

CHAPTER SEVENTEEN

EDT in the context of psychotherapy research and mental health policy in the UK

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Introduction

Anyone versed in psychotherapy research will wonder why we need another brand of therapy? Over thirty years of meta-analysis and comparative trials have pointed to equivalent outcomes for different models of therapy (Lambert & Ogles, 2004; Wampold, 2001). The Dodo bird's verdict from the Caucus race in *Alice in Wonderland* (Carroll, 1865)—that “Everyone has won and all must have prizes”—has long been declared in the context of the equivalent effectiveness of different therapy models (Luborsky, Singer & Luborsky, 1975; Rosenzweig, 1936; Wampold, 2001). True to the Dodo bird's pronouncement, the only comparative trial comparing an experiential dynamic therapy (EDT) with another non-psychodynamic model of therapy found equivalent outcomes between EDT and cognitive therapy (Svartberg, Stiles & Seltzer, 2004). In spite of recurrent evidence of the equivalent effectiveness of different psychotherapy models, there has been a prolific expansion of different brands of therapy, with in excess of 400 models of therapy in existence (Garfield & Bergin, 1994). This trend towards proliferation can be seen within the field of experiential dynamic therapies, where currently it is possible to distinguish derivatives of Davanloo's (1990) and Malan's (2001; Malan & Coughlin Della Selva, 2006) work, including Intensive Short-Term Dynamic Psychotherapy (ISTDP) (e.g., Coughlin Della Selva, 1996), Accelerated Experiential-Dynamic Psychotherapy (AEDP) (Fosha, 2000), Intensive Experiential-Dynamic Psychotherapy (IE-DP) (Osimo, 2009), and Short-Term Affect-Regulating Therapy (START) (McCullough Vaillant, 1997; McCullough et al., 2003).

Is this process of fragmentation necessary to the development of psychotherapy? Certainly in the United Kingdom, the development of evidence-based practice in the National Health Service (NHS) has largely confined itself to the validation of particular models of psychotherapy, found to be effective for treatment of particular diagnoses. This is enshrined in the Department

of Health's National Institute for Health and Clinical Excellence (NICE) guidelines. Further development along these lines would logically lead to the proliferation of new therapies each tailored to a specific diagnosis, a venture which is both practically and scientifically questionable (Westen, Novotny & Thompson-Brenner, 2004). However, in the broader field of psychotherapy research, another approach to the dissemination of evidence has begun to emerge. This latter approach consists of systematic attempts to summarise the current state of our knowledge of "principles of therapeutic change"—in other words, what psychotherapy research tells us, so far, about the therapeutic processes which contribute to positive outcomes in psychotherapy. These principles, derived from studies relating therapy "process" to therapeutic "outcome", may be operational to a greater or lesser extent in a range of therapeutic models (Castonguay & Beutler, 2006a), and for this reason have sometimes been referred to as "common factors". In this chapter, an attempt will be made to justify the entry of a further acronym into the psychotherapy world by arguing that EDT represents a promising integration of a number of therapeutic principles of this kind. Following this, there will be a review of empirical studies of the efficacy of EDT. The chapter will conclude with a brief outline of EDT within current mental health policy in the National Health Service in the UK.

For the purposes of this chapter, EDT will be defined broadly as short-term psychodynamic psychotherapy that draws mainly on Malan's (2001) theoretical framework and Davanloo's (1990) clinical methodology. It prioritises active engagement by therapist and client on manifestations of defence, anxiety, and underlying feeling as these occur in the here and now of the therapeutic relationship. The objective is to clear away the barriers to a "corrective emotional experience" (Alexander & French, 1946) in which both the client and the therapist are attuned to the client's previously avoided affective experience. This corrective emotional experience is assumed to enable the client to become more energised as a result of being in touch with underlying emotional experience or needs, more able to connect in an emotionally alive way (evoking appropriate responses from others and greater capacity for emotional intimacy), and to give up handicapping emotional defences.

Principles of therapeutic change in EDT and the evidence

The first decade of the twenty-first century yielded several systematic reviews of evidence-based "principles of therapeutic change" in psychotherapy (Castonguay & Beutler, 2006a; Norcross, 2002; Orlinsky, Rønnestad & Willutzki, 2004). Castonguay and Beutler assembled a working party of psychotherapy research experts, drawn from across the spectrum of theoretical models, to conduct what, to date, has been the most comprehensive review of the process-outcome research. Their goal was to cut across the different models of therapy in order to pinpoint evidence-based principles of therapeutic change. In their review, the working party distinguished between principles associated with the *technique*, the *therapeutic relationship* and the *participants* in therapy. Evidence will be presented relating to each of these three domains as it pertains to the practice of EDT.

