THEORY AND PRACTICE OF EXPERIENTIAL DYNAMIC PSYCHOTHERAPY

Edited by

Ferruccio Osimo and **Mark J. Stein**

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LONDON AND NEW YORK

First published 2012 by
Karnac Books Ltd.

Published 2018 by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN
711 Third Avenue, New York, NY 10017, USA

Routledge is an imprint of the Taylor & Francis Group, an informa business

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British Library Cataloguing in Publication Data

A C.I.P. for this book is available from the British Library

ISBN-13: 9781780490632 (pbk)

Typeset by V Publishing Solutions Pvt Ltd., Chennai, India

This book was conceived within the first Experiential Dynamic Therapy training group in the UK. Together we have built on the inspirational work of colleagues who dedicated so much to helping ease the suffering of others. We hope our writing stimulates and nurtures creative new beginnings.

—gratefully, the authors

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FOREWORD

Jeremy Holmes

On the whole, Brits don't do *Festschrifts*. Maybe we are too suspicious of hierarchies, too allergic to idealisation, too democratic, healthily sceptical, too polyphonic—or perhaps just too envious! And, so often, "a prophet is not without honour, except in his own country, and among his own kin, and in his own house". But if any UK psychoanalytic psychotherapy researcher deserves to be celebrated for a lifetime contribution, it is David Malan. This book is perhaps best thought of as a species of *Festschrift*, with Italian overtones.

It is more than sixty years since Malan first started his MD thesis on brief psychotherapy at the Tavistock—and he is still going strong. One of his many attributes is that he has always been open to influence and change. There have been significant mutations since Malan first enunciated his seminal brief dynamic psychotherapy credo in *Individual Psychotherapy and the Science of Psychodynamics* in the 1970s, especially those attributable to Davanloo and McCullough. Nevertheless, EDT still retains the fundamental features first enunciated by Malan, and this book should be seen as the coming of age and culmination of his work, together with a celebration of the fact that EDT is beginning to find a place for itself within the UK National Health Service.

What are the essential qualities which Malan has brought to the field? They can be summarised as: openness and honesty, clarity of thought, the scientific spirit of enquiry, simplicity that does not sacrifice subtlety, and an active stance that does not preclude receptiveness.[1]

One of the key features of his work from the start, and permeating the spirit of this volume, is the recognition that if psychotherapy is to be properly studied, both for purposes of research or supervision, it must be in the public domain. The use of audio or videotape recording—with appropriate confidentiality safeguards—is integral to EDT in a way that is notably absent from all other established therapies.

Nevertheless this spirit of openness is beginning to be accepted within the psychodynamic research community. It is not that therapists' own written process recordings are deliberately

dishonest, but rather that unconscious forces are ubiquitous. Therapists, no less than their clients, are shaped by narcissism, the Oedipal need to please, obsessional fears of failure, the desire to bend reality to conform to a preconceived story or theory.

Malan's second great contribution, his clarity of expression and thought, sets him apart from many psychoanalytic writers. "Malan's triangles" may not be entirely of his own making, but in his hands they become a rubric in which the therapist can reflect upon what he or she is doing and where he or she "is" in relational space at any given moment.[2]

This capacity to demystify and penetrate the aura of mystique which surrounds psychoanalytic work, yet not devaluing or vulgarising it, is one of Malan's extraordinary gifts. As this volume attests, therapists from a variety of backgrounds can understand the EDT approach, without feeling that they need to undergo a prolonged period of priestly initiation before they can embark on psychoanalytic therapy. Malan's triangles are an invaluable *vade mecum* in introducing the principles and practice of dynamic therapy to trainee therapists. These are often experienced professionals from medicine or clinical psychology who need to "unlearn" the tendency to "help", advise, prescribe, and begin to acquire a new set of skills, including receptiveness and "active passivity". Like many great ideas, the triangles are deceptively simple, yet however convoluted the clinical situation or sophisticated the analyst, it is always worth thinking about what is going on in Malan's-triangles terms.

Malan started off his professional life as a scientist and remains one to this day. From the outset he promoted the need for accurate, reproducible clinical descriptions, and the prediction of desirable outcomes prior to embarking on therapy (i.e., "intention-to-treat"), followed by unbiased evaluation post-treatment. This approach was viewed in the 1950s with intense suspicion by the analytic community, to its detriment and shame, not least among Malan's colleagues at the Tavistock Clinic. Malan managed, far ahead of his time, to do justice to the subtlety of psychoanalytic assessment of character and dynamics, while at the same time to subject it to scientific scrutiny. Brief dynamic therapies are finally beginning to accumulate a respectable evidence base (Abbass, 2006), an impetus which can be traced directly back to Malan's influence.

Another of Malan's crucial contributions, manifesting his analytic heritage through Balint and Ferenczi, is that of the "active therapist". This is the "masculine" psychoanalytic vector whose counterpart is the "feminine" capacity for the receptive encouragement of free association. The "active therapist" reaches its apotheosis with Davanloo's quasi-surgical (i.e., using violent means for curative ends) assault on the patient's defences. This is based on the conviction that once the walls come tumbling down, the patient will finally get in touch with warded-off affects in need of expression. This book is replete with examples of the therapist's active engagement with the patient—challenging, guiding, questioning, suggesting—all skills that are sharpened by the context of time-limited therapy. As Dr Johnson famously said, nothing concentrates the mind more than the prospect of a hanging (the built-in termination for brief therapies) in the morning.

Malan's heirs, Osimo and Stein and their collaborators in this book, illustrate a set of EDT-based concepts that have wide applicability to dynamic therapies generally. One of the most useful EDT formulations, deriving directly from Davanloo, is the distinction between strategic and tactical defences.

The wider psychoanalytic community is familiar and comfortable with the range of strategic defence mechanisms, originally systematised by Anna Freud, and explored empirically by Vaillant. The innovative aspect of the idea of tactical defences arises out of EDT's focus on the "minute particulars" (a Keatsian phrase picked up by another brief therapy theorist, Robert Hobson, 1985) of patient-therapist interaction. The ways in which people avoid painful affect in the here-and-now—by gaze aversion, vague generalisations, changing the subject, adopting a physically defensive posture and so on—are all grist to the psychodynamic mill. They provide the entry point for therapists' compassionate probes into the psychic pain they are designed to protect.

There is an obvious link between video recording and tactical defence analysis in that in supervision the therapist can observe defences in action and how he or she responds: by collusively going along with the avoidance; by over-enthusiastically trying to break them down in a species of "friendly fire" (another useful EDT concept introduced in the book), which may merely serve to reinforce defensive manoeuvres; or by a sensitive sticking to the point so that the patient feels both sufficiently held and challenged to be able finally to express and to let go long-suppressed painful emotions.

Relevant to tactical defence is the idea of the "character hologram", a metaphor based on the idea that, like a hologram, every part of the client's existential being is contained in each fragment of interaction and behaviour. Thus the first session contains in embryo all of the subsequent treatment; focusing on a fragment of clinical interaction can illuminate not just the whole of a session, but may typify the patient's problems more generally. Malan-influenced therapists strive always to make a Strachean (1934) "complete interpretation"—one that brings together into a single focus the patient's current relationship outside therapy, the transferential constellation in the consulting room, and the childhood and family structures which underlie both—T, C, and P.

An interesting facet of EDT is the way in which it strives to breathe fresh life into classical psychoanalytic formulations. The idea of the character hologram for instance loops back to Freud's observation that:

He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore. And thus the task of making conscious the hidden recesses of the mind is one which is quite possible to accomplish. (Freud, 1905e, p. 94)

One difference that distinguishes EDT, and perhaps contemporary psychodynamic therapy generally, from Freud's 1905 formulation is that in the latter, the therapist's task is primarily cognitive: to "make conscious the hidden recesses of the mind". EDT, with its Ferenczian antecedents, sees emotional avoidance—affect phobia—as the crucial target for interpretation and intervention. Many of the case examples in this book illustrate the movement from avoidance of painful affect to release of pent-up feelings, as the therapist both warmly holds and vigorously challenges old-established patterns of defensiveness. Thus EDT would always be pushing towards a present moment, an in vivo experience, as opposed to an intellectual detached discussion, which would be construed as a tactical defence.

Another standard psychoanalytic concept that animates much of the EDT therapist's activity is working with, or rather against, the "sadistic superego". This too can be traced back to

Strachey (1934), and his idea that people's problems flow from the prohibitions located in an internalised parent-figure—thou shalt not love, hate, cry, assert yourself, protest, etc. In the Strachey model, the patient assumes transferentially that the therapist will similarly be cruelly critical; but there is a discrepancy between that expectation and the therapist's benign and validating, albeit challenging, presence; that then leads to psychic reorganisation and the internalisation of a portion of a more loving superego.

The idea of the superego's "sadism" derives in part from the Kleinian tradition, where the child's own death-instinct-derived hostile impulses are postulated as projected into the parents, and then re-introjected in the form of the superego. In my view the sadistic superego concept is questionable (Holmes, 2011), and to some extent incompatible with the idea of affect phobia. From this perspective, the reason why people try to stop unwanted feelings surfacing into consciousness is primarily because a) they are by definition painful, and b) because to feel them threatens security. Expressing protest and manifestations of fear in situations of insecure attachment reduce further the sub-optimal security offered by the caregiver: their suppression is not a manifestation of sadism, but the need to achieve a modicum of safety. Indeed, conceptualising emotional inhibition as deriving from a harsh anti-hedonic internal parent may in itself be a defence against a sense of helplessness and vulnerability (Fairbairn's "better a bad self in a good world rather than a good self in a bad world").

