ISTDP with a Person-Centered Emphasis
Habib Davanloo meets Carl Rogers

JOHANNES KIEDING
MSW, PRIVATE CLINICIAN
ANDRE MARQUIS
PHD, ASSOCIATE PROFESSOR AT THE UNIVERSITY OF ROCHESTER

Abstract

This paper explores the potential integration of the person-centered approach (PCA), developed by Carl Rogers, with Intensive Short-Term Dynamic Psychotherapy (ISTDP), developed by Habib Davanloo. Despite the differences between the PCA's non-directive stance and ISTDP's directive and often confrontational techniques, ISTDP is arguably most effective when it incorporates the relational components central to the PCA as well as the common factors. These factors—including empathy, congruence, and curiosity—are vital for fostering a conscious therapeutic alliance which, in turn, is essential for deep emotional closeness between therapist and patient. The authors argue that ISTDP can be practiced in a manner congruent with the core principles of the PCA, such as respect for patient autonomy and authentic connection, and which ultimately may enhance the efficacy of ISTDP interventions. However, achieving this integration presents challenges, as the emotional intensity and complexity of ISTDP may provoke anxiety in therapists, potentially leading them to employ techniques defensively, thereby compromising the person-centered qualities of the therapeutic relationship and undermining the emotional closeness that is central to ISTDP. Ways that these challenges may be mitigated are discussed, including the balance between specific and common factors, a focus on the real relationship, and reflections on Davanloo's admiration for his patients and the role of intuition in his work.

Keywords: Intensive Short-Term Dynamic Psychotherapy, Habib Davanloo, Person-Centered Approach, Carl Rogers, the conscious therapeutic alliance, the real relationship, therapist resistance, Experiential Dynamic Therapies, humanism, integrative

CONFLICT OF INTEREST STATEMENT
JK serves on the Editorial Board and is a senior editor of this journal. AM serves as a scientific advisor to the journal. Neither authors participated in the decision making procedure regarding acceptance of the manuscript for publication. No further conflicts.

ACKNOWLEDGEMENTS
We wish to thank Aspasia Karageorge for assistance with the editing process, as well as Nat Kuhn, Peter Lilliegren, Stephen Buller, Eric Schneider, and Thomas Hesslow for their helpful feedback. We also wish to thank Marvin Skorman, who taught us to nurture and preserve the real relationship at the core of ISTDP.

Introduction

> ....the two extremes, encounter and technique, seem to be a matter of theoretical importance only. Live practice hovers between the extreme poles. Neither should be looked upon contemptuously or disparagingly....[However,] Technique, by its very nature, tends to reify whatever it touches.... Worshiping technique at the expense of encounter involves making man not only a mere thing but also a mere means to an end. [...] Seeing in man a mere means to an end is the same as manipulating him. (Frankl, 1967, p. 80, brackets added)

The person-centered approach (PCA), developed by Carl Rogers, emphasizes the therapeutic relationship as key to fostering personal growth and change. Research consistently supports the PCA's effectiveness across healthcare settings, demonstrating that the therapeutic relationship—particularly empathy—is a stronger predictor of positive outcomes than specific techniques (Norcross & Lambert, 2019; Elliott et al., 2011). The PCA asserts that individuals possess an inherent capacity for self-actualization, and the therapist's role is to create an environment that supports patients to access these inner resources. Rogers (1957) proposed six essential conditions for effective therapy: (1) psychological contact between patient and therapist, (2) patient incongruence or distress, (3) therapist congruence (genuineness), (4) unconditional positive regard, (5) empathic understanding, and (6) the patient's perception of the therapist's empathy and positive regard. A key feature of the PCA is non-directiveness, wherein the therapist refrains from directing the treatment, instead empowering patients to make their own choices.

Furthermore, the PCA emphasis on the therapeutic relationship and core qualities such as empathy and congruence align directly with the common factors approach in psychotherapy whereby non-specific elements—such as the quality of the therapeutic relationship, patient expectations, and therapist qualities—significantly contribute to successful outcomes - regardless of the specific approach (Wampold & Imel, 2015).

In contrast, Intensive Short-Term Dynamic Psychotherapy (ISTDP), developed by Habib Davanloo, is an emotion-focused and highly directive form of psychotherapy. ISTDP aims to quickly process unconscious emotional conflicts through pressure, confrontation, and unlocking repressed memories and emotions. It often involves actively challenging a patient's maladaptive defenses to create an emotionally charged environment that facilitates breakthroughs of unconscious material (Davanloo, 1990). Unlike the PCA, ISTDP employs specific technical interventions to help patients confront and overcome emotional barriers that hinder their progress and well-being.

Despite what may sound like divergent sets of principles on the surface, PCA principles are in fact ideally situated to enhance ISTDP praxis. On the one hand, ISTDP's directive approach to challenging patient defenses sits in contrast with the PCA's non-directive and unconditional positive regard dictates. Looking more closely, however, several elements of ISTDP align closely with PCA values, particularly the "conscious therapeutic alliance." These elements emphasize mutual agreement, empathy, and respect for patient autonomy, which will be explored in greater detail.

In fact, emphasizing the aspects of the PCA which overlap with ISTDP may be pivotal to overcoming or at least mitigating some of the risks inherent in such a technique-heavy model. This is especially true for those in the early stages of learning and applying the complex technical details of ISTDP, particularly the dramatic "unlocking of the unconscious," which can make ISTDP therapists vulnerable to becoming overly therapist-centric.

