

Restructuring in the Treatment of Depressive Disorders with Davanloo's Intensive Short-Term Dynamic Psychotherapy

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The author, using the trial therapy of a patient whose chronic depression culminated in a serious suicide attempt a month prior to the initial interview, illustrates the application of Davanloo's system of Intensive Short-Term Dynamic Psychotherapy to the treatment of depressive disorders. The discussion will highlight distinctive technical parameters, such as the "restructuring of the defensive structure of the ego," which are essential in work with these patients.

In *Mourning and Melancholia*, Freud writes his famous description of the phenomenology of depression: "The distinguishing mental features of melancholia are profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of self-regarding feelings that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment" (1917). Davanloo (1987a) grounds his formulation of the dynamics which produce that picture of depression in the terms of the triangle of conflict. A core concept for Davanloo (1980), the triangle of conflict is a scheme which captures the relationship among three principal psychoanalytic constructs: impulse/feeling, anxiety and defense. The unconscious impulse/feeling, because of its painful and/or unacceptable nature, gives rise to anxiety which, in turn, gives rise to psychic defenses. Davanloo's technique of the "unlocking of the unconscious" (1986a,b, c) demonstrates that central to certain depressive disorders is the reliance on repression and internalization to deal with powerful aggressive impulses. Thus, Davanloo conceptualizes the phenomenologic hallmarks of depression -the withdrawal, the self-reproaches, the passivity, the helplessness, the sense of inferiority and inadequacy- as the result of regressive mechanisms used not only to defend against sadistic impulses but also to avoid the experience of the associated painful feelings, such as guilt and grief (1986-1987).

The regression characteristic of the depressed person's ego is further reflected in an inability to differentiate the three aspects of the triangle of conflict. The depressed patient cannot distinguish between the impulse/

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feeling, the anxiety, and the defense; the confusion between the impulse/feeling and the anxiety it generates is particularly pronounced (Davanloo, 1987a; Said, 1986; Zois, 1986).

Chronic reliance on depressive mechanisms leads to their entrenchment in the form of ego-syntonic characterologic traits -such as passivity, helplessness, a tendency to assume a paralyzed, victimized stance- which lend to the individual's entire personality organization an air of defeat; he/she comes across as a beaten, crippled individual who gives every indication of being resourceless and depleted.

The factors discussed above- sadistic impulses dealt with via repression

and internalization, regressive defenses becoming entrenched and reflected in ego-syntonic character traits, as well as a state of low energy and ego depletion- all play salient and interdependent roles in the depressive disorders. During the trial therapy, each of them has to be assessed and, depending on the relative predominance of regression and depletion, the appropriate Intensive Short-Term Dynamic Psychotherapy technique must be applied.

Before presenting the technique of *restructuring* the ego's regressive defense mechanism I will highlight the standard technique of handling resistance as developed by Davanloo. He writes, "My standard technique for handling highly resistant patients is as follows:

Pressure toward the experience of repressed feelings, which leads to an intensification of resistance.

Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of resistance.

Systematic pressure and challenge to the transference-resistance leading to a further intensification of resistance.

Head-on collision with the transference-resistance. Creation of intrapsychic crisis with turning of the ego against its own defenses.

Direct experience of the complex transference feelings- the "triggering" mechanism.

Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious.

Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.

Major de-repression of current or recent past (C) and distant past (P) conflicts, leading to a direct view of the dynamic unconscious and multifocal core neurotic structure." (Davanloo, 1987 a).

The technique of *restructuring* was developed by Davanloo (1987a,b) to work with the regressed, weakened ego organization characteristic of patients suffering from depressive disorders. If the standard Short-Term Dynamic Psychotherapy technique of challenge and pressure of the defenses would be used with such patients, negative feelings and impulses, already overwhelming to a weakened ego, would only be further intensified: the pressure would lead to a collapse of the ego, i.e., an increase in the negative

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impulses directed against the self, with a worsening of the depression and/or the depletion. Such an eventuality would lead to the disruption of the therapeutic alliance and might even create a major misalliance.

It is important to underscore that the technique of intensive challenge and pressure assumes an ego organization where regression and depletion do not predominate. The technique of *restructuring* aims at getting the ego of the depressed person to the level where the standard Short-Term Dynamic Psychotherapy technique of challenge and pressure can be applied. It is for this reason that, prior to the application of challenge and pressure, the ego of the depressed patient must be restructured (Davanloo, 1987a).

The goal of *restructuring* is the direct experiencing of the aggressive impulse. Implicit in that capacity is a psychic organization characterized by (1) an ego that can withstand the pressure of heightened impulse, (2) sadistic impulses which are not channelled against the self, and (3) sufficient energy available for therapeutic work.

Restructuring of the defensive operations of the ego of the depressed patient takes place in the context of the triangle of conflict. As the defense mechanisms of repression and internalization responsible for the depression are undone and the discharge pathway of the impulse is redirected, the

patient is able to directly experience his/her aggressive impulses in the hereand-now of the transference situation. This direct experience of the impulse is the essential aspect of the restructuring of ego-syntonic defenses.

How does the process of *restructuring* take place? Initially, clarification is used in working with the patient toward being able to distinguish the triangle of conflict. There is no concerted challenge to the patient's use of a particular defense nor is there pressure on the patient to stop using that mechanism. In the early phases of restructuring, the tension in the process is generated by the tight holding, i.e., keeping a narrow focus, and the vigilant, relentless clarification. When there is evidence that the patient is better able to differentiate impulse from anxiety from defense, the therapist begins to introduce low levels of challenge and pressure. Using the level of the patient's anxiety as a guide, the therapist gradually raises the level of challenge and pressure until there is a breakthrough of the aggressive impulse, i.e., the patient now directly experiences what was previously repressed and internalized. (It should be noted that a breakthrough of the aggressive impulse through the repressive barrier is not synonymous with a breakthrough in to the unconscious; the distinction will be discussed below.)

There are several principles which guide the work of *restructuring*:

(1) Specificity. Although a basic tenet of Intensive Short-Term Dynamic Psychotherapy, this applies *a fortiori* to restructuring. Any exploration of the reactions of a patient should be distinctively framed in a specific episode, involving a specific other person, at a specific time, in a specific place. The Aristotelian principles of good tragedy are equally apt here. Vagueness and lack of precision in the therapist only reinforce the patient's already vigorous defensive efforts (Davanloo, 1986-1987).