The therapeutic consequence of that perspective is that the key provision of the therapist is not so much that of a benign superego-figure ousting a sadistic one, but someone who provides conditions of real security, which in turn releases the capacity for exploration of affect. In the latter situation it becomes safe to ventilate feelings, whether these be angry protest at poor caregiving, grief at loss and absence, or cries of unrecognised distress.

Implicit acknowledgement of the limitations of the "sadistic superego" concept may lie behind Osimo's development of the idea of maieutics in contrast to Davanloo-esque challenge. The midwifery metaphor—deriving originally from Socrates—is not original to EDT (see Feldman, 1966; Padel, 1991; Rycroft, 1985), but tends to be downplayed as psychoanalysts like to emphasise the mutative impact of interpretation as opposed to the holding, soothing, function they provide as the patient pushes to give birth to a new self—or rather a new version of the old self—which might be seen as the aim of analytic work.[3]

As this book magnificently attests, the next generation of EDT leaders is now well established. The anecdotal evidence is persuasive, but a new set of tasks present themselves. There is a need for full manualisation of EDT so that it can stand alongside CBT, and the newly emerged Dynamic Interpersonal Therapy (Lemma et al., 2012) as an established evidence-based effective therapy. That in turn will allow for outcome studies and for incorporation into the Increasing Access to Psychological Therapies programme as a treatment for complex depressive and anxiety disorders. In his much-quoted article defending psychodynamic therapy Shedler (2010) cites the Castonguay et al. (1996) study showing that many of the features integral to psychodynamic work are, despite its declared anti-analytic stance, associated with good outcomes in cognitive therapy. These include three factors central to EDT: the working alliance (or "real relationship" as Osimo dubs it); emotional experiencing; and developing conscious awareness of previously implicit affects. EDT is a powerful technique for fostering lived affective experience, and then moving on from that to verbal and cognitive awareness of avoided feelings.

In my view the next decade will see a progression from "brand name" therapies to integrated and dimensional approaches which highlight the structural ingredients of intimate relationships that lead to change and those that inhibit it. The task for EDT is to continue to develop its identity as a distinct psychodynamic school, while beginning, in collaboration with other therapies, to identify key mutative elements and theoretical constructs. The intelligence and commitment of this volume suggest that that is not just a pious hope, but an achievable aspiration.

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Notes

1. If we accept Jung's aphorism that all psychological theories are a disguised form of autobiography, one might say that these typify not just Malan's theoretical approach, but also his mode of being-in-the-world.
2. He borrowed the idea from Menninger, and of course Freud in that nothing could be more triangular than the "Oedipal situation". Also, the moment a sibling is added, the geometry becomes a four-way matrix rather than a triangle (cf. Holmes, 2009).
3. My anxiety as an obstetrically naïve medical student doing his "midder" was alleviated by a very experienced midwife who reassured me, "Don't worry – you don't have to do anything – it's the woman who is having the baby, not you. Just be there and accept her gratitude when the baby is born!" I sometimes tell this story to reassure beginner psychotherapists who are often in a similar state of panic.

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INTRODUCTION

Ferruccio Osimo & Mark J. Stein

This book has many co-authors, all of us experienced clinicians, mostly working within the National Health Service in England, who met regularly, for up to eight years, to train in Experiential Dynamic Therapy (EDT). As is the custom in an advanced EDT training setting, learning was facilitated by supervision of audio-visual recordings of direct clinical work. One of us (FO), due to his longer experience with EDT, served as teacher and supervisor. Over time, the process of learning from each other's experience familiarised us with the techniques and the atmosphere of EDT. The idea of co-writing a book arose from the wish to share some of our ways of applying theory to clinical practice with fellow practitioners, by bringing together the essence of the experience gathered from different contexts and perspectives. The result is this fairly exhaustive account of how EDT is really applied by people experienced in the approach as well as those at different stages of learning, and the effective tools it can offer in day-to-day clinical work.

EDT developed during the last two decades of the twentieth century and therefore is a relatively recent methodology, but its historical roots are longer. Its scientific reliability stems from clinical research as well as from a process of Darwinian selection of the most effective techniques that, starting with Sandor Ferenczi and Otto Rank, was powerfully boosted in the last thirty years by David H. Malan, Habib Davanloo, and their students. As we set out to present EDT to colleagues, our aim is to offer therapists and counsellors a rich and articulate body of theory-grounded, technical interventions whose effectiveness is supported by process and outcome research. We are immensely grateful to the authors and patients who have allowed the inclusion of a great deal of annotated transcript from real psychotherapy sessions to illustrate how EDT is and can be applied to a wide range of presenting problems in our work with patients, achieving remarkable therapeutic results, even in a limited time.[1] To this end, we decided to focus on the interventions that characterise EDT, and, one of us (FO), began to articulate the

essential ingredients of the therapeutic approach. In addition, we wanted to provide illustrative examples, from several service settings, of treatments for different presenting problems, and with patients at different levels of global functioning. Contributions were invited from interested colleagues and the result is the book you are now reading.

The essence of Experiential Dynamic Psychotherapy

Experiential dynamic therapy is intended to be a comprehensive system of psychotherapy that involves much briefer treatment than traditional psychodynamic or psychoanalytic psychotherapy. It is considered one of the short-term dynamic psychotherapies (STDP). EDT is based on creating a relational setting and atmosphere favourable to experience of all human emotions, whether they are primitive, as rage impulse, sexual arousal, disgust, and total despair can be, or more differentiated, like anger, concern, sadness, grief, and desire. EDT relies on a set of techniques administered in the context of a genuine, personal, and respectful human interchange, in this way guiding the individual to experience all of their emotion as fully as possible. The process leading to such emotional experience, and helping the individual to attain an understanding of the roots of their suffering and its pathological perpetuation, is regarded as the main way to activate the potential for healing and integration at its best. The ultimate objective of EDT is to remove or repair the causes of pathological suffering in a reasonably short time, and to help patients achieve a good-enough integration of the Self, personal happiness, and adaptation to their interpersonal and socio-cultural milieu.

EDT is experiential and psychodynamic or "dynamic". It is experiential in that it promotes the actual physical (through the body), and mental (related mental representations, thoughts, and fantasies) experience of feelings, impulses, and desires. Indeed, EDT practitioners regard emotional experiencing as a deep and meaningful expression of the Self. Moreover, EDT is psychodynamic in that it relies mainly on the basic dynamic theory of conflict and on transference phenomena to make sense of the mental mechanisms whose interplay is responsible for much of human suffering: in particular, the interplay of defences (D), anxiety (A), and deep emotion (X). EDT is, however, open to integration with concepts and techniques drawn from other paradigms/models, whenever this is felt to be appropriate in order to help the patient or to make sense of the complexity of the human mind.

Overview of the book

Part I, "Experiential dynamic therapy: from history to theory and clinics", opens with Ferruccio Osimo's introduction to and history of the experiential dynamic therapies, including the groundbreaking Intensive Short-Term Dynamic Psychotherapy (ISTDP) of Habib Davanloo and its subsequent development. The centrality of relationship in therapy is emphasised, and the current state of the art and science is described. Amanda Baker then presents material from interviews with David Malan, sharing some of his experiences, thoughts, and insights over decades of clinical practice, research into and promotion of short-term dynamic therapies. Ferruccio describes the nine essential ingredients of experiential dynamic therapies, and the reader is escorted step-by-step towards the discovery and understanding of the main

treatment guidelines and technical interventions. Key characteristics of taking care of the real relationship, mirroring, history taking, and putting into perspective are described. In addition, high technical content, experiential-dynamic interventions, including defence restructuring, emotional maieutics, anxiety regulation, dealing with the pathological Superego, connecting corners of the Triangle of Others, and Self- and Other-restructuring are explained and discussed. The reader is introduced to a coding system, used throughout the clinical chapters, to clarify the nature, and application, of therapist interventions in the therapies presented. Ferruccio then describes Intensive Experiential-Dynamic Psychotherapy (IE-DP), a form of EDT, illustrating how, in IE-DP, the personal relationship between therapist and patient, and the physical experience of conflicting emotions are regarded as the basis of therapeutic change. Various aspects of IE-DP are touched upon and Ferruccio explains in detail, and illustrates with clinical material, his conceptualisation of the "character hologram". The associated transcript provides an example of IE-DP from assessment to six-month follow-up, with an Axis I and Axis II disordered patient taken on for IE-DP within the Servizio Sanitario Nazionale (Italian national health service).

Part II, "Clinical applications of experiential dynamic therapy", describes the application of experiential dynamic individual approaches within the UK National Health Service and counselling services, primarily, but also in other countries (Holland, Israel, and Italy) which have similar public health services.

