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The Therapeutic Focus in Significant Sessions of Master Therapists: A Comparison of Cognitive–Behavioral and Psychodynamic–Interpersonal Interventions

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Using the Coding System of Therapeutic Focus, this exploratory study was a comparative process analysis of clinically significant sessions obtained from 22 master cognitive–behavior and 14 master psychodynamic–interpersonal therapists. Therapists were nominated by experts in each of these orientations, and clients were seen in a naturalistic setting for problems with anxiety, depression, or both. Relatively few between-groups differences emerged with this master therapist sample. However, regardless of theoretical orientation, several differences were found between those portions of the session labeled by therapists as being clinically significant and those viewed as less significant. As these findings are different from those obtained in a previous study of the therapeutic focus in interventions carried out within the context of a controlled clinical trial, some of the possible factors contributing to these differences are noted.

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The growing interest in psychotherapy integration has originated from clinical observation and experience, with relatively little of a research base (Norcross & Goldfried, 1992; Stricker & Gold, 1993). Outlining possible directions for research on psychotherapy integration, a National Institute of Mental Health conference dealing with this topic suggested that comparative process research be carried out between different orientations, so as to shed light on both the common and unique change processes that each might contribute to an integrated and, presumably, more effective intervention (Wolfe & Goldfried, 1988).

In reviewing what therapists from various orientations have described as being essential to change, Goldfried (1980) found that one of the ingredients consisted of therapeutic feedback, whereby patients are helped to become more aware of what they are doing and not doing, thinking and not thinking, and feeling and not feeling in various situations. Although increasing patients' awareness may be a common change process, orientations may differ in the specific nature of this therapeutic focus. Thus, cognitive–behavior therapy may focus on the connection between patients' thoughts and feelings, and psychodynamic–interpersonal therapy may highlight increasing patients' awareness about their feelings toward their parents.

To provide a common metric for conducting a comparative analysis of the therapeutic process in cognitive–behavior and psychodynamic–interpersonal therapy, the Coding System of Therapeutic Focus (CSTF; Goldfried, Newman, & Hayes, 1989) was developed. Using the vernacular instead of theoretical jargon, the CSTF contains coding elements on which core constructs in both orientations are based. Thus, the CSTF classifies therapists' verbal interventions along five axes: (a) the components of the client's functioning (e.g., emotions and thoughts), (b) any links or connections that are made, be they intrapersonal or interpersonal, (c) the general interventions used (e.g., support), (d) the persons who are the focus of the intervention, and (e) the time frame of the focus.

A number of different studies have made use of the CSTF to study the change process with different data sets (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldsamt, Goldfried, Hayes, & Kerr, 1992; Hayes, Castonguay, & Goldfried, 1996). Most relevant to the present investigation was the study by Goldfried et al. (1997), which compared manual-driven cognitive–behavioral and psychodynamic–interpersonal interventions in the Sheffield II study (Shapiro et al., 1994). The results of this comparative process analysis revealed numerous differences between orientations. The findings for the psychody-

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namic–interpersonal interventions reflected therapists' exploration of clients' problematic interpersonal relationships, the way they misperceived things about others, and how this was part of a pattern in their lives. These therapists also focused on the historical origins of this pattern and how problems might be occurring within the session. In general, the focus was on what had not worked in the past. Cognitive–behavior therapists were more likely to focus on the future and what clients might do to function more effectively. Although there were these several differences between orientations, none emerged between what therapists judged to be high- and low-impact sessions.

These manual-based therapies clearly reflect a theoretically consistent therapeutic focus. The question remains, however, as to whether or not therapists' working within a more naturalistic setting would be so clearly differentiated. Our past research on master cognitive–behavior and psychodynamic–interpersonal therapists working in a naturalistic setting have revealed some theoretically consistent differences. For example, Wiser and Goldfried (1993) found that, although patients' emotional experience level was comparable across the two orientations in therapist-judged significant sessions, psychodynamic–interpersonal therapists viewed the most important portion of the session to be the one in which there was higher emotional levels. Cognitive–behavior therapists, on the other hand, believed the most important portion of the session was associated with a decrease in patients' emotional experiencing. We also found that, although the therapeutic alliance was high within each orientation, it was somewhat lower and more variable for the psychodynamic–interpersonal sessions, where strains in the therapist–client relationship were the focus of the session (Raue, Castonguay, & Goldfried, 1993).

