Schielke, H. J., Fishman, J. L., Osatuke, K., & Stiles, W. B. (2009). Creative consensus on interpretations of qualitative data: The Ward method. *Psychotherapy Research, 19*, 558–565. doi:10.1080/10503300802621180

Schmitz, N., Hartkamp, N., & Franke, G. H. (2000). Assessing clinically significant change: Application to the SCL-90–R. *Psychological Reports, 86*, 263–274.

Thompson-Brenner, H. & Westen, D. (2005). Personality subtypes in eating disorders: Validation of a classification in a naturalistic sample. *British Journal of Psychiatry, 186*, 516–524. doi:10.1192/bjp.186.6.516

Welch, R. D., & Houser, M. E. (2010). Extending the four-category model of adult attachment: An interpersonal model of friendship attachment. *Journal of Social and Personal Relationships, 27*, 351–366. doi:10.1177/0265407509349632

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CORRECTIVE EXPERIENCES IN COGNITIVE BEHAVIOR AND INTERPERSONAL–EMOTIONAL PROCESSING THERAPIES: A QUALITATIVE ANALYSIS OF A SINGLE CASE

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In a seminal publication, Goldfried (1980) identified a number of principles of change that cut across different forms of psychotherapy, among which was the therapist's facilitation of corrective experiences (CEs). As with all of the other principles he identified, Goldfried asserted that the types of CEs (and/or the procedures to foster them) are likely to differ from one theoretical orientation to another. In humanistic and psychodynamic therapies, for instance, CEs are assumed to take place within the context of the therapeutic relationship (e.g., disconfirmation of transference-related fears). CEs most frequently emphasized in cognitive behavior therapy (CBT), however, are assumed to involve between-sessions activities (e.g., gradual exposure to feared situations).

To our knowledge, no one has directly compared different types of therapy to empirically explore how CEs differ or are similar across orientations. In this chapter, we address this issue by examining CEs in two manualized treatments for generalized anxiety disorder (GAD): CBT and interpersonal–emotional processing therapy (I-EP). Specifically, we present the qualitative analysis of the case of one client who, as part of a randomized clinical trial (RCT), received both of these treatments. Methodologically, this design provides unique conditions to assess similarities and differences in CEs involved

in the therapeutic conditions investigated, as both treatments were conducted by the same therapist, with the same client, and at the same time (i.e., sessions occurring on the same day).

Adopting the Penn State University conference definition of CEs as our starting point ("CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way"; see Chapter 1, this volume, p. 5), our goal was to shed light on the nature of CEs, as well as on what facilitates them and what follows them within and across two different therapeutic approaches.

METHOD

Data for this case study were derived from an RCT for GAD (Newman et al., 2011) that tested the efficacy of a CBT treatment augmented with I-EP interventions. In the condition from which this case was drawn, the therapist provided the client with 50 minutes of CBT followed by 50 minutes of I-EP, for each of 14 sessions. This case was chosen because it was known to be a successful case of reduction in GAD symptoms. Within this case, we conducted intensive analyses of several therapeutic events identified as containing CEs.

Participants

The client, "Adam," was a 50-year-old, European American, heterosexual man. As a participant in the therapy trial described above, he was seeking treatment to address his GAD symptoms. At the onset of therapy he was also experiencing marital difficulties and stress at work. He was slightly overweight and typically dressed in business casual attire. He had previously been divorced and was remarried, living with his second wife at the time of treatment. He had several children from his first marriage as well as several stepchildren. He had a doctoral degree and was employed in an applied science field. The therapist, "Dr. E," was a European American woman in her late 30s. She was thin and dressed in a professional manner. She had a doctoral degree in clinical psychology and more than 10 years of postdoctoral therapy experience. Her theoretical orientation was primarily psychodynamic, but she had been trained in CBT and previously served as a protocol therapist in a CBT trial for panic disorder. Before the current study, she participated in a preliminary open trial on the integrative protocol received by the client (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008) and demonstrated both adherence to, and competence in, its CBT and I-EP components. She believed that CBT and I-EP were both effective treatments for GAD.

Measures

Four instruments assessing anxiety symptoms were used in the RCT as primary outcome measures, each demonstrating good psychometric qualities (see Newman et al., 2011, for a detailed description). Two of these measures were administered and rated by the therapist: The Hamilton Anxiety Rating Scale (HARS; Hamilton, 1959) is a 14-item measure of severity of anxious symptoms, and the Clinician Severity Rating (CSR) for GAD (ranging from 0 = *none* to 8 = *very severely disturbing/disabling*) of the Anxiety Disorders Interview Schedule for *DSM–IV* (ADIS-IV; Brown, Di Nardo, & Barlow, 1994). The other two were self-report measures: The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) is a 16-item measure of frequency and intensity of worry, and the State–Trait Anxiety Inventory—Trait version (STAI–T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is a 20-item measure of trait anxiety. Because one of the goals of the RCT was to assess whether the integrative treatment could improve the impact of CBT with regard to interpersonal functioning, the Inventory of Interpersonal Problems–Client (IIP-C; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) was also used. The IPP-C is a 64-item measure of distress arising from interpersonal sources.

Treatments

Cognitive Behavior Therapy

Targeting intrapersonal aspects of anxious experience, the CBT protocol included self-monitoring of anxiety cues, relaxation methods (e.g., breathing techniques), cognitive restructuring, and self-controlled desensitization (SCD), which involves the client imagining coping with a stressful situation while being relaxed. Therapists addressed only the learning and application of these methods as they related to intrapersonal anxious experience. For example, when doing cognitive therapy with aspects of client anxiety that related to other people, the therapist and client could work on identifying nonadaptive thoughts and on logical analysis of such cognitions to generate more accurate ways of perceiving. However, the therapist could not work on developmental origins, the deepening of affective experience, analysis of how client behavior may have been contributing to relationship difficulties, and behavioral interpersonal skill training.

Interpersonal–Emotional Processing Therapy

This treatment protocol was informed by Safran and Segal's (1990) interpersonal schema model, which provides a coherent integration of cognitive,

interpersonal, and emotional issues in human functioning and therapeutic change. However, in contrast to Safran and Segal's model, our modification was specifically designed to address interpersonal problems and facilitate emotional processing without the direct integration of cognitive techniques. The goals of I-EP were (a) identification of interpersonal needs, past and current patterns of interpersonal behavior that attempt to satisfy those needs, and the underlying emotional experience; (b) generation of more effective interpersonal behavior to better satisfy needs; and (c) identification and processing of avoided emotion. The interventions were based on the principles of an emphasis on phenomenological experience; therapists' use of their own emotional experience to identify interpersonal markers; use of the therapeutic relationship to explore affective processes and interpersonal patterns, with therapists assuming responsibility for their role in the interactions; promotion of generalization through exploration of between-sessions events and provision of homework experiments; detection of alliance ruptures and provision of emotionally CEs in their resolution; processing of patient's affective experiencing in relation to past, current, and in-session interpersonal relationships using emotion-focused techniques; and skill training methods to provide more effective interpersonal behaviors to satisfy identified needs.

Procedures for Coding Corrective Experiences

For the present case study, four researchers (the first four authors) acted as judges in conducting the qualitative analyses. One judge (the first author) was a licensed PhD-level clinician and experienced psychotherapy researcher. The other three judges were advanced doctoral students in clinical psychology, each with a master's degree and between 4 and 7 years of clinical and research training and experience. They were three men and one woman. The three doctoral students were all European American (average age of 30 years); the first author was French Canadian (in his late 40s). The judges were of diverse theoretical orientations (two identified more heavily with CBT and two with combinations of psychodynamic, interpersonal, and humanistic orientations), although all shared an interest in psychotherapy integration and a respect for a variety of theoretical orientations.

Before conducting the analyses, the judges recorded their expectations and biases related to CEs in psychotherapy. All four judges indicated that they believed that CEs in general could be therapeutic. Furthermore, they indicated that different types of CEs would be therapeutic in the two treatment segments. For example:

- In CBT, CEs might be more likely to focus on intrapersonal concerns (e.g., challenging automatic thoughts or core schemas, creating mastery experiences, facing feared situations, or challenging the fear of negative consequences of letting go of worry) (endorsed by all four judges).
- In I-EP, CEs might be more likely to focus on interpersonal concerns (e.g., challenging interpersonal fears as well as beliefs that wishes or needs will not be met) (endorsed by all four judges) or on intrapersonal concerns specifically around the experience of emotions (e.g., allowing oneself to experience or express emotions previously believed to be unacceptable) (endorsed by two judges).
- CEs may be more likely to take place in session within the therapeutic relationship in I-EP, whereas they may be more likely to take place outside of the session (as homework) in CBT (endorsed by two judges).
- Across both treatments, CEs are likely to build on one another—that is, small or mini-CEs may be likely to lay the groundwork for larger, more impactful CEs (endorsed by two judges).