The therapist's agenda and eagerness to facilitate an emotional breakthrough can easily override the importance of meeting the patient where they are and ensuring that the patient's agenda drives the treatment, in contrast to the other way around. This is especially risky for patients who are inclined to please others, who may superficially comply with the therapist's direction without genuine engagement. While such compliance may have been a creative adaptation in childhood, a therapist who colludes with this behavior by pushing an agenda that the patient has only superficially bought into will surely create untoward and iatrogenic responses. For example, in challenging a patient's defenses using pressure, clarification, and confrontation, an ISTDP therapist may help the patient to access repressed memories and emotions. The risk, however, is that confrontational interventions may be administered and/or experienced as controlling, lacking empathy, and without regard for the specific needs of the patient in that moment. The question, then, is how to combine ISTDP's directive techniques with PCA's core relational qualities; in other words, how can a therapist maintain a person-centered stance while using directive, pressure-laden, and confrontational methods, so that both sets of principles are preserved ?

We will outline a detailed consideration of integrating these two sets of principles when practicing ISTDP, drawing on theory, research, and our own clinical knowledge . We will discuss details of the key themes related to this integration, including consideration of the challenges and complexities of ISTDP praxis while foregrounding PCA principles. We maintain that emphasizing person-centered principles within ISTDP practice may in fact reduce the risks inherent to an otherwise technique-heavy form of therapy.

Emotional Closeness and the Conscious Therapeutic Alliance

We argue that emotional closeness is crucial to ISTDP's success, and that this hinges on the relational elements as described by Rogers. The conscious therapeutic alliance in ISTDP—a clear agreement between therapist and patient that prioritizes patient autonomy—embodies core person-centered values. However, fostering this conscious alliance in ISTDP treatment can be challenging, particularly in cases where the alliance is only possible after the patient has undergone challenging interventions. Therapists must be mindful of their approach to ensure that directive techniques strengthen rather than undermine the therapeutic bond. However, when practiced skillfully, ISTDP's interventions can enhance, rather than diminish, the person-centered qualities of psychotherapy.

Balancing these two approaches requires skillful navigation to ensure that interventions enhance, rather than compromise, the therapeutic relationship. For example, when a patient presents with entrenched defenses, the ISTDP therapist must find ways to confront these barriers to facilitate emotional engagement while preserving the patient's sense of being fundamentally accepted. Navigating this balance becomes particularly precarious when patients perceive even the most delicate confrontation as invalidating, risking a rupture in the therapeutic alliance. However, by guiding the patient to confront and move beyond these defenses, the ISTDP therapist ultimately demonstrates a deep regard for the patient's true self and their autonomy—since it is the maladaptive defenses that undermine the patient's autonomy. Davanloo puts it this way, "...his defenses... paralyzed his autonomy and function" (Davanloo, 1990, p. 200). This process may not align with the traditional concept of pure, unconditional positive regard, but it reflects a profound commitment to the patient's well-being and emotional growth. Furthermore, from an ISTDP perspective, it can be recognized that a therapist can defensively remain "empathetic and supportive" when what the patient truly needs (and what would actually be more empathetic) is a more confrontational and challenging intervention.

Despite the complexities and differences between a strict person-centered approach and ISTDP, one component of ISTDP that aligns closely with the spirit of PCA is the conscious therapeutic alliance. Fundamentally, this alliance is based on a profound respect for the patient's autonomy, aiming to cultivate an environment of deep emotional engagement and authentic connection. When skillfully applied, ISTDP fosters a trusting therapeutic relationship in which elements of pressure and confrontation are used not to diminish but to enhance the therapeutic bond and the patient's autonomy, ultimately reinforcing the person-centered qualities of the therapy.

Balancing Specific and Common Factors

The overlap between Rogers' six conditions and the common factors framework underscores the importance of connection, empathy, and authenticity in driving therapeutic change. Indeed, within ISTDP, Patricia Coughlin has emphasized the value of integrating specific ISTDP techniques with common therapeutic factors, noting that "moderate use of specific factors, along with the common factors of empathy, safety, and curiosity, seem to yield the best results" (2017, p. 4). While research supports the importance of common therapeutic factors (Wampold & Imel, 2015), effectively integrating these within ISTDP practice requires a careful balance between directive interventions and maintaining a strong therapeutic relationship.

ISTDP's focus on an active confrontation of patients' maladaptive defenses presents a unique challenge for balancing empathy with directive interventions. Unlike the PCA, where the patient sets the pace and direction of therapy, ISTDP often requires the therapist to actively confront defenses while ensuring that patients do not perceive *themselves* as being under attack. This dual focus requires constant attunement to the patient's tolerance of anxiety in order for the therapist to maintain a productive and stable therapeutic alliance.

When effectively implemented, ISTDP integrates directive techniques with common therapeutic factors, aligning with many—but not all—PCA principles. For example, ISTDP therapists may clarify and challenge a patient's rationalizations to help them confront painful emotions. While such confrontations can move the patient beyond entrenched defenses, they also carry the risk of alienation if not handled carefully. Conversely, overemphasizing PCA's non-directiveness can lead to stagnation, particularly for patients needing clear guidance or pressure to overcome defenses. Thus, balancing these approaches ensures both progress and respect for the patient's autonomy. By integrating directive interventions with relational qualities, the ISTDP therapist supports the patient in confronting defenses while maintaining an empathic and respectful stance. This approach ensures that the therapeutic process remains both effective and deeply humanistic.

Hickey (2017) characterizes Davanloo's ISTDP as an approach marked by inherent empathy and an absence of therapist domination, emphasizing a highly attuned relationship without a predetermined agenda. This highlights the importance of maintaining flexibility and empathy throughout the therapeutic process, allowing the therapist to remain responsive to the patient's unique needs. Whether this depiction accurately reflects Davanloo's consistent practice is open to debate, but Hickey seems to assert that this was at least his aspirational goal. Similarly, Schmitt (2024) underscores the importance of emotional warmth and partnership in the therapeutic process. She notes that the intensity of the relationship between the therapist and patient is a critical factor for achieving successful treatment outcomes. This focus on relational closeness emphasizes that even in a technically demanding model like ISTDP, the human connection between therapist

and patient remains central. By helping patients confront and move beyond their maladaptive defenses, ISTDP therapists demonstrate a profound commitment to their well-being and growth, even if this process may not always align with a purely supportive stance.

