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## EFFECTIVE AND LESS EFFECTIVE THERAPISTS FOR GENERALIZED ANXIETY DISORDER: ARE THEY CONDUCTING THERAPY THE SAME WAY?

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At its core, this book is guided by simple but disarming questions: What are therapist effects? What might they look like? Previous studies exploring similar questions have highlighted the importance of attending to the interaction between therapist and client, and the impact that interventions have on eliciting change in the client's cognitions, emotions, behaviors, and self-perceptions (Strupp, 1980a, 1980b, 1980c, 1980d). In this chapter, we examine client–therapist interactions to investigate the processes that might differentiate therapists in the effective implementation and enhancement of empirically supported treatments.

The current study uses data from a randomized controlled trial (RCT) aimed at determining whether cognitive–behavioral therapy (CBT) for generalized anxiety disorder (GAD) could be improved by the addition of techniques targeting GAD difficulties not systematically addressed

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in traditional CBT. Briefly, research suggests that individuals with GAD worry, in part, to avoid emotional processing (Borkovec, Alcaine, & Behar, 2004; Newman & Llera, 2011). Interestingly, research and conceptual critiques of CBT (e.g., Mahoney, 1980; Wisner & Goldfried, 1993) point out that interventions in this approach are used to control or reduce affect, thereby reinforcing the maladaptive function of worry—the primary symptom of GAD. In addition, research has demonstrated that GAD is associated with a wide range of past and current interpersonal problems, and that a high level of interpersonal difficulties post CBT-treatment is linked with higher relapse (Newman, Castonguay, Borkovec, & Molnar, 2004). Process research shows that CBT tends to focus more on intrapersonal (e.g., thoughts) than on interpersonal issues (e.g., Castonguay, Hayes, Goldfried, & DeRubeis, 1995), thereby reducing its ability to address variables involved in the etiology or maintenance of GAD. Aggregating these psychopathology and psychotherapy factors together, one way to improve the efficacy of CBT for GAD would be to add humanistic, psychodynamic, and interpersonal interventions to its protocols, developed to foster the deepening of emotions and to facilitate the fulfillment of interpersonal needs. On the basis of this reasoning, a theoretically driven combination of CBT and non-CBT interventions was built in an integrative therapy manual (which is described in the Method section of this chapter and more fully in Newman et al., 2004).

Despite the promising results of a preliminary open trial of the integrative therapy (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008), a subsequent RCT (from which this study is based) failed to find significant differences between the integrative treatment and the control condition (Newman et al., 2011). However, recent analyses suggest that the predicted superiority of the integrative treatment was obfuscated by differences in therapists. Although all three therapists were adherent to the integrative and control conditions, the clients of one of the three therapists in the study had significantly inferior outcomes compared with the clients of the other two. Furthermore, when this less effective therapist was removed from the analyses, the integrative therapy was significantly better than the control condition at posttreatment and 6-month follow-up.

These results obviously raise the question of what the less effective therapist might have done differently from the other two. Sessions of three client–therapist dyads were assessed via a combination of quantitative and qualitative methods to understand what the effective therapists might have done, or avoided doing, to foster positive outcome in their clients, as well as explore how the less effective therapist may have inhibited or interfered with optimal therapeutic change.

## METHOD

### Data Set

Data for this study were derived from the treatment condition of an RCT for GAD that explored the efficacy of augmenting CBT treatment with interpersonal and emotional processing (I/EP) interventions. Using an additive design, individuals with GAD received 2-hour sessions of integrative therapy for 14 weeks. The first 50-minute segment focused on CBT techniques, whereas the second segment involved the use of I/EP techniques. Each 50-minute segment was followed by a period of 10 minutes to complete process measures.

### Participants

Three clients were selected, one seen by each of the therapists involved in the RCT. The three protocol therapists, all with doctoral degrees in clinical psychology, had extensive postdoctorate clinical experience. Prior to the RCT, they had received intensive training in and had conducted all components of the additive design delivered in the preliminary open trial mentioned previously (Newman et al., 2008). During the RCT, the three therapists met an a priori set of criteria for adherence and competence of the CBT and I/EP components of the integrative therapy (Newman et al., 2011).

### Research Team

#### *Coders*

The first three authors of this chapter were the coders for this study—one female and two male doctoral students, all of them Asian American. The female coder had 3.5 years of clinical experience, and the two male coders had 1.5 years of clinical experience at the start of the study. In terms of theoretical orientation, the female coder described herself as integrative, whereas the male coders identified as psychodynamic and cognitive-behavioral. Following Hill's (2012) recommendation, the coders discussed their overall biases and experiences that could have influenced their assessments prior to commencing the coding process, including biases regarding the effectiveness of the treatments, differences in clinical experience within the coding team that may affect the discussion process, and potential cultural biases because of the ethnic background of the coders.

The coders were aware of the overall treatment effectiveness results of the RCT, namely, that there were no significant outcome differences between

the integrative (CBT+I/EP) and control conditions. However, to decrease biases in the coding, they did not know the differences among the three therapists in the RCT, and were not aware of the individual results of the clients selected for this study. In other words, the coders did not know which of the therapists achieved better or worse outcomes, the reason why the three clients had been selected, or the outcome for any of the three clients. The results were revealed to the coders once all of the coding had been completed.

### *Auditors*

The auditors for this study, the fourth and fifth authors of this chapter, included a professor who was one of the investigators on the trial from which the dyads were selected. It also should be noted that this auditor was one of the supervisors with whom the study therapists met weekly to discuss treatment adherence and competence, as well as client progress. He was aware of the outcome differences among the three therapists, as well as the general outcome of each of the three selected clients. The other auditor was a doctoral student with 5.5 years of clinical experience at the start of this study, and he was also aware of the differences between the therapists and clients. Before starting the project, the auditors discussed their overall biases, including how their knowledge of the dyads may influence the auditing process, and these biases were shared with the coders once the coding was completed.