Jessica Bolton outlines the provision of primary care mental health services (PCMHS) in the UK, and the characteristics of a typical primary care mental health service. Jess then discusses the relevance of experiential dynamic approaches in treating the more complex presentations of common mental health problems in primary care. The case Jess presents demonstrates taking care of the real relationship, and the subsequent acceleration of therapeutic gains that were maintained at two-year follow-up. In particular, the case focuses on the early therapeutic work with a patient for whom the more common therapies (i.e., CBT and counselling) offered in PCMHS teams were thought to be less suitable. Notable aspects of the therapy include prioritising the real relationship, emotional maieutics, and helping the client free herself from a pathological Superego and embrace her creative, humorous, and healing parts. Jess asserts that the therapeutic relationship needs only to be *good enough* and *long enough* to encourage the healing Self to emerge, and how emotional maieutics need only cover a *good enough* range of feelings to enable the patient to be free from fear of emotional experience and expression. Furthermore, Jess nicely illustrates how encouraging/helping the patient to stay with feeling leads to an uncovering of important dynamic links, a clear understanding of character pathology, and provides an opportunity for a corrective emotional and relational experience.

Mark J. Stein presents a therapy with a patient suffering from intrusive thoughts in the aftermath of cancer. The reader is introduced to psychological aspects of cancer and the presenting problems of patients attending treatment for cancer-related difficulties. Through linking the psychological aspects of cancer with specific therapeutic activities of EDT, Mark provides a coherent rationale for a circumscribed, but important, role for EDT in augmenting the range of interventions available in psychological therapies services working in oncology. In particular, he argues that developments in EDT, and in particular, aspects of ISTDP and IE-DP (mirroring, anxiety assessment and regulation, emotional maieutics, defence

work, attention to the "real" relationship, interventions that focus on Superego pathology), and AEDP (acknowledging mastery, mourning-the-self, receiving affirmation), make EDT approaches particularly helpful to patients with cancer, for whom psychological adaptation is associated with regaining a sense of control, restoration of self-esteem, and finding meaning in their experiences.

Margarita Lobeck then discusses interconnectedness of physical trauma and psychological symptoms. Specifically, Margarita describes the psychological issues that can arise from physical trauma such as a burn injury, hand injury, or road traffic accident, highlighting their complex interplay, and shows how a modified and creative use of aspects of EDT can facilitate healing, helping a person with psycho-physical trauma to shift from a position of being split off from their injured part to integration. Psychological treatment of patients who have suffered physical trauma has only recently begun to receive increased attention from mental health professionals and, as a result, therapeutic approaches are still at a very early stage in their development. Margarita draws on the literature and her clinical experience to suggest that experiential dynamic therapies, with their explicit focus on the patient-therapist relationship, and moment-to-moment tracking and regulation of emerging emotion, are well suited to treatment of patients who have suffered physical trauma. Two case vignettes illustrate how an experiential approach can be both a starting point for trauma work as well as a means of helpfully guiding the patient experientially through trauma.

Also within clinical health psychology, Richard Aubrey suggests that experiential dynamic therapies, with their consideration of affective factors, are an appropriate treatment option for patients with treatment-resistant poly-symptomatic somatic problems. Richard presents a clear and concise account of helping a patient to build ego-adaptive capacity. In particular, Richard demonstrates a comprehensive assessment of anxiety manifestations, interventions to help a patient turn against automatic, habitual, and self-defeating defences (including ignoring and self-neglect), unmasking of Superego pathology, and exploration of deep feelings towards current and past attachment figures.

Ferruccio highlights the unique way in which EDT can undo the triggering and maintenance of depressive mechanisms and describes a therapy of a patient with long-standing depression. In particular, Ferruccio suggests that, by promoting emotional experience in mind and body, EDT sets in motion a benign circle of being oneself, feeling in touch with emotion, and having a sense of being oneself and capable of feeling. The case presented highlights some of the salient dynamics that tend to characterise depressive patients, and their treatment with Intensive Experiential-Dynamic Psychotherapy, in particular, focusing on some aspects of the patient-therapist relationship, handling of the pathological Superego and character defences with the help of the Character Hologram, and restructuring the relationship with Self and Other.

Ronete Cohen then introduces the reader to the problem of underachievement in gifted adolescents, and illustrates how aspects of EDT, in particular, anxiety work and separating healthy Ego from pathological Superego, can be helpful in addressing the problems faced by underachieving gifted adolescents. Parts of the therapeutic process are illustrated with transcript from a psychological therapy with a young gifted adolescent. Ronete describes significant and

measurable improvements in aspects of the presenting problem reported by the patient, staff at the patient's school, and the therapist at (premature) termination of therapy.

Amanda Baker describes the context of university counselling, and presents a rationale for the inclusion of experiential dynamic therapy-informed work among the range of therapeutic responses offered by a university counselling service. Amanda makes links between the issues facing university students, developmental issues relevant to therapy with university students, and specific therapeutic activities of EDT. Transcript of therapy with a student presenting to a university counselling service illustrates how some experiential and dynamic interventions were applied within the counselling, with an emphasis on taking care of the "real relationship", restructuring the client's sense of Self and Others, and facilitating use of fantasy, to explore hidden impulses, and desensitise the client to experience and expression of anxiety-provoking and painful feelings, especially anger.

Thereafter, Derek, a client who had recently completed a brief course of EDT in an NHS psychological therapies service, writes about his journey through therapy. Derek shares his views on the difficulties and achievements in his therapy and describes how, through facing his emotions with his therapist, he ultimately was able to resolve the legacy of trauma in his early attachment relationships. James Macdonald adds an afterword.

Part II of the book concludes with a chapter by Arno Goudsmit who discusses and illustrates the development of an interpersonal transitional space in which corrective emotional experiences can take place. In particular, Arno suggests that therapy can offer a new interpersonal space, from which the patient can develop a new or an enhanced Ego position. The case presented illustrates how a patient begins therapy failing to distinguish between pathological Superego and healthy Ego parts and how, once the distinction between the two parts becomes clear, the inner conflict in which the patient had been trapped becomes visible and can be worked through. Arno argues that a full acknowledgement of this crucial distinction is made possible in the course of the formation of an interpersonal experiential therapeutic space.

Part III, "Training and Research", opens with Silvia Landra's chapter on an EDT group psychotherapy. In a public health service—like the Italian one—in which capacity to provide psychotherapy is exceeded by growing demand, any treatment options that allow therapy providers to respond to the greatest number of requests for treatment, in the shortest possible time, are welcome. Group treatments have the potential to achieve this. Although EDT is mostly administered in a two-person setting, Silvia Landra, together with Ferruccio, recently offered an EDT group psychotherapy. In her chapter, Silvia shows how two consolidated approaches—group analysis and EDT—can merge into something new and effective. Eight patients, four male and four female, with Axis I and Axis II disturbances, and different degrees of resistance and levels of ego-adaptive capacity, were treated with group IE-DP. Based on review of the video recorded material and reflection on the experience of providing an EDT group psychotherapy, nine learning points stand out as being crucial in bringing about meaningful therapeutic effects. Silvia discusses the lessons learned from this pioneering clinical experience, and presents transcript to illustrate important aspects of the therapy process.

Naomi Wilson then describes how experiential dynamic principles can improve the workplace, through privileging relationships within National Health Service teams. In particular, Naomi argues for accumulating evidence of the centrality of relationships,

attunement, and a highly affective focus as prerequisites to psychological healing, that these aspects of clinical work can be motivating for caregivers, and that emotional connection is personally and professionally sustaining. In contrast, current "quality" indicators are objective and exclusively derived from scientific, economic, or political rationalities. Naomi argues that such quantitative scrutiny can sabotage discourses around human connectedness, thus rendering the vital relational dimension of care invisible. Using EDT frameworks Naomi then formulates how services might operate to validate the experiential aspects of professionals' roles.

An erudite chapter by Joop Meijers, a respected cognitive behavioural psychotherapist, who has recently begun to explore the use of experiential-dynamic activities in his practice, follows. Joop carefully compares and builds a bridge between two streams of therapy that, on the surface, appear very far apart, if not contradictory to each other: cognitive-behaviour therapy (CBT) and EDT. Joop explains how mainstream CBT focuses on the role of cognitions as a determinant of emotions and, therefore, in its interventions, stresses the importance of changing beliefs, interpretations, perceptions, and, in this way, brings about change in emotion and emotion-driven behaviour. EDT, instead, assumes that, at the root of the problem there is an inability to connect with, experience, and express authentic feelings and impulses, due to the anxiety they provoke. In particular, it is thought that, because of the individual's guilt, grief, and fear—lest their authentic feelings and impulse should threaten attachment bonds—they become anxious about their authentic feelings and longings. To bring about change it is then necessary to help patients regulate their anxiety, so as to be able fully to experience and express their true feelings. For EDT therapists, "cognitive" pathology is regarded as impaired ideation linked to insufficient opportunities to take in health-promoting stimuli or "experience of nonexperience [for example, severe sensory or educational deprivation]" (Vaillant, 1993, p. 44), defensive processes (e.g., rumination, selective attention, ignoring), and self-attacking and self-diminishing thoughts and ideas linked to Superego pathology. In EDT, it is the reawakening of dormant feelings and impulse that is believed to be pivotal in bringing about change. The EDT therapist—similarly to the CBT therapist—helps the patient to distinguish between cognitions that reflect their real Self, and those originating from deprivation and their pathological Superego (dysfunctional core beliefs, in CBT terminology). In EDT, however, the focus will be, in particular, the patient's emotional response to this new awareness, for example, enabling them to take a stand against the pathological cognitions, and to experience, acknowledge, and express their authentic feelings, impulse, and longings. Only at this stage can the patient revise their impaired ideation, and relinquish cognitive defensive processes, inasmuch as they have had an experience of the Self (and Other) that is very different to previous Self (and Other) experiences, and defences have ceased to serve a "useful" function. In other terms, when the individual has dealt with the painful and anxiety-provoking feelings, the defensive avoidance of authentic feelings is no longer required. Joop shows how understandings of CBT and EDT, and techniques deriving from those understandings, can complete each other and be integrated. The case of a patient with severe obsessive-compulsive disorder (OCD) is presented. Joop describes how, in this particular case, the patient was first treated with traditional CBT (exposure therapy), and how, after the patient decided that the CBT was not helpful enough, he approached Joop, who, being trained in both CBT and EDT, decided to change the approach and