(2) Alternating between Exploration of Current Life Episodes (C) and

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Transference Interactions (T). During restructuring, the therapist moves back and forth between one or more specific episodes from the patient's current life and specific interactions in the transference. The level of anxiety and the dynamic quality of the work guide the move from one example to another. Since transference work stirs up more anxiety than work on episodes in the patient's current life, below are some rules of thumb: if the process becomes stagnant, move to a different example; if the work is too flat, and the patient exhibits little or no anxiety, shift from exploring a current episode to exploring a transference interaction; if, on the other hand, the patient experiences too much anxiety, move out of the transference and explore a recent episode. However, since (a) the ultimate aim of restructuring is to obtain a breakthrough of the sadistic impulse through the repressive barrier, and since (b) the more powerful the direct experience of the impulse is, the more profound will be the impact of the restructuring, it should be remembered that breakthroughs which are achieved via the transference tend to be more powerful than breakthroughs achieved in the context of exploring a current episode. With each individual patient, work at his/her highest level of optimal anxiety (Davanloo, 1987c).

(3) The Quantitative Factor. Another essential aspect of the process of restructuring is its gradual nature. The level of challenge and pressure is always titrated against the patient's level of anxiety. If too much anxiety floods the patient's ego, the work cannot proceed until the anxiety decreases to more manageable proportions. If the patient tolerates the process, the therapist can increase the intensity of the challenge and pressure, because ultimately, the quantitative factors are of great importance. The more intense the level of challenge and pressure, the more intense will be the actual experience and expression of the impulse when it breaks through the repressive

barrier and the more massive will be the breakthrough into the unconscious (Davanloo 1986-1987, 1987c).

I will next examine how *restructuring* is integrated within Davanloo's comprehensive system of trial therapy. What follows is a discussion of the structure of the trial therapy of patients with depressive disorders, examining some of the branch-offs in the clinical decision tree. Though the trial therapies of patients with diagnoses other than depression--such as functional and psychosomatic disorders- raise similar and related issues, their consideration is beyond the scope of this article.

(A) Review of the Areas of Disturbance. The first phase of the initial interview is devoted to a rapid but thorough review of all the areas of disturbance. It is in this phase that the initial identification of depression is made, either through the patient's report or as a result of the clinician's direct observations and inquiry; even if the patient does not volunteer that depression is a problem, the clinical presentation and/or the interaction with the therapist may very well suggest it.

(B) Detailed Phenomenologic Exploration. When depression is one of the areas of disturbance, the next phase of the interview is a detailed, dynamically-informed exploratory inquiry into the phenomenology of the patient's condition. Areas to be investigated include: (1) sleep, appetite, sex

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drive, concentration, level of activity, relations with others, functioning at work, etc.; (2) previous depressions, their severity, prior treatment, etc.; (3) mood, state of mind as well as any ideation and/ or actions relating to suicide. This phase of the trial therapy is not a symptom checklist; the inquiry is pursued in a dynamic fashion. The therapist is not only gathering information about mood, vegetative functions, and suicidal ideation, but also obtaining valuable information about the current state of ego functioning, human relations, as well as characterologic patterns (with their transference implications, crucial in later phases of the process). Inasmuch as this phase generates little anxiety and can even reduce anxiety, it also cements the conscious therapeutic alliance. At the end of this phase, the therapist should have a preliminary assessment of the current state of the patient's ego, i.e., the relative degrees of defect, depletion, and regression. The clinician's next move is based on this assessment.

Branches in the Decision Tree: (1) If there is evidence of defects in the ego (such as poor reality testing, cognitive impairment or lapses of impulse control), as is the case in the psychoses and borderline disorders, then the clinician moves to therapeutic techniques outside the domain of Short-Term Dynamic Psychotherapy. (2) If there is a significant degree of ego depletion, but no evidence of structural ego deficits, the therapist should not proceed with more intensive levels of the interview. With a very depleted patient, a major modification of the trial therapy is recommended. The therapist's interventions aim at reversing the depletion through a supportive/ cognitive approach. That approach continues until the depleting depression has lifted to a sufficient degree so that the ego is more resilient and has energy to proceed with the dynamic part of the process. At that time, the trial therapy resumes and restructuring of the patient's *ego* becomes the next major task. (3) If there is depression, i.e., major ego-syntonic and regressive psychopathology, but no severe defects and no depletion, then the therapist moves to the phase of restructuring (Davanloo, 1986-1987).

(C) Restructuring. The work focuses on the triangle of conflict, starting with reflection and clarification, then gradually increasing the level of challenge and pressure until the aggressive impulse breaks through the repressive barrier and regressive defenses no longer predominate.

Branches in the Decision Tree: Davanloo, based on his clinical data, has

identified two groups of patients according to their respective responses to restructuring, and has described and audiovisually demonstrated (1987c) two corresponding subsequent paths that their trial therapies take. (1) For patients in the first group, he has demonstrated that the breakthrough of the aggressive impulse avalanches into a breakthrough into the unconscious. The threshold point is usually when the ego experiences the "complex transference feelings" (Davanloo, 1987c), i.e., not only aggression but also the painful feelings associated with it, such as grief and guilt. This leads to the derepression of both current and genetic past experiences. "After doing some analysis of the transference to remove any residual resistance" (Davanloo, 1986a; Malan, 1986), the therapist moves to the phase of content, actually doing work with the patient's core neurotic structure. Thus, with this group, restructuring leads to a breakthrough into the unconscious, with

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out extensive postrestructuring challenge and pressure. (2) For patients in the second group, Davanloo's clinical data show that restructuring also leads to a breakthrough of the aggressive impulse, but their unconscious remains locked. Here, the phase of restructuring is followed by a phase of heavy "challenge and pressure"- now that their ego is restructured, the pressure can be tolerated-at high relentless intensity until there is a breakthrough into the unconscious. Once the breakthrough into the unconscious occurs, the therapist follows the standard procedure, outlined by Davanloo, i.e., analysis of the transference followed by the phase of content.