All four judges also indicated that they believed that GAD could be successfully treated using psychotherapy, yet they all also saw it as a relatively difficult problem to treat. All believed that both CBT and I-EP could be potentially effective in treating GAD. None thought that CBT or I-EP would generally be more effective than the other, although two noted that the treatments might be differentially effective for different types of individuals or based on the nature of the presenting concerns (e.g., whether worry focused on primarily intra- vs. interpersonal issues). Two judges also suggested that the combination of the two treatments might be most effective for some individuals. All had some experience treating individuals with GAD (ranging from having treated one client with a primary diagnosis of GAD to substantial experience across a number of years), and all had used several different approaches to treating GAD.

Qualitative Analyses

The qualitative analyses were conducted using Elliott and colleagues' (Elliott, 1994; Elliott et al., 1994) comprehensive process analysis (CPA). One researcher (the second author) had previous experience conducting qualitative research, although the others had no such experience. In

preparing to conduct the analyses, the authors read a detailed manual on conducting CPA (Elliott, 1994) and also consulted with Robert Elliott before beginning coding.

After the judges watched all of the taped sessions of the case and took detailed process notes, they individually went back through their notes and identified moments throughout the treatment in which they thought that CEs had occurred. The judges then met to arrive at a consensus regarding CE events in each segment of therapy (CBT and I-EP) on which to focus their analyses. Based on this consensus meeting, two events were identified in each segment. In line with the definition of CEs mentioned above, the primary criterion used to identify a therapeutic event as a CE was that it involved an actual moment of disconfirmation of the client's expectations. Specifically, the events identified as CEs involved the client doing something different or reacting in a way that was inconsistent with his previous maladaptive pattern of reacting to anxiety-provoking situations and experiencing a different outcome. After consensus was reached regarding the identification of CE events, the judges then used session transcripts to identify the speaking turns that marked the beginning and ending of each event, as well as the speaking turns that composed the pivotal moments of each event.

The CPA framework comprises three broad domains: context, key responses, and effects. The domain of *context* includes factors that led up to or impact the manifestation of the event and includes four levels: *background* (relevant features of the client and therapist that preceded the event—including aspects of the client's presenting problems, characteristic coping style, history, and current life situation, as well as therapist personal characteristics and treatment principles); *presession context* (relevant events that have occurred since treatment began, either in or out of session, e.g., previous therapist interventions, experiences between sessions); *session context* (relevant features of the session in which the event occurred, leading up to the event, including aspects of therapeutic tasks and the alliance); and *episode context* (important features of the episode containing the event, i.e., what was being discussed immediately leading up to the event, interventions made, etc.).

The second domain, *key responses*, includes four aspects of client and therapist responses: *action* (e.g., client self-disclosure), *content* (e.g., belief, fear), *style* (e.g., warm, respectful), and *quality or skillfulness* (e.g., well-timed, evocative).

The third domain, *effects*, refers to the consequences of the event over time, including *immediate effects* (e.g., weeping), *within-session effects* (e.g., strengthening of the therapeutic alliance), *postsession effects* (e.g., increased willingness to try something new between sessions, decreased scores on symptom measures at future sessions), and *posttreatment effects* (e.g., increased ability to assert interpersonal needs in relationships). All decisions throughout the process are made by consensus among judges.

In conducting this study, it became clear that the CEs in this case could not be captured by a few discrete interventions by the therapist and one or two specific statements of the client, thus making the domain of key responses less useful for analysis. Because of this, we collapsed the analyses of two of the domains mentioned above—that is key responses and immediate effects—into a broader analysis of *significant events*. In addition, because some of the CEs in this case took place outside of session and were then reported and processed in the therapy, we have modified the format of presentation slightly to improve readability (although it is important to note that the CPA analyses themselves were not modified).

RESULTS

Following Elliott's (1994) guidelines and previously published research using CPA (Elliott et al., 1994), we first provide background information about the client. We then present the analyses in terms of context, the CE, and the effects for the CBT treatment, followed by the same analyses for the I-EP treatment. We also present quantitative analyses based on the outcome measures.

Background

Adam defined himself as a man with integrity (trustworthy, honest) and deep commitment to his religion and the contract of marriage. In terms of coping style, he revealed himself to be a logical and analytical thinker, frequently providing detailed and intellectual responses and at first rarely expressing emotions even when directly prompted. His problem solving style appeared to fit the Type A category, such that in stressful situations he reportedly tended to deny ("stuff away") his painful feelings and act in a manner that was impulsive and hostile.

At the beginning of therapy, Adam reported a high level of GAD symptoms (including worry and somatic distress across a broad range of situations and events). He reported that he was also experiencing stress at work and marital conflict, both other major concerns for which he had sought treatment. He was contemplating divorce because he was tired of feeling torn between his needs and his wife's needs but felt trapped by his religious beliefs, which led him to believe that divorce was unacceptable. The marital conflict had escalated after they moved from a state where his wife had important family ties so that he could take a new job. Because he had previously promised

her that they would never make such a move, his wife accused him of being untrustworthy (an accusation that was in conflict with the way he defined himself). She also complained that he did not trust her, a statement that was consistent with the way that he admittedly viewed women.

Throughout the treatment, Adam reported a difficult interpersonal history. His father was authoritarian, distant, and physically abusive. His mother was kind but submissive to his father and did not protect him from the father's abuse. He reported being a rebellious child who had no close friends. His divorce from his first wife was traumatic, and his children were removed from his care. In addition, he reported feeling animosity toward young, attractive, and rich women (a categorization that could fit the therapist).

Corrective Experiences in Cognitive Behavior Therapy Treatment

Presession Context

Early in treatment (Sessions 1–4), Adam had difficulty implementing and benefiting from techniques prescribed in the CBT protocol (e.g., progressive muscle relaxation, deep breathing, cognitive restructuring) in response to the stressful events with which he was confronted. At the end of a guided relaxation exercise in Session 4, however, the client reported a substantial reduction in anxiety and stated to the therapist, "That's the impact you have on me."

In Session 5, Adam reported having experienced a shift in his average mood from anxious to relaxed. He also stated that he was able to make this shift by monitoring his anxiety during the day and challenging the associated thoughts ("Maybe I am not so bad"; "We can work with this"). Perhaps reflecting a small CE, he seemed intrigued by the impact of these techniques, as they had led him to understand (or at least contemplate) events in a different and unexpected way. The therapist reinforced Adam for reacting differently to his internal experience and realizing that he has a choice to evaluate his thoughts rather than engage in all-or-none thinking. The session ended with Dr. E examining the fears associated with a list of worries that Adam developed during the previous week and giving a relaxation exercise for homework.

Dr. E began the subsequent session (Session 6) with a brief relaxation exercise that helped the client "find calmness inside." After this exercise, Adam spontaneously stated, "This stuff is working, shaving off the peak [of the intensity of the anxiety]." This statement led to a discussion of how Adam had discovered that when he catches himself feeling tense (physical sensations), using diaphragmatic breathing helps him reduce his anxiety. Dr. E tried to help Adam learn how to let go of whatever was on his mind when he worried

(what he called "mind grinding"). The client stated that the idea of letting go was very threatening, as he worried that he would not be able to pay attention to what was going on and would forget things that he needed to do as part of his daily responsibilities at work. The therapist then focused on these specific thoughts and ended the session with homework to track the worry, generate alternatives to worry, and note how many times Adam catches himself worrying and try to make a shift.

Session Context

The first identified CE in the CBT treatment occurred in Session 7. Dr. E began this session by asking whether Adam had experienced any successful (even if small) shifts in his reactions to anxiety cues, such as breathing more deeply, focusing more on the present moment, or becoming more aware of self-talk. Adam answered generally (without providing any specific examples) that this had happened significantly in different instances during the week and stated that he had experienced an increased impact and accelerated use of the techniques he had learned thus far in treatment. Dr. E reflected and reinforced Adam's increased awareness and repeated practice of what they had been working on. Adam felt supported and then reported being surprised by how the different techniques (cognitive and behavioral) had meshed together. After the therapist validated this experience ("They really do all start out as separate pieces. You learn them separately but then you get to see how they fit together, as you work with them more"), the client stated that this experience in itself had been an unexpected and significant change:

> I'm not a good assembler. I'm a dissembler type of person, where I'll take a big picture and break it apart, and look at it until I can understand. But this whole thing is sort of like an assembly, and that's not a typical way of me thinking. I'm thinking a sort of the reverse. I'm having to shift a paradigm.

Dr. E then asked Adam to talk about a specific occurrence during the past week when he successfully applied something that they had been talking about.

Corrective Experience Episode Context

Adam then described a situation that was typically stressful for him that had recurred in the past week (driving in traffic when late for an appointment), as well as the associated somatic symptoms (sweating) and automatic thoughts. This time, however, he reminded himself of the techniques that were discussed and worked on in therapy. The following is a transcription of the significant event. (At the beginning of treatment, both client and

therapist agreed to refer to one another by their first names, and this was consistently done throughout. To avoid potential confusion, however, we refer to the therapist as "Dr. E" and the client by his first name [which we changed here for confidentiality purposes]).