apply principles of EDT. Joop presents transcript to illustrate how, in the EDT part of therapy, the patient overcame some of the fear of his authentic feeling of anger, which resulted in a significant decrease in OCD symptoms and improvement in well-being and functioning. Although Joop asserts that this was accomplished without using the typical CBT techniques of exposure and response prevention, he acknowledges that Leigh McCullough's conceptualisation of affect phobia (McCullough Vaillant, 1997; McCullough et al., 2003) provides a framework for understanding the therapy in precisely those terms. Similarly, Joop's chapter makes a meaningful contribution to the dialogue between two schools of therapy that can only gain by learning each other's language and—eventually—creating a new, richer, language that merges and integrates the existing ones.

Part III concludes with James Macdonald's chapter on EDT in the context of psychotherapy research. James spells out the key elements of EDT, linking them with evidence-based "principles of change" derived from process-outcome research, and examines the evidence base for EDT relative to other therapies and to psychodynamic therapy. In particular, James introduces the reader to the relevant research indicating the equivalent effectiveness of different therapy models and notes that these findings apply also when EDT has been compared to other approaches in formal research studies. James argues that, while EDT may not have been demonstrated as more effective than other models of therapy, it provides a coherent theoretical approach that is congruent with a variety of evidence-based therapeutic processes, drawn from diverse models of therapy. This lends itself to an integrative perspective on EDT and its relationship to other models of therapeutic practice. James also reviews the randomised controlled trials of EDT and summarises EDT's place in recent efforts to promote evidence-based practice in the field of psychological therapies in the UK. James concludes that EDT holds promise as a contemporary model of psychodynamic psychotherapy that harnesses a variety of evidence-based processes of therapeutic change with evidence of its efficacy in a growing number of formal research studies.

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Note

1. It is certainly the case that, within the UK, demand for psychological therapy from commissioners and referrers has tended to exceed resources, and many services have found it necessary to operate a waiting list. Therapists working in the public (and even the private) sector are under an increasing time constraint and pressure to obtain good results while remaining cost-effective and competitive.

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PART I

EXPERIENTIAL DYNAMIC THERAPY FROM HISTORY TO THEORY AND CLINICS

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CHAPTER ONE

A historical overview of experiential dynamic psychotherapies

Ferruccio Osimo

Experiential dynamic therapies descend from the line of thinking and research historically initiated by Alexander and French (1946), who were the first to declare their aim of making psychoanalytic therapy "briefer and more effective". Before Alexander and French, some of the theoretical contributions by Sandor Ferenczi, Otto Rank, and Wilhelm Reich have been particularly relevant to the development of EDT and, more recently and specifically, David Malan and Habib Davanloo are the most prominent proponents of experiential dynamic therapy. For an account of these contributions the reader is also referred to Amanda Baker's chapter (Chapter Two), that includes an interview with David H. Malan.

A precursor

Charles Darwin, in a pre-psychoanalytic era, had already understood the links between emotion, defence ("force of habit"), body muscles, and conscious and unconscious mental mechanisms.

> Certain complex actions are of direct or indirect service under certain states of the mind, in order to relieve or gratify certain sensations, desires, etc.; and whenever the same state of mind is induced, however feebly, there is a tendency through the force of habit and association for the same movements to be performed, though they may not then be of the least use. Some actions ordinarily associated through habit with certain states of the mind may be partially repressed through the will, and in such cases the muscles which are least under the separate control of the will are the most liable still to act, causing movements which we recognize as expressive. (Darwin, 1872, p. 34)

Thirteen years after publishing his great work on the origin of species by means of natural selection, the great scientist published *The Expression of the Emotions in Man and Animals*. Ekman (1996) commented on the importance to Darwin of universality and emotional expression:

> Universality mattered to Darwin because it provided support for his theory of evolution. Universality would make more plausible his claim that emotional expressions are not unique to humans but are shared with other primates. (p. 366)

As elaborated by Ekman in his book, currently such universality is substantially demonstrated for the facial expressions of happiness, disgust, surprise, sadness, anger, and fear.

Origins of experiential dynamic therapy

Experiential dynamic therapy (EDT) historically originates from short-term psychotherapies, especially Malan's brief psychotherapy (1963, 1976a, b, 1979). EDT is a comprehensive approach, aiming to take care of all the significant aspects of an individual at a deep level, but more quickly than in previous dynamic therapy models. This is achieved by means of an *acceleration* of the therapeutic process. The idea of accelerating the therapeutic process is not new in the field of psychodynamic therapy and, perhaps surprisingly, even in psychoanalysis. Ferenczi (1920), in the first lines of his essay, *The Further Development of an Active Therapy in Psychoanalysis*, wrote: "Psycho-analysis, as we employ it today, is a procedure whose most prominent characteristic is passivity" (p. 199).

Ferenczi deeply sensed the need to introduce more active techniques and this played a major role in the more conflictual aspects of his relationship with the founder of psychoanalysis. A few pages further he goes on:

> In seeming contradiction with the fundamental rule of psycho-analysis I had in a few cases to decide to encourage or discourage patients directly towards or against the production of thoughts and fantasies. I have in this way induced patients to carry out this plan who threatened to deceive me, for instance, to feign dreams. But when I became aware of the "misuse of freedom of association" by means of misleading, futile, and sidetracking ideas or fantasies, I did not hesitate to show the patient that by this he was only trying to escape the more difficult task, and to bid him resume the interrupted train of thought. These were just cases in which patients wished to *avoid* what touched them closely … (1920, p. 207)

When the new science he founded was dawning, even Freud carried out a number of treatments we would define as short-term. Osimo (2003a, chapter 11) describes a case of short-term psychoanalysis reported by Breuer and Freud (1895), seen through the theoretical lens of contemporary short-term psychotherapy. However, it is important to say that an abbreviation of psychoanalysis was never the intention of its founder who, moreover, regarded with suspicion all attempts in this direction. Rather, he took utmost care to let the fundamental discovery of the unconscious world unfold its potential in all possible directions and always opposed alternative approaches aiming at accelerating the process, like those by Ferenczi (1908–1933), Rank (1924), Ferenczi & Rank (1925), Adler (1928–1937), and Reich (1933). His recommendation for a *passive* attitude, where the analyst behaves as a sounding board to the analysand's free associations, and keeps attention "free-floating", promoted a progressive lengthening of psychoanalytic treatments.

It was certainly no coincidence that Freud put an end to the relationship with his brilliant disciple Otto Rank, when the latter published *The Trauma of Birth* in 1924. Rank's theory of the birth trauma as prototypical of all subsequent traumas led him to propose that the re-experiencing of it and of the related fears in the analytic transference would prevent the "unconscious reproduction of the same in the severance from the analyst" (p. 214). A somewhat cruel irony is that the painful "severance" between Freud and Rank occurred precisely because of the publication of this theoretical viewpoint. Rank's enormous insistence regarding the birth trauma and his idea of setting a time limit to treatment certainly triggered Freud's fierce opposition but, nevertheless, Rank's theoretical position is relevant to the development of short-term psychotherapies. Indeed, Rank was deeply concerned with the healing side of psychoanalysis, thus with emotional experience, rather than simply theoretical aspects: "… therapeutic possibilities do not conform, in any expected degree, to the increase of our knowledge, and […] even simple therapeutic action can be arrested by too much knowledge and too much [cognitive] insight" (1924, p. 202).

Adler's theoretical focus on the complexes of inferiority and superiority, thus also on the power aspects inherent in the analyst/analysand relationship, and his consequent modifications of technique and setting are certainly relevant to the shortening of therapy. Indeed, Adler was the first analyst who gave up the couch and, choosing to sit face to face with his patients, emphasised that: "… the psychological development of a person can reach a normal condition only when he can achieve the necessary degree of ability to co-operate" (1928–1937, p. 199).

Adler also addressed the problem of "over-gratification" as a by-product of therapy, leading to a patient's dependence on the therapist, and consequent difficulty in terminating treatment. He called this the "psychopathology of the pampered child", or "a view of life in which the individual assumes that the other person is there for him" (p. 195). In calling for a countering of the patient's strivings to get the therapist to take on the pampering role at a very early stage, Adler's approach can be regarded as a contribution to the acceleration of the therapeutic process.

