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Article *in* Journal of Consulting and Clinical Psychology · November 1997

DOI: 10.1037//0022-006X.65.5.740 · Source: PubMed

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Journal of Consulting and Clinical Psychology
1997, Vol. 65, No. 5, 740-748

0022-006X/97/$3.00

A Comparative Analysis of the Therapeutic Focus in Cognitive–Behavioral and Psychodynamic–Interpersonal Sessions

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This study compared therapeutic foci in a sampling of 30 cognitive–behavioral and 27 psychodynamic–interpersonal manual-driven treatments for depression. High- and low-impact sessions were coded for each client, with the Coding System of Therapeutic Focus. Results indicated that psychodynamic–interpersonal sessions focused more on such variables as emotion, patterns, incongruities, the impact that others made on clients, clients' expected reaction of others, the tendency to avoid therapeutic progress, therapists themselves, clients' parents, and links between people and time periods in clients' lives. Cognitive–behavioral sessions placed greater emphasis on external circumstances and clients' ability to make decisions, gave more support and information and encouraged between-session experiences, and focused more on the future. Relatively few differences emerged as a function of session impact. Results are discussed in terms of the different and similar theoretical conceptions of the change process.

Despite the growing clinical interest in psychotherapy integration, there has been surprisingly little research to provide empirical underpinnings for this movement (Arnkoff & Glass, 1992; Castonguay & Goldfried, 1994; Goldfried, 1991; Stricker, 1994; Wolfe & Goldfried, 1988). Recognizing the need for empirical research, a National Institute of Mental Health (NIMH) Conference on Psychotherapy Integration provided some potential directions for future research. Among these was the suggestion that, before conducting controlled outcome research to compare integrated interventions with "pure form" treatments, "desegregation" process research is in order (Wolfe & Goldfried, 1988). With a clearer understanding of the change processes associated with different intervention procedures, steps could then be taken to determine the comparative effectiveness of those processes that are similar and unique to different orientations.

In the search for common processes or principles of change, it has been suggested (Goldfried, 1980) that such commonalities may be usefully construed as existing at a level of abstraction somewhere between the specific techniques associated with a given school of therapy and the more general theoretical explanation for the effectiveness of these techniques. The focus of the present study is on one such principle; namely, the use of therapeutic feedback to enhance patients' awareness.

That cognitive bias and selective inattention play a significant role in perpetuating psychological disorders is a conclusion that has been drawn by therapists of different orientations (e.g., Beck, Rush, Shaw, & Emery, 1979; Klerman, Weissman, Rounsaville, & Chevron, 1984; Strupp & Binder, 1984; Wexler & Rice, 1974). Indeed, the central importance of attention and awareness in psychological functioning in general was highlighted over a century ago by William James (1890), when he noted, "My experience is what I agree to attend to. Only those items which I notice shape my mind—without selective interest my experience is utter chaos" (p. 402). Within the clinical context, therapists may be viewed as providing feedback to help patients redeploy their attention to therapeutically relevant aspects of themselves and others, toward the goal of acquiring a new perspective on self and the world.

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This study was supported in part by Grant MH40196 from the National Institute of Mental Health. We thank Anne Rees for her untiring efforts in supervising the preparation of the transcriptions of the therapy sessions used in this study; Anna Samoilov and Cecily Osley for their work on data analysis; Michael Barkham, Gillian Hardy, Shirley Reynolds, and Mike Startup for their participation as therapists; Anne Rees and Leslie Morrison for assessment interviews; and Mary Lou Hughes and Jane Revill for administration of the Sheffield Clinic. We also acknowledge the helpful comments from Anna Samoilov on an earlier version of this article.

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A problem that has plagued theoreticians and researchers who have been interested in conducting comparative process analyses across orientations has been the use of different language systems—jargon—associated with a given school of thought. With a theoretically biased language system, it is difficult to ascertain whether the processes of change are similar or different across orientations. In accordance with the recommendations made by the NIMH's workshop on research in psychotherapy integration (Wolfe & Goldfried, 1988), we used a process coding system that made use of the vernacular, providing a language that is common to different therapeutic conditions.

The Coding System of Therapeutic Focus (CSTF; Goldfried, Newman, & Hayes, 1989) was developed to code five foci of the therapist's feedback: (a) the components of the clients' functioning (e.g., emotions, thoughts, actions); (b) links, in which connections are made either intrapersonally (e.g., between client's thoughts and feelings) or interpersonally (e.g., between the actions of another and the actions of the client); (c) general interventions (e.g., reality testing, information giving); (d) people involved (e.g., parent, therapist); and (e) the time frame of the therapeutic focus (e.g., adult past, future).

