Psychotherapy

The Effectiveness of Accelerated Experiential Dynamic Psychotherapy (AEDP) in Private Practice Settings: A Transdiagnostic Study Conducted Within the Context of a Practice-Research Network

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Accelerated experiential dynamic psychotherapy (AEDP) is an integrative model of psychotherapy that brings together relational and experiential work, with the aim of not only alleviating suffering but also bringing about flourishing. The present study took place within a developing AEDP practice research network and examined outcomes for 62 self-referred adults treated using a 16-session format of AEDP treatment. Participants completed self-report measures before and following treatment. Measures assessed a variety of psychological problems, subjective distress, as well as aspects of positive psychological functioning. Treatment occurred in naturalistic independent practice outpatient settings in the United States, Canada, Israel, Japan, and Sweden. Large effect sizes ($d > 0.80$) were obtained for clinical problems and subjective distress. The majority of patients evidenced clinically reliable change according to Jacobson, Roberts, Berns, and McGlinchey's (1999) criteria. Effectiveness was further examined by dividing the sample into a clinical group with pervasive and severe problems and a subclinical group with fewer problems and mild severity. Within the clinical group, total and global scores on all measures improved significantly following treatment. Effect sizes were $d > 1.00$ for all scales. The subclinical group also demonstrated significant improvements, with effect sizes ranging from $d = 0.46$ to $d = 2.07$. These results provide initial empirical support for the effectiveness of AEDP as a model of therapy that can effect meaningful and significant improvements across a range of psychological symptoms.

Clinical Impact Statement
Question: This study examines the effectiveness of accelerated experiential dynamic psychotherapy (AEDP), a transdiagnostic treatment for psychological problems and positive psychological functioning in independent practice settings. Clinical researchers and practitioners partnered in the development of an AEDP practice research network (PRN) model. ***Findings:*** Findings support the use of AEDP for a range of presenting problems and symptoms. ***Meaning:*** Results support the clinical application of AEDP across a variety of psychological problems and functionings and ongoing research using a PRN model. ***Next Steps:*** Future research will continue AEDP PRN initiatives and partnerships in independent practice settings and will investigate maintenance of therapeutic gains over a 6- and 12-month follow-up period.

Keywords: treatment outcome, emotion, transdiagnostic, accelerated experiential dynamic psychotherapy (AEDP), practice research network

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Accelerated experiential dynamic psychotherapy (AEDP) is an integrative model of psychotherapy that brings together relational work, experiential techniques, and a focus on experientially working with the in-session experience of positive change (see metatherapeutic processing in the following text), with the aim of not only alleviating suffering but also enhancing functioning and bringing about positive flourishing (Fosha, 2000, 2017a; Fosha & Thoma, 2020; Russell, 2015). Drawing upon research in attachment, affective neuroscience, emotion theory, and positive psychology, AEDP navigates the complex interactions between positive and negative emotions toward psychological growth and adaptation (Fosha, Thoma, & Yeung, 2019). It has been clinically developed and elaborated over the past 2 decades and has come to be practiced by a growing number of practitioners worldwide, with therapists on six continents, including therapists and patients doing AEDP therapy in Arabic, Cantonese, Danish, English, Farsi, French, German, Greek, Hebrew, Italian, Japanese, Korean, Mandarin, Norwegian, Portuguese (as spoken in both Portugal and Brazil), Romanian, Spanish, Swedish, and Turkish. The AEDP Institute has trainings across the world offering experiential courses in AEDP principles and techniques and also has a formalized program for therapists wishing to be certified in AEDP and also a formalized program for certification as AEDP supervisors.

AEDP is transdiagnostic in its focus: The model targets a set of central psychopathological processes that are believed to underlie a variety of diagnoses and symptoms, such as depression, anxiety, and various maladaptive behaviors (Sauer-Zavala et al., 2017). These psychopathological processes center on early life attachment trauma and consequent disrupted capacity for emotional processing, including the avoidance of adaptive emotion (Fosha, 2003). AEDP reframes psychopathology as arising from the individual's unwilled and unwanted aloneness in the face of intense emotions, which then become too overwhelming to be regulated and processed and necessitate reliance on defenses, which are strategies instituted to avert overwhelming emotional experience. Symptoms represent the maladaptive consequences of inflexible defenses instituted to manage unbearable emotions in the absence of effective dyadic affect regulation by primary attachment figures. Accordingly, disorders such as depression, anxiety, and interpersonal problems are manifestations of common underlying difficulties in attachment, emotional regulation, and emotional processing and reflect reliance on emotional avoidance. Avoidance of adaptive emotion is seen as a key psychopathological process in other transdiagnostic treatments, such as the unified protocol for the transdiagnostic treatment of emotional disorders (Barlow et al., 2011). However, rather than rely primarily on structured, skills-based behavioral and cognitive strategies, which can be viewed as a top-down approach to working with emotion, AEDP, with its emphasis on moment-to-moment tracking and fostering of emergent emotional phenomena, works bottom up. This parallels other experiential and somatically focused therapies, such as emotion-focused therapy (Greenberg, 2015) and somatic experiencing (SE: Levine, 2008). AEDP adds to the experiential tradition a substantial focus on in-session relational work by explicitly focusing on processing the therapy relationship to rewire the internal working model, work through defenses, create emotional safety, and ultimately foster greater relational capacity.

In this way, AEDP is an experiential therapy that also remains rooted in developmentally informed relational psychoanalysis and short-term psychodynamic psychotherapies from which the approach originated (Fosha, 2000). However, AEDP differs from more traditional models of psychodynamic psychotherapy that emphasize the importance of transference interpretations to bring about insight into the ways in which the past intrudes upon the present (Levy & Scala, 2012). Instead, the focus on the therapy relationship in AEDP is aimed at creating and calling attention to here-and-now *corrective relational experiences*, thus using the therapy relationship less as a source of insight and more as a wellspring of healing new experience (Fosha, 2017b; Lipton & Fosha, 2011). Explicitly affirming and celebrating what is right and good about the patient rather than what is wrong is central to the practice of AEDP, as is authentic relating through therapist self-disclosure of immediate feelings instead of a more neutral stance for uncovering unconscious material.

In addition, unlike traditional psychoanalytic models (Gabbard, Litowitz, & Williams., 2012), AEDP does not seek to explore early life events to uncover conflicted emotions. Rather, AEDP takes a different approach: an experiential focus on deepening present-tense affect can automatically link to early experience, unlocking memories, child-based ego states, as well as a welling up of emotion that was disallowed at the time. Allowing and accepting the previously disallowed emotion becomes a healing experience, alleviating symptoms such as anxiety and hopelessness while also reducing the need for inflexible defenses and maladaptive coping strategies that avoid emotional experience. AEDP's aim is to help patients become better able to experience their emotions and reap their adaptive benefits.

AEDP further differs from other models of psychotherapy in that it does not end its therapeutic process once emotions are processed to their adaptive completion. There has been a growing interest in the field of psychotherapy to focus on more than reducing psychopathology and symptoms and to actively foster positive emotion, positive experiences, and what Keyes (2002) has called "flourishing" (see e.g., the recent special issue in this journal, Volume 57, Issue 3). AEDP and additional approaches such as acceptance and commitment therapy (ACT) can be considered fellow travelers in sharing the aim of moving beyond mere symptom reduction and helping patients move actively toward more meaningful living (Hayes, Strosahl, & Wilson, 2012). AEDP shares an interest with ACT in helping patients cultivate their personal values to bring greater clarity on how to live more meaningfully. However rather than dialogic examinations of values (Luoma, Hayes, & Walser, 2007), AEDP uses a technique called *metatherapeutic processing* to work with incipient positive emotion within session by focusing upon experiences of therapeutic change that have just taken place (Fosha, 2009; Fosha & Thoma, 2020). In AEDP, the experience of change is itself considered to be a mechanism of change. Emotions such as pride, joy, serenity, delight, gratitude, and compassion for self and others frequently arise as patients notice and savor their here-and-now experience of healing (Iwakabe & Conceição, 2016). These positive emotions, called "transformational affects" in AEDP, bring with them clarity in values and priorities as well as the motivation to pursue meaningful actions. These positive emotions can themselves become the object of further metatherapeutic processing, forming an upward spiral that broadens patients' mindset, increases resilience, and builds their inner resources and capacities (Fosha & Thoma, 2020; also cf. Fredrickson, 2013; Iwakabe &

Conceição, 2016). The bottom-up, experiential technique of meta-therapeutic processing (or sometimes simply "metaprocessing" for short in the AEDP literature) is also what distinguishes AEDP's work with positive emotion from positive psychology and positive psychotherapy, which mainly use top-down, structured induction exercises to bring about positive emotion (Seligman, Rashid, & Parks, 2006). For clinical examples of AEDP, including transcript material demonstrating the use of metaprocessing, see the case studies in Fosha (2004, 2009) and Fosha & Thoma (2020).