### **Measures**

A number of outcome measures were used at different phases of the RCT (pretreatment; posttreatment; 6-, 12-, and 24-month follow-ups; see Newman et al., 2011, for a detailed description). Two instruments assessing anxiety symptoms were therapist administered and rated: The Hamilton Anxiety Rating Scale (Hamilton, 1959) and the Clinician Severity Rating for GAD from the Anxiety Disorders Interview Schedule for the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (Brown, Di Nardo, & Barlow, 1994). Two self-report measures of anxiety were completed by the clients: the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990), and the State-Trait Anxiety Inventory–Trait Version (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). The clients also completed a measure assessing relaxation-induced anxiety (The Reactions to Relaxation and Arousal Questionnaire; Heide & Borkovec, 1983). At the end of each session's therapy components (CBT, I/EP), the client and the therapist also completed modules of the Therapy Session Report (TSR; Orlinsky & Howard, 1966), a self-report instrument measuring diverse aspects of the therapy.

## Treatment

### CBT

The techniques used in the CBT segment included self-monitoring of anxiety cues, relaxation methods, self-controlled desensitization, and cognitive restructuring. During CBT, therapists were allowed to address only the learning and application of these methods as they related to intrapersonal anxious experiences, such as the challenge of irrational thoughts or the reduction of anxiety symptoms.

### I/EP

To address interpersonal problems and facilitate emotional processing, the techniques in the I/EP segment included the therapists' use of their own emotional experience to identify interpersonal markers, the use of the therapeutic relationship to explore affective processes and interpersonal patterns, the provision of emotional corrective experiences via the repair of alliance ruptures, the processing of clients' affective experiencing in relation to past and current interpersonal relationships, and the use of skill training methods to provide more effective behaviors to satisfy identified interpersonal needs.

## Procedure

### *Dyad and Session Selection From Archival Data*

After consultation with an expert (Clara Hill) in qualitative research methodology, the auditors selected one session from each of the three dyads for intensive case study analyses. The three clients were chosen on the basis of stringent criteria of treatment response called *end-state functioning*, which was used for each of the five outcome measures described previously. For four of these outcome measures, high end-state functioning was defined as a score in the nonclinical range. For the fifth measure, the clinician severity rating, end-state functioning was defined as a score exceeding a face valid level of meaningful change, as normative data are not available (see Newman et al., 2011, for more details). Specifically, for the two most effective therapists (Therapists A and B), the clients chosen met criteria for high end-state functioning in four of the five outcome measures, at posttreatment, as well as at 6-, 12-, and 24-month follow-ups. For the less effective therapist (Therapist C), the client chosen failed to meet criteria for high end-state functioning on all but one outcome measure at a 6-month follow-up (see Table 14.1). In sum, the clients selected for the two effective therapists were treatment responders, whereas the client chosen for the less effective therapist was a non-treatment responder.

TABLE 14.1  
Therapy Session Report (TSR) Ratings for the Selected Session,  
and Level of Functioning at Posttreatment and Follow-Up

Client/ therapist	TSR for selected session		End-state			
	Client- rated	Therapist- rated	Posttreatment	6-	12-	24-
				month follow- up	month follow- up	month follow- up
Sharon/ Therapist A	1.5	4	5	5	4	5
Kate/ Therapist B	2	3	5	5	5	5
Ana/ Therapist C	2.5	4.5	0	1	0	0

*Note.* The ratings are the average for the CBT and I/EP segments, ranging from 1 (*perfect*) to 7 (*very poor*). The end-state data are the number (out of five) of measures on which clients met high level of functioning at each respective assessment point.

To provide a fair comparison of the therapeutic processes of the two responsive clients and the nonresponsive client, the session analyzed for each client was chosen because it had the highest combined helpfulness score across the two segments (CBT and I/EP), as rated by the client and the therapist on the following item of the TSR: “How do you feel about the session which you have just completed?” (ranged from 1 [*perfect*] to 7 [*very poor*]). All the sessions chosen were also within the middle phase of therapy (between Sessions 7 and 9). TSR ratings for the selected sessions are shown in Table 14.1. Coders were unaware of the reason for choosing the sessions.

### Combined Methods Analysis: Quantitative and Qualitative

The three videotaped sessions selected by the auditors were transcribed verbatim, had identifying information removed, and were analyzed using a combined quantitative and qualitative methods approach. The qualitative portion was guided by consensual qualitative research—case study (CQR-C), which specifically applies to case analyses (Jackson, Chui, & Hill, 2012). Starting with one randomly selected dyad, the three coders independently watched the first session of therapy, the session prior to the selected session, and the selected session itself. They wrote down their initial impressions of the dyad, with special attention to the therapists and their use of interventions and interactions with their clients. The coders then met and discussed initial impressions and potential biases that may have impacted their assessments. The selected session was then independently watched again and coded following guidelines of CQR-C, and the coders discussed the results of their coding

until a consensus was achieved and sent to the auditors for further review. Consistent with CQR-C, the team of coders engaged in open discussion and interpretation to arrive at a consensus for each of the analytic steps:

1. Domain coding involved organizing the data into meaningful, unique, and discrete topic areas. When coding for the domains, coders were guided by the Coding System of Therapist Focus (Goldfried, Newman, & Hayes, 1989), as well as the general ways by which the therapists interacted with their clients. This process resulted in eight domains of therapist–client interaction.
2. The data within each domain were summarized to capture their essence, including the context and content of what the client and the therapist discussed.
3. The summarized data were cross-analyzed to develop and understand the interventions used across the three cases during each of the CBT and I/EP portions of treatment. The interventions were used to highlight similar and different techniques used by the therapists across their clients.
4. To differentiate the effectiveness of the interventions (and the therapists), the research team categorized the interventions into three codes based on their impact on the client (Strupp, 1980a, 1980b, 1980c, 1980d):
  - *Positive*—Interventions that were deemed highly impactful and were followed by noticeably positive or active responses from the client, such as corrective experiences, increased insight, behavioral changes, or skill acquisition.
  - *Neutral*—Interventions that had an average level of impact. These interventions did not lead to negative outcome, but on their own did not lead to the type of significant changes that followed the interventions with positive impact.
  - *Negative*—Interventions that had an absence of an impact or seemed to lead to a mismatch between therapist and client in terms of their experience of the intervention.

