Experiential Dynamic Therapy: A Preliminary Investigation Into the Effectiveness and Process of the Extended Initial Session

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Objective: This study explored whether patients in specialist psychology services made early gains on theoretically relevant therapeutic processes and outcomes after a trial therapy session (one 2- to 3-hour initial Experiential Dynamic Therapy session). **Method:** This practice-based, nonrandomized trial used a pre–post design. Thirty-one patients (23 women, average age of 37) completed standardized measures of symptoms of general distress, interpersonal functioning, self-compassion, and remoralization before and after the trial therapy session. Video recordings of the sessions' therapy process were rated on the Achievement of Therapeutic Objectives Scale. **Results:** After the trial therapy session, patients reported a significant increase in remoralization and self-compassion and a significant decrease in symptoms of general distress but not interpersonal problems. Process ratings were not significantly associated with improvement on these outcome measures. **Conclusions:** This initial positive effect could be due to the session or an effect of time or placebo. Future research using active control conditions is warranted. J. Clin. Psychol. 00:1–10, 2014.

Keywords: Short-Term Dynamic Therapy; Experiential Dynamic Therapy; initial session; effectiveness; outcome

Experiential Dynamic Therapy (EDT) is an umbrella term for a collection of Short-Term Dynamic Psychotherapies (STDP) supported by a number of efficacy and effectiveness studies (Osimo & Stein, 2012). According to McCullough and Magill (2009), the EDT therapist helps the patient through a process of (a) recognizing and relinquishing maladaptive defensive behaviors, (b) systematic desensitization of warded-off feelings through exposure and regulation of anxiety, and (c) restructuring maladaptive conceptions of self and others.

Psychotherapy research suggests that the first sessions of therapy constitute a critical phase in treatment and play a disproportionate role in determining therapy outcomes (Lutz, Stulz, & Köck, 2009). In EDT a practice has developed of offering one longer (2–3 hours) initial session as an impetus to start therapeutic processes and offer "corrective" emotional and relational experiences at the earliest opportunity. This extended initial EDT session is termed the "trial therapy session" (Coughlin Della Selva, 2006) and is seen as an important therapeutic intervention in its own right.

The present study aims to improve our understanding of the early benefits in this type of psychotherapy and what specific therapy processes are initiated.

The only previous study on the effect of trial therapy sessions was done with 30 patients experiencing anxiety, depression, personality disorder, or somatoform disorder in a tertiary psychotherapy service in Canada (Abbass, Joffres, & Ogrodniczuk, 2008). The present study builds on this by exploring responses to a single trial therapy session in patients attending specialist National Health Services (NHS) in the United Kingdom. The study expanded on the work of Abbass, Joffres, et al. (2008) in two ways: In addition to measures of symptom severity and interpersonal problems, the present study investigated remoralization (Vissers, Hutschemaekers, Keijsers, Van der Veld, & Hendriks, 2010) and self-compassion (Schanche, Stiles, McCullough, Svartberg, & Høstmark Nielsen, 2011), as they have been shown to be

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important mechanisms of symptom change as well as additional outcomes of therapy. The present study also assessed seven therapeutic processes associated with the EDT model during the trial therapy session. Previous research (e.g., Schanche et al., 2011) has shown a relation between these processes during therapy and outcome in long-term STDP. Based on the literature it was hypothesized that:

- The observed therapy process during the trial therapy session would indicate that patients achieve initial psychodynamic objectives in line with the EDT model of change.
- Self-reported pre–post change after the trial therapy session would show a significant decrease in general distress symptoms and interpersonal problems and a significant increase in remoralization and self-compassion.
- The observed therapy process (i.e., the achievement of psychodynamic objectives) during the trial therapy session would be associated with self-reported improvement in symptoms of general distress, interpersonal functioning, remoralization, and self-compassion after the session.

Method

Design

This practiced-based study used a pre–post design to measure the effect of the trial therapy session in its own right. In the study's clinical context, most of the patients were then allocated to a waiting list for a course of treatment. Participants completed standardized outcome measures on two occasions: prior to the trial therapy session and before the follow-up appointment 2 weeks later. It was outside of the scope of this research design to relate the outcome after the trial therapy session with longer term therapy outcome.