Thus, AEDP is an integrative psychotherapy that brings together many principles and elements of interest to the field in a unique way. It has also generated considerable enthusiasm among its growing base of practitioners worldwide. However, empirical investigations of AEDP have only just begun. Several systematic case studies have been conducted (Gonzalez, 2018; Markin, McCarthy, Fuhrmann, Yeung, & Gleiser, 2018). Qualitative research has used task analysis to describe the stages of metaprocessing and the way metaprocessing can be used to broaden and build positive emotion within session (Iwakabe & Conceição, 2016). A randomized controlled trial of an Internet-based psychotherapy for anxiety and depression based on AEDP principles showed moderate-to-large effects (Johansson et al., 2013) and a similar Internet-based trial targeting social anxiety disorder showed large effects (Johansson et al., 2017). However, a direct test of the efficacy or effectiveness of AEDP had as yet not been conducted. The present study was aimed at testing the effectiveness of AEDP.

Bridging Practice and Research

We decided that testing outcomes within the natural environment of independent practice settings was an ecologically valid approach to assessing AEDP treatment within the context in which it was developed and is currently practiced. To do so, we developed a practice research network (PRN; Castonguay, Barkham, Lutz, & McAleavy, 2013). Setting up a PRN was also a way to establish an enduring connection between practice and research among AEDP therapists and a culture of researcher–practitioner partnership (Castonguay et al., 2013). We sought to assess the effectiveness of AEDP within a transdiagnostic research context, working with patients who self-referred with a wide variety of problems and symptom profiles rather than restricting our assessment to pure-form DSM diagnoses, which some have argued are not as generalizable to real-world practice (Westen, Novotny, & Thompson-Brenner, 2004). Because of the transdiagnostic nature of this study, we used outcome measures that tapped a wide range of psychological problem areas, including depression, anxiety, emotional avoidance, emotional dysregulation, and interpersonal problems along with positive indicators of mental health including self-compassion and self-esteem that were relevant to assessing the effectiveness of AEDP in a comprehensive manner (Barkham, Lutz, Lambert, & Saxon, 2017; Cuijpers, 2019).

We hypothesized, first, that AEDP is an effective model of treatment, achieving clinically significant improvement on patients' general psychological symptoms, depression, and subjective distress with a large effect size. Second, we hypothesized that experiential avoidance will improve, that is, lessen, at a similar magnitude, as enhancing patients' emotional functioning through helping them become increasingly able to experience their adaptive emotions is one of the key components of AEDP. We predicted that interpersonal relationships, though not a primary focus of AEDP treatment, would be improved as a result of AEDP's positive affirming therapeutic relationship and explicit relational work. Furthermore, positive psychological functioning such as self-compassion and a sense of well-being will improve to a similar extent with AEDP's emphasis on enhancing positivity via metatherapeutic processing in addition to alleviating psychological distress. In sum, we hypothesized that a large effect size will be obtained for all outcome scales.

For feasibility as well as greater comparability with outcome studies of other psychotherapy models, we modified the treatment duration to be standardized at 16 sessions. In practice, AEDP treatment duration is determined by collaboration between therapist and patient, and can range from very short-term to longer term work. However, the AEDP model needed relatively little modification to fit the time-limited format due to the AEDP ethos of "healing from the get-go" (Fosha, 2017a). That is, AEDP applies the same principles and techniques throughout the treatment, including from the first moments of the first session, relying on therapist responsiveness to the patient's needs and emotional capacities at any given time, seeking to maximize the possibilities of positive change at each moment, calibrating the work to the patient's present-tense level of functioning. The work focuses on enhancing glimmers of positive affect, facilitating deep emotional experiencing, dyadically regulating dysregulated emotions, or working through entrenched defenses that protect more vulnerable parts of the self, depending on what emerges from the patient. For clinical examples of working with patients of varying degrees of difficulty, see the studies by Vigoda Gonzalez (2018) for work with a patient with major depression, Fried (2018) for work with a psychotic patient, and Piliero (2020) for work with a patient with complex posttraumatic stress disorder (PTSD). The main way in which the treatment was modified to fit the fixed number of sessions offered for the purposes of this study centered on integrating Mann's (1973) principle of calling attention to the finiteness of the treatment from the start of treatment and maintaining awareness of this finiteness throughout, making this awareness an integral and active part of the treatment (Harrison, 2020).

Method

Patients

The AEDP PRN is an ongoing research program. For this study, we used the initial data, gathered between June 2016 and November 2019. Patients were 62 (20 men and 42 women) self-referred adults who completed the 16-session AEDP treatment in independent practice settings. Demographic information is shown in Table 1. The patients ranged in age from 22 to 72 years ($M = 36.8$, $SD = 13.52$). Prospective patients contacted AEDP therapists in independent practice requesting services for common psychological difficulties, such as depression, anxiety, and interpersonal difficulties. Individuals involved in another treatment, or who started or withdrew from medication within 3 months of participation in the study, were excluded to control for confounding effects. Additional exclusion criteria included the following: (a) active suicidality; (b) addiction and substance abuse; (c) psychosis and severe impulse disorders; (d) prior dissociative identity disorder (DID), bipolar disorder, or moderate to severe autism spectrum diagnosis;

Table 1

Patient Characteristics at Pretreatment Baseline

Variable	N (%) Total	N (%) Clinical	N (%) Subclinical
N	62	39	23
Gender			
Female	42 (67.74%)	26 (66.67%)	16 (69.57%)
Male	20 (32.26%)	13 (33.33%)	7 (30.43%)
Age *M* (*SD*/range)	36.81 (11.87/22–72)	34.49 (9.64/22–65)	40.74 (14.31/22–72)
Self-identified ethnic or cultural background			
White	45 (72.58%)	25 (64.10%)	20 (86.96%)
BIPOC	14 (22.58%)	12 (30.77%)	2 (8.70%)
No response	3 (4.84%)	2 (5.13%)	1 (4.35%)
Highest level of education			
Primary school completed	1 (1.61%)	0 (0.00%)	1 (4.35%)
Secondary/high school completed	7 (11.29%)	5 (12.82%)	2 (8.70%)
College/university completed	33 (53.23%)	23 (58.97%)	10 (43.48%)
Postgraduate degree	21 (33.87%)	11 (28.21%)	10 (43.48%)
Primary work status			
Employed	52 (83.87%)	32 (82.05%)	20 (86.96%)
Student	7 (11.29%)	5 (12.82%)	2 (8.70%)
Homemaker	2 (3.23%)	2 (5.13%)	0 (0.00%)
Unemployed	1 (1.61%)	0 (0.00%)	1 (4.35%)
Marital status			
Married/common law	27 (43.55%)	15 (38.46%)	12 (52.17%)
Single	28 (45.16%)	20 (51.28%)	8 (34.78%)
Divorced or separated	4 (6.45%)	3 (7.69%)	1 (4.35%)
Other	3 (4.84%)	1 (2.56%)	2 (8.70%)

Note. BIPOC = Black, Indigenous, and People of Color includes people who self-identified as Lantinx, Black, Asian, Middle Eastern, Israeli, or multiracial.

and (e) a current crisis situation requiring immediate crisis intervention (e.g., intimate partner violence). Severe impulse disorders were excluded because of the strong possibility that such problems would be better addressed by a behaviorally oriented treatment and the possibility that strong emotions experienced in sessions may be acted out. Moderate-to-severe autism spectrum diagnosis was excluded due to uncertainty whether such persons, who are often highly concrete and emotionally constricted, would make good use of this emotionally focused treatment. DID, and bipolar disorder were excluded due to concerns that short-term treatment would not be sufficient for such diagnoses and ethical concerns led us to refer such patient to longer term treatment. Inclusion criteria included a level of distress as measured by the Target Complaint (Battle, Imber, Hoehn-Saric, Nash, & Frank, 1966) score, for the main presenting issue, of at least 6 or 7 (*very much*) on a 15-point Likert scale. One year into the research project, we decided to also screen out those patients who had two or less problems that reached 1 *SD* of elevation from the normal population mean on a total of 16 clinical scales. The decision was made to make the reduced-fee therapy available for those who needed it most and also to further ensure that we were testing the model on those with clinical levels of problems. Those who did not meet our criteria were given referrals to other appropriate professionals. All therapy sessions were conducted in English. All patients and therapists were fluent in English, though in some cases, English was not their first language.

Measures

In keeping with recent calls for comprehensive examination of therapeutic outcome (Barkham et al., 2017; Cuijpers, 2019), we included measures that were associated with four different outcome targets: a subjective measure of distress and change; measures of psychological symptoms (e.g., Beck Depression Inventory [BDI], Symptom Assessment-45 [SA-45]), measures of positive mental health, and measures of subjective well-being, as well as secondary measures associated with the change mechanisms of AEDP.

Subjective measure of distress. Target Complaints (TC; Battle et al., 1966) is used to assess main problems and the level of associated subjective distress as experienced by patients. They were asked to write down three issues they would like to see change as a result of therapy. They were then asked to rate each of the three problems on a 12-point distress scale (ranging from 1 [*not at all*] to 12 [*couldn't be worse*]) in terms of how distressing the problem. The TC was administered pretreatment. Posttreatment, the same three complaints initially identified were given and patients rated the current intensity of distress of each of the three problems. Battle et al. (1966) reported good test–retest reliability as well as high correlations of the TC with other outcome measures.

Measures of psychological symptoms. BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a self-report measure of depression, widely used in psychotherapy outcome research. The BDI is shown to be highly correlated with other self-reported measures of depression as well as clinicians' ratings of depression. The coefficient alpha in the present sample was .91.

