**Research in Intensive Short-term Dynamic Psychotherapy**

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**Evidence for Intensive Short-term Dynamic Psychotherapy – Introduction**

This paper examines the state of evidence for Intensive Short-term Dynamic Psychotherapy (ISTDP) outcome and process across a broad spectrum of clinical conditions and settings.

**What is Intensive Short-term Dynamic Psychotherapy?**

Developed from the 1960’s to recent years by Dr Habib Davanloo, ISTDP is a broadly applicable focused form of short-term psychodynamic psychotherapy which has modifications to treat highly resistant, depressive and dissociative individuals. It emphasizes body-focus, emotional experiencing and defense handling. It centers on work in the here and now, mobilizing complex transference feelings and defenses as a means of providing direct access to attachment related emotions. Through this work in the therapeutic relationship, memories and emotions related to past attachment trauma are mobilized and accessible. For individuals with repressive processes and dissociative features with more severe personality disorders, a phase of capacity building precedes this access and for this reason the treatment may be longer in those individuals. The method has been researched by Dr Davanloo and other researchers through detailed video recorded large case series, process-based research, patient feedback on video, long-term follow up, and the following tabulations of outcome research conducted by independent centers. Training is all based on video demonstrations from actual case material, detailed supervision of video and self-review of video.

**Overall Research Evidence**

Overall, there are over 150 outcome studies with approximately 75 randomized controlled trials included under the following categories:

* 25 studies of anxiety disorders
* 30 cost-based studies
* 16 studies of depression
* 22 miscellaneous studies of various populations
* 19 studies of mixed disorders
* 9 studies of personality disorders
* 25 qualitative and process studies
* 4 studies of severe mental disorders
* 53 studies of somatic conditions
* 4 studies of substance use disorders
* 38 studies of treatment refractory non-somatic populations
* 5 studies of the trial therapy interview
* 50 studies of somatic conditions

**Replications**

There are independent replications of randomized controlled trials of ISTDP for treatment resistant depression, major depression, personality disorders, chronic pain, and social anxiety disorder. Based on this, the method meets the criteria for empirically supported treatment.

**Studies of ISTDP in Learners and Learning Processes**

There is a small series of studies showing that the treatment is effective in the hands of new learners, that the treatment can bring structural change in personality, that the treatment can be also cost-effective, and that the amount of training correlates with some of the outcome measures. In the final years of his teaching, Dr Davanloo developed a method of experiential learning in small group format (Beeber, 2018).

**Future Research Directions**

An overall updated meta-analysis of this outcome research is pending. There is some research into the learning process of this method, but further research will be beneficial. Randomized controlled trials would be beneficial in the case of adjunctive treatment for people with severe mental disorders.

**Section 1: Anxiety Disorders**

There are now over 20 published outcome studies of the intensive short-term dynamic psychotherapy for the spectrum of anxiety disorders. These include 18 randomized controlled trials and a number of case series and single case studies with pre-post comparisons.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Panic Disorder (Wiborg & Dahl, 1996) | 40Treatment group: N=20, Control group: N=20 | 15 | RCTPre-post + 6, 9, 12, 18 month follow up | Clomipra-mine only control | Less symptoms in ISTDP group at 9 months follow up. Medication use reduced vs control at 18 month follow up. More relapses in medication only group  |
| Anxiety Disorders (Rocco et al., 2014) | 8 | 33 (average) | Pre-post | - | ISTDP reduced anxiety symptoms |
| Performance Anxiety (Kenny et al., 2016) | 1 | 1 | Case report | - | Description of one session only |
| Social Anxiety in intellectually impaired (Sudejani & Sharifi, 2016) | 16Treatment: N=8, Control: N=8 | 12 | RCT | No treatment | ISTDP > Control |
| Generalized Anxiety Disorder (Lilliengren et al., 2017) | 215 | 8.3 | Case series. Pre vs 4 years post | - | Anxiety reduction, Interpersonal problem reduction, physician and hospital costs reduction – $16,200 per case |
| OCD (Sudejani & Malek Mohamadi Galeh, 2017) | 32ISTDP: N=16, Control: N=16 | 20 | RCTPre-post | No treatment control | ISTDP reduced irrational beliefs and cognitive avoidance |
| Mixed Anxiety Disorders – female sample (Qaziani & Arefi (2017) | 30Treatment group: N=15, Control group: N=15 | 15 | RCTPre-post | Waitlist control | Greater reduction in anxiety |
| Obsessive- compulsive Disorder (Ranjbar et al., 2017) | 30 | 20 | RCTPre-post | No treatment | Greater reduction in OCD symptoms (YBOCS, IBT) |
| Social Anxiety – mothers of children with Aspergers (Fooladi et al., 2018) | 16 Treatment group: N= 8, Control group: N=8 | 12 | RCTPre-post | Wait list | Greater anxiety reduction |
| Separation anxiety (Haljoo et al., 2019) | 30 | 12 | RCT | Anxiety modulating method + no treatment control | ISTDP > Comparison therapy and control |
| Post-traumatic stress – earthquake victims (Safarnia, 2019) | 45 |  | RCT | Mindfulness based CBT + no treatment control | ISTDP = MBCT > control on pain, post-traumatic stress and depression |
| Fear of flying (Singh, 2019) | 1 | 2 x 90 minutes | Case study | - | ISTDP reduced fear of flying |
| Mixed Anxiety in rheumatoid arthritis (Amani et al., 2020) | 40Treatment group: N=20, Control group: N=20 | 15 x 90 minutes | RCTPre-post | Wait list | ISTDP > ControlReduced RA, anxiety and alexithymia |
| GAD (Taghavi et al., 2020) | 40STDP: N=20, Control: N=20 | 8 | RCTPre-post | No treatment control | ISTDP > Control |
| OCD (Almadani & Said, 2020) | 1 |  | Case study | - | “This case suggests that psychodynamic psychotherapy could be an effective intervention for patients with treatment-resistant obsessive-compulsive disorder…” |
| GAD (Aziz et al., 2020) | 36Integrative (STPP + CBT): N=12, CBT: N=12, Control: N=12 | 15 | Pre-post | CBT + no treatment control | Integrative treatment reduced GAD symptoms > CBT + no treatment control |
| Social Anxiety Disorder (Rhamani et al., 2020) [1] | 42ISTDP with Challenge: N=14, ISTDP without Challenge: N=14, Control: N=14 | 10 | RCTPre-post | Wait List  | ISTDP > Control – reductions in fear and avoidance |
| Social Anxiety Disorder (Rhamani et al., 2020) [2] | 41FF-ISTDP: N=14, DF-ISTDP: N=14, Control: N=13 | 8-10 | RCTPre-post + 6 month follow up | Wait List | ISTDP > Control – reductions in fear and avoidance |
| Anxiety and post traumatic stress – bereavement after COVID-19 deaths (Mohammadi et al., 2021) | 30ISTDP: N=15, Control: N=15 | 15 x 90 minutes | RCTPre-post + follow up | No treatment | ISTDP > Control on anxiety, depression, guilt and post-traumatic stress |
| Mixed Anxiety Disorders (Rocco et al., 2021) | 22 | 24 | Case seriesPre-post + follow ups at 6 and 12 months | - | Anxiety reduction, Personality Changes (SWAP-200, IIP) |
| Post-Traumatic Stress Disorder (Roggenkamp et al., 2021) | 41 | 5.5 | Case seriesPre-post + annual follow ups for 3 years | - | Reduced symptoms, interpersonal problems, physician costs and hospital costs  |
| Death anxiety in cancer patients (Alirezaee et al., 2022) | 30ISTDP: N=10, CBT: N=10, Control: N=10 | 11 x 90 minutes | RCTPre-post | Wait list control group | ISTDP = CBT > control |
| OCD (Jamali et al., 2022) | 3 | 20 | Single case experimental design | - | ISTDP reduced fear of guilt and latent aggression |
| Sexual Assault Victims (Khatami & Fard, 2022) | 30ISTDP: N=15, Control: N=15 | 15 x 90 minutes | RCTPre post | No Treatment | ISTDP > Control on anxiety and self-compassion |
| Social Anxiety (Mehboodi et al., 2022) | 20ISTDP: N=10, Control: N=10 | 15 | RCTPre-post + 2 month follow up | No treatment | ISTDP > control with anxiety, defence maturation, emotional regulation |
| Death anxiety in Covid (Mousavi & Naji (2022) | 34ISTDP: N=17, Control: N=17 | 8 x 75 minutes | RCTPre-post + follow up | No treatment | ISTDP > Control |