The auditors provided feedback after each of the steps, which was then further discussed by the coders and auditors until a consensus was achieved before moving to the next step. This process was repeated for all three dyads.

## RESULTS

Findings are divided into two sections. First, the within-dyad results are presented to understand each therapist’s style and focus of intervention. Within this section, a broad description of the therapist’s relational style

is provided, followed by the most frequently used interventions for the top three domain areas for each dyad (see Table 14.2 for the number and percentage of interventions per domain by each of the therapists).

Second, between-therapists comparisons are drawn for each domain and during each treatment segment (CBT and I/EP), to highlight similarities between the two successful cases, and differentiate these from the unsuccessful case to address the goal of this chapter: What are some of the ways that therapists intervene and interact with clients that might explain, at least in part, therapist effects.

### **Within-Dyad Results: Qualitative Description and Quantitative Results**

#### *Dyad 1: Sharon and Therapist A*

“Sharon” is a White, heterosexual, married woman in her early 40s living with her husband and child. Therapist A is a White, male therapist in his early 40s. He identifies primarily as a CBT therapist but has expressed strong interest in learning and augmenting his treatment with exploratory interventions.

*Qualitative Description.* Overall, Therapist A was judged as reinforcing and validating, especially with regard to the changes that Sharon accomplished. He continually facilitated Sharon’s progress by supportively challenging her to entertain alternative views to distressing thoughts and interpretations, as well as by attempting to open new directions for exploration. Although the therapist was adherent to the treatment protocol (in terms of the focus of the content and techniques prescribed), the judges viewed him as generally non-directive and instead, mainly as using explorations of new client experiences in a curious and nonskeptical way. Therapist A did not talk over Sharon, and although his interventions were not always synchronized with Sharon’s affective state in session, there were also no overt alliance ruptures. Therapist A did, however, use lengthy interventions at times with little active client interaction. Sharon appeared comfortable in the room. For example, during the second half of the session, she found it difficult to control her laughter, and Therapist A’s repeated attempts to explore the affect in the room did not have the desired effect of productively using this positive emotion to facilitate increased understanding of self or insight. Nevertheless, Sharon was in high spirits during the session, and Therapist A’s attunement to this positive emotion seemed aligned with her experience, as also assessed by Sharon’s TSR session rating of *excellent* to *perfect*.

*Quantitative Results.* Overall, Therapist A spoke nearly 50% more than Sharon in terms of number of words in the selected session. Almost half of all the interventions focused on Sharon’s emotional processes. Over half of the interventions in this domain consisted of reflections that were judged



TABLE 14.2  
Number (and Percentage) of Interventions per Domain of Functioning for Each of the Three Dyads

Therapist	Domains of functioning <i>n</i> (%)								Total
	A	C	E	I	P	SL	TP	TPP	
A	1 (0.39)	47 (18.29)	118 (45.91)	16 (6.23)	8 (3.11)	36 (14.01)	21 (8.17)	10 (3.89)	257
B	7 (2.39)	118 (40.27)	57 (19.45)	14 (4.78)	43 (14.68)	20 (6.83)	11 (3.75)	23 (7.85)	293
C	12 (4.55)	149 (56.44)	55 (20.83)	27 (10.23)	5 (1.89)	12 (4.55)	0 (0.00)	4 (1.52)	264
Total	20 (2.46)	314 (38.57)	230 (28.26)	57 (7.00)	56 (6.88)	68 (8.35)	32 (3.93)	37 (4.55)	814

*Note.* Domains: A = action, C = cognitive processes, E = emotional processes, I = intentions/needs, P = psychophysiological processes, SL = supportive listening, TP = therapist presence, TPP = therapy protocol procedures. Total refers to the total number of interventions used by each therapist or per domain.

to match Sharon's affect, as she discussed her developing awareness of her emotions. Therapist A also seemed to use clarifications to increase his and Sharon's understandings of these emotions, and validations to further support Sharon's new understandings. Although these interventions were deemed to more likely promote Sharon's interactivity in the session, they also were at times mismatched with Sharon's experience, particularly during the second half of the session (the I/EP segment), during which Sharon found it difficult to control her laughter. During this part of the session, Therapist A's reflections, validations, and clarifications, which were judged as helpful earlier on, were instead coded as highlighting a discrepancy in Therapist A's interventions and Sharon's response in the room. Overall, although these mismatches did occur, Therapist A's emotionally based interventions were largely judged as helpful, and he encouraged Sharon to talk about her emotional experiences in a supportive manner.

One third of all interventions addressed Sharon's cognitive processes. Therapist A adopted a more exploratory style, and primarily used clarifications and reflections within this domain to better understand Sharon's difficulties. These interventions were also judged to be more likely to help Sharon gain new insight and understanding of her difficulties. Within this domain, Therapist A used different interventions frequently and therefore was viewed as being varied and flexible in his technique use.

Finally, Therapist A also used his own experience of the therapy process as interventions and provided Sharon with feedback. He would refer to his own thoughts when he described the present-moment impact of Sharon's responses, although this was deemed as not fostering emotional growth or interactive discussion. Specifically, these interventions seemed to occur when he tried to refocus the session. Therapist A also frequently used supportive listening as a way to provide supportive statements and gather information in a nonspecific manner.