SA-45 (Davison et al., 1997) is a shorter version of the Symptom Checklist-90 (Derogatis, Rickels, & Rock, 1976) a widely used measure of different symptoms. The SA-45 consists of 10 symptom indexes: nine 5-item scales assessing each of the same

symptom domains as the Symptom Checklist-90 and a Global Severity Index, calculated by summing the scores of nine subscales. For the present sample, coefficient alpha for Global Severity Index (GSI) was .94, and for subscales, it ranged between .63 (Psychoticism) and .95 (Depression).

Inventory of Interpersonal Problems-32 (IIP-32; Barkham, Hardy, & Startup, 1996), a 32-item measure, assesses the severity of problems in interpersonal functioning (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988). All items are answered using a 5-point scale, ranging from 0 to 4. The original IIP includes 127 items tapping into eight dimensions of interpersonal functioning. The shorter version was developed to allow for greater convenience in administration in clinical practice and research. Barkham et al. (1996) concluded that hardly any of the psychometric properties of this short version were inferior to a full 127-item scale. The coefficient alpha in the present sample in this scale was .91.

Automatic Thought Questionnaire (ATQ; Hollon & Kendall, 1980), a 30-item instrument, measures the frequency of automatic negative statements about the self. The five subscales include the following: Demoralization, Self-Criticism, Brooding, Amotivation, and Interpersonal Disappointment. The ATQ demonstrates excellent internal consistency with a coefficient alpha of .97. In this sample, we used a full-scale score with a coefficient alpha of .97.

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004), a 41-item self-report measure, was designed to assess clinically relevant difficulties in emotion regulation. It is rated on a 5-point Likert scale. The four subscales include the following: awareness and understanding of emotions, acceptance of emotions, the ability to engage in goal-directed behavior when experiencing negative emotions, and access to emotion regulation strategies. In the present sample, the full-scale coefficient alpha was .95.

Acceptance and Action Questionnaire (AAQ-II; Hayes et al., 2004), a nine-item self-report scale, measures experiential avoidance, a tendency to avoid unwanted internal experiences. It is significantly related to the tendency to suppress emotionally relevant thoughts and feelings. Items are rated on a 7-point Likert scale. The coefficient alpha in the present sample was .90.

Measures of positive mental health. Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), a 10-item scale, is one of the most widely used scales for measuring global self-esteem. Items include both positive and negative feelings about the self and are answered using a 4-point Likert scale. The coefficient alpha for the present sample was .91.

Self-Compassion Scale (SCS; Neff, 2003) consists of 26 items that measure the ability to hold one's suffering within a sense of warmth, connection, and concern in situations of a perceived difficulty. Items are rated on a 5-point Likert-type scale. The six subscales are Self-Kindness, Common Humanity, Mindfulness, Over-Identification, Isolation, and Self-Judgment. The coefficient alpha for the full scale was .91 in the present sample.

Measure of well-being. Mental Health Continuum–Short Form (MHC-SF: Keyes, 1998) consists of 15 items that each measure dimensions of subjective sense of psychological wellbeing. Items are rated on a 7-point Likert scale. The scale was used to measure the psychological wellness of patients by categorizing into three levels: languishing, moderately mentally healthy, and flourishing. The coefficient alpha in the present sample was .92.

Table 2
Therapist Characteristics at Pretreatment Baseline

Variable	N (%)
Gender	
Female	26 (74.29%)
Male	9 (25.71%)
Age M (SD)	55.97 (9.06/35–70)
Experience M (SD/range)	20.83 (11.14/1–44)
AEDP experience M (SD/range)	4.54 (4.85/0–15)
AEDP	
Faculty member	10 (28.57%)
Supervisor	9 (25.71%)
Certified therapist	10 (28.57%)
Recommended as study therapist by AEDP supervisor	6 (17.14%)
Ethnicity	
White	31 (88.57%)
BIPOC	4 (11.43%)
Degree	
PhD/PsyD	12 (34.29%)
MSW	12 (34.29%)
MA/MFT	8 (22.86%)
Other	3 (8.57%)
Number of patients	
One patient	18 (51.43%)
Two patients	10 (28.57%)
Three patients	4 (11.43%)
Four patients	3 (8.57%)

Note. AEDP = accelerated experiential dynamic psychotherapy; BIPOC = Black, Indigenous, and People of Color includes people who self-identified as Lantinx, Black, Asian, Middle Eastern, Israeli, or multiracial.

Treatment

Therapists. Thirty-five therapists participated in this study (Table 2). All therapists but one (who was a psychiatrist) held a minimum of master's or doctoral level degree in clinical or counseling psychology or social work. All participating therapists received extensive prior training in AEDP. A majority of therapists (n = 29, 82.86%) were trained at a certified level or higher, which entails 120 to 200 hr of seminar-based training that includes didactics, extensive session video analysis, experiential practice, plus extensive (a minimum of 40 hr) individual supervision of video-taped sessions. Six therapists (17.14%) who received an intermediate level of training but who were not certified were invited to participate based on the recommendation of supervisors who had viewed the therapists' previous clinical work and judged it to demonstrate substantial mastery of AEDP skills. Among the 35 therapists, 18 therapists had one case, whereas 17 had multiple cases: Of those 17, 10 therapists had two cases, four therapists had three cases, and three therapists had four cases.

All study therapists participated in a 2-hr online-training session outlining AEDP interventions according to the modified 16-session treatment protocol. In addition, therapists received two individual supervision sessions with a faculty member of the AEDP Institute for each case in the study they treated. There was also a weekly drop-in supervision group coled by two AEDP Institute faculty members that participating therapists were encouraged to attend as often as possible. All therapy sessions were videotaped. Both individual and group supervision were based on direct viewing of segments of videotaped sessions. Supervisors

viewing the video segments closely monitored interventions in accordance with AEDP principles.

Intervention protocol. AEDP treatment in this study consisted of sixteen 1-hr sessions. According to AEDP principles and training, therapists were instructed to use the AEDP framework actively and to work to optimize the therapeutic relationship to provide safety, "undo aloneness" and facilitate patients' emotional processing according to AEDP's four-state model of change (Fosha, 2009, 2018). Therapist intervention strategies included the following (Fosha, 2000; Prenn & Fosha, 2017): (a) focusing on and working with glimmers of healing from the get-go, (b) restructuring strategies to work with patient defenses against emotional experiencing, (c) dyadic affect regulation and other relational strategies aimed at building relational capacities, (d) experiential-affective strategies to work with patient painful emotions, and (e) metatherapeutic processing strategies to work with and enhance the emerging positive affective experiences. To navigate which of the five strategies to focus on at any given moment, the therapists used the four-state map that articulates the phenomenology of the transformational process as a road map to guide moment-to-moment decision making for interventions within the AEDP therapeutic process (Fosha, 2017a, 2018; Fosha et al., 2019). Although AEDP therapists usually do not determine the number of sessions prior to the beginning of treatment, we decided to limit the number of sessions to 16, which is a typical length of therapy in many outcome studies for depression and other anxiety disorders.

Procedure

Prospective patients were self-referred individuals. Participating therapists explained the nature of the study and invited prospective patients to visit a website that provided detailed information about the study. Subsequently, if they were interested, prospective patients were asked to fill out the pretreatment questionnaires on the website. Patients who met the inclusion/exclusion criteria were invited to participate in the study. All those who were invited to participate did so. When it was ascertained that the prospective patients understood their role in the study, a written informed consent was reviewed by the patient and signed. Patients received a significant fee reduction to offset the additional time required to participate in the study protocol, such as filling out assessments and postsession forms. Institutional review board approval from Shigeru Iwakabe's institutional affiliation (Ochanomizu University, Japan) was obtained before conducting the study and also when any changes were made in the procedures.

Within a week of the completion of the 16 sessions, patients were asked to fill out the posttreatment questionnaires and measures. All patients, except two, attended 16 sessions. Two patients were given three extra sessions because their treatment was disrupted by life events. The decision to add three sessions followed a discussion between the therapist and their patient and the therapist's consultation with the research team. It was determined that three extra sessions were necessary to fulfill clinical and ethical responsibilities. Analyses were conducted to control for this variation in treatment length to ensure that inclusion of these patients did not significantly impact the outcome findings.

Results

Sixty-nine patients started the treatment, and 62 completed the treatment. Seven patients dropped out of the study (Sessions 2 to 12). The dropout rate in this study (10.15%) is lower than the average rate (20%) reported in a recent meta-analysis (Swift, Greenberg, Tompkins, & Parkin, 2017). The patients who dropped out were contacted to ask about their reasons for discontinuation and to assess potential distress and risks. Reasons for dropout included the patient's feeling that the treatment did not directly address their needs and therapist-patient mismatch in terms of style. The six therapists of those dropout cases (one therapist had two dropout cases) had significantly less experience in AEDP (average years of AEDP experience for therapists with study dropouts = 1.17 SD = 1.33) than other therapists (3.65, SD = 3.24; F = 5.123, $p < .05$), though their overall clinical experience did not differ significantly, F = .006, $p > .94$.