One of the specific goals of the present study was to use the CSTF to determine whether cognitive–behavior and psychodynamic–interpersonal master therapists working within a naturalistic setting would be similar or different in their therapeutic focus. On the basis of our findings with the Sheffield II data set (Goldfried et al., 1997), as well as the results of our comparative analyses of clients' emotional experiencing and therapeutic alliance with these master therapist sessions (Raue et al., 1993; Wiser & Goldfried, 1993), one might predict that theoretically consistent differences would emerge. However, as found in the classic study by Fiedler (1950), clinically extensive experience may mask certain differences associated with theoretical orientations. Indeed, Schön (1983) has observed that master professionals in general (e.g., therapists, musicians, and athletes) working within naturalistic settings may not "follow the book." In considering these various factors, we have been reluctant to make specific predictions about what we might find in the present study; instead, we decided to frame this as an exploratory study, examining those same variables studied in the Sheffield II data set.

In line with Greenberg's (1986) recommendation that the mechanisms of therapeutic change are more likely to be revealed in the analysis of effective sessions, we were also interested in evaluating clinically significant sessions, which these master therapists believed to contribute to the therapeutic change process. Although the session as a whole was selected by therapists because of its significant nature, we were particularly interested in studying the specific portion of the session judged to be clinically significant. Thus, we additionally sought to explore whether the particular portion of the session that was deemed to be most significant differed from the less significant portion of the session.

Method

Participants

Therapists. A total of 36 master therapists participated in the study: 22 cognitive–behavior therapists and 14 psychodynamic–interpersonal therapists. These master therapists were identified by expert therapists, consisting of professionals who had written books on either cognitive–behavior therapy or psychodynamic–interpersonal therapy or had been actively involved in providing clinical training and supervision in psychoanalytic or cognitive–behavioral institutes and graduate programs in clinical psychology. Approximately 30 psychodynamic–interpersonal experts in the field and 30 expert cognitive–behavior therapists were asked to identify experienced practicing therapists from within their own particular orientation. Therapists, who had at least 5 years of postgraduate clinical experience, were those to whom these experts would refer a close friend or relative. Those therapists receiving two or more nominations from experts were then contacted and asked to participate in the study. As a check on the manipulation, master therapists were asked to rank order the theoretical orientation within which they worked, choosing from psychodynamic–interpersonal, cognitive–behavioral, experiential, and other. All therapists ranked their primary orientation as being consistent with how they were identified by the experts.

The average number of years of postdegree clinical experience for the 36 therapists participating in the study was 15.0 (SD = 8.4). For the 22 cognitive–behavior therapists, the mean years of experience was 12.6 (SD = 5.9); for the 14 psychodynamic–interpersonal therapists, it was 18.6 (SD = 10.4). The cognitive–behavior therapists consisted of the following individuals: Mary Bandura, David D. Burns, Dianne L. Chambless, Vernon T. Devine, Gary D. Emery, Allen Fay, Myles Genest, Steven B. Gordon, Ruth Greenberg, Norman J. Kanter, Arnold A. Lazarus, Bruce S. Liese, Peter O'Conner, Christine Padesky, Jacqueline B. Persons, Laura Primakoff, Lynn P. Rehm, Zindel Segal, Carolyn Shaffer, Janice Abrahms Spring, Geoffrey L. Thorpe, and Jesse H. Wright. The psychodynamic–interpersonal therapists were Jack C. Anchin, Bernard Apfelbaum, Lorna S. Benjamin, Jeffrey L. Binder, Simon H. Budman, Eduardo Bustamente, Stephen F. Butler, Robert C. Carson, Sheldon Cashdan, Hugh S. Davis, Jesse Geller, Hanna Levenson, Morris B. Parloff, and Thomas E. Schacht.

Clients. Inasmuch as each therapist submitted a session involving his or her work with a different client, there were a total of 36 clients in the present study; 22 were being seen by cognitive–behavior therapists and 14 by psychodynamic–interpersonal therapists. Therapy itself was conducted within a naturalistic setting, in the sense that no predetermined treatment manuals were followed. To be included in the study, clients needed to have presented with anxiety, depression, or both; to have had issues that were interpersonal in nature; and to be between the ages of 20 and 55 years. Clients were excluded from participating in the study if they were taking psychoactive medication, showed indications of psychotic or borderline features, or were being treated for particular situational life stresses (e.g., job loss or bereavement) or if the focus of therapy was on a specific delineated problem (e.g., simple phobia) for which there were clearly delineated therapy procedures (e.g., desensitization).

The average age for the entire sample was 34.5 years. Thirty-three of the 36 clients were Caucasian, 2 were African American, and 1 was Latino. Thirty-six percent of the sample had some college education, 32% completed college, and 32% had some graduate education. The average age for clients undergoing cognitive–behavior therapy was 33.0

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years (SD = 8.5). For clients being seen by psychodynamic–interpersonal therapists, the average age was 35.5 years (SD = 7.6).

