The Long-Term Outcome of Accelerated Experiential Dynamic Psychotherapy (AEDP): Six and 12-Month Follow-up Results

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We have no known conflict of interest to disclose.

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Abstract

Accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000, 2021b) is an integrative, healing-oriented, mind-body, affect-focused therapy. A post-treatment outcome study demonstrated AEDP's effectiveness (Iwakabe et al., 2020) on a variety of measures of psychological functioning. This study sought to address AEDP's long-term effectiveness. As previously reported, 63 adult patients completed a 16 session AEDP treatment with qualified therapists in private practice in the United States, Canada, Israel, Japan, and Sweden. Forty patients responded to six-month follow-up and 52 responded to 12-month follow-up. Results indicate that patients maintained their post-treatment therapeutic gains, both six and 12 months later. Large effect sizes (d = 0.74 to d = 1.60) both for reductions on measures of psychopathology (e.g., depression, negative automatic thoughts, experiential avoidance) and improvements on measures of positive mental health (e.g., well-being, self-compassion) were obtained. Patients with more pervasive and severe problems tended to have larger effect sizes (all d 's > 1.0) and a larger proportion of them achieved clinically significant change over six and 12 months than patients with subclinical symptomatology. Piecewise growth modeling was used to confirm these results, with attrition over the follow-up period taken into account. Consistent with the above findings, piecewise growth modeling similarly showed that patients significantly improved from pre- to post-treatment and maintained gains from post-treatment through the six and 12-month follow-up. These results provide empirical support for the long-term effectiveness of AEDP for alleviating a variety of psychological problems and enhancing positive functioning.

Keywords: accelerated experiential dynamic psychotherapy, follow-up outcome, effectiveness, experiential therapies, emotion.

Introduction

Accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000, 2021b) is an experiential, mind-body, healing-oriented, "attachment and emotion *and* transformation model" (Fosha, 2021a, p. 7; italics in the original). With roots in developmentally oriented relational psychoanalysis and the short-term psychodynamic psychotherapies from which the approach originated, AEDP is an integrative model of psychotherapy that brings together relational work, experiential techniques, transformational techniques and a systematic experiential focus on the process of change and healing itself. Non-pathologizing and transformation-focused, AEDP assumes a healthy core within all people, emphasizes adaptive motivational strivings, works actively and explicitly to co-create the experience of safety in the therapeutic relationship, and stresses the importance of experiential work with evolutionarily adaptive affective change processes, like emotion, attachment, and transformation (Fosha, 2013, 2017).

AEDP works experientially with the therapeutic relationship (Lipton & Fosha, 2011) to process both the negative emotions associated with emotional suffering as well as the positive emotions that accompany transformation (Fosha, Thoma &Yeung, 2019). AEDP's theoretical framework brings together understandings and empirical findings from affective neuroscience, attachment theory, emotion theory, relational psychoanalysis, recognition science and positive psychology (Fosha, 2008; Russell, 2015). Transdiagnostic in its focus (Gleiser et al. 2008; Iwakabe et al., 2020) AEDP targets a set of central psychopathological processes (Lamagna, 2021: Lamagna & Gleiser, 2007), specifically the individual's unwilled and unwanted aloneness in the face of overwhelming emotional experience (Fosha, 2017) believed to underlie a variety of diagnoses and symptoms, such as depression, anxiety, and various maladaptive behaviors and interpersonal patterns (see Sauer-Zavala et al., 2017). However, rather than focusing solely or

even primarily on psychopathology, AEDP therapists systematically focus on adaptive affective change processes (Fosha, 2021a), psychological processes with transformational potential that underlie resilience, and well-being (Russell, 2015). As advocated by Keyes (2002), AEDP theory gives primacy to the belief that emotional suffering coexists with the ever-present potential for flourishing (Fosha & Thoma, 2020). Four central psychological processes form the foundational pillars of AEDP theory and clinical practice and are briefly described here.

Transformation and a healing orientation

The AEDP therapeutic process is informed by the fundamental assumption of an innate, wired in human potential for healing and self-righting (Fosha, 2013). Termed *transformance* (Fosha, 2008), this potential for transformation, self-righting and personal growth, is conceptualized as co-extensive with the wired-in potential for positive neuroplasticity, and is presumed to reside as an adaptive motivational striving within all individuals, at all times (Fosha, 2017; Russell, 2015). Transformance is held to be "there from the get-go" and AEDP therapists seek to cultivate its slightest signs of manifestation, called *glimmers of transformance*, starting with the very first moments of the very first therapy session (Iwakabe et al., 2021).

Attachment and the experiential processing of relational experience

AEDP understands psychopathology as a result of earlier attachment traumas and the unprocessed emotions that result from such painful experiences (Fosha, 2000; Frederick, 2021). Within AEDP, the therapeutic relationship forms an attachment pillar: intentional, affirmative, emotionally engaged, and foundational to building relational safety. Within this active relationship, difficult and painful emotions are dyadically regulated and then processed (Harrison, 2020). Further, in the service of transforming maladaptive internal working models formed earlier, the present moment therapeutic relationship is explicitly and experientially processed

throughout, to create corrective emotional experiences, and build greater capacities for attachment security (Lipton & Fosha, 2011).

The experiential processing of emotional experience

In order to process the negative, painful, overwhelming emotions associated with emotional suffering (Lamagna, 2021), AEDP works experientially, from the bottom up, with an emphasis on moment-to-moment tracking and dyadic affect regulation, to facilitate somatic and affective processing of painful emotional experiences to completion. The completion of experiential processing is invariably marked by positive affect, i.e., a subjective sense of relief, increased hope and the release of the adaptive action tendencies associated with that emotional experience, setting up the transformational work that follows.

Metatherapeutic processing: **The experiential processing of transformational experience**

The completed processing of an emotional experience is not an end in AEDP: it is the start of another round of therapeutic work to consolidate and expand the positive change that follows from processing negative emotions to completion (Fosha, Thoma & Yeung, 2019). *Metatherapeutic processing*, or *metaprocessing,* is an AEDP technique for systematically working with transformational experience (Yamauchi, 2018) and broadening and building the positive emotions associated with change moments (Fosha & Thoma, 2020): the immediate experience of positive emotion associated with change moments is explicitly brought into awareness, dyadically shared, experientially deepened and processed, reflected on and integrated (Iwakabe & Conceiçao, 2016). More positive, transformational affective phenomena thus emerge, which are then further nurtured, experientially processed, and expanded upon, leading to upward spirals (Fosha, 2000; Fredrickson & Joiner, 2018). The in-session flourishing that metatherapeutic processing brings about is thus a natural culmination of the process of working with emotional suffering in AEDP (Fosha, 2021a).

Over the past 15 years, the AEDP model has been disseminated internationally through professional workshops that attract seasoned therapists who are eager to learn approaches that make the best use of the therapeutic relationship and the session hour to help their patients. Rooted in a similar tradition of deliberate practice as ISTDP, involving meticulous and intensive process analysis of videotaped sessions (cf. Rousmaniere, 2016), AEDP uses the practice of micro-analysis of video-taped sessions to refine the AEDP model and to deepen the skills of its practitioners, in workshops, supervision, and individual self-supervision (Prenn & Fosha, 2017).