Case Presentation: The Twice-Jilted Daughter

What follows are segments from a trial therapy with a depressed patient in which *restructuring* played a major role. To preserve the process of the interview, the dynamic and genetic data will be presented roughly in the sequence in which they emerged clinically.

The patient is a 28-year old single professional woman. The author was the second independent evaluator. The trial therapy was conducted in two interviews, set one week apart.

Part 1: The First Interview

(1) *The Opening Minutes*

The patient arrived half an hour late. On the way to the interview room, she announces that she can only stay one hour, though she had been specifically asked to leave open a block of time. Her first comment, upon nervously sitting down, is: "I am anxious about what you are going to do."

The patient's opening moves give notice to the therapist that there is ready-made resistance in the transference, that the patient will take a passive position in the interview and that she will rely on regressive mechanisms, such as externalization and projection. The forecasting of passivity and use of regressive defenses in an aura of resistance and moderately high anxiety already suggests that one of the major tasks of the trial therapy will be to restructure the patient's ego.

At this stage, the therapist takes note of the above but proceeds with the basic inquiry.

TH: Can you tell me about the problems that bring you to therapy?

PT: I've been feeling really depressed. Last January was when I first started seeing a psychologist. I'd been feeling very depressed at that time, I was having a bad relationship with the guy I was going out with at that time and I hated my job at the time and I just felt that I couldn't breathe, like everything was crashing at one time. I just wanted to talk to someone because I was crying all the time for no reason and I wanted to do something about it ...

TH: How did you experience your depression?

PT: Well, I was just crying all the time, I just felt really sad all the time,

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you know, I didn't like myself, I didn't want to get up in the morning and I would be out with my friends and I would start crying at dinner or something, I would be at work, I would start crying.

TH: So the tears would just come?

PT: I didn't like myself I was snapping at everybody.

TH: You were irritable as well?

PT: I was really desperate, I didn't know what else to do at that point.

From the foregoing passage it is clear that the patient's ego mechanisms are primarily regressive defenses, such as depression and weepiness. This indicates that the standard technique of persistent challenge and pressure to the resistance is not indicated and that the technique of restructuring should be applied.

(2) The Triangle of Conflict in the Transference

Even though the patient answers the questions directly, she is detached: her eye contact is poor and she speaks in a monotone. As the interview continues, she speaks about the previous treatment and then, matter-of-factly, mentions that three weeks prior to the interview she made a serious suicide attempt for which she was hospitalized for 10 days. She remains detached, distant, and uninvolved. Evidence of her resistance continues to accumulate.

Ideally, the first stage of trial therapy is concerned with the descriptive phenomenology, in this case, the depressive symptoms and any other major difficulties the patient might present. But if there is resistance in the transference, it must be addressed; if one ignores it, the resistance intensifies and the material obtained cannot be meaningfully used (Davanloo, 1986a; Malan, 1986).

The process of restructuring begins here, in the context of dealing with the patient's resistance. As the patient is depressed, at this point in the trial therapy, the level of the challenge in working with the resistance should be applied accordingly, just enough to enable the patient to be a partner in the process. Entanglement in the transference should be avoided: if strong impulses are mobilized in the transference before the ego is restructured, it can lead to an exacerbation of the depression. Similarly with character defenses: if they are much in evidence during this early part of the process, they should not be challenged, but systematic reflection on them should be interlaced with the basic inquiry (Davanloo, 1986-1987).

Of necessity, the patient-therapist relationship becomes the focus of the diagnostic evaluation. The patient's resistance has to be addressed. The therapist focuses on the triangle of conflict in the transference and explores the patient's feelings about the session. At this stage, the patient is unable to differentiate the different components of the triangle of conflict: her experience of her feelings- anger in this case- is not distinct from her experience of anxiety, or from her defenses, which at this point, are primarily regressive. This work on the triangle of conflict in the transference is the first step in restructuring. We now continue the interview. The following

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passage shows the beginning of systematic work with the triangle of the conflict in the transference. There is clarification as well as some degree of challenge to the patient's resistances in the transference and careful monitoring of the patient's responses.

TH: What do feel right now talking to me, because I notice that you hold yourself in and you're avoiding my eyes.

PT: (big nervous smile)

TH: And as I bring it to your attention, a smile comes to your face.

PT: I'm nervous, I guess, 'cause I don't know you. In the past month I've seen so many people and spoken to so many doctors I just feel that I am repeating the same thing over and over again.

TH: Let's just see what your feelings about that are.

PT: Well, coming here tonight I was thinking I'm going to have to go through this whole thing again about why I'm here and how I tried to kill myself and why I tried to kill myself (big smile) I guess I'm sick of telling the same things over and over again.

TH: When you say "sick of it," what's the emotion you have about it;

PT: It's tiring.

TH: You say tiring. But what is the emotion?

PT: (smile) Well, I don't know, I feel like it's boring, the same thing over and over again.

TH: You notice how when we get to feelings, you jump to some thought or a lot of sentences?

PT: I can't describe a feeling. I mean, how do you describe a feeling?

TH: Let's look at your experience. You said you were feeling nervous. How do you experience your nervousness with me right now?

PT: Well, I feel ... I guess awkward because I don't know you.

TH: But what is the feeling?

PT: I don't know. How do you describe a feeling? I'm feeling awkward. There is no feeling.

The therapist returns to inquiry exploring the physiological concomitant of the anxiety.

TH: You mentioned to me that you were feeling nervous and then as we start to examine it, do you notice that you take a helpless position, saying "I don't know" and "how do I do it"?

PT: (she shrugs her shoulders in gesture of helplessness and smiles) Uh ...

TH: And also that there is a lot of difficulty with eye contact.

PT: That's because my contacts are bothering me. I don't know, I'm nervous. My hands are sweaty. I don't know. How do you describe it?

TH: Your hands are sweaty. What other physical sensations do you have?

PT: I guess my heart feels like it's going faster because ...

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TH: It's pounding?

PT: Well, not pounding, but I have more nervous energy than usual.

TH: What else?

PT: My mouth is dry.

TH: What else are you feeling? (shoulder shrug from PT) ... So you say your hands are sweaty, you're feeling nervous tension, your heart is beating faster. Anything else?

