated with analytically oriented training could be considered “significantly improved.”) Following Davanloo's lead, these therapists concentrate on the pre-interpretive phase of treatment, identifying, challenging and exhausting the patient's defenses. Feelings, fantasies and memories that the patient has guarded against then appear, providing access into the unconscious. The patient then experiences true feeling about the past and present.

Using ISTDP techniques, these therapists seek to do more than just relieve symptoms. They attempt to change personality - or character - in a short period of time. Producing radical change comparatively quickly is a basic part of how all these therapists approach their work and comes directly out of Malan's counter-intuitive discovery in the 1950's that there seemed to be no relationship between the length of treatment and its effectiveness.

The Use of Videotaping

These therapists also converge in their use of videotape as an *essential* part of treatment. Davanloo's discoveries and refinements would have been impossible without this tool, and viewing his tapes has had a profound effect on these practitioners. Alpert stated in 2000 that he would never have gotten interested in this technique if he hadn't seen it "performed". Until fairly recently, he observed, learning therapists couldn't see what was going on. Psychotherapy was a hidden or secret science. Therapists were taught theoretical principles, told to behave in certain ways, do certain things, but could never really *see* how it was portrayed. Alpert remembers buying books on technique and then trying to apply them. The door opened for him with Davanloo. Suddenly there were videotapes he could watch. "If you can see it, your level of description and discussion changes", Alpert said. "Not everyone is as good a theoretician, but the tapes allow people who have other skills, whether they're particularly insightful, whether they're great technicians, to show their work as well. And the field then stops being overly driven by theory."

Alpert's last point is significant. To a large extent, videotaping has buffered the evolution of ISTDP from the deadening effects of abstract theorizing because the evidence for what works and what doesn't is present in a tangible record. It will also, hopefully, protect the future of ISTDP from the trap of a fixed allegiance to tradition and the patriarchal idealization that stifled post-Freud psychoanalysis. The STDP therapists presented in this volume would also agree that videotape has a corrective function to practitioners who finds themselves going down paths that don't work. Neborsky notes, too, that videotape "makes people work harder", and finds that when videotaping it is much harder to take an "emotional breather" during the session because, "you kind of know that it is going to be seen". Alpert and McCullough both allow patients to view tapes of their own sessions and they've found that doing so can expedite the course of therapy. Alpert feels sending tapes home with patients empowers them, allowing them to make changes on their own as they discover their ability to "treat themselves". McCullough claims that an overwhelming majority of patients she has shared tapes with agree that therapy did move along much faster as they observe their own behavior in therapy.

Both McCullough and Alpert cite another of videotape's corrective functions. Patients have come to them alleging therapeutic mistakes. Watching the videotape with their patients allows them to correct the error, or to explain a misunderstanding. "Whenever there was a disagreement in session," Alpert observed a few years ago, "I used to assume that the patient was obviously distorting, or there was a transference problem. And the terrible thing that I learned from videotape is that a sizable percentage of the time it was me and not the patient". His readiness to review objective data and to be open to self-correction would have seemed remarkable to many traditional therapists. "When I find my patient and I do not see our interaction the same way," Alpert continues, "I ask if they would like to review the tape with me. I explain that an 'instant replay' would help us to find how we came to have such different views. The different views can be legitimate and based on different assumptions or due to defensiveness. I have discovered that the review can be as informative for the therapist as for the patient, and, much to my chagrin, that I am as liable to misperceive events as my patients". Neborsky has found that even skilled therapists are unable to listen to content or to observe phenomenology in a consistent way, that there are errors of "attunement". Using videotape in a supervisory process accelerates therapist change exponentially because the supervisor can actually see what is going on rather than merely hearing about it filtered through the supervisee's counter-transference distortions.