The CSTF has been used in a number of different research contexts (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Castonguay, Hayes, Goldfried, & DeRubeis, 1995; Goldsamt, Goldfried, Hayes, & Kerr, 1992; Hayes, Castonguay, & Goldfried, 1996; Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992). The study most closely related to the present investigation was a preliminary comparative analysis by Kerr et al. (1992) of the therapeutic focus in sessions with 14 patients who received eight sessions of cognitive–behavioral therapy and 13 patients treated with psychodynamic–interpersonal therapy in the Sheffield I study (Shapiro & Firth, 1987). The cognitive–behavioral intervention (called *prescriptive*) was based on the assumption that psychopathology is a result of intrapersonal issues (e.g., how thoughts influence emotions, ineffective functioning at work) and was concerned with teaching self-control skills, correcting maladaptive thoughts, and modifying the patient's behavior outside the session. By contrast, the focus of psychodynamic–interpersonal therapy (called *exploratory*), based on the assumption that problematic functioning results from conflicts between the individual and significant others, emphasized the use of the therapeutic relationship to explore and revise repeated ways of perceiving and relating to others. Consistent with theory, it was found that the psychodynamic–interpersonal interventions focused more on interpersonal than intrapersonal links. In contrast to theoretical expectation, however, cognitive–behavioral sessions showed a similar tendency toward focusing more on interpersonal than intrapersonal links. No between-group differences were found in the use of either an intrapersonal or interpersonal focus.

In the present study, we extend our previous work with the CSTF by comparing the foci of interventions in cognitive–behavioral and psychodynamic–interpersonal sessions from the Sheffield II study (Shapiro et al., 1994). Complementing the work of Elkin et al. (1989) on the treatment of depression, Shapiro and his colleagues conducted a large-scale comparative outcome study to investigate a number of parameters associated with treatment of depression (e.g., severity of depression, effectiveness of 8 vs. 16 sessions). Overall, their findings indicated that both treatment procedures were equally effective, regardless of depression severity. However, the 8-session interventions were found to be somewhat less effective than the 16-session condition, at least for clients presenting with relatively severe depression.

For purposes of our comparative process analysis, we restricted our investigation to only the longer term intervention condition, collapsing across severity of depression. Inasmuch as our earlier studies resulted in findings that were both consistent and contrary to theoretical expectations, we did not generate any specific hypotheses as to which CSTF categories would differentiate the therapeutic orientations. However, given the manualized nature of the intervention, we anticipated that, in being theoretically consistent, psychodynamic–interpersonal interventions would focus more on exploration and understanding, whereas cognitive–behavioral interventions would place a greater emphasis on helping clients to cope with difficult life situations (Messer, 1986). The goal of this study was to uncover more specifically how these two orientations are different and similar in their more particular therapeutic foci.

Rather than randomly selecting sessions for investigation, we followed Greenberg's (1986) suggestion that process research deal with particularly effective sessions. According to Greenberg, even though process research need not deal with the prediction of ultimate outcome, the effective ingredients associated with the process of change are more likely to be revealed if one samples therapeutically relevant sessions. Thus, in addition to comparing the therapeutic foci in these two approaches with the treatment of depression, another goal of the study was to compare high- and low-impact sessions within each orientation.

Method

As noted, the therapy sessions used in the present investigation were from Shapiro et al.'s (1994) study, which involved the random assignment of 60 depressed clients to a cognitive–behavioral treatment and 60 to psychodynamic–interpersonal treatment. Within each orientation, half of the clients were seen in 8 weekly sessions, and the remaining received 16 weekly sessions. The present analyses were based on only the 16-session conditions. Clients who were assigned to each therapy orientation were stratified according to high, medium, and low levels of depression, as defined by the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Further details regarding the nature of the design can be found in Shapiro et al. (1994).

Clients

Although the original intention was to include sessions from 30 clients from each of the two therapy orientations, sessions for 3 clients in the psychodynamic–interpersonal condition could not be analyzed because of either the inability to select high- and low-impact sessions or the unavailability of the audiotape for the designated session. Consequently, the final *N* consisted of sessions from 30 and 27 clients in the cognitive–behavioral and psychodynamic–interpersonal conditions, respectively.

All 57 clients included in the current study were diagnosed with major depressive disorder. The sample consisted of managerial, professional, and white-collar workers whose problems were adversely effecting their occupational functioning. Potential clients were initially screened on the basis of having BDI scores of 16 or above, and whose scores remained at that level following an intake assessment. Additional criteria for exclu-

sion involved the presence of a psychiatric disorder for more than two years, having received any form of psychosocial treatment during the previous five years, and any change in psychotropic medication during the previous 6-week period.