PT: No, not really.

TH: What's your thought?

PT: Right now?

TH: (nods) And there is nervous laughter.

As this segment proceeds, there is further clarification as well as some degree of challenge to the patient's defenses in the transference.

PT: (more nervous laughter) I feel that I want to run away 'cause I feel like I am being ... like I'm getting the third degree about my feelings. I don't know how to describe my feelings.

TH: So there is the thought of running away.

PT: Uh huh.

TH: ... of walking out, of dealing with the anxiety by just avoiding the

situation. But let's see if we can look at what the anxiety is about. Because avoidance is a way of dealing with anxiety, it's not the feeling. And you also said that you feel like you're getting the third degree?

PT: Yeah, like . . .

TH: How do you feel toward me?

PT: (big giggle) Right now I'm angry.

TH: Do you notice that you say "angry," but a big smile comes to your face? And your eyes are moving away from me? ... And you say "angry" but now you get very silent.

PT: Well, I feel like ... have you ever been in court? I feel like the prosecutor's asking me questions. I mean, I don't know how to describe how I feel.

TH: Let's see how you experience this anger because you say you're angry at me for asking all these questions about your feelings but when you say "angry," a big smile comes to your face.

PT: I guess that's nervousness.

TH: And you say "I guess."

PT: Well, it is.

TH: But the nervousness is not the anger. Let's see how you experience your anger with me.

PT: What do you mean how do I experience it?

TH: And now again you turn helpless.

As we see, there is maintenance of the focus of working on the triangle of the conflict, monitoring of the patient's anxiety and clarification as well as challenges to the patient's defenses. The patient indicates that she is angry

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inside but at the same time uses the regressive defense of weepiness. We take up the interview.

PT: No, I don't know what you are asking. Well, I'm angry because you're asking me questions I can't answer.

TH: And again, you move to "because." And now you get very silent.

PT: Well, I'm going to start crying any minute.

TH: But the tears are also a mechanism of dealing with the anger underneath. Let's look at how you experience your anger. Because weepiness is another way of dealing with the anger.

PT: I guess by crying.

TH: Is that something that happens to you in other situations?

PT: Uh huh.

TH: Of feeling angry inside, but then the tears come.

PT: Uh huh.

TH: What comes to your mind about that?

PT: When I have to confront people. I can't confront them without . . . especially when I'm angry, like in a situation at work, I can't do it without getting all emotional.

TH: Without getting weepy and teary?

PT: Yeah

TH: So that what you're feeling inside is you're feeling angry in a situation, but you experience anxiety and tears. Just like in here with me right now?

PT: Uh huh.

TH: Does a situation come to mind where this happened? Can you give me an example?

At this stage, there is primarily clarification with some degree of challenge to the resistance. Additionally, narrowing the focus of the investigation and

grounding the work in the patient-therapist interaction in the here-and-now raises the patient's level of anxiety and brings into view her defensive repertoire in the following order: smile (to cover up irritation), avoidance ("I want to run away"), externalization/projection ("I feel like you're giving me the third degree"), and weepiness (as another cover for irritation and anger). It should be noted that even though the patient's anxiety is rising, thus far, there is no evidence of any ego weakness, of any cognitive disruption. The patient remains focused on the material.

(3) Strengthening the Therapeutic Alliance

The examples that the patient brings in are explored in the context of doing work on the triangle of conflict. The therapist consistently points out the operation of patient's defensive mechanisms- both intrapsychic (designed to deal with impulse and feeling) and interpersonal (designed to deal with intimacy and closeness).

At this stage, the negative, self-defeating consequences of continuing to employ these mechanisms are explored. The patient has an emotional in-

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sight, realizing that her behavior in the interview, were it to continue, would be self-sabotage. With this realization, the patient's nonchalance disappears, she becomes a more active partner in the process and the therapeutic alliance -both conscious and unconscious- is strengthened.

(4) Return to Inquiry; the Exploration of the Suicide Attempt

Since the patient's involvement in the process is heightened and her resistance is diminished, the phenomenological inquiry can proceed. The session continues with an exploration of her depression. It started in October, a year prior to the interview. By the summer, she felt better and began a relationship with an attractive man named Mac. For the first time in many years, she was involved with a man who, much to her surprise, was both appropriate and interested in her. Of the evolving relationship, she said: "It wasn't until I started really liking him that I started getting scared. I feel like, on one hand, I really want a relationship with somebody and I'm almost clinging on to them, I want it so much, but on the other hand, I do stupid things or say stupid things. I don't know what I was unhappy about, but I was unhappy." As she became more and more depressed, she became increasingly jealous, suspicious, and demanding. The relationship progressively deteriorated. Her depression worsened. In October, after two days in which she was unable to get out of bed and go to work, the therapist she was then seeing suggested that she go for an evaluation for anti-depressants. She did so and Elavil was prescribed. Later that evening she had a big argument with Mac. The next vignette, comprising an exploration of the suicide attempt, in which she took 45 Elavil tablets, begins with her arrival home after the fight with Mac.

PT: I just remember coming home very calmly, thinking I'm going to take all the pills and when I came in the door, my roommate said "Are you all right? Do you want to talk?" and I said, "No, I'm fine."

TH: So already at that point you had the thought that you were going to take all the pills.

PT: My roommate and I talked later and she said she thought everything was fine because I seemed fine and she thought I'd resolved things with Mac. And I went to bed and I was going to take them when I went to bed but I decided not to and I put them under my pillow, the pills, and I woke up at 4:30 in the morning and I went to the kitchen to get a glass of water.

TH: You just woke up at 4:30. You were getting up early those days?

PT: I get up early to get to work.

TH: What was the thought in your mind?

PT: At that time I felt like no one would know how I ever felt.

TH: When you say "no one", specifically, who comes into your mind?

PT: The people who are close to me, my parents, my friends.

TH: Both parents came to mind?

PT: Uh huh. (some tears)

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TH: Who else?

PT: My roommate who's my best friend and her sister who just got married. I really didn't think about anybody else because they are the people closest to me. So I got up and I went to the kitchen and got a glass of water and I looked down the hall and I saw my roommate looking at me and I went into my bedroom and took the pills.