Technique

EDT is of course characterised by a primary focus on affect as it manifests in the here and now of the therapy situation. Therapeutic strategies are directed at raising awareness of barriers

to adaptive affective experience (the Defence pole in Malan's Triangle of Conflict), evoking underlying adaptive affective experience (the Feeling pole in Malan's Triangle of Conflict), and regulating affective experience (by acting to reduce inhibitory emotions such as shame, guilt, or anxiety, associated with the Anxiety pole in Malan's Triangle of Conflict). In addition, therapeutic interventions aim to promote insight into the nature of emotional conflicts (the relationship between the three poles in the Triangle of Conflict), their relational origin, and current interpersonal contexts (Malan's Triangle of Person) (see Malan, 2001; Malan & Coughlin Della Selva, 2006).

While the theoretical basis of EDT remains rooted in Malan's (2001) psychodynamic framework, therapeutic strategies aimed at achieving these objectives can be drawn from or are congruent with the strategies of a variety of schools of psychotherapy (McCullough et al., 2003). In addition to traditional psychodynamic techniques (such as clarification, confrontation, and interpretation), recent versions of EDT (particularly as conceptualised by McCullough and colleagues) can encompass techniques shared with Gestalt therapy (interventions aimed at deepening emotional experiencing), behaviour therapy (graded exposure to feared affect), CBT (Socratic exploration of anxiety), mindfulness (awareness and acceptance of thoughts and feelings, developing self-compassion), and motivational enhancement therapy (motivational work on giving up maladaptive defensive strategies) (see table 1).

A distinctive aspect of EDT is the rigorous work on defences, and the focusing on emotional experiencing in body-and-mind, particularly as it manifests in the context of the therapeutic relationship. While psychodynamic and humanistic approaches have always emphasised the centrality of emotional experience, recent theoretical and clinical innovations in both cognitive and behavioural therapy have also begun to see emotional avoidance as central in maintaining psychopathology, and the achievement of new emotional experiences in therapy as key to recovery (see Ehrenreich, Buzzella & Barlow, 2007, for an example). In this review of the

Table 1. Examples of strategies drawn from various therapeutic models that contribute to achieving the psychodynamic aims of EDT.

<i>Edt strategy</i>	<i>Model</i>	<i>Examples of congruent principles of change</i>
Raising awareness of barriers to adaptive affective experience	CBT: motivational enhancement therapy Psychodynamic therapy	Motivational work on giving up maladaptive defensive behaviours Clarification, interpretation
Evoking underlying adaptive affective experience	Gestalt therapy CBT: mindfulness	Deepening emotional experience Awareness and acceptance of here and now experience
Regulating inhibitory affective experience	Behaviour therapy CBT CBT: mindfulness	Graded exposure to feared stimuli Socratic exploration of anxiety Developing self-compassion
Gaining insight into the interpersonal roots of emotional conflicts	Psychodynamic therapy	Interpretation

evidence on therapeutic technique, I shall highlight the evidence as it relates to focusing on affect as a key to therapeutic change.

Although there is little published research on process-outcome relationships in EDT, the approach appears congruent with evidence that techniques relating to the client's affective experience may be important mediators of therapeutic outcome (see Malan & Coughlin Della Selva, 2006). Orlinsky et al.'s (2004) review of process-outcome research highlighted the potency of "experiential confrontation" (affectively evocative techniques generally studied in the context of humanistic "process-experiential" therapy), as well as the strong evidence relating client openness (versus defensiveness) to therapy outcome. In the context of psychodynamic therapy, Diener, Hilsenroth, and Weinberger (2007) have conducted a meta-analysis of well-conducted studies examining psychodynamic therapists' focus on affect and concluded that "the more therapists facilitate the affective experience/expression of patients in psychodynamic therapy, the more patients exhibit positive changes" (p. 939).

One problem with research on affect in psychotherapy is that distinctions among different affective experiences (e.g., between activating and inhibitory emotions, McCullough et al., 2003) are often omitted, resulting in some confusion in this area (as noted by McCullough & Magill, 2009, and illustrated in some mixed findings in this area reviewed by Orlinsky et al., 2004). A small but intriguing body of process-outcome research in EDT, linked to two randomised controlled trials involving EDT (the Beth Israel Medical Center study, by Winston et al., 1991, and the Trondheim study, Svartberg et al., 2004), has used the "achievement of therapeutic objectives scale" (ATOS) (McCullough et al., 2008) to distinguish the relative proportions of "activating" (related to Malan's Feeling pole in the Triangle of Conflict), and "inhibitory" (relating to Malan's Anxiety pole in the Triangle of Conflict) emotions in psychotherapy sessions. This enables researchers to differentiate between the impact of work on regulating inhibitory affect and on activating underlying adaptive emotions. Findings to date are outlined in a recent chapter by McCullough and Magill (2009). In summary, process-outcome research by McCullough's group suggests that, while outcomes were equivalent between EDT and cognitive behavioural therapy (CBT) in Svartberg et al.'s study, this may have been achieved by different processes, with EDT appearing more successful in increasing the experience of adaptive activating affects, and CBT appearing more successful in helping clients decrease problematic inhibitory affects such as anxiety.