Treatment Intervention

The trial therapy session commences with a specific example of the patient's current emotional problems and exploration of how they relate to past experiences and trauma. When anxiety or defenses block the feelings that emerge in the session, the therapist explores the visceral experience and the nature and effect of defenses. The therapist helps the patient to gradually experience more underlying feeling while regulating anxiety and reducing defensive behaviors (Coughlin Della Selva, 2006). Unlike an assessment session common in some other therapy approaches, the EDT therapist does not take a structured interpersonal or (mental) health history but instead focuses on the patient's adaptive but avoided feelings.

Participants

Selection criteria. Patients were invited to participate in the study unless they were deemed unable to benefit from a trial therapy session due to the following reasons: (a) patients in an acute crisis who needed input from the crisis team, (b) patients with obvious concentration difficulties or inability to retain information in the session, (c) patients who reported symptoms of psychotic illness, (d) patients with a limited understanding of the English language, and (e) patients who requested a particular approach other than EDT, or a particular therapist they had worked well with before.

Recruitment. Participants were recruited from two secondary care English NHS services, providing specialist psychological therapies to adults (aged 18–65 years) with moderate to severe emotional problems. From the patients referred between January and July 2012, 126 were invited, and 31 agreed to participate, representing a 25% response rate.

Sample size analyses. Preliminary power analyses with an error probability of .05 and power of .80 showed that a minimum of 24 participants was required.

Table 1
Characteristics of the Participants Reported on the CORE-TAF Form

Characteristics	$n = 31$	%
Age: Mean years	37 (11.25)	
Level of functioning: Mean GAF score	48 (7.69)	
Women	23	74.2%
Employed	18	60%
Ethnic origin		
White (English/European)	23	74.2%
Previous use of primary, secondary or specialist services	28	90.3%
Current use of medication	21	67.7%
Identified problem		
Depression	26	83.9%
Anxiety	26	83.9%
Personality problems	12	38.7%
Trauma	15	48.4%
Bereavement	5	16.1%
Interpersonal	21	67.7%
Risk		
Suicide	22	71%
Self-harm	16	51.7%

Note. CORE-TAF = Clinical Outcomes in Routine Evaluation – Therapy Assessment Form; GAF = Global Assessment of Functioning Scale.

Participant characteristics. The descriptive data (Table 1) show that all 31 participants functioned at a low to moderate level on the Global Assessment of Functioning scale (GAF; Spitzer, Gibbon, Williams, & Endicott, 1994), with scores ranging from 32 to 63. Most participants (90.3%) had previous experience of mental health services, were taking antidepressant or anxiety-reducing medication (67.7%), and presented with a mild to moderate risk of suicide (71%) or self-harm (51.7%). Depression (83.9%), anxiety (83.9%), and interpersonal problems (67.7%) were identified most frequently.

Measures

Participant characteristics. The therapists completed the Clinical Outcomes in Routine Evaluation-Therapy Assessment Form (CORE-TAF), which is part of the CORE system, a standardized evaluation package used in the NHS (Barkham, Mellor-Clark, Connell, & Cahill, 2006). The CORE-TAF captures contextual information, such as age, reason for referral, previous treatments and risk.

Symptoms. The severity of symptoms of general distress is measured by the 34-item Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham et al., 2006) and the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2001), both measures with established reliability and validity (Evans et al., 2002; Franke et al., 2011).

Level of functioning. The therapists rated the patient's overall psychiatric disturbance on the GAF scale (Spitzer et al., 1994), presented in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (American Psychiatric Association, 2000), a reliable and valid measure of psychiatric disturbance (Jones, Thornicroft, Coffey, & Dunn, 1995).

Interpersonal functioning. The Inventory of Interpersonal Problems-32 (IIP-32; Barkham, Hardy, & Startup, 2011) comprises 32 statements about problems relating to others and has adequate psychometric properties (Barkham et al., 2011).

Self-compassion. The Self-Compassion Questionnaire-Short Form (SCQ-SF; Raes, Pommier, Neff, & Van Gucht, 2011) is the validated 12-item version of the original Self-Compassion Questionnaire (SCQ), where self-compassion is defined as having a kind, balanced, and supportive attitude towards oneself.

