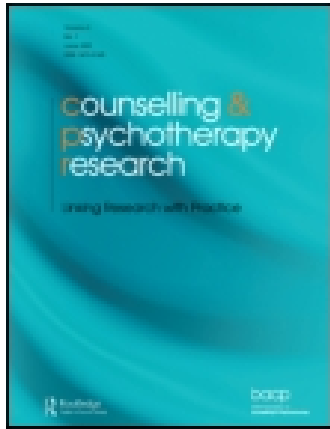


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Therapist orientation, supervisor match, and therapeutic interventions: Implications for session quality in a psychotherapy training PRN

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Abstract

Background: Theoretical orientation is a multifaceted construct that is integral to the process of psychotherapy and psychotherapy training. While some research has been conducted on personal identification with particular schools of psychotherapy, techniques used in psychotherapy sessions, and match between trainees and supervisors in training, there is insufficient information regarding how these may interact with one another. *Aim:* This study, conducted in a practice research network of trainee therapists, was designed to test whether these variables may be related to one another in predicting session quality. *Method:* The sample comprised 328 sessions from 26 clients and 11 therapists, with the clients completing session quality measures and therapists completing measures of technique immediately post-session. *Results:* Using multilevel linear modelling, the data showed varied results. For behavioural therapy and person-centred therapy, techniques and orientation were unrelated to session quality in the sample. However, process-experiential, psychodynamic, and cognitive therapy techniques were all involved in interactions with therapist and/or supervisor orientations. *Conclusions:* These results suggest that the impact of specific psychotherapy techniques sometimes depends on the orientation of the therapist and/or supervisor. For instance, sessions high in cognitive therapy techniques were only associated with positive outcome when both the therapist and supervisor were highly cognitively oriented. Though preliminary, these results suggest that orientation may be an important variable to consider in training and supervision, especially in the context of other variables.

Keywords: psychotherapy; psychotherapy supervision; psychotherapy orientation; practice research network

Introduction

Despite providing the foundations of professional practice, training has not been a central focus of research in psychotherapy. In fact, the paucity of research on training has recently led the Society for Psychotherapy Research to create a special interest group aimed at fostering empirical investigations on the process and outcome of therapists' training and development (Orlinsky, Strauss, Hill, Carlsson, & Castonguay, 2012). In addition to addressing a significant gap in the empirical knowledge, investigations in training process may hopefully provide helpful information to instructors, supervisors, and clinicians themselves about how to optimally develop therapeutic skills.

Arguably, few issues are more central to psychotherapy training than the development of trainees'

theoretical orientation. We propose that there are three principle features of theoretical orientation development. The first is the trainee therapist's own personal theoretical orientation: the degree to which a therapist identifies himself or herself with models and techniques associated with particular schools of psychotherapy (e.g. 'I'm mostly a cognitive-behavioural therapist'). A second is in the interventions that a trainee actually uses in therapy, irrespective of a therapist's personal allegiance. As discussed below, this is not always consistent with one's orientation. And finally, theoretical orientation is influenced and manifests during training through the theoretical orientation and expertise of clinical supervisors. That is, trainees mostly develop in their theoretical understanding of psychotherapy through the structured training provided by supervisors, who are informed by their own theoretical orientation.

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While therapist personal orientation has received considerable attention, previous research has not consistently found it to have a meaningful and direct effect on treatment outcome (Beutler et al., 2004). For instance, Okiishi, Lambert, Eggett, Nielsen, and Dayton (2006) found no significant relationship between therapists' primary theoretical orientation and outcome as measured by the Outcome Questionnaire-45. Stiles and colleagues (Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006) found no meaningful differences in outcome between three primary orientations, and little difference when accounting for whether a therapy was 'pure' or integrated with another form of therapy.

The relationship between specific techniques and outcome is also far from clear. While a number of studies have found a positive association between some particular psychodynamic, cognitive-behavioural and humanistic interventions and outcome (see Castonguay, 2013), a recent meta-analysis found that therapist levels of adherence and competence to prescribed techniques have little impact on client improvement during treatment (Webb, DeRubeis, & Barber, 2010).

With some important exceptions (e.g. Hilsenroth, Defife, Blagys, & Ackerman, 2006; Henry, Strupp, Butler, Schacht, & Binder, 1993), the research on orientation-specific supervision has often been limited to surveys, retrospective methods, and studies of trainees' perceptions rather than client outcomes (Holloway & Neufeldt, 1995). Hilsenroth et al. (2006), using a prospective study design, found that psychodynamic-interpersonal technique use by graduate clinicians increased with specific psychodynamic training, and Henry et al. (1993) found that manualised training had widespread effects on psychotherapy variables apart from adherence. In a meta-analysis, Stein and Lambert (1995) found that increased training at the graduate student level was associated with consistent but modest effect sizes in some outcomes such as client satisfaction. These authors did note a lack of research specifically demonstrating a relationship between graduate training and enhanced therapy outcomes. Echoing this, Miller and Binder (2002) found that there is little direct evidence of an improvement in client outcomes due to routine supervision and clinical training.