Table 3 presents the pre- and posttreatment means and standard deviations and pre–post Cohen's d. Large effect sizes were obtained for most scales: TC, SA-45, BDI, ATQ, SCS, and AAQ-II. For IIP-32, RSES, and DERS, the effect sizes approached a large effect size ($d > .74$). Therefore, our hypotheses about the effectiveness of AEDP and effect sizes were mostly supported.

Target complaints had missing data because patients listed target complaints at the end of treatment that did not match the target complaints they had listed at pretreatment. Out of a total of 62 patients, there were 27 (43.5%) patients whose first target complaint did not match at pre- and posttreatment, 34 (54.8%) whose second target complaint did not match, and 37 (59.6%) whose third target complaint did not match.

Table 4 provides the proportions of patients who reached reliable change posttreatment according to the updated criteria of Jacobson et al. (1999): patients who moved into a functional distribution, patients who achieved clinically significant change (patients who achieved both reliable change and movement into a functional range), and patients who significantly deteriorated. In our calculations, we used cutoff b, which is achieved when the level of functioning falls within 2 SD from the normal population. We adopted this cutoff as our sample included some patients whose pretreatment scores were not elevated into a clinical range. A series of paired t tests were conducted using the Holm-Bonferroni correction, setting the initial Type I error rate at .005.

The reliable change was calculated using Speer's (1992) method that controls the effect of regression toward the mean by the use of test-rest reliability instead of Cronbach's α for its estimation. We used this more stringent method as our study did not have a control group. The proportion of the patients who achieved the reliable change criterion varied from scale to scale: The highest proportion of patients with reliable change achieved was found with GSI (74.2%), whereas on the IIP-32 it was 19.4% of patients. On most other scales around 50% of patients achieved reliable change. The majority of patients achieved the cutoff for movement into a functional distribution. The proportion of patients who achieved both reliable change and movement into a functional distribution exceeds 50% with the exception of IIP-32. The lower proportion of patients achieving clinically significant change on the IIP-32 is partly owing to the low test–retest reliability of this scale ($r = .78$).

Deterioration was observed on all scales except on SA-45, with between one to five individuals on each scale: AAQ-II

Table 3

Pretreatment Baseline, Posttreatment Outcome, Improvement (Paired t Test), and Effect Sizes (Cohen's d) for All Outcome Measures for All Patients

		Pop			Pre		Post		Pre–Post t test		
Measure	α	M	SD	N	M	SD	M	SD	T	p	ES
TC1				35	8.23	1.50	5.83	2.58	4.148	.000*	−1.60
TC2				28	7.89	1.81	6.00	3.21	3.085	.005	−1.04
TC3				25	7.36	1.75	5.36	2.25	3.333	.003*	−1.14
GSI	.95	60.30[a]	18.00	62	48.98	24.08	24.15	17.66	10.195	.000*	−1.03
BDI	.91	7.28[b]	6.89	62	17.94	8.45	8.06	6.28	9.095	.000*	−1.17
ATQ	.97	48.57[c]	10.89	62	70.55	24.16	50.08	19.51	8.185	.000*	−0.85
IIP-32	.91	50.00[d]	10.00	62	59.34	9.02	52.44	9.11	6.305	.000*	−0.77
RSES	.90	22.62[e]	5.80	62	16.29	5.02	19.98	5.14	−6.565	.000*	0.74
DERS	.95	77.99[f]	20.72	62	94.39	23.05	77.35	21.20	6.361	.000*	−0.74
SCS	.95	18.25[g]	3.75	62	15.51	3.96	19.34	4.70	−7.653	.000*	0.97
AAQ-II	.90	17.34[h]	4.37	57	30.51	6.66	22.46	8.01	8.054	.000*	−1.21
MHC-SF	.92			38	31.11	12.04	43.53	12.41	−6.316	.000*	1.03

Note. Pop = population mean; TC = target complaints; GSI = Global Severity Index of Symptom Assessment-45; BDI = Beck Depression Inventory; ATQ = Automatic Thoughts Questionnaire; IIP-32 = Inventory of Interpersonal Problems-32; RSES = Rosenberg Self-Esteem Scale; DERS = Difficulties in Emotion Regulation Scale; SCS = Self-Compassion Scale; AAQ-II = Acceptance and Action Questionnaire-II; MHC-SF = Mental Health Continuum–Short Form. ES = Cohen's d.
[a] Extracted from Strategic Advantages, Inc. (2000). [b] Extracted from Beck, Steer, and Carbin (1988). [c] Extracted from Hollon & Kendall (1980). [d] Extracted from Horowitz, Alden, Wiggins, and Pincus (2000). [e] Extracted from Sinclair et al. (2010). [f] Extracted from Gratz & Roemer (2004). [g] Extracted from Neff (2003). [h] Extracted from Bond et al. (2011).
* $p < .0042$.

($n = 5$), DERS ($n = 4$), ATQ, IIP, and RSES ($n = 2$), and BDI and SFS ($n = 1$). There were two patients who showed deterioration on three scales and one patient on two scales. All of these patients also showed significant improvements on other scales; therefore, their outcome presented a mixed picture. In sum, these results indicate that AEDP was generally highly effective in reducing a variety of psychological symptoms as well as patients' subjective sense of distress, and also effective in producing an increase in positive indexes of psychological functioning, with a small number of patients showing some deterioration on some outcome scales (while still improving on others).

Finally, with MHC-SF, we conducted a Pearson chi-square using three categories of wellbeing by pre- and posttreatment. The result showed the significant change from pretreatment to posttreatment with an increase in the number of patients who moved out of the Languishing category and moved into the Flourishing category at posttreatment ($\chi^2 = 9.81$, $p < .007$). The number of

Table 4

Proportions of Patients Who Reached Reliable Change (Jacobson et al., 1999)

		Pop		Pre–Post			
Measure	Test–Retest	M	SD	RC	MIFD	CSC	DF
GSI	.82[a]	60.30	18.00	74.2%	100.0%	74.2%	0.0%
BDI	.90[b]	7.28	6.89	67.7%	95.2%	62.9%	1.6%
ATQ	.71[c]	48.57	10.89	51.6%	87.1%	50.0%	3.2%
IIP-32	.78[d]	50.00	10.00	19.4%	95.2%	19.4%	3.2%
RSES	.87[e]	22.62	5.80	40.3%	95.2%	40.3%	3.2%
DERS	.88[f]	77.99	20.72	51.6%	95.2%	50.0%	6.5%
SCS	.93[g]	18.25	3.75	62.9%	96.8%	62.9%	1.6%
AAQ-II	.81[h]	17.34	4.37	56.1%	73.7%	49.1%	8.8%

Note. Pop = population mean; GSI = Global Severity Index of Symptom Assessment-45; BDI = Beck Depression Inventory; ATQ = Automatic Thoughts Questionnaire; IIP-32 = Inventory of Interpersonal Problems-32; RSES = Rosenberg Self-Esteem Scale; DERS = Difficulties in Emotion Regulation Scale; SCS = Self-Compassion Scale; AAQ-II = Acceptance and Action Questionnaire-II; RC = the proportion of patients who achieved reliable change according to Speer's method (1992), controlling the effect of regression toward the mean; MIFD = movement into a functional distribution: the proportion of patients who achieved the level of functioning that fell within the range of the normal population, where range was defined as beginning at 2 SDs below the mean for the normal population; in other words, those who achieved cutoff point *b* according to Jacobson et al. (1999); CSC = clinically significant change: the proportion of patients who achieved both RC and MIFD; DF = deteriorated in functioning: patients who exceeded reliable change index in the negative direction.
[a] Extracted from Strategic Advantage, Inc. (2000). [b] Extracted from Lightfoot & Oliver (1985). [c] Extracted from Charles, Bouvard, Mollard, and Cottraux (1989). [d] Extracted from Horowitz et al. (2000). [e] Extracted from Torrey, Mueser, McHugo, and Drake (2000). [f] Extracted from Gratz & Roemer (2004). [g] Extracted from Neff (2003). [h] Extracted from Bond et al. (2011).

patients who were initially Languishing decreased from 9 at pretreatment to 2 at posttreatment, whereas the number of patients who were Flourishing increased from 3 at pretreatment to 15 at posttreatment.

In examining the initial results, we noted a bimodal distribution in pretreatment patient profiles, with one group of patients with numerous elevated pretreatment symptom scales and another group of patients with only a few elevated pretreatment symptom scales. To adequately distinguish these two important profiles (Cuijpers et al., 2014; Fava & Mangelli, 2001), we report the results for the whole sample (as discussed earlier) as well as results of a post hoc analysis separating the sample into clinical and subclinical groups (discussed later). This allowed us to examine the effects of AEDP on these two profiles separately.

In defining the clinical and subclinical groups, we used 16 outcome indices: seven different outcome scales (described earlier except MHC-SF, which was added later in the study) and nine of the 10 subscales of the SA-45. (The Psychoticism subscale was excluded owing to a lower internal consistency in our sample, with Cronbach's α = .63.) Patients with elevated scores on four or more of these 16 indices were defined as the clinical group, where elevation was defined as one standard deviation or more from the normal population mean. Patients who had three or fewer elevated scores across the 16 indices were defined as the subclinical group. Similar symptom severity grouping procedures can be seen in the study by Barkham, Shapiro, Hardy, and Rees (1999).

