Cognitive Therapy and Research, Vol. 19, No. 5, 1995, pp. 485-503

The Focus of Therapist Interventions in Cognitive Therapy for Depression[1]

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The goal of this study was to provide a detailed analysis of the focus of therapist interventions in cognitive therapy for depression. Rather than measuring the techniques or specific procedures used by therapists, this study aimed at describing the aspects of clients' functioning targeted by the interventions. A transtheoretical coding system was used to classify the focus of therapists interventions in therapy sessions from the Cognitive-Pharmacotherapy Project (Hollon et al., 1992). Consistent with the cognitive therapy model, the results indicated that therapists focused primarily on producing cognitive changes. More emphasis was also

[1]This study was supported in part by a grant from the National Institute of Mental Health (MH40196) awarded to Marvin R. Goldfried, principal investigator. Louis G. Castonguay and Adele M. Hayes served as coinvestigators on the same grant. The study was also conducted while the first author received a fellowship from the Conseil de Recherche en Sciences Humaines du Canada. The authors are grateful to Steve Hollon for his major role in collecting the data and materials upon which this study was based, as well as for his help and support in preparing this article. We thank Michelle Newman and Kathleen Murphy for their assistance in writing the manuscript, as well as Ed Bein and David Smith for their statistical guidance. We are also grateful to Patrick Raue for his help in data collection.
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0147-5916/95/1000-0485$07.50/0

placed on intrapersonal issues than on interpersonal issues. When therapists did address interpersonal issues, they focused more on the impact that others were having on clients' functioning than on the potential contribution that clients brought to their interpersonal difficulties. Finally, when addressing persons involved in clients' lives, therapists focused mostly on the clients' mates and others in general, rather than on their parents or the therapists themselves.

KEY WORDS: therapist interventions; process research; cognitive therapy; depression.

In line with the recommendations of a National Institute of Mental Health (NIMH) workshop on research on psychotherapy integration (Wolfe & Goldfried, 1988), Goldfried, Newman, and Hayes (1989) developed a process measure that provides a fine-grained analysis of therapist interventions used in different theoretical approaches: The Coding System of Therapeutic Focus (CSTF). Rather than measuring therapists' adherence to techniques or specific types of intervention, this classification system describes the aspects of client functioning that are targeted by the interventions. The measure of treatment focus rather than treatment techniques is based on the assumption that different approaches may serve the same therapeutic functions or rest on similar principles of change, even though they require different technical procedures. For many authors, it is at the level of therapeutic principles that the most robust processes of change may lie (e.g., Goldfried, 1980; Goldfried & Padawer, 1982; Stiles, Shapiro, & Elliot, 1986).

Wolfe and Goldfried (1988) also recommend that psychotherapy researchers measure important characteristics of effective and "pure" forms of therapy. The study of pure forms of therapy represents the first step toward the elucidation of successful elements of therapists' focus, setting the stage for the identification of unique and common mechanisms of change in different types of psychotherapy. In doing so, such process research provides the building blocks of knowledge in our search for particular treatments of specific clinical problems, as well as our understanding of change processes that may be combined in integrative therapies. In line with Wolfe and Goldfried's recommendations, the goal of this study was to describe the focus of therapist interventions in cognitive therapy for depression.

Although considerable attention has been paid to the outcome of cognitive therapy for depression, relatively few efforts have been made to empirically examine the specific interventions contained in this treatment package (Hollon & Beck, 1994; Robins & Hayes, 1993; Whisman, 1993). In addition, most of the process research has examined interventions that are tied directly to the cognitive model (e.g., hypothesis testing, homework). As a transtheoretical descriptive system, the CSTF can be used to identify

interventions used in cognitive therapy that are not part of the cognitive model and thus can facilitate comparisons with other approaches.

In a recent study with the CSTF, Goldsamt, Goldfried, Hayes, and Kerr (1992) compared the focus of interventions used by a cognitive (A. Beck), cognitive-behavioral (D. Meichenbaum), and psychodynamic (H. Strupp) therapist in a demonstration session with the same depressed individual. According to the cognitive model for psychotherapy (Beck, Rush, Shaw, & Emery, 1979), therapists demonstrate to clients the influence that their thinking has on their affect and behavior, and then teach them how to identify and challenge negative thinking. This approach is primarily intrapersonal in focus and aims at producing cognitive changes. Consistent with the cognitive model, Goldsamt et al. found that Beck's session differed from the other two approaches in that he placed more emphasis on facilitating cognitive change. Although Beck frequently addressed the client's emotions and (to a lesser extent) actions, his approach was characterized by a focus on the client's thinking (e.g., self-evaluation, expectation, general beliefs). Beck challenged the client's negative thinking by examining the client's subjective view (including his view of others) and offering another, more objective perspective.