#### *Dyad 2: Kate and Therapist B*

"Kate" is a White, heterosexual, single woman in her early 30s. Therapist B is a White, female therapist in her late 30s. She describes herself primarily as psychodynamic, but she has extensive CBT training and served as a protocol therapist in a CBT trial for panic disorder.

*Qualitative Description.* Overall, Therapist B was judged as very active, focused, and adherent to the protocol in her treatment delivery, but also flexible and attuned to Kate's concerns and markers prescribed by the protocol within the session. Therapist B was directive, especially during the first half of the session (CBT), but in a collaborative and attentive manner, rather than being domineering or overpowering Kate and session content. She was

deemed as reinforcing and validating of Kate's changes, but she also continuously challenged the client using interventions that were consistent with mechanisms of change underlying both treatments. These interventions were viewed as encouraging Kate to continue with her process of change in an empathic and affirming manner. The coders and auditors judged all aspects of the working relationship in the dyad, bond, tasks, and goals as strong, with no alliance ruptures, and Kate and Therapist B appeared to work collaboratively on the same issues in a consistent manner. This positive overall judgment was further corroborated by Kate's TSR rating of the session as *excellent*.

*Quantitative Results.* Overall, Therapist B spoke almost 40% more than Kate in terms of total number of words in the selected session. Almost half of the interventions were targeting Kate's cognitive processes. Therapist B actively used Socratic questioning to challenge and clarify Kate's thoughts in the session, and these interventions were judged to be facilitative of positive changes, including new understandings of the self and behavioral changes. Therapist B seemed to increase Kate's ability to effectively use anxiety coping skills through flexible use of various interventions, including validations, reflections, and instructions on how and when to apply these skills.

Therapist B also used session time to address Kate's emotional processes. One of Kate's difficulties in this area was her inability to stay with her emotions. She appeared to have a tendency to cognitively analyze her emotions and remove herself from the experiential level. Therapist B directed Kate's attention to this tendency in an emphatic manner through a variety of interventions, such as clarifications of her emotions, metacommunication, and gently, yet firmly, pointing out Kate's avoidant tendencies when she shifted her focus away from her affect to her cognition and worries. Also, Therapist B facilitated Kate's experiential processes by providing her with feedback of the impact that this tendency had on others, including Therapist B and their relationship. For example, Therapist B encouraged Kate to be spontaneous in the session, sharing that she felt more connected with Kate. The dyad successfully used this intervention to foster changes in the interpersonal patterns in Kate's relationships with Therapist B, as well as with others outside of the session.

Therapist B's interventions also frequently focused on Kate's psychophysiological processes. She included relaxation training in the session, as well as outside of session, and seemed to work collaboratively with Kate to identify when and how to apply the various anxiety coping skills tailored to Kate's unique psychophysiological experiences so as to effectively manage her anxiety symptoms. For instance, Therapist B helped Kate identify that the most common psychophysiological presentation of her anxiety was through stomach discomfort, and she instructed the client to apply the relaxation skills learned in treatment to diverse situations in which she noticed these symptoms, such as at work or in interpersonal situations.

### Dyad 3: Ana and Therapist C

“Ana” is a White, heterosexual, single woman in her mid-30s who was pursuing a doctoral degree at the time of the RCT trial. Therapist C is a White, male therapist in his mid-40s. His theoretical orientation is primarily psychodynamic, but he also has experience with CBT.

*Qualitative Description.* Overall, Therapist C was judged as highly directive and adherent to the protocol, and he was viewed as less collaborative and more leading and controlling than the other two therapists. Therapist C identified and noted areas of distress for Ana, but, with the exception of segments during the latter part of the CBT hour, the coders and auditors agreed that he was not able to engage Ana in initiating and fostering active work on her side. Instead, Ana seemed to passively follow Therapist C’s lead and failed to bring about change for herself in these areas of difficulty. Therapist C repeatedly reminded Ana to apply her new skills, but he did not follow by describing how to use these interventions effectively in her life or what obstacles have made it difficult for her to readily use these skills outside of session. Despite his apparent domineering and frequently interruptive presence in the session, Therapist C was reflecting, validating, and normalizing of Ana’s experience, especially surrounding an interpersonal fear, as she described feeling understood by the therapist (which may help in understanding Ana’s TSR rating of the session as *very good* to *excellent*). However, Therapist C was judged as not fostering specific change, emotionally or behaviorally, but rather remaining focused on global issues in Ana’s life (e.g., her sense of loneliness), which inadvertently seemed to support Ana’s lack of agentic initiative for change. Notably, Therapist C focused substantially on the cognitive aspect of Ana’s experience during the I/EP section, providing new intellectual rationale or insight rather than fostering emotional deepening.

*Quantitative Results.* Overall, Therapist C spoke 10% less than Ana in terms of number of words in the selected session. More than half of the interventions were targeting Ana’s cognitive processes. Therapist C actively used Socratic questioning to challenge and clarify Ana’s thoughts in the session, but these interventions were judged to more likely have a neutral level of impact in Ana and not necessarily facilitate or encourage new change processes. Ana seemed attuned to what Therapist C was saying, but the coders and auditors did not view the interventions as fostering active meaningful changes in Ana at the emotional, cognitive, or behavioral level. There were a few instances in which Therapist C’s cognitive restructuring was deemed to increase self-awareness in Ana, but Therapist C seemed to have difficulty continuing any behavioral or emotional changes in relation to this new self-understanding. In addition, Therapist C provided a lot of psychoeducation of anxiety coping skills, and instructed Ana to apply these in her life outside of session, but he

did not work with her to determine when or how to use these skills, nor did he discuss and remediate possible obstacles that limited their use in Ana's life.