Remoralization. The Remoralization Scale (RS; Vissers, Keijsers, van der Veld, de Jong, & Hutschemaekers, 2010) measures growth of hope, subjective well-being, and sense of mastery. The construct validity and sensitivity to change was found to be sufficient (Vissers, Keijsers, et al., 2010).

Although changes in remoralization and self-compassion may be seen as mediators/predictors of long-term therapy outcome, in the present study both the RS and SCQ-SF were used as outcome measures after the trial therapy session.

The study's CORE-OM, BSI-18, IIP-32, SCQ-SF and RS had good internal consistency (Cronbach's $\alpha = .93$, .92, .89, .86, and .90, respectively).

Therapy process. The Achievement of Therapeutic Objectives Scale (ATOS; McCullough, Larsen, et al., 2003) offers a rigorous analysis of therapy process based on patients' in-session responses to the interventions. The ATOS research tool focuses on seven specific therapeutic objectives:

- Insight: The patient's understanding and recognition of their own patterns of maladaptive behavior or defensiveness.
- Motivation: The patient's motivation to change or to give up the defensive behavior.
- Exposure: Emotional arousal of the adaptive but conflicted feeling during the session, whether consciously expressed by the patient or based on visible physiological signs
- New learning: The patient's ability to appropriately express feelings, wants, and needs to others, either with the therapist or in interactions outside therapy
- Inhibition: The patient's inhibitory feelings such as anxiety, shame, guilt, or pain that prevent affect experiencing
- Sense of self: The patient's adaptive view of self in terms of pride in positive qualities, acceptance of their own realistic limitations, care for self, and self-esteem.
- Sense of others: The patient's ability to acknowledge and respond adaptively to positive or negative qualities in others.

The ATOS was developed as a process measure to determine the achievement of therapeutic objectives associated with the psychodynamic model. Given that the current study only has two time points, it is impossible to meet all the requirements necessary to support process-outcome causal relationships (Haynes & O'Brien, 2000). Therefore, in this study the ATOS functions as a preliminary first exploration of process variables, which may (if supported by future research) prove to be important in determining outcomes in trial therapy sessions.

The ratings range from 0 (*not at all*) to 100 (*completely*) and reflect the degree to which the particular therapeutic objective has been observed. For Insight, Motivation, Exposure and Inhibition a score is generated for each of the 10-minute therapy segments. The subscales of New Learning, Sense of self and Sense of others are rated hourly because there is no opportunity to interact with people outside of therapy during the trial therapy session (Berggraf, Ulvenes, Wampold, Hoffart, & McCullough, 2012), which makes change in these scales within one longer session unlikely. In addition to this, the ratio of Exposure to Inhibition provides a rating of Desensitization (i.e., the hidden feeling being tolerated with reduced levels of anxiety or shame).

The ATOS has demonstrated sufficient inter-rater reliability (kappas: 0.61–0.84; McCullough, Kuhn, Andrews, Valen, et al., 2003) as well as adequate validity and sensitivity to change (Valen, Ryum, Svartberg, Stiles, & McCullough, 2011).

The first, fourth, and fifth author were trained in rating the ATOS at the Modum Bad Institute in Norway. The three raters then practiced for at least 20 hours through the online training tool (http://www.atostrainer.com; McCullough, Bhatia, Ulvenes, Berggraf, & Osborn, 2011), rated nine American Psychological Association therapy DVDs, and completed an online reliability

test on 25 10-minute segments. The raters' calculated intraclass correlations were adequately reliable (.65, .70, and .72) and similar to Bhatia et al. (2009) and Schanche, Høstmark Nielsen, McCullough, Valen and Mykletun (2010; .42–.71). The three raters rated 10, 10, and 11 video-recorded sessions each.

Procedure

Patients received an initial appointment letter asking them to attend either the trial therapy session as part of the study or a regular initial appointment. Participants were asked to complete the same questionnaire battery before the trial therapy session and before the follow-up session, 2 weeks later. They received £15 to thank them for their participation. After the trial therapy session, most participants were accepted for further therapy within the service ($n = 29$).