In summary, though therapeutic techniques, orientation, and supervision have been studied to varying degrees, it is not clear what their effects are on therapy outcomes. A major gap in the literature is

the relationship between these variables and how they may interact with one another to predict outcomes. In other words, is there any impact from match or mismatch of these variables on therapy outcomes?

The dearth of such studies is likely due to the fact that they require several treatments and therapists, which are difficult to obtain in traditional randomised controlled trials. In contrast, practice research networks (PRNs) provide an infrastructure that is well suited for this type of complex investigation (Castonguay, Barkham, Lutz, & McAleavey, 2013). PRNs are collaborative organisations of researchers and practitioners that encourage communication in both directions. Clinicians are often involved in designing and carrying out research studies, such that their everyday practice generates research data. With the cooperation of several psychotherapists, data can be collected on multiple clients and supervisors. Reflecting a balance of scientific rigour and clinical sensitivity, such data collection can take place in the context of a prospective observational design without disrupting the natural progress of training and treatment. This study was such a PRN study, conducted with the collaboration of several psychotherapists in training and associated colleagues.

Boswell, Castonguay, and Wasserman (2010) recently investigated a number of training variables within the context of this training PRN. The results showed that techniques are related to session outcome in complex ways. For example, sessions higher in CBT techniques were rated as especially helpful only for some clients of some therapists. In addition, CBT techniques were likely to be associated with relatively unhelpful sessions under two conditions: (1) when implemented by therapists who typically used high levels of common factor-related techniques, and (2) when the clients of these therapists were receiving especially high levels of common factor techniques (compared to their other clients even within the high-common-factor therapists' caseload). Contrary to their predictions, the authors also found that therapists' personal orientation and practicum orientation were not significantly related to technique use. However, these authors did not investigate the interaction between these two potential predictors, nor the potential moderating effect that they may have in predicting helpfulness of different techniques.

In an attempt to expand on the Boswell et al. (2010) investigation, the present study examined the relationships between three facets of theoretical

orientation during training – techniques used, personal orientation and supervisor orientation – and how these relationships affect psychotherapy session outcome. We made three predictions. First, techniques that are more consistent with a therapist's personal orientation will be perceived to be more helpful by clients than techniques that are less consistent with the therapist's orientation. Second, techniques consistent with the supervisor's orientation will be associated with helpfulness. And third, therapist-supervisor orientation match will matter. That is, the extent to which a therapist and supervisor match in their personal orientation will be related to the helpfulness of those techniques.

Method

Recruitment to the study

Therapists were recruited from the Clinical Psychology PhD programme at a large American university. Eligible therapists had to be actively conducting supervised adult psychotherapy during the 2010–11 academic year. Of the total 20 eligible trainee therapists identified, 17 were recruited to the study. One therapist joined the study but did not successfully recruit any client participants, leaving a total sample of 16 trainee psychotherapists.

Participants

Therapists. Therapists ranged from 24–34 years old ($M = 27.5$; $SD = 2.83$), and eight therapists were female. The majority of the therapists (13) identified as White/Caucasian, one self-identified as Black/African-American, and two as multi-racial. In this training programme, typical of American PhD programmes, students conduct supervised psychotherapy beginning in the summer after their first year. Therapists in this study ranged from less than one year to six years of psychotherapy experience, with a mean of 2.7 years and SD of 1.54. The number of face-to-face clinical hours ranged from 40–1500, with a mean of 469 hours and SD of 415.8.

Clients. Clients were recruited from the adult clientele of the same community mental health centre by their treatment therapists, following Institutional Review Board-approved procedures. In order to minimise interference with the operations of the clinic and the training of the therapists, therapists were allowed to select the total number of clients on their caseload they would be willing to recruit, prior to their beginning participation in the study. For

therapists who elected to recruit fewer clients than their full caseload, we randomised which of their clients would be recruited in order to minimise sampling bias.

A total of 31 clients were recruited to the study. The client sample was highly comorbid, with an average of 2.7 diagnoses given per client. Of these, 28 clients had been given a diagnosis on Axis I and 25 had been given a diagnosis on Axis II. The most common types of Axis I disorders were mood disorders (20 clients) and anxiety disorders (17 clients), and the most common diagnosis on Axis II was Borderline Personality Disorder (11 clients). Clients were recruited by therapists on an ongoing basis, and could begin participation in this study at any point in their treatment course.