Therapist C also actively addressed Ana's emotional processes during the session, mainly through clarifications and reflections of her emotions. These interventions seemed to allow Ana to express her feelings, including frustrations and fears in the context of romantic relationships, and Ana seemed relieved at being able to share these emotions with Therapist C without reservation or judgment. However, overall, the coders and auditors did not view the interventions as fostering additional processes of change, such as deepening her emotional experience or exploring unfulfilled needs in Ana's relationships, that would have allowed Ana to further use this experience. Therefore, Therapist C and Ana were viewed as stuck in a cycle in which Ana talked about her feelings but failed to fully experience these and use them to bring about changes in session or address her distress in the relationships outside of session. Ana even asked Therapist C for specific skills to increase her chances of successful interactions with potential partners, but he was not able to link these to her understanding of her anxiety symptoms or to ways to bring about changes for herself.

Therapist C's interventions also frequently explored Ana's intentions and needs through clarifications, reflections, and validations. However, as noted previously, he was not able to work with Ana to enhance her understanding of her unmet needs or develop new ways to have these met in a fulfilling manner. The inquiries in this area seemed metacognitive, with limited affect involvement on Ana's part, and therefore appeared to increase the client's self-understanding but with no significant changes occurring in conjunction or resulting from this knowledge.

### **Between-Dyads Results: Domain-Specific Comparisons**

In this section, a brief description of each domain is presented, followed by a comparison of intervention use and their impact on the client by each of the therapists during the CBT and I/EP treatment segments. The domains are listed in order of most number of interventions used across therapists. See Table 14.2 for the number and percentage of interventions per domain for the three dyads, and Table 14.3 for the number and percentage of positive, neutral, and negative interventions per domain for the three dyads.

#### *Cognitive Processes*

This domain included interventions that addressed client thoughts and cognitive processes. As expected, the majority of the cognitive processes interventions occurred during the CBT segment of treatment for all three

TABLE 14.3  
Number of Positive, Neutral, and Negative Interventions per Domain  
of Functioning for Each of the Three Dyads

Domain of functioning	Codes	Therapists <i>n</i> (%)			Total (%)
		A	B	C	
C	Positive	8 (17.0)	25 (21.2)	13 (8.7)	46 (14.67)
	Negative	2 (4.3)	0 (0)	0 (0.0)	2 (0.6)
	Neutral	37 (78.7)	93 (78.8)	136 (91.3)	266 (84.7)
E	Positive	19 (16.1)	11 (19.3)	5 (9.1)	35 (15.2)
	Negative	9 (7.6)	0 (0)	0 (0.0)	9 (3.9)
	Neutral	90 (76.3)	46 (80.7)	50 (90.9)	186 (80.9)
SL	Positive	2 (5.6)	1 (5.0)	0 (0.0)	3 (4.4)
	Negative	0 (0.0)	0 (0.0)	1 (8.3)	1 (1.5)
	Neutral	34 (94.4)	19 (95.0)	11 (91.7)	64 (94.1)
I	Positive	6 (37.5)	7 (50)	0 (0.0)	13 (22.8)
	Negative	0 (0.0)	0 (0)	0 (0.0)	0 (0.0)
	Neutral	10 (62.5)	7 (50)	27 (100)	44 (77.2)
P	Positive	0 (0.0)	1 (2.3)	1 (20.0)	2 (3.6)
	Negative	0 (0.0)	0 (0)	0 (0.0)	0 (0.0)
	Neutral	8 (100)	42 (97.7)	4 (80.0)	54 (96.4)
TPP	Positive	0 (0.0)	3 (13.0)	0 (0.0)	3 (8.1)
	Negative	0 (0.0)	0 (0)	0 (0.0)	0 (0.0)
	Neutral	10 (100)	20 (87.0)	4 (100)	34 (91.9)
TP	Positive	0 (0.0)	1 (9.1)	0 (0.0)	1 (3.1)
	Negative	6 (28.6)	0 (0)	0 (0.0)	6 (18.78)
	Neutral	15 (71.4)	10 (90.9)	0 (0.0)	25 (78.1)
A	Positive	0 (0.0)	2 (28.6)	1 (8.3)	3 (15.0)
	Negative	0 (0.0)	0 (0.0)	0 (0)	0 (0.0)
	Neutral	1 (100)	5 (71.4)	11 (91.7)	17 (85.0)

Note. Domains: A = action, C = cognitive processes, E = emotional processes, I = intentions/needs, P = psychophysiological processes, SL = supportive listening, TP = therapist presence, TPP = therapy protocol procedures. Total refers to the total number of interventions per code per domain, and the corresponding percentage out of the total number of interventions per domain.

therapists. Therapist C was coded to have the most interventions in this domain. However, Therapist B had the most positive interventions in this domain, with 21% of her interventions judged to facilitate positive changes in Kate. Therapist A was also judged to have no negative interventions in this domain. Despite the low overall number of interventions, Therapist A was also deemed to use the most diverse types of interventions, rarely using the same type twice. Therapists B and C on the other hand, were similar in their flexibility of cognitive interventions used.

Clarifications related to the clients' cognitive processes, such as (a) increasing the clients' awareness of their thought processes in general, as well as the

ways in which their distressing thought patterns changed, and (b) facilitating an understanding of the clients' use of anxiety coping skills, including cognitive restructuring, were judged to yield the most positive results across all therapists. It also appeared that the therapist's actively challenging the client's thoughts in session facilitated positive change in the latter.