Diagnoses of major depressive disorder were based on the Present State Examination (PSE; Wing, Cooper, & Sartorius, 1974), and relevant items from the Diagnostic Interview Schedule (DIS; Eaton & Kessler, 1985). To be included in the study, clients had to have demonstrated a PSE Index of Definition of five or more during the 1-month period before the interview and to have met criteria for major depressive episode in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III;* American Psychiatric Association, 1987) within the prior 3 months. Of the 57 clients included in this study, 19% received a diagnosis of major depression alone, and the remaining 81% had additional diagnoses of panic disorder, generalized anxiety disorder, or both. All clients were Caucasian. In the cognitive–behavioral condition, 16 clients were female, and 14 were male. In the psychodynamic–interpersonal therapy, 15 clients were female, and 12 were male. The mean age in the cognitive–behavioral and psychodynamic–interpersonal therapies was 41 and 42, respectively. Clients in the two therapy conditions did not differ on the basis of any of these pretreatment variables. Further details regarding the selection procedure and more precise nature of the sample can be found in Shapiro et al. (1994).

Therapists

A total of five therapists (3 male, 2 female) conducted both the cognitive–behavioral and psychodynamic–interpersonal treatments. All therapists were clinical psychologists from the United Kingdom specifically trained in each of the two therapy orientations and completed at least four training cases in each orientation before conducting therapy with clients in the present study. A noteworthy feature of this design is that inasmuch as therapists were trained to deliver both treatments, the potential confounding between personal characteristics of therapist and treatment procedure was ruled out. Each therapist saw 6 clients in cognitive–behavioral therapy and 6 in psychodynamic–interpersonal therapy in the 16-session condition.

Therapy Procedures

Both the cognitive–behavioral and psychodynamic–interpersonal therapies were manual-based (Firth & Shapiro, 1985; Shapiro & Firth, 1985). The cognitive–behavioral intervention involved a combination of cognitive and behavior therapy and made use of procedures such as anxiety management, testing and correction of maladaptive beliefs, assertiveness training, time management, and various other cognitive–behavioral procedures. The psychodynamic–interpersonal therapy used both interpersonal and experiential methods and focused primarily on the use of the therapeutic relationship and transference as a means for dealing with depression-related interpersonal relationships. Adherence ratings revealed that therapists followed the procedures outlined in the respective treatments (Startup & Shapiro, 1993). Further details regarding the intervention procedures may be found in Shapiro et al. (1994).

Therapy Sessions

Within the course of therapy for each client, two therapy sessions were selected: one having the highest impact, and one having the lowest impact. In selecting the high- and low-impact sessions, we excluded the first and last three sessions to avoid a therapy focus directed toward initial evaluation and relationship formation and termination issues. The impact of the session was based on therapists' postsession ratings of helpfulness (Elliott, Barker, Caskey, & Pistrang, 1982), where 7 = greatly helpful and 1 = greatly hindering. Client ratings of helpfulness, although obtained after each session, were insufficiently variable for purposes of discrimination; most sessions were typically rated as helpful by clients.

For sessions to be selected as having a high versus a low impact within a course of therapy, there needed to be at least a 2-point difference between therapists' ratings after the session. We summed the therapist ratings from three relevant items on the Session Evaluation Questionnaire (SEQ; Stiles, 1980) and used them to decide on the high–low impact differential in those instances where there was only a 1-point difference in therapists' ratings of helpfulness. The three 7-point SEQ scales were Valuable-Worthless, Special-Ordinary, and Full-Empty. Client ratings were taken into consideration only when clients' rating of high and low helpfulness directly reversed those of the therapist. In such instances, an alternate high or low therapist-rated impact session was selected to avoid contradiction of the client rating.

Coding of Sessions

The CSTF (Goldfried, Newman, & Hayes, 1989) was used to code transcriptions of therapists' "turns" (i.e., therapists' statements after one client utterance and preceding the next). The clients' statements were used for contextual information but were not scored. Each coding category was scored once per turn as being present or absent. As indicated earlier, the CSTF is divided into separate sections: therapist focus on (a) Components of the client's functioning, (b) Intrapersonal and Interpersonal Links, (c) General Interventions, (d) Persons Involved, and (e) Time Frame. Table 1 presents a description of the coding categories included within each of these sections.

Each section of the CSTF was coded by a distinct group of coders, with the exception of the Persons Involved and Time Frames, which were coded by the same team. Coder teams received between 60 and 90 hr of training by Louis G. Castonguay or Adele M. Hayes, depending on the section of the code involved. Components, Intrapersonal and Interpersonal Links, and General Interventions were scored by advanced graduate-level students in clinical psychology. Because clinical experience is not required to code the fairly explicit and straightforward items included in the Persons Involved and Time Frame sections, advanced psychology undergraduate-level students and beginning graduate-level students in clinical psychology scored these sections. Each transcript was coded by two coders, drawn from the pool of five to six coders that constituted each separate team. Each coder, in their own respective team, coded approximately the same numbers of transcripts. Every coder was paired approximately the same number of times with every other coder, and the score for each therapy session was based on the average frequency of occurrence for the two coders. Weekly or biweekly meetings were held in all coding teams to prevent rater drift and provide corrective feedback when necessary.