Demographic characteristics and pretreatment scores for the clinical and subclinical groups are shown in Table 2. Thirty-nine patients met the criteria for the clinical group with a mean number of 8.0 (SD = 2.8) elevated indices with a range between 4 and 16. Twenty-three patients met the criteria for the subclinical group with a mean number of 1.6 (SD = 1.1) elevated indices with a range between 0 and 3. There were no significant differences in demographic characteristics between the clinical and subclinical groups.

Table 5 presents the pre- and posttreatment means and standard deviations and pre–post Cohen's *d* values. As seen in Table 5, at pretreatment, patients in the clinical group had significantly higher mean scores than patients in the subclinical group on all outcome scales except on the target complaints. Patients from both groups scored similarly on all three target complaints, showing similarity between the groups in intensity of ratings of subjective distress. Similarly, at posttreatment GSI, ATQ, IIP-32, RSES, DERS, and AAQ-II scores were all significantly higher in the clinical group than the subclinical group, whereas BDI and SCS were not significantly different in the two groups, but highly improved in both. The BDI pretreatment average for the clinical group (BDI: M = 21.95; SD = 7.38) was in the moderately depressed range (BDI = 19–29), while the subclinical group (BDI: M = 11.13; SD = 5.16) was, on average, in the mildly depressed range (BDI = 10–18). In the clinical group, each of the pretreatment mean scores on the ATQ, BDI, IIP-32, RSES, DERS, SCS, and AAQ-II fell outside 1 SD from the population means.

The Holme–Bonferonni correction was used to control for multiple comparisons, setting the initial Type I error rate at .005. The clinical group had achieved large effect sizes over $d > 1.00$ on all scales. The subclinical group had a large effect size $d > .80$ on the first TC, SA-45, BDI, and AAQ-II. For IIP-32, RSER, DERS, and SCS, moderate to large effect sizes were obtained (d = 0.46–0.69).

Table 6 presents the proportion of patients in the clinical group who, at posttreatment, reached a level of reliable change according to Jacobson et al.'s (1999) classification. In the clinical group, 82.1% of patients reached reliable change (Speer, 1992) on SA-45 and 79.5% on the BDI. For most scales, approximately 50% of patients were classified as achieving reliable change. According to Jacobson et al.'s (1999) classification, for BDI, the proportion of those who moved into a functional distribution was 92.3% and the proportion of those who achieved clinically significant change was 71.8%.

Table 5

Pretreatment Baseline, Posttreatment Outcome, Improvement (ANOVA), and Effect Sizes (Cohen's d) for All Outcome Measures for Clinical and Subclinical Groups

| | Pre | | | | | | | | Post | | | | | | | Pre–Post | | | |
| | Clinical | | | Subclinical | | | *t*-test | | Clinical | | Subclinical | | *t*-test | | ANOVA | | ES | |
Measure	N	M	SD	N	M	SD	t	p	M	SD	M	SD	t	p	F	p	Clinical	Subclinical
TC1	21	8.33	1.74	14	8.07	1.07	0.55	.586	5.81	2.66	5.86	2.57	−0.05	.958	15.65	.000*	−1.45	−2.07
TC2	16	8.25	1.84	12	7.42	1.73	1.22	.235	5.81	3.29	6.25	3.22	−0.35	.728	8.47	.007	−1.32	−0.67
TC3	14	7.43	1.87	11	7.27	1.68	0.22	.831	5.07	2.53	5.73	1.90	−0.72	.482	10.18	.004*	−1.26	−0.92
GSI	39	61.67	20.79	23	27.48	9.61	8.80	.000*	29.41	19.01	15.22	10.40	3.80	.000*	103.24	.000*	−1.55	−1.28
BDI	39	21.95	7.38	23	11.13	5.16	6.18	.000*	9.33	6.53	5.91	5.30	2.13	.037	75.36	.000*	−1.71	−1.01
ATQ	39	82.90	21.75	23	49.61	8.53	8.51	.000*	55.46	22.46	40.96	6.78	3.75	.000*	60.96	.000*	−1.26	−1.01
IIP-32	39	63.46	7.58	23	52.35	6.73	5.81	.000*	55.21	9.34	47.74	6.52	3.69	.000*	33.10	.000*	−1.09	−0.69
RSES	39	13.85	3.33	23	20.43	4.70	−6.45	.000*	18.44	5.00	22.61	4.32	−3.33	.001*	35.69	.000*	1.38	0.46
DERS	39	105.79	18.57	23	75.04	15.97	6.62	.000*	84.92	20.79	64.52	15.01	4.11	.000*	33.46	.000*	−1.12	−0.66
SCS	39	13.89	2.86	23	18.24	4.10	−4.49	.000*	18.33	4.52	21.04	4.59	−2.27	.027	50.05	.000*	1.55	0.68
AAQ-II	39	32.95	5.29	18	25.22	6.34	4.81	.000*	24.18	8.28	17.90	6.44	3.01	.004*	50.50	.000*	−1.66	−1.15
MHC-SF	31	28.84	11.11	7	41.14	11.51	−2.63	.012	41.77	11.71	51.29	13.33	−1.90	.066	20.30	.000*	1.16	0.88

Note. TC = target complaints; GSI = Global Severity Index of Symptom Assessment-45; BDI = Beck Depression Inventory; ATQ = Automatic Thoughts Questionnaire; IIP-32 = Inventory of Interpersonal Problems-32; RSES = Rosenberg Self-Esteem Scale; DERS = Difficulties in Emotion Regulation Scale; SCS = Self-Compassion Scale; AAQ-II = Acceptance and Action Questionnaire-II; MHC-SF = Mental Health Continuum–Short Form; ES = Cohen's *d*; ANOVA = analysis of variance.
* $p < .0042$.

Table 6

Proportions of Participants Who Reached Reliable Change (Jacobson et al., 1999) for Clinical and Subclinical Groups

Outcome scale	Clinical ($N = 39$)				Subclinical ($N = 23$)			
	RC (%)	MIF (%)	CSC (%)	DF (%)	RC (%)	MIFD (%)	CSC (%)	DF (%)
GSI	82.1	100.0	82.1	0.0	60.9	100.0	60.9	0.0
BDI	79.5	92.3	71.8	0.0	47.8	100.0	47.8	4.3
ATQ	64.1	79.5	61.5	5.1	30.4	100.0	30.4	0.0
IIP-32	23.1	92.3	23.1	5.1	13.0	100.0	13.0	0.0
RSES	48.7	92.3	48.7	2.6	26.1	100.0	26.1	4.3
DERS	59.0	92.3	56.4	10.3	39.1	100.0	39.1	0.0
SCS	61.5	94.9	61.5	2.6	65.2	100.0	65.2	0.0
AAQ-II	59.0	64.1	48.7	10.3	50.0	94.4	50.0	5.6

Note. GSI = Global Severity Index of Symptom Assessment-45; BDI = Beck Depression Inventory; ATQ = Automatic Thoughts Questionnaire; IIP-32 = Inventory of Interpersonal Problems-32; RSES = Rosenberg Self-Esteem Scale; DERS = Difficulties in Emotion Regulation Scale; SCS = Self-Compassion Scale; AAQ-II = Acceptance and Action Questionnaire-II; RC = reliable change: The proportion of patients who achieved reliable change according to Speer's (1992) method controlling the effect of regression toward the mean; MIFD = movement into a functional distribution: The proportion of patients who achieved the level of functioning that fell within the range of the normal population, where range was defined as beginning at 2 SDs below the mean for the normal population; in other words, those who achieved cutoff point *b* according to Jacobson et al. (1999); CSC = clinically significant change: The proportion of patients who achieved both RC and MIFD; DF = deteriorated in functioning: patients who exceeded reliable change index in the negative direction. For AAQ-II, *N* for subclinical group was 18.

In the subclinical group, although each participant exceeded 1 *SD* from the population mean on at least one symptom scale, on average as a group these patients started less than 1 *SD* from the population mean score across the measures. Therefore, there was less room for improvement for these patients in the subclinical group. Nonetheless, over 60% of patients in this group made clinically significant change on GSI and SCS, and about 50% on BDI and SCS. About 30% to 40% of patients achieved clinically significant change on ATQ and DERS.

We also looked at what Jacobson et al. (1999) define as deterioration within the clinical and subclinical groups. Deterioration more frequently occurred in the clinical group, with about 10% of patients showing deterioration on DERS and AAQ-II. Three patients from the subclinical group showed significant deterioration on a total of three scales.

A series of analyses of variance were conducted to examine the interaction between groups. On all outcome scales, patients in the clinical group improved significantly more than those in the subclinical group (Table 5).

Finally, for MHC-SF, patients moved toward flourishing in both clinical and subclinical groups. For the clinical group, Pearson χ^2 showed that there was a significant relationship between the pre–post scores and three categories of well-being ($\chi^2 = 9.814$ *df* = 2, $p < .007$). For the subclinical group, Fisher's exact test showed a nearly significant result ($\chi^2 = 4.667$ *df* = 1, $p = .051$). There were more patients who were classified as flourishing in both groups at the end of treatment than there were at the beginning of treatment.