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**Section 2: Cost-effects Studies**

There are now at least 30 published studies that have outcomes measuring cost effectiveness of ISTDP. The domains covered include medication use, physician visits, healthcare visits, hospital use and disability rates or costs. The studies vary a great deal in terms of quality and type of study. Five have non-randomized control conditions and four are randomized controlled trials while the others compare pre to post.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sample**  | ***n***  | **# Sess**  | **Study design** | **Control** | **Effect/outcome (cost reduction per case)** |
| Panic disorder (Wiborg & Dahl, 1996)  | 40 Treatment group: N=20, Control group: N=20 | 15  | RCTPre-post + 6, 9, 12, 18 month follow up | Medication only control | Less symptoms in ISTDP group at 9 months follow up. Medication use reduced vs control at 18 month follow up. More relapses in medication only group  |
| Mixed sample (Abbass, 2002 [1])  | 89  | 14.9  | 1-2 years post vs 1 year pre | - | Hospital, physician, medication and disability costs – $6,202/case  |
| Mixed sample (Abbass, 2002 [2])  | 166  | 16.9  | Pre vs 1.75 year passive follow-up | Wait list – non-randomized control | Medication and disability reductions  |
| Personality disorders (Cornelissen & Verheul, 2002)  | 93  | Up to 6 months  | 2 years post vs 1 year pre | - | Hospital, physician, and health professionals cost – utilization rates only. |
| Mixed sample (Abbass, 2003)  | 88  | 14.9  | 3 years follow-up vs projections | - | Hospital and physician costs – $1,827/case  |
| Treatment-resistant depression (Abbass, 2006) | 10  | 13.6  | 6 months post vs 6 months pre | - | Hospital, medication and disability costs – $5,688/case  |
| Workers Compensation patients (Abbass, 2008) | 188 | 10 | 2 years pre vs post | - | Reduction in payments – $28,116/ case |
| Mixed sample – Trial therapy (Abbass, Joffres et al., 2008)  | 30  | 1  | Naturalistic1 month post vs pre | - | Medication and disability reductions, increased employment rate |
| Chronic headache (Abbass, Lovas et al., 2008)  | 29  | 19.7  | 1 year post vs 1 year pre | - | Medication and disability costs – $7,009/ case  |
| Personality disorder (Abbass, Sheldon et al., 2008)  | 27 Treatment group: 14. Control: 13 | 27.7  | RCT2 years post vs 1 year pre | Waitlist control group | Medication and disability costs – $10,148/case  |
| Medically unex­plained symptoms (Abbass et al., 2009)  | 50  | 3.8  | 1 year post vs 1 year pre | Non-randomized control: Patients referred but not seen | Medical visits (emergency) and costs – $910/case  |
| Hospital emergency (Abbass et al., 2010) | 50 |  | Pre-post | - | Cost savings |
| Chronic Welfare Patients (Dept. Comm. Services Report – Novia Scotia, 2012) | 65 | 12 | 5 years post vs 1 year pre | - | Welfare costs – $11,384/ case |
| Psychiatry inpatients (Abbass, Town et al., 2013)  | 33 | 9 | 1 year post vs 1 year pre | Other psychiatric ward – Non-random­ized | Electroconvulsive therapy costs – $1,400/case |
| Mixed sample: Treated by Residents (Abbass, Kisely et al., 2013)  | 140  | 9.9 (average) | 3 years post vs 1 year pre | - | Physician and hospital costs – $3,773/ case  |
| Personality disorder (Cornelissen, 2014) | 155  | Up to 6 months  | 10 years post vs 1 year pre | - | Increased employment 39% to 88% |
| Mixed Sample (Abbass, Kisely et al., 2015) | 1082Treatment Group: N= 890, Control: N = 192 | 7.3 | Quasi-experimental design3 years post vs 1 year pre | Non-randomized control – patients referred but not seen | Physician and hospital costs – $12,700/case |
| Psychotic Disorders (Abbass, Bernier et al., 2015) | 38 | 13 | Pre vs 4 years post | - | Physician and hospital costs – $80,400/case |
| Pseudoseizures (Russell et al., 2016)  | 28 | 3.6 | 3 years post vs 1 year pre | - | Physician and hospital costs – $57,400/case |
| Inpatient Refractory cases (Solbakken & Abbass, 2016) | 95 | 8 wk | Pre vs post  | Wait list control | Reduced healthcare use, medications and disability |
| Family Medicine Cases (Cooper et al., 2017) | 37 | 4.2 (average) | Pre vs post 6 months | - | 23% drop in family doctor visits |
| Generalized Anxiety Disorder (Lilliengren et al., 2017)  | 215 | 8.3 | Pre vs 4 years post | - | Physician and hospital costs – $16,200/ case  |
| Treatment Resistant Depression (Town, Abbass et al., 2017) | 60ISTDP: N= 30, TAU: N=30 | 20 | RCTPre vs 6 month post | Mental Health Team TAU (mostly CBT + medication) | Reduced medication use vs controls |
| Mixed Conditions: Trial Therapy (Abbass et al., 2018) | 344 | 1 | 3 years post vs 1 year pre | - | Physician and hospital costs – $10,840/case |
| Bipolar Disorder (Abbass et al., 2019) | 29 | 4.6 | I year pre vs 4 yearly post-treatment follow ups | - | All health care costs – $81,632/ case |
| Eating Disorders (Nowoweiski et al., 2020) | 27 | 9.8 | 3 years post vs 1 year pre |  | All health care costs – $15,024/ case |
| Chronic Pain (Lilliengren et al., 2020)  | 228 | 6.1 | 3 years post vs 1 year pre | - | All health care costs – $14,000/case  |
| Treatment Resistant Depression (Town et al., 2020) | 60Treatment group: N=30, Control: N= 30 | 20 | RCTPre vs 18 months post  | Mental Health Team TAU (mostly CBT + medication) | $503/case  |
| PTSD (Roggenkamp et al., 2021) | 41 | 6 | 3 years post vs 1 year pre | No treatment | All health care costs – $10950/case |
| Functional Seizures (Malda-Castillo et al., 2023) | 18 | 3 | 1 year pre and post | - | Reduced utilization – mental health, medications and emergency |
| Hospital Occupational Health referred – Halifax, NS (26) | 18 | 7.5 | 1 year pre vs 18 months post |  | Sick payments – $13,333/ case  |