Adam: . . . and that's a good word. I was more aware of my emotional state. And so, I was driving along, and then I suddenly became aware—"I'm really tailgating that guy," I mean, I'm really, I can sense myself . . .

Dr. E: [Laughs.] Oh, good . . .

Adam: . . . doing the typical thing, which is . . .

Dr. E: Good . . .

Adam: . . . pressing, just pressing the issue, driving . . .

Dr. E: Good . . .

Adam: I don't do road rage, but I, uh, but people tend to push . . . and I said, "OK, well, we've been working on this. I can, I can relax." So, sort of like, "Eh, OK, I can slow down here." It, so part of this fitting in says, "Well, OK. Uh, what can I do? Well, I can relax, or I can look at the scenery, or I, this thing about being in the now." . . . So, I, I was driving along, and I thought, "OK, I can settle down here and I'll just look around, and I'll [raises eyebrows] do what I told Dr. E I was doing, and I'll look at the trees, and the flowers . . ."

Dr. E: Yeah.

Adam: And so I found . . . that I was more conscious of . . .

Dr. E: Great!

Adam: . . . of that, and so, I'm not saying I was super good at it, but at least I was conscious of . . .

Dr. E: Absolutely. Yeah.

Adam: . . . the things that we've been talking about . . .

Dr. E: Yeah . . .

Adam: . . . and then, um, usually when I'm uh, in a, in a group of four or five people that are doing sequential presentations, a bunch of [different experts] and all this stuff. So, I, usually I got a little bit tense when [sniffs loudly] this one guy was chopping into my time, you know I drive. It's really costly for me to go out on the road for a 20-minute presentation, [raises eyebrows, laughs] and this guy's cutting into my time, and I, I'm standing there thinking, "Darn, darn, darn, darn, darn." And then I thought, "So, what? So what can I do here? Well, you know, not lots, just lay back and enjoy it." [Shrugs shoulders.] You know?

Dr. E: [Laughs.]

Adam: So, I, I, I shifted to, "OK, no big deal. They'll get my message. No matter." And, and, so that stuff is meshing in.

Significant Event (Analysis of Corrective Experience)

In this event, Adam related an experience in which he became aware of both somatic symptoms and a maladaptive behavior—tailgating another vehicle—as they were happening. He also noted becoming aware of the situational cues that triggered these internal responses and that were at the core of his GAD symptoms. He then chose to respond differently than usual: He reminded himself of the techniques he had learned in therapy to react in a more adaptive manner and engaged in responses (e.g., relaxation, mindfulness, cognitive reappraisal) that were different from previous cognitive, somatic, and behavioral reactions typically triggered in similar stressful situations. In contrast to his previously held belief that he was helpless to impact his experience in such situations, Adam then felt relief and an increased sense of agency: While he was anxious, hostile, and uncomfortable at the beginning of the experience, he appeared to become confident, forthright, active, and even happy, as it progressed. It is interesting to note that immediately after describing the tailgating event, Adam then reported using the same skills (awareness of anxiety, self-efficacy statements, and behavioral activation) in response to a stressful situation that happened on the next day of the same business trip, as well as other occasions when he used applied relaxation techniques almost automatically ("I am not consciously doing it but it's sort of soaking in"), self-monitoring of anxiety states, and cognitive reappraisal ("What are the alternatives?"). This was in contrast to past responses to situational and internal cues that would typically lead to an anxiety spiral and maladaptive behaviors.

It is important to note that while he was reporting the events just described, Adam seemed aware of his maladaptive responses. Throughout the session, he also appeared to have evidenced an increased sense of control over his habitual reactions, as well as an accurate self-evaluation of the limits of his current change. In response to Dr. E's questions about the effects of his increased awareness of internal and situational anxiety cues and his shift in response to these cues, Adam reported a decrease in overall stress level (experienced specifically in somatic symptoms associated with GAD, i.e., physical tension such as "crunching" his teeth, lower levels of muscle tension and general tension, "brain pressure"). It should also be mentioned that the

nature of this CE (and the manner in which it was described by the client in the session that follows it) seemed to indicate a strong therapeutic alliance at this stage of treatment. A high level of agreement on goals and tasks was evidenced by the client's willingness to continue thinking about and practicing concepts and skills learned in treatment outside of session. Furthermore, evidence of a strong bond was manifested in the client's explicit evocation of the therapist during the event.

Within-Session Effect

Although a strong therapeutic alliance appeared to have facilitated this CE, the event itself may have also further enhanced the bond and collaboration between Adam and Dr. E. During the session, the client appeared happy, if not proud of himself, in sharing his success with the therapist. Dr. E also appeared authentic in her support and praise of Adam, and he was genuinely accepting of (and attentive to) her compliments. There was also reciprocity in the explicit affirmation of others, as manifested by the client complimenting the therapist on her skill at capturing his experience. As a whole, a pleasant, mutually attuned, and productive atmosphere emerged from the session. Both of them were fully engaged in the work of therapy, yet there was also laughter (as an expression of delightful surprise and praise for Adam's successful experiences).

Postsession Effect and Second Corrective Experience Presession Context

Subsequent CBT sessions appeared to build on the first CE event through their focus on applying the same skills to conflictual interactions with his wife. Consequently, these sessions were an effect (or consequence) of the first CE, yet also provided context for the second CE event, which occurred in Session 12.

In the sessions leading up to the second CE event, Adam reported an increase in marital tension, including experiencing frequent arguments with his wife. Continuing to become more self-aware, he described what he typically experiences during these interactions, including thoughts (worry, rumination, automatic thoughts such as "I am a failure"), emotional and physical sensations (anxiety, tension), and behaviors (becoming hostile and defensive, withdrawing). Dr. E introduced several interventions to address these experiences and modify Adam's reactions in these situations. For example, she set up and repeated several SCD exercises in which she asked Adam to imagine being in the interaction with his wife he had just described, only this time, to imagine staying in the situation, being honest with her while remaining calm (as opposed to going with his typical thought, "I am a failure"). The therapist also assigned homework exercises designed to practice

skills learned in session (e.g., "letting go") and "de-automize" and challenge statements (such as, "This is a test and I will fail") by introducing alternative self-statements (e.g., "I am valuable"), appraisals, and the downward-spiral technique (i.e., "What does it mean when someone is not affirming you?").

Corrective Experience Episode Context

The second CE in the CBT treatment was identified at Session 12. Adam began this session by reporting having engaged in a different and more adaptive reaction during the week. The following is a transcription of the report of the significant event.

Dr. E: . . . you're saying you were able to kind of sit still better through this 2-hour discussion with [your wife] . . .

Adam: Yeah . . .

Dr. E: . . . that you were able to kind of shift a little bit in your head . . .

Adam: Yeah [Nods.] . . .

Dr. E: . . . in terms of . . . not just interpreting everything she was saying as something you need to defend against . . .

Adam: [Nods.]

Dr. E: . . . but, but rather what—what—what might you have been saying to yourself?

Adam: Well, I don't know exactly. I was saying, "Well, OK, I hate this, [rubs forehead] I'm tired, I'm, uh, I can't absorb any more of this conversation; it's been going intensely for two hours, it's exhausting." She said, "Well you talk with Dr. E for two hours." I said, "Yeah, I walk out of there and I'm exhausted too!" [Laughs.] I re—, I mean it, it's really intense. So anyway, but [points finger] to, to do the, to talk about this part, I was better able to listen and try to discern what she was saying. I, I, I'm not, I still felt . . . defensive but . . .

Dr. E: Mm hmm . . .

Adam: I didn't start crashing inside like I used to do . . .

Dr. E: Excellent!

Adam: So, so anyway . . .

Dr. E: Excellent . . .

Adam: Uh . . .

Dr. E: OK, Adam, tell me what . . .

Adam: [Sips beverage.]

Dr. E: Let's go back, um, to that time you were having that discussion with her. What kinds of things . . . were you saying to yourself that helped you stay less defensive, to help you just kind of, you know . . .

Adam: [Nods.]

Dr. E: . . . not crash inside?

Adam: Well I, [sighs] I think a couple things.

Dr. E: OK.

Adam: One is that, something that she said to me. She said, "You know, you have . . ." and we'll get back to this . . .

Dr. E: OK.

Adam: . . . she said, "You have, uh, ceased or, or, or dispensed yourself from almost every other relationship . . .

Dr. E: Hmm . . .

Adam: . . . in, in the family, your father, your mother, your first wife, your kids. You have really just terminated almost . . . all the relationships." But she said, "You know, I'm still here, even though these people hurt you," she said, "I'm still hanging in here, I'm still tenacious; I'm still loving you," and, and she said, "I'm showing you I am interested and tenacious . . .