Returning to the broader research field, Castonguay and Beutler (2006b), summarising the main principles identified by their psychotherapy researcher panels, concluded that, with regard to emotion, existing research evidence supports the effectiveness of two principles of therapeutic change: (i) "Therapeutic change is likely if therapists help clients accept, tolerate, and at times, fully experience their emotions" (p. 364) while at the same time, (ii) "Interventions aimed at controlling emotions can [also] be helpful" (p. 365). EDT, with its fine distinctions between varieties of affective emotional experience, and its well-specified techniques aimed either at deepening adaptive affective experiences, regulating inhibitory emotional experiences, or addressing defences and blocks to emotional awareness and experience, provides a comprehensive theoretical and clinical resource for accomplishing the complex engagement with client emotional experience hinted at in Castonguay and Beutler's two principles. It may be that further process-outcome research will result in enhanced effectiveness of EDT techniques

and possible integration of strategies that work in both CBT and EDT. If so, it is likely that modifications to technique will not require reworking of the theoretical model in EDT, which, as noted above, suggests that “many roads can lead to Rome” or at least to the “achievement of therapeutic objectives” as described by Malan (2001).

The therapeutic relationship

Early formulations of EDT, for example, the work of Davanloo (1990), emphasised innovations in the technique of working with defences and emotion rather than the therapeutic relationship. However, it was assumed that challenge to defences could only be successful when there was an “unconscious therapeutic alliance” in which the client tacitly recognises that the therapist values the client and is on the side of liberation from destructive defences. Davanloo’s “graded approach” (Abbass & Bechard, 2007; Davanloo, 1990) emphasises a variety of means of regulating the client’s experience of anxiety, shame, and guilt in order to prevent negative therapeutic effects and, by implication, to maintain a positive therapeutic relationship. Some recent developments in EDT have highlighted the role of the therapeutic relationship in providing a corrective emotional experience that can resolve the emotional conflicts associated with problematic attachment relationships in the past. This has been most fully elaborated by McCullough Vaillant (1997) and Fosha (2000). These clinicians have emphasised techniques designed to increase the client’s capacity to receive the corrective emotional experience of the therapist’s positive feelings and, in so doing, challenge the client’s defences against emotional closeness and intimacy.

In a review of 2354 findings in process-outcome studies, Orlinsky, Grawe, and Parks (1994) concluded that “the strongest evidence linking process to outcome concerns the *therapeutic bond* or alliance, reflecting more than 1000 process-outcome findings” (p. 360; see also Orlinsky, Rønnestad & Willutzki, 2004). However, the actual size of the effect is relatively modest, suggesting, perhaps not surprisingly, that the therapeutic relationship accounts for a moderate amount of the effectiveness of psychotherapy, but other ingredients are important too (Horvath & Bedi, 2002). Following the series of expert reviews in Castonguay and Beutler (2006a), the authors concluded that there is evidence that a strong therapeutic alliance, a high level of collaboration, therapist empathy, caring, warmth, acceptance, and congruence are all likely to contribute towards positive outcomes in therapy (Castonguay & Beutler, 2006b).

Within the field of EDT there have been different views on the manner of confronting clients with their self-damaging defences and underlying feelings (McCullough & Kuhn, 2009). It is probably fair to say that Davanloo’s work may have failed to take root at an earlier date in the UK due to the perception that his approach lacked empathy towards the client, that is, this approach may have been perceived as lacking the relational qualities that have subsequently been demonstrated to lead to positive therapeutic outcome. Malan has since argued that Davanloo’s own personal style is not a necessary ingredient of the effectiveness of his approach, and has recently highlighted the degree to which EDT therapists after Davanloo have been able to achieve the same therapeutic objectives while adopting a more validating and empathic stance (see Malan & Coughlin Della Selva, 2006). However, there continue to be different shades of opinion within the EDT community as to the degree to which pressure

towards underlying feeling should ever be, as Davanloo (1990) put it, “unremitting”. Advocates of more “unremitting” pressure towards feeling have increasingly stressed the importance of very careful ongoing assessment of signs that the client may be overwhelmed, so that the focus can, when necessary, be redirected to regulating the client’s anxiety (Abbass & Bechard, 2007; ten Have de Labije, 2001, 2006). Others (e.g., Fosha, 2001; Lamagna, in press; Lamagna & Gleiser, 2007; McCullough Vaillant, 1997) have emphasised means of accessing underlying feeling which do not require the same level of interpersonal challenge and potential for ruptures in the therapeutic relationship. In particular, these latter writers have elaborated on ways of maximising the therapeutic impact of therapist empathy (Fosha, 2001; McCullough Vaillant, 1997), exploration of the emotional stances involved in client ambivalence (e.g., Lamagna, in press; Lamagna & Gleiser, 2007), and consideration of the strengths as well as the weaknesses of the client’s defensive strategies (McCullough Vaillant, 1997). Osimo (2003a) has likened these two broad approaches to the stances adopted by the Sun and the Wind in Aesop’s Fable of the *The Sun and the Wind*, although, in contrast to the spirit of the fable, he sees both approaches as valid and believes many styles are possible, with each therapist’s approach reflecting their own unique personality.