The analytical psychology of Carl G. Jung included the concept of *archetypes* (1912, 1934–1954) as primordial images deriving from the *collective unconscious*. Archetypes are elements of a matrix that is common to all peoples, a virtual image that is genetically transmitted. As such, archetypes would not seem to help shorten treatment, rather to make things more complicated by populating the unconscious with an endless crowd of mythological characters. In clarifying what he meant by "archetypal images" Jung (1964) stated:

> … some contents of modern man's unconscious resemble products of the mind of ancient man … the archetype is a tendency to form such representations of a motif—representations that can vary a great deal in detail without losing their basic pattern … [rather than an] "inherited representation" … [they are] an instinctive trend … Instincts are physiological urges, and are perceived by the senses. But at the same time, they also manifest themselves in fantasies and often reveal their presence only by symbolic images. These manifestations are what I call the archetypes. (pp. 66–69)

In *Psychological Types*, Jung (1921) paid tribute to a clinical application of archetypes when he focused on the way the effect of archetypes is manifest in each individual, and articulates the concept of co-existence of two opposites: (i) the *persona* or the social mask, and (ii) the *shadow*,

representing its repressed negative. Seen through the lens of EDT, this concept becomes clinically incisive inasmuch as, by focusing on the overall mode of presentation of an individual, it can be used to address the character defence. As such, Jung's (1964) conceptualisation of dream and archetypal images has particular relevance to the conceptualisation of the character hologram articulated by Osimo (2009) (see also pp. 107–132):

> They form a bridge between the ways in which we consciously express our thoughts and a more primitive, more colourful and pictorial form of expression. It is this form, as well, that appeals directly to feeling and emotion. These "historical" associations are the link between the rational world of consciousness and the world of instinct. (Jung, 1964, pp. 47–49)

Furthermore, Jung was interested in the therapeutic power of images as messages from the unconscious because he believed that modern life had led to a stripping away of the emotional energy from ideas, but that symbolic images retained their potency, thereby having the potential to make an impact on the perceiver: "… its symbolism has so much psychic energy that we are forced to pay attention to it" (1964, p. 49).

Again, referring to the energy attached to these images:

> We can perceive the specific energy of archetypes when we experience the peculiar fascination that accompanies them. They seem to hold a special spell … They [archetypes] are, at the same time, *both images and emotions*. One can speak of an archetype only when these two aspects are simultaneous. When there is merely the image, then there is simply a word-picture of little consequence. But by being charged with emotion, the image gains numinosity (or psychic energy); it becomes dynamic, and consequences of some kind must flow from it … they are pieces of life itself—images that are integrally connected to the living individual by the bridge of the emotions … it must be explained in the manner indicated by the whole life-situation of the particular individual to whom it relates … archetypes come to life only when one patiently tries to discover why and in what fashion they are meaningful to a living individual … they gain life and meaning only when you try to take into account their numinosity—i.e., their relationship to the living individual. (1964, pp. 79, 96–97, italics added)

In 1933, Reich published *Character Analysis*, in which he outlined a totally new dynamic approach to personality disorders. Reich was a radical critic of Freud's "basic rule" of free association and held a different position as regards the approach to analytic patients. Instead of privileging verbal communication, that is, speech and language, Reich started to look to the body as a major source of interpersonal communication, and information about the individual's unconscious mechanisms and conflicts. Davanloo's confrontation of character pathology would seem related to Reich's view of character, which is also relevant to the concept of character hologram (Osimo, 2009) (see also pp. 107–132). It is therefore worth quoting from Reich's (1933) book that the character of an individual

> is usually expressed in a specific *attitude* or *mode of existence* … [that] represents an expression of the person's entire past … The way the patient speaks, looks and greets the analyst, lies on the couch, the inflection of the voice, the degree of conventional politeness which is

> maintained, etc., are valuable cues in assessing the secret resistances with which the patient counters the basic rule. (pp. 48–49, italics in original)

In other words, when we are faced with a character problem, we are faced with defences that have been incorporated into the patient's behaviour, or "character armour" (p. 48) which the patient perceives as the way they *naturally* are, that is as a part of their ego. Consequently, Reich's technical recommendation is to focus consistently on the patient's "ego defence" (p. 70), because "unless the ego defence has been systematically and thoroughly worked through beforehand, no interpretation would evoke an *affective* response" (p. 68, italics added). Another fundamental recommendation by Reich is,

> … we merely single out from the orbit of the personality the character trait from which the cardinal resistance proceeds, and, if possible, we show the patient the surface relation between the character and the symptoms. But for the rest, we leave it up to him whether or not he wants to make use of his knowledge to change his character. (p. 59)

Reich's theoretical position, technical recommendations, emphasis on emotional experiencing, and his view of the body as a source of information about human conflict, are highly relevant to most EDT models.

The first clinical trial explicitly aiming to make psychoanalysis "briefer and more effective" is the one reported in the book by Alexander, French, and colleagues published in 1946, a true milestone of psychotherapeutic reading. These authors regarded emotional experience as the major therapeutic factor, and this led them to elaborate an *ante-litteram* form of EDT. Historically, moving the focus of attention from giving interpretations at a cognitive level to actively promoting the experience of buried feeling within the therapeutic relationship represented a paradigm shift in psychoanalysis, and a shift in emphasis from theory to clinical practice. For example, I would like to summarise an interesting clinical case described in Alexander and French (1946, pp. 293–299).

> The patient was a highly intelligent man of nineteen. Symptomatically he was remarkably depressed and this interfered with his university studies. He was also anxious and worried to have to face his father's disappointment. Dr Adelaide McFayden Johnson offered him thirty-five sessions. "In giving his history the patient had difficulty in reporting that his mother had been accidentally burned to death when he was three."

For a full account of the case the reader is referred to Alexander and French's (1946) book. Here, I wish to highlight the therapist's attitude of focusing on the emotionally charged incidents, paving the way to the in-session experience of deep emotion and sharing it with the patient.

> The treatment lasted for three months and in the third month, the patient's resistance about recalling his mother's death led the therapist to focus on this. At some point, the patient asked out of the blue: "But did I tell you I went to the hospital and got my birth certificate three weeks ago?" This was done to learn his mother's last name, but, surprisingly, the patient now could not remember it. The therapist commented that the patient possibly harboured angry feelings at his mother for dying and abandoning him. The patient said: "I must have been a

> stinker, for no relative would take me." The therapist related this to anger and asked again for his mother's name. In response to the therapist's putting pressure, the patient answered angrily: "I have it on me. I don't want to look, because before when I looked at it, I was uneasy for hours afterwards." After some further resistance and further pressure the patient took out the certificate bearing his own mother's name, but did not hand it over. He commented, "The name is G-," and replaced the paper in his wallet. After a few lines the therapist said empathically: "… I feel you have been repressing not only your angry feelings for her, but also, perhaps, the fact that you and she loved each other." To this the patient said the thought came to him of writing to his aunt asking her to send him a picture of his mother. Suddenly tears welled up and the patient threw himself sobbing on the couch. After ten minutes he grew calm and said, with great feeling, "Silly, but I feel as if my own mother were all around me here. It's something so familiar." He then embarked on a kind of accelerated imaginary recapitulation of some crucial questions he would have wanted to put to his mother, to which the therapist gave some answers. What he was most probably seeking were not the answers, but the corrective relational experience, which could give him the emotions he wished he could have experienced with his mother. In fact, before the end of the session, he exclaimed: "I know who I've been talking to: my mother! And I feel wonderful! "I feel my mother is all around me." After the session the patient's depression lifted, he was able to successfully complete his courses, and his view of his parents became more realistic. In the two-year follow-up period he remained symptom-free and many changes occurred in his life. In his last letter to the therapist the patient wrote that he had "never been so satisfied with his relationships with people as now".

This case provides the unbiased observer a clear suggestion of the following:

- The intense re-experiencing of buried emotions in the actual relationship with an emotionally responsive therapist brings about therapeutic change. This is what Alexander and French (1946) called *corrective emotional experience* and is pivotal to dynamic change.
- If such re-experiencing can be brought about rapidly, dynamic change will also be rapid, that is, the phase of consolidation of change or "working through" is not quite a matter of time, but of good-enough emotional experience.
- When an effective approach is employed, even relatively early traumas can be re-activated and solved independent of the length, frequency, and total number of sessions.

Alexander and French's innovative and somewhat revolutionary therapeutic approach triggered an adverse reaction from the traditional psychoanalytic establishment, some of whose most prominent representatives attacked these authors savagely and quite irrationally (e.g., Eissler,1950; Jones, 1946). In contrast, other independent thinkers were more open to the idea of accelerating the therapeutic process. For example, Fromm, though more recently, wrote:

> … by having the courage of using analytic insight to approach the patient very directly [a therapist can] possibly do in twenty hours what one feels obliged to do, as an analyst, in 200 hours. There is no reason for false shame to use direct methods when they can be used. (1964, p. 41)

In an article about Fromm's technical views we can read: "This is reminiscent of certain modern techniques of brief psychotherapy … and confirms that Fromm had a very active approach to resistance" (Bacciagaluppi, 1989, p. 237).