We calculated interrater agreements using the formula of intraclass correlation recommended by Shrout and Fleiss (1979) when each transcript is coded by a different set of coders randomly selected from a larger pool of coders (i.e., Case 1). The rater reliability coefficients for all CSTF items included in the analyses are presented in Table 1. As can be seen from Table 1, the reliability was good for virtually all coding categories, reaching .60 or above. Given the theoretically relevant nature of certain coding categories and the somewhat exploratory nature of this study, three categories with marginal reliabilities (situation = .59, difference–incongruity = .59, and time links = .54) were included in the analyses.

Results

Inasmuch as our interest was in comparing the relative therapeutic focus within a session, the average frequencies of the two coders for each coding category were transformed into percentages, reflecting the proportion of turns within a session

Table 1
Descriptions and Coder Reliability for Categories in the Coding System of Therapeutic Focus (CSTF)

Code category	Description	Intraclass correlations
	Components	
Situation	Circumstances external to the patient/client that are relevant to understanding his or her functioning	.59
Self-observation	Thought reflecting patient's/client's objective perception of self	.64
Self-evaluation	Patient's/client's appraisal, judgment, estimation, of own worth or abilities	.68
Expectation	Thought reflecting patient's/client's anticipation about the future	.73
General thought	Patient's/client's thinking that is unspecified	.80
Intention	Patient's/client's future-oriented volition, such as wish, desire, motivation, or need	.82
Emotion	Patient's/client's feelings	.95
Action	Patient's/client's performance of specific behaviors	.71
Unspecified	Patient's/client's functioning where no specific component has been identified	.67
	Intrapersonal Links	
Similarity/pattern	Similarities or recurrences within the patient's/client's functioning	.80
Difference/incongruity	Divergences noted within the patient's/client's functioning	.59
Consequence	Therapist implies that a particular component or functioning is having an impact on another component	.83
	Interpersonal Links	
Pattern	Therapist highlights patient's/client's interpersonal functioning repeated over time, settings, or people	.62
Compare/contrast	Therapist compares or contrasts the patient's/client's functioning with that of another person	.73
Consequence (self affecting other)	Patient's/client's functioning has an impact on another person	.65
Consequence (other affecting self)	Another person's functioning has an impact on patient/client	.73
General interaction	An interchange between the patient/client and another that cannot be otherwise categorized	.78
	General Interventions	
Choice/decisions	Pointing to patient's/client's options, choices, or decisions	.65
Reality/unreality	Helping patient/client to step out of his or her subjective perception and view things more objectively	.69
Expected/imagined reaction of other	Patient's/client's subjective view of another person as it pertains to his or her interpersonal relationship	.66
Therapist support	Therapist gives reassurance regarding either specific or general aspects of patient's/client's functioning	.64
Changes	Therapist refers to patient's/client's change associated with treatment	.68
Information giving	Providing general facts and knowledge that have therapeutic implications for the patient/client	.82
Between-session experiences	Therapist encourages patient/client to act, think, or feel between sessions	.88
Avoidances	Therapist points to patient's/client's thoughts, feelings, or actions that interfere with progress	.76
	Persons Involved	
Patient/client	Focus is on the patient or client	.96
Therapist	Focus is on therapist	.98
Parent	Focus on patient's/client's parent	.98
Mate	Focus on patient's/client's current intimate relationship	.94
Acquaintance/strangers/others in general	Person involved in patient's/client's life that is not captured by any of the other person categories	.96
Person links	Therapist makes connection between functioning of people in patient's/client's life	.60
	Time Frame	
Preadult past	Infancy through high school	.98
Adult past	From high school to beginning of therapy	.86
Current	Since start of therapy	.70
In session	Within present session	.87
Future	After present session	.81
General	Spanning more than one time frame	.66
Irrelevant	Time frame unspecified or irrelevant	.98
Time links	Therapist notes similarity or difference between different times in patient's/client's life	.54

in which the therapist focused on a given CSTF category. We calculated percentages by dividing the frequencies of each category by the number of turns in each session. Table 2 presents the means and standard deviations on each code category for the cognitive–behavioral and psychodynamic–interpersonal groups as a whole, as well as for the high- and low-impact sessions.