There is little evidence to assess the relative merits of the more “challenging” versus the more “validating” styles within EDT. One of the few randomised controlled trials involving an EDT compared Davanloo’s “anxiety-provoking” model of EDT with a more supportive psychodynamic approach (Winston et al., 1991; Winston et al., 1994). This study found no significant differences in outcome between the two different approaches. This would suggest that a more confrontational style neither adds to nor subtracts from the therapeutic effect. However, follow-up process research on this data, summarised recently by McCullough and Magill (2009) suggests that, contrary to the expectations of the researchers, “supportive, empathic, and clarifying methods generated more affect than did *confrontive* interventions” (p. 258, italics in the original). They describe previously unpublished work that examined “confrontations sustained over 1–9 minutes, hypothesising that it was the *continued confrontation* that would ‘break through’ the defences to underlying feeling” (p. 258). This work, they report, found that, in fact, “confrontation did not predict improvement”, while further research appeared to show that confrontation in general elicited more defensive behaviour, but confrontation “given along with a supportive or empathic statement by the therapist ... resulted in greater likelihood of expression of affect” (p. 259). McCullough and Magill do not advocate abandoning confrontation on the basis of these findings but rather stress ways of modulating confrontation (for example by working on increasing self-compassion) so that “when confrontations are given, they are not experienced as attacking” (p. 259). While further research in this area would clearly be desirable (see McCullough & Kuhn, 2009), the findings described by McCullough and Magill are in keeping with the broader conclusions of Castonguay and Beutler (2006b) regarding the importance of therapist empathy, caring, warmth, and acceptance.

Participants

It has been estimated that approximately 40 per cent of the variance in outcome in therapy is attributable to “client factors”, and events which happen outside therapy (Asay & Lambert,

1999). In this category, client level of psychological functioning is a very significant predictor of outcome. Castonguay and Beutler's (2006b) first participant "principle" is that "clients with a high level of impairment are less likely to benefit from therapy than those with a better level of functioning at pretreatment" (p. 355). Further related principles include the fact that clients diagnosed with personality disorders, clients with financial and occupational difficulties, and clients who have experienced significant interpersonal problems during their early development are all less likely to be able to benefit from psychotherapy (Castonguay & Beutler, 2006b).

Current UK mental health policy, manifest in NICE guidelines, takes a diagnosis-led view of what treatment is appropriate for an individual client. However, diagnostic categories are not reliable indicators of client level of functioning or prognosis (see Duncan, Miller & Sparks, 2004, for a review of this literature). In the current author's experience within the NHS, diagnosis-led NICE guidelines can result in confused and inappropriate expectations on the part of both clients and referrers when no account is taken of client level of psychological impairment. In routine clinical practice a more pragmatic approach is to tailor treatments to suit the client's level of functioning.

In EDT, Davanloo (1990) described a "spectrum of psychopathology". Based on patients' responses to invitations to explore here-and-now emotion within a "trial" clinical interview, an assessment of "character structure" is possible through consideration of the type of defences used, the level of dystonicity/syntonicity of defences and how unconscious anxiety is channelled and manifests within the body. This has informed ten Have-de Labije's (2001) "traffic light" framework for "taking the road to the unconscious". In other words, observable aspects of the patient's experience are used to inform the nature of the work so that an appropriate balance can be maintained between more supportive/cognitive and more challenging interventions. McCullough Vaillant (1997) has linked this aspect of EDT to the Axis V 'Level of Functioning' Scale of the Diagnostic and Statistical Manual (4th Edition) (American Psychiatric Association, 1994), and described a variety of means of "self and other restructuring" that may be required before clients who suffer with more severe psychological impairments can tolerate greater awareness of their affective experience. In this way, EDT has evolved mechanisms for adapting in significant ways to the needs of clients with varying degrees of psychological impairment.

In addition to the client's level of functioning, EDT also contains a focus on the client's motivation to change. This typically occurs when the client has recognised the self-destructive defences associated with their psychological problems, and the therapist either highlights the fact that it is only the client who can decide whether they will go on living with these defences, or explores with the client the consequences of maintaining and/or relinquishing them. To my knowledge, neither the motivational aspect of EDT nor the adaptations tailoring EDT for different levels of client functioning have been subjected to systematic research, although numerous individual case studies testify to their helpfulness for many clients (e.g., Davanloo, 1990; Malan & Coughlin Della Selva, 2006).

In summary, the EDT literature provides a clear description of different levels of functioning, and Davanloo and his followers have provided a useful blueprint for how to modify therapeutic techniques in order to tailor therapy to clients with various degrees of impairment.