To reiterate: to achieve this balance between confrontation and genuine relational closeness, it is critical to emphasize the conscious therapeutic alliance, which serves as the foundation for both ISTDP and PCA principles. In this regard, it is important to revisit Davanloo's conception of the conscious therapeutic alliance to underscore how its components overlap with the relational qualities central to the PCA. Deborah Lebeaux (2000) provides a detailed description of the conscious therapeutic alliance, which highlights the essential elements needed for effective therapy:

> The conscious therapeutic alliance consists of an explicit agreement between therapist and patient on the goals and the therapeutic task, as well as a felt sense of partnership and confidence in the ability to have therapeutic success. ... The patient must also feel that the relationship with the therapist is genuine, that the therapist is interested in the patient. ...Without the conscious therapeutic alliance, however, no unconscious therapeutic alliance is possible.... The most common elements that make up the conscious therapeutic alliance for any form of psychotherapy include the following factors: first, the therapist and patient agree on the goals of the treatment, including a mutual understanding of the problem areas to be treated, and what a successful outcome would be; second, the patient experiences the therapist as operating in the best interests of the patient....The patient must have a clear understanding of the therapeutic task, especially the intrapsychic focus of the treatment. The patient must understand and clearly grasp that the "road map" to freedom is through experiencing his or her inner thoughts and feelings at the deep unconscious level (Lebeaux, 2000, pp. 40-41).

The effective integration of these elements that constitute both the conscious therapeutic alliance and the spirit of the PCA is not without challenges. Less skillful application of ISTDP that does not focus sufficiently on the conscious therapeutic alliance can result in the PCA components of the model being lost. We believe that one common reason for the loss of person-centered principles and genuine emotional contact and engagement with the patient is the emotional intensity and complexity inherent in ISTDP. This intensity and complexity often provoke anxiety in the therapist. This anxiety may lead the therapist to rely too heavily on technical interventions as a way of managing their own anxiety, thus using ISTDP techniques in a ritualistic, defensive manner. When this occurs, the therapy risks becoming overly rigid and technical, distancing the therapist both from their own centered presence as well as from the patient's emotional experience, thus weakening the emotional contact essential to a healing relationship and to effective treatment.

This rigidity often stems from an attachment to a manualized version of ISTDP, where techniques become a defensive barrier between the therapist and the patient. Such therapists may fall back on scripted lines or rigid interventions, working *on* the patient rather than *with* them (Osimo, 2012). While procedural knowledge is vital, problems arise when techniques take precedence over the person, transforming therapy into a mechanical, impersonal process driven by the therapist's own neurosis (Reher-Langberg, personal communication, 2017). Mahoney and Marquis (2002) described this as the "tyranny of technique," where methods eclipse the human connection. As Mahoney (2003) emphasized, "the art of human helping will not be found in specific words or meticulously repeated rituals unless those words and rituals reflect something deeper than their own surface structure" (p. 168). Allen Kalpin (1993) puts it this way, "...the therapist must be highly attuned to his or her own emotional reactions to a patient, and not be sitting behind a wall of intellectual analysis and planning. The therapist must not use the therapeutic principles as a defense..." (p. 25). Ultimately, while technique is essential to ISTDP, it must not overshadow the deep emotional engagement that is the heart of effective therapy.

To prevent this overshadowing, it is crucial for the ISTDP therapist to work on their own anxieties and resistances against emotional closeness. This will increase the odds that the therapist will be able to keep the therapeutic relationship and the conscious therapeutic alliance at the core of their clinical work. By doing so, they can utilize the more pressure-filled and confrontational ISTDP interventions from a grounded and undefended state of mind, which allows for an integration of the directive techniques of ISTDP without sacrificing the connection, empathy, and authenticity that are fundamental to person-centered therapy. Ultimately, ISTDP, when skillfully applied, can offer a unique and powerful blend of directive interventions and deep empathic connection, allowing for optimal therapeutic results (Coughlin, 2017).

We will dedicate the rest of this paper to elaborating on the problems associated with an excessive focus on techniques that become a substitute for genuine relating and emotional contact with the patient, and how this violates what we see as the therapeutic prime directive both in ISTDP and the PCA. We will begin by describing in more detail why ISTDP can provoke so much anxiety in therapists, and then expound on the risk of using techniques defensively to manage that anxiety. Next, we will deepen our analysis of the areas where ISTDP and the PCA overlap, particularly in relation to connection, empathy, authenticity, and autonomy. This analysis will also cover the "real relationship" and the often-overlooked dimensions

of ISTDP that involve the therapist's genuine affection and admiration for the patient—similar to Carl Rogers' concept of unconditional positive regard and "prizing."

Why the ISTDP Therapist May Become Anxious

Change is universally frightening, and with it comes the anxiety of stepping out of one's comfort zone. As a result, people often resist change. Imagine a patient who avoids emotional pain by adopting a dismissive, nonchalant demeanor, gazing out the window while commenting on the therapist's perceived incompetence. Imagine addressing these behaviors immediately and honestly, highlighting how they not only create difficulties in relationships outside of therapy but also hinder therapeutic progress. The reader can likely sense how this kind of direct honesty could be anxiety-provoking for the therapist.