The trial therapy sessions were conducted by two clinical psychologists, each with more than 8 years' clinical experience. Both therapists had completed core EDT training with Dr. F. Osimo, as well as other STDP training. One therapist conducted 22 trial therapy sessions, the other 9. As is routine practice in EDT, the trial therapy session was video-recorded. After the trial therapy session, the therapists completed the CORE-TAF and GAF for each participant.

Data Analyses

Calculation of achievement of therapeutic objectives. In line with other ATOS outcome studies (e.g., Schanche et al., 2011), 10-minute segment ratings were pooled across segments to derive a mean session rating for each participant on the seven ATOS subscales: (a) Insight, (b) Motivation, (c) Exposure, (d) Inhibition, (e) New learning (f) Sense of self, and (g) Sense of others. In addition to mean scores, for Exposure and Inhibition, peak and trough scores, i.e., highest exposure and lowest inhibition, were calculated as they better reflect the intensity of affective arousal (Bhatia et al., 2009). Desensitization (the ratio of the Exposure rating to the Inhibition rating) for each 10-minute segment, as well as mean and peak (highest exposure to lowest inhibition) Desensitization were calculated.

Analysis of outcome scores. One-tailed tests were used because of the directional nature of the hypotheses. The Reliable Change Index was calculated as 1.96, standard deviation [*SD*] of prescore in our sample * $\sqrt{2}$ * $\sqrt{}$(1- Cronbach's α in our sample). The clinical cut-off scores for the CORE-OM (10), BSI-18 (13), and IIP-32 (39) were used; no clinical cut-off scores for the SCS-SF and RS have been published.

Analysis of achievement of therapeutic objectives and outcome scores. Pearson/Spearman's correlations explored the level of association between the seven mean ATOS subscale scores, peak Exposure and trough Inhibition, mean and peak Desensitisation, and mean change scores on the five outcome measures. A Bonferroni correction for the large number of comparisons was applied.

Ethics

The South Central NHS National Research Ethics Service, Oxford Health and South West Yorkshire Partnership NHS Foundation Trust approved the study.

Results

Intervention Checks

The average trial therapy session was 150 minutes ($SD = 30$) long, ranging from 69 to 211 minutes. The mean interval to follow-up was 15 days ($SD = 5$). The Mann-Whitney test showed no significant differences between the therapists in patient's severity of symptoms at baseline, change scores, or length of the session.

Table 2
Means and Standard Deviations of Outcome Measures, Change Scores, Paired t-Test Scores and Wilcoxon Signed-Rank Test Scores

	Mean (*SD*)					
Outcome measure	Pre	Post	Change score	*t(30)/Z*	*P*	Cohen's *d*
CORE-OM	20.23 (7.00)	16.41 (8.34)	3.27 (4.16)	2.87	0.002**	0.79
BSI-18	30.31 (15.12)	25.91 (15.52)	3.61 (10.22)	1.49	0.07	0.35
IIP-32	54.04 (21.63)	49.93 (22.04)	3.82 (16.89)	1.26	0.11	0.23
SCQ-SF	24.88 (8.10)	27.16 (7.85)	2.15 (5.71)	2.10	0.02*	0.38
RS	23.42 (6.53)	27.77 (8.70)	4.33 (7.21)	3.08	0.001**	0.60

Note. $n = 31$. CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure; BSI-18 = Brief Symptom Inventory; IIP-32 = Inventory of Interpersonal Problems; SCQ-SF = Self-Compassion Questionnaire-Short Form; RS = Remoralization Scale.
*$p < .05$. **$p < .01$.

Achievement of Therapeutic Objectives

The ATOS mean scores showed that, during the trial therapy session, participants tended to achieve "moderate recognition of maladaptive behavior patterns" (mean [*M*] = 50.96, *SD* = 7.43) and "low-moderate motivation to give up maladaptive behavior" ($M = 43.79$, SD = 9.32). The participants' mean rating of Inhibition ($M = 49.14$, $SD = 12.48$) was higher than their mean rating of Exposure ($M = 37.71$, $SD = 8.00$). An Exposure score higher than 30 means that the rater observed physiological signs of affect, such as tension of a fist or tearing up of the eyes. Participants' general level of Desensitization (< 1) suggests that anxiety, shame, and guilt were rated as high, while adaptive anger, grief, and self-esteem were rated as low. However, according to peak Exposure ($M = 55.16$, $SD = 11.15$), trough Inhibition ($M = 34.55$, $SD = 13.35$), and peak Desensitization ($M = 1.55$, $SD = 0.74$) ratings, participants were able to achieve a moderate level of Desensitization in some of the 10-minute segments.