Although it was not possible to obtain any reliable formal diagnosis in this naturalistic study, Symptom Checklist—90 (SCL–90) and Global Assessment of Functioning (GAF) scores were obtained for each participant once the significant session had been identified. For the cognitive–behavioral participants, 4 of whom were men and 18 women, the mean SCL–90 score was 79.5 (SD = 50.1); their GAF score was 65.4 (SD = 6.0). For the 8 male and 6 female clients in the psychodynamic–interpersonal group, the average SCL–90 score was 73.3 (SD = 49.8); their mean GAF score was 59.5 (SD = 10.1). Neither of these differences was statistically significant.

Session Selection

Once therapists agreed to participate in the study, they selected 1 or more clients who met both inclusion and exclusion criteria. After receiving the client's informed consent, therapists audiotaped sessions on a routine basis until they identified a significant session. The criteria for defining *significance* were threefold: (a) The session needed to focus on an interpersonal issue that was central to the client's clinical problems; (b) the therapist observed an in-session impact on the client (e.g., a shift in clients' emotional state, the emergence of important clinical material, or the acknowledgment by the client of the importance of the session); and (c) the therapist noted a change in the client, not due to external factors, within 1 or 2 weeks following this pivotal session.

Preliminary contact with the master therapists indicated that it would have been too intrusive to the course of therapy to involve the client in the selection of this session. Consequently, only the therapist determined which session would be submitted. The first three and last three sessions were excluded from consideration, so as to avoid issues dealing with either relationship formation or termination. As the session tapes were obtained during an ongoing course of therapy, no information was available about the length of treatment. However, the average session number selected by cognitive–behavior and psychodynamic–interpersonal therapists was the 22nd and 29th, respectively.

Along with the audiotape of the identified significant session, therapists completed a detailed questionnaire, describing the nature of the session and its impact and the criteria used for selection. They also specified the portion of the session that they believed to be particularly associated with the observed change in the client, indicating where this portion began and ended. Clients also completed a questionnaire describing what was helpful about the session, as well as the SCL–90 and the GAF.

Once the audiotape was transcribed, a copy of the questionnaire and transcript was returned to therapists for them to indicate more precisely where on the transcript the significant portion occurred. This was carried out so as to ensure that therapists would use their original criteria for identifying the significant portion of the session, rather than arriving at any decision on the basis of hindsight. As will be seen below, the length of significant and nonsignificant session portion were controlled for statistically when arriving at coding scores for each portion.

Instrument

The coding of therapeutic focus was carried out with the CSTF, which has been used in a number of other studies that attest to its discriminant and predictive validity (Castonguay et al., 1996; Goldfried et al., 1997; Goldsamt et al., 1992; Hayes et al., 1996). Using the CSTF, we scored transcriptions of therapist's utterances along the following five dimensions: (a) focus on components of the client's functioning (e.g., thoughts, feelings, and actions); (b) links or connection made by the therapist, either of an intrapersonal (e.g., connecting client's thoughts and feelings) or interpersonal nature (e.g., connecting client's actions to another person's actions); (c) general interventions, as when the therapist offers information or support; (d) the persons discussed (e.g., parent and spouse); and (e) the time frame of the therapeutic focus (e.g., past and future). A description of the coding categories within each of these sections of the CSTF may be found in Goldfried et al. (1997).

The coding makes use of transcriptions of sessions, and the unit of analysis is the therapist *turn*, which is everything said by the therapist following the client's utterance and preceding the next. Although the client's statement is not coded, it can be used to provide contextual information for coding the therapist turn. Each coding category is scored once per turn as being present or absent. Therapists' comments associated with scheduling and small talk (e.g., the weather) were not scored.

Coding of Sessions

In light of the multifaceted nature of the CSTF, three separate teams of coders were used. One team of four advanced graduate students in clinical psychology coded Components of client functioning, a second team of four coded both Intrapersonal and Interpersonal Links and General Interventions, and a third team of three coded both Persons Involved and Time Frame. Each coder team received between 60 and 90 hr of training by Patrick J. Raue, Louis G. Castonguay, or both. In addition to reading and discussing the CSTF manual, training involved coding session transcripts of cognitive–behavior and psychodynamic–interpersonal therapy that differed from those used in the present study. Coders met regularly during the training process to discuss possible discrepancies and to arrive at a common understanding of each coding category with which they would be working.