Dr. E: Mmm . . .

Adam: . . . in hanging in with you." She said, "Most other people would have walked away from you a long time ago." And I agree. They probably would of 'cause I have not been a very nice person [fidgets with mug]. I mean, I'm no lawbreaker and I'm not a rapist, and all that stuff but I, I, I have distanced myself from these people because of hurt [raises eyebrows] and fear of, a fear of hurt.

Dr. E: OK. Alright.

Adam: . . . But anyway, so . . .

Dr. E: You . . .

Adam: I recognized, I recognized that she does love me, and she has a, a, an interest and a tenacity and a love . . .

Dr. E: Boy . . .

Adam: . . . that, that, that, it, she's hanging in there, and so to answer your question, now I recognize that, that she does care and her wisdom is good [licks lips]. And so my shift, my paradigm shift a little bit has been, "I don't have to be defensive about this, but I have to be honest about it." I have to be, to, to not shut up and run away, but I have to be able to say, "OK, let's talk about this." I'm not good at that, but I'm getting better at it.

Dr. E: Ah, Adam, you're doing great!

Adam: Well . . .

Dr. E: If you're saying . . .

Adam: . . . thank you [sips beverage.].

Dr. E: . . . these things to yourself, you're doing great! That's . . .

Adam: Yeah, pretty much, I'm, I mean, I'm . . .

Dr. E: [Laughs.]

Adam: I'm beginning to say, "OK, maybe we can make this work here."

Dr. E: [Sighs.] That's huge!

Significant Event (Analysis of Corrective Experience)

Although he reported signs of being defensive and argumentative early in this event, Adam remained in a stressful and emotionally difficult situation for nearly 2 hours, during which his wife told him both painful and nurturing things. He appeared at first to be emotionally vulnerable, anxious, depressed, hurt, bitter, physically uncomfortable (tired), and uncertain and then showed himself to be active, effortful, expressive, assertive, introspective, respectful, and collaborative. This shift apparently occurred when he made a conscious effort not to interpret what she was saying as something that he had to defend himself against, as he typically had interpreted these discussions in the past. Instead, he told himself not to be defensive and to stay present in the situation, while listening to and being honest with his wife. Adam also stated that he was becoming better at handling this discussion. This conveyed not only a shift in his appraisal of his wife's intentions toward him and his new intentions toward her but also a change in the self that involved increased confidence, assertiveness, and a sense of mastery or efficacy. He agreed with his wife that he had contributed to the difficulty he experiences in their relationship, as well as his past relationships. He also explicitly and fully recognized that his wife loves him and that, in contrast with other people in his life, she has not given up on their relationship. As a result, he did not "crash inside" (grow angry, feel overwhelmed, and withdraw) as he had in the past. After having reported the event that took place with his wife, Adam stated that from this new experience, he was beginning to have a sense of hope

and self-efficacy about improving his marital relationship, as conveyed by his comment "OK, maybe we can make this work here."

It should be noted that throughout the examination of the event, Dr. E facilitated Adam's awareness of important changes in his pattern of appraisal, attitude toward himself and others, intentions, and behavior related to his relationship with his wife. The therapist also praised him for being able to make these changes. This praise appeared to enhance the alliance, as shown by Adam's expression of gratitude. In addition to letting her know that her feedback was important to him, Adam's acceptance of the therapist's positive view of his change may have facilitated the processing and integration of the new experience.

Within-Session Effect

This event had a direct impact on what took place for the rest of the session. Specifically, after a discussion about Adam's internal reactions in interactions with his wife, Dr. E set up an SCD with the goal to cement his new and adaptive reaction. She asked him to visualize the very event that he reported, followed by a different internal reaction. Specifically, she instructed him to "imagine saying to yourself, as you did, 'Here is a woman who loves me, who cares. . . . Let's see if I can stay here, not being defensive. . . . I can do this.'" After the SCD was completed, the therapist told Adam that if he does what he just imagined when he is afraid, he will have more choice. Adam then reported that he feels threatened by people and that he gets scared when he becomes attached. He also stated that he gives control to others and then resents it. When Dr. E asked about his fear with his wife, Adam replied that she might prevent him from accomplishing his personal goals. The exploration and challenging of this fear then led to the uncovering of what appeared to be a core belief: "Every time I've cared about someone, I've lost something of myself. Therefore, it is dangerous to get close." The session ended with Adam remarking that he has never had a good relationship. Dr. E asked him to examine the meaning of this statement: "Does this mean that you cannot have a good relationship?"

Postsession Effect

The CE that was reported in Session 12 also had a direct impact on the remaining CBT sessions, which focused on further integration of learned concepts and skills, as well as relapse prevention. Specifically, Dr. E continued to assign homework targeted at practicing and reinforcing new and more adaptive behaviors in potentially stressful situations, particularly while communicating with his wife. In the penultimate session, Adam described his ability to see that not everything is a threat and not all criticism is a challenge. Following an SCD exercise similar to the one that took place in Session 12 (which he reported finding helpful), Adam gained the following insight: "She, my wife, is more threatened than I am . . . and if I can keep this in mind, I will be less defensive." In the final CBT session, Dr. E asked Adam what he would take with him. He answered, "Shifting focus." He then provided two examples: (a) doing deep breathing or increasing his awareness of his surroundings when he is in stressful situations, such as when driving in the car (clearly referring to the event described in Session 7); and (b) changing his view—"I don't have to feel attacked; I can negotiate" (clearly referring to the event described in Session 12).

Summary

Two CE events were identified in Adam's CBT treatment. The first took place between Sessions 6 and 7, and the second took place between Sessions 11 and 12. The first event involved the client's successful implementation of the techniques learned thus far in therapy in a stressful situation (caught in traffic while being late for a job-related meeting), leading to a more positive, and disconfirming, outcome (e.g., reduced tension, allowing him to stay in the present moment). The second event also involved implementing skills learned in therapy and trying something different, this time in the context of an emotionally charged interaction with his wife. Although both of these events occurred outside of sessions with Dr. E., they were clearly linked with the work being done in treatment and the use of between-sessions homework, a core component of CBT. Furthermore, the disclosure and processing of the events with Dr. E appeared to be essential to the absorption of the CE event. Finally, a strong therapeutic alliance appeared to be both a facilitator and an effect of these CEs.

Corrective Experiences in I-EP Treatment

Presession Context

Immediately after Dr. E described the rationale and procedures involved in I-EP in Session 1, Adam expressed his apprehensions about relating with her in a nonchoreographed way (i.e., in a personal, spontaneous way). Throughout the initial I-EP sessions, when asked to talk about his emotions, Adam described thoughts and engaged in long storytelling. However, even early on, he was able to recognize that talking a lot allowed him to put a shield up, especially to prevent women (including Dr. E) from getting close. He wondered aloud what would happen if he let go of this shield and reported being concerned about experiencing and expressing sexual feelings toward Dr. E. He also reported being concerned about the therapist investigating his

emotional experience while adopting a distant, objective attitude of a doctor. He stated that showing emotion would be painful to him because of being hurt in the past. The therapist validated and normalized Adam's experience, then reassured him about the balance that she would maintain in terms of facilitating emotional experience (not being cold and distant) while maintaining boundaries (not being an intimate friend). When she asked, at the end of the session, how he felt, Adam reported finding himself "weepy, but also being calm and relieved."

An apparent alliance rupture occurred in Session 2 when Dr. E attempted to facilitate Adam's expression of feelings toward his wife. When he described thoughts, she focused him back on emotion. He then became noticeably irritated with Dr. E, yet resisted talking about his irritation by speaking about his thoughts rather than feelings. Adam then expressed significant distress, stating that he had had "two weeks from hell" in his relationship with his wife and felt trapped: "If I could figure out a way to kill myself without pissing off Jesus . . ." He also disclosed examples of significant animosity toward unmarried women, expressing his frustration with "the young coed in a new car." The session ended with Dr. E asking him (as homework) to think about what he wanted from his wife, suggesting that failing to consider his needs may contribute to his marital problems. The following week, Adam reported that he wanted acceptance and affirmation. He was, however, unwilling to answer the therapist's questions about his feelings toward his wife. Adam acknowledged that he did not trust that the therapist would accept him if he were to reveal himself. The therapist responded that she had observed that when Adam had been willing to take risks (rather than worrying about what to say and how to say it), she had felt that he was more real and was able to feel more compassionate toward him. Adam acknowledged his awareness of the distance he puts between himself and others out of defensiveness: "I'll divest myself of everything before I let people take them from me."