Goldsamt et al. (1992) also found that the focus of Beck's interventions was more intrapersonal than interpersonal, as he more frequently addressed the links between different aspects of the client's functioning (e.g., the influence of thoughts on emotions) than connections between the functioning of the client and others. When Beck did focus on interpersonal issues, however, he focused more on how others affected the client than on how the client may have contributed to the relationship problems. By contrast, Meichenbaum and Strupp focused as much on the impact that the client had on others as they did on the effect that others had on the client. Finally, when Beck focused on persons involved in the client's life, he placed much emphasis on the client's mate and on others in general, rather than on him or the client's parents.

The Goldsamt et al. (1992) study represents a preliminary demonstration of how the CSTF can be used to assess the focus of therapist interventions both within a theoretical model and across theoretical orientations. Specifically, it served to explore the focus of Beck's interventions in comparison to two other therapists from different orientations. However, the findings relevant to cognitive therapy are based on a single demonstration of an initial session with one client. The next question, which the present study attempted to answer, is whether what Beck does in a demonstration session generalizes to what other therapists do across several clients in a course of cognitive therapy demonstrated to be effective in reducing symptoms of depression

and preventive relapse. Based on the cognitive model, it was predicted that the findings from the Goldsamt et al. (1992) study would be replicated.

METHOD

Design

In the present study, the focus of therapists' interventions was coded from therapy sessions collected as part of the Cognitive-Pharmacotherapy Project (CPT; Hollon et al., 1992), which was designed to study the effectiveness of different treatments for depression. The clients were randomly assigned to one of four experimental conditions: pharmacotherapy without maintenance, pharmacotherapy with maintenance, cognitive therapy, or a combination of cognitive therapy and pharmacotherapy.

Only the clients who received cognitive therapy, with or without medication, were included in the present study. These clients were considered as a single group. As in previous investigations conducted with the CPT (e.g., DeRubeis et al., 1990; Evans et al., 1992), the two cognitive conditions (alone and in combination with medication) were combined to increase the sample size, and therefore the power of statistical analyses. This is justified on the basis of the equivalence of the two groups in terms of the number and duration of cognitive therapy sessions, as well as the quality of the cognitive therapy administered. Moreover, the two groups did not differ with regard to clients' demographics, rates and predictors of attribution, pretreatment or posttreatment level of depressive symptoms and cognitive processes, or rates of relapse (DeRubeis, Hollon, & Evans, 1989; Evans et al., 1992; Hollon et al., 1992).

Participants

Clients. Hollon et al.'s (1992) original sample consisted of 107 outpatients who had requested therapy, of which 64 completed treatment (16 for each group). To be included in the study, the clients had to meet the Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978) for major depressive disorder, derived from a modified version of the Schedule for Affective Disorders and Schizophrenia—Lifetime (SADS-L; Endicott & Spitzer, 1978); a score of at least 20 on the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961); and a score equal to or greater than 14 on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960). Excluded from the study were individuals with past or current RDC criteria of schizophrenia, bipolar I affective disorder,

organic brain syndrome, antisocial personality disorder, panic disorder, generalized anxiety disorder, or substance abuse disorder (within the last year). Other exclusion criteria included the presence of psychotic or organic symptoms, an immediate hospitalization due to suicidal risk, and an IQ score of less than 80.

The average age for the 32 clients who completed the cognitive therapy was 33.8 years old. The majority were female (78%), Caucasian (88%), employed (59.5%), and with a high school diploma (75.5%). Moreover, 41% of the clients were married. The clients were moderately to severely depressed: At intake, the mean BDI and HRSD were 28.97 (±7.15) and 24.17 (±4.28), respectively. Also at intake, 75% reported suicidal ideation and 31% reported having made one or more prior suicide attempts. The median number of previous depressive episodes was 3.5, and 81% had been hospitalized previously for depression.