Each therapy transcript for the study was coded independently for Components of client functioning by three of the four coders in this team. All four coders met to discuss coding of each transcript and to achieve a consensus on the appropriate components for each therapist turn. This consensus was obtained so as to enable the second team of coders to code for Intrapersonal and Interpersonal Links between components. Each therapy session was coded independently for these Links and also for General Interventions by three of the four coders in this team. Lastly, sessions were coded independently for Persons Involved and for Time Frame by all three coders in this team. Each coder coded approximately the same number of sessions and was paired approximately the same number of times with each of the other coders in their team. Regular meetings were held for all coding teams during the coding process to prevent rater drift.

Scores for each coding category were obtained for the significant and nonsignificant portions of the sessions by summing the number of therapist turns per significant or nonsignificant portion that a given category was coded by a particular coder. Final scores were obtained by averaging these portion sums across the three coders. For example, if Coder 1 scored 26 emotions for the significant portion of a given therapy session, Coder 2 scored 24, and Coder 3 scored 28, the final score for that portion would be 26 emotions. To control for varying number of therapist turns between significant and nonsignificant portions and across sessions, we divided final scores in each coding category by the total number of turns within that session portion, yielding the percentage of turns each category was focused on by a particular therapist. Good intercoder agreement was obtained, with intraclass reliabilities averaging .89 (range = .56–.99).

Results

Table 1 presents the means and standard deviations for each coding category for the cognitive–behavioral and psychodynamic–interpersonal sessions, the significant and nonsignificant portions within each orientation, and the significant and nonsig-

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Table 1
Percentage of Therapist Turns for Each Coding System of Therapeutic Focus (CSTF) Category in Cognitive–Behavioral and Psychodynamic–Interpersonal Sessions