When Balint started to experiment with brief forms of therapy at the Tavistock Clinic in 1955, notwithstanding his acquaintance with Alexander, he developed a similar but independent research and study setting. Balint founded the Brief Psychotherapy Workshop (BPW), consisting of a group of selected and gifted clinicians, one of whom was David Malan. Their initial idea was to circumscribe the area of conflict, designated by Balint with the term *focus*, on which to concentrate dynamic work. According to Malan (1999), the therapies supervised within the BPW were never *really* focal, since interpretations actually involved all the meaningful material, and not only the focal conflict. However, the popularity of the term *focal* applied to brief therapy became enormous, to the point of being regarded as a necessary attribute of all brief therapies. This term also appears in the title of Balint's posthumous book on the subject, published by his wife, Enid, and his disciple, Peter Ornstein (Balint, Balint & Ornstein, 1972). Its value seems to have been mostly diplomatic, in that circumscribing the area of intervention by selecting a therapeutic focus made it easier for long-term analysts to accept brief therapy as something different—therefore less confusing or threatening—from what they did. In this way, it was seemingly focality—and not more effective techniques—that made brevity possible. This is, however, untrue, as even a dynamically simple case with a single and highly meaningful focus offers no guarantee for brief and effective therapy. In other cases, using an effective approach, resolution of dynamically complex, or "multi-focal", conditions, may be achieved within a relatively short time. Given the contribution of different factors, the term "focal" as a label for short-term psychotherapy is as misleading as it would be to use "couch" or "free-association" to label long-term psychoanalysis. Malan (1999, personal communication) told me that Balint once told him: "I used to think that the essence of analysis was five times a week on the couch, free association, etc., but now I realize that the essence of analysis lies in the attitude of the therapist" (Balint, personal communication to Malan).

Sifneos's (1972) Short-Term Anxiety-Provoking Psychotherapy (STAPP) is probably the purest example of really focal and really brief psychotherapy. His emphasis on the crucial role of anxiety in closing or indeed opening the gates of deep, unconscious communication is certainly relevant to contemporary EDT. However, Sifneos failed to develop effective tools to *regulate* the level of anxiety, with the consequence that selection criteria for STAPP were very narrow, and made it applicable to a very low proportion of patients, probably three to five per cent of all psychotherapy referrals.

Malan and Davanloo

In the mid 1960s Malan took over the Tavistock BPW from Balint. The members of his workshop were all trainees, making the group quite different from Balint's, which consisted entirely of experienced therapists. Malan postulated the crucial interplay of selection criteria, therapeutic technique, and the *quality* of results obtained. His elucidation of the dynamic process and of factors of change in brief psychotherapy and, subsequently, in EDT, is invaluable. His (1963, 1979) books, translated in various languages, contain a rich harvest of clinical material, illustrating

the backbone on which the "science of psychodynamics" is based. In this respect they represent an ideal continuation of the book by Alexander and French. Thanks to his extensive clinical research, Malan was able to reject the "hypothesis of superficiality", according to which brief psychotherapy is a *superficial treatment*, applicable to *superficially ill* patients, and bringing about *superficial results*. His pivotal contribution to psychotherapy in general, and EDT in particular, should never be ignored and can be encompassed under four sub-headings: (i) theoretical position, (ii) scientific approach to change mechanisms, (iii) follow-up studies, and (iv) respect for the Other.

Malan's (1979) theoretical position was eminently experiential and dynamic: "The aim of every moment of every session is to put the patient in touch with as much of his true feelings as he can bear" (p. 74).

Malan was a chemist before becoming a doctor and specialising in psychiatry and psychotherapy. His scientific approach to change mechanisms is consistent with his interest in transformative phenomena and may partly explain his unique skill in measuring change by keeping a clear distinction between real deep change and simple migration of pathology from one to another symptom. Most of Malan's published studies include long-term follow-up. These studies are actually process *and* outcome studies, since they mostly include both a narration of the unfolding therapeutic process and a detailed analysis of change. By means of these studies over a period of five decades, Malan set in motion a two-way process. On the one hand he was able to measure the effectiveness of selection criteria and technical method and, as a parallel process and further bonus, he distilled the essence of what really matters in terms of quality of results; what makes the difference in someone's quality of life (Malan & Coughlin Della Selva, 2006; Malan & Osimo, 1992). Malan trained many therapists at the Tavistock—me being one of the lucky ones—and one of the things he taught us was deep respect for the patient-as-a-person. His attitude to trainees was respectful but could be harsh too. The following anecdotes will help to highlight his attitude to patients, trainees, and the unfolding of truth.

In my training years it happened to me—and I believe it to be a common experience—to take for granted that a patient, in a given circumstance, must surely feel a certain feeling. In my first supervisions with David I found it surprising—and indeed frustrating—when he asked, "What is the evidence that that was what he felt?", or plainly, "How do you know this?". I would hastily try to articulate a plausible explanation, calling upon my psychoanalytic concepts of Oedipal jealousy, rivalry, and the like, without realising that, in so doing, I was just trying to make up for my actual ignorance of what feeling was being experienced. David found this infuriating. Once, I had to report to David about my first follow-up interview with a former patient from his workshop, and I got a lot of criticism for not having gathered clear-enough evidence that things were exactly the way they seemed to be. The interview had lasted for two-and-a-half hours and, at the end, the patient and I were both exhausted; he had shared a lot of his life history with me, and I had had to keep focused and attentive in my effort to find what I was looking for and prove myself a good trainee. At supervision I initially felt fairly proud, but it did not last very long: "You let him talk too much without interrupting"; "How do we know if the quality of the relationship with the wife is really improved? You should have got him to give you a detailed

description; what do they do when they are together, go to the movies? Do they talk or not? What is their social life like? How do they deal with differences?" I answered what I could, that is, what I *thought* it was, or that *surely* it was and … that was the last time I did that, since the more I used my imagination to fill the gaps of my interview the angrier David got. The cherry on the cake came when I reported that, towards the end of the interview, the patient had told me he remembered almost nothing of his therapeutic sessions, including his decision to terminate before the term of fifteen sessions. At that point, feeling moved by this man who, after telling me all the details of his life, told me he had forgotten all of his therapy, I thought it would be reassuring to hear me saying that many think this means that therapy is still working inside him and this is a good indicator. The patient did actually feel reassured, and left the place feeling as happy with his ignorance as I felt with mine. When I reported this, however, David asked why on earth I said that—I again tried to justify—then he stared at me in the eye and said, "This is rubbish: you must never lie to patients." That time I gave up trying to answer, and never again tried to make things up with David, and indeed with patients.

On another occasion, while I was reporting to him about the follow-up interview with one of his own former patients, Malan suddenly recalled an incident that had occurred in a session with that patient, many years earlier. This patient was very rigid, his emotional life thwarted, and Malan felt disappointed with their interchange. At some point, exasperated by the patient's coldness, Malan put to him the following question, "Why you think I do this job?", to which the patient promptly answered, "Because they pay you good money." Malan responded, "Did it ever occur to you that I might enjoy helping people?" This time the patient kept silent, but his nose started to bleed. I found this incident extremely touching and, also, dynamically interesting. Malan's humble comment was, "That was the first time I realised that nose-bleeding may have a psychological basis."

Malan (1963, 1976a, 1979) first conceived the importance of placing, side by side, the two triangles known as the "Triangle of Conflict" (Ezriel, 1952) and the "Triangle of Others" (Menninger, 1958) (Figure 1). Taken together, they serve to shed light on the psychodynamic content of every verbal and non-verbal communication of the patient.

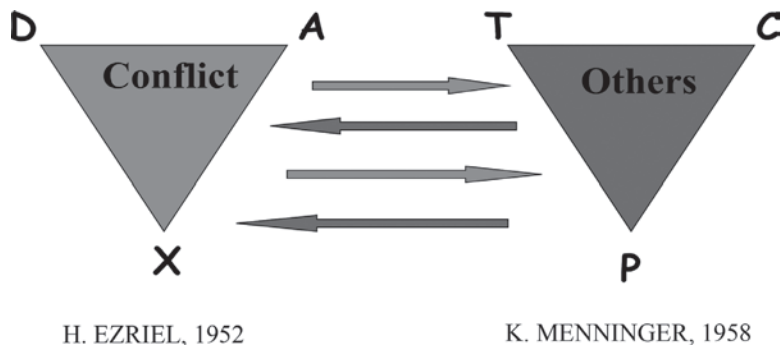

Figure 1.

The Triangle of Others allows a therapist to distinguish three categories of patients' interpersonal relationships: (i) those that are current or belong to the recent past (**C**), (ii) the relationship with the therapist (**T**), and (iii) relationships of the more distant past (**P**), that is, with the primary attachment figures (Bowlby, 1982). This last corner of the Triangle of Others is placed at the bottom, signifying that it is "deeper" and typically reached at a later moment with respect to the other two. The Triangle of Conflict represents the three elements on which psychodynamic theory is based, that is, defence (**D**), unconscious feelings, desires, representations, and impulses (**X**), and anxiety (**A**), which is often accompanied by other inhibitory emotions such as pain, guilt, and shame. Again, the **X** corner of the triangle is placed at the bottom since feelings and impulses that are excluded from consciousness are regarded as "deeper" because they tend to be reached only after the anxieties and defences that are mobilised for the purpose of excluding them. The Triangle of Others actually represents the other people in the patient's life, and the Triangle of Conflict represents the patient's psychodynamic Self. Drawing a few arrows joining the two Triangles highlights also the relationship between the individual and the other significant people in their life. The two Triangles are well known and their use by dynamic therapists is widespread.