Given that the distributions for percentage scores are typically skewed, the scores for each code category were normalized by means of arcsin transformations before statistical analyses. As our interest was in the differential use of categories in each of the separate sections of the CSTF within cognitive–behavioral and psychodynamic–interpersonal high- and low-impact sessions, we conducted 2 × 2 analyses of variance (ANOVAs)—crossing therapeutic orientation with session impact—on each code category within the five separate sections of the code: Components, Intrapersonal and Interpersonal Links, General Interventions, Persons Involved, and Time Frame. Differences were considered to be statistically significant if the probability level was equal to or less than .05.

The results for the ANOVAs computed on the therapeutic

Table 2
Mean Percentages (and Standard Deviations) of Therapist Turns for Each CSTF Category in Cognitive–Behavioral and Psychodynamic–Interpersonal Sessions

	Cognitive–behavioral (n = 30)						Psychodynamic–interpersonal (n = 27)					
	Total		High impact		Low impact		Total		High impact		Low impact	
Section and category	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Components												
Situation	8.3	3.5	8.4	5.4	8.3	4.3	6.7	4.2	5.4	5.5	7.9	5.5
Self-observation	2.1	1.7	2.5	3.0	1.8	1.3	2.1	1.6	2.1	2.1	2.1	1.9
Self-evaluation	3.4	2.9	3.7	4.1	3.1	2.7	5.5	3.8	6.1	5.6	4.8	4.2
Expectation	9.9	4.4	10.0	5.7	9.8	4.8	10.7	6.1	9.7	6.9	11.8	6.3
General thought	20.6	6.4	21.4	7.6	19.8	7.4	24.1	10.1	23.2	10.8	24.9	10.7
Intention	10.5	4.8	9.8	5.6	11.3	6.2	12.6	5.9	12.3	7.3	12.9	6.2
Emotion	11.8	5.6	12.5	6.9	11.1	6.3	25.6	10.6	27.5	11.8	23.7	11.3
Action	27.4	9.5	26.7	10.6	28.1	10.2	25.0	7.9	25.1	10.4	24.9	8.0
Unspecified	39.7	8.0	38.9	10.3	40.3	7.9	44.1	9.8	44.0	11.6	44.1	9.9
Intrapersonal Links												
Similarity/pattern	5.4	2.5	5.6	4.3	5.2	2.8	7.1	4.1	7.4	5.6	6.9	3.7
Difference/incongruity	3.0	1.4	2.9	2.0	3.0	2.4	5.9	3.2	6.1	4.5	5.6	3.2
Consequence	13.2	6.0	13.3	6.8	13.2	6.9	15.7	9.1	16.9	11.5	14.4	8.2
Interpersonal Links												
Pattern	2.2	1.7	2.2	2.4	2.3	2.2	4.7	3.1	5.2	3.9	4.3	3.5
Compare/contrast	1.8	1.5	1.6	1.4	2.1	2.0	3.0	2.7	3.2	3.5	2.8	2.8
Consequence (self affecting other)	2.9	2.3	2.4	1.8	3.5	3.6	4.2	2.7	4.4	3.4	4.1	3.2
Consequence (other affecting self)	5.1	3.5	4.5	3.6	5.7	5.2	8.2	4.2	8.9	5.8	7.5	4.6
General interaction	4.6	2.3	4.9	3.7	4.2	2.7	7.9	5.2	9.0	7.1	6.7	4.1
General Interventions												
Choice/decisions	3.1	2.8	3.2	3.6	2.9	3.5	1.4	1.7	1.7	2.9	1.1	1.3
Reality/unreality	3.7	2.6	3.0	2.7	4.4	4.9	4.3	3.6	3.4	3.4	5.2	5.5
Expected/imagined reaction of other	1.5	1.2	1.5	1.5	1.5	1.9	5.7	4.4	5.3	4.9	6.2	5.5
Therapist support	2.2	1.8	2.9	3.7	1.4	1.1	1.0	1.0	1.2	1.3	0.8	1.2
Changes	2.9	3.2	4.1	6.0	1.8	1.5	2.6	2.3	2.7	2.6	2.5	3.4
Information giving	2.4	1.9	2.7	2.5	2.1	2.3	1.4	1.8	1.7	2.2	1.0	2.1
Between-session experiences	7.0	5.9	6.3	8.9	7.6	6.3	0.6	0.9	0.5	1.0	.01	1.6
Avoidances	1.9	2.2	1.9	3.9	1.8	2.2	5.7	4.9	5.7	4.8	5.7	7.2
Persons Involved												
Patient/client	68.5	11.0	69.7	11.3	67.2	17.4	72.1	19.0	69.5	28.9	74.8	15.0
Therapist	2.2	3.2	2.4	2.8	2.0	4.8	8.0	7.9	9.2	11.0	6.7	8.9
Parent	2.2	5.5	2.2	4.3	2.2	7.5	8.4	7.0	10.9	12.9	5.9	8.1
Mate	4.5	4.1	4.1	4.7	5.0	5.4	5.9	6.2	6.4	7.4	5.5	6.5
Acquaintance/strangers/others	18.4	9.1	19.9	10.5	17.0	12.7	19.1	7.5	19.9	9.4	19.1	10.6
Person links	0.7	0.6	0.8	0.9	0.6	0.8	2.2	2.0	2.3	2.2	2.2	2.5
Time Frame												
Preadult past	1.1	3.1	1.8	5.5	0.3	0.9	10.2	12.4	15.7	27.6	4.8	11.8
Adult past	4.4	5.3	5.5	9.0	3.2	4.8	7.3	6.2	7.4	7.0	7.2	9.2
Current	42.3	10.2	42.1	13.4	42.5	14.0	45.2	16.2	40.5	23.2	49.8	16.7
In session	4.3	3.8	5.6	6.6	2.9	3.2	7.5	4.3	8.0	6.5	6.9	5.1
Future	31.5	8.9	29.6	10.1	33.5	12.1	17.9	10.6	16.1	14.7	19.6	10.5
General	17.0	6.1	18.2	7.7	15.8	9.3	26.6	10.2	26.4	15.6	26.8	10.4
Irrelevant	25.5	11.1	25.9	11.1	25.0	12.9	18.8	12.3	17.4	13.4	20.2	12.6
Time links	1.4	1.2	1.8	2.0	1.0	1.1	2.7	2.1	3.4	3.4	2.0	1.4