Recently, programmatic empirical investigations of AEDP have begun. Several systematic case studies have documented the course of AEDP treatment (e.g., Iwakabe et al., 2020; Markin et al., 2018; Pass, 2012; Vigoda Gonzalez, 2018). Pass (2012) described a successful change process in a treatment with a trauma survivor in which the therapist integrated expressive writing with the principles of AEDP. Vigoda Gonzalez (2018), reported on the successful treatment with AEDP of a patient suffering from trauma and major depression. She showed that AEDP can be sensitively applied to a multicultural therapy context, with attuned language switching by both patient and therapist contributing to optimal emotional processing. Markin et al. (2018) used a single case comparison method and demonstrated that in a successful case conducted by an experienced AEDP therapist, observed changes were consistent with AEDP's theory of change, i.e., overall improvement is driven by accessing deep affect within a secure attachment relationship with the therapist, which results in a series of corrective emotional experiences. More recently, Iwakabe et al. (2021) examined patients' subjective experience in the first session of AEDP, showing that the experience of change occurs right from the beginning of the therapy, with a rapid establishment of relationship and a sharp focus on the immediate feelings in the session. A task analytic study examining change processes associated with metaprocessing interventions identified its essential therapist responses and steps of patient

performance (Iwakabe & Conceiçao, 2016). Therapists used affirmation, experiential guiding, and restructuring strategies to help patients process their experience of change. In turn, patients developed a positive sense of self, disconfirming and letting go of long held negative beliefs, and created new narratives based on their experience of change. Finally, 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).

Building on these early initiatives, Iwakabe et al. (2020) developed a Practice Research Network (PRN) in the international AEDP community to test the effectiveness of AEDP in community-based settings, i.e., the private practice settings in which AEDP is usually practiced (see Castonguay et al., 2013 for further elaboration of the PRN paradigm). The AEDP PRN involves collaborative, bi-directional relationships between AEDP clinical practitioners and researchers. AEDP prizes therapist flexibility and moment-to-moment responsiveness to patient emotional experience. Furthermore, therapeutic actions need to be based on therapist authenticity: therapist affirmation and empathy cannot be effective unless they are genuine and patients experience them as such. Though videotaping sessions is a part of everyday AEDP practice, training and supervision, its effectiveness has not been tested. Therefore, instead of testing the efficacy of AEDP in a highly controlled setting, we thought it more effective and beneficial to build an infrastructure of research throughout the AEDP community to examine the effectiveness of AEDP in the naturalistic, ecologically valid settings in which it is practiced, with the goal of facilitating the involvement of the AEDP therapeutic community in the research endeavor, with the possibility of building toward more controlled studies in the future.

In the first published outcome study conducted within the AEDP PRN (Iwakabe et al., 2020), we tested a 16-session AEDP treatment with 62 patients, self-referred to AEDP clinicians in private practice. AEDP is most often practiced in an open-ended manner without setting a limit

on the number of sessions. However, given AEDP's early roots in short-term dynamic psychotherapy (Davanloo, 1990; Malan, 1976), in order to facilitate the comparison of AEDP with other evidence-based models and to enhance AEDPs applicability to different treatment settings, the decision was made to develop a 16-session version of AEDP. To do so, we leaned into the work of James Mann (1973; Mann & Goldman, 1977), whose de facto transdiagnostic focus on the universality of issues of loss fit well with AEDP's attachment focus. We then adapted Mann's work to fit with our focus on transformance and the dyadic regulation of both negative and positive emotions (Harrison, 2020) and we developed a series of online webinars to train AEDP therapists in the 16-session format (Edlin & Fosha, 2015). This focus has important clinical implications, as termination in AEDP involves dyadically processing both (i) the sadness and grief of saying goodbye and (ii) the positive emotions arising from the gains and achievements of the therapy (Harrison, 2020; Silvan; 2022; Woods, *in press*).

This sample of patients, presenting with a variety of symptoms and problems, showed marked improvements from pre- to post-treatment in five of the six outcome target areas proposed by Cuijpers et al. (2019). Large effect sizes ($d = 0.74$ to $d = 1.60$) were evident for a variety of psychological problems (e.g., depression, negative automatic thoughts, experiential avoidance, interpersonal difficulties) and for measures of positive mental health (e.g., self-esteem, self-compassion). The proportion of patients who achieved reliable change (Jacobson et al., 1999) varied from 62.9% (depression) and 74.2% (general psychiatric symptoms) to 19.4% (interpersonal problems), mostly hovering around 50%.

An additional analysis was conducted to examine the effectiveness of AEDP in two distinct groups: a clinical group with more severe symptoms in several areas, and a subclinical group (Fava & Mangelli, 2001) with problems in fewer areas and milder in severity, yet where subjective distress was as pronounced as in the more severe group. While the clinical group had

larger effect sizes overall (all *d* 's > 1.0), patients in the subclinical group (effect sizes from *d* = 0.46 to *d* = 2.07) also demonstrated notable improvements. Further, at termination, almost all patients in the subclinical group achieved the criterion for movement into the functional distribution for all scales. In sum, the first PRN outcome study demonstrated the post-treatment effectiveness of AEDP in a 16-session format, as practiced in private practice settings. Our next task was to demonstrate the long-term effectiveness of AEDP.

Meta-analytic studies on psychodynamic psychotherapy have shown that patients maintained their therapeutic gains in both general symptoms and interpersonal functioning (Abbass et al., 2012; Town et al., 2020). Ellison et al. (2010) reported 6- and 18-months follow-up of experiential therapies, both emotion-focused and client-centered, for depression. Patients in both treatment conditions achieved clinically significant change post-treatment; however, a larger number of patients in the emotion-focused therapy maintained their therapeutic gains than in the client-centered therapy. These findings suggest that affect-focused, psychodynamic and experiential therapies tend to produce long-term effects after termination. In addition, therapeutic gains include symptom reduction, as well as secondary outcomes such as enhanced self and interpersonal functioning. Consistent with these findings, it is anticipated that AEDP, being affect-focused, psychodynamic and experiential, will also have long-term positive effects on varieties of psychological functioning beyond symptom reduction.

The purpose of the present study was to examine AEDP's long term effectiveness and the maintenance of gains from post-treatment through a six and 12-month follow-up period. We hypothesized that the therapeutic gains, demonstrated from pre-treatment to post-treatment (Iwakabe et al., 2020), would be maintained over the six and 12-month follow-up period. We examined a wide variety of measures of psychopathology, including depression, automatic negative thoughts, emotion dysregulation, experiential avoidance, interpersonal problems, and

general psychological symptoms, as well as aspects of positive psychological functioning, such as self-compassion, self-esteem, and flourishing. Given that AEDP seeks to facilitate optimal functioning of patients through the experiential processing of both negative and positive emotions, we expected to find a sustained reduction of all the measures of psychopathology, alongside sustained gains in all the measures of positive mental health at six and 12 months. Therefore we included all outcome variables examined in the pre-and post-treatment in this follow-up study.

Method

Patients

Information regarding the original outcome study is summarized below (Table 1). The AEDP PRN is an ongoing research program. For this study, we used the data, gathered between June 2016 and March 2021. Patients were 63 (20 men and 43 women) self-referred adults from 22 to 72 years old (M = 36.73, SD = 11.80) who completed the 16-session AEDP treatment in private practice settings. A majority of the patients were White (n = 46, 73.02%), with 14 (22.22%) BIPOC individuals and 3 individuals with no response.

Prospective patients contacted AEDP therapists in private practice requesting services for common psychological difficulties, such as depression, anxiety, emotional pain (or distress), and interpersonal difficulties. To enter into the study, they were asked to fill out the online pre-treatment assessment questionnaires. Exclusion criteria included: active suicidality, active addiction and substance abuse, psychosis, thought disorder and severe impulsive and behavioral problems, moderate to severe autism spectrum diagnosis, and a current crisis situation requiring immediate crisis intervention (e.g., intimate partner violence). Individuals involved in other therapies, or who started or withdrew from psychiatric medication within 3 months of

participation in the study were also excluded to control for potential confounding effects. These criteria also applied to the entirety of the follow-up period.