Similar issues were reenacted in subsequent sessions when Dr. E tried to focus on Adam's feelings and needs with regard to his wife. He had difficulty connecting with his feelings, which he avoided by intellectualizing (providing "why" responses to emotional questions), a dynamic that was pointed out by the therapist. Adam admitted that he was afraid of sharing his feelings with others, including Dr. E, for fear of being criticized, but he also recognized that he was sad for hurting Dr. E by rejecting her efforts to have him connect to his feelings. He also recognized he was missing something in relationships, that he is "numbed" when he is with others and that he wanted to experience more emotional intensity. In the following session (Session 6), Dr. E pointed out that in the previous session Adam appeared to be working harder not to intellectualize.

Adam recognized that this was difficult, yet there was also a sense of a "new adventure," in which Dr. E was challenging him, while in the context of asking him to trust her. The therapist wondered about her own contribution to their lack of task agreement (she asked about emotion, and he went into his head). In response to this, Adam described his conflict in their relationship: He wanted a deep connection but did not know how (and was afraid) to have an intimate yet nonsexual relationship with a woman. Exploration of this conflict led Adam to express his frustration at not being able to break out of his shell. Despite this, in the following session, he reported needing to keep his emotions "in the box" when talking about his painful relationship with his children. Dr. E's attempts to explore his feelings about his children only led to more long-winded intellectual discourse. Dr. E stated that she had tried to get close to Adam's hurt, yet he responded by talking about something else, which made her feel pushed away.

Session Context

The first identified CE in the I-EP treatment occurred in Session 8. With the intention of helping Adam improve his relationship with his daughter, Dr. E began the session by asking him what he wanted from the relationship. After showing signs of anxiety (shifting body position, smirking, rubbing hand around mouth, sighing), Adam went into a long intellectual discourse about the time course of this relationship. After Dr. E reiterated the original question, Adam stated, "The bottom line is I don't want a relationship with her because it would just bring up more hurt than it's worth."

Corrective Experience Episode Context

After this comment, Dr. E asked Adam to put aside what is possible or not with his daughter and to describe his feelings and needs. Rather than answering the question, Adam asked Dr. E whether she had a child and went on to describe, in a very intellectual and global way, how his daughter was taken out of his life and he had become used to it. The therapist pointed out that Adam answered her question with a thought and asked whether he was aware of his feelings toward his daughter, to which he replied that he did not know what feelings he had toward her. Dr. E then pointed out Adam's pattern of failing to directly answer her questions and the distancing impact this has on her. Adam reacted by acknowledging that he provides an intellectual answer to an emotional question: "I am a scientist . . . I'm giving you a rational response to an emotional question." The following is a transcription of the significant event that followed.

Dr. E: This is even before I asked about your feeling, I think. It can be almost anything that I ask. It doesn't have to be just in regard

to emotion. So, and, and that was something I was watching because I thought, "Well, maybe it is just an issue of feelings, and if they're not that accessible to you, and you go around and figure out how to respond." And that's fine, that's, I, um, I appreciate that, but it's not just about feelings. It seems as though nearly any question that I might ask you to try to help, further us, further your work . . . your response [sighs] . . . I guess the impression is, it comes back based on how you want it . . . how you want to answer and what information you want to provide as opposed to what I'm asking for . . .

Adam: [Raises eyebrows.] Hmmm. [Looks up; rubs mouth.] So, it's a control issue . . .

Dr. E: I think so . . .

Adam: [Has a 6-second pause; appears to be thinking.]

Dr. E: Mm hmm.

Adam: I, I would agree that it's a control issue [nods head]. I . . . all right, let's leave it at that.

Dr. E: OK.

Adam: I, I realize that it's a control issue . . .

Dr. E: OK.

Adam: . . . and by doing that kind of stuff, um, I control the quality and content of the information that I give you.

Dr. E: Yeah, and you have every right to do that, but you need to know the impact it has on me.

Adam: [Smiles during therapist's pause.]

Dr. E: [Has a 7-second pause.] You could, you could tell me if there's something you don't know, or you don't want me to know, or just don't feel comfortable talking about. You could tell me that, but that would have a different impact on me. You have every right to control the information you give me, and what you share. Absolutely. And I don't want, I have no need to take that away from you . . . but like I said, you just need to know by doing it in the way you're doing it has . . .

Adam: I would be a good politician because I could give you spiel [laughs] . . .

Dr. E: Yeah.

Adam: . . . and, and uh, not answer it at the same time.

Dr. E: Absolutely, and you can do it. You, you have a gift of being able to do it a way that I think many people would find smooth and congenial. But, if there's anyone . . .

Adam: [Laughs.]

Dr. E: . . . who is intent on wanting to know you . . .

Adam: [Raises eyebrows and sighs.]

Dr. E: . . . or wanting to share with you, um, it's going to be frustrating.

Adam: I'm sure it is.

Dr. E: Yeah.

Adam: [Smiling.] Thank you for your honesty. Yeah, that's a good observation, I . . . I don't, I, I, I, emotionally, I work, maybe what I do is, that I don't want to hurt people. That's a feeling, I guess that that's a feeling that I have, is that I don't want to hurt people.

Dr. E: But you do. So, your intent is gonna be quite different than your impact.

Adam: [Nods.] Having said that, I also don't want to be criticized by people [slight smile]. And so, I suppose what I might do, thinking about it, is that I give people some palatable words and some palatable thoughts so that they can find something positive to say even if they didn't wanna say or had criticisms of me . . .

Dr. E: Wait a minute; I'm not sure I understand that. Let's try that again. You don't want to be criticized. But, wait. Maybe you misunderstood when I say how do you try to avoid criticism, you say you like to present certain palliative persona . . . in an effort to avoid criticism. So, that, is that, what are you doing in here exactly to try to . . . avoid being criticized by me?

Adam: Putting on a good front in an effort to control, in an effort to avoid . . . being hurt by perhaps bringing up emotions or feelings that are hurtful or painful to me . . .

Dr. E: OK, so, so you mean really, it would be hurtful or painful to be criticized if you put a part of your core out there, whether it's real feelings or whatever . . .

Adam: Yeah, and . . .

Dr. E: And?

Adam: . . . so I smoke screen it . . .

Dr. E: Ah, you know what? [Laughs.] OK. That seems obvious that that's what you're doing . . .

Significant Event (Analysis of Corrective Experience)

In this event, the therapist confronted Adam about his pattern of reacting defensively toward her questions and interventions. Adam recognized the way he interacts with her and, after Dr. E communicated her acceptance and support, he further specified his interaction pattern in therapy (avoiding responding to her questions as a way to "control the quality and content of the information" he gives her). Dr. E validated Adam's right to choose how he interacts with her, but she also disclosed the impact that this has on her and informed him that he would have a different impact on her if he would tell her why he does not answer her questions. Adam further self-disclosed about his way of interacting with the therapist, yet in a sarcastic, defensive manner. Dr. E reiterated Adam's right to choose (and complimented him on) how he interacts with others but also further specified the frustrating impact this may have on people who really want to know him, including her. This intervention seemed to positively impact the alliance (with Adam thanking Dr. E for her honesty) as well as foster the client's awareness and insight. Adam recognized the negative impact he has on others and then disclosed conflicting fears of, on the one hand, hurting people, and on the other, being criticized. He also recognized that the latter fear is a motivating factor to deceive or manipulate people. Dr. E reflected Adam's disclosure and then asked whether he was also manipulating her, to avoid being criticized. He acknowledged this. Using the evocative term *smoke screen*, Adam symbolized why and how he is evasive and manipulative with the therapist, a disclosure that she validated and supported. Throughout the event, Dr. E used (in a focused, persistent, gentle, warm, nonjudgmental, and tactful way) a number of interventions (interpretation, confrontation, self-disclosure, reformulation, validation) primarily aimed at fostering a process of metacommunication. She also simultaneously drew links between how the client was interacting with her and how he interacts with others. Dr. E did so by demonstrating a skillful balance of challenge and support (as described by Linehan, 1993), most likely providing a CE by exploring (in an emotionally immediate way) his fear of being criticized and his need for control, while neither controlling nor criticizing him—and in fact, doing quite the opposite.

Issues related to the working alliance before and during the event also seem noteworthy. There was disagreement on the tasks of therapy early in the session, as Adam did not answer Dr. E's questions, engaged in emotional avoidance, and thereby controlled the content and process of their interaction. Despite this, however, the bond appeared to be strong, as he clearly respected the therapist and kept track of what she was asking him. In addition, the bond was strong enough for Dr. E to interrupt Adam when he was avoiding and to explicitly challenge him about his way of reacting to her.

When the metacommunication took place during the event, the agreement on the task was high, as shown by Adam's willingness to engage in difficult work. As noted above, the bond also appeared to increase during the event, as Adam expressed his gratitude for the therapist's self-disclosure.