Summary of evidence-based principles of change and EDT

In the preceding section it was suggested that the psychodynamic objectives associated with Malan's theoretical model provide a robust framework within which it is possible to integrate a variety of principles of therapeutic change drawn from other models of therapy, including emerging "evidence-based" principles of change. In this way the core theory of EDT provides a "meta-perspective" which can encompass a plurality of strategies for achieving the objectives of therapy. It was noted that the research literature suggests the helpfulness both of accessing and of regulating emotional experiences. It was suggested that EDT provides the clinician with a particularly rich and helpful set of distinctions between the varieties of different emotional experience and thus orients clinicians to respond flexibly to emotion, depending, for example, on where the affect is located on the Triangle of Conflict. With regard to the therapeutic relationship, while this stratum of the therapy has received hardly any attention in the small research literature on EDT (in contrast to the voluminous empirical literature on the therapeutic relationship in the broader field of psychotherapy research), the relationship has been given prominence by some EDT theorists, who have emphasised the capacity of the real relationship with the client to provide a corrective emotional and relational experience within therapy. Further empirical work in this area might enable EDT clinicians to gain greater consensus on handling risks to the therapeutic relationship posed by more affectively challenging interventions. Finally, I have outlined how EDT theorists have addressed the issue of the client's level of functioning, which research indicates is a robust predictor of therapeutic outcome. I have highlighted how different strands of EDT recommend important adaptations to the therapeutic approach in response to the client's characteristic defensive style and capacity to tolerate emotional exploration.

*Research on the effectiveness of EDT**A brief note on the orientation to evidence and transparency*

EDT was initially developed by Davanloo from study of videotapes of his own work, which enabled him to notice what appeared to be most effective. Further refinements to theory and practice have also taken place after the detailed examination of videotaped therapies (e.g., McCullough Vaillant, 1997), and training and dissemination of EDT has emphasised video-based supervision and video demonstrations of effective therapies by expert therapists. In addition to the focus on what actually happens in therapy via observation, Malan (e.g., Malan & Coughlin Della Selva, 2006; Malan & Osimo, 1992) pioneered the use of idiographically oriented follow-up interviews demonstrating the long-lasting effects of EDT.

More recently, a number of leading EDT therapists have worked hard on developing the evidence base for this form of therapy in more formal ways, most notably Allan Abbass and Leigh McCullough. In comparison to more traditional forms of psychodynamic therapy, the theoretical clarity and emphasis on observation in EDT lends itself relatively easily to research and, as we shall see below, it appears to have punched above its weight (in the sense of the number of practitioners of EDT in the UK) in a recent UK attempt to map the evidence-based "competencies" of psychodynamic therapy.

Current evidence base in EDT

I have reviewed how EDT encompasses therapeutic processes that have been shown to contribute to positive outcomes in the wider psychotherapy research literature. In this section, I aim to do a quick round-up of the major relevant studies of EDT, and place them in the context of the evidence for psychodynamic therapy more generally. An overview of the relevant studies is presented in table 2.

The first randomised controlled trial (RCT) of EDT is the Beth Israel Medical Center study of Winston et al. (1991). Study participants were thirty-two clients diagnosed with DSM-III (American Psychiatric Association, 1980) personality disorders (including compulsive, avoidant, dependent, passive-aggressive, histrionic, and mixed personality disorders, but excluding paranoid, schizoid, schizotypal, narcissistic, and borderline diagnoses). They were assigned either to short-term dynamic psychotherapy based on the work of Davanloo (the EDT condition) or to a less confrontational and more cognitive type of psychodynamic therapy known as brief adaptational therapy. The outcomes of each therapy following approximately forty sessions were compared with each other and with a waiting list control. The results demonstrated the effectiveness of both treatments relative to the control, however, (as we might expect from the “Dodo bird verdict” described above) the two treatment groups had similar outcomes. Winston et al. (1994) reported from the same study, with a larger sample of eighty-one clients, and arrived at the same conclusions. Hellerstein and colleagues reported on an entirely new data set collected as an extension of the same research project, this time comparing the Davanloo-based short-term dynamic psychotherapy with another psychodynamic model, brief supportive psychotherapy (Hellerstein et al., 1998). Once again, they found equivalence in the outcomes of the two types of treatment.

A second major psychotherapy research project, the Trondheim study of Svartberg et al. (2004), randomly allocated fifty patients to short-term dynamic psychotherapy or CBT. The short-term dynamic psychotherapy model used in the study was the “anxiety regulating” adaptation of Davanloo’s model developed by McCullough (1997). Therapists in the EDT condition received training from McCullough, and therapists in the CBT condition received training from well-known American schema-focused therapists, such as Jeffrey Young. As noted at the beginning of the chapter, this is the only RCT to compare an EDT with a non-psychodynamic model of therapy, and the study was carefully conducted with monitoring of adherence to each model. As noted above, the (perhaps by now) unsurprising conclusion of this RCT was that both models of therapy were effective, and that there were no significant differences between the two models.