As we have alluded to, therapists' unresolved emotional conflicts, along with their anxieties about engaging in an intense, emotionally intimate process, make ISTDP practitioners vulnerable to certain mistakes. These often include an overemphasis on technique, driven by a personal need to succeed in ISTDP. When therapists focus excessively on techniques to manage their own anxiety, the therapeutic relationship can become "therapist-centric" and "technique-forward," leading to a loss of genuine emotional contact.

This highlights why it is essential for ISTDP therapists to address their own unresolved issues and seek ongoing supervision. As Nat Kuhn notes: "The problems of misalliance that we all run into especially as we learn ISTDP... are very real, and every trainee needs to learn to deal with them" (N. Kuhn, EDT-List, May 8, 2022). However, we should note that while this developmental trajectory is anecdotally recognized within the ISTDP community, there is no published research confirming that it is steeper than in other approaches. Thus, although many of the principles we discuss apply across modalities (Norcross & Lambert, 2019; Wampold, 2015), our focus here is on the tensions between technique and emotionally intimate relating in ISTDP.

Consistent with the person-centered approach, we emphasize a prime directive that prioritizes an experiential connection with both the therapist's and patient's inner experiences. Take, for instance, the previously mentioned patient who exhibits nonchalant, distancing behaviors. A therapist following this prime directive would be attuned to their felt responses—concern for the patient, annoyance at the self-defeating behavior, or an understanding of the behavior's communicative function: the feelings induced in the therapist may convey something of what the patient has experienced. They might recognize that if these behaviors provoke irritation in the therapist, they likely do the same in others, contributing to the patient's isolation and suffering. The therapist knows that as long as these behaviors persist, little progress can be made, yet also acknowledges that the patient has the right to impede their own progress. By pointing out how the distancing behaviors hinder treatment, the therapist ensures that the patient makes a more informed choice while maintaining a stance of empathy, respect for autonomy, and a genuine connection. Schmitt (2024), also describing the importance of the aforementioned therapeutic stance and the common factors, puts it this way, "...a close relationship between patient and therapist is required. A therapist who is free from anxiety is needed who is able to create a climate of freedom, equality, and emotional closeness. ...Positive feelings towards the therapist and trust in the therapist who is not anxious have a strengthening effect on the will to change" (p. 137).

While we have raised concerns about being *therapist-centric* and *technique-forward*, it is crucial to recognize that viewing technique and the therapeutic relationship as inherently opposing forces is ultimately a false dichotomy. Ideally, techniques should not be employed to manage the therapist's anxiety but rather as tools for forming a healing connection— "ways of being together" (Frederickson, 2013, p. 8). However, this does not negate the fact that therapists can use ISTDP techniques defensively, which may overshadow genuine connection. For this reason, it is warranted to discuss how an overly technical focus can indeed undermine authentic emotional contact with the patient. Since we are emphasizing the problems associated with rigidity and excessive focus on techniques, in the interest of balance we wish to briefly refer to the reverse problem: insufficient discipline and inadequate procedural knowledge. Flexibility must coexist with discipline and structure. Though we do not address the problems of insufficient technical mastery in this paper, we recognize that this can also be problematic. In the words of Allen Kalpin (1993), "A deep grasp of metapsychology along with a high level of technical mastery is required to give order to one's perceptions, and to provide tools for successful intervention" (p. 27).

We have discussed the key areas of overlap between ISTDP and PCA, including the importance of the therapeutic relationship and the elements that foster it: connection, empathy, authenticity, and autonomy. These foundational elements are essential in creating an effective therapeutic bond, regardless of the techniques employed. Having laid this foundation, we now turn to a concept that encapsulates the essence of both approaches: the real relationship. It represents these core relational qualities and offers a pathway to genuine therapeutic engagement that transcends specific methods.

The Real Relationship

The *real relationship* refers to an authentic, empathetic, and mutually respectful connection between therapist and patient. It is characterized by the therapist's genuineness, congruence between internal experience and outward expression, and a

commitment to understanding the patient on their own terms. The real relationship allows for two separate individuals maintaining a strong bond even in the face of differences. The therapist prioritizes the patient's needs while fostering emotional closeness, keeping theories and techniques in the background. The real relationship involves openness, acknowledging therapist fallibility (or therapist non-defensiveness), and respecting the patient's autonomy and right to self-determination, aligning closely with Rogers' principles (1959, 1961, 1980).

Lewis Aron (1996) presents ideas about an egalitarian therapeutic relationship characterized by mutuality, which also captures what we mean by the real relationship. Aron refers to a therapeutic dyad where both the therapist and the patient influence each other and contribute to the unfolding process. He emphasizes the importance of the therapist's openness and willingness to be affected by the patient, creating an environment of genuine dialogue. This mutual openness fosters a more authentic and connected relationship, which, in turn, facilitates deeper self-understanding and transformation for the patient. Aron acknowledges that while there is asymmetry in the roles of therapist and patient, the concept of mutuality allows for a dynamic interplay in which the analyst's influence is not purely objective or removed but instead is part of a living, evolving relationship. While Aron highlights the aspect of the real relationship that involves mutual influence, Ferruccio Osimo, a clinician trained by both Habib Davanloo and David Malan, underscores the element of the real relationship that pertains to a transparent and genuine presence. Osimo writes about the need to "take care of the real relationship" and urges therapists to "renounce hiding oneself behind the therapist role" (Osimo, 2012, p. 47). This sentiment mirrors Carl Rogers' statement during the renowned 'Gloria' interviews, where he expressed his desire for the patient to see him transparently, without pretense.