Within-Session Effect

The above CE directly influenced the rest of the session, both in terms of content and process. Having agreed on Adam's tendency to smoke screen, Dr. E asked him whether smoke screening works in his relationships with others and whether this allows him to avoid getting hurt and to get what he wants. Adam replied that the answer to both of these questions was no. A few minutes later, when talking about what he wants in his relationship with his wife, Dr. E pointed out that Adam was again smoke screening and asked whether he was aware of this. Dr. E asked him how he can find what he wants (to be accepted for who he is) with his wife if he smoke screens her. In response to this, Adam exclaimed, "This is an 'aha' moment for you and me." When Dr. E asked how this realization felt, Adam again began to smoke screen, and the therapist noted this. Adam then reported this in the moment processing of their experience was threatening in one way, yet exciting in another, adding that if he could get past the perceived threat, he could find in Dr. E someone who could bring "clarity with care." After Dr. E replied that "this sounds to me like trust," Adam mentioned that he does not know what trust is but that perhaps things can be different with her. In turn, Dr. E suggested that their relationship might be worth Adam taking a chance to be hurt. While continuing to process what happened between them, the therapist summarized that Adam wants someone to help him without criticizing him, and this led him to recognize that he was afraid that she would criticize him. When asked how he had been feeling for the past 30 minutes, Adam said "relieved"—a clear description of disconfirmation of his expectations and fear. The therapist ended the session by asking whether Adam could try to generalize what he learned in the session (what he feared, what he did, what happened, and what he got) to relationships outside therapy.

Postsession Effect and Second Corrective Experience Presession Context

The CE that took place in Session 8 of I-EP seemed to have a major impact on all of the following sessions of I-EP treatment as well as on events that emerged between sessions. In the following session, Adam and Dr. E processed the new way of relating that the last session represented. They further explored Adam's difficulty and unwillingness to share his emotion with the therapist (partially based on his belief that engaging in any type of intimacy with another woman would be dishonest to his wife) and the

impact this has on Dr. E (e.g., feeling frustrated and discounted) and other people in his life (e.g., his wife). They explored his sadness at not being able to establish the type of relationship he wants with others, beginning with his wife. In Session 10, Dr. E complimented Adam for not having smoke screened in the previous session while they were exploring his smoke screening. In fact, she apologized for not appreciating this as it was happening. This exchange represented a new experience for Adam, as being open and expressing his feelings led not only to the opposite of what he feared but also to what he actually wanted (to be accepted and validated rather than criticized by the therapist). They explored what this meant to him (insight that he can trust and let his guard down with a woman), what he has done to make this happen (taking a chance in opening up), and the control that he has in choosing which relationships are worthy and safe enough to do this. They then worked on generalizing this new way of relating, including conducting a role play in which Dr. E played Adam's son, who recently hurt his feelings.

In Session 11, Dr. E remarked that Adam had changed and that she much preferred sitting with him now because he seemed more genuine, and this also allowed her to be more herself. Adam stated that very few people see his "real self," as he does not share his feelings with them (including his wife). Dr. E replied that she found this sad because he is a "wonderful person to be with." They then explored what prevented him from being himself, as opposed to being angry, which he felt he was most of the time and expected from others (including his wife and father). However, a subsequent two-chair exercise led Adam to recognize that one of his wife's expectations was for him to be more connected with her. After Adam voiced a need to be affirmed by his wife, Dr. E drew a parallel with the therapy by asking Adam to accept and process it ("let it sink in") when his wife affirms him. In the following session (Session 12), Adam recognized the impact of his anger and his deception on others and its contribution to unsatisfying dynamics in his relationships, to which Dr. E further disclosed the impact of his deception on her. This openness on the part of the therapist led Adam to share something very important about his anger: that he destroys precious possessions, the way that his father previously destroyed a precious toy. Adam then voiced that he was embarrassed about telling her this story, leading Dr. E to reassure him that there was no need to be embarrassed and to express sadness at hearing the story. When Adam said that he did not want her to feel for him, Dr. E replied, "I care about you because you bothered to show yourself to me." At the end of the session, the client stated that all of the six important people in his life had hurt him. Dr. E then provided Adam with advice about getting what he wants from relationships, especially with his wife (specifically, she recommended that he not cave in, not give up on getting what he needs, and not "trash" parts of

himself). Adam then stated that, unlike in the past, he now has some control over his reactions to others.

Session Context

Dr. E began Session 13 by asking how Adam was doing with not smoke screening (i.e., being more genuine and real) with people outside of therapy. After reminding the therapist that he destroys possessions that he prizes, Adam disclosed that it occurred to him that he does the same thing to relationships—he trashes people by rejecting or walking away from them when there is a conflict.

Corrective Experience Episode Context

Adam then described an event that took place during the past week with a mentor and close friend of his, in which he felt rejected. After sharing his feelings and processing the event with his wife, he decided to disclose his feelings to this friend, rather than "trashing" the relationship (his initial impulse). Although we viewed this event (and the fact that he shared his feelings with his wife) as an effect of the CE that took place in Session 8, it also appeared to be a significant CE on its own. The following is a transcription of the event.

Adam: I shared with him my feelings and how I reacted to that conversation we had [licks lips] and I said, "This is really tough for me to talk about because [looks upward, shakes head] it, it sounds so irrational [raises eyebrows] that I, I just, I really . . .

Dr. E: Mm hmm . . .

Adam: . . . felt rejected [nods]. He says, "Well, that's good, you're sharing." [Looks to side, laughs.] I thought, [laughs] "Right." [Laughs.] And so he said, "Well I real—, I really appre—" but there was [motions outward with hands] some chitchat, some talk. He said, "Well, I wanna tell you something." He said, [shrugs shoulders] "I really value your relationship and I, and I, I'm not gonna run away from you." He said, "I have many new friends but," he says, "You're a real special friend to me." And, and so . . . and then he explained [nods] to me [motions toward self with right hand] why he had to meet with another person he was mentoring and [licks lips] he said, "But I . . . but I'm not gonna" he said, "I'm not gonna run away from you. I'm not gonna leave you." [Nods.] Like, and part of this, part of this thread [throws hands up slightly] is like [covers left side of face], "This is really strange, it sounds like this is two lovers talking" [laughs] . . . and it wasn't . . .

Significant Event (Analysis of Corrective Experience)

In this event, Adam disclosed his feelings of rejection to his mentor after realizing that he was once again "trashing the relationship." Rather than moving away from his mentor, he took the risk and disclosed his feelings. In doing so, he behaved differently from what was typical for him (he did not avoid or smoke screen), and he took the risk of being criticized or rejected by revealing his true, negative, and painful feelings. When his mentor complimented Adam for sharing his feelings, he had doubts about his mentor's reaction. However, as the mentor described how he valued their friendship and that he did not want to reject him, Adam appeared to process this unexpected and positive experience, including the fact that such intimacy between two men made him uncomfortable. Throughout the event, Adam appeared anxious and uncertain (he at first dismissed the veracity of his mentor's reaction). However, by disclosing his feelings directly, appropriately, nonjudgmentally, and in an emotionally present way (by metacommunicating), as well as by letting his mentor express his own reactions more fully, Adam showed himself to be introspective, respectful, gentle, active, expressive, and collaborative.

Within-Session Effect

As with all of the CEs described here, this event directly influenced the rest of the session within which it occurred (or was reported). It impacted the content and process of the interaction, as well as the homework prescribed at the end of the session. Immediately after reporting the event, Adam acknowledged that this was a new experience for him. Although he had previously expressed anger and frustration to other male friends, this was the first time that he had expressed feelings of rejection. Dr. E reinforced this experience and highlighted the short- and long-term consequences of behaving differently. She also highlighted the energy cost of keeping a façade (a comment that the client described as a "tremendous insight"), using a personal story in her life to make this point. Dr. E then disclosed how much more enjoyable it has been for her since Adam stopped keeping that façade (or the smoke screen) and asked him what he thought made the difference. Adam replied that it was her challenging of his smoke screening (the CE in Session 8 described above). Later in the session, Adam stated that he views others as the enemy and if he stops seeing them as a threat, he would not need to smoke screen. The therapist then set up a homework assignment for him to behave differently with his wife in the middle of an argument (reminding himself that she is not a threat and that he has to be assertive in expressing his needs, rather than walk away or cave in).

Postsession Effect

Building on his interactions with the therapist and the recent event with this mentor and friend, the final I-EP session (Session 14) focused on how Adam could improve his relationship with his wife. Several role plays with feedback led to a greater understanding of how Adam could get what he wants with his wife and have a more harmonious relationship (e.g., taking more initiative rather than waiting for his wife to complain about not doing things together), as well as skill acquisition regarding how he could relate better (be more empathic, recognize his contribution to their marital problems). Dr. E shared that she very much appreciated working with Adam. She pointed out the changes that he had made in therapy and how hard he had worked to make a shift in their relationship. Adam recognized that no longer smoke screening with Dr. E and his attempts at clarifying their relationship led to tremendous change in other domains, such as work and dealing with depression, further stating, "I got the 'aha' here and then I had to do the work. . . . It has been a life changing experience."