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**Section 3: Depression**

There are now 16 published outcome studies of ISTDP for depression and related processes such as defense styles and attention bias. These include 13 randomized controlled trials and 3 case series with pre-post designs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Treatment-resistant depression (Abbass, 2006) | 10  | 13.6  | Case Series6 months post vs 6 months pre | - | Post > Pre + cost effective: hospital, medication and disability costs – $5,688 per case |
| Major depression. (Khoryaniyan et al., 2012) | 16 |  | RCTPre-post | No treatment | ISTDP > control |
| Depression (Ajilchi et al., 2013) [1] | 32ISTDP: N=16, Control: N=16 |  | RCTPre-post | Waitlist control | ISTDP > Control |
| Attention bias in depression (Ajilchi et al., 2013) [2] | 32ISTDP: N=16, Control: N=16 |  | RCTPre-post | Waitlist control | ISTDP reduced attention bias |
| Major depression (Ajilchi et al., 2016) | 32ISTDP: N=16, Control: N=16 | 15 (average) | Pre-post + 12 month follow up | Waitlist control | ISTDP reduced depression and increased executive functioning |
| Treatment Resistant Depression (Town, Abbass et al., 2017) | 60ISTDP: N= 30, TAU: N=30 | 20 | RCT Pre vs 6 month post | Mental Health Team TAU (mostly CBT + medication) | ISTDP > CMHT on depression, reduced medication + cost effective |
| Major Depressive Disorder (Town, Salvadori et al., 2017) | 4 | Treatment duration varied among patients | Case series design | - | Peak Affect Experiencing predicted strong therapeutic alliance next session in 3 cases |
| Social cognition in major depression (Ajilchi et al., 2020) | 32ISTDP: N=16, Control: N=16 | 15 (average) | Pre-post | Waitlist control | ISTDP > Control |
| Depression (Jafarian et al., 2020) | 10 | - | RCTPre-post | Laser therapy only control | Laser = Laser plus ISTDP – reduced depression |
| Treatment Resistant Depression (Town et al., 2020) | 60Treatment group: N=30, Control: N= 30 | 20 | RCTPre vs 18 months post | Mental Health Team TAU (mostly CBT + medication) | ISTDP > CMHT on depression, reduced medication + cost effective |
| Treatment Resistant Depression (Heshmati et al., 2021) | 3 | 10 | Case seriesSingle-case study | - | Post > Pre on emotional suppression and negative affect |
| Treatment Resistant Depression (Town et al., 2022) | 27 | 20 | RCT | - | Experiencing previously avoided anger positively predicts reduction in Depression via Working Alliance and Insight |
| Defense styles in depressed patients (Habiba & Arab, 2023) | 30ISTDP: N=15, Control: N=15 |  | RCTPre-post | No treatment | Maturation of defenses |
| Treatment Resistant Depression (Heshmati et al, 2023) | 86ISTDP: N=43, Control: N=43 | 43 | RCTPre-post | Waitlist control | ISTDP > Waitlist on depression, repression and negative affect |
| Sexual function and marital satisfaction in depressed women (Ziapour et al., 2023) | 60ISTDP: N=30, Control: N=30 | 2 | RCTPre-post | Waitlist control | ISTDP > Control on depression and marital satisfaction |
| Anger and guilt in depression(Sarlaki et al., 2024) | 32ISTDP: N=16, Control: N=16 | 8 x 90 minutes | RCTPre-post + 3 month follow up | Wait list | ISTDP> control |

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**Section 4: Miscellaneous**

There are further a large series of studies of various other populations including workplace stress and burnout, marital issues, cancer and eating disorders.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Eating Disorders (Nowoweiski et al., 2011) | 6 | 4 week Day Treatment Program (DTP) including ISTDP group | Pre-post | - | “Results indicate that the pilot DTP described above appears to be partially effective in decreasing the behaviours and psychosocial impairment associated with ED symptoms”. |
| Psychiatric Inpatients (Abbass et al., 2013) | 33 | 9 | Case Series | - | Post > Pre ECT reduction Cost Effective |
| Dementia (Ericson & Eriksson, 2013) | 3 |  | Case study | - |  |
| Mother-child conflict (Pasbani et al., 2018) | 16ISTDP: N=8, Control: N=8 | 8 | RCTPre-post + 2 month follow up | No treatmernt control | ISTDP improved the mother-child relationship |
| Defensive styles, anxiety and fear of intimacy (Nabizadeh et al., 2019) | 26ISTDP: N=13, Control: N=13 | 10 x 45 minutes | Pre-post | Active treatment control group | Neutralization of tactical defenses reduced immature and neurotic defensive styles, and state and trait anxiety. |
| Marital conflict (Parisiuz et al., 2019) | 40ISTDP: N=20, Control: N=20 | 8 | RCTPre-post + 3 month follow up | No treatment | ISTDP > Control Reduced conflict, better IP function |
| Inflammatory Bowel Disease (IBD) (Watt & Irving, 2019) | 7 | 2-12 | Case SeriesPre-post | - | Improvement on IBD symptoms  |
| Eating Disorders (Nowoweiski et al., 2020)  | 27 | 9.8 | Case Series | 3 years post vs. 1 year pre | Post > preReduction in all health care costs – $15,024/ case |
| Executive function in grade 9 girls (Sarihi et al., 2020) | 9 |  | RCTPre-post | Awareness training vs ISTDP plus awareness training control | ISTDP > Awareness training  |
| Type 2 diabetes (Moharer & Harafteh, 2021) | 40Treatment: N=20, Control: N=20 | 8 x 90 minutes | Pre-post | TAU control | ISTDP > Control in increasing emotion regulation and health hardiness |
| Self Injurious Behaviors (Moradzadeh et al., 2021) | 5 | 20 | Case seriesPre-post + 2 months follow up | - | Post > Pre |
| Air Traffic Controller with Burnout (Pakdel et al., 2022) | 30ISTDP: N=15, Control: N=15 | 20 x 90 minutes | RCTPre-post | No treatment | ISTDP > Control on job stress, quality of life and self-efficacy |
| Emotional expressiveness and differentiation in Betrayed Women (Ranjbar et al., 2022) | 40ISTDP: N=20, Control: N=20 | 9 x 75 minutes | RCTPre-post | Wait list | ISTDP > control |
| Attachment styles in women with marital conflicts (Sarafraz & Moradi, 2022) |  |  | RCT | Treatment as usual | ISTDP > Control in attachment styles |
| Women victims of marital infidelity (Shams et al., 2022) | 45ISTDP: N=15, MBT: N=15, Control: N=15 | ISTDP: 15 x 90 minutesMBT: 20 x 90 minutes | RCTPre-post | Mentalization based therapy + Waitlist control | MBT > ISTDP on defense developmentISTDP + MBT > control |
| Cancer (Alirezaee et al., 2023) | 30 |  | RCT |  | ISTDP = CBT > Control on self-compassion |
| Couples with Alexithymia (Afrooz et al., 2023) | 60 | - | RCTPre-post + 3 month follow up | Emotion focused therapy and control | ISTDP =EFT > Control |
| Financial Marker Traders Stress (Jabalameli and Borujeni 2023) | 30 |  | RCT | No treatment | ISTDP > Control on emotional intelligence and ambiguity tolerance |
| Breast Cancer (Jamshidi et al., 2023) | 3 |  | Case Series |  | Post > Pre in pain anxiety and self-compassion |
| Couple relationships when treatment women tending to infidelity (Kashefi et al., 2023) | 40ISTDP: N=20, Control: N=20 | 9 x 90 minutes | RCTPre-post | No treatment | ISTDP > Control in attachment behavior and self differentiation |
| Oppositional Defiant Disorder in adolescents (Nikakhlagh & Manavipour 2023) | 30Treatment group: N=15, Control: N=15 | 8 | RCTPre-post | No treatment | ISTDP> Control |
| Treating mothers of children with Social Anxiety (Harchegani & Ghazanfari, 2024) | 45ISTDP: N=15, Schema therapy: N=15, Control: N=15 | 10 x 90 minutes (ISTDP + Schema Therapy) | RCTPre-post + 3 month follow up | Schema Therapy and no treatment | Schema Therapy > ISTDP > control in reducing child anxiety |
| Maternal ambivalence (Pollack, 2024) | 2 |  | Case study | - | ISTDP reduced maternal ambivalence |

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**Section 5: Mixed Disorders**