CSTF category	Cognitive–behavioral (CB) session						Psychodynamic–interpersonal (PI) session						CB and PI sessions			
	Entire session		Significant portion		Nonsignificant portion		Entire session		Significant portion		Nonsignificant portion		Significant portion		Nonsignificant portion	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Components																
Situation	1.4	2.2	1.2	2.2	3.8	5.6	1.1	1.6	1.7	3.0	0.9	2.4	1.4	2.5	2.7	4.8
Self-observation	3.6	5.6	4.8	8.6	2.0	3.1	2.0	4.0	3.2	6.4	0.5	1.4	4.2	7.8	1.4	2.6
Self-evaluation	12.6	11.4	16.3	17.5	6.6	7.0	6.0	5.8	6.5	6.9	4.7	6.0	12.5	15.0	5.9	6.6
Expectation	10.6	9.2	13.9	14.4	5.7	5.5	8.2	4.2	10.0	5.8	5.2	5.5	12.4	11.9	5.5	5.4
General thought	18.2	6.6	22.4	11.2	16.9	8.7	25.8	11.8	29.6	16.2	20.3	13.5	25.2	13.7	18.2	10.8
Intention	14.6	7.1	14.8	8.9	12.7	8.0	17.1	12.6	18.7	18.0	13.5	13.6	16.3	13.1	13.0	10.4
Emotion	18.0	10.2	17.8	11.0	16.5	11.7	19.7	9.3	25.0	10.7	16.9	14.2	20.6	11.3	16.7	12.5
Action	21.0	8.2	21.7	8.1	20.2	9.8	21.0	9.8	22.4	14.2	17.9	10.6	21.9	10.7	19.3	10.1
Unspecified	41.6	8.2	45.4	10.6	38.3	12.4	38.3	12.7	42.1	10.7	35.5	20.4	44.1	10.6	37.2	15.8
Intrapersonal links																
Similarity or pattern	3.0	2.4	3.8	4.5	2.4	2.4	1.9	1.9	3.4	4.5	2.1	2.9	3.6	4.5	2.3	2.6
Consequence	20.6	6.6	22.5	11.2	14.7	8.1	18.8	8.2	22.6	8.1	13.8	10.6	22.6	10.0	14.3	9.1
Interpersonal links																
Pattern	0.9	1.3	1.3	1.9	0.8	1.6	2.5	3.1	3.1	5.1	1.6	2.5	2.0	3.6	1.1	2.0
Compare or contrast	2.6	1.7	2.9	3.4	1.6	1.6	1.3	1.2	1.9	2.0	0.5	1.0	2.5	2.9	1.2	1.5
Consequence (self affecting other)	5.6	5.4	6.2	7.4	3.4	4.6	6.0	4.4	4.9	4.1	6.6	6.6	5.7	6.3	4.6	5.6
Consequence (other affecting self)	8.5	4.9	9.6	5.9	6.2	7.4	11.3	6.8	14.4	6.7	8.1	9.3	11.4	7.2	6.7	6.6
General interaction	17.9	8.8	19.1	11.9	13.4	9.4	21.5	10.6	22.1	10.3	18.3	14.8	20.3	11.2	15.3	11.8
General interventions																
Choice or decisions	1.1	1.7	1.4	3.0	1.5	2.8	1.8	3.4	1.6	2.7	1.7	4.8	1.4	2.8	1.6	3.7
Reality or unreality	18.3	12.6	24.7	22.4	7.5	6.4	10.4	7.7	12.4	11.1	7.1	7.0	19.9	19.6	7.4	6.6
Expected or imagined reaction of other	2.0	2.5	2.6	4.4	1.1	2.0	3.5	4.1	3.9	5.3	2.6	4.3	3.1	4.7	1.7	3.2
Instance-significant theme	0.6	0.6	0.7	0.9	0.4	0.7	3.2	3.5	4.5	5.2	1.4	2.7	2.3	3.7	0.8	1.8
Therapist support	1.8	2.2	2.0	3.2	1.3	1.4	1.0	1.1	1.1	1.9	0.7	1.2	1.6	2.7	1.1	1.3
Changes	1.4	2.2	1.5	2.7	0.9	1.8	2.7	5.6	3.1	7.7	2.0	5.3	2.1	5.2	1.3	3.6
Information giving	2.9	3.2	3.7	4.6	1.3	2.5	1.8	3.3	2.6	6.1	0.8	2.9	3.3	5.2	1.1	2.7
Between-session experiences	3.6	2.9	3.1	3.3	3.8	5.8	1.7	4.0	0.6	1.9	2.5	6.4	2.2	3.1	3.3	6.0
Self-disclosure	1.5	2.7	1.7	3.1	1.0	2.3	1.0	1.6	1.3	2.0	0.5	1.4	1.6	2.7	0.8	2.0
Avoidances	0.6	1.5	1.5	3.7	0.4	1.0	1.3	2.5	3.1	5.4	1.3	3.1	2.1	4.4	0.8	2.1
Persons involved																
Patient or client	77.5	8.6	81.0	9.7	73.4	12.2	76.5	14.4	83.9	11.2	69.0	27.3	82.1	10.3	71.7	19.3
Therapist	7.0	5.3	8.7	7.3	5.2	7.2	19.7	17.6	22.6	22.2	14.0	16.0	14.1	16.2	8.7	12.0
Parent	9.1	10.9	10.1	15.1	6.7	11.8	12.5	12.6	17.1	21.1	8.1	10.8	12.8	17.7	7.2	11.3
Mate	14.9	16.3	11.2	17.2	13.5	16.9	16.4	23.9	15.1	22.1	15.4	25.2	12.7	19.0	14.2	20.2
Acquaintances, strangers, or others	25.6	15.4	31.4	19.7	13.6	13.9	14.7	13.0	16.7	12.8	10.8	17.7	25.7	18.6	12.5	15.3
Person links	2.4	2.3	2.9	3.1	1.3	2.3	4.3	7.7	7.1	14.8	0.9	2.2	4.5	9.6	1.1	2.2
Time frame																
Preadult past	7.7	11.1	12.1	19.9	3.1	4.9	12.2	13.1	17.3	20.3	8.8	14.0	14.1	19.9	5.3	9.8
Adult past	3.7	3.6	4.1	5.7	2.1	3.8	3.3	5.9	3.3	3.5	2.9	8.5	4.4	5.1	2.7	6.4
Current	52.4	13.9	45.1	18.6	51.8	16.0	51.6	21.4	53.1	22.0	46.1	29.1	48.2	20.1	49.6	21.8
In session	7.9	9.0	11.2	13.0	9.5	16.7	8.9	7.3	13.6	11.7	5.6	6.4	12.1	12.4	7.9	13.6
Future	23.7	8.6	27.9	11.4	20.7	12.5	16.1	12.0	17.0	13.8	13.7	17.1	23.7	13.4	18.0	14.7
General	1.3	2.1	3.0	4.9	2.5	4.1	0.9	1.3	1.6	2.5	1.5	5.6	2.5	4.2	2.1	4.7
Irrelevant	3.0	2.1	4.7	4.0	4.4	5.9	1.9	3.5	5.2	10.2	1.3	2.6	4.9	6.9	3.2	5.1
Time links	0.8	1.0	1.1	1.6	0.4	1.1	1.1	1.6	1.7	3.0	0.3	0.7	1.3	2.3	0.3	1.0

nificant portions within both cognitive–behavior and psychodynamic–interpersonal sessions combined.