Summary

Like in the CBT treatment, two CE events were identified in Adam's I-EP treatment. The first took place within Session 8, and the second took place between Sessions 12 and 13. The first event involved in-the-moment processing of the therapeutic relationship in an emotionally immediate way, which was facilitated by the use of metacommunication. This communication was corrective in that it involved the exploration of Adam's fear of being criticized and his need for control, while Dr. E was neither controlling nor criticizing him. The second event also involved emotional processing and metacommunication; however, in this case, the client was the one to generate the CE with an important other outside of the therapy context. This event was disconfirming in that the client was able to communicate his fears and needs in an emotionally immediate way, and not only was he not met with anger or criticism, but the relationship was strengthened. Once again, a strong relationship appeared to be both a facilitator and an effect of these CEs.

Quantitative Analysis

Using the same composite outcome variable derived by Newman et al. (2011), we examined the relative course of the client's GAD symptoms from intake to posttreatment, and at six-, 12-, and 24-month follow-up. The composite score was composed of the anxiety scale from the STAI–T, the HARS, PSWQ, and the GAD CSR from the ADIS-IV. These ratings were

converted to standardized scores and averaged for the client, which provided a composite measure of his anxiety symptoms. On the basis of this composite measure, the client's GAD symptoms, which were significantly elevated above the study sample mean ($z = 1.07$), had fallen meaningfully by the end of treatment ($z = -0.47$) and improvement was maintained throughout the follow-up period ($z = -0.22$ at 6 months, $z = -0.56$ at 1 year, $z = -0.43$ at 2 years). Analysis of this client's IIP-C indicated that the interpersonal distress scale, although high at the start of treatment, fell significantly (as determined by the reliable change index [RCI]) by the end of treatment, and fell further (another RCI increment) by 6-month follow-up, passing below the clinical cutoff during this time. These gains were maintained at 2-year follow-up.

DISCUSSION

The qualitative analyses revealed both similarities and differences across treatment modalities with regard to the nature of CEs, the factors that may foster them, and their consequences. The findings also suggest ways in which the combination of different approaches can have a synergistic impact on the facilitation and realization of a core principle of change that can involve many dimensions of human functioning and change.

What Is the Nature of a Corrective Experience?

CEs in both approaches were characterized by the client deliberately and consciously engaging in responses that were different from, or opposite to, those that were typically triggered by feared situations in the past. Also in both treatments, Adam's reaction (surprise, relief, and pride) to his new responses reflected disconfirmation of his previous expectations and fears (consistent with the Penn State definition of CEs).

In addition, however, we found differences in the way that CEs manifested across treatments. In CBT, Adam learned that when confronted with stressful situations, he was capable of shifting his thoughts and intentions, reducing his somatic reactions, and modifying his behavioral responses. In I-EP, the client learned that when he was with significant people in his life, he was capable of being in touch with his emotions and interacting in a genuine, open, and nonmanipulative way. Although CEs that took place in CBT also involved interpersonal change, the client acquired intrapersonal skills that were different from the skills he learned in I-EP. For CBT, in contrast to I-EP, when being confronted by his wife, the focus was not on disclosing his emotions but on resisting his urges to avoid or escape, challenging his automatic thoughts that she was a source of threat, and paying attention to what she was saying. Although CBT and I-EP used different pathways toward new experiences (e.g., intra- vs. interpersonal), the client clearly exhibited gains in both domains.

What Facilitates Corrective Experiences?

Our findings suggest that CEs, within and across the two treatments, were facilitated, at least in part, by several factors related to the therapist, client, relationship, and external events. We present these variables as separate categories, while fully recognizing that they interact dynamically and are interdependent (at a conceptual and clinical level).

Therapist Technique Factors

CEs seemed to be facilitated by the persistent, systematic, and competent use of interventions prescribed by (and at the core of) the treatments. For example, in CBT, these include helping the client face anxiety-provoking situations through self-monitoring, the teaching and repeated practice of breathing and relaxation exercises, cognitive restructuring, and exposure techniques. In I-EP, these include exploring emotional and interpersonal needs, exploring the client's maladaptive behaviors as they happen in the here and now, using metacommunication skills, and training in specific interpersonal skills. Although these sets of interventions underscore important differences between these treatments in the procedures used and the focus of interventions (e.g., reducing tension vs. emotional deepening), a number of common, underlying change processes are apparent. Examples include increasing client awareness, helping the client to tolerate stressful or difficult situations and experiences, the processing of new experiences, and the generalization of learning outside of therapy.

Therapist Relationship Skills

In both CBT and I-EP treatments, the therapist's empathy, warmth, and openness likely provided facilitative conditions for the client's deliberate and successful engagement in new responses to threatening situations. The therapist's normalizing, support, and validation of the client's difficulties, as well as her reinforcement of new adaptive responses are also likely to have facilitated CEs. While working with different clinical material between the therapy segments, Dr. E showed a great sense of timing (e.g., when she swiftly moved from the client's mastery of anxiety-provoking situations in the session [e.g., by means of SCD] to the prescription of relevant homework) and tact (as exemplified by her nonjudgmental attentiveness to and reflection of emotionally sensitive issues that were unfolding in therapeutic relationship).

In terms of personal style, or the interpersonal manner with which she implemented the interventions that contributed to CEs in both treatments, the therapist was involved, collaborative, respectful, and gentle but also confident (enacting her role as an expert in dealing with difficult and/or delicate issues in a warm and professional way) and instructive (providing the client with direct and explicit guidance and feedback related to events in and between sessions). Using Linehan's (1993) metaphor, the therapist's style could be described as reflecting a skillful balance of support and challenge.

Client Factors

Considerable evidence pointed to the crucial role of the client in facilitating and achieving CEs. Perhaps speaking to client motivation and engagement, our observations suggest that it is important for the client to be willing to repeatedly face difficult situations and experiences, in and outside of the therapy session, that will allow maladaptive responses to be systematically triggered. In other words, the client must be willing to take risks and be open to the tasks of treatment. Adam's fear, for example, was activated when he was asked to imagine stressful scenes in CBT or to explore his emotions in I-EP, leading him to respond defensively by keeping information from the therapist and controlling the course of the conversation. Both of these client-generated situations set the stage for CEs.

In addition to anxiety, other negative emotions experienced by the client may have facilitated CEs, such as hurt, hostility, and vulnerability associated with the experience of being rejected and criticized, or depression and physical discomfort triggered by stress. Psychological distress and pain, in other words, may have motivated the client to take risks rather than continuing to respond (intra- and interpersonally) in ways that were not working for him. Adam's awareness of, and insight into, his maladaptive patterns of reacting (e.g., realizing in I-EP that he destroys relationships when hurt by others, recognizing avoidance in CBT) may also have contributed to his willingness to engage in new ways of behaving and relating, both within and outside of sessions.

Beyond these important motivating factors, transformative experiences appear to have necessitated the client's willingness and ability to learn, practice, and/or implement adaptive responses in sessions. This included, for example, Adam's use of breathing and relaxation techniques in reaction to early anxiety cues during CBT, as well as answering the therapist's questions without smoke screening and learning how to metacommunicate in I-EP (self-disclosing his defensiveness and owning the conflict over his wish and fear with the therapist). Thus, compliance and diligence on the part of the client appeared to be crucial (using a pharmacotherapy metaphor, for interventions to be effective, they not only need to be prescribed—they also need to be absorbed).

Also reflecting the agentic role of the client, the occurrence of CEs outside of therapy sessions seemed to have been facilitated by the client reminding himself of the techniques learned in therapy to help him react differently in these situations. Adam explicitly mentioned using these techniques in the first CE event reported in the CBT treatment, and a similar process can easily be inferred from what took place in the sessions preceding the second CE in the I-EP treatment. It is important to note, however, that these between-sessions CEs were contingent on the client's access to, and willingness to engage in, meaningful activities (e.g., having a job) and relationships (e.g., being in a committed relationship). As obvious as it may seem, one not only needs to learn and remember new ways of functioning but also needs opportunities to use and/or consolidate them. Our results also suggest that Adam's ability to recognize and willingness to report (in session) between-sessions CEs may have helped him process and integrate their therapeutic impact.

In both treatments, two CEs were identified, and in each case the first one appears to have facilitated the second. It may be that clients who possess characteristics that are facilitative of one CE may also be predisposed to experiencing multiple CEs throughout the course of treatment. Alternatively, CEs may sometimes build on each other relatively independent of client factors, and the client's first successful experiment with a new way of reacting, being, or relating can serve as a stepping stone or springboard for additional transformative experiences. In line with this, although ultimately representing an interaction between intervention and client factors, clients may possess certain characteristics that increase their probability of experiencing a CE in particular treatment approaches, as opposed to others. In the present case, Adam's logical, analytical coping style may have made him particularly suited to the rationale underlying and procedures prescribed in CBT. This suitability may in turn enhance engagement, which may increase a client's willingness to take the sorts of risks that underlie CEs. Interestingly, additional evidence from this same case addresses the converse argument (low suitability would result in limited engagement). Although Adam initially expressed confusion and defensiveness related to the tasks and goals of the I-EP treatment, his ability to trust the therapist and stay with it eventually led to multiple CEs.