There are 19 studies of ISTDP for mixed anxiety and depression, largely consisting of case series with pre-post designs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Mixed sample (Abbass, 2002) [1]  | 89  | 14.9  | Case series1-2 years post vs 1 year pre | - | Significant symptom reduction$6,202/case cost reduction: hospital, physician, medication and disability costs |
| Mixed sample (Abbass, 2002) [2] | 166  | 16.9  | Before vs 1.75 year passive follow-up | Wait list. Non-randomized control.  | Medication and disability reductions |
| Refractory/ Severe Personality Disorders, (Cornelissen & Verheul, 2002) | 93 | Up to 6 months | Case Series2 years post vs 1 year pre. | - | Post > PreHealthcare and disability reductions: Hospital, physician and health professionals cost – utilization rates only. |
| Mixed sample (Abbass, 2003)  | 88  | 14.9  | 3 years follow-up vs projections | - | $1,827/case cost reduction |
| Workers Compensation Patients (Abbass, 2008) | 188 | 10 | 2 years pre vs post | - | Reduction in payments – 28,116/case |
| Mixed sample. Trial therapy (Abbass, Joffres et al., 2008)  | 30  | 1  | Naturalistic Pre vs 1 month post | - | Medication and disability reductions.Trial therapy reported to be clinically effective and cost-effective in a tertiary setting; 43% had recovery from case criteria as shown through BSI scores; one-third required no further treatment, seven stopped medications and two returned to work following trial therapy |
| ISTDP Trial therapy vs standard intake interviews (Abbass et al., 2009) | 50 | 1 | Non-randomized clinical trial | 20 standard intake assessment interviews | Trial therapies were clearly distinguishable from standard intake assessments. The trial therapy resulted in statistically significant improvements on all BSI subscales. In the follow-up interview, one third (10) of individuals in the trial therapy group required no further treatment, 7 were able to stop 11 psychotropic medications, and 2 were able to return to work. |
| Refractory Mixed Diagnoses Tier 3 or 4 NHS, UK (Hajkowski, 2012) | 23 |  | Case Series |  | Post > Pre |
| Mixed sample: Treated by Residents (Abbass, Kisely et al., 2013)  | 140  | 9.9  | 3 years post vs 1 year pre | - | $3,773/case cost reductions – physician/hospital. |
| Mixed outpatients (Town et al., 2013) | 89 | - | Naturalistic | - | **Emotional experiencing correlates with healthcare cost reduction, symptom reduction** |
| Extended Trial Therapy (Aafjes-van Doorn et al., 2014) | 31 | 1 | Non-randomized trial – Pre post design | - | After the trial therapy session, patients reported a significant increase in remoralization and self-compassion and a significant decrease in symptoms of general distress but not interpersonal problems. Process ratings were not significantly associated with improvement on these outcome measures. |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2014) | 250 – projected | 8 weeks intensive residential programme – 8 x 90 minutes or 16 x 45 minutes individual sessions | Pre vs post + follow up at 6 and 12 months | Waitlist control: TAU | ISTDP > ControlCost Effective: Reduced healthcare use, medications and disability . |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2015) | 90ISTDP treatment: N=60, Control: N=30 | 8 weeks intensive residential programme – 8 x 90 minute sessions | Pre-post + through treatment + follow up at 6 and 14 months | Waitlist control: TAU | ISTDP > ControlCost Effective: Reduced healthcare use, medications and disability |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2016) | 95 | 8 weeks intensive residential programme – 8 x 90 minutes or 16 x 45 minutes individual sessions | Pre-post + at weeks 3 and 5 of treatment + follow up at 6 and 14 months | Waitlist control: TAU | ISTDP> WaitCost Effective: Reduced healthcare use, medications and disability |
| Trial therapy – role of unlocking the uncs, mixed sample. Tertiary centre (Abbass et al., 2017) | 500 | 1 | Baseline vs 1 month post | - | 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 (self-reported symptoms and interpersonal problems) were greater in patients (psychoneurotic and fragile) who had a major unlocking of the unconscious compared with those who did not. |
| Mixed Conditions: Trial Therapy (Abbass et al., 2018) | 344 | 1 | Case Series 3 years post vs 1 year pre | - | Post > PreCost Effective (physician and hospital costs): $10,840/case |
| **Group Intensive Experiential-Dynamic Psychotherapy (Landra, 2018)** | 8 |  | Case study | - | “The group IE-DP approach yielded encouraging results for resistant patients with Superego pathology, and that the group setting lends itself to Self- and Other-restructuring”. |
| Complex Populations, UK (Malda-Castillo et al., 2020) | 8 |  | Case Series |  | Enduring symptom reduction |
| Hospital Occupational Health referred – Halifax, NS (26) | 18 | 7.5 |  |  | Reduction in sick payments – $13,333/ case |

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**Section 6: Personality Disorders**

There is an increasing number of studies of ISTDP for personality disorders including case series and 6 randomized controlled trials with pre-post designs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Personality Disorder (Winston et al., 1994) | 81ISTDP: N=25, BAP: N=30, Control: N=26 | 40.3 (mean) | RCTPre-post + 1.5 year follow up | Brief Adaptive Psychotherapy + Waitlist control | STDP > Ctrl |
| Cluster C Personality Disorder (Hellerstein et al., 1998) | 49STDP: N=25, BSP: N=24 | 40 | Pre-post + 6 month follow up | Brief Supportive Psychotherapy control | STDP =/> BSP |
| Personality Disorder (Svartberg et al., 2004) | 50STDP: N=25, CBT: N=25 | 40 | RCTPre-post + 2 year follow up | CBT control group | STDP =/> CBT |
| Personality Disorder (Abbass, et al., 2008) | 27 Treatment group: N=14. Control: N=13 | 27.7 | RCT 2 years post vs 1 year pre | Waitlist control group | ISTDP > Minimal ContactCost effective (medication and disability costs) – $10,148 per case |
| Refractory/ Severe Personality Disorders (Cornelissen, 2014) | 155 | Up to 6 months | Case Series 10 years post vs 1 year pre |  | Post > PreIncreased employment – 39% to 88%. |
| Obsessive-compulsive and Avoidant Personality Disorders (Moazzami et al., 2021) | 6 | 15 | Single experimental design:Baseline, after every 3 sessions, 3 follow ups at 1 month intervals | - | ISTDP reduced symptoms and defense mechanisms. |
| Histrionic Personality Disorder (Salehian, 2022) | 16 |  | RCTPre-post | No treatment | ISTDP > control on multiple variables |
| Antisocial Personality Disorder (Salehian & Moradi, 2022) [1] [2] | 16 |  | RCTPre-post | No treatment | ISTDP > Control (aggression ++, social adjustment) |
| Histrionic Personality Disorder (Salehian & Moradi, 2023) |  |  | RCTPre-post | No treatment | ISTDP > control on multiple variables |

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**Section 7: Qualitative and Process Studies**