Given the fact that ratio scores were used, the distribution of percentage scores for each of the coding categories was normalized by means of arcsin transformations (Cohen, 1988). For the coding categories within each of the five sections of the CSTF, 2 × 2 analyses of variance (ANOVAs) were computed, in which therapeutic orientation (cognitive–behavioral vs. psychodynamic–interpersonal) was crossed with portion of session (significant vs. nonsignificant). In light of the exploratory nature of this study and the sample size, no Bonferroni correction was made and the significance level was set at .05 for all comparisons (cf. Kazdin, 1994).

Table 2 summarizes the ANOVA findings for each section of the CSTF. As can be seen from Table 2, no statistically significant main effects for therapeutic orientation were found for any of the analyses involving the Components of clients' functioning. Using eta squared to determine effect size, where .10 is small, .30 is medium, and .50 is large (Cohen, 1988), we found that the average effect size was .03. By contrast, several main

Table 2
Analysis of Variance of Therapy Orientation and Session Impact for Coding System of Therapeutic Focus (CSTF)

	Main effects of orientation		Main effects of session portion		Orientation × Session Portion interaction	
Section and CSTF category	$F(1, 34)$	p	$F(1, 34)$	p	$F(1, 34)$	p
Components						
Situation	1.41	.24	<1.00	—	6.17	.018
Self-observation	1.91	.20	9.81	.005	<1.00	—
Self-evaluation	3.13	.10	8.30	.009	1.35	.29
Expectation	<1.00	—	15.21	.001	<1.00	—
General thought	1.08	—	6.33	.018	<1.00	—
Intention	<1.00	—	2.36	.13	<1.00	—
Emotion	1.17	.29	8.98	.005	6.19	.018
Action	<1.00	—	1.62	.23	<1.00	—
Unspecified	1.50	.21	5.80	.024	<1.00	—
Intrapersonal links						
Similarity or pattern	<1.00	—	2.20	.15	<1.00	—
Consequence	<1.00	—	17.26	.001	<1.00	—
Interpersonal links						
Pattern	1.75	.19	2.94	.096	<1.00	—
Compare or contrast	5.76	.02	6.21	.018	<1.00	—
Consequence (self affecting other)	<1.00	—	<1.00	—	3.56	.068
Consequence (other affecting self)	1.50	.23	15.80	.001	3.31	.078
General interaction	<1.00	—	5.45	.026	<1.00	—
General interventions						
Choice or decisions	<1.00	—	<1.00	—	<1.00	—
Reality or unreality	2.14	.15	14.18	.001	2.82	.10
Expected or imagined reaction of other	1.40	.24	2.23	.15	<1.00	—
Instant-significant theme	8.40	.007	13.53	.001	4.57	.04
Therapist support	2.52	.12	<1.00	—	<1.00	—
Changes	<1.00	—	1.41	.24	<1.00	—
Information giving	2.52	.12	7.87	.008	<1.00	—
Between-session experiences	9.21	.005	<1.00	—	<1.00	—
Self-disclosure	<1.00	—	4.30	.046	<1.00	—
Avoidances	1.37	.25	6.37	.016	<1.00	—
Persons involved						
Patient or client	<1.00	—	9.81	.004	1.34	.25
Therapist	5.27	.028	8.81	.005	<1.00	—
Parent	<1.00	—	2.53	.12	<1.00	—
Mate	<1.00	—	<1.00	—	1.08	—
Acquaintances, strangers, or others	4.50	.04	21.17	.001	2.70	.11
Person links	<1.00	—	13.97	.001	2.05	.16
Time frame						
Preadult past	2.17	.15	5.80	.02	<1.00	—
Adult past	<1.00	—	5.91	.02	<1.00	—
Current	<1.00	—	<1.00	—	4.40	.04
In session	<1.00	—	21.52	.001	1.59	.22
Future	10.09	.003	3.96	.005	<1.00	—
General	2.12	.15	1.87	.18	<1.00	—
Irrelevant	3.43	.07	5.17	.03	<1.00	—
Time links	<1.00	—	6.96	.01	<1.00	—