All these therapists use videotape for self-supervision, but Neborsky - who credits Davanloo with the idea - has videotaped a session in which a patient watches and comments on an earlier taped session of her treatment. At professional conferences, the audience, in effect, sees both sessions simultaneously, allowing for a lucid demonstration of the patient's therapeutic progress: the way she looked, the way she reacted to the therapist in the past contrasted with the present interactions, and the insights she now had about her former functioning. Observers watching that tape find it a fascinating experience. And fascinating, too, is a tape Neborsky presented in which we witness his supervision of a colleague's work as they - and we - see a tape of the therapeutic session being supervised.

Alpert has commented on one further aspect of videotape, namely the discomfort that virtually all therapists have when first viewing themselves. He remembers his first videotape, when he was an intern. The embarrassment of seeing himself being a “human pretzel” stopped him from videotaping for some time. McCullough, despite her extraordinary level of accomplishment, has confessed to have never gotten over that “cringing feeling” of watching her own videotapes, and she continues to ask herself, “Why did I make that intervention? I should have done something else”. Neborsky feels that the experience of uncomfortable self-observation is the critical variable to self-analytical change in the therapist and that the continued development in the therapist’s technique is his or her willingness to endure that feeling.

The Use of Medications

One further area of convergence among these therapists is their belief that psychiatry’s increasing dependence on psychopharmacology at the expense of psychotherapy is a trend that is both shortsighted and wrong-headed. So entrenched has the medical model become that, when Neborsky discussed, at a conference in 2000, a case of a major depression patient he had successfully treated without medication, one distinguished psychiatrist remarked, “You treated a major depressive without medications? Good luck.”

The reasons for this growing reliance on drugs can be argued, but Joan Acocella (2000a,b) may have gotten it right when she wrote that “...the return of the biomedical approach... occurred within the context of the despiritualization of our society after the sixties, that it fit in so well with the abandonment of any value that was not commercially profitable (as psychotherapy apparently was not, and drugs were).”

Increasingly, psychiatric patients are being seen as carriers of diagnosable symptoms that suggest an organic disease treatable with medications. Although there is substantial evidence that psychotherapy combined with medications, where *necessary*, is the very best combination for treatment, each competing mode has its partisans and a dialectic rivalry has replaced collaboration.

It is ironic that, with the seeming triumph of the biomedical model, psychotherapy in its maturity may be facing the same challenges it faced near its birth. As Freud (1918) observed eighty-five years ago: “... the study of psychiatry... in its present shape, is exclusively descriptive in character; it merely teaches the student to recognize a series of pathological entities, enabling him to distinguish which are incurable and which are dangerous to the community. Its sole connection with the other branches of medical science lies in organic aetiology: that is, in its anatomical findings; but it offers not the slightest understanding of the facts observed.”

The Areas of Divergence

The Differences in Technique

All the above areas of convergence of technique testify to the validity and effectiveness of STDP. But it’s the areas of divergence - both technical and paradigmatical - that are so fascinating.

First, there is the different spin each practitioner brings to the technique. For instance, Davanloo instructs therapists to treat the patient’s defenses with “disrespect”. Neborsky adheres to this tradition, showing a veritable contempt for defenses. Alpert, on the other hand, seems far more tolerant. As the term Accelerated Empathic Therapy suggests, Alpert challenges the patient with an obvious empathic attunement. But empathy, in the hands of Alpert, is not a balm to be dosed out by the bucket. Alpert’s formulation of how empathy works is straightforward, but complex, and requires the therapist to continually monitor the feedback in the dyad. “Patients who lose contact with their pain,” Alpert (2003) writes, “when it becomes too strong, can be reconnected with a diluted form or it when they empathize with the therapist who has been empathizing with them.” The therapist, then, must be able

to demonstrate empathy in a way that exactly fits the capacity of the patient. If the therapist's empathy seems more painful than the patient can bear, the patient may be retraumatized.

And McCullough (1997) will even go so far as assuring patients that learned defenses were at some point no doubt valuable to their survival: "You didn't ask to be taught this way of responding; it just occurred because this was the only way you could have managed in the chaotic situation that surrounded you". This is a kind of soothing interpretation one cannot imagine Davanloo uttering. Having laid the groundwork with careful clarification of defenses, a therapist like Neborsky is able to challenge patients in seemingly stern ways without creating what Davanloo (1988) calls a "misalliance". Alpert and McCullough, while equally expert at clarification, prefer to maintain pressure with a velvet glove.