**There are now a large series of process studies examining events in sessions, and some relating processes to outcomes. Overall, these studies validate the core principles of the method has developed by Dr Davanloo.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| **Dr Davanloo’s Original case research** |  |  |  |  | **Documented with many case examples and presented over numerous workshops over 30+ years, the key processes of the central dynamic sequence, necessity of repeated recapping, and other key principles of the method were studied and developed.** |
| **Patient-therapist interaction – STDP (McCullough et al., 1991)** | 16 | 27-53 sessions | Case series | - | Results indicate that patient-therapist interpretations followed by patient affect bears a significant relationship to improvement at termination, whereas an intervention (of any type) followed by defensiveness correlates negatively with outcome. These findings suggest that an examination of patient- therapist interaction episodes may be more productive than examining process variables in isolation. |
| Patient defense/therapist interventions – STDP (Winston et al., 1994) | 28 | 44 (mean) – 4 sessions coded per patient | RCTPre-post + 1.5 year follow up | - | The frequency of therapist addressing defense (TAD) is significantly correlated with patient outcome […] Further, there is a significant correlation between patient defensive behavior and the therapist addressing this behavior, as well as a decrease in immature and intermediate defenses which correlates with the frequency of the therapist addressing these behaviors earlier in treatment. |
| **Single case (Stalikas et al., 1997)** | 1 | 16 | Single case design | - | “Good moments were related to the patient’s provision of information, exploration of feelings, and insight and understanding. In-session behavioral change also was an important component of therapeutic process.”  |
| Personality Disorder (Callahan, 2000) | 6 |  | Case Series | - | Post > Pre.Resistance seen as avoidance of eye contact decreased from early to late therapy; decrease in resistance marginally correlated with therapeutic improvement.  |
| Study of “good moments” – single case (De Stefano, 2001) | 1 | 16 – 3 sessions rated | Single case design | - | “Confrontation and information seeking were associated with the appearance of immediate good moments; interpretation and provision of information were not. “ |
| Analysis of counselor response mode profile in ISTDP (Bernardelli et al., 2002) | 1 | 16 – 3 sessions analysed (early,middle,late)  | Single case design | - | “The bulk of counselor response was characterized by a pattern of four techniques, namely information seeking (46%), providing information (21%), interpretation (17%), and confrontation (10%); ISTDP was observed to use a consistent set of verbal response modes; the combination of these response modes was almost exclusively present in all the sessions examined; frequency of response modes seemed to remain similar in the two earlier sessions with a predominance of interpretation, whereas in the last session provision of information increased; when the therapist functioned at a semantic level, the grammatical structure of the interventions followed statistically significant patterns. “ |
| Trial therapy – tertiary setting: Mixed sample (Abbass et al., 2008)  | 30  | 1  | Naturalistic – Pre vs 1 month post | - | Trial therapy reported to be clinically effective and cost effective (medication and disability reductions) in a tertiary setting: 43% had recovery from case criteria (shown through BSI scores); one-third required no further treatment, seven stopped medications, two returned to work following the trial therapy; most commonly used therapist interventions were “pressure” (59%), “linkage” between past-present feelings, anxiety, and defenses (19%), “clarification and challenge” (14%).  |
| ISTDP Trial therapy vs standard intake interviews (Abbass et al., 2009) | 500 | 1 | Non-randomized clinical trial – Baseline vs 1 month post | - | Trial therapies were clearly distinguishable from standard intake assessments. The trial therapy resulted in statistically significant improvements on all BSI subscales. In the follow-up interview, one third (10) of individuals in the trial therapy group required no further treatment, 7 were able to stop 11 psychotropic medications, and 2 were able to return to work. |
| Attachment status (Neborsky & Bundy, 2013) | 8 |  | Case series | - | The authors predicted seven out of eight AAI main classifications correctly…the systematic ISTDP inquiry at the level of the stimulus (current, past, and therapeutic relationship) and response (defence, anxiety, and impulse/feeling) and combined with the clinician’s knowledge of the patient’s clinical history can effectively substitute for the AAI interview… . |
| **Mixed outpatients (Town et al., 2013)** | 89 | 14.9 | Naturalistic | - | **Emotional experiencing correlates with healthcare cost reduction, symptom reduction** |
| Mixed Treatment Refractory Nova Scotia Psychiatric sample (Johansson et al., 2014) | 412 | 10.2 | Case series | - | Cost effective vs control. Savings=17 x cost.“Overall effectiveness of ISTDP supported in a tertiary unit. Patients classified as fragile and/or psychotic had more symptom severity pretreatment and a steeper rate of recovery; average number of sessions provided was 10.2. Professional therapists (vs. trainees) did not seem to conduct more effective treatments; patients with extreme resistance seemed to require major unlocking of the unconscious to benefit. Patients of a single therapist, considered expert in ISTDP, had better outcomes than patients of the other therapists on one of the outcome measures.” |
| Body temperature (Manavipour & Roshani, 2015) | 1 |  | Case study | - | Intensive short-term dynamic psychotherapy changes the body temperature. The body temperature is a sign to review the protocol and determine the level of anxiety and the patient’s defenses. |
| Guilt and self-compassion (Nygren & Johansson, 2015) | 5 | 20 | RCT | - | Guilt arousal was not shown to positively predict self-compassion for any of the five patients. For one patient guilt arousal negatively predicted self-compassion two sessions ahead in time. |
| Case study. (Fleury et al., 2016) | 1 | 2 x 60-90 minutes | Case study | - | “Activation of sympathetic system during defensive responses associated with anxiety and during the passage of unconscious aggressive impulses; increased vagal tone following the experience of unconscious guilt”. |
| Patients’ affective processes (Aafjes-van Doorn et al., 2017) | 31 | Data from initial sessions | Case study | - | Results suggest that, to intensify patients’ immediate affect experiencing in initial EDT sessions, therapists should focus on increasing insight into defensive patterns and, in particular, motivation to give them up. |
| Trial therapy – role of unlocking the unconscious: Tertiary centre, mixed sample (Abbass et al., 2017) | 500 | 1 | Baseline vs 1 month post | - | Major unlocking positively associated with improvements in self-reported symptoms and interpersonal problems in both fragile and psychoneurotic patients.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 (self-reported symptoms and interpersonal problems) were greater in patients (psychoneurotic and fragile) who had a major unlocking of the unconscious compared with those who did not. |
| **Affect Experiencing (AE) in ISTDP for depression (Town et al., 2017)** | 4 | 20 | Case study series | - | “The study found mixed results: 2 participants showed a reduction in distress associated with increased affective experiencing and working alliance; 2 patients showed no association between these variables; 2 partcipants showed mixed results”. |
| **Group Intensive Experiential-Dynamic Psychotherapy (Landra, 2018)** | 8 |  | Case study | - | The therapeutic process by means of the three main dynamic activities: defence restructuring, anxiety regulation, and emotional maieutics…the group IE-DP approach yielded encouraging results for resistant patients with Superego pathology, and that the group setting lends itself to Self- and Other-restructuring. |
| **Anxiety measurement scale (Baker & Manavipor, 2019)** | 1395 |  |  |  | The Anxiety scale can test each of the channels of anxiety: cognitive disturbances, smooth muscle, skeletal muscle. |
| **Therapist interviews – Intense emotional experiencing (Flynn, 2019)** | - | - | IPA – Interpretative Phenomeno-logical Analysis | - | The findings of the study reveal: (1) a paradox of the moment-by-moment precision aimed for by therapists, whereby effectiveness can be accompanied by a heightened focus on what gets missed; (2) how therapists make sense of the therapeutic relationship as a place of safety and risk; and (3) the importance of deliberate practice to help therapists build their capacity to work effectively with their clients’ deep emotions. |
| Social Anxiety Disorder (Rhamani et al., 2020) [2] | 42IB-ISTDP: N=14, ISTDP: N=14, Control: N=14 | 10 | RCT | Waitlist control  | ISTDP > ControlISTDP delivered with emphasis on feelings versus emphasis on defense yielded the same outcomes. |
| Social Anxiety Disorder (Rhamani et al., 2020) [1] | 41FF-ISTDP: N=14, DF-ISTDP: N=14, Control: N=13 | 10 | RCT | Waitlist control | Greater reductions in fear and avoidance vs control.ISTDP delivered with challenge to defences versus emphasis clarification, yielded the same outcomes. |
| The role of grief in change (Sayar & Hjeltnes, 2021) | - | - | - | - | Grief and grieving represent a central process of change in contemporary psychotherapies (including ISTDP). |
| **Treatment Resistant Depression RCT (Town et al., 2022)** | 27 | 20 | RCT | - | Experiencing Previously Avoided Anger Positively Predicts Reduction in Depression via Working Alliance and Insight |

Quotations are from items in Hoviatdoost, P., Schweitzer, R. D., Bandarian, S., & Arthey, S. (2020). Mechanisms of change in intensive short-term dynamic psychotherapy: Systematized review. *American Journal of Psychotherapy*, *73*(3), 95-106. doi:10.1176/appi.psychotherapy.20190025

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**Section 8: Severe Mental Disorders**

A small number of case studies focus on ISTDP for severe mental disorders such as bipolar disorder and schizophrenia.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| OCD and Schizophrenia (Abbass, 2001) | 1 | 20 | Case report | - | Symptom reduction |
| Bipolar Disorder (Abbass, 2002) | 4 | 5 | Case SeriesPre-post | - | Post > Pre |
| Mixed Treatment Refractory Nova Scotia Psychiatric sample – Psychotic Disorders (Abbass et al., 2015) | 38 | 13 | 1 year pre (baseline) + 4 yearly follow ups after treatment | Non-randomized control: Patients referred but not seen | Physician and hospital costs – $80,400 per case |
| Refractory Bipolar Disorder (Abbass et al., 2019) | 29 | 4.6 | Case Series 1 year pre and 4 years post | - | Post > PreReduction in all healthcare costs – $81,632 per case |