For the present study, session transcripts for 30 of the 32 clients who completed a cognitive treatment were obtained (15 in the cognitive therapy condition and 15 in the combined condition). Transcripts for the other two clients were unavailable due to technical difficulties.

Therapists. The clients were seen by one of four therapists: one clinical psychologist (male) and three social workers (two male and one female). All four were experienced psychotherapists, having accumulated from 8 to 20 years of practice, although none had prior training in cognitive therapy when selected for the study. Their theoretical orientations were rational-emotive, dynamic-eclectic, gestalt, and systemic. Thus, before being assigned to any client, therapists received intensive training in cognitive therapy. The duration of the training varied for each therapist (from 6 to 14 months), and continued until the therapist showed consistent skills in cognitive therapy, as measured by the Cognitive Therapy Scale (CTS; Young, Beck, & Budenz, 1983). Supervision sessions were also conducted after the training on a biweeky basis for the first two-thirds of the study, and on a weekly basis for the last third. Each therapist treated eight clients, four in each of the two conditions. No significant difference was observed among the therapists with regard to the adherence to cognitive techniques as measured by the Minnesota Therapy Rating Scale (DeRubeis, Hollon, Evans, & Bemis, 1982), quality of execution of cognitive therapy as measured by the CTS, or posttreatment outcome measures (DeRubeis, Hollon, & Evans, 1989).

Treatment

Cognitive therapy was conducted according to the guidelines of a manualized treatment (Beck et al., 1979). Clients were seen for a maximum

of twenty 50 to 60-min sessions over a 12-week period: two weekly sessions in the first 4 weeks of treatment, one or two sessions per week in the middle 4 weeks, and one session per week in the last 4 weeks. In the cognitive therapy alone condition, clients received an average of 15.4 sessions of treatment within an average period of 11.9 weeks, whereas clients in the combined cognitive-pharmacotherapy condition received an average of 14.4 sessions of cognitive therapy during an average of 11.6 weeks of treatment. In the combined group, clients were also administered individual dosages of imipramine hydrochloride (up to 200 to 300 mg per day after the second week of treatment). Clients met once a week (averaging 8.8 sessions) with a psychiatrist for drug management.

Sessions

For all but one client, two transcribed sessions were obtained from the Cognitive-Pharmacotherapy Project. For the 29 clients with two sessions, one of these was randomly selected from the first half of therapy and the other from the second half of the treatment. For the other client, the only session available was randomly selected from the first half of therapy. The first three and last three therapy sessions for each client were deleted from the selection pool to eliminate issues restricted to the beginning of treatment and termination. For each session selected, three 10-min segments (taken from the beginning, middle, and the end of the sessions) were coded with the process measure described below. Before being coded, however, the transcripts were edited by two graduate students so that nonclinically significant materials (e.g., scheduling issues) were eliminated.

Instrument

The focus of therapist interventions was scored using the CSTF (Goldfried et al., 1989). The items included in this coding system were generated from both a cognitive-behavioral and psychodynamic-interpersonal orientation. Leading researchers and practitioners from these two orientations were consulted to ensure that important constructs of change were captured. Moreover, the development and refinement of the coding system was also based on preliminary scoring of therapeutic vignettes obtained from other psychotherapy researchers and published transcripts appearing in the literature. In light of the language barrier that often separates the varying therapeutic orientations, an attempt was made to describe the coding system in jargon-free terms. The overall goal of the system was to pro-

vide a common language that could be used in conducting comparative process analyses across orientations.

As can be seen in Table I, four sections of the CSTF were used in this study. The first section concerns the *components* of client functioning focused on by the therapist, such as thought, emotion, and action. For instance, a therapist statement such as "How did you interpret that situation?" is scored for a focus on thought. These categories were used to determine whether therapists focused more on clients' thinking than on other aspects of their experience.

The second section of the CSTF reflects *general interventions* performed by the therapist, which refer to a focus on broader aspects of client functioning. This section includes a category to measure the therapist's comparison of the client's subjective view with a more objective perspective of reality (i.e., reality/unreality). Also included here is the therapist focus on the client's distorted perception of others (i.e., expected/imagined reaction of others).