Discussion

The present study is the first large-scale investigation of the effectiveness of AEDP using a 16-session treatment format in the independent practice settings where AEDP is most frequently practiced. It is based on the AEDP PRN that has come to form an infrastructure of research in the AEDP community of clinicians. The present study used a naturalistic sample consisting of adults who sought psychotherapy from private practitioners. To capture the effect of AEDP comprehensively, the current study employed an array of robust measures of psychological symptoms widely used in other psychotherapy outcome studies. In our primary analysis, the 62 patients improved significantly on a number of outcome measures, with large effect sizes at posttreatment. Only three patients deteriorated on one or more of the outcome measures. Furthermore, even these patients also achieved reliable positive change on other outcome scales. In sum, the initial attempt to build a PRN and to demonstrate the effectiveness of AEDP in independent practice settings successfully achieved its goals.

In addition to demonstrating the effectiveness of AEDP, our study contributes to the emerging field of PRN research by showing that a PRN that centers on a specific theoretical orientation and model of treatment can be effectively implemented. Our PRN is built within the community of AEDP therapists who share not only a therapeutic method but also the worldview underlying the theory and practice of AEDP. We were able to increase the interest of clinicians in research and in integrating research more seamlessly in their everyday practice. Individual communications from therapists indicated enthusiasm for contributing to the research project as well as for the benefits of increased intertherapist engagement (Edlin, Fosha, & Iwakabe, 2020). Using online individual and group supervision, clinicians who were geographically dispersed across different continents were able to participate in the study and connect with one another. In addition to offering a way of participating in research, this also helped undo the isolation of private practitioners, as participant therapists indicated. This dual function can both enrich therapists' professional development and also provide a way to monitor effectiveness in the era of evidence-based practice. In sum, with many approaches establishing their own community of therapists, our PRN can serve as a model to instill a research infrastructure into a community of therapists of a particular theoretical orientation.

Cuijpers (2019) listed five targets of psychotherapy outcome research that need to be examined to comprehensively assess the effectiveness of any psychotherapy: symptom reduction, patient-defined targets and outcomes, quality of life, intermediate outcomes or mediators and working mechanisms, negative outcomes,

and economic outcomes. In this study, we covered the first four of these five areas, and in all four, we had favorable results according to important outcome indexes such as effect size and the reliable change index.

The effect sizes of improvement on depression, experiential avoidance, as well as psychological symptoms were similar to those obtained in outcome studies on major approaches such as psychodynamic psychotherapy (Shedler, 2010), cognitive–behavioral therapy (Butler, Chapman, Forman, & Beck, 2006; Hans & Hiller, 2013), ACT (A-Tjak et al., 2015) and experiential therapies (Elliott, Greenberg, & Lietaer, 2004), as well as transdiagnostic approaches on affective disorders (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015). Although a direct comparison cannot be made because of the differences in focus, sampling, and other treatment parameters, AEDP in a 16-session format is effective and worth continuing to examine in a more controlled experimental design as well as for more specific clinical populations. Currently, most research-supported treatments for depression and anxiety disorders are cognitive–behavioral in orientation (e.g., https://www.div12.org/treatments/). However, there are a substantial number of patients who drop out from cognitive–behavioral therapy and may seek different therapy approaches (Hans & Hiller, 2013). In addition, a greater variety of effective models can make for a greater range of patient choice as well as potential alternatives for more refractory cases.

To further examine the effectiveness of AEDP on subgroups within our sample, a secondary analysis divided patients into two groups based on the number of pretreatment symptom scales that were elevated to clinical levels for a given patient. This division showed a clear bimodal distribution, making two groups which we labeled the "clinical group" and the "subclinical group." The clinical group was elevated on an average of 8 symptom scales out of a total of 16 subscales, versus the subclinical group, whose scores were elevated on an average of two subscales.

Notably, the effect sizes in the clinical group, which had more complex problems, appeared even larger than the group as a whole, showing the strength of AEDP with the more complicated cases within our sample. In the clinical group, large effect sizes ranged from $d = 1.12$ to $d = 1.78$ on patients' main target problem, depression, experiential avoidance, emotion regulation, and general symptom distress. Avoidance of emotion (experiential avoidance) and emotion regulation are both targets of AEDP, which shows that AEDP methods appear to produce substantial change in these domains.

In addition, large effects were seen on the decrease in negative automatic thoughts, despite the fact that automatic thoughts specifically and cognitions in general are not targeted for restructuring in AEDP. In AEDP theory negative automatic thoughts are seen as either forms of defense used to avoid core emotion, and then therapists seek to bypass them, or else as internalizations of negative parental messaging, and then they are worked with experientially. Thus, it appears that a focus on relational work and emotion processing may be an alternative method from the approach of cognitive–behavioral therapy (Beck, 2011) to substantially reduce such detrimental ways of thinking.

The subclinical group presented with a similar level of pretreatment subjective distress as the clinical group despite having fewer pretreatment symptom scales that were elevated beyond a clinical threshold. Although the subclinical group was less symptomatic

according to validated scales, these patients experienced themselves as suffering, and thus still appeared to be in need of treatment. Similar to the clinical group, the subclinical group also demonstrated notable improvement, with effect sizes for depression, global severity index, experiential avoidance, and negative automatic thoughts exceeding 1.0. Even though their pretreatment average score for emotion regulation problems was similar to the (nonclinical) population mean, the group still achieved the improvement of moderate effect size. Overall, the effect sizes were smaller for the subclinical group than the clinical group at least in part because these patients had less room to improve.

Yet, in some nonpathological measures that centered on positive capacities, the subclinical patients started out close to the population mean and then went on to exceed it. Thus, notably, although the mean score for self-compassion at pretreatment for the subclinical group was about the same as population mean, these patients improved more than two thirds of standard deviation beyond the population mean. Along these same lines, the MHC-SF for those in the subclinical group showed that those who started out in the moderately functioning range improved to the category of Flourishing. These findings show initial support, at least in subclinical populations, for the AEDP aim of not only in facilitating therapeutic changes from the negative range to the normal range but also in facilitating improvement from normal range to stronger functioning and flourishing.

The present study strongly indicates that we continue examining AEDP as an effective approach to treat subclinical populations and also explore its potential as a preventive and health-promoting intervention in future studies. The study of subclinical populations has important implications for individuals at risk for mental disorders (Cuijpers et al., 2014; Fava & Mangelli, 2001). Recent research supports therapeutic work with subclinical populations and indicates that preventative mental health strategies play an important and cost-effective role in averting mental health disorders (Arango et al., 2018). It will also be worth examining whether AEDP can be used to bring those who it has helped recover from substantial symptomology to go on to surpass moderate levels of functioning that they achieved posttreatment in the current study.

Both clinical and subclinical groups improved their capacity to access, experience, and process emotion, as evidenced in their improvement in their experiential avoidance and emotional regulation. The facilitation of and exposure to specific emotional experiences has been shown to improve participant outcome (Greenberg & Pascual-Leone, 2006; Lilliengren, Falkenström, Sandell, Mothander, & Werbart, 2015). These findings are consistent with the dyadic regulation and processing of emotional experience, one of the main mechanisms of change in AEDP. An additional proposed mechanism of change in AEDP centers on experiential work with experiences of healing and positive change through the technique of metaprocessing, which aims to bring patients past alleviation of suffering and into flourishing (Fosha & Thoma, 2020).

These proposed mechanisms of change in AEDP will need to be refined into testable hypotheses and then tested by using multiple methods from process research, systematic case studies, and also process-outcome studies. One potential avenue of research is an intensive analysis of in-session therapist-patient interactions to examine whether those improved cases show more episodes of successful dyadic regulation in which patient and therapist process

and work through patients' painful or positive emotions in session. This would require developing scales that can efficiently code the occurrence of effective dyadic regulation and distill the essential steps and components leading to change (Elliott, 2010). The present study, nonetheless, provides sufficient support that this mechanism is worth testing in the future.

One of our goals was to encourage a continuous research engagement with AEDP therapists and to build a sustainable research culture within the international AEDP therapeutic community. This study sets the AEDP PRN in place in order to examine process and outcome of AEDP in the AEDP community at large. It also supports AEDP effectiveness and its findings are similar to those found in psychotherapy meta-analyses (Cuijpers, 2017). As a pre–post study, however, the current study lacks the controls for internal validity embedded in randomized controlled trial studies (RCTs). Spontaneous remission of depression for adult within 6 months is estimated to be about 30% (Whiteford et al., 2013). Supportive therapy based on nonspecific factors can produce moderate effect size (Cuijpers et al., 2012). Our results showed that 67.7% of the patients who received AEDP made reliable changes on depression and 74.2% on general symptom severity. We need to complement the emphasis on external validity in the present trial with testing the effect of AEDP in a controlled research design with comparison groups and an emphasis on internal validity. With the increasing involvement of AEDP therapists in research studies, a future goal is to build a design that involves independent practice based RCTs. Future RCTs may also focus on testing the effectiveness of AEDP for treating specific disorders to further refine our understanding of its effectiveness and the breadth of application in various clinical settings. A natural extension of the current study will be to study the effectiveness of AEDP for depressive disorders, in light of its strengths in improving depressive symptoms and related variables such as negative rumination, emotion regulation, and self-compassion demonstrated in the current study. Using the RCT design while setting treatment parameters and the severity of psychopathology comparable to those studies on other evidence approaches will provide a more exact test of the effectiveness of AEDP.