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**Section 9: Somatic Symptoms**

There are now over 50 published papers related to the use of ISTDP in somatic symptom conditions. Some of these studies are combined with Emotion Expression and Awareness Therapy (EAET), and some use EAET which is derived from ISTDP and related models, on its own. Seven of the studies measure symptoms in patients with structural or known organic physical conditions influenced by stress factors.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Irritable Bowel Syndrome (Svedlund et al., 1983) | 101Medical treatment + psychotherapy group: N=50, Medical treatment group: N=51 | 10 | RCTPre-post + 1 year follow up | Active treatment control group | ISTDP > Medical TAU  |
| Urethral Syndrome/ Pelvic Pain (Baldoni et al., 1995)  | 36Treatment Group: N=13, Control: N=26 | 12-16 | RCTPre-post + follow up at 6 months and 4 years | Active treatment control group | ISTDP > Medical TAU |
| Atopic Dermatitis (Linnet & Jemec (2001) | 32Treatment group: N=16, Control group: N=16 | 6 months | RCTPre-post + 12 month follow up | Active treatment control group | ISTDP > control in anxious Cases |
| Mixed MUS (Abbass, 2002) | 29 | 16.9 | Case Series | Wait listNon-randomized control | Sig symptom reduction |
| Back Pain (Hawkins, 2003) | 47 |  | Case Series |  | Sig pain reduction |
| Functional Movement Disorders (Hinson et al., 2006) | 10 |  | Case Series |  | Sig symptom reduction |
| Chronic Headache (Abbass et al., 2008) | 29 | 19.7 | Case Series1 year post vs 1 year pre | - | Sig symptom and healthcare cost reduction – $7,009 per case |
| MUS in Emergency (Abbass et al., 2009)  | 50 | 3.8 | 1 year post vs. 1 year pre | Non-randomized control. Patients referred but not seen | Sig symptom reduction and emergency visit reduction pre vs post and vs control |
| MUS (Abbass, Campbell et al., 2010) | 50 |  | Pre-post | - | Cost savings |
| MUS emergency (Abbass, Tarzwell et al., 2010) | - | - | Case study | - | ISTDP introduced as secondary measure in emergency to explain symptoms with no clear medical causes |
| Fibromyalgia (Flibotte, 2012) | 67 |  | Case Series |  | Sig symptom reduction  |
| Priaprism (Abbass et al., 2013) | 1 | 2 year treatment | Case study | - | Sig symptom reduction – intensity and frequency |
| Psychogenic movement disorders (Kompoliti et al., 2014) | 15STPP-immediate: N=7, STPP-delayed: N=8 | 12 | Cross-over designPre-post + 3 month follow up | STPP delivered immediately vs 3 months delayed | “PMDs as well as depression and anxiety improved, but without specific benefit time-linked to psychotherapy as opposed to neurological observation and support”. |
| Mixed MUS (Abbass et al., 2015) | 1082Treatment Group: N= 890, Control: N = 192 | 7.3 | Quasi-experimental design3 years post vs 1 year pre | Patients referred but not treated | Sig symptom reduction and Cost reduction – $12,700 per case |
| Bruxism (Chirco et al., 2015) | 41  |  | RCT |  | ISTDP > control  |
| Chronic Pain (Burger et al., 2016) | 73 | Individual consultation + 4 group sessions | Case SeriesPre-post + 6 month follow up | - | EAET Post > pre |
| Chronic Pain (Chavooshi et al., 2016) [1] | 100ID-ISTDP: N=50, Control: N=50 | 16 | RCTPre-post + 6 month follow up | TAU control group | ISTDP > control – pain reduction |
| Chronic Pain (Chavooshi et al., 2016) [2] | 63ISTDP: N=23, MBSR: N=20, TAU: N=20 | 20 | RCTPre-post + 6 month follow up | MBSR + TAU controls | ISTDP > Mindfulness Based Stress Reduction and TAU |
| Chronic Pain (Chavooshi et al., 2017) [1] | 81ISTDP: N=42, ID-ISTDP: N=39 | 16 | RCT Pre-post + 12 month follow up | Active treatment control group | ISTDP in person > ISTDP by Skype |
| Pseudoseizures (Russell et al., 2016)  | 28 | 3.6 | Case Series3 years post vs. 1 year pre | - | Sig symptom and cost reduction (physician costs, hospital costs) – £57,00 per case |
| Chronic Pain (Chavooshi et al., 2017) [2] | 341ISTDP: N=177, CBT: N=164 |  16 | RCTPre-post + 3 month follow up | CBT control group | Sig symptom effects ISTDP=CBT |
| Mixed Somatic Symptoms in Family Practice (Cooper et al., 2017) | 37 |  4.2 (average) | Case SeriesPre vs post 6 months | - | Sig symptom improvement. 23% drop in family doctor visits |
| Treatment resistant sexual dysfunction in females (Moradian et al., 2017) | 5 | Trial therapy session + 20 x 120 min sessions | Case seriesPre-post + 8 week follow up | - | Post > PreNormalization on outcomes |
| Fibromyalgia (Lumley et al., 2017) | 230EAET: N=79, CBT: N=75, FM-Education: N=76 | 8 x 90 minute session | RCTPre-post + 6 month follow up | CBT + Fibromyalgia eduction controls | EAET > CBT |
| Functional Neurological (Russell et al., 2017)  | 11 |  | Case Series  |  | Improvement on multiple domains |
| Irritable Bowel Syndrome (Thakur et al., 2017) | 106Treatment group: N=53, Control: N= 53 | 3 | RCTPre-post + 10 week follow up | Waitlist control | EAET > Structured Relaxation |
| Multiple Sclerosis (Abbass, 2018) | 10 |  | Case series |  | Post > Pre on symptoms and doctor visits |
| MUS (Ziadni et al., 2018) | 75Interview: N=49, Control: N=26 | 1 x 90 minute interview | RCTBaseline + 6 week follow up | TAU control group | EAET Post > pre |
| Urogenital/Pelvic Pain (Carty et al., 2019) | 62Interview: N=37, Control: N=25 | 1 x 90 minute life stress interview | RCTPre-post: Baseline + 6 week follow up | TAU control group | EAET > waitlist control |
| Chronic Pain in Veterans (Jazi et al., 2019)  | 64 | 1 x 90 minute individual + 8 x 90 group | RCTPre-post + 3 month follow up | CBT control | EAET > CBT |
| Chronic Pain (Lumley & Schubiner, 2019)  | 228 | 1-8 | Case Series Pre-post + follow ups | Various controls including CBT and relaxation training | Symptom reduction and healthcare cost reduction  |
| Breast Cancer (Mahdavi et al., 2019) | 6 | 15 x 2 hours | Case seriesPre-post |  | Post > pre Defense maturation and emotion expression |
| Inflammatory bowel disease (Watt & Abbass, 2019) | 2 | 12 | Case study | - | Psychosomatic improvement following therapy |
| Inflammatory Bowel Disease (Watt & Irving, 2019) | 7 | 1-12 sessions | Case SeriesPre-post + 6 month follow up | - | Improvement on IBD symptoms  |
| Chronic Pain (Lilliengren et al., 2020)  | 228 | 6.1 | RCT3 years post vs 1 year pre | - | EAET > or equal to CBT – reduction in all healthcare costs, £14,000 per case |
| Irritable Bowel Syndrome (Farzdi et al., 2021)  | 30STDP: N=15, Control: N=15 | 12 x 90 minutes | RCT Pre-post + 3 month follow up | No treatment control | ISTDP > Control  |
| Somatic Symptom Disorder (Maroti et al., 2021) | 52 | 9 weekly modules | RCTPre-post + 4 month follow up | - | EAET > control  |
| Cancer (Alirezaee et al., 2022) | 30ISTDP: N=10, CBT: N=10, Control: N=10 | 11 x 90 minute sessions | RCTPre-post | Waitlist control | ISTDP = CBT > Control on self compassion |
| Functional Seizures (Malda-Castillo et al., 2022)  | 18 | 3 | Case Series Pre-post + 1 month follow up | - | Reduced symptoms, long term health cost reductions  |
| Somatic Symptom Disorder (Maroti et al., 2022) | 72I-EAET: N=37, Control: N=37 | 10 weeks | RCTPre-post + 4 month follow up | Waitlist control | Internet administered-EAET Post > pre  |
| Chronic Pain (Narimani et al., 2022) | 60ISTDP: N=20, Hynotherapy: N=20, Control: N=20 | 8 | RCTPre-post + follow up | No treatment control | ISTDP > hypnosis > Control |
| Fibromyalgia (Farzadakia et al., 2023) [1] | 36ISTDP: N=12, MBSR: N=12, Control: N=12 | 8 x 120 minute sessions | RCT Pre-post + 3 month follow up | No treatment control | ISTDP> MBSR> Control – Intolerance of uncertainty + depression |
| Fibromyalgia (Farzadkia et al., 2023) [2] | 36ISTDP: N=12, MBSR: N=12, Control: N=12 | 8 x 120 minute sessions | RCT Pre-post + 3 month follow up | No treatment control | ISTDP> MBSR> Control – Alexithymia + depression  |
| Irritable Bowel Syndrome (Jafari, 2023)  | 30ISTDP: N=15, Control: N=15 | 15 x 90 minutes | RCT  | No treatment control | ISTDP > Control  |
| Chronic Pain (Karimi et al., 2023) [1] | 45ISTDP: N=15, MBCT: N=15, Control: N=15 | 8 x 90 minutes | RCTPre-post + follow up | Waitlist control | ISTDP >/= Mindfulness based Cognitive Therapy > Control |
| Chronic Pain (Karimi et al., 2023) [2] | 45ISTDP: N=15, MBCT: N=15, Control: N=15 | 8 x 90 minutes | RCTPre-post + follow up | Waitlist control | ISTDP >/= Mindfulness based Cognitive Therapy > Control |
| Chronic Pain (Krohner et al., 2023) | 91Emotion-focused interview: N=46, Control: N=45 | 1 x 90 minutes | RCTPre-post + 6 week follow up | Waitlist control | EAET + ISTDP > control |
| Functional Seizures (Malda-Castillo et al., 2023)  | 18 | 3 | Case Series. 1 year pre and post | - | Reduced symptoms, medication and emergency utilization, long term health cost reductions  |
| Atopic Dermatitis (Naghibi et al., 2023) | 5 | 10 | Case seriesPre-post | - | Post > Pre |
| Mixed Somatic Symptoms (Irani et al., 2024) | 45ISTDP: N=15, Existential therapy: N=15, Control: N=15 |  | RCTPre-post |  | ISTDP > Existential Therapy > Control |
| Chronic Pain (Moghadam et al., 2024) | 30ISTDP: N=15, Control: N=15 | 15 x 90 minutes | RCTPre-post + follow up | No treatment | ISTDP> Control Attachment styles improved, as did health anxiety and somatization |
| Tension Headaches (Shahverdi et al., 2024) | 30ISTDP: N=15, Control: N=15 | 16 | RCTPre-post + 10 week follow up | Waitlist control | ISTDP > Control in headache, anger, anxiety and emotion regulation |
| Chronic pain in older veterans (Yarns et al., 2024) | 126EAET: N=66, CBT: N=60 | 1 x 90 minute individual + 8 x 90 minute group | RCTPre-post + 6 month follow up | Emotional Awareness and Expression Therapy (EAET) vs CBT | EAET > CBTGreater pain relief + reduced anxiety, depression, increased life satisfaction |