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effect differences emerged for session portion, whereby therapists of both orientations placed more of a focus on clients' self-observations, self-evaluations, expectations, general thoughts, emotions, and unspecified aspects of their functioning during the clinically significant portion of the session. The average effect size for session portion was .15, with a range of .01 (situation) to .31 (expectation). Statistically significant Orientation × Session Portion interactions were found for situation and emotion, each of which had an effect size of .15. An analysis of simple effects indicated that the cognitive–behavior therapists placed less of a focus on situations in significant, as compared with nonsignificant, portions of the session ($p < .015$). At the same time, within the nonsignificant portions, the psychodynamic–interpersonal therapists were less likely than the cognitive–behavior therapists to emphasize situations ($p < .041$). The simple effects for emotion revealed that in significant portions of the sessions, the psychodynamic–interpersonal therapists were more likely to highlight the clients' emotion than they were during both the nonsignificant portions of their own sessions ($p < .001$) and the significant portions of the cognitive–behavior therapists' sessions ($p < .011$). The average effect size for all orientation by portion comparisons was quite small (.04).

For Intrapersonal and Interpersonal Links, only one of the seven comparisons yielded a statistically significant main effect for therapy orientation, whereby the cognitive–behavior therapists were more likely to compare or contrast clients' functioning with the functioning of others. The average effect size was .04. However, main effects for session portion revealed that in comparison with nonsignificant portions of sessions, therapists of both orientations were more likely during the significant portion to highlight the intrapersonal link that pointed to the consequence that one aspect of clients' functioning had on another, to compare and contrast clients' functioning to others, to point to the impact that others made on clients, and to deal with clients' interpersonal relations in general. The average effect size for session portion was .16, with a range of .06 (similarity or pattern) to .34 (intrapersonal consequence). No Orientation × Session Portion interactions were obtained.

For General Interventions, the only statistically significant main effects for orientation were obtained for two categories, whereby the cognitive–behavior therapists were more likely to encourage between-session experiences and the psychodynamic–interpersonal therapists were more likely to highlight instances of significant themes in clients' lives. The average effect size was .07. By contrast, five main effects were found for session portion, revealing that in significant portions of the session, therapists, regardless of orientation, were more likely to emphasize the difference between clients' realistic versus unrealistic view of things, to note instances of significant themes in clients' lives, to provide information, to self-disclose, and to point out ways clients may be avoiding making therapeutic progress. The average effect size for session portion was .11, with a range of .00 (therapist support) to .29 (reality vs. unreality). The only Orientation × Session Portion interaction found was for instance-significant theme, which was more likely to be highlighted in the significant psychodynamic–interpersonal than cognitive–behavioral portions of sessions ($p < .003$) and more likely to be within significant than nonsignificant psychodynamic–interpersonal portions ($p < .001$). The average effect size for all interactions was .02.

Two statistically significant main effects for Persons Involved were found for theoretical orientation, indicating that in comparison with the cognitive–behavior therapists, the psychodynamic–interpersonal therapists focused more on themselves and less on acquaintances, strangers, and other people in general. However, the average effect size was .05. Main effects for session portion revealed that therapists of both orientations were more likely to focus on patients; themselves; acquaintances, strangers, or other people in general; and links between the functioning of different people in clients' lives. For all portion comparisons, the average effect size was .20, with a range of .00 (mate) to .38 (acquaintances, strangers, or others). There were no statistically significant Orientation × Portion interactions; the average effect size was .04.

For Time Frame, only one of the eight ANOVAs for theoretical orientation reached statistical significance, with a main effect indicating that the cognitive–behavior therapists were more likely to focus on the future. The overall average effect size was .06. By contrast, six main effects were found for session portion, revealing that in comparison with nonsignificant portions, therapists of both orientations worked within a wide variety of different time frames, including preadult past, adult past, in session, and future, and with a therapeutic focus in which a time frame was not relevant. Moreover, they were also more likely to make links between different time periods in clients' lives during the significant portion of the session. The average effect size was .14, ranging from .00 (current) to .39 (in session). Although there was an Orientation × Session Portion interaction for the current time frame, no statistically significant simple effects were found. The average effect size for all interactions was .03.

Discussion

This study extended our previous comparative analysis of the therapeutic processes in cognitive–behavioral and psychodynamic–interpersonal interventions by studying what master therapists focus on in what they judge to be a clinically significant session. As a trade-off to the rigorous methodological controls associated with process studies of therapy sessions taken from clinical trials, the present study emphasized external validity, investigating therapy the way it is carried out in actual clinical practice.