The third section of the code is concerned with *links* or connections made by the therapist to increase clients' awareness. This section served to test whether the focus of cognitive therapy interventions is more intrapersonal than interpersonal. This section includes *intrapersonal links*, which depict the connections made by the therapist between two components of the client's functioning (e.g., "you thought you did poorly, which made you feel depressed"). It also includes *interpersonal links*, pertaining to the connections made between a component of the client and the component of another person (e.g., "when your wife walked out, you became depressed"). In addition, the specific type or characteristic of both intrapersonal and interpersonal links is scored, such as whether it represents the "consequences" any component has on another aspect of the client functioning or on the functioning of a significant other.

Finally, the fourth section of the CSTF concerns the *person involved* in the client's life. This dimension of the therapeutic focus involves the individuals on whom the focus is being placed on during the session: mate, parents, therapist, or other people in general.

The unit of coding is the "turn," which is the therapist statement that follows one client utterance and precedes the next. The client utterances before therapist turns can be used as contextual cues, but they are not scored per se. Each coding item is coded for presence or absence within a turn. The different items, within and across sections, are not mutually exclusive. This means that a therapist's turn can be coded for items of the same and/or different sections of other CSTF. A turn, however, does not have to be coded, if none of the items is applicable.

Table I. Descriptions and Interrater Agreement Levels in the Coding System of Therapeutic Focus

Coding Item	Description	Intraclass Correlations
	Components	
Situation	Circumstances external to client that are relevant to understanding his/her functioning	.70
Self-observation	Client's awareness and/or objective perception of self	.68
Thought	Client's thinking (e.g., general beliefs, expectations, appraisal of self-worth)	.82
Intention	Client's future-oriented volition, such as wish, desire, motivation, or need	.70
Emotion	Client's feeling	.85
Action	Client's behaviors	.77
	General interventions	
Reality/unreality	Helping client to step out of his/her subjective perception and view things more objectively	.68
Expected/imagined reaction of other	Exploration of client's subjective view of another person's reaction	.65
Therapist support	Therapist gives client encouragement	.68
Information-giving	Providing general facts and knowledge that have therapeutic implications for client	.78
Changes noted	Therapist refers to client's change associated with treatment	.74
	Links	
Intrapersonal Links		
Consequence	Therapist implies that a particular component of client's functioning is having an impact on another component	.74
Interpersonal Links		
Consequence (self affecting other)	Client's functioning is impacting on another person	.82
Consequence (other affecting self)	Another person's functioning is impacting on client	.71
Compare/contrast	Therapist compares or contrasts the client's functioning with the functioning of another person	.70
General interaction	An interchange between the client's functioning with the functioning of another person	.78
	Persons involved	
Therapist	Therapist	.90
Mate	The client's intimate relationship partner(s)	.97
Parent	The parent of client	.97
Acquaintance/stranger/ others in general	Person involved in client's life that is not captured by any of the other person categories	.87

In previous studies, the interjudge agreement for some of the CSTF items was mixed (Goldsamt et al., 1992; Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992). Because of these mixed results, the previous studies have used a conservative method of data reduction for their analyses. Rather than using average ratings, a consensus method recommended by Stiles (1986) was chosen. Following this method, an item was coded as having occurred if it had been scored by at least two of there independent coders. In addition to adopting the same conservative method of data reduction, an extensive training period and specific coding procedures have been adopted in the present study to increase the reliability. Moreover, only the items showing minimally acceptable levels of interjudge agreement (i.e., intraclass correlation coefficient above .60) were retained in the present study.

A total of seven coding items that were reported in Goldsamt et al. (1992) were omitted in the present study because they did not reach acceptable levels of inter-judge agreement. In the components of functioning section of the CSTF the following items were omitted: physiological signs of emotions (physical markers of the client's emotions, e.g., blushing) and unspecified (client's functioning where no specific components have been identified). Two items of the general interventions section also failed to achieve acceptable levels of intraclass correlation coefficients: choices/decisions (pointing to client's options, choices or decisions) and instance of a significant theme (highlighting a particular instance of client's functioning as part of an overall trend or pattern). In addition, three types of links were not retained. Two of these links were intrapersonal: similarity/pattern (similarities or recurrences within the client's functioning) and difference/incongruity (divergence noted within the client's functioning). One interpersonal link, interpersonal patterns (client's interpersonal functioning repeated over time, settings, or with different people), was also omitted. It should be noted that the difficulty to obtain adequate levels of interjudge agreement for most of these items (i.e., physiological signs of emotion, choices/decisions, instance of a significant theme, difference/incongruity, and interpersonal pattern) was, in part, due to their very low frequency. Table I presents the level of inter-judge agreement for each of the coding categories retained.[3]