### *Emotional Processes*

This domain included interventions targeting emotions and emotional processing. As would be expected, most of the interventions in this domain occurred during the I/EP segment of treatment for all three therapists. Therapist A was judged to have more than double the number of interventions in this domain compared with the other two therapists. However, Therapist B had the highest percentage of interventions coded as positive, with almost 20% of her interventions facilitating a significant change in Kate. Interestingly, however, Therapist A was the only one with interventions coded as negative, and these comprised about 8% of his interactions with Sharon in this domain. This may have been due to the fact that, as mentioned previously, Sharon spent a big portion of the session laughing, and Therapist A attempted to redirect her multiple times without success. Therefore, the impact of these types of interventions was coded as "negative" because there was no change in the client at all. The three therapists were comparable in the variety of interventions used.

The therapists' clarifications and reflections of their clients' emotions seemed to facilitate the most significant positive change. These interventions were judged as not only aiding clients to become aware of their emotional processes but also fostering a newer self-understanding. Interestingly, this domain, especially when focused on by these specific interventions, had the highest consensus in terms of facilitating positive client change across the three therapists, with emotion clarifications coded as the most positive for Therapists B and C, and one of the highest for Therapist A. Therapist A used significantly more reflections when processing Sharon's feelings compared with other interventions within the dyad, and also when compared with the other two therapists. These interventions were deemed to facilitate the most positive change with Sharon but were also coded as the most frequently used negative intervention.

### *Supportive Listening*

These were both general and supportive interventions. Therapists used interventions in this domain regardless of segment of treatment: Therapist A was coded to use them most in the CBT segment, Therapist C used them most in the I/EP segments, and Therapist B used them evenly across the two treatments. Therapist A had almost one and a half times more interventions

than Therapist B, and almost two and a half times more than Therapist C. However, Therapists A and B were judged to have comparable numbers of positive interventions, whereas Therapist C had none, and was coded to have delivered the only negative intervention in this domain. In other words, this type of intervention was deemed to yield different reactions by dyad.

Most of the interventions in this domain involved the therapists' gathering factual information from their clients and providing supportive statements. This domain was mutually exclusive from others and was purposefully designed to include only a limited number of specific types of interventions, explaining the lack of diversity among therapists.

### *Intentions/Needs*

This domain included interventions that focused on clients' needs, wants, and intentions. Therapist A was coded to use more interventions in this domain during the CBT segment, whereas Therapists B and C used more interventions during the I/EP segment. Therapist C had almost double the amount of interventions in this domain than the other two therapists. However, none of Therapist C's interactions with Ana in this domain were coded as positive, and instead, were all rated as neutral. In other words, Therapist C was successful at capturing Ana's intentions and needs but was not viewed as being able to use this awareness to foster significant changes. In contrast, 50% of Therapist B's and 38% of Therapist A's interventions were coded as positive for their clients in this area of functioning. It is notable that no interventions were coded as negative in this domain across all three therapists. Furthermore, Therapists A and B were coded to have used a diversity of types of interventions, rarely using the same more than twice, whereas Therapist C used a limited repertoire of interventions in this domain.

Similar to the emotional processes domains, the therapists' clarifications and reflections of the clients' intentions were judged to yield the most positive results across Therapists A and B. These therapists seemed to increase their clients' awareness of intentions in interpersonal relationships, as well as changes in intentions associated with previously distressing areas.

### *Psychophysiological Processes*

These interventions focused on the psychophysiological reactions of the clients. As expected given the therapists' high adherence to the protocol, 98% of interventions in this domain occurred during the CBT segment, with only one intervention during the I/EP segment by Therapist B. A significant difference in intervention use was apparent in this domain, with Therapist B using 5 times more interventions than Therapist A and almost 9 times more than Therapist C. Most notably, the majority of Therapist B's interventions



in this domain involved providing her client psychoeducation regarding the anxiety coping skills targeting Kate's physiological symptoms, such as progressive muscle relaxation, and working with Kate to consistently apply these skills in session, as well as outside of it. Therapists B and C were deemed to have one intervention rated as positive, which was instructing their clients to apply the anxiety coping skills learned. Therapist B used more than double the types of interventions as Therapist A, and almost 4 times as many types compared with Therapist C.

It should be noted, however, that the limited number of positive changes linked to this intervention during session may have been due, at least for Therapist B, to the fact that these skills had already made an impact on Kate's functioning in prior sessions. When instructed to apply these skills outside of session in a variety of situations by Therapist B, Kate said that she was consistently practicing and using the relaxation skills already, to which she attributed her decreased anxiety symptoms. This suggests that helping clients apply the learned skills in various situations in and outside of session can lead to change as clients become more agentic in their ability to manage their own anxiety symptoms through increased awareness and successful application of these skills.

#### *Therapy Protocol Procedures*

This domain addressed homework and other such assignments. Overall, most of the interventions in this domain were coded during the CBT segment of treatment. Therapist B seemed to apply the most interventions within this domain, more than double Therapist A and more than 5 times compared with Therapist C. Notably, Therapist B was deemed to also use these interventions to have a positive impact on Kate, facilitating significant change. For example, through the assignment of homework, Therapist B's interactions with Kate facilitated positive changes on three occasions, especially in terms of increasing the client's awareness of the change within herself in her ability to successfully monitor her anxiety symptoms and apply the skills learned in session to applicable situations. Interestingly, Therapists A and B were judged to use a comparable number of types of different interventions within this domain.

#### *Therapist Presence*

These interventions included utterances that revealed therapists' experience of clients. Consistent with treatment protocol, most of the interventions in this domain were during the I/EP segment. Only Therapists A and B were coded to use interventions targeting this domain, and the former had double the number of interventions. However, despite the majority, Therapist A did

not have any interventions coded as positive, and in fact, almost a third of the interventions were coded as negative. All of the negative interventions resulted from Therapist A's sharing his experience of the therapy process with Sharon, such as expressing his confusion about whether to let Sharon continue to laugh or redirect treatment to explore potential areas of difficulties. Therapist B, on the other hand, was coded to have one intervention rated as positive, which involved her checking in with Kate about her reaction to the therapist's intervention.