TH: In what frame of mind?

PT: I was very calm.

TH: And what did you think would happen?

PT: I didn't really think about it. I just thought ... I have a brother, Tommy, that killed himself 5 years ago and I thought that I would be with him soon (tearful) and that I wouldn't have to worry anymore.

TH: The thought of your brother came to you at that point? How did he kill himself?

PT: He took pills also.

TH: He took pills. What was the thought about you and he being reunited?

PT: Well, I thought he would take care of me and that I would not have to worry anymore (voice cracking with emotion) ... I felt at that time that by doing this, I would not ever feel sad or lonely again.

TH: So you thought of being reunited with your brother. Any other thoughts?

PT: Not really. Then I took the pills. As soon as I did it, I felt like I should tell my roommate I did it or I should go to the bathroom to make myself vomit.

TH: What did you do?

PT: Nothing. I went to bed.

TH: With what thought?

PT: I didn't really think about it, I went to sleep.

The brother's suicide by the same method emerges in a dynamic fashion from an involved patient. This is evidence that the unconscious therapeutic alliance is now also in operation. The rest of the interview finished the dynamic descriptive phenomenology, while continuing to differentiate the triangle of conflict.

(5) The Ego-Syntonicity of Suicidal Behavior

The following passage from the first part of the trial therapy comes from the last few minutes of that interview. It demonstrates the degree to which maladaptive patterns can be ego-syntonic. Realizing for the first time the self-destructiveness embodied in her suicide attempt, the patient has one of her first deep emotional insights. This passage also demonstrates how the motivation of the patient and thus the therapeutic alliance have been strengthened. The patient's spontaneous insight and its emotional reverberations further contribute to her motivation.

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TH: How do you feel about this time that you and I have spent together?

PT: I feel good about it. Well, because I've never ... even with the therapists I've had in the past, they didn't talk to me like this, they

didn't make me think about, I mean, I did think about things that I didn't want to think about, but not in this way.

TH: So you have some positive feelings.

PT: I think you can help me. Because in just the short time that we spent-! mean, I know certain things, I've been told certain things -you've made me see things that I have never, that I've never seen. I know that I am self-destructive and selfdefeating, but I've never thought of taking my life as being self-destructive. And it is, I mean, that's the total self-destruction and there is nothing left after that. And I have never thought of it in those terms before.

*(6) Summary of the First Part of the Trial Therapy
(One Hour Duration)*

By the end of the first interview, the descriptive phenomenology had been completed. The following problem areas were delineated: depression, anxiety, inability to have a successful relationship with a man as well as pervasive problems with intimacy and closeness. The following defensive mechanisms were identified: avoidance, weepiness as a cover for anger, taking a passive, helpless position, as well as pronounced self-sabotaging, self-destructive tendencies. In Short-Term Dynamic Psychotherapy, these conclusions are shared by patient and therapist, and are not merely a dynamic formulation of a case residing in the therapist's mind (Malan, 1986).

In terms of assessment, she demonstrated a good ego adaptive capacity and gave no evidence of ego fragility, ego impairment, or any significant depletion. The reflection and clarification of the negative consequences of her characterologic defenses-explored both in the T and the C-had a major impact on the patient: she had a crucial insight as previously egosyntonic behaviors became ego-dystonic and, with horror, she realized the extent to which she was actively engaged in self-sabotage. Rapport deepened and the interview continued at a more intense level. This also provided a major boost to therapeutic alliance as the patient became a much more active participant in the process.

The work of restructuring began at a low level of challenge. The patient already had an experience of differentiating a feeling- anger- from the anxiety its expression generated in her, as well as from the mechanisms she used to deal with it (weepiness, helplessness, etc). However, the ego restructuring did not go beyond clarification and some degree of challenge and there was no evidence of any breakthrough of the sadistic impulse: the patient's affective tone remained constricted, despite her increasing involvement in the process.

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Part II of the Trial Therapy

(7) The Patient's Reaction to the First Part of the Trial Therapy

She was seen a week later. She arrived for the interview punctually and giving every indication of being ready to work. There was more energy and brightness in her manner, which was that of a participant, not that of a victim or of a subject in an experiment. The following passage shows the patient's reaction to the first interview.

TH: Tell me your thoughts after our last meeting Did you have any thoughts?

PT: Oh yeah. I thought a lot about it. You made me think about a lot of things I never thought about, especially the part about self destruction. I realized the seriousness of what I did, but saying it in those terms made me realize that I tried to get rid of myself!

(8) History of Family Dynamics

Since the remaining vignettes will focus on the process of restructuring

and not on the working through of the genetic material, let us at this point briefly summarize the patient's history and family dynamics as they emerged in the second part of the trial therapy.

The oldest of four children and only girl of an Irish Catholic family, the patient was always her father's favorite and fondly remembers trips to the amusement park and Sundays at the movies with him. Her fondest memories though, are of sitting on the couch watching TV, with her father's arm around her. Her mother favored Tommy, the first boy: in her eyes he could do no wrong. In the patient's perception, not only did mother blatantly favor her brother over herself, but mother also deeply resented the closeness between her and her father. She remembers going shopping in preparation for a party and not being able to decide which of two dresses to buy; her father bought her both; when her mother learned this, she was enraged. Until the age of 20, the patient functioned well: she did well in school, was spunky and energetic, had a lot of friends, was involved in extracurricular activities and had boyfriends. From 17 on, she was involved in a satisfying relationship with a classmate.

When the patient was 20 years old, her father left her mother. He was not heard from for three days, at which time he telephoned to say that he was on the West Coast, where he remained for several months. Though her parents' marriage had always been stormy, the patient was shocked. From that point on, there was a drastic change in patient's functioning: her relationship with her mother, never warm, further deteriorated into chronic fighting. She deeply resented her mother for having driven away her father. She became subject to bouts of depression, which had never troubled her before. Her relationship with her boyfriend began to fall apart. When she was 23, her brother Tommy committed suicide by overdosing

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on antidepressants. It was she who made all necessary arrangements. However, she never really mourned her brother's death.