More recently, Abbass, Sheldon, Gyra, and Kalpin (2008) conducted a study comparing Intensive Short-Term Dynamic Psychotherapy (ISTDP) with a pre-treatment control group. The clients were twenty-seven clients with personality disorders. The five therapists in the study were all experienced practitioners who had been trained by Davanloo. Abbass and colleagues reported significant improvement relative to the control condition, an 83 per cent reduction of personality disorder diagnoses, and 74 per cent of treated clients coming off psychotropic medication. In addition to this, the authors estimated cost effectiveness benefits in the form of reduced disability benefits and reduced costs of medicines that were noted to exceed three times

Table 2. Characteristics of four randomised controlled trials (RCTs) featuring an EDT.

<i>Study</i>	<i>Client sample</i>	<i>No. clients</i>	<i>Dropout</i>	<i>No. sessions</i>	<i>Therapists</i>
Winston et al. (1994)	DSM-III PD (excluding paranoid, schizoid, schizotypal, narcissistic, and BPD)	81	6 STDP 2 BAT (not included in n of 81) ns	40	13 STDP 11 BAT (STDP av 10 yrs experience)
Hellerstein et al. (1998)	DSM-III PD (pre-dominantly cluster C or Not Otherwise Specified)	49	10/25 STDP (40%) 7/24 BSP (29%) ns	30–40	23 STDP 11 BSP (STDP av 6.5 yrs experience)
Svartberg et al. (2004)	DSM-III-R Cluster C PD (other PD excluded)	50	1 dropout (was not included in n of 50)	40	Experienced full-time clinicians trained in each model for the study 8 STDP (av 6 yrs experience with this model) 6 CBT (av 4 yrs experience with this model)
Abbass et al. (2008)	DSM-IV PD	27		Av 28 (range 2–64)	5 therapists with a minimum of 5 yrs supervision with Davanloo

Abbreviations: STDP: short term dynamic psychotherapy; BAT: brief adaptational therapy; BSP: brief supportive psychotherapy; DSM: Diagnostic and Statistical Manual; PD: personality disorder; BPD: borderline personality disorder; SCL-90 GSI: Symptom Checklist (90 item) General Symptom

<i>Model of EDT</i>	<i>Comparison group</i>	<i>Measures</i>	<i>Follow-up</i>	<i>Outcome</i>
Davanloo STDP	Brief adaptational therapy (BAT) Waiting list control	SCL-90-R GSI Social Adjustment Scale Target complaint ratings	6 months— 4.5 years (av 1.5 yrs)	Equivalent outcomes between treatments Both effective Effectiveness maintained at follow-up
Davanloo STDP	Brief supportive psychotherapy (BSP)	SCL-90-R GSI IIP Target complaint ratings	Termination scores used in analysis. Follow-up means reported but no indication of length of follow-up	Equivalent outcomes between treatments Both effective (though STDP did not reach significance on IIP)
McCullough STDP	Schema focused CBT	SCL-90-R GSI IIP Millon Clinical Multiaxial Inventory	2 year follow-up	Equivalent outcomes between treatments Both effective Effectiveness maintained at follow-up (About 50% of STDP clients returned to general population functioning) Effect size for STDP in this study noted to be 3x higher than in Winston et al. 1994 study
Davanloo ISTDP (“graded technique”)	W/L control	BSI-GSI IIP GAF SCID-II PQ Medication Employment Disability costs	2 year follow-up	Major benefits of treatment on all outcomes (e.g., 83% reduction PD, 74% stopping meds) Effectiveness maintained at follow-up

Index; IIP: Inventory of Interpersonal Problems; GAF: Global Assessment of Functioning; SCID-PQ: Structured clinical interview for DSM disorders personality disorders questionnaire.

the cost of treatment by two year follow-up. Abbass and colleagues noted that the outcomes in this study were superior to those reported in the Beth Israel Medical Center study, and they speculate that this may be due to innovations in technique since Winston et al.'s (1991, 1994) work (specifically the development of Davanloo's "graded technique" for treatment of fragile patients), and the participation of more experienced therapists. In addition to randomised control trials, Abbass (2002) conducted a "naturalistic" study of eighty-nine consecutive patients treated by himself in private practice, demonstrating considerable effectiveness of his approach. Another naturalistic study by Abbass, Joffres, and Ogrodniczuk (2008) involving a consecutive sample of thirty patients showed significant improvement in client symptoms following trial therapies consisting of one long session and a single five week follow-up.