Inclusion criteria included (i) a level of distress as measured by the Target Complaint (Battle et al., 1966) score, for the main presenting issue, of at least six or 7 (very much) on a 12-point Likert scale. After one year into the research project, we decided to screen out those patients who had two or less problems that reached one standard deviation of elevation from the normal population mean on a total of 17 clinical scales, as we wanted to ensure that we were testing the model on those with clinical levels of problems.

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 few elevated pretreatment symptom scales. In order to adequately distinguish these two important profiles (Cuijpers et al., 2014; Fava & Mangelli, 2001), we report the results for the whole sample as well as results of separating the sample into clinical and subclinical groups.

In defining the clinical and subclinical groups, we followed the procedure as outlined in the initial outcome study (see Iwakabe, et. al, 2020). Briefly, we used 17 outcome indices: seven different outcome scales and the 10 subscales of the Symptom Assessment-45. Patients with elevated scores above 1 standard deviation from the population mean on four or more of these 17 indices were defined as the clinical group. Patients who had three or fewer elevated scores across the 17 indices were defined as the subclinical group. Similar symptom severity grouping procedures can be seen in Barkham et al. (1999). Forty patients met the criteria for the clinical group with a mean of 8.03 (SD = 2.79), and elevated indices with a range between 4 and 16. Twenty-three patients met the criteria for the subclinical group with a mean 1.61 (SD = 1.12), and elevated indices with a range between 0 and 3. There were no significant differences in demographics, such as age or gender, between the clinical and subclinical groups.

All therapy sessions were conducted in English. All patients and therapists were fluent in English, though for some patients and some therapists, English was not their first language. More detailed information regarding patient selection, therapists, and treatment process can be found in the original outcome study (Iwakabe et al., 2020). All patients attended 16 sessions, except two patients who were given three additional sessions: as disruptive life events occurred during the treatment (e.g., a temporary job assignment in another country), it was determined the extra sessions were necessary to fulfill clinical and ethical responsibilities. Patients responded to the post-treatment outcome questionnaires after their 19th session. Their data was treated in the same way as that of the other patients. The average number of weeks that it took to complete the treatment was 22.25 (SD = 5.46: range 13 to 38 weeks). During the follow-up period, one patient received three booster sessions due to a personal crisis after termination. No other patients reported to have sought other therapies or psychiatric medication during the post-treatment follow-up period.

Therapists

Thirty-five therapists participated in this study. All therapists had either master's or doctoral degrees in clinical or counseling psychology or social work, except one who was a psychiatrist. All therapists had extensive training in AEDP. A majority of therapists (n = 29, 82.86%) were certified AEDP therapists or higher, i.e., certified supervisors or AEDP faculty. AEDP therapist certification entails 120-200 hours of seminar-based training and a minimum of 40 hours of individual supervision using video-taped sessions. Six therapists (17.14%) who completed an intermediate level of training and were not yet certified were invited to participate based on the recommendation of their supervisors who judged them to demonstrate superior AEDP skills.

All therapists participated in a two-hour online-training session outlining AEDP interventions according to the modified 16-session treatment protocol. Additionally, each therapist received two individual supervision sessions with a faculty member of the AEDP Institute for each study patient they treated. There was also a weekly drop-in group supervision group co-led by two AEDP Institute faculty members open to all therapists in the study who had an active case. Like all AEDP supervision (Prenn & Fosha, 2017), both the individual and the group supervision the study therapists received were based on the direct viewing of segments of the therapist's videotaped sessions with the study patient.

Treatment

AEDP treatment in this study consisted of 16 one-hour sessions. Therapists were instructed to use the AEDP framework actively to optimize the therapeutic relationship and facilitate patients' experiential processing of emotional, relational and transformational experiences (Edlin & Fosha, 2015; Fosha, 2013). Therapist intervention strategies included: (a) focusing on and working with glimmers of transformance from the get-go (b) strategies to restructure or bypass patient defenses, (c) dyadic affect regulation and other relational strategies aimed at building relational capacities, (d) experiential-affective strategies to process patients' painful emotions, and (e) metatherapeutic processing strategies to deepen and expand the emerging positive affective experiences associated with transformational 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 to guide moment-to-moment decision making for interventions (Fosha, 2021a; Russell, 2015).

Measures

In keeping with recent calls for comprehensive examination of therapeutic outcome (e.g., Cuijpers, 2019), we included measures that were associated with five different outcome targets: a

subjective measure of distress and change; measures of psychological symptoms and interpersonal difficulties; measures of positive mental health; measures of subjective wellbeing; and secondary measures associated with change mechanisms.

Subjective Measure of Distress

Target Complaints (Battle et al., 1966), is used to assess main problems and the level of associated subjective distress as experienced by patients. Patients 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). At post-treatment and two follow-ups, 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) reports high correlations of the TC with other outcome measures and test-reliability.

Measures of Psychological Symptoms

Beck Depression Inventory (BDI; Beck et al., 1961) is a 21-item self-report measure of depression, widely used in psychotherapy outcome research. Responses are scored on a 4-point Likert scale, with higher scores indicating greater severity of depression. The coefficient alpha in the present sample was .91.

Symptom Assessment-45 (SA-45; Davison et al., 1997) is a shorter version of the Symptom Checklist-90 (SCL-90, Derogatis et al., 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 SCL-90 and a Global Severity Index (GSI), calculated by summing the scores of nine subscales. GSI was used for this study. For the present sample, coefficient alpha was .94.

Inventory of Interpersonal Problems-32 (IIP-32; Barkham et al., 1996), a 32-item measure, assesses the severity of problems in interpersonal functioning (Horowitz et al., 1988).

All items are answered using a 5-point scale, ranging from 0 to 4. The coefficient alpha in the present sample for the full scale was .91.

Automatic Thought Questionnaire (ATQ; Hollon & Kendall, 1980), a 30-item instrument, measures the frequency of automatic negative statements about the self, which are rated on a 5-point scale. The five subscales include: Demoralization, Self-Criticism, Brooding, Amotivation, and Interpersonal Disappointment. 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. The four subscales include: 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, which are rated on a 5-point Likert scale. The full-scale coefficient alpha for the present sample was .95.

Acceptance and Action Questionnaire (AAQ-II; Hayes et al., 2004), a 9-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), a 26-item measure, includes six aspects of self-compassion, 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 include Self-Kindness, Common Humanity, Mindfulness, Over-Identification, Isolation, and Self-Judgment. The coefficient alpha for the full scale was .91 in the present sample.

Mental Health Continuum-Short-Form (MHC-SF: Keyes, 1998) consists of 15 items that 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.

Procedures

Prospective patients were self-referred individuals. A written informed consent was reviewed and obtained and patients filled out the pre-treatment measures. Patients received a significant fee reduction to offset the additional time required to participate in the study protocol. Institutional Review Board approval from the first author's institutional affiliation was obtained prior to conducting the study. Within a week of the completion of the 16 sessions, patients were asked to fill out post-treatment questionnaires and measures. Patients were also contacted for a 30-minute exit interview about their experience of therapy.

Patients filled out the follow-up questionnaires at six and 12 months post-treatment. E-mail reminders were sent directly to each patient for the follow-up assessment. If patients did not respond to the initial e-mail and did not fill out the questionnaire, the researchers contacted them three more times by e-mail. When there was no response at the third attempt, we did not further pursue these patients. Before concluding this study, we sent out one final request to all patients who did not respond to 12-month follow-up reminders. Fifteen patients responded. There were a total of 63 patients who responded to the post-treatment questionnaire, 40 (63.4%) responded at

6-month follow-up, and 52 (82.5%) at 12-month follow-up. The average time that passed from the post-treatment for these 15 patients was 19.61 months (*SD* = 3.77).