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**Section 10: Substance Use Disorders**

There are 4 randomized controlled trials of ISTDP for substance use disorders.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Inpatient Drug Rehabilitation Program (Frederickson et al., 2018) | 62Treatment group: N=42, Control group: N=20 | 6 individual sessions + groups over a 30 day period | RCT6 month follow up | TAU Control group | ISTDP > controlDropout: 23.8% vs 40%, Sobriety at 6 months: 48.8% vs 17.6% |
| Substance Dependence (Ahmadi et al., 2021) | 30Treatment group: N=15, Control: N=15 | 15 x 90 minutes | RCTPre-post | Active treatment control group | ISTDP > control  |
| Substance Dependence (Kafee et al., 2021) | 58ISTDP + 12 step: N=38, Control: N=20 | 7 | RCTPre-post | No treatment control | ISTDP + 12 step > Control |
| Substance Dependence (Kashfi et al., 2023) | 39 |  | RCT |  | ISTDP > control in relapse prevention |

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**Section 11: Treatment Refractory – Non-somatic**

**Intensive Short-term Dynamic Psychotherapy has now been studied for a broad range of complex and refractory treatment populations. Below are published studies including 14 randomized controlled trials and 16 case series. These are outcome and cost-based studies, but there are also other types of published research studies of these patient groups.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Personality Disorder (Winston et al., 1994) | 81Brief-Adaptive: N=30, STDP: N=25, Waitlist: N=26 | 40 (average) | RCTPre-post + 1.5 year follow up | Brief Adaptive Psychotherapy + Waitlist control | STDP > Ctrl |
| Personality Disorder (Hellerstein et al., 1998) | 49STDP: N=25, BSP: N=24 | 40 | RCTPre-post + 6 month follow up | Brief Supportive Psychotherapy (BSP) control | ISTDP =/> BSP |
| Personality Disorder (Callahan, 2000) | 6 |  | Case Series | - | Post > PreResistance seen as avoidance of eye contact decreased from early to late therapy; decrease in resistance marginally correlated with therapeutic improvement.  |
| Bipolar Disorder (Abbass, 2002) | 4 | 5 | Case SeriesPre-post | - | Post > Pre |
| Refractory/ Severe Personality Disorders, (Cornelissen & Roel, 2002) | 93 | Up to 6 months | Case Series2 years post vs 1 year pre. | - | Post > PreHealthcare and disability reductions: Hospital, physician and health professionals cost – utilization rates only. |
| Refractory/ Severe Personality Disorders, (Cornelissen & Roel, 2002) | 155 | Up to 6 months | Case Series10 years post vs 1 year pre | - | Post > PreIncreased employment 39% to 88%Reduced hospital, physician, health professionals cost – utilization rates only |
| Personality Disorder (Svartberg et al., 2004) | 50STDP: N=25, CBT: N=25 | 40 | RCTPre-post + 2 year follow up | CBT control group | STDP =/> CBT |
| Treatment Resistant Depression (Abbass, 2006) | 10 | 13.6 | Case Series6 months post vs 6 months pre | - | Post > PreReduced hospital, medication and disability costs – $5,688 per case |
| Personality Disorder (Abbass, et al., 2008) | 27 Treatment group: N=14, Control: N=13 | 27.7 | RCT 2 years post vs 1 year pre | Waitlist control group | ISTDP > Minimal ContactCost effective (medication and disability costs) – $10,148 per case |
| Refractory Mixed Diagnoses Tier 3 or 4 NHS, UK (Hajkowski, 2012) | 23 |  | Case Series |  | Post > Pre |
| Nova Scotia (Canada) Dept Community Service Cases Chronically on Social Assistance (Internal Report, 2012)  | 63 |  | Case Series |  | Net Government savings of $740,000 by 5 years later |
| Psychiatric Inpatients (Abbass et al., 2013) | 33 | 9 | Case Series1 year post vs 1 year pre | Other psychiatric ward – Non-random­ized | Post > Pre ECT reduction Cost Effective |
| Refractory/ Severe Personality Disorders (Cornelissen, 2014) | 155 | Up to 6 months | Case Series 10 years post vs 1 year pre | - | Post > PreIncreased employment – 39% to 88%. |
| Mixed Treatment Refractory Nova Scotia Psychiatric sample (Johansson et al., 2014) | 412 | 10.2 (average) | Case seriesPre vs 4 years post | - | Cost effective vs controlReduced physician and hospital costs – $80,400 per case |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2014) | 250 – projected | 8 weeks intensive residential programme – 8 x 90 minutes or 16 x 45 minutes individual sessions | Pre vs post + follow up at 6 and 12 months | Waitlist control: TAU | ISTDP > ControlCost Effective: Reduced healthcare use, medications and disability |
| Psychotic Disorders (Abbass, Bernier et al., 2015) | 38 | 13 | Pre vs 4 years post | - | Physician and hospital costs – $80,400/case |
| Mixed Sample (Abbass, Kisely et al., 2015) | 1082Treatment Group: N= 890, Control: N = 192 | 7.3 | Quasi-experimental design3 years post vs 1 year pre | Non-randomized control – patients referred but not seen | Symptom reduction + Physician and hospital costs – $12,700/case |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2015) | 90ISTDP treatment: N=60, Control: N=30 | 8 weeks intensive residential programme – 8 x 90 minute sessions | Pre-post + through treatment + follow up at 6 and 14 months | Waitlist control: TAU | ISTDP > ControlCost Effective: Reduced healthcare use, medications and disability |
| Mixed Treatment Resistant Samples (Solbakken & Abbass, 2016) | 95 | 8 weeks intensive residential programme – 8 x 90 minutes or 16 x 45 minutes individual sessions | Pre-post + at weeks 3 and 5 of treatment + follow up at 6 and 14 months | Waitlist control: TAU | ISTDP > WaitCost Effective: Reduced healthcare use, medications and disability |
| Trial therapy – role of unlocking the uncs, mixed sample. Tertiary centre (Abbass et al., 2017) | 500 | 1 | Baseline vs 1 month post | - | 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 (self-reported symptoms and interpersonal problems) were greater in patients (psychoneurotic and fragile) who had a major unlocking of the unconscious compared with those who did not. |
| Treatment Resistant Depression (Town et al., 2017) | 60ISTDP: N= 30, TAU: N=30 | 20 | RCT Pre vs 6 month post | Mental Health Team TAU (mostly CBT + medication) | ISTDP > CMHT on depression, reduced medication + cost effective |