[3]Other differences between the CSTF items used in the Goldsamt et al. study (1992) and the present investigation should be mentioned. In Goldsamt et al., three types of cognition (i.e., expectation, self-evaluation, and general thoughts) were coded as distinct items. In the present study these cognitions were coded as one item (i.e., thought). Moreover, some items were not coded in the present study but were scored in the Goldsamt et al. study: Three items included in the persons involved section of the CSTF (i.e., patient/client, child, and dream/fantasy figure), and the coding items in an additional section of the CSTF (time frames, such as preadult past, adult past, future).

Coders

Each transcript was coded by three coders. There were two sets of coders, all of whom were advanced graduate students from the State University of New York at Stony Brook. The first set of coders coded for components, general interventions, and persons involved. The second set coded for the links (intrapersonal and interpersonal). In order to avoid coders' drift, not all of the transcripts were coded by the same three coders. In the first set of coders, a pool of five individuals were used, and each transcript was randomly assigned to rotated teams of three coders. The second set of coders was composed of four individuals, three of whom were randomly assigned to the different transcripts. All individuals in each set of coders coded approximately the same number of transcripts, and none served in both sets of coders.

The two sets of coders were trained for more than 60 hours, which involved the scoring of different data sets similar to the cognitive therapy transcripts used in the present study. During the coding period, the coders met at least biweekly to prevent reliability drift.

RESULTS

Within-subjects analyses of variance (ANOVAs) were performed within each section of the CSTF to test the specific predictions that were made from Goldsamt et al.'s (1992) observations of Beck. The analyses were conducted using proportions (percentages) of therapists' turns for which each item was coded. These proportions were averaged for the two sessions of each client, except for the subject for whom only one session was available.

The first series of predictions concerned clients' components of functioning. A within-subjects ANOVA was conducted to determine whether the client's thought was the component focused on most frequently by the therapist. The within-subjects ANOVA was significant, $F(6, 24) = 111.95$; $p < .0001$, and as predicted, pairwise comparisons of means (using t-tests) indicated that therapists focused more on clients' thoughts than on any other components of functioning (see Table II). A second within-subjects ANOVA was performed to test whether the client's emotion was the next most frequent component to be focused on during therapy, as was the case in Beck's demonstration session (Goldsamt et al., 1992). The ANOVA was significant, $F(5, 25) = 116.31$; $p < .0001$, and the comparison of means revealed that, as predicted, a focus on emotion was more frequent than a focus on situation, self-observation, or intention. What was unexpected, however, was that therapists focused more frequently on action than on

Table II. Comparison of Proportion of Therapist's Focus on Client's Components of Functioning ($N = 30$)

	Components	M	SD	Pairwise comparison
1	Situation	.06	.06	
2	Self-observation	.05	.03	
3	Thought	.40	.10	3 > 1, 2, 4, 5, 6[a]
4	Intention	.11	.05	
5	Emotion	.20	.07	5 > 1, 2, 4[a]
6	Action	.25	.06	6 > 1, 2, 4, 5[a]

[a] $p < .01$.

client's affect. The focus on action was also significantly more frequent than all other components except for the client's thoughts (see Table II).

Although no inferential statistics were conducted to compare other components, one can see in Table II that the client's intention received some attention during the sessions, while the client's situation and self-observation were not frequent foci of therapist interventions.

Two specific predictions were derived from Goldsamt et al.'s (1992) study regarding therapists' general interventions. Both hypotheses had to do with therapists' examinations and challenges of clients' subjective views. A within-subjects ANOVA was first conducted to test if the most frequent general intervention was the therapist focus on reality/unreality (i.e., helping a client adopt a more objective perspective on self and reality). The ANOVA was significant, $F(5, 25) = 55.82$; $p < .0001$, and pairwise comparisons of means showed that this focus was significantly more frequent than any other general intervention (see Table III). A second ANOVA was performed to test whether the therapist's focus on the client's expected/imagined reaction of others (i.e., the therapist's exploration of the client's subjective view of another person's reaction) was the next most frequent general intervention, as Goldsamt et al. (1992) observed for Beck. The within-subjects ANOVA was also significant, $F(4, 26) = 68.06$; $p < .0001$. It was followed by a comparison of means, which revealed that this general intervention was significantly more frequent than a focus on the client's change and the therapist's explicit expression of support. The focus on expected/imagined reaction of others, however, was not statistically more frequent than the therapist's provision of information.