On average, participants had a maladaptive Sense of self ($M = 34.49$, $SD = 9.00$), with minimal pride in their own strengths and a great deal of self-blame and shame and a similarly maladaptive Sense of others ($M = 38.92$, $SD = 9.49$), with little trust and acceptance, and some devaluation and idealization. The New learning subscale scores ($M = 35.52$, $SD = 9.52$) suggest that participants generally struggled to appropriately express their thoughts, feelings, wishes, and needs.

Outcome

See Table 2 for means and standard deviations for the outcome measures. After the trial therapy session, participants reported a decrease in symptoms; a significant effect on the CORE-OM, $t(30) = 2.87$, $p = .002$, and a nonsignificant trend on the BSI-18, $Z = 1.49$, $p = .07$. A significant increase was found for self-compassion on the SCQ-SF, $t(30) = 2.10$, $p = .02$, and remoralization on the RS, $Z = 3.08$, $p = .001$. Participants reported fewer interpersonal problems postsession, IIP-32, $t(30) = 1.26$, $p = .11$, though this difference was not statistically significant.

The effect sizes for change on the BSI-18, IIP-32, and SCQ-SF were small to moderate (.23–.38), and large on the RS (.60) and CORE-OM (.79; Cohen, 1992). Of the 31 participants, five (16.1%) recovered (reached both clinical significance and reliable change) on the CORE-OM, BSI-18, or IIP-32. One participant (3.2%) improved on the IIP-32 (showed reliable change, but did not reach clinical significance). The majority of participants did not reach clinical or reliable change on the CORE-OM ($n = 26$; 83.9%), BSI-18 ($n = 22$; 71%), IIP-32 ($n = 22$; 71%), RS ($n = 19$; 61.3%), or SCS-SF ($n = 18$; 58%). Some participants reported a deterioration (reliable change in negative direction) of interpersonal functioning ($n = 3$; 9.7%), self-compassion ($n = 3$; 9.7%), or remoralization ($n = 1$; 3.2%).

Associations Between Achievement of Therapeutic Objectives and Outcome

Trough Inhibition was significantly negatively related to change on the BSI-18 ($r = -.31$, $p < .05$), Sense of others was significantly related to change on the IIP-32 ($r = .32$, $p < .05$) and significantly negatively related to change on the SCQ-SF ($r = -.37$, $p < .02$). None of the (other) ATOS subscale scores were significantly related to change on the BSI-18 (all ps $> .06$), IIP-32 (all ps $> .22$), or SCQ-SF (all ps $> .06$), CORE-OM (all ps $> .09$), or RS (all ps $> .11$). All these associations lost their significance after applying a Bonferroni correction (.05/55).

Discussion

Summary

This preliminary practice-based study explored whether patients in specialist psychology services made early gains on theoretically relevant therapeutic processes and outcomes after a trial therapy session (one 2- to 3-hour initial EDT session). It appeared that during a trial therapy session, the predicted therapeutic processes (measured on the ATOS) were initiated, in line with this model of therapy. Furthermore, after the trial therapy session, significant early symptom improvement and increased remoralization and self-compassion suggested an initial positive effect. After controlling for multiple comparisons, none of the in-session processes measured on the ATOS were associated with improvement on outcome measures after the session.

Comparison With Other Studies

Achievement of therapeutic objectives. Although no statistical comparison has been conducted, in comparison with data from Svartberg, Stiles, and Seltzer (2004) from the sixth session of STDP, participants in the trial therapy session appeared to achieve higher levels of Insight, Motivation, Exposure, and New learning, with equivalent scores on Inhibition, even though their problems were rated as more severe (i.e., lower Sense of self and Sense of others). As might be expected, the ATOS ratings for the trial therapy session appeared to be lower than those recorded for patients in a 36th STDP session (Valen et al., 2011). The levels of desensitization in the trial therapy session also appeared lower than most other desensitization ratios calculated post hoc from later therapy sessions in other studies (McCullough, Berggraf, & Ulvenes, 2010).