In the 1970s Malan first saw Davanloo's video recordings of his clinical work. Witnessing his innovative approach of directly confronting, identifying, clarifying, and challenging patients' defences raised Malan's enthusiasm to the point that he stated, "Freud discovered the unconscious and Davanloo discovered how to use it therapeutically." Thus Malan envisaged a totally new therapeutic power in Davanloo's work, something that he deemed missing in psychoanalysis and dynamic therapy hitherto: the power to address and undo patients' defences from the first therapeutic session, by means of highly specific techniques. Malan's excitement was understandable given that he was a clinician and researcher who was already internationally known and respected for his clinical studies. Moreover, Malan immediately decided to devote himself to study and articulate Davanloo's techniques and associated theory, something he has never stopped doing for the last twenty-five years (e.g., Malan 1986a, b). He was always eager to lend his unique understanding of psychodynamics to all those he believed to be valid contributors to the development of EDT—and this is indeed rare—like McCullough Vaillant (1997), Osimo (2003a), and Coughlin Della Selva (Malan & Coughlin Della Selva, 2007).

In the early 1980s, by means of video recorded clinical cases, Davanloo was the first to demonstrate that even severe character problems could be effectively dealt with in less than forty sessions. As a medical doctor and psychiatrist, Davanloo was experienced in psychoanalysis and dynamic therapy before developing Intensive Short-Term Dynamic Psychotherapy (ISTDP). Notwithstanding his appreciation for the way in which psychoanalysis made sense of the conscious and unconscious dynamics in the human psyche, he found that the way in which psychoanalysis was *practised* was too lengthy and not effective enough, that is to say, inadequate to deal effectively with the complexity and intensity of human emotion, and bring about the desired change. He therefore deemed it necessary to elaborate new technical interventions, catalysing the change process more efficiently and giving therapists more healing power. His idea—and indeed his accomplishment—was to give psychoanalysis new tools to counteract pathology and promote healthy functioning. Davanloo's view of the human unconscious is centred on the conceptualisation of two conflicting parts: (i) the Self-sabotaging, pathological

Superego part, and (ii) the Ego part, healthy but for having become a hostage and victim to the Superego. Davanloo spent some twenty years studying his own video recorded therapy sessions and, as a result of this endeavour, was able to identify, select, and maximise the really useful interventions and drop the rest. His prevailing therapeutic attitude—with which his patients are immediately confronted—is one of calling upon the patient's potential to ally with the therapist and fight against the self-sabotaging Superego, in order to defend and finally rescue the prisoner Ego. This does not fail to make his clinical presentations on video extremely involving and fascinating. Some of his strategies for breaking through the defensive barrier of even the most resistant patients are remarkably effective. Seeing his patients change in real time, in response to his surgically accurate interventions, administered by a therapist who is only apparently uninvolved—and sometimes even irritating—but can be empathic at a deeper level, makes him a highly charismatic therapist.

Davanloo's discoveries

Davanloo's model has two main distinctive technical features that make his Intensive Short-Term Dynamic Psychotherapy the prototype of all subsequent EDT models: (i) his new conceptualisation of defence mechanisms, the way they are met in the here-and-now of the session, and his new ways of dealing with defences, and (ii) the techniques leading to rapid uncovering and experiencing of even the most primitive layers of human feeling and impulse, shedding light on aspects of human conflict—indeed of human nature—that do not usually surface, nor do they tend to be welcome, in the soft tone atmosphere of more traditional consulting rooms.

Davanloo called the overall process, "unlocking of the unconscious" (1986, 1990). His way of handling defences is extremely dynamic in that it follows the unfolding of the moment-to-moment interaction with the patient. Defences are not interpreted—as in psychoanalysis and dynamic psychotherapy—since this type of intellectual explanation makes the process over-cognitive. The more a therapist keeps on interpreting defences one by one at the cognitive level, the more the patient will mobilise new sets of defences, for example, tactical defences, such as vagueness, tentativeness, evasiveness:

> In ISTDP the process set in motion by the therapist differs profoundly from traditional psychoanalytic psychotherapy in that the therapist does not concentrate on a single defence in a static way, but is trained to recognize every defence the moment it arises, rapidly shifting from one defence to the next and addressing each one in highly specific ways. (Osimo, 1991, p. 44)

Davanloo's model is especially suitable for highly resistant personality disorders presenting with ingrained character pathology. To break through these character defences, Davanloo recommends a standard set of interventions, the "central dynamic sequence" (Davanloo, 1989, pp. 35–36), which incorporates the major technical interventions in the process of unlocking the unconscious. At the core of this sequence is pressure for feeling. Resistance is thus mobilised in the form of tactical and character defences. As defences come to the forefront they can be clarified and challenged by the therapist. This promotes deeper and deeper emotional experiencing, until new defences are mobilised and come to the forefront. These new defences are clarified

and challenged in their turn, and the process continues, in this way, until a breakthrough of feeling occurs, followed by an unlocking of the unconscious, that is, when the therapist and patient have a clear view of the pathological components within the psyche. After this has happened repeatedly, the unconscious becomes open and fluid. According to Davanloo, this means that there is no resistance in operation and the deep dynamic content can now flow freely. More on the central dynamic sequence can be found in my later chapter (pp. ??–??). For a thorough and exhaustive description of Davanloo's model of ISTDP, the reader is referred to his own writings (e.g., Davanloo, 1990, 2000) as well as to Coughlin Della Selva (1996), Malan (1986a, b), and ten Have-de Labije (1999, 2001a).

Current state of the art

All the EDT approaches are indebted to Davanloo's discoveries, his innovations, and his demonstration of how it is possible to have an understanding of all defences much more quickly than it was previously believed. Because of the reverberation of Davanloo's own personality on his theoretical conceptualisation, this is historically linked to the idea of a challenging attitude of the therapist. However, subsequent clinical studies revealed that, if defences are correctly identified, understood, and clarified to the patient, their renunciation can be achieved also with a different personal attitude, for instance a validating attitude (McCullough et al., 2003; McCullough et al., 1991; McCullough Vaillant, 1997). In time, this has made it easier to keep the personal aspect distinct from the crucial technical requirement of timely identification of and effective dealing with the patient's defences. Osimo (2003b) elaborated on the complementary functions of challenge/wind and empathy/sun in the therapist's attitude and techniques. The "sun and wind" theory was taken up and further elaborated by Tunnell (2006) who emphasised that the patient's as well as the therapist's position on the sun vs. wind spectrum is relevant to the success of both the patient-therapist and the therapist-supervisor interchange.

Over the last three decades, various EDT approaches originating from the Malan and Davanloo pioneering work have been empirically tested and scientifically investigated. Each of them has some characteristic features of its own, whereas other features are common to all. Some of Davanloo's former students went on elaborating Davanloo's theoretical-technical framework, keeping the founder's acronym (e.g., Abbass, 2002; Coughlin Della Selva, 1996; ten Have-de Labije, 2001a, b, 2010), or modifying it slightly, as in Attachment Based (AB) ISTDP (Neborsky, 2003). Others modified some of Davanloo's theoretical-technical principles and the new acronyms are indicative of differences rather than similarities. Examples include Accelerated Empathic Therapy (AET) (Alpert, 1992; Fosha, 1992; Sklar, 1992), Accelerated Experiential-Dynamic Psychotherapy (AEDP) (Fosha, 2000, 2003; Russell & Fosha, 2008), Intensive Experiential-Dynamic Psychotherapy (IE-DP) (Osimo, 2002, 2003a, 2009), Mindfulness Informed Experiential Dynamic Therapy (MI-) EDT (Kalpin, 2003, 2008), Personality-Guided Relational Psychotherapy (Magnavita, 2005), and Short-Term Anxiety-Regulating Therapy (START), also known as Affect Phobia Therapy (APT) (McCullough Vaillant 1997; McCullough et al., 2003a). McCullough, though, never abandoned the STDP acronym.

The process of learning from each other was greatly catalysed by the scientific events promoted by the International Experiential Dynamic Therapy Association (IEDTA), founded in 2001. This process has been bringing about a sort of Darwinian selection of the most effective

techniques and productive concepts. Based on experience, our recommendation is not to miss any opportunity of a prolonged and repeated exposure to clinical videos. Viewing sessions carried out by highly experienced EDT therapists, shown at symposia and immersion courses, with a teaching purpose, may be especially intensive, moving, and spectacular. Also, clinical videos presented by colleagues who are less experienced and still in training, do not fail to mobilise our deep emotion and have an activating effect on our unconscious. Such involved and attentive observation of the therapist-patient interaction does in time increase therapists' capacity to tolerate the intensity of emotional experiencing in their patients as well as in themselves. As a result of this, and of advanced training, therapists will stop inadvertently avoiding, and instead facilitate and sustain, the surfacing of very intense emotional experiencing, on which EDT relies as its main change factor.