Her relationships with men took an even deeper plunge. She broke up with her boyfriend of several years and began a long string of relationships with men who were either inappropriate or unavailable; the relationships inevitably ended in failure. Finally, her relationship with her father was strained after he returned to the East Coast. It became even more so when he remarried and moved to a different town. She complained that the only time she saw her father was at funerals.

The severe depression that brought her into treatment began in October of the year prior to her suicide attempt. Her suicide attempt was in the early hours of a Thursday in the following October. Her father had left the family on a Thursday morning in October eight years before.

(9) Further Restructuring

The next passage demonstrates further the process of restructuring. Though no longer detached and resistant, the patient is still unable to differentiate the triangle of the conflict and she is still using regressive defenses, such as weepiness and helplessness to defend against underlying impulses. The therapist quantitatively increases the level of challenge and in addition puts pressure on the patient's resistances and she declares that she wants to stand up for herself. Note also the operation of the therapeutic alliance when the patient makes her own defense interpretation: she says that her weepiness and self-pity are "covering-up" her true feelings.

Triangle of Conflict in Relation to her Father

The work on the triangle of the conflict is in the context of the patient's rage at her father for jilting her twice, once when he left his wife and then, again, when he remarried.

TH: Can we look at how you experience the anger?

PT: (crying) By crying . . .

TH: But that's not anger. How do you experience the anger?

PT: I don't. I hold it in. I avoid it.

TH: Right now, when you ... Is the anger something that you're telling me or is it that you ...

PT: No, I do. I feel angry that my father did it, that he's not there when I need him.

TH: When you say "did it", what do you mean?

PT: He left.

TH: And ... Let's see how you experience that anger . . . Because tears are the helpless position, we know that. Let's see how you experience your anger towards him.

PT: Right now I feel like I'm holding my breath.

TH: What else?

PT: I just feel like there's a lump in my throat. And I can't breathe.

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TH: So there's a lot of anxiety about your angry feelings toward your father. So let's see what they are.

PT: I feel like on one hand I'm saying I love my father and I miss him, but on the other hand I'm angry with him and I shouldn't feel angry.

TH: Now there's rationalization about "shouldn't."

PT: But . . .

TH: So let's see how you experience that anger with him.

PT: How do I?

TH: Yes.

PT: Right now?

TH: Yes . . . 'Cuz there's a part of you that's very angry at him.

PT:

TH: And now again you g:::t very silent . . . and I bet you're not breathing.

PT: (smile of momentary relief)

TH: And now you get totally silent.

PT: Cuz I don't know how I'm feeling angry.

TH: And now you want to ruminate about it. I mean you say you're angry and yet there's no experience of it.

PT: Uh ...

TH: There are clearly mixed feelings about him. And there is a lot of sadness and a lot of missing him and a lot of loving him (patient nods her head). But then, there's the other side. That he left, that he left you and then the family fell apart after that and that you lost the closest relationship you ever had. So let's see what are your feelings toward him.

PT: I feel that my father destroyed my life and that I'm not normal anymore.

Further Challenge and Pressure to the Patient's Resistance

The focus on the triangle of the conflict in relation to her father is maintained as more challenge and pressure is applied.

TH: So let's see what you experience, 'cuz you say your father destroyed your life. So what do you feel toward this man?

PT: I'm mad at him.

TH: Do you notice that as soon as there's any talk of anger, you pull back, start having difficulty breathing, you stop breathing and you become utterly paralyzed. And the tears come. You take a totally crippled, paralyzed position when it comes to your angry

feelings. And you become weepy. Let's see what your feelings are toward him.

PT: (frustrated crying) I'm angry. I don't know how to express it.

TH: Let's look at what's inside you.

PT: I just feel that I've been holding it in and I can't express it.

TH: More helplessness. Now you're going to take the helpless position

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about how you can't express it and you're scared and now there's more weepiness. And you're holding yourself in and your hands are crossed and your hand is between your legs. And you get very silent. 'Cuz there is a tremendous amount of rage you have toward your father, isn't it?

PT: (nods)

TH: And now again the weeping comes. Weeping and more helplessness . . . There is a feeling of tremendous anger that you've been sitting on for what? . . . eight years (nod). So let's see what you're going to do about it. I mean, because you can sit and weep and cover up your anger with helplessness and with tears. You can certainly do that.

PT: I don't know what to do.

TH: More helplessness . . .

PT: I don't know . . .

TH: More helplessness.

PT: (crying, whiny voice) I feel like its the only way I know how to act and it's no good.

TH: Now you want to rationalize about the way . . . And you know that it's not good. So let's see how you experience your anger toward him. If you were to have him before you . . .

PT: I would tell him that he ruined my life.

TH: But how do you feel, what's the emotion?

PT: Angry, like I hate you right now, I hate what you did to me.

TH: But you say "hate," but there is this pitiful, sorry-for-myself person here. That on the inside there is hatred, but on the outside is this hurt little girl. So let's see what you're going to do about this hurt little girl. And the tears. More tears. And do you notice how your body is sort of limp (Pt nods). What are you feeling inside?

PT: I feel I want to stand up for myself

TH: Do you think that the tears and taking this "helpless little me" attitude and feeling sorry for yourself are mechanisms for dealing with your angry feelings?

PT: Uh huh. I think it's covering up.

TH: A facade?

PT: (nods)

TH: The facade of this hurt little girl to cover up what's really inside (Pt nods). So let's see how you experience that anger. I mean, because if you keep the facade up . . . you know the consequences of that (Pt nods). You take it out on yourself, you get depressed, and you feel utterly isolated. So let's see what you're going to do about it. 'Cuz you're sitting there, like in a lump, totally helpless. Sitting on eight years of angry feelings, taking a totally paralyzed and crippled position.

(1 0) Breakthrough of the Aggressive Impulse in the Transference Central to Davanloo's technique of restructuring is the derepression of the aggressive impulse and undoing the mechanism responsible for depres

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sian. In the following passage, the work of restructuring comes to fruition in the transference. The patient's posture, tone of voice and general level of activation announce the derepression of the aggressive impulse. The absence of weepiness is yet another indicator that the patient's ego has been restructured and she is no longer relying primarily on regressive defenses. At this point, the patient's defensive repertoire consists mainly of higher level defenses, such as rationalization and intellectualization.