Outcomes of the trial therapy session. Similar to Abbass, Joffres, et al. (2008), on average, the trial therapy session appeared to be effective in reducing symptoms in the short term. In contrast to their findings, however, interpersonal functioning did not significantly change after the trial therapy session in the present study. The reported significant mean increase in remoralization is congruent with findings by Coppock, Owen, Zagarskas, and Schmidt (2010), who found that hope increased after one session of brief psychotherapy and Vissers, Hutschemaekers et al.'s (2010) view that remoralization develops in parallel with symptom change.

Similarly, in line with the findings by Schanche et al. (2011), on average, patients' self-compassion significantly increased. These initial improvements seem promising, especially because patients with these kind of longstanding difficulties (e.g. GAF score < 50) were relatively less likely to benefit from therapy and might be expected to change slowly, requiring longer term therapy (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). However, as might be expected in treatment of patients with longstanding difficulties, the majority of the patients did not demonstrate reliable or clinical change in symptom severity or interpersonal functioning after the trial therapy session.

Therapeutic objectives and outcome. Given that the significant associations between process ratings and outcome change scores disappeared when a Bonferroni correction was applied, it seems likely that these were due to the number of comparisons rather than true significance. A possible explanation for the lack of significant associations might relate to the validity and reliability of the ATOS: the ATOS measures behavior rated by observers, which may not do justice to "internal" changes experienced by the patient.

Similarly, ATOS scores may not be totally attributed to the session. Most participants had previously attended mental health services; therefore, the raters may have observed participants' previously acquired ability rather than change processes instigated through the therapy. In addition to this, the ATOS was originally designed to measure change processes over a number of treatment sessions (e.g., 20–40 sessions) and therefore might not be sensitive enough to measure detailed processes in one trial therapy session.

Limitations and Future Research

A weakness of this preliminary practice-based study design is the lack of a control condition, as the possibility remains that the observed changes would take place in any initial therapy session or assessment. It is also possible that the reported change was linked to factors other than the intervention, such as the use of medication, previous therapy, or a placebo effect. In future research, trial therapy sessions might be usefully compared to a waitlist control, an active control condition of a shorter EDT session, two or three shorter initial (EDT) sessions, or an equivalent period in an alternative therapeutic model, in line with the qualitative comparison by Abbass, Joffres, and Ogrodniczuk (2009). Moreover, given the small-scale nature of the research, with only two therapists, it is impossible to disentangle therapist effects from the effects of the therapeutic model, something that would require research on a far larger scale than was possible in this study.

Another limitation of the study was the low participation rate (25%). Anecdotal evidence suggests that some patients did not want to complete a large set of questionnaires or for their initial session to be video-recorded, or they wanted to be seen at a particular day or time, when research therapists were unavailable. A responder–nonresponder analysis could not be performed because characteristics of patients who chose not to participate were not recorded as part of the study. However, in spite of the relatively low participation rate, gender balance, age, ethnic origin, and severity of problems of the participants appeared to be representative of patients in secondary care UK services (Barkham et al., 2001).

Also, due to the length of the trial therapy session, participants were not asked to complete any measures straight after the session. A measure of therapeutic alliance, for example, might have been relevant, because alliance develops early in therapy and is predictive of later therapy outcome (Hilsenroth & Cromer, 2007). This would be a possible example of a "common factor" (rather than a model specific factor) that could influence outcome.

Furthermore, the process and outcome measures do not give information about the long-term effects of the trial therapy session. Further research should examine whether changes observed at the 2-week follow-up session are maintained or enhanced as therapy continues.

Conclusion

The trial therapy session appears to be an effective initial intervention for patients in specialist psychology services. During the trial therapy session, the therapeutic processes associated with the EDT model were initiated and participants subsequently reported a symptom reduction and improvement in remoralization and self-compassion. The broader research literature suggests these gains are a good indication of subsequent therapeutic benefit. Results of this exploratory study should be interpreted cautiously within the limitations of the study's naturalistic design. Future research comparing trial therapy sessions to other ways of initiating therapy seems warranted.

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