Interestingly, this domain had the lowest diversity in terms of types of interventions, with only four. Of these, the two therapists' sharing their own experiences of the therapy processes were used the most frequently. Most of the interventions were targeted at increasing clients' awareness of their impact on the other person, in this case on the therapists.

### *Action*

This domain included interventions focused on actual physical actions taken by the client. As revealed by the coding, Therapist A's only intervention in this domain occurred during the CBT segment, whereas Therapists B's and C's interventions were during the I/EP portion of treatment. Therapist C had the most interventions addressing this area. Therapists B and C had a comparable overall number and number of different types of interventions coded as positive.

The interventions most widely used within this domain included clarifications of clients' behaviors, reflections, and validations related to these actions and changed behaviors. Compared with the other areas of functioning, the therapists appeared to address this domain the least, with the fewest overall number of interventions targeting it. From these, the interventions coded as positive were clarifications surrounding clients' actions and changed actions, and validation of these changes.

### **Comparisons Across Domains**

All three therapists used a similar number of interventions during the allotted session time, ranging between 257 (Therapist A) and 293 (Therapist B). The interventions coded most frequently across the three therapists targeted clients' cognitive processes (Therapists B and C) and emotional processes (Therapist A). Except for these, the three therapists appeared to be differentially attuned to their client's areas of functioning, with Therapists A and B significantly addressing all areas and Therapist C more selective in his interventions. Table 14.2 shows the total interventions per therapist for each domain, as well as the percentage of the total number of interventions per domain.

All three therapists were judged to use interventions that were highly impactful; about 13% of all interventions across all three therapists facilitated noticeably positive changes in the clients. However, there were also differences between the three therapists in this area. Therapist B seemed to have the most of these types of interventions, with almost 18% having a positive effect on Kate, followed by Therapists A and C. Notably, Therapist B had no interventions that were rated as negative. Interestingly, Therapist A, deemed to have the second-highest percentage of positive interventions across all domains of functioning, also had a substantial number of interventions that were rated as negative in terms of client response—in fact, this therapist accounted for 95% of these types of interventions. The three therapists were evenly distributed in terms of interventions that were rated as neutral, and these accounted for about 85% of all interventions across all areas of functioning. As expected, the vast majority of interventions were neither positive nor negative. But it is important to note that each of these therapists did indeed make impactful interventions. What seemed to differentiate Therapists A and B as more effective than Therapist C was their use of these impactful interventions to elicit clients' engagement in the treatment's prescribed mechanisms of change.

## DISCUSSION

The goal of this chapter was to shed light on therapist effects by investigating interventions and therapist–client interactions that took place in an RCT in which there were noticeable outcome differences among the therapists. These differential outcomes were observed despite the fact that treatment was closely monitored for adherence to the study protocol, and the fact that all therapists received the same training, as well as same type and level of supervision during the study. Therapist differences are not only important for research purposes but also have significant conceptual consequences. Although ignoring therapist effects typically leads to overestimation of the magnitude of treatment effects (Baldwin & Imel, 2013), the therapist effects reported here seem to hide predicted treatment differences: The primary outcome paper of the RCT did not take into account therapist effects, which appears to have led to the inaccurate conclusion that the CBT+I/EP integrative treatment was not superior to CBT alone (Newman et al., 2011). On the basis of analyses conducted on therapist outcomes, a more accurate conclusion might have been that CBT for GAD can be improved by the assimilation of humanistic, psychodynamic, and interpersonal techniques—at least when the integration of these different interventions is practiced by some therapists. In our attempt to assess what therapist effects look like, at least

within the context of a particular treatment for a specific disorder, we conducted intense analyses of the best sessions from two treatment responders (each seen by one of the two more effective therapists) and one nonresponding client (treated by the less effective therapist).

First, it is important to note common themes that emerged from our analyses of the three dyads, as these highlight possible heuristics for the process of change in general. Not surprisingly, most therapist interventions were judged as neutral. This should be expected, as it would be unrealistic to anticipate that most interventions of a therapist would be characterized as a “lightbulb” moment, nor should we assume sessions would be filled with non sequiturs and incoherent, hostile, or otherwise negative statements. However, there were differences in the frequency of positive and negative types of interventions.

A second theme that cuts across the cases involves the techniques used and their relationship with the domains and impact of interventions. The results show that the therapists used different types of interventions when they focused on each of the domains that were coded in this study. This is consistent with Goldfried et al.’s (1989) assumption that a diversity of interventions (within and across different approaches) can be used to serve the same function or to target the same aspect of functioning (e.g., emotion, thought, action). However, our findings also suggest that, in particular contexts, some interventions may be better than others. Specifically, the kinds of interventions that were deemed positive seem to correlate with the treatment modality. For example, the most impactful interventions in the CBT portion of treatment focused on clarifications and challenges of thoughts, and the interventions in the I/EP portion focused on clarifications and reflections of emotions were particularly impactful. It would seem that a wide range of techniques can be used when working with one client, but that these techniques may be especially helpful when they are consistent with the conceptual framework that has been established with the client. Put in terms of a general, yet tentative guideline: Many interventions are available to therapists, but they should aim to use what is best to activate the mechanism of change that they are supposed to foster. Finally, and again not surprisingly, the relationship matters. In all cases, and in both therapy segments, we observed therapists being respectful and attentive, as well as frequently offering supportive and validating statements. As for the interventions used and their impact, however, differences in the way the therapists interacted with their clients were observed.