Our understanding of the real relationship also aligns with Ralph Greenson's definition, which emphasizes "genuineness and realism" (1967, p. 217), mirroring Osimo's emphasis on the therapist's transparent and authentic presence. Charles Gelso (2011), expanding on Greenson's ideas, describes the real relationship as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p. 12). All of these ideas together underscore the importance of authenticity and perceiving each other as they truly are—as free from distortions as possible.

This perspective aligns with Davanloo's emphasis on addressing and undermining "transference resistance" (1990), which involves distortions of the therapist's role due to unresolved emotional conflicts from past relational experiences. Transference can be conceived of as the "unreal relationship," while Davanloo's focus on emotional closeness between therapist and patient suggests that he considered realism essential for therapeutic progress. Davanloo emphasized the importance of a relatively undistorted connection between therapist and patient. His views on realism are evident when he writes about the conscious therapeutic alliance, emphasizing the patient's willingness to "tell the truth, even when it is painful" (1990, p. 2), and the therapist's commitment to understanding "exactly what the patient experiences" without accepting "evasions and half-truths" (p. 4). Davanloo elaborates:

> Undoing the omnipotence is closely linked with the deactivation of the transference. Many patients have a strong tendency to transfer to the therapist the role of someone from the past. The aim is to emphasize and bring the patient back into the reality of the task and to avoid getting involved in the patient's transference. As the therapist's major task is to mobilize the unconscious therapeutic alliance against the resistance, he must at all costs avoid getting into the position of implying that the purpose of the interview is for him to change the patient, rather than for the patient to change himself. The therapist's task is to avoid getting into the position of being omnipotent and a figure of the past. (2000, p. 238)

Davanloo's emphasis on realism reflects his belief that true healing emerges as the veil of distortion is lifted, allowing for an unfiltered, genuine emotional closeness between patient and therapist.

While aspiring to realism is critical, it is essential to acknowledge that such an approach carries inherent risks. For instance, the emphasis on being the sole bearer of "truth" may lead to unintended idealization of the therapist, positioning them as an infallible authority and thereby fostering arrogance or self-deception. The therapist must balance striving for objectivity with a recognition of their subjective limitations, ensuring they do not assume privileged access to an ultimate truth beyond their own perspective (Rogers, 1961, 1980; Stolorow et al., 2002). This balance is particularly important when attempting to deconstruct transference or move toward an authentic connection—what Davanloo referred to as "undoing omnipotence." This understanding ties into the real relationship: both the patient and therapist must be seen as autonomous individuals with their own perspectives, without one assuming superiority.

As we previously noted, the real relationship also involves recognizing that both the patient and therapist have the right to their own views and opinions. This respect for subjectivity ensures that the therapist does not fall into the trap of believing that they possess privileged access to the truth. Instead, they must maintain a balanced stance, inviting genuine dialogue. Irwin Hoffman (1992) argues that there are contexts where therapists should freely express their convictions,

even when they contrast with those of the patient: "Analysts can now 'speak their minds,' including expressing conviction about their points of view, even sometimes when they clash with those of their patients" (p. 287). In line with Hoffman's assertion, we propose that the real relationship does not require that the therapist agree with the patient but instead calls for thoughtful openness about differing views—always inviting differences of view, never demanding agreement. This is consistent with Rogers' (1959) emphasis on the therapist being congruent. Gelso's historical review of the concept elaborates that the real relationship includes "the authentic being of the analyst, his or her personality and behavior" (2011, p. 19). Davanloo demonstrates this element of genuineness in his transcripts, such as when he clarifies his position: "If you move to avoidance, we are not going to get there, and I hope that your decision is that we get there" (1990, p. 253). However, genuineness should not be conflated with indiscriminate self-disclosure. Gelso (2011) instead describes it as "controlled openness" (p. 39).

Regarding how a therapist can be genuine while remaining restrained in self-disclosure, we agree with Greenberg (2002) that this apparent contradiction can be resolved within the context of the therapeutic relationship—where the therapist's role is to prioritize the patient's best interests. For example, sharing that the therapist has also experienced anxiety or depression may not benefit the patient, and withholding such information does not diminish the therapist's genuineness if it is done in the patient's best interest.

The real relationship framework emphasizes the patient's autonomy—always regarding, supporting, and protecting it (Ryan et al., 2011). This stance allows for two separate minds to coexist, with neither being an extension of the other. The therapist, therefore, communicates messages such as: "I don't need you to be different from the way you are." The therapist might also express, "You may see things differently from me, and that is perfectly fine." Similarly, the therapist may recognize and accept, "You may not be as concerned about the things that concern me, or as encouraged by the things between us that encourage me. You may feel very differently than I." The therapist can share their perspective with curiosity: "Here is

"The real relationship framework emphasizes the patient's autonomy—always regarding, supporting, and protecting it"

how it looks to me, but what about you?" When faced with an impasse, the therapist might say, "I am not sure I can help you very much as long as you do X, but that doesn't obligate you to change. I am willing to sit here with you to see if something will shift in terms of the impasse we seem to find ourselves in." A critical component of these messages is that they must be demonstrated through the therapist's behavior rather than merely stated. Anyone can say these words, but what truly resonates with the patient is a therapist who embodies these attitudes through their way of being. All of these messages ultimately convey: "I don't need you to be an extension of me. There is room for you the way you are in our relationship. You are not required to agree with me or please me to have a relationship with me." When the patient experiences this kind of relationship, it communicates unconditional positive regard (Rogers, 1959) and indirectly undermines defensive compliance and defiance – and thus fosters genuine healing.