Data Analysis

Effect size and the reliable change index. We calculated Cohen's *d* effect size for pre- and post, pre- and six-month follow-up and pre- and 12-month follow-up comparisons. In addition, we calculated the proportion of patients who reached a level of reliable change, made movement into a functional distribution, achieved clinically significant change, significantly deteriorated, as well as one additional category of those who started from within one normal deviation from the population mean (Jacobson et al., 1999). Reliable change index was based on Speer's (1992) method that uses test-rest reliability for its estimation to control the effect of regression toward the mean. We decided to use this more stringent method as we did not have a control group. We used cutoff *b*, which is achieved when the level of functioning fell within 2 *SD* from the normal population. We adopted this cutoff as our sample included patients whose pre-treatment 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 to control for an experiment-wise error. An additional analysis was conducted on the clinical group (n = 40) with an average of 8 pretreatment scores out of 17 outcome scales reaching a clinical range and a subclinical group (n = 23) with an average of 2 pretreatment scores in the clinical range.

Multi-level modeling. Multi-level modeling was used to examine the rate of change from pre-therapy through the course of the 12-month follow-up. Multilevel modeling is a statistical method that examines nested data that are repeated across time (level 1) and nested within individuals (level 2). There are a few advantages to using multilevel analysis (Tasca & Gallup, 2009). First, it accounts well for missing data, which often poses a major statistical challenge in psychotherapy research due to drop-outs. Traditional methods, such as the repeated measures

ANOVA, require complete data for each participant and when there is even one missing data point, the data from that individual has to be dropped completely. Multilevel modeling allows the researchers to retain the data from those individuals whose data are partially missing. Second, multilevel modeling allows a more accurate estimation of regression coefficients and error variances for data that is nested. Third, it allows for the flexibility in the time of assessment for each participant. Therefore, even when the patients did not respond to the outcome assessment at the same time point, it can account for the variation without discarding those individuals who did not fit the assessment schedule. This was particularly important since our data included 15 patients who filled out the follow-up questionnaires much later than at the originally scheduled 12-month point. Finally, multilevel analysis allows for examining nonlinear change. We anticipated that the patients would improve from pretreatment to posttreatment and that they would maintain their therapeutic gains, rather than continue improving during the follow-up period. We also sought to check whether significant worsening of symptoms in the follow-up period occurred. For this goal, we used a piecewise growth model (Singer & Willet, 2003). For an initial improvement from the pre- to post-treatment, the slope was coded 0 (pre-treatment) and 1 (post-treatment) to represent a linear improvement. The second slope from the post-treatment, six-month and 12-month follow-ups were coded as 1, 1, and 1 to represent the maintenance of therapeutic gains. The time parameter was ‘months since pre-therapy’ for each participant. In our model, we did not include therapist as a level because it was not possible to have a reliable estimate of therapist effect as a level due to a small sample size and the large number of therapists. Although piecewise models allow testing hypotheses on level change which represents change in mean level at a particular time point (Owen et al., 2019), we assumed only change in slope in this study, which represents improvement from pre- to post-treatment and maintenance in the follow-up period.

Target complaints had a large number of missing data (n = 29) because patients listed target complaints at the end of treatment that did not match those they had listed at pre-treatment. The data for 31 patients at six-month and for 28 patients at 12-month follow-up were also missing.

Missing Data. Forty patients (60.03%) out of 63 patients filled out the 6-month follow-up questionnaires. For calculating effect sizes, we used listwise deletion. The missing data were investigated using logistic analysis whether the patient gender, age, ethnicity years of therapist clinical experience, years of experience in AEDP as well as two main symptom variables, depression and GSI in SA-45 were related to non-response at six and 12 month follow-ups (Table 2). Those who responded to the six-month follow-up (compared to non-responders at follow-up) tended to have a significantly higher level of depression at pre-treatment than non-responders (Est/S.E.= -1.97, p = .049) and also had also a larger improvement on BDI at termination (Est/S.E.= -2.29, p = .022). However, GSI was not significantly different in two groups (Est/S.E.= -.33, p = .740) for pretreatment and Est/S.E.= 1.00, p = .316 for pre-post treatment change. There was no statistically significant relationship between these variables and responses to the 12-month follow-up (p > .090). For six-month follow-up, we also tested whether pre-treatment or pre-post treatment change of all other outcome scale scores predicted the response at 6-month follow-up. There was no significant relationship between the outcome scales and the response at 6-month follow-up. Therefore, we decided that we can assume that the data was missing at random and ran the multilevel analysis by including all dyads in the analysis.

In piecewise modeling, we used a full information maximum likelihood method (FIML) in Mplus (Muthén, 1998-2004). FIML has been shown to produce unbiased parameter estimates and standard errors under missing at random (MAR) and missing completely at random (MARS). FIML requires that missing values to be at least MAR (Enders & Bandalos, 2001). FIML

estimates a likelihood function for each individual based on the variables that are present so that all the available data are used. It has been demonstrated that FIML produces less biased estimates than multiple imputation method (Yuan et al., 2012).

Results

Pre- to Post-treatment Outcome. Means and SDs for all scales at pre-, post-, six-month, and 12-month follow-ups are presented in Table 3. As reported in Iwakabe et al. (2020), the outcome at the post-treatment showed a generally large effect size for almost all scales ranging from d = -.77 for DERS to d = -1.25 for AAQ-II. Three target complaints, a personalized measure of complaints had the largest effect sizes (-1.67 > d >.-1.04). The majority of patients reached a criterion for movement into functional range (74.1% for AAQ to 100% for GSI). The proportion of patients who achieved reliable change as well as clinically significant change varied depending on the scales (20.6% for IIP to 74.6% for GSI). Both clinical and subclinical groups made large improvements on almost all outcome scales, though the effect sizes as well as the proportion of patients who reached clinically significant change were generally larger in the clinical group, whose symptomatology was higher and more pervasive than that of the subclinical group. There was a small proportion of deterioration: 0% (GSI), 1.6% (BDI, SFS), 3.2% (ATQ, IIP-32, RSES), 6.3% (DERS), and 8.6% (AAQ). In sum, a series of analyses consistently supported the effectiveness of AEDP at post-treatment.

Six and 12-month follow-up. The effect-size (Cohen's d) from pre-treatment to the 6-month follow-up ranged from 1.03 (RSES) to -1.77 (AAQ-II), and were slightly larger than those obtained at post-treatment. Over 95% of patients achieved movement into functional distribution, except on two scales (ATQ = 87.5% and AAQ = 75.7%). Target Complaints had consistently large effect sizes (-2.38 > d >.-1.75). The proportion of patients who achieved clinically significant change varied from 47.5% (IIP-32) to 82.5% (GSI), with most scales having over 60%

of patients achieve clinically significant change. The proportion of patients who showed significant deterioration (Jacobson et al., 1999) in any of the outcome scales was small, ranging from 0% (GSI, IIP-32) to 7.5% (ATQ, RSES).

The analyses of two subgroups showed that at six-month follow-up, (i) patients in both groups made improvements of large effect sizes; and also that (ii) patients in the clinical group (relative to the sub-clinical group) tended to have slightly larger effect sizes and a larger proportion of patients who achieved a clinical reliable change criterion from pre-treatment to six-month follow-up. Deterioration occurred minimally: in the subclinical group, almost all patients remained in the functional distribution at 6-month follow-up and no deterioration occurred except on the RSES with two patients (7.7%).