Note. CSTF = Coding System of Therapeutic Focus.

focus codes for all five sections of the CSTF are summarized in Table 3. Of the nine analyses carried out for specific components of the client's functioning, statistically significant main effects for treatment orientations were found for only two components: emotion and situation. Psychodynamic–interpersonal interventions placed twice as much emphasis on emotion as cognitive–behavioral interventions. Conversely, cognitive–behavioral sessions were more likely to focus on the external situational circumstances in the client's life. No significant differences were obtained for session impact or for interactions between orientation and impact.

With regard to the ANOVAs conducted on Intrapersonal and Interpersonal Links, five of the eight comparisons revealed significant main effects between therapy orientations. Specifically, psychodynamic–interpersonal sessions placed more of a therapeutic focus on similarities and patterns within clients' functioning, as well as differences or incongruities that may exist between aspects of their functioning. At the level of interpersonal links made, psychodynamic–interpersonal interventions also were more likely to highlight interpersonal patterns, focus on the impact that others made on clients, and deal in general with their interpersonal relations. No significant differences were

Table 3
Analysis of Variance of Therapy Orientation and Session Impact for the Coding System of Therapeutic Focus

	Main effects of orientation		Main effects of impact		Orientation × Impact	
Section and category	*F*	*p*	*F*	*p*	*F*	*p*
Components						
Situation	4.28	.05	<1	—	<1	—
Self-observation	<1	—	<1	—	<1	—
Self-evaluation	2.25	.14	<1	—	<1	—
Expectation	<1	—	3.34	.07	3.21	.08
General thought	1.35	.25	<1	—	1.02	.32
Intention	1.29	.26	3.35	.07	<1	—
Emotion	37.61	.001	3.79	.06	<1	—
Action	2.28	.14	<1	—	<1	—
Unspecified	2.75	.10	1.27	.27	<1	—
Intrapersonal Links						
Similarity/pattern	3.96	.05	<1	—	<1	—
Difference/incongruity	22.9	.001	<1	—	<1	—
Consequence	1.11	.30	<1	—	<1	—
Interpersonal Links						
Pattern	17.90	.001	<1	—	1.46	.23
Compare/contrast	2.08	.15	<1	—	<1	—
Consequence (self affecting other)	3.00	.09	<1	—	1.92	.17
Consequence (other affecting self)	11.40	.001	<1	—	2.93	.09
General interaction	10.90	.002	3.60	.06	<1	—
General Interventions						
Choice/decisions	12.51	.001	<1	—	<1	—
Reality/unreality	<1	—	<1	—	1.20	.29
Expected/imagined reaction of other	35.49	.001	<1	—	<1	—
Therapist support	13.85	.001	4.54	.05	<1	—
Changes	<1	—	3.73	.06	<1	—
Information giving	10.62	.002	3.51	.07	<1	—
Between-session experiences	74.87	.001	1.34	—	<1	—
Avoidances	23.36	.001	<1	—	<1	—
Persons Involved						
Patient/client	3.79	.06	1.03	.31	<1	—
Therapist	14.20	.001	<1	—	<1	—
Parent	9.11	.004	<1	—	<1	—
Mate	<1	—	<1	—	1.98	.17
Acquaintance/stranger/others	<1	—	1.11	.30	1.07	.30
Persons links	16.39	.001	<1	—	<1	—
Time Frame						
Preadult past	14.85	.001	4.65	.04	1.04	.31
Adult past	5.63	.021	3.74	.06	<1	—
Current	1.84	.18	<1	—	1.02	.32
In session	13.6	.001	3.88	.05	<1	—
Future	16.19	.001	1.42	.24	<1	—
General	20.00	.001	2.17	.15	<1	—
Irrelevant	4.24	.04	<1	—	3.10	.08
Time links	8.91	.004	6.66	.013	<1	—