The present study excluded prospective participants with a history of psychotic disorder and current substance abuse disorder, mostly focusing on depression, anxiety, and interpersonal problems. Further, although fidelity was supported by the use of advanced and certified AEDP therapists and by incorporating supervision meetings, future studies may include expert raters to monitor therapists' adherence and treatment fidelity and to systematically test therapist effects. AEDP prizes the therapist's flexibility and responsiveness, which needs to be more operationally defined and contrasted against adherence empirically (Owen & Hilsenroth, 2014). Future goals include evaluating the maintenance of gains at follow-up and also gathering a larger sample of patients showing greater diversity both in their clinical problems and their cultural backgrounds in order to fully assess the effectiveness of AEDP.

There were a small number of patients who showed some deterioration. Since we used a stringent criterion for judging clinically significant change (Jacobson et al., 1999), the range for reliable change was small, contributing to categorizing cases with minor deterioration into the deterioration category. Of note is that two patients who showed deterioration on three outcome scales also showed significant improvements in other areas. Therefore, their results were mixed. Five patients showed worsening on experiential avoidance and four patients on emotion regulation. A close look at these particular cases showed that these patients were working on issues related to their past traumatic experiences toward the end of their treatment. For example, one patient who worked on difficult, painful emotions associated with her past traumas made significant improvement on depression; however, her scores on emotion regulation and experiential avoidance were lower at posttreatment. A closer look at subscale scores on DERS indicated that although she was significantly more accepting of her emotional responses and acquired more emotion regulation strategies, her emotional clarity and awareness were significantly lowered. Previous empirical work on emotion-exposure based treatment for depression has shown nonlinear patterns of change, with some symptoms worsening before they improve (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007). It may be the case that a small number of patients were only part way through this process by the end of treatment. It may also be relevant to note here that we had a very low dropout rate, at only 11.3%, which is a little more than half the rate found in a recent meta-analysis of dropout rates (Swift et al., 2017). Thus, it may also be the case that we retained in treatment patients who might otherwise have simply dropped out, which, when considering those patients who deteriorated, may still be considered an overall strength of AEDP with these patients, in that treatment was provided and improvements were still made on some scales. These complex pictures of deterioration urge us to conduct a series of systematic case studies so that both the unique pattern of deterioration in each case as well as common contributing factors associated with deterioration can be identified and studied.

Future studies will help elucidate mechanisms of change related to outcome, including the role of the working alliance, explicit relational-experiential interventions, emotional processing and AEDP's focus on positive emotional experience through metatherapeutic processing, as well as therapist effects. However, we need to examine the relative contributions of both common factors and change mechanisms unique to AEDP in a rigorous and differentiated manner. Relationship factors such as the therapeutic alliance, empathy, and collaboration that have been consistently found to be related to outcome in various approaches are also important in AEDP. We need to take a step further towards specifying which particular components of these relational constructs are shared with other approaches and which are specific to AEDP (Weinberger, 2014). Process-outcome research focusing on AEDP-specific processes will also help rule out the possibility that outcomes are due in part or in whole to factors common to all psychotherapies. We predict that the improvements in interpersonal functioning in AEDP patients, as well as the improvements in depression, negative cognitions and experiential avoidance will contribute to better interpersonal and emotional environments so that therapeutic gains will be maintained. To examine this prediction, 6- and 12-month follow-up data from the patients of the present study will be analyzed to evaluate the long-term effectiveness of AEDP.

References

Arango, C., Díaz-Caneja, C. M., McGorry, P. D., Rapoport, J., Sommer, I. E., Vorstman, J. A., . . . Carpenter, W. (2018). Preventive strategies for mental health. *The Lancet Psychiatry, 5,* 591–604. http://dx.doi.org/10.1016/S2215-0366(18)30057-9

A-Tjak, J. G., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A., & Emmelkamp, P. M. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84,* 30–36. http://dx.doi.org/10.1159/000365764

Barkham, M., Hardy, G. E., & Startup, M. (1996). The IIP-32: A short version of the Inventory of Interpersonal Problems. *British Journal of Clinical Psychology, 35,* 21–35. http://dx.doi.org/10.1111/j.2044-8260 .1996.tb01159.x

Barkham, M., Lutz, W., Lambert, M. J., & Saxon, D. (2017). Therapist effects, effective therapists, and the law of variability. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others? Understanding therapist effects* (pp. 13–36). Washington, DC: American Psychological Association; http://dx.doi.org/10.1037/ 0000034-002

Barkham, M., Shapiro, D. A., Hardy, G. E., & Rees, A. (1999). Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology, 67,* 201–211. http://dx.doi.org/10.1037/0022-006X.67.2.201

Barlow, D. H., Ellard, K. K., Fairholme, C. P., Farchione, C. P., Boisseau, C. L., Allen, L. B., & Ehrenreich-May, J. (2011). *The unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide.* New York, NY: Oxford University Press.

Battle, C. C., Imber, S. D., Hoehn-Saric, R., Nash, E. R., & Frank, J. D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20,* 184–192. http://dx.doi.org/10.1176/appi .psychotherapy.1966.20.1.184

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8,* 77–100. http://dx.doi.org/10.1016/0272-7358(88)90050-5

Beck, A., Ward, C., Mendelson, M., Mock, J., & Erbaugh, J. (1961). Beck Depression Inventory (BDI). *Archives of General Psychiatry, 4,* 561–571. http://dx.doi.org/10.1001/archpsyc.1961.01710120031004

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., . . . Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire-II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy, 42,* 676–688. http://dx.doi.org/10.1016/j.beth.2011.03 .007

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17–31. http://dx.doi.org/10 .1016/j.cpr.2005.07.003

Castonguay, L. G., Barkham, M., Lutz, W., & McAleavy, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85–133). Hoboken, NJ: Wiley.

Charles, S., Bouvard, M., Mollard, E., & Cottraux, J. (1989). *Validation and factorial structure of the French version of the Automatic Thoughts Questionnaire* [poster presentation]. Oxford, United Kingdom: The World Congress of Cognitive Therapy.

Cuijpers, P. (2017). Four decades of outcome research on psychotherapies for adult depression: An overview of a series of meta-analyses. *Canadian Psychology, 58,* 7–19. http://dx.doi.org/10.1037/cap0000096

Cuijpers, P. (2019). Targets and outcomes of psychotherapies for mental disorders: An overview. *World Psychiatry, 18,* 276–285. http://dx.doi .org/10.1002/wps.20661

Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: A meta-analysis. *Clinical Psychology Review, 32,* 280–291. http://dx.doi.org/10.1016/j.cpr.2012.01.003

Cuijpers, P., Koole, S. L., van Dijke, A., Roca, M., Li, J., & Reynolds, C. F., III. (2014). Psychotherapy for subclinical depression: Meta-analysis. *The Journal of Mental Science, 205,* 268–274. http://dx.doi .org/10.1192/bjp.bp.113.138784

Davison, M. L., Bershadsky, B., Bieber, J., Silversmith, D., Maruish, M. E., & Kane, R. L. (1997). Development of a brief, multidimensional, self-report instrument for treatment outcomes assessment in psychiatric settings: Preliminary findings. *Assessment, 4,* 259–276. http://dx.doi .org/10.1177/107319119700400306

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *The British Journal of Psychiatry, 128,* 280–289. http://dx.doi.org/10.1192/bjp.128 .3.280

Edlin, J., Fosha, D., & Iwakabe, S. (2020). *A practitioner-research collaborative network in AEDP: Building on the worldview and capitalizing on the change mechanisms.* Manuscript in preparation.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20,* 123–135.

Elliott, R., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. J. Lambert (Ed.), *Bergin and S. Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 493–539). New York, NY: Wiley. http://dx.doi.org/10.1002/0471264385.wei0812

Fava, G. A., & Mangelli, L. (2001). Assessment of subclinical symptoms and psychological well-being in depression. *European Archives of Psychiatry and Clinical Neuroscience, 251,* 47–52. http://dx.doi.org/10 .1007/BF03035127

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

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganized attachment. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 221–281). New York, NY: Norton.

Fosha, D. (2004). 'Nothing that feels bad is ever the last step:' The role of positive emotions in experiential work with difficult emotional experiences. *Clinical Psychology & Psychotherapy, 11,* 30–43. http://dx.doi .org/10.1002/cpp.390

Fosha, D. (2009). Emotion and recognition at work: Energy, vitality, pleasure, truth, desire & the emergent phenomenology of transformational experience. In D. Fosha, D. J. Siegel, & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development & clinical practice* (pp. 172–203). New York, NY: Norton.

Fosha, D. (2017a). How to be a transformational therapist: AEDP harnesses innate healing affects to re-wire experience and accelerate transformation. In J. Loizzo, M. Neale, & E. Wolf (Eds.), *Advances in contemplative psychotherapy: Accelerating transformation* (pp. 204–219). New York, NY: Norton. http://dx.doi.org/10.4324/97813 15630045-18

Fosha, D. (2017b). Something more than "something more than interpretation:" AEDP works the experiential edge of transformational experience to transform the internal working model. In S. Lord (Ed.), *Moments of meeting in psychoanalysis: Interaction and change in the therapeutic encounter* (pp. 267–292). New York, NY: Routledge.