Relationship Variables

Reflecting the collaborative nature of a positive working alliance, the transformational experiences observed in both CBT and I-EP required that the client be open to Dr. E's interventions and willing to take risks. Within

the holding environment provided by the therapist, Adam showed courage and persistence in working beyond his anxiety, defensiveness, and mistrust. Throughout his efforts to change, he remained extremely collaborative and respectful toward Dr. E. The interpersonal style of both the client and therapist (before, during, and after the CEs) displayed a reciprocal level of engagement, as well as a mutual attunement to each other's efforts and reactions. In addition to being facilitated by a strong alliance, the transformative experiences observed in both CBT and I-EP also appeared to have led to the increase in agreement on the various therapeutic tasks and goals, as well as a strong bond (as manifested, e.g., by the therapist acknowledging that she liked Adam and Adam explicitly recognizing and appreciating Dr. E's support and honesty). While resting on a solid foundation, ruptures in the alliance were observed in the I-EP treatment (e.g., when Dr. E attempted to explore Adam's emotions and needs toward others). As noted, such ruptures may have been due, in part, to a clash between some of the interventions prescribed in I-EP and the personal characteristics of the client mentioned above (i.e., his logical, analytic style). What clearly emerged from our qualitative analyses, however, is that these ruptures set the stage for the two CEs in I-EP.

External Variables

An example of a facilitative external event observed in this study was the encouragement the client received from his wife before he took the risk of calling his mentor and the alternative view that this mentor provided to the client's perception of having been rejected. Another example was his wife's expression of her love, while confronting him about important (positive and negative) issues in their relationship.

What Were the Consequences of Corrective Experiences?

Adam's shift from habitual maladaptive reactions to new, difficult, but also rewarding (personally and interpersonally) adaptive reactions appeared to have had a number of therapeutic consequences that were observed in both treatments. First, CEs seem to have facilitated symptomatic improvement. This is illustrated, for example, in the decrease in anxiety reported in CBT sessions and the reduction of depression that the client attributed to his more genuine way of interacting with others during I-EP. Although we cannot infer that CEs were solely or mostly responsible for the client's symptomatic (and interpersonal) improvement, our qualitative observations are very much in line with the quantitative changes that we found in the outcome measures. Second, a sense of self-efficacy also appeared to build progressively, as the client faced and successfully dealt with threatening and/or previously avoided situations and experiences. As explicitly stated by the therapist, the client's willingness and effort to engage in situations and new experiences allowed him to experience a disconfirmation. These disconfirmations, characterized by the integration of new information (that was counter to previous experience and expectations), helped Adam to become more flexible—cognitively, emotionally, and interpersonally.

All of these findings suggest that the factors that appear to facilitate CEs (therapist and client variables, as well as relationship factors) interact dynamically as therapy unfolds. For example, the first CE event in each treatment allowed Dr. E to further identify and understand Adam's maladaptive patterns of response and also helped Adam to increase his own awareness and insight regarding these processes. Dr. E was then better able to teach and reinforce new and more adaptive response patterns. CEs not only appeared to be facilitated by several relationship variables, but they also seemed to enhance the alliance and deepen the therapeutic relationship. Initial CEs, and their processing in each treatment, also seemed to facilitate generalization (and automatization, consolidation, integration) of therapeutic learning outside session.

Convergences, Divergences, and Integration of Therapeutic Interventions

The findings discussed here highlight several common factors of CBT and I-EP, especially with regard to the effect of CEs and the variables that appear to facilitate them. Common client factors that facilitated CEs appeared to be motivation, treatment engagement and compliance, and an ability to trust in the therapist and the treatment. Common relationship factors included a strong bond and (at least eventual) agreement on tasks and goals. Common effects included future CEs; decreased tension and anxiety; and increased cognitive, emotional, and interpersonal flexibility. In addition, CEs in both treatments appeared to instill a sense of mastery and hope in the client.

Our analyses also revealed important differences, primarily with regard to the type (or nature) of CEs that took place in these treatments (e.g., intra- vs. interpersonal, reduction of arousal vs. emotional evocation and deepening) and the techniques that were used to foster them (e.g., breathing training vs. identification of interpersonal needs). These differences, however, are far from irreconcilable and can be viewed as complementary. For example, a therapist could, with a similar client, use CBT interventions that focus on specific internal issues (e.g., somatic markers, cognitions) to help the client cope with particular stressful situations (e.g., to reduce anxiety, worry, and anger when stuck in traffic) and humanistically based interventions (e.g., exploration of emotion) to help the client become more aware of his interpersonal needs.

The focus on different dimensions of functioning can also allow the client to acquire and simultaneously use a variety of skills to handle complex

situations. There are several potential skills following from CBT and I-EP that are likely to help clients resolve interpersonal conflicts. For example, learning to reduce anxiety cues as they emerge; paying attention to and evaluating negative thoughts; resisting urges to avoid or escape; focusing on what another person is saying; being aware of one's emotions, needs, and impact on the other; and genuinely and openly metacommunicating are all skills that are likely to help clients resolve interpersonal conflicts. In addition, several of the techniques used in the two treatments are procedurally different yet are aimed at facilitating the same process of change—these are, one might say, different means to the same end (e.g., facilitating awareness of maladaptive patterns, exposure, processing of new experiences, reality testing). Furthermore, these techniques are likely to have a synergic impact, working together to promote even greater change. For instance, learning strategies for more effectively managing his own emotional reactions likely helped Adam to be more present in his interactions with others and respond more adaptively to them, thus leading to more satisfying interactions and further reducing his distress. Technical commonalities between these two treatments should also be mentioned. For example, both therapies are directive (i.e., requiring the therapist to frequently and explicitly direct the focus of treatment) and use homework. These similarities may also have had a synergic effect.

Our analyses also suggest that some client characteristics might fit more easily within some treatments than others (e.g., those who are more problem-focused and logical or analytical might be inclined toward CBT). However, this does not mean that other treatments are incompatible with some clients. In fact, although this client's logical and analytical style may have been one of the reasons why he was initially reluctant to accept the rationale of and engage in the tasks prescribed in I-EP, his eventual involvement in this treatment appears to have led to a significant and gratifying transformation.

Limitations

Limitations of this study include the reliance on a single case that came from the controlled setting of an RCT. In addition, many of the findings confirmed expectations of the research team regarding differences between the two approaches, leaving open the possibility that confirmation biases contributed to the analysis. It should also be noted that although the members of the research team each had different beliefs and expectations, many of them had also discussed other clients in supervision together, which may have led to the judges mutually influencing one another. Another important limitation is that three of four identified CEs in this case occurred outside of sessions and that therefore the researchers had to rely on only the client's report in their analyses of these events. Therefore, future studies (in naturalistic and controlled settings), with therapists using different treatments, with different clients, and different researchers are needed before more confident assertions can be made about the convergence and complementary processes that were observed in this study about CEs.

REFERENCES

Brown, T. A., Di Nardo, P. A., & Barlow, D. H. (1994). *Anxiety Disorders Interview Schedule for DSM–IV*. New York, NY: Oxford University Press.

Elliott, R. (1994). *Understanding the change process in psychotherapy: Comprehensive process analysis*. Unpublished manual, Toledo, OH.

Elliott, R., Shapiro, D. A., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., & Margison, F. (1994). Comprehensive process analysis of insight events in cognitive–behavioral and psychodynamic–interpersonal psychotherapy. *Journal of Counseling Psychology, 41*, 449–463. doi:10.1037/0022-0167.41.4.449

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35*, 991–999. doi:10.1037/0003-066X.35.11.991

Hamilton, M. (1959). The assessment of anxiety states by rating. *The British Journal of Medical Psychology, 32*, 50–55. doi:10.1111/j.2044-8341.1959.tb00467.x

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885–892. doi:10.1037/0022-006X.56.6.885

Linehan, M. M. (1993). *Cognitive behavioral treatment for borderline personality disorder*. New York, NY: Guilford Press.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28*, 487–495. doi:10.1016/0005-7967(90)90135-6

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., Boswell, J. F., Szkodny, L., & Nordberg, S. (2011). A randomized controlled trial of cognitive–behavioral therapy for generalized anxiety disorder with integrated techniques from emotion-focused and interpersonal therapies. *Journal of Consulting and Clinical Psychology, 79*, 171–181. doi:10.1037/a0022489

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. (2008). An open trial of integrative therapy for generalized anxiety disorder. *Psychotherapy: Theory, Research, & Practice, 45*, 135–147. doi:10.1037/0033-3204.45.2.135

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. New York, NY: Basic Books.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State–Trait Anxiety Inventory: STAI (Form Y)*. Palo Alto, CA: Mind Garden.