Note. The degrees of freedom for all *F* tests are 1 and 55.

found between orientations with regard to highlighting how clients' functioning has consequences for another or the comparison between clients' functioning and that of someone else. No significant differences were found for session impact or for the interaction between orientation and impact.

Of the eight categories within the General Interventions section of the code, six were found to differentiate significantly between the two therapy orientations. In comparison with cognitive–behavioral interventions, psychodynamic–interpersonal sessions were more likely to highlight clients' subjective interpretation of another person's functioning and to note how clients might be behaving in such a way as to interfere with the process of therapy. By contrast, cognitive–behavioral sessions were more likely to refer to possible choices or decisions that clients might make in their life, to offer them support and reassurance, to provide them with therapeutically relevant information, and to encourage them to engage in between-session experiences.

No main effects were found between the therapy orientations with regard to the tendency to provide a more realistic contrast to clients' unrealistic view of things or to note any therapeutic changes that might have been made. A main effect was found for impact, whereby high-impact sessions were more likely to include the therapist's support and information than were low-impact sessions. No significant interactions were found between orientation and impact.

The findings that deal with the therapist's focus on different Persons Involved in the client's life revealed that three of the six comparisons had significant main effects between therapy orientations. Compared with cognitive–behavioral sessions, psychodynamic–interpersonal interventions were more likely to place a focus on the therapist and on the client's parent and were more likely to draw parallels or similarities between different individuals in the client's life. There were no significant differences with regard to the therapist's focus on clients, their partners, or other people in general. A significant main effect was found for session impact, whereby low-impact sessions were less likely to involve a focus on the client. There were no significant interactions between orientation and impact.

For Time Frame, six of the eight comparisons resulted in significant main effects between orientations. ANOVAs revealed that psychodynamic–interpersonal interventions were more likely to focus on preadult past, adult past, what was occurring within session, and events that generally tended to cover more than one time frame; they were also more likely to make specific links between clients' functioning at one point in life and their functioning at another point. In contrast to psychodynamic–interpersonal sessions, cognitive–behavioral interventions were more likely to focus on future events and to highlight material in which the time frame was irrelevant or unimportant. The analyses also revealed significant main effects for therapy impact, in that there was a greater likelihood to focus on what was occurring within the session and to make links between time periods in high-impact sessions, regardless of therapy orientation. No difference between orientations was found for current time frame, and no interactions were obtained between orientation and session impact.

Discussion

Using the CSTF as a common metric for a process analysis of cognitive–behavioral therapy and psychodynamic–interpersonal therapy, we found that a number of findings emerged. Psychodynamic–interpersonal interventions were found to focus more on emotion, intrapersonal patterns, and discrepancies–incongruities within clients' functioning. They were also more likely to highlight interpersonal patterns in clients' lives, the impact that others made on them, their expectation of how others would react to them, their general interpersonal interactions, and what they were doing that interfered with the process of therapy. Finally, therapists in the psychodynamic–interpersonal condition placed more of an emphasis on themselves and clients' parents; a time frame that dealt with clients' childhood, adult past, events within the session itself, what occurred across different periods in the client's life, as well as parallels among people in the client's life and continuities or discontinuities over time. By contrast, cognitive–behavioral sessions placed more emphasis on external circumstances in clients' lives and their ability to choose and make decisions, and they offered more support, information, and the encouragement to engage in between-session experiences. They also focused more on future events and provided interventions in which no particular time frame was relevant.

In the most general sense, psychodynamic–interpersonal therapy underscored the importance of "insight," whereas cognitive–behavioral therapy emphasized the importance of "action" (Messer, 1986; Wachtel, 1987). The therapeutic focus within psychodynamic–interpersonal sessions was on *what has not worked in the past.* These interventions attempted to provide clients with a better understanding about the nature of their difficulties, particularly those of an interpersonal nature. The effect that others have on clients and the particular ways they may misperceive or distort things about others was presented as being part of a larger theme in their life. Where this pattern comes from, and how it manifests itself within the session and across the lifetime of clients, especially in their relationship with parents, was salient. All this occurred within an emotional context, in which therapists pointed out to clients some of the difficulties that they may have with these issues.