Measures

Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009). The MULTI is a 60-item inventory of therapist behaviours. Each item on the MULTI describes a therapist behaviour that may or may not have occurred in a given psychotherapy session (e.g. 'I focused on the ways my client copes with his/her problems') and provides a five-point Likert-type scale, description-anchored at 1: *Not at all typical of the session*; 2: *Slightly typical of the session*; 3: *Somewhat typical of the session*; 4: *Typical of the session*; and 5: *Very typical of the session*. The MULTI has eight subscales, each representing one of eight orientations of psychotherapy. The subscales have been found to adequately represent each theory based on face, content and criterion validities (McCarthy & Barber, 2009). The subscales are Cognitive Therapy (CT), Behavioural Therapy (BT), Dialectical Behavioural Therapy (DBT), Psychodynamic Therapy, Process-Experiential Therapy, Person-Centred Therapy, Interpersonal Therapy (IPT) and Common Factors.

Session Progress Scale (SPS; Kolden, 1996). The SPS comprises four items rated on a Likert-type scale that form a single rating of session quality, sometimes called session helpfulness. As one example, the first item is 'How helpful was the session just completed?' The present study only used the patient-rated version. Kolden et al. (2000) found that therapists' ratings of session quality did not relate to client-reported session impacts, leading them to suggest that session impacts may best be assessed by clients. The four items of the SPS have been found to assess a single factor of psychotherapy

session helpfulness/impact. Kolden (1991) reported internal consistency of the SPS at .85. The SPS is scored with lower values indicating better session quality.

Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky et al., 1991). The DPCCQ is an instrument assessing numerous psychotherapy training and experience variables. Following Boswell et al. (2010), in the current study we used only a subset of items from its Professional Characteristics section. Specifically we used six items that ask therapists to rate, on a five-point Likert scale, their own orientation across the following types of therapy: analytic/psychodynamic, cognitive, behavioural, humanistic, systems and eclectic/integrative. These ratings (one for each orientation) served as the primary measure of therapist orientation. In addition, we altered the DPCCQ question wording slightly to ask therapists to rate their supervisor's orientation on the same six variables. These ratings served as the primary measure of supervisor orientation.

Treatment

Following a routine diagnostic intake, clients are assigned to treatment therapists based on treatment need and availability. All treatment provided in the clinic is outpatient, and is typically once- or twice-weekly. There are no session limits for psychotherapy, and most clients in the clinic receive some form of government-subsidised healthcare assistance. Many clients in this clinic have long-term outpatient treatments, not limited to psychotherapy, lasting one year or longer.

Procedure

Once therapists were consented into the study, they completed some basic information about their training history and clinical experience, along with the DPCCQ questions regarding their and their supervisors' orientation. Following this, each therapist recruited clients into the study, acting as a researcher in this regard. Once a client consented, the therapist completed a brief questionnaire about that client's treatment and history. After each session during the data collection period, therapists completed the MULTI and clients completed the SPS. This sample was also used in a separate study regarding techniques and insight (McAleavey & Castonguay, 2014). Though the data partially overlap, the DPCCQ,

SPS, and therapeutic orientation ratings were not published in that study.

Analyses

Because the data were not independent random observations, as each session takes place in the context of other sessions of a particular client and a particular therapist, we used multilevel linear models (MLM) and mixed effects modelling. MLM is preferable when data are nested in this way (Raudenbush & Bryk, 2002). In order to be able to discriminate between client and therapist contributions, therapists who successfully recruited only one client were removed from the sample prior to analysis. The final sample comprised 11 therapists and 26 clients, with a combined total of 328 separate sessions (average 12.6 sessions per client).

Accounting for the nesting of clients in this data appeared to be necessary. Preliminary analyses showed that clients differed substantially in the average session quality they reported. The intraclass correlation was 0.583, indicating that 58.3% of the variance in SPS total score existed at the client level (i.e. some clients rated sessions as being higher or lower quality on average, compared to other clients). However, we could not directly estimate the effect of therapists on session quality, most likely due to either a very small effect of nesting at the level of therapists, or too few observations of clients within therapists, both of which may cause estimation problems.¹

All analyses were conducted in SAS using the MIXED procedure (SAS Institute, 2011). We conducted five series of models, each with the same dependent variable: SPS total score, an overall rating of session quality. Because interactions between predictors were of primary interest, we used a backwards elimination method, starting with all possible interactions and main effects between session-level technique use, therapist orientation, and supervisor orientation. Only the final model is presented, but non-significant effects can be interpreted as null effects.