In summary, randomised controlled trials of EDT are comparatively few in number, and have all focused on personality disorders. Although both the Beth Israel Medical Center and Trondheim studies focused on DSM Cluster C personality disorders, the Abbass et al. (2008) study encompassed a broader range of personality disorders. Where studies have compared EDT with another therapy, in all cases, to date, the results have conformed to the "Dodo bird verdict" of equivalent effectiveness. These findings are consistent with findings from research into psychodynamic therapy in general. For example, Leichsenring, Rabung, and Leibing (2004) conducted a meta-analysis of psychodynamic therapy, focusing only on well-conducted RCTs of short-term psychodynamic therapy.¹ They found seventeen such studies, including the EDT studies of Winston et al. (1994), Hellerstein et al. (1998), and Svartberg et al. (2004)—the RCT by Abbass et al. (2008) had yet to be published. Leichsenring et al. concluded that psychodynamic therapy "yielded significant and large pretreatment-posttreatment effect sizes" (p. 1208), although no differences were found between short-term psychodynamic therapy and other forms of therapy. More recently short-term psychodynamic therapy has also been subjected to a systematic Cochrane review by Abbass, Hancock, Henderson, and Kisely (2006). Their review included twenty-three studies, including two EDT studies. They concluded that there was evidence that short-term psychodynamic therapy was a promising treatment with modest to moderate benefits, which were often sustained over time.

EDT and mental health policy in the UK

As we have seen, the evidence suggests that EDT is neither more nor less effective than any other bona fide therapy. However, neither EDT nor psychodynamic therapy in general has found itself well-positioned in the current implementation of evidence-based practice' in the NHS. In part, this is because comparatively few RCTs of psychodynamic therapy have been conducted—only seventeen methodologically sound studies in the Leichsenring et al. (2004) meta-analysis, for example. Thus, while those seventeen studies point to the general utility of psychodynamic approaches, they are spread thinly across the range of psychological disorders: for example, four RCTs of psychodynamic therapy for depression, and only one for anxiety disorders, compared with large numbers of RCTs examining the effectiveness of CBT for specific disorders.

The National Institute of Health and Clinical Excellence (NICE) guidelines, which are intended as a guide to the commissioning of evidence-based treatments, are diagnosis-based, meaning that they review the evidence of the effectiveness of treatments tailored to specific

disorders, based on RCTs of treatments of that specific disorder—an approach to the evidence on psychotherapy that has been questioned by a number of commentators, for example, Westen et al. (2004). The paucity of RCTs examining the effectiveness of psychodynamic therapy means that NICE guidelines make bleak reading for psychodynamic therapists working in the NHS. For example, the NICE (2005a) guideline for OCD states that “there is doubt as to whether it [psycho-analysis] has a place in mental health services” (p. 104). The guideline for PTSD states that “the review did not find support for any clinically important benefits of [psychodynamic] treatments” (NICE, 2005b, p. 70). The guideline for depression states that there is “C class evidence” (a low level of evidence) for psychodynamic therapy for depression, but only when it is co-morbid depression (NICE, 2004a). Although the NICE (2009) guideline for borderline personality disorder is more open to the potential usefulness of psychodynamic therapy, it states that the evidence is at an early level of development. In fact the only NICE guideline that seems to contain a positive endorsement for psychodynamic therapy is that for eating disorders (NICE, 2004b) which recommends “focal psychodynamic therapy” for anorexia.

In 2007 the UK government committed £173 million towards its “Improving Access to Psychological Therapies” (IAPT) programme, designed to enhance access to evidence-based psychological therapies in primary care. While the main emphasis has been on increasing access to CBT (for example, twenty-three centres have been commissioned to provide CBT training), there has been some acknowledgement that other therapies can be of value. The former health secretary, Alan Johnson, stated in 2008 that, although CBT “will remain at the core of the psychological therapies programme ... it will not do so at the exclusion of other equally valid [i.e., NICE approved] forms of therapy” (Johnson, 2008). Although there does not appear to have been parallel investment in non-CBT approaches to therapy, in 2008, a document (Lemma, Roth & Pilling, 2008) on “psychodynamic competencies” was published as part of IAPT based on an expert reference group’s review of psychodynamic approaches that have proved efficacious in RCTs,

Lemma et al. (2008) derived their competencies from the “manuals” of therapy used in RCTs. Because research trials monitor therapists’ adherence to the manuals, as they put it, “[T]his makes it possible to be reasonably confident that if the procedures set out in the manual are followed there should be better outcomes for clients” (p. 7). Although the RCTs used to derive the competencies are not listed in this document, the authors state that McCullough et al.’s (2003) book is one of a small number of “widely-cited texts” that were used in developing the guidelines “which explicate psychodynamic terminology and provide clear descriptions of how these concepts translate into clinical practice” (p. 8). Appendix B of the document lists thirteen manuals used in the compilation of the competencies (four of which are unpublished), including Osimo’s (2003b) published description of EDT. It therefore appears that, despite its relatively undeveloped potential within the UK, the efforts of those who have conducted research into EDT, and the clarity with which EDT has been explicated, have resulted in recognition that the EDT approach embodies important aspects of evidence-based “psychodynamic competencies”. It remains to be seen whether this translates into increased acceptance of EDT within the psychoanalytic community in the UK, particularly as, to date, EDT has adopted a very different model of training from more traditional psychodynamic therapies, emphasising video demonstrations, and micro-process video supervision, as compared to the more traditional

emphasis in psychodynamic training on the trainees' own psychotherapy, and supervision that does not emphasise direct observation and the learning of skills.