TH: And what do you want to do with the impulse?

PT: The impulse is to scream, to stand up and scream.

TH: And what would you do towards me? What's the emotion towards me? 'Cuz you say there's the wish to scream but you still sit there passive. Totally passive.

PT: I'm not passive though.

TH: And totally paralyzed to tell me what your experience of your anger is.

PT: It's to scream right now, that's what I want to do. I feel it coming up within me, like I said before, it's going to erupt.

TH: But meanwhile, you want to hold on to the chair and you want to hold it in.

PT: Because you're not supposed to scream.

TH: Let's not look at what you're supposed to do.

PT: That's not civil.

TH: And now civil comes in. More rationalization.

PT: People don't scream at each other.

TH: More rationalizations. And shoulds.

PT: It's something my mother does and I don't want to be like my mother.

TH: Now you bring in your mother.

PT: Well, it's true. My mother is a screamer and a whiner and I don't want to be like her . . .

TH: You say that you're not going to be crippled and paralyzed anymore.

PT: I'm going to stand up for myself (tough tone of voice)

TH: What are you feeling? What is the emotion?

PT: Anger, I told you that. (exasperated, loud)

TH: You told me anger, but meanwhile what we see is passivity. Passivity and tension and restlessness. And limp position.

PT: Well, it's not limp, I'm sitting up straight.

TH: What are you feeling inside?

PT: Anger. (with intensity)

TH: How?

PT: Rage, Right here. Angry. You're making me angry. You're making me act like I don't want to act. I don't want to scream at you and tell you that you're making me angry.

TH: More rationalizations. But there's also the thought of your mother that comes in.

PT: Yes, my mother screams and I hate screaming I think that people

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can discuss things without screaming at each other.

TH: But the thought of screaming comes into your mind.

PT: Yes, the thought of screaming comes into my mind, the thought of shaking you comes into my mind. But I wouldn't do that.

TH: Let's see how you picture that.

PT: Well, I picture going like this.

TH: And ...

PT: And telling you "Listen to me, you're not listening"

TH: *How would you do that?*

PT: *I would stand up and . . . do it.*

TH: *And now you want to stop again.*

PT: *No, I'd stand up. That's what I would do, but I'm not going to do it.*

TH: *Clearly, we're talking not in reality, we are talking in thought and fantasy. You're not going to take me and shake me and it's not about screaming, it's about examining your experience. And your experience is made up of what you feel inside and what your thoughts and fantasies are (Pt is rolling up her sleeves). And you're telling me that there is this feeling of erupting anger inside. Right?*

PT: (nods) *Uh huh.*

TH: *Where is it up to?*

PT: *Like here (rubs across her chest)*

TH: *So let's see what that's like.*

PT: *Well, it's . . . I told you, I'm angry, it's . . .*

TH: *Do you notice how you somehow have to preface it with some kind of whiny remark about "I told you" or "I don't know" . . .*

PT: *I am angry right now (very firm tone of voice) and you're making me more angry.*

TH: *So let's see how you experience it. Because you're going to want to get away from it.*

PT: *By telling you. I'm telling you. I'm angry.*

TH: *More words. More words. We know that you're a master of words.*

(Pt chuckles) *That we know. And of rumination. And these have been the ways . . .*

PT: *My fantasy is to stand up right now and shake you.*

TH: *Immediately you say that and you slump down and . . .*

PT: *Well I would stand up and shake you. I mean what, you want me to stand up and show you what I would do?*

TH: *I want to know how you experience . . .*

PT: (very activated, animated) *I would be shaking you and I would be telling you "Listen, listen to me, you're not listening to me just like no one else listened to me before." But before I held it in.*

(J) *Breakthrough of Aggressive Feeling toward the Father & T-C, T-P Link*

Davanloo points out derepression of the impulse/feeling in the transference leads to a derepression of the impulse/feeling in the "C" as well as

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towards genetically significant figures. In this case, the derepression of the aggressive impulse in the transference which we saw in the last vignette, sets the stage for the derepression of the aggressive impulse toward the father. It is important to note that at this point there is an absence of anxiety.

PT: *Anger again. (voice is loud). Rage . . .*

TH: *How do you experience it?*

PT: *Inside me.*

TH: *Where?*

PT: *Here. (moves hand up and down her front). It's in my hands, it's in my feet.*

TH: *How do you feel it in your hands and in your feet?*

PT: *I just feel like pacing and saying to him, "you're not listening."*

TH: *But if you don't pace, since that's a way of discharging the anger?*

PT: *Hitting something, kicking something.*

TH: *Who's something? 'Cuz it's not about something.*

PT: *My father . . .*

TH: *Can we look at that? Or are you going to get all passive?*

PT: *No (with indignation in her voice), I'm not passive, I'm telling you ...*

TH: *In your fantasy, how would you see that, how ...*

PT: *Well, I would hit my father in the stomach.*

TH: *Where?*

PT: *Here. (points to her own stomach, where she first experienced the anger)*

TH: *How?*

PT: *Just kick him like this (makes a vigorous kicking motion with her foot) so he'd be out of breath and then he'd have to listen to me.*

TH: *And then what? Because you also said . . .*

PT: *I would just kick him and make him sit down and I would be standing . . .*

TH: *Where would you kick him?*

PT: *In the leg.*

TH: *Where?*

PT: *In the shins.*

TH: *Which one?*

PT: *I guess his left leg because I kick with my right leg.*

TH: *And what position is he in?*

PT: *He would be sitting at that point and I would have the upper hand and tell him.*

TH: *And then what would you do?*

PT: *I would stand above him and tell him . . .*

TH: *But you've just hit him in the stomach and kicked him in the shins. How do you picture him?*

PT: *Probably doubled over and I would make sure he was all right before he listened.*

TH: *And then what?*

PT: *And then I would tell him . . .*

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TH: *And he'd say "Yes, yes, yes" . . .*

PT: *No, I think at that point he would see that I'm not kidding around.*

TH: *How do you feel toward this doubled over body?*

PT: *Well, it upsets me but it would be the way I would get his attention, that he knows I'm serious. .*

TH: *You talk about wanting to get his attention, but there is this tremendous impulse inside you . . .*