| Refractory Psychotic Disorders (Abbass et al., 2018) | 38 | 1 | Case Series3 years post vs 1 year pre | - | Post > PreCost Effective (physician and hospital costs): $10,840/case |
| Inpatient Drug Rehabilitation Program (Frederickson et al., 2018) | 62Treatment group: N=42, Control group: N=20 | 6 individual sessions + groups over a 30 day period | RCT6 month follow up | TAU Control group | ISTDP > controlDropout: 23.8% vs 40%, Sobriety at 6 months: 48.8% vs 17.6% |
| Refractory Bipolar Disorder (Abbass et al., 2019) | 29 | 4.6 | Case Series1 year pre and 4 years post | - | Post > PreReduction in all healthcare costs – $81,632 per case |
| Refractory Generalized Anxiety Disorder (Lilliengren et al., 2020)  | 215 | 8.3 | Case SeriesPre vs 4 years post | - | Post > PreCost Effective |
| Complex Populations, UK (Malda-Castillo et al., 2020) | 8 |  | Case Series | - | Enduring symptom reduction |
| Refractory Eating Disorders NS (Nowowieski et al., 2020) | 27 | 9.8 | Case Series3 years post vs 1 year pre | - | Post > PreReduction in all healthcare costs – $15,024 per case |
| Treatment Resistant Depression (Town et al., 2020) | 60Treatment group: N=30, Control: N= 30 | 20 | RCTPre vs 18 months post | Mental Health Team TAU (mostly CBT + medication) | ISTDP > CMHT on depression, reduced medication + cost effective |
| Chronic musculoskeletal pain (Yarns et al., 2020) | 53EAET: N=28, CBT: N=25 | 1 x 90 minutes individual + 8 x 90 minutes group | Randomized comparison trialPre-post + 3 month follow up | EAET vs CBT | EAET > CBT Significantly lower pain severity |
| Substance Dependence (Ahmadi et al., 2021) | 30Treatment group: N=15, Control: N=15 | 15 x 90 minutes | RCTPre-post | Active treatment control group | ISTDP > control  |
| Treatment Resistant Depression (Heshmati et al., 2021) | 3 |  | Case series |  | Post > Pre on emotional suppression and negative affect |
| Substance Dependence (Kafee et al., 2021) | 58ISTDP + 12 step: N=38, Control: N=20 | 7 | RCTPre-post | No treatment control | ISTDP + 12 step > Control |
| Histrionic Personality Disorder (Salehian, 2022) | 16 |  | RCTPre-post | No treatment | ISTDP > control on multiple variables(aggression, social adjustment) |
| Antisocial Personality Disorder (Salehian & Moradi, 2022) [1] [2] |  |  | RCTPre-post | No treatment | ISTDP > control on multiple variables |
| Treatment Resistant Depression (Heshmati et al, 2023) | 86ISTDP: N=43, Control: N=43 | 43 | RCTPre-post | Waitlist control | ISTDP > Waitlist on depression, repression and negative affect |
| Substance Dependence (Kashfi et al, 2023) | 39 |  | RCT |  | ISTDP > control in relapse prevention |
| Histrionic Personality Disorder (Salehian & Moradi, 2023) |  |  | RCTPre-post | No treatment | ISTDP > control on multiple variables |
| Chronically disabled or missing work days: HHospital employees NS (SBAR Report, internal hospital document)  | 18 |  | Case Series |  | Net CDHA savings of $250,000 18 months later |

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**Section 12: Trial Therapy**

5 outcome studies of the Trial Therapy point to benefits of the initial interview. The first study was all expert conducted trial therapies and the second was compared to standard intake interviews an expert had also done. The third was an EDT trial therapy and can be considered an independent replication on the first study. The 4th is a large sample study with many different therapists overcoming the issue of one expert doing the interview: It found outcomes in the trial related to status of unlocking the unconscious, a very interesting finding. Finally, a large subset of these cases was analyzed separately and found to show large measurable reductions in health care costs in long follow-up.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study/Sample** | ***n***  | **# Session**  | **Study design** | **Control** | **Main Outcomes/Effect** |
| Trial therapy – tertiary setting: Mixed sample (Abbass et al., 2008)  | 30  | 1  | Naturalistic – Pre vs 1 month post | - | Trial therapy reported to be clinically effective and cost-effective in a tertiary setting; 43% had recovery from case criteria as shown through BSI scores; one-third required no further treatment, seven stopped medications and two returned to work following trial therapy; most commonly used therapist interventions were “pressure” (59%), “linkage” between past-present feelings, anxiety, and defenses (19%), “clarification and challenge” (14%). |
| ISTDP Trial therapy vs standard intake interviews (Abbass et al., 2009) | 500 | 1 | Non-randomized clinical trial – Baseline vs 1 month post | - | Trial therapies were clearly distinguishable from standard intake assessments. The trial therapy resulted in statistically significant improvements on all BSI subscales. In the follow-up interview, one third (10) of individuals in the trial therapy group required no further treatment, 7 were able to stop 11 psychotropic medications, and 2 were able to return to work. |
| Extended Trial Therapy (Aafjes-van Doorn et al., 2014) | 31 | 1 | Non-randomized trial – Pre-post | - | After the trial therapy session, patients reported a significant increase in remoralization and self-compassion and a significant decrease in symptoms of general distress but not interpersonal problems. Process ratings were not significantly associated with improvement on these outcome measures. |
| Trial therapy – role of unlocking the unconscious: Mixed sample. Tertiary centre (Abbass et al., 2017) | 500 | 1 | Baseline vs 1 month post | - | 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 (self-reported symptoms and interpersonal problems) were greater in patients (psychoneurotic and fragile) who had a major unlocking of the unconscious compared with those who did not. |
| Trial therapy: Mixed conditions (Abbass et al., 2018) | 344 | 1 | Case Series3 years post vs 1 year pre | - | Post > PreCost Effective (physician and hospital costs): $10,840/case |

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