We are not aware of any writings by Davanloo that explicitly address the *real relationship*, but several of his transcripts and commentaries demonstrate an application of the concept. In "The Case of the Teeth-Grinding Woman" (1978), Davanloo highlights careful attention to the patient's life, a commitment to truly understanding the patient's internal frame of reference (Rogers, 1959), and sensitivity to themes around compromised autonomy. Davanloo demonstrates this through frequent reflections capturing the patient's essential message, open-ended questions seeking clarity and elaboration, and empathic responses when the patient describes mistreatment by her husband. For example, when the patient shares how her husband accuses her of starting arguments and upsetting everyone, Davanloo responds, "He says that?" (1978, p. 172), ensuring that he captures and empathizes with her experience. This type of empathic understanding and sensitivity to autonomy aligns with the real relationship and the person-centered therapeutic stance. Davanloo also implicitly addresses these ideas through his emphasis on "emotional closeness," undoing compliance/defiance, and undermining transference resistances (1990). This emphasis highlights his appreciation of the real relationship.

Thus, the real relationship—characterized by congruence, transparency, mutuality, therapist non-defensiveness, and equality—forms the foundation for effective therapeu-

tic work, and integrates values of both ISTDP and the PCA. This integration allows therapists to create a more empathetic, human connection while maintaining the structured approach necessary for addressing deep-rooted defenses, ultimately enhancing therapeutic effectiveness and fostering genuine emotional transformation. By balancing directive techniques with person-centered values, the therapist can ensure that interventions are delivered within an atmosphere of trust, safety, and genuine partnership. In doing so, this integrated approach supports the therapist's ability to maintain an emotionally close and realistic connection with the patient—allowing the patient to experience the therapeutic process not as a power struggle, but as a journey toward mutual understanding and personal growth. This alignment between ISTDP and PCA ensures that both emotional vulnerability and structured intervention are balanced, thereby enriching the therapeutic experience for both parties. Further exploration into how these two approaches can be practically combined could provide valuable insights for therapists seeking to balance directive interventions with a deeply person-centered ethos. Such a balanced approach not only honors the patient's autonomy but also empowers therapists to support profound change in a genuinely collaborative way.

Davanloo's Prizing, Tenderness, and the Role of Intuition

Davanloo often emphasized that the heart of his work in Intensive Short-Term Dynamic Psychotherapy (ISTDP) was the emotional connection and collaboration between patient and therapist (M. Skorman, personal communication, June 16, 2016). Jim Schubmehl, who trained with Davanloo for 35 years, also affirmed that Davanloo consistently stressed the importance of genuine affection and admiration for his patients in his oral teachings (personal communication, October 16, 2023). According to Skorman, Davanloo's teaching videos from the 1970s and 1980s clearly demonstrated this sense of collaboration and warmth, a sentiment we can confirm from our own viewing of some of these recorded sessions.

At times, Davanloo would show trainees video sessions, not to demonstrate specific techniques, but rather to assess whether the trainees could emotionally respond with tenderness and compassion for the patients. According to Skorman, Davanloo did this to ensure that trainees had the requisite emotional capacity, and to cultivate it further. It was a reminder that ISTDP is fundamentally about the therapeutic relationship and the emotions shared between therapist and patient, not solely about technique. In Skorman's view, it was crucial to Davanloo—and thus to ISTDP—that patients perceived the therapist's empathy and positive regard, closely aligning with Rogers' conditions for effective therapy, such as empathy, unconditional positive regard, and the patient's perception of these qualities (Rogers, 1959, p. 239). The respect, affection, and admiration that Davanloo felt for his patients essentially reflected what Rogers (1959) described as unconditional positive regard.

Although there are no explicit publications from Davanloo that address these views, they are demonstrated in his filmed sessions and during his training of therapists in his core supervision groups. He also conveyed these ideas indirectly through his published transcripts. As Skorman noted, "So much of the essence of Davanloo's work seems to have gotten lost—the admiration and affection part—it somehow got 'techniqued' away. The technique was secondary for Davanloo; it came from his intuition, which I think is an invitation to all of us to use our intuition" (M. Skorman, personal communication, June 16 , 2016).

Davanloo himself highlighted the role of intuition in his work: "I have worked out standard types of intervention adapted to each move on the patient's part. These interventions have often been reached intuitively" (1990, p. 3). According to Skorman, even when Davanloo employed challenging or confrontational methods, the genuine emotional connection with the patient was never lost; rather, it formed the foundation of the entire therapeutic endeavor (M. Skorman, personal communication, 2012–2021).

Even as late as 2015, Skorman recounted moments when Davanloo would make therapeutic decisions without fully understanding why. When Skorman asked about one of these interventions—"I see that that was the correct thing to do, but I don't understand why you did it"—Davanloo responded, "I don't know either. I can also see that that was the right intervention, but I don't know why I did it. It must have been my unconscious" (M. Skorman, personal communication, March 6, 2023). Thus, even toward the end of his career, Davanloo often operated intuitively, demonstrating that he was not rigidly attached to his techniques. If Davanloo himself was not attached to his techniques, it raises the question of why contemporary practitioners should be. Importantly, much of what is often referred to as intuition can be seen as the unconscious therapeutic alliance (UTA) reverberating in the therapist. Nat Kuhn writes about this phenomenon: "things that 'pop into' the therapist's head can often have great therapeutic significance and should not be ignored" (Nat Kuhn, 2014, p. 331).

Having discussed the concept of the real relationship and the role of intuition, it is important to note that while the real relationship is a crucial ingredient in therapeutic change, we do not believe that it is sufficient by itself. Instead, it is a prerequisite for the key therapeutic task of helping the patient confront and process what they have previously avoided. When discussing intuition, it is important to clarify that we are not advocating an "anything goes" approach that disregards the importance of reason and evidence-based practice.