PT: *Well it would hurt him and . . .*

TH: *... of anger toward him and . . .*

PT: *... and then he would know how my stomach feels . . .*

TH: *... of wishing to hurt him. What else would you do?*

PT: *At that point I would just tell him.*

TH: *So there is the thought of making him feel as bad as you feel.*

PT: *Uh huh.*

TH: *And punching him in his stomach ... What are you seeing in your mind?*

PT: *He would have the same feeling of breathlessness inside as I have when I can't talk or I can't express myself and then he'd know that's how I get.*

(12) Partial Derepression of Libidinal Feelings toward the Father

The portrayal of the rage toward her father is followed by sadness about their lack of closeness, which then releases a partial derepression of her libidinal feelings. As she speaks of her tremendous love for him and wishes

for greater closeness, she says with a shudder "The way I feel is almost incestuous. The way that I feel about him is the way that I feel about Mac." It is the patient who makes the interpretation, linking up a current figure, her boyfriend, with a genetically significant figure, her father.

PT: I feel like he's the only man that would ever make me feel happy again . . . and he's my father. You can't marry your father. You can't . . .

TH: What's that thought, because there is a part of you that's had that thought for a long time, that your father is the only right man for you . . .

PT: Well, I just want him to be mine and nobody else's.

TH: Who comes to mind?

PT: My mother. And his wife.

(13) Derepression of Sadistic Feelings toward the Mother

In the next vignette, the process of *restructuring* has led to the derepression of the patient's sadistic impulses toward her mother. In the last vignette, there is a continuation of the breakthrough, of the penetration of the impulse through the repressive barrier. The patient is expressing directly what she feels; there is a concomitant change in her posture to suggest altered physiology; there is little or no anxiety; she no longer slumps in her

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chair, her voice is louder and clear; furthermore, in the fantasy material, i.e., the portrayal, there are detailed images which lead to further amplification of the impulse. There has been a partial breakthrough into the unconscious: layers of material emerge spontaneously, without direction from the therapist: angry feelings at the father are followed by libidinal feelings toward the father and the link between her father and Mac, followed by murderous impulses toward her mother.

TH: So let's see how you feel towards her.

PT: Her I have a lot of anger toward.

TH: Let's see how that looks.

PT: Well, my mother I would just ... Sometimes like I said I feel like choking her to death. (this is just flowing)

TH: Let's see how you would do that.

PT: I would take her like this (motions choking motion) and just shake her (mother transference before-kicks and hits father, shakes me and shakes and chokes her mother)

TH: What are you feeling right now?

PT: Angry.

TH: How?

PT: Just like wanting to choke her.

TH: Where in your body do ...

PT: In my hands.

TH: You feel it in your hands (Pt nods vigorously). Let's see in your fantasy ...

PT: Because my mother's mouth is always the thing I always think of, her always nagging me, her always (pant of exasperation) ... her always ... not shutting up and just going on and on and always whining. I just want to shut her off

TH: What do you feel toward her right now?

PT: Anger. Resentment. Hate sometime. Sometimes I hate her. When I would get mad, I would say under my breath "I hate you, I hate you, you're a wicked bitch. "

TH: You'd say that under your breath.

PT: Uh huh.

TH: What else?

PT: *And then just cry and clench my teeth.*
 TH: *And the feeling is now in your hands.*
 PT: *Yeah, because I feel that's the only way to control her.*
 TH: *Can we look at how you would see that in your mind.*
 PT: *Just shaking her and choking her until she shuts up.*
 TH: *Can you describe it to me? What is she wearing?*
 PT: *Clothes ... Pants.*
 TH: *What color?*
 PT: *Blue.*
 TH: *And what top?*
 PT: *A sweater.*
 TH: *What color?*
 PT: *It's a green sweater.*
 TH: *And what does her body look like?*
 PT: *She's just standing there and me . . .*
 TH: *Standing there and saying what?*

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PT: *Staring me face to face and just nagging "Well, you know, your father this and your father that and your father ruined the family when he left and your father's to blame for your brother's death and your father doesn't pay any attention to you and your father doesn't give your brothers any money and your father this and your father that" and just taking her by the neck and choking her until she's a lump on the floor.*
 TH: *What do you picture?*
 PT: *Her just laying there and me just feeling guilty about doing it.*
 TH: *How do you choke her?*
 PT: *Like this, with my hands around her neck. (motions vividly with her hands)*
 TH: *With what feeling in your hands?*
 PT: *A tight feeling around her neck. With strength.*
 TH: *With strength. And the feeling is one of rage?*
 PT: *Uh huh.*
 TH: *Towards her?*
 PT: *Yes.*
 TH: *Rightnow?*
 PT: *Yes.*
 TH: *Do you experience the rage right now?*
 PT: *Uh huh. Just wanting to shake her and saying "Shut up, I hate you.*

(14) *Summing up of Trial Therapy- Part II (Four Hours Duration)*

The *restructuring* of the defensive organization of the ego resulted in the lifting of the depression through the undoing of the mechanism responsible for the depression. This in turn led to the breakthrough of the aggressive impulse in the transference and the subsequent revelation of major aspects of the core neurotic structure. As these vignettes illustrate, this was not achieved through interpretation. Insight was achieved through the patient's direct experiences. As Malan (1986) wrote, in this technique, the therapist's interpretations have primarily the function of a summing up. As we will see in this last passage, through her experiences in the trial therapy, the patient has grasped a basic fact: her depression is the result of the internalization of sadistic impulses. In Intensive Short-Term Dynamic Psychotherapy, it is the patient who always has the last interpretation.

PT: I have done every thing to myself

TH: What are you thinking?

PT: I'm thinking that the way I feel about my father, I've done that to myself; the way I feel about my mother, I hate myself

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Summary and Conclusion

This article described the process of *restructuring*, a technique developed by Davanloo (1987a,b) for dealing with the regressed and depleted ego organizations of patients suffering from depressive disorders. The author illustrated the application of restructuring to the trial therapy of a suicidal patient. With the advent of this technical development, the already wide range of psychopathological conditions that can be successfully treated with Intensive Short-Term Dynamic Psychotherapy has been further expanded.

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