A total of 52 patients responded to the SA-45, BDI, ATQ, SCS, and AAQ-II for the 12-month follow-up. The effect sizes from the pre-treatment to the 12-month follow-up were large ranging from d = 0.80 on RSES to d = -1.46 on AAQ-II. Over 94.2% of patients moved into the functional range on all outcome scales except on AAQ (87.2%). The proportion of patients who achieved clinically significant change from pre-treatment to 12-month follow-up ranged from 40.4% (IIP-32) to 69.2% (GSI). Deterioration occurred 3.8% for GSI, IIP-32, and DERS, 7.7% for RSES and SCS, 9.6% for BDI and ATQ, and 10.6 for AAQ.

For analyses on clinical and subclinical groups, the effect size (Cohen's d) from pretreatment to the 12-month follow-up for the clinical group ranged between d = -1.51 (ATQ) and d = -2.25 (AAQ) (*See* Table. 4 & 5). Over 90% of patients in the clinical group achieved a criterion movement into functional range for all scales except two (ATQ & AAQ). Deterioration occurred between 0% (IIP-32) and 9.7% (BDI, ATQ, & AAQ). On the other hand, in the subclinical group, effect sizes were still in the moderate to large effect size range, though somewhat smaller in magnitude, as compared to those in the clinical group, ranging from d = .49

on RSES and d = -2.23 on first Target Complaints, with most scales hovering around d = .80. Over 93.80% of patients in the subclinical group achieved movement into the functional range with 100% on GSI, IIP-32, DERS, and SCS. The proportion of patients who achieved clinically significant change ranged between 38.10% and 57.10%. Deterioration over the follow-up period was higher in the subclinical group, between 0% on GSI and 14.3% on RSES.

Target Complaints had a missing data due to unmatched complaints at four data points. Cohen's d was generally large, ranging from -1.04. and -2.68. At 12 months, for patients in both clinical and subclinical groups, almost all the effect sizes for target complaints exceeded $d > 1.00$, with slightly larger effect sizes seen in the clinical group.

In sum, at 12-months post termination, the effect sizes for most outcome scales were large, with over 50% patients achieving clinically significant change, and the overall proportion of patients who deteriorated was less than 10% in the 12-month period after termination. Both clinical and subclinical groups achieved large effect sizes over the 12 month follow-up period.

Multi-level Modeling: Piecewise Growth Model

A piecewise growth model was tested in order to examine the hypotheses about the maintenance of therapeutic gains. This modeling allows us to test the maintenance of therapeutic gains more rigorously by eliminating the possibility that those who responded to the follow-up included more improvers because it estimates the model with the data from all participants, including those whose data are partially missing. Figure 1 presents piecewise models for all eight outcome measures. Table 6 shows the results of piecewise growth model for all patients. The Comparative Fit Index (CFI) for most scales was above .90 (.952 to 1.000), except for the second target complaint (.728), GSI (.882), and MHC (.850), indicating that they were generally acceptable for all scales. We were not able to obtain a proper solution for the first target complaint. Consistent with the above analyses on the effect size and clinically reliable change,

slope 1, which represents a linear improvement from pre-to post-treatment, were all significant ($p < .001$) with absolute values of means ranging from 25.675 to 2.670. In addition, variances for TC2, GSI, BDI, ATQ, IIP, DERS, and SCS were statistically significant indicating that there were also individual differences in the angle of the slope or the magnitude of improvements. Patients differed in the rate of improvement on their second target complaint, general psychological symptoms, depression, automatic negative thoughts, interpersonal problems, emotion dysregulation, and self-compassion.

For slope 2, which tested whether patients significantly deteriorated from post-treatment to 12-month follow-up via six-month follow-up, the slope was not significant for all scales. The results confirmed the above findings on effect sizes and the proportion of patients who achieved clinically significant change. There was no significant worsening from the post-treatment to 12-month follow-ups. There was no individual difference in the angle of the slope at the follow-up period for most scales except ATQ ($p < .001$) and IIP ($p = .007$).

In sum, the results of piecewise growth model that controlled for the missing data showed that patients improved pre-to post-treatment and that their therapeutic gains were maintained over the 12-months after termination. Individual differences were more conspicuous in the rate of change during the treatment than during the follow-up period.

Discussion

The present study investigated the long-term effectiveness and maintenance of therapeutic gains of a 16-session AEDP format in naturalistic, private practice settings, over a six and 12-month follow-up period. In an earlier study, we reported the post-treatment outcomes of individuals presenting with a range of symptoms to AEDP practitioners in five countries (Iwakabe et al., 2020). Both studies are part of a large-scale AEDP PRN, an international

community of researchers and clinicians collaborating on deepening the understanding of AEDP change processes and on improving the effectiveness of AEDP. Improvements in psychological functioning had been demonstrated from pre-treatment to post-treatment, with large effect sizes for most measures. The present study found that these gains were largely maintained at six and 12-month follow-up. By setting treatment parameters such as session number to those of empirically supported treatments, this study also allows comparison of AEDP to other models of therapy.

The current study documents the maintenance of therapeutic gains, providing evidence of significant reductions in global symptom severity; depression; negative automatic cognitions; along with improvements in emotional regulation; interpersonal functioning; and in the capacity to tolerate and make adaptive use of emotional experience (i.e., a decrease in experiential avoidance) over a 12-month follow-up period. It also documents the maintenance of gains in positive measures of mental health, e.g., self-compassion and well-being. The proportion of patients who initially achieved positive, clinically significant change post-treatment and maintained their overall gains at 12 months was high, with an average of 67.25% of patients for outcome scales. Most patients (83.9%-100%) maintained functional improvements within the range of the normal population. The small proportion of patients who deteriorated on some measures was similar to other psychotherapies (e.g., Cuijpers et al, 2018; Lambert, 2013), and piecewise growth modelling analyses confirmed that deterioration was not a significant factor overall.

Overall, present findings support the long-term effectiveness of AEDP at six and 12-months follow-up. These results showing the long term effectiveness of AEDP are consistent with the long-term effectiveness of other experiential and psychodynamic psychotherapies, such as emotion focused therapy (EFT) for depression (Ellison et al., 2010), and short and long term

psychodynamic psychotherapy for a variety of psychological issues (Abbass et. al, 2012; Town et al., 2022), including treatment-resistant depression (Town et al., 2020). The results are also comparable with the long-term effectiveness of cognitive behavioural therapy (CBT; Karyotaki et al., 2016). This is particularly notable in that AEDP focuses on in-session change rather than the direct teaching of coping skills and between-session skills practice.

AEDP is transdiagnostic, targeting psychopathological processes believed to underlie an array of diagnoses (see Sauer-Zavala et al., 2017). However, beyond its transdiagnostic focus, AEDP is, at its essence, healing-oriented and focuses on working actively with transformational experience (Fosha, 2017). AEDP seeks to simultaneously reduce the suffering associated with psychopathology and facilitate the emergence of in-session flourishing (Fosha, Thoma, & Yeung, 2019), with AEDP therapists guided by a therapeutic roadmap grounded in the phenomenology of transformational experience (Fosha, 2021a). In keeping with AEDP's essential ethos, we predicted a specific pattern of outcome findings: not only reduced symptoms of pathology, but also improvements in positive mental health. The results supported this prediction: from pre-treatment to post-treatment, to six and 12-month follow-up post-treatment, the sample showed diminished pathology (e.g., depression, global symptom severity, subjective distress, experiential avoidance, automatic negative cognitions) alongside concurrent improvements in positive mental health, including self-esteem (RSES), self-compassion (SCS), and general well-being (MHC-SF), with large effect sizes at post-treatment, and with therapeutic gains maintained at follow-up periods.