Conclusion

Undertaking a complex psychotherapeutic approach such as ISTDP is often fraught with challenges. Because the therapist is the vehicle through which the psychotherapeutic treatment is delivered, the therapist's conflicts around emotional engagement add yet another layer of complexity. The therapist must navigate their own trauma history and unresolved issues while maintaining a focus on understanding the patient and acting in the patient's best interest. The therapist must tolerate uncertainty and complexity while constructively responding to patient behaviors that range from criticism, adoration, and hostility to sexual advances and disappointment.

To mitigate these vulnerabilities, ISTDP practitioners must place special emphasis on the elements that ensure that the model remains person-centered: genuineness, empathy, positive regard, the conscious therapeutic alliance, and meeting the patient where they are. It is essential to help patients differentiate the therapist from past authority figures and address any barriers to engagement in a compassionate, conversational, and collaborative manner, as Abbass (2015) emphasizes.

While some may find it paradoxical to call ISTDP "person-centered," we strive to practice and teach ISTDP in precisely this manner. We are not purists, though we value understanding the core elements of ISTDP, partially because that serves as a reference point for creative adaptations. Flexibility is only meaningful in relation to discipline and structure, and adaptations lose meaning without reference to the original technique or process that is being adapted. It is within this dynamic interplay between discipline and flexibility that true therapeutic artistry emerges—where steadfast principles serve as the canvas for creative adaptations. We encourage trainees to adapt ISTDP techniques in a way that integrates and resonates with their own therapeutic style. In our teaching and supervision, we have observed that encouraging an integrative approach—one that prioritizes the therapist and the patient relationship above a narrow fidelity to technique—anecdotally improves treatment outcomes, reduces therapeutic misalliances, and enhances therapist work satisfaction.

However, we want to be clear that embracing flexibility, integration, and adaptation does not equate to rejecting or devaluing traditionalism. Some therapists pursuing ISTDP training may prefer a more disciplined, traditional approach to ISTDP. A failure to accept clinicians with these preferences, or assuming that the more traditional stance necessarily involves idealization, would merely represent another form of rigidity. Such a viewpoint needlessly pits flexibility and adaptation against discipline and traditionalism.

We do not intend for this paper to inspire a separate movement called "Person-Centered ISTDP." Rather, we hope it prompts therapists to reflect on how to balance ISTDP technique with patient-centered principles. We have highlighted how an overemphasis on technique in ISTDP can have detrimental consequences, while a naïve person-centered approach may risk colluding with a patient's defenses or leave the dyad aimless without an effective focus. In such situations, a greater emphasis on a disciplined focus and the use of ISTDP techniques may be important. Ultimately, technique and person-centered principles should not be viewed as antithetical but as complementary.

Malan (1979) once said that what was wounded in relationship must be healed in relationship. Stripped to its essentials, psychotherapy is precisely that—two imperfect human beings working together to help the patient heal what was broken. If all goes well, the dyad will inevitably take wrong turns, find their way back, and eventually, as they work through the patient's initial complaints, both therapist and patient will grow and learn from the process. In this way, the technical intervention which can be so crucial to therapeutic success can only ever be at the behest of an overarching human relationship.

References

Abbass, A. (2015). *Reaching through resistance: Advanced psychotherapy techniques.* Kansas City, MO: Seven Leaves Press.

Abbass, A. (2021). *Intensive Short-Term Dynamic Psychotherapy: Methods, evidence, indications and limitations.* Tidsskrift for Norsk psykologforening, 58(10), 874-879.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Coughlin Della Selva, P. (2004). *Intensive Short-Term Dynamic Psychotherapy.* New York, NY: Routledge.

Coughlin, P. (2017). *Maximizing effectiveness in dynamic psychotherapy.* New York, NY: Routledge.

Coughlin, P. (2023). *Facilitating the process of working through in psychotherapy: Mastering the middle game.* New York, NY: Routledge.

Davanloo, H. (1978). *The case of the teeth-grinding woman.* In H. Davanloo (Ed.) Basic principles and techniques in short-term dynamic psychotherapy (pp. 171-187). Lanham, MD: Jason Aronson.

Davanloo, H. (1990). *Unlocking the unconscious: Selected papers of Habib Davanloo, MD.* West Sussex, England: John Wiley & Sons.

Davanloo, H. (2000). *Intensive Short-Term Dynamic Psychotherapy: Selected papers of Habib Davanloo, MD.* West Sussex, England: John Wiley & Sons.

Davanloo, H. (2005). *Intensive short-term dynamic psychotherapy.* In B. J. Sadock & V. A. Sadock (Eds.) Kaplan & Sadock's comprehensive textbook of psychiatry, Volume II (pp. 2628-2652). New York, NY: Lippincott Williams & Wilkins.

Elliott, R., Watson, J. C., Goldman,

R. N., & Greenberg, L. S. (2011). *Learning emotion-focused therapy: The process-experiential approach to change.* Washington, DC: American Psychological Association.

Ezriel, H. (1950). *A psychoanalytic approach to group treatment.* British Journal of Medical Psychology, 23(1-2), 59-74.

Flaaten, C. B. (2021). *One year with IST-DP: A message of concern.* Tidsskrift for Norsk psykologforening, 58(6), 510-512.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change.* New York, NY: Basic Books.

Frankl, V. (1967). *Psychotherapy and existentialism: Selected papers on Logotherapy.* New York, NY: Simon and Schuster.

Frederickson, J. (2013). *Co-creating change: Effective dynamic therapy techniques.* Kansas City, MO: Seven Leaves Press.

Freud, A. (1954). *The widening scope for indications for psychoanalysis.* Journal of the American Psychoanalytic Association, 2, 607–620.

Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change.* Washington, DC: American Psychological Association.

Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings.* Washington, DC: American Psychological Association.