Watching these divergent styles, the beginning STDP practitioner may be more at ease with Alpert's touch because it seems more "loving". But an imitation of Alpert without his depth of experience would be nothing more than wearing one's empathy on one's sleeve, an approach that would benefit no one. Jonathon Lear (1998) has written of his own psychoanalytic work that, while confrontation may seem harsh or even pitiless, the therapist can either love the injured and emotionally cut-off person, or that part of the person who has come to him to experience closeness. And, quoting Loewald (1980), he adds, "Scientific detachment in its genuine form, far from excluding love, is based on it. In our work it can be truly said that in our best moments of dispassionate and objective analyzing we love our object, the patient, more than at any other time and are compassionate with his whole being".

There is also divergence in the way these therapists view the very working of STDP. McCullough, for instance, sees its goal of releasing the blocked expression of true feeling as just another way of saying, "we have phobias about feeling, and so we do something other than express or experience the feeling that we need to". She sees patients getting healthier with STDP because it is actually a process of "emotional desensitization". To that end, she departs from Davanloo's technique of confronting defenses head on and raising a patient's anxiety - which she claims is really desensitization through flooding - and prefers to gradually lead her patients through increasing levels of emotional "exposure" to help them be able to tolerate more authentic feelings. Citing the large body of research validating systematic desensitization as the treatment of choice for phobias, McCullough feels that "lower levels of affect experiencing" overlaid on Malan's Triangles of Conflict and Feeling, actually moves the therapy along quicker.

For Malan, McCullough's construct is a misunderstanding. Yes, he admits, desensitization is part of the model of ISTDP - and one, in fact, both he and Davanloo have acknowledged - but the critical thing to remember is what's specific to dynamic psychotherapy, namely, that what gives the patient relief is the getting in touch with feelings that have been hitherto unconscious. And for Malan, that is not desensitization, but a different phenomenon. "When you talk about desensitization", Malan says, "you are in danger of implying that the feeling is already conscious and you're only trying to desensitize (the patient) to it". Malan cautions that in a push to unify learning theory with psychodynamic principles, something will be missed. McCullough (1997) insists that such unification is warranted. "If principles of reinforcement can apply to both overt and covert behavior", she writes, "it (takes) only one more intuitive step to posit that learning principles can also apply to the representational behavior of intrapsychic functioning".

McCullough, citing Stern (1985) also insists, "that psychodynamic theory focused too exclusively on intense affective experiences". In *Changing Character* she writes: "Indeed, in our early research on short-term dynamic therapy, my colleagues and I sought tremendous affective intensity, believing that it was essential for change. As (our) research evolved, we discovered that lower levels of affect experiencing resulted in distinct behavioral change, even in characterological shifts, despite our belief to the contrary. We also noticed that intense levels of affect were often disruptive to cognitive functioning, so that interpretations could not be absorbed, and sufficiently unsettling that some patients dropped out of treatment. Alpert (1992) reports the same observations.

Unfortunately, McCullough doesn't offer any reasons why her early research on short-term dynamic therapy sought "tremendous affective intensity". Davanloo (1987) himself has noted: "Although there was nothing dramatic in the breakthrough of the patient's anger, in fact it represented a major change

in his psychic system”. And while Davanloo certainly urges a patient to recognize and experience his/her affect at whatever level of intensity it is occurring, he clearly cautions the therapist to monitor what a patient can bear. In the case of anxiety-laden patients, Davanloo writes, “The therapist should apply the restructuring technique, the essential features of which consist of regulating the pressure very carefully and immediately reducing it when there are signs that too much anxiety is being aroused...” Also, tremendous affect without a container - a high therapeutic alliance - would indeed be counterproductive. Davanloo’s techniques make the alliance a priority.