The means and standard deviations shown in Table III also allow a descriptive analysis of the three general interventions that were not the direct subjects of specific predictions: the therapist's focus on the client's change, explicit expression of support, and provision of information. The first two were coded fairly infrequently, while the third one seems to have been used somewhat more frequently.

Table III. Comparison of Proportion of Therapist's General Interventions ($N = 30$)[a]

	General Intervention	M	SD	Pairwise comparisons
1	R/U	.12	.09	1 > 2, 3, 4, 5[b]
2	E/I	.04	.04	2 > 3, 5[b]
3	Support	.02	.02	
4	Information	.03	.02	
5	Change	.02	.03	

[a]R/U = reality/unreality; E/I = expected or imagined reaction of others.
[b]$p < .01$.

Two specific predictions were tested for the links section of the CSTF. To test whether therapists focused more on intrapersonal links than on interpersonal links, a within-subjects analysis of variance was performed and found significant, $F(5, 25) = 121.18$; $p < .0001$. Pairwise comparisons of the means summarized in Table IV indicated that intrapersonal consequences (e.g., effects of distorted thoughts on clients' emotions) were significantly more frequent than any other type of link. A secondary analysis demonstrated that therapists focused significantly more on intrapersonal consequences specifically than on all interpersonal links combined. The second prediction concerned two specific types of interpersonal links: consequence (self affecting other) and consequence (other affecting self). As predicted, therapists focused significantly more on the impact that other

Table IV. Comparison of Proportion of Therapist's Focus on Links ($N = 30$)[a]

	Link	M	SD	Pairwise comparisons
	Intrapersonal			
1	Consequence	.21	.07	1 > 2, 3, 4, 5[c]
	Interpersonal			
2	Consequence (S/O)	.03	.02	
3	Consequence (O/S)	.05	.03	3 > 2[b]
4	Compare/contrast	.02	.01	
5	General interaction	.05	.04	

[a]Consequence (S/O) = consequence (self affecting other); Consequence (O/S) = consequence (other affecting self).
[b]$p < .05$.
[c]$p < .01$.

Table V. Comparison of Proportion of Therapist's Focus on Persons Involved (N = 30)[a]

	Persons involved	M	SD	Pairwise comparisons
1	Therapist	.07	.06	
2	Mate	.17	.19	2 > 1, 3[b]
3	Parents	.03	.07	
4	A/S/OG	.18	.12	4 > 1, 3[b]

[a]A/S/OG = acquaintances/strangers/others in general.
[b]$p < .01$.

people had on the clients (other affecting self) than on the impact that the clients had on others (self affecting other), $t = 2.32$; $p < .05$.

The means and standard deviations shown in Table IV also suggest that therapists focused less on similarities or differences between clients' functioning and other people's functioning (i.e., compare/contrast) than any other type of link. It also indicated that the focus on general interactions (i.e., interchanges between clients and others) was at least as frequent as any other type of interpersonal link. Since these findings were not included in a priori hypotheses, however, no inferential statistics were performed to test their statistical significance.

As for the items of the CSTF section on persons involved, it was predicted that the client's mate and others in general would be the individuals most frequently focused on by the therapist. A first within-subjects ANOVA performed to compare the client's mate with all other items of this section was significant, $F(4, 26) = 59.56$; $p < .0001$. As predicted, the pairwise comparisons outlined in Table V show that the therapist focused significantly more on the client's mate than on any other person, except for the category called others in general. A second within-subjects ANOVA was performed to test the hypothesis that therapists focused more on "others in general" than on themselves and the clients' parents. The ANOVA was significant, $F(3, 27) = 54.28$; $p < .0001$, and the comparison of means revealed that the hypothesis was confirmed (see Table V).

Although no inferential analysis was conducted to compare therapists' focus on themselves with their focus on the client's parents, the means presented in Table V suggest that the former is more frequent than the latter in cognitive therapy.