Greenberg, L. (2011). *Emotion-focused therapy (Theories of Psychotherapy Series). Washington, DC: American Psychological Association.*

Greenberg, L., Rice, L., & Elliot, R. (1993). *Facilitating emotional change: The moment-by-moment process.* New York, NY: Guilford.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis, volume 1.* New York, NY: Routledge.

Gustafson, J. P. (1986). *The complex secret of brief psychotherapy.* Ontario, CA: Penguin Books.

Hickey, C. (2017). *Understanding Davanloo's Intensive Short-Term Dynamic Psychotherapy: A guide for clinicians.* London, England: Karnac.

Hoffman, I. Z. (1992). *Some practical implications of a social-constructivist view of the psychoanalytic situation.* Psychoanalytic Dialogues, 2(3), 287-304.

Kalpin, A. (1993). *The use of time in intensive short-term dynamic psychotherapy. International Journal of Short-Term Psychotherapy, 8, 75-91.*

Kirschenbaum, H. (2007). *The life and work of Carl Rogers. Herefordshire, UK: PCCS Books.*

Kirschenbaum, H. (2012). *What is "person-centered"? A posthumous conversation with Carl Rogers on the development of the person-centered approach.* Person-Centered and Experiential Psychotherapies, 11(1), 14-30.

Kuhn, N. (2014). *Intensive short-term dynamic psychotherapy: A reference.* North Charleston, SC: Experient Publications.

Lebeaux, D. J. (2000). *The role of the conscious therapeutic alliance in Davanloo's intensive short-term dynamic psychotherapy.* International Journal of Intensive Short-Term Dynamic Psychotherapy, 14(1), 39-48. https://doi.org/10.1002/

Mahoney, M. J. (2003). *Constructive psychotherapy: A practical guide.* New York, NY: Guildford.

Mahoney, M. J., & Marquis, A. (2002). *Integral constructivism and dynamic systems in psychotherapy processes.* Psychoanalytic Inquiry, 22(5), 794-813.

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics.* London, England: Butterworth.

Marquis, A. (2018). *Integral psychotherapy: A unifying approach.* New York, NY: Routledge.

McCullough Vaillant, L. (1997). *Changing character: Short-term anxiety-regulating psychotherapy for restructuring defenses, affects, and attachment.* New York, NY: Basic Books.

Menninger, K. (1958). *Theory of psychoanalytic technique.* Whitefish, MT: Kessinger.

Norcross, J. C., & Lambert, M. L. (Eds.). (2019). *Psychotherapy relationships that work: Vol.* 1: Evidence-based therapist contributions (3rd ed.). Oxford University Press.

Osimo, F. (2012). *The essence of experiential dynamic psychotherapies.* In F. Osimo & M. J. Stein (Eds.) Theory and practice of dynamic psychotherapy. New York, NY: Routledge.

Renik, O. (1993). *Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity.* The Psychoanalytic Quarterly, 62(4), 553-571.

Rogers, C. R. (1957). *The necessary and sufficient conditions of therapeutic personality change.* Journal of Consulting Psychology, 21, 95-103.

Rogers, C. R. (1959). *A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework.* In H. Kirschenbaum & V. L. Henderson (Eds.), The Carl Rogers Reader (pp. 236-263). New York, NY: Houghton Mifflin Company.

Rogers, C. R. (1961). *On becoming a person.* New York, NY: Houghton Mifflin Company.

Rogers, C. R. (1980). A way of being. New York, NY: Houghton Mifflin Company.

Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2011). *Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice.* The Counseling Psychologist, 39, 193-260.

Sadler, J. Z. (2005). *Values and psychiatric diagnosis.* New York, NY: Oxford University Press.

Safran, J. (1993). *The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual issues.* Journal of Psychotherapy Integration, 3(1), 33-49.

Schmitt, A. (2024). *Davanloo's psychotherapeutic techniques: Notes from Montreal: Fusion and Delusion.* German first edition. Agentur.

Stolorow, R. D., Atwood, G. E., & Orange, D. M. (2002). *Worlds of experience: Interweaving philosophical and clinical dimensions.* New York, NY: Basic Books.

Tursi, M. M., & Cochran, J. L. (2006). *Cognitive-behavioral tasks accomplished in a person-centered relational framework.* Journal of Counseling & Development, 84(4), 387–396.

Wachtel, P. L. (2008). *Relational theory and the practice of psychotherapy.* New York, NY: Guildford Press.

Wachtel, P. L. (1999). *Resistance as a problem for practice and theory.* Journal of Psychotherapy Integration, 9, 103-117.

Wachtel, P. L. (1993). *Therapeutic communication: Knowing what to say when.* New York, NY: Guilford Press.

Wachtel, P. L. (1982). *Resistance: Psychodynamic and behavioral approaches.* New York, NY: Plenum Press.

Wampold, B. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd ed.).* New York, NY: Routledge.

Andre Marquis

Andre Marquis is associate professor of Mental Health Counseling at the University of Rochester. He is a leading figure in Integral Psychotherapy and psychotherapy unification. Marquis is the author of four books, including Integral Psychotherapy: A Unifying Approach and dozens of scholarly articles. He was trained and supervised by Marvin Skorman from 2017 until Skorman's retirement in December of 2021. Marquis is a Licensed Mental Health Counselor in New York with a small private practice.

Johannes Kieding

Johannes is an LCSW from Tucson, Arizona, where he has a private practice. From 2012 to 2022 he was trained and supervised by Marvin Skorman, who was one of Dr. Davanloo's right-hand men in the late 1980s. Marvin encouraged Johannes to begin to teach in 2017, and since then Johannes has been teaching and supervising clinicians from all over the world. Johannes is also an adjunct faculty at the Rochester Institute of Technology, where he intermittently supervises their clinical staff.