Working in the “T”

There has been a clear evolution among all the therapists represented in this book towards work in the Transference, the “T”. While all STDP therapists link T issues with Past (P) events, there is some difference of opinion as to where the most effective work is done. Davanloo’s model is clear. “A major breakthrough”, he writes “*always* (emphasis added) requires direct experience of the aggressive impulse in the transference...” (1988) and “...since pressure and challenge invariably produce a rapid rise in transference feelings, the area in which (the defense mechanism is undone)... is the transference”.

Patricia Coughlin Della Selva (1996) cites Ferenczi, Rank, Alexander and French as historical precursors to Davanloo’s insistence that focusing the patient’s experience of feeling in the transference is the key to gaining rapid access to the unconscious, and his insistence that therapists should deal with the present before dealing with the past.

Neborsky stresses work in the here-and-now to an even greater degree. “It’s a whole lot easier”, he said in 2000, “to talk about the past and ignore the present. But the great therapeutic work is done in the here and now of the “T”. I don’t go back to the Past, the “P”. I want the breakthrough always to be in the “T”. I want it to be in the here and now”.

McCullough has stated that whether there should be an imperative to always do critical work in the “T” is an issue that can only be solved with more research. For now, she finds that some patients have to have here-and-now interaction and with others - particularly higher functioning ones - you can just work on current and past and get the resolution. In “Changing Character” she writes: “The insistence on the early analysts on transference as the only mechanism of therapeutic change may have been due to their realization that the transference feeling was the most affect-laden of all interactions and often represented the origin of the maladaptive pattern. In short-term treatment, we actively pull for affect in the context of *any* relationship being discussed. This reduces our reliance on the transference interaction. Transference issues sometimes play a minimal role in short-term cases with well-adjusted individuals who have limited focal problems and good alliance. The bulk of the work can be done with current and past figures, and it can be sufficient for change to occur”.

Transference and Counter-Transference

There has also been a notable divergence among these practitioners in their handling of counter-transference, but in their openness to change, that divergence appears to be narrowing. Neborsky is on record as believing that as the patient’s loss of connection with the parent becomes conscious (trauma of attachment), there will be a grief response behind the transference behavior. This creates a counter-transference response in the therapist.

Davanloo’s writings offer little guidance in the therapeutic use of counter-transference, and my review of his published transcripts failed to uncover any obvious example. Davanloo relayed to Coughlin-Della Selva (2000, personal communication) that what is often chalked up to counter-transference is simply a poorly trained therapist who doesn’t understand metapsychology and that, once one obtains better training, one finds less counter-transference.

McCullough, in “Changing Character”, writes at some length on counter-transference issues, reminding therapists that “patients often do not respond as desired and that this can bring up feelings of frustration and anger in the therapist”. She advises therapists not to blame patients for not “yielding

or not complying". For therapists experiencing strong negative counter-transference, McCullough advises that the "beleaguered" therapist should seek out a "compassionate colleague" to talk to, and for therapists experiencing strong positive transference, she cautions, the "tormented therapist needs the support of several colleagues". McCullough notes that "all uncovering work will have its influence on the therapist. It is crucial to be mindful of these constant influences and one's minute-to-minute reactions to them so that this information can be a contribution rather than an impediment to treatment". McCullough seems to imply, then, that, as in the psychoanalytical tradition, counter-transference is either explicitly kept out of the session entirely, or treated very guardedly.

But there is another tradition wherein the therapist's feelings are thought to have important therapeutic relevance and interpreting them to the patient can contribute to the treatment's efficacy (Tansey & Burke, 1989). Alpert has been the trail-blazer in bringing this belief to STDP. First he has developed "reciprocal monitoring", in which, "the patient is encouraged to look for and experience the therapist's affect as well as his or her own affect" (McCullough, 1997). Second, he acknowledges the counter-transference emotion to the patient, at the same time informing the patient that he will not react as the patient's past figures have, i.e. with abandonment or retaliation, has effected the methodology of his peers. Neborsky has commented that feeding back to a patient what he or she is making you feel in a warm, empathic and non-threatening way, with total openness, with no shame, no embarrassment, no sense of humiliation, and no defensiveness, is an "incredibly courageous and innovative step".