How did the dyads differ? There was certainly variation in terms of focus on domains. Therapist C directed more attention to cognitions, whereas Therapist A focused more on emotions. But these differences, taken alone, are not necessarily meaningful. In fact, Therapist C was coded to have the lowest percentage of positive interventions in the cognitive domain, and

Therapist A had the highest percentage of negative interventions in the emotion domain. Consistent with previous findings, the frequency of certain interventions appeared to have been less important than whether or not the interventions worked (Strupp, 1980a). The therapist effects observed in the study were not due to a mysterious, unknown factor, but instead were best explained as the summation of many individual interventions, some of which were helpful and others of which were not. This suggests that training therapists in specific skills and techniques can potentially lead to improvements.

On the basis of all the information (quantitative and qualitative) gathered, the most meaningful difference between the dyads observed can be summarized as follows: Compared with the two treatment responders, Ana, the nonresponsive client, did not show as frequent or as deep engagement in the mechanisms of change targeted during each treatment segment of the integrative therapy. Even though the least effective therapist, Therapist C, used interventions that were permitted by the treatment protocol, these interventions, and the way they were used, did not appear to lead to the therapeutic effect at which they were aimed—whether cognitive, emotional, and/or behavioral change. The lack of intended impact is evidenced by the fact that Therapist C showed a distinct lack of positive interventions compared with the other therapists across all domains.

Bringing our quantitative and qualitative findings together, we argue that this lack of impact resulted from two broad types of therapeutic mistakes: errors of commission and omission. One commission error repeatedly observed relates to the use of technical interventions. Specifically, during the I/EP segment, Therapist C seemed to focus on what Ana worried about, as he was supposed to do, but rather than exploring the emotions underlying Ana's concerns, he most frequently provided interpretations. In doing so, Therapist C replaced the worry, a cognitive process, with another cognition. This is not only inconsistent with, but opposite to, the process or mechanism of change that I/EP interventions are aimed at activating. As noted in the introduction of this chapter, I/EP has been built on research findings that worry is used by individuals with GAD to avoid emotions. By providing interpretations, Therapist C essentially reinforced Ana's cognitive avoidance of her emotional experience. Ana had some insights and felt understood, which likely explains the high helpfulness score she gave for the session, but she remained in "her head" rather than fully experiencing the painful affect triggering her worries.

Another type of commission error relates to the way the therapists used the techniques prescribed by the protocols. In what could be viewed as a breach of alliance, Therapist C repeatedly interrupted Ana. Although providing useful psychoeducation, clarifications, and reflections, his delivery of interventions often superseded Ana's attempts to react and respond. And although Ana frequently agreed with Therapist C, what was perceived as

a jarring and controlling manner of intervening may have been counterproductive and, as such, could in part explain the lack of impactful interventions observed and coded.

With regard to errors of omission in the therapeutic interaction, a number of content markers that the therapist did not respond to with interventions prescribed by the treatment were observed. For example, Ana frequently referred to her anxiety and sadness about being single. Rather than inquiring about her interpersonal needs and exploring ways to fulfill them, Therapist C simply reflected what she already knew—that she was sad. At other times Ana brought up specific relational situations, which Therapist C could and should have used as markers for social skills training. Again, however, he reformulated Ana's situation without providing ways to change it. Although the errors of commission appeared to have interfered with the process of change, these errors of omission reflected missed opportunities for change. In both cases, the interventions did not have the most desirable impact.

Interestingly, negative interventions can and do occur, but they may not necessarily represent irreversible failures. Therapist A was found to perform over 90% of the mismatched interventions observed during the coded sessions, yet he also achieved a favorable outcome. In contrast, Therapist C was coded to have only one negative intervention. The difference appears to be that Sharon and Therapist A were fully engaged in the therapeutic processes that were meant to be activated. The mismatched interventions represented moments of lack of synchronicity that importantly, did not derail the therapeutic impact of therapy. One lesson that could be derived from this is that a faux pas or lack of perfect attunement does not necessarily represent a therapeutic mistake. Not everything in the treatment has to flow smoothly, especially if the relationship is solid and if healthy processes of change (e.g., experiencing positive emotions related to more adaptive and fulfilling interpersonal relationships) have been facilitated by the therapy.

## LIMITATIONS

The sample size of this study was small, and only included three therapists that were providing treatment to clients that met criteria for GAD within the context of an RCT. Therefore, the findings of this study were limited in their generalizability. Additionally, only one session midtreatment was selected for coding for each dyad. Even though the coders were not aware of the reason for selection, the content discussed during these sessions may have impacted the results observed. Furthermore, future studies should look at additional clients interacting with these therapists to investigate the presence, or lack of mechanisms of change identified in this chapter, not only to assess the reliability of

our findings but also to assess the variance accounted for by the therapists and the clients in outcome.

## CONCLUSIONS

Approaching our findings from a global perspective, our analyses suggest two general conclusions. First, therapist effects may well be nested within a client–therapist dyad. Just looking at what the therapists do or fail to do may not be enough to explain outcome differences. Crucial to our understanding was the impact that the therapist had on a client—whether the therapist allowed, fostered, or interfered with activation of the process or mechanism of change targeted by therapy. Second, the most effective therapists, or each therapist at his or her best, are not likely to be defined by the use of specific sets of interventions. Rather, some of the qualities of the most skillful therapists, or when a therapist is particularly effective, entail (a) knowing when to use particular interventions to start and deepen a process of change, (b) knowing how to validate and consolidate changes that have taken place, (c) knowing when not to continue to intervene when the desired changes have been achieved (i.e., when health has replaced pathology in the session), (d) knowing what mechanisms of change should be activated to facilitate change, (e) knowing when and why the interventions do not have an impact on these mechanisms, and (f) knowing how to repair errors of commission and omission that may have prevented or hindered the process of change. The manner in which these qualities present themselves in a given dyad will vary by client, but the underlying characteristics of what makes a therapist effective seem to transcend the therapy dyad.

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