Results

Descriptive statistics for all variables in this study are presented in Table I. Overall, the most common techniques reported in sessions were person-centred therapy techniques, and the least common were BT techniques. The therapists rated themselves as

Table I. Sample means and standard deviations.

Type of variable	Variable	Mean	SD
<i>MULTI subscales</i>			
	Process-Experiential techniques	2.55	0.76
	Psychodynamic techniques	2.60	0.76
	Person-Centred techniques	2.92	0.84
	Behaviour Therapy (BT)	2.16	0.65
	Cognitive Therapy (CT)	2.48	0.81
<i>Therapist orientation ratings</i>			
	Cognitive	3.90	0.74
	Behavioural	2.92	1.46
	Analytic/Psychodynamic	3.38	1.14
	Humanistic	2.47	0.93
<i>Supervisor orientation ratings</i>			
	Cognitive	1.70	1.72
	Behavioural	1.59	1.53
	Analytic/Psychodynamic	3.89	1.81
	Humanistic	1.04	1.80
<i>Session quality ratings</i>			
	SPS	2.52	1.10

considerably more cognitively oriented than their supervisors. Paired-samples t-tests showed that this was significant, $t(10) = 3.39$, $p = .007$. There was also a significant difference for humanistic orientation, $t(10) = 2.22$, $p = .05$; and again, therapists rated themselves as more highly humanistic than their supervisors. The differences between therapists and supervisors on Analytic/Psychodynamic and Behavioural orientations were not statistically significant.

All fixed-effects results of the MLM analyses are found in Table II. The analyses for person-centred

therapy and BT techniques revealed no significant relationships between these techniques, orientation, supervisor orientation, or any of the interactions in predicting client-rated session quality. That is, neither person-centred nor BT techniques, therapist orientation, or supervisor orientation predicted session quality in any meaningful way – they were unrelated to session helpfulness.

There was a significant two-way interaction ($p = .05$) between session-level psychodynamic therapy technique use and supervisor psychodynamic orientation. This interaction is plotted in Figure 1. Generally, it shows that higher than usual psychodynamic therapy technique use in sessions was associated with less helpful sessions particularly when the supervisor was highly psychodynamic-oriented. For supervisors who were less psychodynamic-oriented than other supervisors, session-level psychodynamic therapy techniques were less predictive of session quality.

For process-experiential therapy techniques, there was also a significant ($p = .03$) two-way interaction with therapist orientation. Interestingly, as can be seen in Figure 2, the effect was similar to that for the psychodynamic therapy interaction: more session-level process-experiential therapy techniques were associated with worse quality sessions, but only for therapists who were highly humanistic. For therapists who were less humanistic than average, there was no meaningful relationship between process-experiential therapy technique use and session quality.

Finally, a significant three-way interaction was found between session-level CT technique use,

Table II. Final fixed-effect models predicting session quality.

Technique group	Fixed effect	Type III (F) test	p
Person-centred	<i>No significant effects</i>		
Behavioural	<i>No significant effects</i>		
Psychodynamic	a. Session-level psychodynamic therapy technique use	F (1, 304) = 0.78	0.38
	b. Supervisor psychodynamic orientation rating	F (1, 26.2) = 1.16	0.29
	Interaction: a × b	F (1, 304) = 3.74	0.05
Process-experiential	a. Session-level process-experiential therapy technique use	F (1, 303) = 1.29	0.26
	b. Therapist Humanistic orientation rating	F (1, 27) = 0.18	0.67
	Interaction: a × b	F (1, 303) = 5.01	0.03
Cognitive	a. Session-level CT technique use	F (1, 303) = 1.93	0.17
	b. Therapist Cognitive orientation rating	F (1, 25.5) = 0.13	0.72
	c. Supervisor Cognitive orientation rating	F (1, 26.3) = 0.17	0.68
	Interaction: a × b	F (1, 303) = 2.58	0.11
	Interaction: a × c	F (1, 303) = 4.42	0.04
	Interaction: b × c	F (1, 26.3) = 0.24	0.63
	Interaction: a × b × c	F (1, 303) = 4.90	0.03