McCullough now employs Alpert's technique of sharing feelings, despite the fact that when she first saw Alpert's work, it turned her off. "All this, how do you feel about me, how do I feel about you", she said at the 2000 conference. "I don't know how long it took, several years, I think, of going to the conferences and saying, "Oh, Mike's group is getting all schmaltzy with his patients". But McCullough had one patient "who didn't believe she mattered, so I said what do you think I feel about you?... And she said, "Well, I'm just another patient". And we played that out over many sessions. Her sense of self was so impaired I could not have reached her without asking her, How do you think I feel about you?"

It is unlikely that Davanloo would invite a projection ("Well, I'm just another patient") by the introduction of a counter-transference question ("What do you think I feel about you?"). Davanloo's (1988) clear avoidance of that kind of encounter can be found in this typical exchange:

- Pt: I'm afraid (if I got angry with you, that) you might put me in my place or say something hurtful to me...
- Th: So then could we look at that?... Now could we look at what evidence there has been that I would retaliate, or react with anger if you get angry with me?
- Pt: I have no evidence.
- Th: So where does it come from? It is very important you look at it. So you say it comes from your head.
- Pt: That's right.
- Th: Was there the thought also that I might terminate... Did that pass through your head?
- Pt: It didn't pass through my head but it's maybe... I don't know.
- Th: It's very important you examine that.

Davanloo (1987) does nothing to assure the patient of the therapist's good intentions, but instead keeps pressure on the patient to take responsibility for his own projections. He avoids every opportunity to become the patient's confidant. To him, a therapist is a combination of scientist and hunter who operates "like a skilled surgeon directing the forces within the patient, entirely in the patient's interest, and above all he can gradually drive the resistance into a corner so as to enable to patient to be freed".

Self-punishment vs Self-caring

McCullough and Alpert (and other STDP therapists not represented in this volume, i.e. Diana Fosha) also guide the patient to feeling “compassion for the self”. We can observe a notable paradigmatic shift from Davanloo’s challenge to self-caring (“Do you want to continue to live a crippled life?”), to Alpert’s and McCullough’s (1997) more heartfelt entreaty (“Can you see how little compassion you have for yourself?... Isn’t it astonishing that an outsider - me - listening to your story, feels sad for you... and yet you feel nothing?”) Davanloo (1987) directs a truly contemptuous attitude (“Do you want to continue living like a cripple”) to the defenses of the punitive superego. McCullough and Alpert seem to be speaking more gently to a somewhat more numinous entity. Whereas Davanloo’s approach seeks immediate loosening of the force that *prevents* self-compassion, McCullough and Alpert attempt to have self-care gradually *sprout*, in McCullough’s (1997) phrase, “like a leaf through parched earth”.

For McCullough, pressure and challenge are not therapeutic imperatives but choices the therapist is free to make. After viewing one of Neborsky’s cases, she remarked, “I might have gone the way you went (challenge to care for self). You know, you never know. You follow your divining rod, your intuition, but I also might have gone for compassion for self, because the patient was so guilt-ridden, and stayed on that. And it’s a different pathway, you know, and the patient may not respond for a while and then suddenly say, “Oh, I’m beating up on myself all the time. How sad that is, that I’ve done that.”.

In this approach, which attempts to cure the guilt-ridden with compassion for self, McCullough’s and Alpert’s divergence from psychodynamic theory in general, and ISTDP orthodoxy in particular, is of primary importance. In 1926 Freud saw the superego’s resistance as “the most powerful factor, and the one most dreaded by us”. Ten years (Freud, 1937) later he was ready to “bow to the superiority” of those (superego) resistances because “even to exert a psychical influence on simple masochism is a severe tax upon our powers”

For Davanloo (1987), neurotic suffering is the result of superego punishment self-inflicted for “violent and murderous impulses toward close members of the family” which are “laden with intense guilt and grief”. They are laden with guilt and grief, says Davanloo, because there is an *innate* prohibition against killing biologic relatives. Unlike Freud, Davanloo (1987) sees the superego as intrinsic - not a post-Oedipal agent - and arising not just from fear, but also from love.