DISCUSSION

The results of this study largely replicated and extended Goldsamt et al.'s (1992) observations of a demonstration of cognitive therapy conducted

by Beck. Consistent with the cognitive model, therapists focused primarily on producing cognitive changes. In addition, we found that cognitive therapists focused more on intrapersonal than interpersonal functioning, as they frequently established connections between some components of clients' functioning (e.g., distorted cognitions) and other aspects of their experience (e.g., depressive mood). When therapists focused on people in a client's life, they most frequently dealt with the client's mate, as well as on other people in general. Taken together, these findings indicate that experienced therapists trained to deliver cognitive therapy can provide, at different phases of therapy and with different clients, the type of intervention focus that is mostly prescribed and practiced by the leading proponent of this approach.

Consistent with the principles of cognitive therapy, more emphasis was given to various thought processes (e.g., general beliefs; expectations) than to any other specific component of functioning. In addition to cognitions, other components of functioning were given attention during the cognitive treatment. As did Beck, therapists focused more on clients' emotions than on most other aspects of their experience (i.e., situations, self-observations, or intentions). Contrary to Beck (Goldsamt et al., 1992), however, they focused more on clients' actions than on their affects. It may be that, in the context of a demonstration, Beck deliberately and repeatedly highlighted the impact of distorted beliefs on painful emotions rather than on any other aspects of the client's functioning, since such impact is at the core of the cognitive therapy rationale for mood disorders. It is also possible that this different finding is in part due to the clinical problems presented by the differing clients. Although the client seen by Beck reported having some of the symptoms of depression, he may not have been as clinically depressed as the subjects in the present study, who were moderately to severely depressed. As noted by Beck and his colleagues (Beck et al., 1979), cognitive therapists are more likely to focus on behavioral activation (e.g., increase in pleasurable activities) when working with more depressed individuals.

As predicted, challenging clients' distorted beliefs (i.e., reality/unreality) was used significantly more frequently than any other general intervention. This intervention corresponds largely to the task of providing evidence to correct distorted beliefs, which is one of the crucial procedures of cognitive therapy (Beck et al., 1979). Also as expected, the next most frequent general intervention was the exploration of clients' expected and/or imagined reactions of others. Such a focus (i.e., how clients think they are perceived by others) is consistent with the recent emphasis given to maladaptive interpersonal schemas in cognitive therapy (Safran & Segal, 1990).

Consistent with Beck's demonstration session, therapists in the present study placed substantial emphasis on intrapersonal functioning, connecting different aspects of clients' experience. In fact, the focus on intrapersonal consequences was significantly more frequent than the focus on all interpersonal links combined together. This result reflects the importance that cognitive therapy attributes to the causal role of the clients' beliefs on their emotions. Like Beck, cognitive therapists in this study were more likely to highlight the impact that others have on the client (i.e., interpersonal consequences, others affecting self) than on the effect that the client has on others (i.e., interpersonal consequences, self affecting others). An interesting contrast is that Goldsamt et al. (1992) found that both Strupp and Meichenbaum focused about equally on the impact others had on the client and the impact the client had on others. Compared to interpersonal therapists (e.g., Coyne, 1976; Strupp & Binder, 1984) and cognitive-behavioral therapists (e.g., Goldfried & Davison, 1976; Meichenbaum, 1977), cognitive therapists appear to place less emphasis on the effect that depressive clients' actions may have on others and their contributions in maintaining maladaptive patterns of interpersonal relationships than they do on clients' interpretations and reactions to these circumstances.

As for the type of persons focused on by the therapists, the predictions made from the evaluation of Beck's demonstration session were confirmed. Except for the clients' mates, therapists' attention in the present study was often not directed to a particular individual but to acquaintances, strangers, or others in general, as was true of Beck. It seems that when cognitive therapists addressed clients' interactions with other persons, they focused mostly on marital/romantic issues or on relationships in general. The therapists' limited focus on themselves and clients' parents suggests that they did not address directly issues of transference, which is what should be expected from the cognitive therapy model.

This study has attempted to provide a comprehensive description of the focus of therapists' interventions in cognitive therapy. Investigating the process of therapy from the perspective of the therapeutic focus, rather than the type of technique, this study has permitted a detailed analysis of the various aspects of client functioning that are highlighted in cognitive therapy. It has also revealed some unexpected findings that might not have been uncovered by the use of scales measuring the adherence to procedures explicitly prescribed by cognitive therapy. Hence, with the use of a transtheoretical coding system, this study has shown some patterns of intervention not described in the cognitive treatment manual, such as therapists' focus on the impact that others have on clients, and their relative inattention to the potential contribution that clients bring to their problematic interactions.