Conclusions

In this chapter an attempt has been made to spell out the key elements of EDT, linking them with evidence-based "principles of change" derived from process-outcome research, and examining the evidence base for EDT relative to other therapies and to psychodynamic therapy. A question posed at the beginning of the chapter concerned what value, if any, is added by introducing yet another brand of psychotherapy into the already teeming pot of branded therapies. The review of EDT's place relative to both the empirically derived principles of change, and evidence to date of its efficacy, suggest a number of strengths. Firstly, the theoretical basis of the model, as outlined originally by Malan (2001), is both clear and parsimonious. As a result it is relatively easy to define the objectives of therapy while being open to a variety of means of achieving those objectives. EDT is therefore an approach in which it is possible to be theoretically coherent while being technically creative or eclectic (e.g., responding to the preferences and needs of different clients), thereby maximising the therapeutic potential of different therapist-client dyads. An attempt was made early in the chapter to link a variety of evidence-based principles of change to the therapeutic objectives from an EDT point of view. Secondly, the specific techniques of EDT, deriving from the study of videotaped psychotherapy, are clear and specific. The variables of relevance to EDT are generally directly observable, as are the outcomes of specific techniques, and this lends itself to effective demonstration, training, and supervision of therapy skills. Thirdly, EDT's focus on affect is congruent with the evidence that successful outcome in therapy involves varieties of both emotional experience and emotional regulation. As we have seen, EDT provides us with a rich set of differentiations between different manifestations of affect (for example as underlying Feeling, inhibitory Anxiety, or affect used as Defence). Finally, as a result of its emphasis on observation and the clear specification of techniques, EDT lends itself to empirical scrutiny. In this respect, EDT has earned a place in the vanguard of psychodynamic therapy models that have embraced the challenge of research, and is comparatively well represented in the small canon of RCTs in psychodynamic therapy. The work summarised illustrates one recent trajectory through which psychodynamic theory has continued to develop and evolve vigorously from its origins in the nineteenth century, through the latter part of the twentieth and now into the twenty-first century.

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Note

1. Meta-analysis is a way of statistically combining the findings of a number of studies.

The considerations presented in this document have been developed by the WHO Department of Mental Health and Substance Use as a series of messages that can be used in communications to support mental and psychosocial well-being in different target groups during the outbreak. Arabic | French | Russian | Spanish. Other languages. Polish | Portuguese. WHO Team. WHO Headquarters (HQ), WHO Worldwide. Number of pages. The scope of mental health research during the COVID-19 pandemic and its aftermath. Br J Psychiatry. 2020; 217: 540-542. UN Policy brief: COVID-19 and the need for action on mental health. https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf. Date: May 13, 2020. Date accessed: December 9, 2020. Public health messages in the UK initially encouraged patients to avoid attending general practices and hospitals to help control the virus. WHO reported substantial disruptions to mental health services in 130 countries. 13. Follow the advice in the social distancing guidance and the guidance for households with possible COVID-19 infection. An easy read version of this guidance is also available. Information on dementia is available from Alzheimer's Research UK. You can also speak to a dementia specialist Admiral Nurse on Dementia UK's Helpline or 0800 888 6687. Experiencing grief or bereavement. Specific mental health support is available for NHS and social care workers and can be found on NHS People for NHS staff, and through the CARE workforce app for adult social care staff. The support includes wellbeing information and confidential listening from trained professionals in a number of areas, from coaching and bereavement care to mental health and welfare support. In the UK, guidelines from the National Institute of Health and Care Excellence (NICE) suggest treating mild PND with guided self-help and moderate to severe PND with a high intensity intervention including Cognitive-Behavioural Therapy (CBT; NICE, 2014). In primary care services in England, mild to moderate depression is typically treated in Improving Access to Psychological Therapy (IAPT) services following referral from a General Practitioner (GP) or via self-referral (Radhakrishnan et al.2013). In-depth understandings of service users' experiences are an important component of mental health research and intervention development (Levitt et al. As described in the Privacy Policy of the American Psychiatric Association (APA), this website & application utilize cookies. By closing this message, continuing the navigation or otherwise continuing to view the APA's websites & applications, you confirm that you understand and accept the terms of the APA's Privacy Policy, including the use of cookies. Read Our Privacy Policy. I agree. To help get the most out of psychotherapy, approach the therapy as a collaborative effort, be open and honest, and follow your agreed upon plan for treatment. Psychodynamic therapy is based on the idea that behavior and mental well-being are influenced by childhood experiences and inappropriate repetitive thoughts or feelings that are unconscious (outside of the person's awareness).