Clinical and Subclinical Group Outcomes

Consistent with the analyses published in our examination of posttreatment results (Iwakabe et al., 2020), we separately examined the maintenance of gains for clinical and subclinical patient groups. The clinical group presented with an array of clinically significant

symptomatology at intake, including depression. From pre-treatment to 12-month follow-up, these patients showed large effect sizes in symptom reduction, as well as positive changes in self-esteem, self-compassion and well-being (E.S. =1.51-2.24). Eighty-three to 100 percent achieved functioning within the normal population range, suggesting overall reduction in mental illness, and increase in positive mental health.

The subclinical group reported fewer symptoms at intake than would meet the threshold of clinical pathology, yet their subjective distress (measured through Target Complaints) was on par with those with more severe symptomatology. Effect sizes in the subclinical group were medium to large from pre-treatment to 12-months follow-up (E.S = .56 - 2.17). Particularly noteworthy were large reductions in Target Complaints and global symptomatology. As a group, they also demonstrated moderate to large improvements in mental health, seen in self-esteem (RSES), self-compassion (SCS) and general well-being (MHC-SF). Altogether, these results also support the effectiveness of AEDP in reducing suffering and enhancing mental health in subclinical patients. These findings are consistent with meta-analyses demonstrating the benefits of preventative programs, using similar outcomes, i.e., depression, anxiety, stress, and emotional skills (e.g., Cuijpers et al, 2014), and with research that suggests interventions for subclinical populations may play an important protective and preventative role for those at risk of developing mental disorders, disability, and other impairments in the future (Keyes, 2002).

AEDP PRN Feasibility at 12 Months

An important feature of the present study is the PRN, the infrastructure of AEDP research. The AEDP PRN is an international partnership between private practice therapists and clinical researchers, collaborating to evaluate AEDP outcomes, gain deeper understanding of its change mechanisms, and to ultimately enhance AEDP's clinical effectiveness. The private practice setting for our PRN gives ecological validity to the study; it was conducted in the naturalistic

settings where AEDP therapy is usually practiced,. It is also the setting where many if not most patients receive their outpatient therapy, regardless of model. This study, accomplished with AEDP clinical practitioners from four continents who collaborated with the research protocol, speaks to their efforts, as well as to their enthusiasm for and commitment to AEDP. The success of our efforts demonstrates the feasibility and potential of community-based psychotherapy and PRN clinician-researcher partnerships to contribute to the science and practice of psychotherapy (Castonguay et al., 2013).

Limitations and Future Directions

The present study had a number of limitations. The lack of a control group precluded controlling for factors such as passage of time and regression to the mean (Hill & Lambert, 2004). Furthermore, the generalizability of the findings is limited by the nature of the sample. Our sample consisted of self-referred patients seeking psychotherapy in community private practice settings for a variety of complaints, problem areas, and diagnoses (Koerner & Castonguay, 2015). Findings may generalize to similar practice settings with a transdiagnostic focus, but more study is needed to understand the generalizability of these findings to diagnostically homogenous samples or other settings, such as clinics, hospitals or universities. In the future, it may be useful to target patients with particular diagnoses, such as depression, to increase experimental control and comparability to treatments applied to such groups. In addition, we need to systematically assess the relationship between fidelity and treatment outcome. Furthermore, with a larger sample, we need to address therapist effect, which will allow variabilities between therapists.

We relied on self-reported outcome measures, without other objective measures of functioning. To balance this limitation, we covered a range of self-report outcome measures,

covering five out of six target domains of psychotherapy outcome recommended by Cuijpers et al. (2019).

Attrition, a common problem in follow-up studies, was present in this study as well, though interestingly, more so at six than at 12-months. We had 36.5% (n = 23) of patients who could not be reached at six-month follow-up, and 17.4% (n = 11) could not be reached at 12-month follow-up. While a number of patients responded to their 12-month follow-up assessment well beyond 15 months post-treatment, their data incidentally shows maintenance of therapeutic gains beyond the 12-months. While multilevel modeling helped address missing data, we are nonetheless working to improve coordination between patients and therapists, so patients can be more reliably reached for follow-up assessments.

As is common in studies of psychotherapy (Lambert, 2013), a small proportion of patients experienced deterioration from pre-treatment to 12 months. For example, a few subclinical patients showed reductions in psychological flexibility (12.5%) and self-esteem (14.3%) over the 12-month follow-up. Future studies will help further elucidate factors that contribute to deterioration, as well as factors that may alleviate such vulnerabilities and support progress for such patients (e.g., longer treatment and/or booster sessions). An intensive analysis into types of affects being addressed, and how they are worked with, may be one of the potential avenues of research (Town et al., 2022). Nevertheless, overall, gains achieved posttreatment were largely maintained at 12 months for both clinical and subclinical subgroups.

Finally, especially given AEDP's healing orientation and its systematic clinical techniques for working with positive affect to promote flourishing, this study was limited in its actual measurement of in-session and out-of-session changes in positive mental health. While we measured self-esteem, self-compassion, and general well-being, more measures are needed to assess flourishing. We recently developed the Moments of Flourishing Experience Scale (MFES),

a self-report scale to measure in-session and out-of-session flourishing (Fosha et al., submitted for publication) to use in future studies. We also added measures to our ongoing PRN research protocol to further examine positive affective experiences, mental health, and flourishing more fully and in a more differentiated fashion in future studies.

Conclusions

The present research is part of an AEDP PRN initiative, a collaborative, long term naturalistic research partnership between clinical practitioners and researchers in the worldwide AEDP community. This study supports the long term effectiveness of AEDP as a model that can: (i) produce lasting therapeutic change over the six and 12-months following treatment, (ii) be applied to a wide range of psychological problems, (iii) reduce psychopathology, (iv) improve positive mental health and well-being, (v) be applied to both clinical and subclinical populations, and (vi) be generalized to the community-based private practice settings where a majority of patients receive their therapy. These findings support AEDP's long term effectiveness as a healing-oriented, mind-body, experiential psychotherapy. Future studies may include a control group, replication studies, measures of in-session and outside-of-session flourishing, and investigations of particular psychological disorders. Future research will also examine specific AEDP affective change processes that contribute to therapeutic change in order to increase our understanding of AEDP's unique mechanisms of change, as well as of the common factors it shares with other psychotherapies.

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Table 1. Patient characteristics at pretreatment baseline

Variable	N (%)		
	Total	Clinical	Subclinical
N	63	40	23
Gender			
Female	43 (68.25%)	27 (67.50%)	16 (69.57%)
Male	20 (31.75%)	13 (32.50%)	7 (30.43%)
Age *M* (SD/range)	36.73 (11.80/22-72)	34.43 (9.54/22-65)	40.74 (14.31/22-72)
Self-identified ethnic or cultural background			
White	46 (73.02%)	26 (65.00%)	20 (86.96%)
BIPOC	14 (22.22%)	12 (30.00%)	2 (8.70%)
No response	3 (4.76%)	2 (5.00%)	1 (4.35%)
Highest level of education			
Primary school completed	1 (1.59%)	0 (0.00%)	1 (4.35%)
Secondary/high school completed	7 (11.11%)	5 (12.50%)	2 (8.70%)
College/university completed	33 (52.38%)	23 (57.50%)	10 (43.48%)
Post graduate degree	22 (34.92%)	12 (30.00%)	10 (43.48%)
Primary work status			
Employed	53 (84.13%)	33 (82.50%)	20 (86.96%)
Student	7 (11.11%)	5 (12.50%)	2 (8.70%)
Homemaker	2 (3.17%)	2 (5.00%)	0 (0.00%)
Unemployed	1 (1.59%)	0 (0.00%)	1 (4.35%)
Marital status			
Married/common Law	28 (44.44%)	16 (40.00%)	12 (52.17%)
Single	28 (44.44%)	20 (50.00%)	8 (34.78%)
Divorced or separated	4 (6.35%)	3 (7.50%)	1 (4.35%)
Other	3 (4.76%)	1 (2.50%)	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.