McCullough and Alpert seem to be redefining self-punishment as a lack of self-caring, so they choose to ignore or bypass - with undeniable therapeutic effect - the punitive role of the superego in the “guilt-ridden” In stark contrast to Davanloo’s approach, Alpert and McCullough do not seem to address superego pathology at all.

Watching McCullough’s (1997, page 49) sessions, and reading her contribution, one is impressed by her ability to probe for affect with great compassion, but she seems never to distinguish between conscious and unconscious affect. In this, her conceptualization is more behaviorist than psychodynamic, while her techniques often resemble those of supportive - even Rogerian - therapy rather than short-term dynamic therapy. In short, she seems to be guiding patients away from “needless” suffering without pushing for a deep exploration of its intrapsychic causes. How different this is from Davanloo (1987), who sees in patients “something more specific than simply the seeking of *suffering*, namely the seeking of *punishment*”

Alpert and McCullough seem to stress trauma as the source of neurosis, harking back to Freud’s original formulation. Davanloo stresses superego (in Freud, Oedipal) conflicts as the etiology of neurosis. For him, of primary importance is not what traumatized a patient, but the patient’s internal response to that trauma, i.e. rage, and the difficulty the patient has reconciling the conflict between the desire to hurt and the need to love primary caregivers. As Davanloo (1999) puts it, “the central issue is the perpetrator of the unconscious which consists of the attachment and bond, the original trauma, the pain of that trauma, primitive murderous rage intense guilt and grief, and subsequent traumas” ISTDP aims its interventions at loosening the force of the perpetrator on the unconscious. McCullough (1997), in a more behaviorist formulation, claims that psychotherapy must impact the full range of emotional associations so that maladaptive responses can be replaced by more adaptive responses.

McCullough and Alpert would almost certainly agree with Davanloo's (1987) observation that "there is a part of almost all patients which is identified with their defenses and hence with their resistances, i.e. the resistance is ego-syntonic". But whereas Davanloo seeks to quickly shatter the grip of the superego with the "essential intervention" of challenge, McCullough and Alpert "help the highly defended patient face the painful and difficult process of defense analysis in dosages that are bearable and not overwhelming," an approach that echoes Freud's (1940) attempt "to bring about the slow demolition of the hostile superego," and seems to reject Davanloo's "somewhat abrasive style." (Malan, 2003)

These are clearly important divergences, and the questions arises, have these practitioners found a way to really loosen the grip of the superego through a careful "regulation of anxiety" - a task that defeated Freud - or does the superego yield only to a relentless - although not necessarily unempathic--attack. Perhaps further research will make this clear.

The Future of ISTDP

Theory and practice are inevitably changed by the particular personalities of those who embrace them. Freud (Roazen, 1971) wryly observed in 1922, that Adler and Jung had diverged from psychoanalysis "evidently with the object of mitigating its repellent features" It is unclear whether Freud thought these ideas were repellent to the patient or the therapist, but the master himself was not immune to mitigating what was repellent for him. Getting his patients to lie on a couch may have helped the patient concentrate, but Freud (1912) admitted, "I cannot put up with being stared at by other people for eight hours a day (or more)".

Just as later psychoanalysts who got their patients off the couch discovered, some ISTDP practitioners will find that what they were told would occur by using a technique doesn't actually occur for *them* with *their* patients. Viable alterations of methodology will then emerge. Malan observed that when he was supervised as an analytical trainee, he always had the impression that there was only, at any given point in the therapy, only one place he could go, and if he went any other place, the patient would go into resistance and it would be of no use to me. "But," he added, "it isn't true. It's another of those taboos, which we have got to break".

Again we are called back to the role of personality in the creation of these taboos, where rigidities form around technique because the personality of a particular practitioner may demand it. In other words, in the example of Malan, does the "resistance" that would make the therapy "of no use" really belong to the patient, or to the practitioner?