Fosha, D. (2018). Moment-to-moment guidance of clinical interventions by AEDP's healing-oriented transformational phenomenology. In *Pragmatic case studies in psychotherapy* (Vol. 14, Module 2, Article 1, pp. 87–114). New York, NY: Rutgers. http://dx.doi.org/10.14713/pcsp .v14i2.2038

Fosha, D., & Thoma, N. (2020). Metatherapeutic processing supports the emergence of flourishing in psychotherapy. *Psychotherapy.* Advance online publication. http://dx.doi.org/10.1037/pst0000289

Fosha, D., Thoma, N., & Yeung, D. (2019). Transforming emotional suffering into flourishing: Metatherapeutic processing of positive affect

as a trans-theoretical vehicle for change. *Counselling Psychology Quarterly, 32,* 563–572. http://dx.doi.org/10.1080/09515070.2019.1642852

Fredrickson, B. L. (2013). Chapter one - positive emotions broaden and build. *Advances in Experimental Social Psychology, 47,* 1–53. http://dx.doi.org/10.1016/B978-0-12-407236-7.00001-2

Fried, M. (2018). Signs of transformance from the asylum. *Transformance, 8.*

Gabbard, G. O., Litowitz, B. E., & Williams, P. (Eds.). (2012). *Textbook of psychoanalysis* (2nd ed.). Washington, DC: American Psychiatric Publishing, Inc.

Gonzalez, N. V. (2018). The merits of integrating accelerated experiential dynamic psychotherapy and cultural competence strategies in the treatment of relational trauma: The Case of "Rosa,". *Pragmatic Case Studies in Psychotherapy, 14,* 1–57. http://dx.doi.org/10.14713/pcsp.v14i1.2032

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41–54. http://dx.doi.org/10.1023/B:JOBA.0000007455.08539.94

Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings* (2nd ed.). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/14692-000

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology, 62,* 611–630. http://dx.doi.org/10.1002/jclp.20252

Hans, E., & Hiller, W. (2013). A meta-analysis of nonrandomized effectiveness studies on outpatient cognitive behavioral therapy for adult anxiety disorders. *Clinical Psychology Review, 33,* 954–964. http://dx.doi.org/10.1016/j.cpr.2013.07.003

Harrison, R. (2020). *Termination in 16-session accelerated experiential dynamic psychotherapy: Together in how we say goodbye.* Manuscript submitted for publication.

Hayes, A. M., Laurenceau, J. P., Feldman, G., Strauss, J. L., & Cardaciotto, L. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27,* 715–723. http://dx.doi.org/10.1016/j.cpr.2007.01.008

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York, NY: Guilford Press.

Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., . . . McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record, 54,* 553–578. http://dx.doi.org/10.1007/BF03395492

Hollon, S. D., & Kendall, P. C. (1980). Cognitive self-statements in depression: Development of an Automatic Thoughts Questionnaire. *Cognitive Therapy and Research, 4,* 383–395. http://dx.doi.org/10.1007/BF01178214

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000). *IIP Inventory of Interpersonal Problems manual.* San Antonio, TX: Psychological Corporation.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885–892. http://dx.doi.org/10.1037/0022-006X.56.6.885

Iwakabe, S., & Conceição, N. (2016). Metatherapeutic processing as a change-based therapeutic immediacy task: Building an initial process model using a task-analytic research strategy. *Journal of Psychotherapy Integration, 26,* 230–247. http://dx.doi.org/10.1037/int0000016

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology, 67,* 300–307. http://dx.doi.org/10.1037/0022-006X.67.3.300

Johansson, R., Björklund, M., Hornborg, C., Karlsson, S., Hesser, H., Ljótsson, B., . . . Andersson, G. (2013). Affect-focused psychodynamic psychotherapy for depression and anxiety through the Internet: A randomized controlled trial. *PeerJ, 1,* e102. http://dx.doi.org/10.7717/peerj.102

Johansson, R., Hesslow, T., Ljótsson, B., Jansson, A., Jonsson, L., Färdig, S., . . . Andersson, G. (2017). Internet-based affect-focused psychodynamic therapy for social anxiety disorder: A randomized controlled trial with 2-year follow-up. *Psychotherapy, 54,* 351–360. http://dx.doi.org/10.1037/pst0000147

Keyes, C. L. M. (1998). Social well-being. *Social Psychology Quarterly, 61,* 121–140. http://dx.doi.org/10.2307/2787065

Keyes, C. L. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior, 43,* 207–222. http://dx.doi.org/10.2307/3090197

Levine, P. A. (2008). *Healing trauma: A pioneering program for restoring the wisdom of your body.* New York, NY: Sound True.

Levy, K. N., & Scala, J. W. (2012). Transference, transference interpretations, and transference-focused psychotherapies. *Psychotherapy, 49,* 391–403. http://dx.doi.org/10.1037/a0029371

Lightfoot, S. L., & Oliver, J. M. (1985). The Beck Inventory: Psychometric properties in university students. *Journal of Personality Assessment, 49,* 434–436. http://dx.doi.org/10.1207/s15327752jpa4904_12

Lilliengren, P., Falkenström, F., Sandell, R., Mothander, P. R., & Werbart, A. (2015). Secure attachment to therapist, alliance, and outcome in psychoanalytic psychotherapy with young adults. *Journal of Counseling Psychology, 62,* 1–13. http://dx.doi.org/10.1037/cou0000044

Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration, 21,* 253–279. http://dx.doi.org/10.1037/a0025421

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists.* Oakland, CA: New Harbinger Publications.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Markin, R. D., McCarthy, K. S., Fuhrmann, A., Yeung, D., & Gleiser, K. A. (2018). The process of change in accelerated experiential dynamic psychotherapy (AEDP): A case study analysis. *Journal of Psychotherapy Integration, 28,* 213–232. http://dx.doi.org/10.1037/int0000084

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2,* 223–250. http://dx.doi.org/10.1080/15298860309027

Newby, J. M., McKinnon, A., Kuyken, W., Gilbody, S., & Dalgleish, T. (2015). Systematic review and meta-analysis of transdiagnostic psychological treatments for anxiety and depressive disorders in adulthood. *Clinical Psychology Review, 40,* 91–110. http://dx.doi.org/10.1016/j.cpr.2015.06.002

Owen, J., & Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology, 61,* 280–288. http://dx.doi.org/10.1037/a0035753

Pilieiro, S. (2020). *Working with trauma in accelerated experiential dynamic psychotherapy. Specific Treatment for Specific Populations Video Series #4310019.* Washington, DC: American Psychological Association.

Prenn, N. C., & Fosha, D. (2017). *Supervision essentials for accelerated experiential dynamic psychotherapy.* Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000016-000

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press. http://dx.doi.org/10.1515/9781400876136

Russell, E. (2015). *Restoring resilience: Discovering your clients' capacity for healing.* New York, NY: WW Norton & Company.

Sauer-Zavala, S., Gutner, C. A., Farchione, T. J., Boettcher, H. T., Bullis, J. R., & Barlow, D. H. (2017). Current definitions of "transdiagnostic" in treatment development: A search for consensus. *Behavior Therapy, 48,* 128–138. http://dx.doi.org/10.1016/j.beth.2016.09.004

Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61,* 774–788. http://dx.doi.org/10.1037/0003-066X.61.8.774

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98–109. http://dx.doi.org/10.1037/a0018378

Sinclair, S. J., Blais, M. A., Gansler, D. A., Sandberg, E., Bistis, K., & LoCicero, A. (2010). Psychometric properties of the Rosenberg Self-Esteem Scale: Overall and across demographic groups living within the United States. *Evaluation and the Health Professions, 33,* 56–80. http://dx.doi.org/10.1177/0163278709356187

Speer, D. C. (1992). Clinically significant change: Jacobson and Truax (1991). revisited. *Journal of Consulting and Clinical Psychology, 60,* 402–408. http://dx.doi.org/10.1037/0022-006X.60.3.402

Strategic Advantages, Inc. (2000). *Symptom assessment-45 questionnaire (SA-45) manual*. North Tonawanda, NY: Multi-Health Systems.

Swift, J. K., Greenberg, R. P., Tompkins, K. A., & Parkin, S. R. (2017). Treatment refusal and premature termination in psychotherapy, pharmacotherapy, and their combination: A meta-analysis of head-to-head comparisons. *Psychotherapy, 54,* 47–57. http://dx.doi.org/10.1037/pst0000104

Torrey, W. C., Mueser, K. T., McHugo, G. H., & Drake, R. E. (2000). Self-esteem as an outcome measure in studies of vocational rehabilitation for adults with severe mental illness. *Psychiatric Services, 51,* 229–233. http://dx.doi.org/10.1176/appi.ps.51.2.229

Weinberger, J. (2014). Common factors are not so common and specific factors are not so specified: Toward an inclusive integration of psychotherapy research. *Psychotherapy, 51,* 514–518. http://dx.doi.org/10.1037/a0037092

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130,* 631–663. http://dx.doi.org/10.1037/0033-2909.130.4.631

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . Vos, T. (2013). The global burden of mental and substance use disorders, 2010. *The Lancet, 382,* 1575–1586. http://dx.doi.org/10.1016/S0140-6736(13)61611-6