Indications and contraindications of EDT

There is more than one way of approaching the theme of indications and contraindications for any therapeutic model. For example, we can focus on the range of disturbances treatable with a given model in ideal conditions, that is, with a fully trained and sensitive therapist, and without any time constraint or other external limitation. If we do so, we run the risk of overestimating the potential of our model, since these ideal conditions rarely occur. We will likely include some candidates who can theoretically be helped in a substantial way, but in actual fact will not benefit substantially from the therapy. Alternatively, by taking into account the specific conditions in which treatment is going to take place, we will be in a better position to predict therapeutic outcome more reliably. If we do so and decide to use our therapeutic model in a flexible way, we are also more likely to make the most of the time and expertise that are available. Another relevant factor is the goal we set out to achieve with our treatment. For example, do we always aim for a full resolution of all symptoms, disturbances, and maladaptive behavioural patterns? Getting *as close as possible* to excellence is an excellent resolution! There are times, however, in which the severity of disturbance, time constraint, or some other external limitation makes it unrealistic to aim for a complete cure. In this case a therapist may be left with two less ambitious options: (i) trying to give at least some help, or (ii) giving up altogether.

Our philosophy is to aim for the best possible result given the circumstances of the patient, and the setting in which therapy is offered. A pragmatic approach is to assess all the disturbances accurately, before committing to treatment, and to evaluate the actual conditions in which therapy will take place as well as our own motivation to treat that patient in those conditions. Psychotherapy in general, and EDT in particular, requires a true personal involvement of the therapist. As human beings, we should assess our limits carefully. As will be shown in subsequent chapters, EDT is a comprehensive psychotherapeutic model, capable of bringing help to people suffering from a wide range of disturbances. A fundamental indication for EDT, however, is the patient's response to EDT. How is it possible to know this before committing to treatment? The answer, of course, lies in the nature of the initial interviews used in EDT, called trial therapy or trial relationship (see also my later chapter, pp. ??–??). This involves one or two extended sessions lasting two and a half to three hours each, prior to making any commitment to treat the patient. These extended sessions are designed to assess how a patient responds to exposure to EDT therapeutic techniques and therapeutic ingredients (see pp. ??–??) as well as

the relationship with the therapist. In this way the selection of candidates rests, ultimately, on the outcome of the extended trial sessions. No scale, questionnaire, or diagnosis, by themselves, would sufficiently answer two crucial questions: (i) did *this* person respond to *this* therapist using *this* approach, and, in the affirmative case, (ii) was the response good enough to make a full therapeutic result a realistic objective given the circumstances of the patient, the setting in which the therapy will be offered, and the motivation of the therapist?

This careful, fine-tuned assessment makes it possible to optimise the use of therapist time and energy, reducing therapist burnout from unsatisfactory, frustrating interaction with patients. Moreover, it helps make the best use of highly specialised professionals, especially in the public sector. The use of descriptive diagnosis, like those provided by the Diagnostic and Statistical Manual (DSM-IV, American Psychiatric Association, 1994) is widespread and useful to orientate the treatment provider to the nature of the patient's problems. Projective testing and the administration of scales and questionnaires may further refine diagnosis. Their level of accuracy is, however, insufficient for a really accurate and specific selection process. To use a metaphor, if a physician suspects an infectious disease, the prescription of a broad-spectrum antibiotic may be at times correct even before the origin of symptoms is proven. Yet, if the specific bacterium is isolated and its sensitivity to different antibiotics tested, this will enable the doctor to make a more accurate prediction, making the healing process more effective. The same applies to EDT, where the descriptive identification and classification of a syndrome or "disturbance", per se, do not give enough information as to the extent that the profound forces underlying the symptoms can be satisfactorily modified, and sensitivity to therapeutic ingredients needs to be tested. Having clarified this point, I will outline the main indications and contraindications for EDT at the clinical and, subsequently, at the descriptive level.

The clinical microscope

The main clinical indicators are the quality of interpersonal rapport developing between therapist and patient during the first trial extended sessions, their ability to come to a clear understanding of the patient's core conflicts, and achievement of an adequate level of emotional activation. The therapist will offer their best personal and professional resources, making use of themselves as well as of their techniques. As a result the patient will generally make dynamically meaningful communications, showing some degree of emotional activation. If this process gives rise to a good-enough emotional experience (Osimo, 2001), and the patient can tolerate the anxiety that is provoked, they can be accepted for EDT. Carrying out this initial assessment and extended trial interviews is a complex undertaking, requiring specific training involving use of videotaped sessions. This is made worthwhile by the level of accuracy—thus of cost-effectiveness—it allows. Depending on the quality of emotional response, on the clarity of the relevant dynamics, and on the actual diagnosis (see next section), a patient may be eligible for a rapid, or a more gradual activation of their unconscious conflicting emotions. If a rapid activation is possible the total number of sessions will tend to be relatively lower than when a gradual activation is needed. Therapy usually lasts between three and approximately thirty-five sessions in the case of rapid activation, and between thirty and seventy sessions if the activation has had to be more gradual. It goes without saying that the faster the healing process, the better for all

those involved and, especially, for the patient. EDT's main goal is not, however, brevity per se, rather a quality of outcome satisfying to both patient and therapist. EDT is not feasible if the trial extended sessions did not result in a clear view of the patient's dynamics, access to emotional experiencing, and indicated an inability to tolerate anxiety. Rather, if the anxiety mobilised during the interaction with the therapist who is trying to activate the patient's conflicting forces, exceeds the patient's tolerance, this is a contraindication to EDT. It does not imply that the patient is unsuitable for dynamic psychotherapy tout court. A more supportive dynamic approach or a different form of treatment can be considered.

The descriptive categories

There are indeed so many scales and classification systems that one can be suspicious that their huge number might inversely correlate with the relevance of the parameters they measure. Although these scales provide some accurate measures of single or groups of items, they only represent an aspect of a far more complex reality. Contemporary descriptive diagnostic manuals such as DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1994) do indeed strive to make up for this complexity by resorting to multi-level diagnosis. Nevertheless, the descriptive diagnosis needs to be integrated and confirmed case by case on the basis of clinical indicators. The same diagnostic tag may indeed serve as an umbrella for a number of conditions that differ remarkably, in terms of their objective and subjective severity, and of the strategies used by the patient in their attempt at adaptation. Finally, a diagnostic label will not provide any information regarding the origins and causation of the disturbance. Three descriptive indicators will be considered here: (i) diagnosis, (ii) defensive style, and (iii) Global Assessment of Functioning.

Diagnosis

Patients with personality disorders and most neurotic disturbances are the main targets of EDT. Therapy and its duration are always patient-tailored. However, patients presenting with personality disorders, such as the avoidant, dependent, passive-aggressive, depressive, antisocial and some obsessive-compulsive, borderline, and histrionic tend to require between three and thirty-five to forty sessions. The same applies to a number of Axis I syndromes like the dysthymic, anxiety, and somatoform disorders, sexual dysfunctions due to psychological factors, bulimia nervosa, binge eating, and others. Patients with narcissistic or paranoid personality disorders and patients "with traits of" (McCullough Vaillant, 1997, p. 408) schizoid and schizotypal disorders tend to require a higher number of sessions, usually ranging between forty and seventy to eighty.

Defensive style

As regards the prevailing defensive style, Vaillant's (1977) hierarchy of defences is an extremely useful frame of reference. In particular, his distinction between neurotic and immature defensive styles provides a helpful indicator for the EDT selection process. The more projection,

schizoid fantasy, hypochondriasis, and other immature defences are woven into the structure of the patient's defensive system, the greater the therapeutic task ahead of therapist and patient.

Global functioning

Even after a DSM-IV diagnostic category and the main defensive mechanisms have been identified, our sense of the patient's level of "functioning" may still be quite vague. Although the term "functioning" is far from being satisfactory, as it relies on a similarity between man and machine (and what's worse a defective one), the concept of "functioning" may help the clinician to understand the extent to which the patient's problems do actually interfere with their daily life. This aspect of assessment should guide the therapist's management of therapy, since when the level of adaptation is good enough, life experience is itself therapeutic—thus a therapist's ally. The same cannot be said when the patient's ways of interacting with "reality" are vastly limited or plainly self-destructive. A practical way of measuring this aspect with ease is represented by the Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 1994). When the other requirements are fulfilled, a GAF score higher than sixty is likely to allow for a short-term course of EDT. A lower GAF score (with the other requirements fulfilled) will generally require a more gradual approach, thus a progressively longer EDT course.

Concluding remark

As the reader will notice, the EDT selection process lays much emphasis on the empirical, clinical assessment of the patient's in-session emotional and anxiety response. As a matter of fact, the accumulated knowledge and techniques deriving from many years' use of video technology applied to psychotherapy and pioneered by Davanloo enables EDT trained professionals to attain a degree of accuracy and specificity much higher than previously possible, by means of the trial extended sessions. Training, trying out techniques, and getting supervision on the video recorded sessions makes a huge difference to the degree of accuracy with which the well-trained interviewer can assess a patient's responsiveness to the specific therapeutic model.

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