Although it has offered a more generalized view of the cognitive approach than the previous demonstration session of Beck (Goldsamt et al., 1992), some limitations must be considered when interpreting the results. First, our sample was limited to four therapists, which may somewhat restrict the generalization of our findings. Second, therapists were practicing a manualized version of cognitive therapy. Thus, it remains to be seen what cognitive therapists focus on when they are not participating in a controlled outcome study, and whether or not their interventions are as consistent with the cognitive model, as was the case for the therapists involved in the present study. Third, the results are limited to Beck et al.'s (1979) original cognitive approach to therapy. It would be important to compare the foci of interventions of therapists whose cognitive approaches are different (e.g., more recent versions of cognitive therapy, rational-emotive therapy, cognitive-behavioral therapy), and to determine which aspects of the therapeutic focus are unique to one and which are common to all. Based on Goldsamt et al. (1992)'s findings, for instance, one might attempt to determine whether cognitive-behavior therapists and therapists practicing new forms of cognitive therapy (e.g., Safran & Segal, 1990) focus more than cognitive therapists on the client's own contribution to his/her interpersonal problems, and whether such a differential focus has an impact on symptomatic reduction and improvement of interpersonal functioning.

The fourth limitation is that the use of a single instrument, such as the CSTF, cannot provide a comprehensive picture of therapists' interventions. As noted above, the CSTF may capture some aspects of clinical reality that are overlooked by more standard measures of adherence. By the same token, these measures as well as other instruments addressing the therapist's intervention modes (e.g., Stiles, 1986) assess the therapist's activities at a different level of analysis—at the level of the specific procedures and techniques. Comparative studies of the CSTF and some of these instruments are clearly needed in order to establish their discriminant and convergent qualities. Such studies may highlight important points of complementarity, which can ultimately provide a more complete view of the therapist's intervention. The CSTF may indeed reveal *what* therapists of different theoretical orientations focus on, while other instruments may describe *how* they do so.

For instance, a study could be conducted to test Messer's argument (1986) that while both cognitive-behavioral and psychodynamic therapists focus on the client's emotional processes in therapy, the former apply methods to reduce the expression of affect, and the latter use techniques to facilitate the experience and exploration of emotion. Another study could be conducted to investigate a consensus that has emerged from clini-

cal literature, according to which therapists of different persuasions attempt to provide their clients with a new perspective of self and the world (Goldfried & Padawer, 1982). Using the Reality/Unreality item of the CSTF, one could determine whether or not therapists trained in divergent models encourage their clients to develop alternate ways of looking at themselves and others. At the same time, using an intervention mode scale, it would be possible to test whether these therapists used different techniques (e.g., interpretation, reformulation, confrontation of distorted beliefs) in this therapeutic endeavor. This type of empirical effort may begin to provide answers to one of the crucial questions with regard to the issue of common versus unique factors in psychotherapy. It may confirm that at some general level of intervention most therapists focus on the same therapeutic aspects, but that they differ in terms of the specific procedures used to deal with these aspects. This kind of study may also reveal what level of intervention, common or unique, is most closely related to the client's improvement.

Finally, on a more methodological note, it should be noted that although transformed into proportions, the focus of therapist interventions was measured in terms of frequency—the number of times the therapist addressed particular aspects of the client's functioning. As suggested by several psychotherapy researchers (e.g., Stiles, 1988), however, the mere frequency of a therapeutic ingredient may not necessarily be the best indicator of its clinical significance. Therapists' timing, flexibility, and skills in their focus of intervention may at times carry more import than the amount of emphasis given on various elements of the client's or another person's functioning. Future studies on the therapeutic focus should include measures that provide different perspectives on the appropriate and successful application of ways to adhere to this focus. The use of a therapeutic alliance scale, for instance, may be used to determine whether a repeated focus on some aspects of the client's functioning might enhance or interfere with the quality of the therapeutic relationship. Postsession questionnaires allowing the therapist and client to identify what they perceive as the most helpful aspects of therapy may also clarify the potential significance and impact of specific aspects of therapists' focus.

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