By contrast, cognitive–behavioral interventions focused on what clients could do to *deal more effectively with events in the future,* particularly how they may cope with problematic, external, environmental circumstances. To help clients better deal with such circumstances, cognitive–behavioral sessions, made use of a psychoeducational approach, imparting knowledge that might enhance clients' ability to cope. The focus was more on the future, particularly what may be done between sessions to facilitate competent functioning. These findings are consistent with our past process analyses and those of others that have found an exploratory and interpersonal emphasis in psychodynamic sessions, compared with the more prescriptive focus in cognitive–behavioral interventions (Goldsamt et al., 1992; Kerr et al., 1992; Stiles, Shapiro, & Firth-Cozens, 1989).

Another finding in the present study was the tendency for psychodynamic–interpersonal interventions to be "richer," in the sense that more categories were used within each therapy session than in cognitive–behavioral sessions. In contrast to 7 coding categories on which there was a significantly greater focus within cognitive–behavior therapy, there were 16 categories on which psychodynamic–interpersonal therapy placed a greater focus. Although this may reflect the possibility that psy-

chodynamic–interpersonal therapy went beyond symptom reduction, the two therapies did not differ in enhancing social functioning and self-esteem (Shapiro et al., 1994). Thus, it cannot be concluded that an intervention with a broader focus is necessarily a therapeutically more effective one.

There were certain aspects of the therapeutic focus in which the two orientations did not differ. Whereas certain sections of the code resulted in several differences (e.g., Time Frame), others (e.g., Components) revealed few differences. There was a comparable focus on self-observation (i.e., encouraging clients to be more objective observers of themselves), self-evaluation, expectations, thoughts in general, intentions, and actions. An Intrapersonal Link that failed to differentiate the two therapies occurred when the therapist highlighted how one aspect of the client's functioning was the cause of another (e.g., thoughts influencing emotions, emotions influencing action). With regard to Interpersonal Links, no difference was found in therapists' comparison of clients' functioning with that of others, or in comparing the impact that clients were having on others. General Interventions that did not differentiate the two orientations were therapists' attempts to help clients update their perception of events in light of reality and to note changes that had been occurring in clients. They were also similar in the amount that they focused on clients and their partners and in their emphasis on what was occurring in clients' current life situation.

It is possible that some differences failed to emerge as a result of insufficient statistical power, a methodological constraint not easily overcome in the process analysis of archival data. In addition, we cannot conclude that the content and function of the therapeutic focus are comparable, even if there is comparability in the coding category. Thus, it is possible that, although both orientations focused on clients' actions in approximately 25% of the turns, the content of the behavior may have differed (e.g., psychodynamic–interpersonal sessions focusing more on interpersonal behavior). Moreover, the function of an intervention may differ even if the frequency of its use does not. For example, findings from an earlier study revealed that the function of correcting clients' perceptions in light of reality was different in these two orientations. Whereas cognitive–behavioral interventions were conveying the message "things are not as bad as you think," psychodynamic–interpersonal interventions were attempting to have clients recognize that "things are not as good as you think" (Castonguay et al., 1990). Still, the possibility that the findings of the present study reflect points of convergence between the two orientations cannot be dismissed.

A second goal of the study was to explore whether there would be differences in therapeutic focus between high- and low-impact sessions. In contrast to 59% of the differences between orientations that were statistically significant, only 10% of the differences were found to be significant for session impact, slightly above what one may expect to find by chance. In addition, there were no significant interactions between therapy orientations and session impact. The fact that the therapy was manual-based and implemented by therapists experienced with the procedures may have resulted in greater consistency from session to session. On the basis of an informal content analysis, the high-impact sessions appeared to be those in which the therapist worked within the orientation's framework and in which the client responded accordingly. In low-impact sessions, the therapist attempted to work within the therapeutic mode, but clients were unable to do so because of resistance or noncompliance because they attempted to pursue the other intervention (e.g., a cognitive–behavioral client who wanted to focus on the past), or because the focus was on realistic life events that did not readily lend themselves to either exploration or coping (e.g., losing a job).

In interpreting these findings, one must keep in mind that these were manual-driven interventions implemented in a controlled outcome study, and it is an open question whether different results would be obtained in the study of nonmanualized interventions within a naturalistic setting. Given the fact that an increasing number of clinicians have reported that they use procedures from other orientations because they find it more clinically helpful (Norcross & Goldfried, 1992; Stricker & Gold, 1993), it is possible that fewer differences would be found between the two orientations. In the final analysis, whether a therapy as practiced is "pure" or "integrated," the question of effectiveness needs to be determined independently, in the relationship of these interventions to ultimate outcome.

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Received September 4, 1996
Revision received December 11, 1996
Accepted March 3, 1997 ■