And, as a new generation - with new ideas, new information, and a greater comfort at integrating knowledge from other disciplines - joins the ranks of ISTDP practitioners, future divergence is bound to occur, at what will undoubtedly seem like an accelerating pace. Neborsky, for instance, is merging attachment theory with ISTDP, which is yielding a gentler, but seemingly more effective, repertory of interventions.

So, returning to where we started, to that moment in Vienna as Freud was about to address his colleagues, could anyone foretell that psychoanalysis would one day become so far removed from the cutting edge of psychological thought, that it would become more like a religion than a science, rigidified by adherence to a liturgy of outmoded ideas and practices? Looking back fifty years from today, can any of us imagine that ISTDP will - or should - be similar to what it is today? Will ISTDP be of any usefulness if it does not assimilate new ideas, if it does not accommodate, not only neurological or biological advances, but also the psychological zeitgeist?

In "Short-Term Therapy for Long Term Change", David Malan states that the "challenging technique" of ISTDP needs to be "modified and softened if it is to be acceptable to the majority of therapists". That is precisely what seems to be occurring on Internet discussion forums, where some ISTDP therapists are pushing the work into new territory, using expressions like "being present with the patient", or "unconditional acceptance", or, even, "feeling love" - concepts that seem far removed from Davanloo's seminal ideas. These spiritual tendencies - is there any other way of seeing them? - would seem to be antithetical to the Freudian foundation of ISTDP, and to its surgically precise interventions. But perhaps ISTDP's most important contribution goes beyond its metapsychology or

its techniques. It has taught a generation of therapists to stay present to a patient's feelings and movements in the moment, to not allow escape into the comfortable, to not be lulled by narrative distractions, and to follow feelings wherever they lead.

I am reminded of what the Tibetan Chogyam Trungpa (1973) had to say about Western psychotherapy:

Once you begin to deal with a person's whole case history, trying to make it relevant to the present, the person begins to feel that he has no escape, that his situation is hopeless, because he cannot undo his past. He feels trapped by his past with no way out. This kind of treatment is extremely unskilled. It is destructive because it hinders involvement with the creative aspect of what is happening now, what is here, right now. But, on the other hand, if psychotherapy is presented with the emphasis on living in the present moment, working with present problems, not just as regards verbal expressions and feelings, then I think that would be a very balanced style. Unfortunately there are many kinds of psychotherapy and many psychotherapists involved with trying to prove themselves and their own theories rather than working with what is. In fact they find it very frightening to work with what is.

Solomon and Shapiro

The two remaining contributors to this book, Marion F. Solomon and Francine Shapiro, each deserve more than a passing note of acknowledgement, but because their practices fall outside of the scope of ISTDP, I will confine my comments to this brief addendum. Marion Solomon, the coeditor of this volume, has brought psychodynamic techniques to couple's therapy, and her contribution to that therapeutic mode has been significant. She is a prolific author and editor, but it is in her vital role as a conference planner that she has been invaluable to ISTDP's development. It was Solomon who first brought Davanloo to California in 1994, and it was he who introduced her to Neborsky. Solomon then featured Neborsky in a number of ISTDP conferences. The Solomon/Neborsky combination has been extraordinarily protean, as the volume under review proves. Through their workshops, ISTDP has been introduced to thousands of therapists and researchers. ISTDP owes a great debt to Marion Solomon.

Francine Shapiro, the originator and developer of Eye Movement Desensitization and Reprocessing, has, through extraordinary insight and dedication, created a new way of treating trauma victims. As with all cutting-edge techniques, controversy surrounds the precepts and efficacy of EMDR, but there is a growing body of research that strongly suggests that it is among the most effective methods of treating PTSD, achieving its effects notably faster than other therapies. (Van Etten & Taylor, 1998) By 2004, only 17 years after Shapiro's discovery of EMDR, there were more than 50,000 practicing EMDR therapists around the world.

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