Table. 2 Logistic Regression

Variables	Estimate	S.E.	Est./S.E.	TwoTailed P-Value
6 months Yes or No				

Demographic				
Gender	-0.10	0.57	-0.17	.865
Age	0.03	0.02	1.41	.159
Ethnicity	0.15	0.46	0.33	.744
Clinical Experience	0.00	0.02	-0.17	.862
AEDP Experience	0.08	0.06	1.39	.166
Pre				
BDI	-0.07	0.04	-1.97	.049
GSI	0.00	0.01	-0.33	.740
Post				
BDI Post	0.03	0.04	0.60	.547
GSI Post	0.01	0.02	0.66	.508
Pre-Post Change				
BDI	0.08	0.04	2.29	.022
GSI	0.02	0.01	1.00	.316
12 months Yes or No				
Demographic				
Gender	-0.26	0.74	-0.35	.726
Age	-0.03	0.03	-0.90	.370
Ethnicity	-0.18	0.63	-0.29	.770
Clinical Experience	0.00	0.03	-0.13	.899
AEDP Experience	-0.24	0.14	-1.70	.090
Pre				
BDI	0.05	0.04	1.29	.197
GSI	0.02	0.01	1.67	.095
Post				
BDI Post	0.08	0.05	1.63	.103
GSI Post	0.01	0.02	0.75	.454
Pre-Post Change				
BDI	0.00	0.04	-0.06	.956
GSI	-0.02	0.02	-1.43	.154

Note. GSI: Global Severity Index of Symptom Assessment-45; BDI: Beck Depression Inventory

Table 3. *Pretreatment baseline, Post-treatment outcome, 6-month and 12-month follow-up, effect sizes (Cohen's d) for all outcome measures, and proportions of participants who reached reliable change (Jacobson & Truax, 1991) for all patients.*

Measure	Pre (*N* = 63)	Post (*N* = 63)	6 months (*N* = 40)	12 months (*N* = 52)	Pre-Post (%)					Pre-6 months (%)					Pre-12 months (%)				
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF
TC1	8.52 (1.62)	5.83 [d] (2.58)	4.68 [i] (2.50)	4.97 [m] (2.67)	-1.67					-2.38					-2.20				
TC2	8.13 (2.05)	6.00 [e] (3.21)	4.15 [j] (2.98)	4.37 [n] (2.84)	-1.04					-1.94					-1.83				
TC3	7.85 [a] (2.07)	5.36 [f] (2.25)	3.78 [k] (2.34)	4.23 [o] (2.49)	-1.20					-1.97					-1.75				
GSI	49.27 (23.99)	23.94 (17.60)	21.13 (17.08)	22.87 (19.88)	-1.06	74.6	100.0	74.6	0.0	-1.17	82.5	100.0	82.5	0.0	-1.10	69.2	100.0	69.2	3.8
BDI	18.08 (8.46)	7.94 (6.31)	7.55 (7.15)	7.58 (6.65)	-1.20	68.3	95.2	63.5	1.6	-1.25	75.0	95.0	75.0	5.0	-1.24	67.3	96.2	67.3	9.6
ATQ	70.70 (23.99)	49.79 (19.49)	47.57 (19.27)	46.83 (21.23)	-0.87	52.4	87.3	50.8	3.2	-0.96	70.0	87.5	70.0	7.5	-0.99	61.5	90.4	61.5	9.6
IIP-32	59.43 (8.98)	52.29 (9.11)	50.58 (9.57)	50.08 (8.62)	-0.80	20.6	95.2	20.6	3.2	-0.99	47.5	95.0	47.5	0.0	-1.04	40.4	96.2	40.4	3.8
RSES	16.25 (4.98)	20.13 (5.23)	20.85 (5.53)	20.71 (5.47)	0.78	41.3	95.2	41.3	3.2	0.92	55.0	95.0	55.0	7.5	0.89	46.2	94.2	46.2	7.7

DERS	94.62 (22.93)	76.97 (21.25)	74.13 (22.48)	71.02 (21.16)	-0.77	52.4	95.2	50.8	6.3	-0.89	55.0	97.5	55.0	2.5	-1.03	59.6	98.1	59.6	3.8
SCS	15.53 (3.93)	19.44 (4.73)	19.98 (5.00)	19.71 (4.69)	0.99	63.5	96.8	63.5	1.6	1.13	65.0	95.0	65.0	2.5	1.06	63.5	94.2	63.5	7.7
AAQ-II	30.57 [b] (6.61)	21.82 [g] (8.24)	19.90 (7.74)	19.75 (8.63)	-1.32	56.9	74.1	50.0	8.6	-1.61	70.3	75.7	67.6	2.7	-1.64	63.8	87.2	63.8	10.6
MHC-SF	31.00 [c] (11.90)	44.58 [h] (11.48)	42.95 [l] (14.11)	46.62 (12.39)	1.14					1.00					1.31				

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; 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.
a: $N = 62$; b: $N = 58$; c: $N = 39$; d: $N = 35$; e: $N = 28$; f: $N = 25$; g: $N = 61$; h: $N = 55$; i: $N = 31$; j: $N = 27$; k: $N = 27$; l: $N = 37$; m: $N = 34$; n: $N = 32$; o: $N = 35$

Table 4. *Pretreatment baseline, Post-treatment outcome, 6-month and 12-month follow-up, effect sizes (Cohen's d) for all outcome measures, and proportions of participants who reached reliable change (Jacobson & Truax, 1991) for clinical group.*

Measure	Pre (N = 40)	Post (N = 40)	6 months (N = 27)	12 months (N = 31)	Pre-Post (%)					Pre-6 months (%)					Pre-12 months (%)				
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF
TC1	8.75 (1.63)	5.81 [c] (2.66)	5.24 [f] (2.47)	5.10 [i] (2.53)	-1.80					-2.15					-2.24				

TC2	8.45 (1.95)	5.81 [d] (3.29)	4.71 [g] (3.29)	4.68 [j] (2.73)	-1.36					-1.92				-1.94				
TC3	8.10 [a] (2.09)	5.07 [e] (2.53)	3.88 [h] (2.32)	4.18 [k] (2.50)	-1.45					-2.02				-1.88				
GSI	61.80 (20.54)	28.95 (18.99)	25.67 (18.85)	28.77 (22.74)	-1.60	82.5	100.0	82.5	0.0	-1.76	85.2	100.0	85.2	0.0	-1.61	77.4	100.0	77.4	6.5
BDI	22.08 (7.33)	9.10 (6.61)	9.48 (7.69)	8.58 (7.14)	-1.77	80.0	92.5	72.5	0.0	-1.72	81.5	92.6	81.5	7.4	-1.84	80.6	96.8	80.6	9.7
ATQ	82.82 (21.47)	54.87 (22.48)	52.30 (21.47)	50.48 (25.16)	-1.30	65.0	80.0	62.5	5.0	-1.42	77.8	81.5	77.8	11.1	-1.51	77.4	87.1	77.4	9.7
IIP-32	63.50 (7.48)	54.90 (9.42)	52.85 (10.25)	51.97 (8.44)	-1.15	25.0	92.5	25.0	5.0	-1.42	51.9	92.6	51.9	0.0	-1.54	41.9	93.5	41.9	0.0
RSES	13.85 (3.29)	18.70 (5.21)	19.22 (5.23)	19.13 (5.16)	1.48	50.0	92.5	50.0	2.5	1.63	55.6	92.6	55.6	7.4	1.61	51.6	93.5	51.6	3.2
DERS	105.87 (18.34)	84.13 (21.14)	79.52 (23.56)	76.90 (22.58)	-1.19	60.0	92.5	57.5	10.0	-1.44	59.3	96.3	59.3	3.7	-1.58	64.5	96.8	64.5	3.2
SCS	13.97 (2.87)	18.52 (4.62)	19.36 (4.99)	19.10 (4.85)	1.58	62.5	95.0	62.5	2.5	1.88	63.0	92.6	63.0	3.7	1.79	74.2	90.3	74.2	6.5
AAQ-II	32.98 (5.22)	23.87 (8.40)	21.41 (8.17)	21.23 (9.17)	-1.74	60.0	65.0	50.0	10.0	-2.22	70.4	74.1	66.7	3.7	-2.25	71.0	83.9	71.0	9.7
MHC-SF	28.78 [b] (10.94)	42.90 (11.55)	40.70 (14.62)	45.58 (12.43)	1.29					1.09					1.54				