A point to keep in mind in interpreting our findings is the particular nature of the presenting problem (anxiety, depression, or both), which was associated with an interpersonal issue in the client's life. Although these represent typical problems dealt with in clinical settings, our findings cannot be extrapolated to cases with more focal problems (e.g., obsessive–compulsive disorder or panic disorder), for which specific cognitive–behavioral interventions have been developed. Moreover, the difficulty in obtaining audiotapes from master therapists working within a naturalistic setting (e.g., private practice and clinics) constrained the number of therapists we were able to study, and the resulting limitations on statistical power must be kept in mind in interpreting our findings. (A power analysis revealed that we only had good power to detect large differences.) In spite of this, however, earlier studies by Raue et al. (1993) and Wiser

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and Goldfried (1993)—which had a somewhat smaller sample size—did find orientation differences on the therapeutic alliance and client emotional experiencing.

In contrast to the numerous differences found between orientations in our earlier study of Sheffield II comparing cognitive–behavioral and psychodynamic–interpersonal interventions (Goldfried et al., 1997), relatively few between-orientation differences emerged with our master therapist sample. In the present study, we found that cognitive–behavior therapists were more likely to compare or contrast the client's functioning with that of others; to encourage between-session experience; to focus on acquaintances, strangers, or other people in general; and to work in a future time frame. They were also more likely to deal with the client's external situation but only in the portion of the sessions judged to be clinically nonsignificant. By contrast, master psychodynamic–interpersonal therapists were more likely to focus on themselves and to highlight instances of more general themes in the client's life. During the significant portions of the session, they also placed more of an emphasis on the client's emotions.

Although these between-orientation differences are certainly consistent with the theoretical underpinnings of each orientation, the differences found in our earlier study of the Sheffield II data set reflected many more theoretical differences. In considering the differences between orientations, there were four theoretically consistent points of agreement between the present study and the Sheffield II study. In both, cognitive–behavior therapists were more likely to focus on the future and to encourage clients to engage in between-session experiences. In considering the finding that psychodynamic–interpersonal therapists focused more on clients' emotions during significant portions of the session than did cognitive–behavior therapists, the two studies are also consistent in the greater psychodynamic–interpersonal emphasis on emotion.

In contrast to the relatively few between-orientation differences found with the master therapists, numerous differences were obtained between those particular portions of the session they labeled as being *significant* and those they viewed as not significant. Regardless of theoretical orientation, the session portions judged to be clinically significant involved a greater focus on clients' ability to observe themselves in an objective way, their evaluation of their self-worth, their expectations about the future, their thoughts in general, their emotions, and aspects of their functioning that were not specified. More connections or links were made during the significant portion of the session, such as how one aspect of client functioning had an impact on another aspect of functioning, how clients' functioning compared with the functioning of others, the impact that others made on them, and how they generally interacted with others. Within the significant segment, therapists of both orientations were also more likely to encourage clients to view things more realistically; to highlight how a specific thought, feeling, intention, or action was part of a larger theme; to provide factual information; and to point to ways that clients might be interfering with therapeutic progress. In addition, therapists made more connections between the functioning of different people in clients' lives and referred more to themselves, the client, and others in general. Finally, significant portions of the session were more likely to include reference to clients' past, in-session functioning, the future, events in which time was not relevant, and links or connections between different times in their lives.

In comparing the present results with those obtained in the Sheffield II study, the differential findings regarding orientation and clinical significance are noteworthy. With the Sheffield II sample, 59% of the between-orientation comparisons resulted in significant differences and the average effect size was in the small to medium range; only 10% of the comparisons made between therapist-judged high- versus low-impact sessions proved to be statistically significant, and the average effect size was near zero. In the present study, the reverse was the case: Only 15% of the between-orientation comparisons were different and the average effect size was negligible, whereas 63% of the comparisons between clinically significant versus nonsignificant portions of the session yielded differences, with an average effect size in the small to medium range. The portions of the session judged by therapists to be clinically significant appeared to reflect a blending of both orientations, as in the finding that therapists were more likely to focus on themselves and make links between different times and different people in the client's life but were also more likely to provide factual information and to highlight what might be done in the future. That master therapists' interventions in this study were less pure theoretically than the manual-based treatment conducted within the context of a controlled clinical trial can be due to several different factors. Methodologically, the two studies differed in a number of ways: The size and nature of the therapist sample was different, the patient population was not necessarily equivalent, and the procedure for rating the clinical significance of sessions was not comparable. Nonetheless, our findings raise an intriguing but complicated question: How do we as psychologists define the "state of the art"? Is it by the treatment manuals included in clinical trials or is it by what master therapists, who have been nominated by those who wrote the manuals, actually do in clinical practice? This is clearly an issue in need of future research.

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Call for Nominations: *Emotion*

The premiere issue of **Emotion**, the newest journal from APA, will be published in 2001. The Publications and Communications (P&C) Board has opened nominations for the editorship for the period from September 1999 through December 2006.

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