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; 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.
a: $N = 39$; b: $N = 32$; c: $N = 21$; d: $N = 16$; e: $N = 14$; f: $N = 21$; g: $N = 17$; h: $N = 17$; i: $N = 21$; j: $N = 19$; k: $N = 22$

Table 5. *Pretreatment baseline, Post-treatment outcome, 6-month and 12-month follow-up, effect sizes (Cohen's d) for all outcome measures, and proportions of participants who reached reliable change (Jacobson & Truax, 1991) for subclinical group.*

Measure	Pre (N = 23)	Post (N = 23)	6 months (N = 13)	12 months (N = 21)	Pre-Post (%)					Pre-6 months (%)					Pre-12 months (%)				
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF	ES	RC	MIFD	CSC	DF
TC1	8.13 (1.55)	5.86 [c] (2.57)	3.50 [h] (2.22)	4.77 [l] (2.98)	-1.47					-2.99					-2.17				
TC2	7.57 (2.15)	6.25 [d] (3.22)	3.20 [i] (2.20)	3.92 [m] (3.04)	-0.61					-2.03					-1.70				
TC3	7.43 (2.02)	5.73 [e] (1.90)	3.60 [j] (2.50)	4.31 [n] (2.56)	-0.84					-1.90					-1.55				
GSI	27.48 (9.61)	15.22 (10.40)	11.69 (5.98)	14.14 (9.90)	-1.28	60.9	100.0	60.9	0.0	-1.64	76.9	100.0	76.9	0.0	-1.39	57.1	100.0	57.1	0.0
BDI	11.13 (5.16)	5.91 (5.30)	3.54 (3.50)	6.10 (5.70)	-1.01	47.8	100.0	47.8	4.3	-1.47	61.5	100.0	61.5	0.0	-0.97	47.6	95.2	47.6	9.5

ATQ	49.61 (8.53)	40.96 (6.78)	37.77 (7.32)	41.43 (12.16)	-1.01	30.4	100.0	30.4	0.0	-1.39	53.8	100.0	53.8	0.0	-0.96	38.1	95.2	38.1	9.5
IIP-32	52.35 (6.73)	47.74 (6.52)	45.85 (5.86)	47.29 (8.31)	-0.69	13.0	100.0	13.0	0.0	-0.97	38.5	100.0	38.5	0.0	-0.75	38.1	100.0	38.1	9.5
RSES	20.43 (4.70)	22.61 (4.33)	24.23 (4.66)	23.05 (5.17)	0.46	26.1	100.0	26.1	4.3	0.81	53.8	100.0	53.8	7.7	0.56	38.1	95.2	38.1	14.3
DERS	75.04 (15.97)	64.52 (15.01)	62.92 (15.44)	62.33 (15.61)	-0.66	39.1	100.0	39.1	0.0	-0.76	46.2	100.0	46.2	0.0	-0.80	52.4	100.0	52.4	4.8
SCS	18.24 (4.10)	21.04 (4.59)	21.25 (4.97)	20.61 (4.39)	0.68	65.2	100.0	65.2	0.0	0.73	69.2	100.0	69.2	0.0	0.58	47.6	100.0	47.6	9.5
AAQ-II	25.22 [a] (6.34)	17.90 [f] (6.44)	16.77 (5.86)	17.57 (7.44)	-1.15	50.0	94.4	50.0	5.6	-1.33	70.0	80.0	70.0	0.0	-1.21	50.0	93.8	50.0	12.5
MHC-SF	41.14 [b] (11.51)	49.07 [g] (10.34)	49.00 [k] (11.10)	48.14 (12.48)	0.69					0.68					0.61				

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; 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.
a: $N = 18$; b: $N = 7$; c: $N = 14$; d: $N = 12$; e: $N = 11$; f: $N = 21$; g: $N = 15$; h: $N = 10$; i: $N = 10$; j: $N = 10$; k: $N = 10$; l: $N = 13$; m: $N = 13$; n: $N = 13$

Table 6. *Piecewise Growth Model (All patients)*

Measure	CFI	Intercept				Slope1 (Pre-Post)				Slope2 (Post-6 months-12 months)			
		Mean	*p*	Variance	*p*	Mean	*p*	Variance	*p*	Mean	*p*	Variance	*p*

TC1	improper solution											
TC2	.728	8.127	.000*	2.186	.042*	-2.670	.000*	7.431	.032*	-0.574	.055	1.329	.123
TC3	.999	7.864	.000*	1.921	.123	-2.689	.000*	4.985	.123	-0.551	.050	0.515	.625
GSI	.882	49.268	.000*	462.722	.000*	-25.675	.000*	189.516	.020*	-0.172	.892	36.967	.073
BDI	.952	18.079	.000*	55.138	.000*	-10.125	.000*	48.414	.002*	0.118	.809	5.475	.096
ATQ	.986	70.698	.000*	512.474	.000*	-20.887	.000*	298.546	.000*	-0.639	.630	71.982	.000*
IIP-32	1.000	59.429	.000*	64.501	.000*	-7.189	.000*	49.451	.001*	-0.986	.086	11.168	.007*
RSES	1.000	16.254	.000*	17.565	.000*	3.889	.000*	8.187	.082	0.245	.400	1.218	.295
DERS	.948	94.619	.000*	389.372	.000*	-17.331	.000*	224.535	.026*	-2.285	.092	37.711	.139
SCS	1.000	15.531	.000*	11.163	.000*	3.912	.000*	8.574	.011*	0.061	.808	1.458	.088
AAQ-II	1.000	30.378	.000*	25.061	.006*	-8.802	.000*	22.499	.087	-0.765	.155	6.436	.091
MHC-SF	.850	31.585	.000*	90.481	.003*	12.984	.000*	64.192	.068	0.398	.630	13.329	.113

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; * $p < .05$

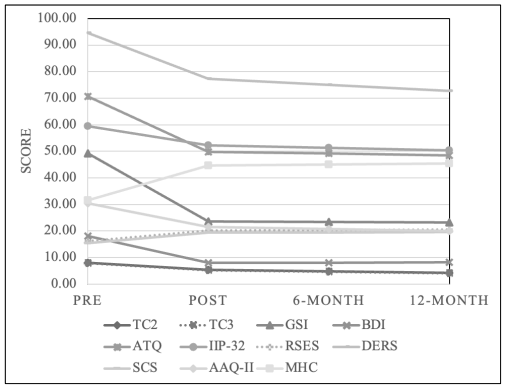

Figure 1. Piecewise Growth Model for all Outcome Measures