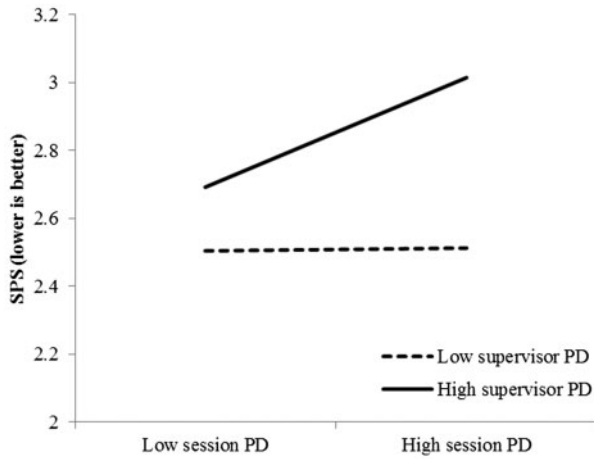


Figure 1. Session quality as a function of psychodynamic therapy techniques and supervisor psychodynamic orientation. Note: SPS, Session Progress Scale; PD, psychodynamic therapy. SPS indicates higher-quality sessions with lower numbers. Groups are defined as the grand mean \pm 1 *SD*.

therapist orientation, and supervisor orientation. As shown in Figure 3, higher CT techniques were associated with better sessions only if both therapist and supervisor were highly CT-oriented. Session-level CT techniques were associated with worse sessions when therapist and supervisor mismatched in either direction (that is, when either one was highly CT-oriented but the other was notably less CT-oriented). Interestingly, when the therapist and supervisor were both not CT-oriented, session-level CT techniques were essentially unrelated to session quality.

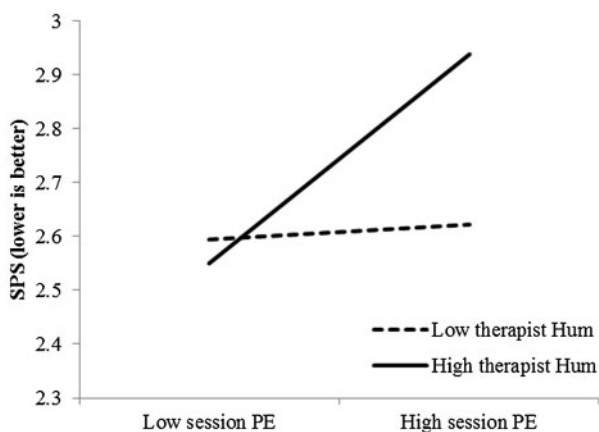


Figure 2. Session quality as a function of process-experiential therapy techniques and therapist humanistic orientation. Note: SPS, Session Progress Scale; Hum, humanistic orientation rating; PE, process-experiential techniques. SPS indicates higher-quality sessions with lower numbers. Groups are defined as the grand mean \pm 1 *SD*.

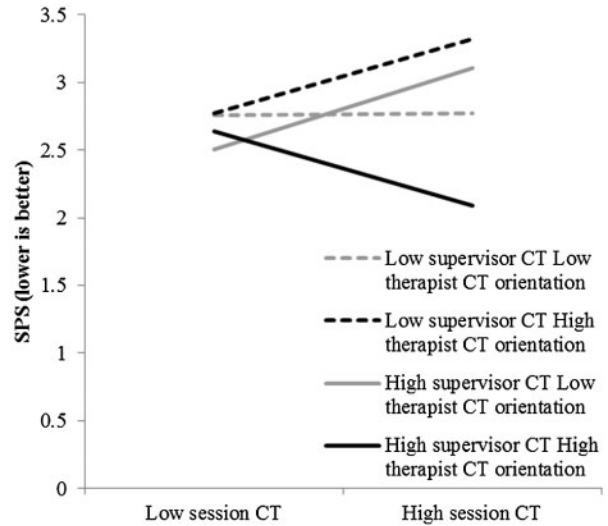


Figure 3. Session quality as a function of CT techniques, supervisor CT orientation and therapist CT orientation. Note: SPS, Session Progress Scale; indicates higher-quality sessions with lower numbers. Groups are defined as the grand mean \pm 1 *SD*.

Discussion

There were several unanticipated results of this study. First, no results conclusively supported the hypothesis that sessions would be improved when therapists reported behaviours consistent with their own orientation. Across different techniques, the therapists' own therapeutic orientation did not predict greater session helpfulness when using orientation-consistent techniques. However, results for process-experiential therapy techniques were relevant to this hypothesis – by providing contrary results. Interestingly, sessions high in process-experiential therapy techniques were associated with less helpful sessions for therapists who identified as more Humanistic than other therapists. This was counter to our hypothesis.

Notably, there was also no indication that sessions were improved when trainees' techniques were more in line with their supervisors' orientation. Supervisors' orientation (and therefore the orientation of the treatment that was likely being provided by the trainee) was not directly related to helpfulness of sessions high in orientation-specific techniques. However we again found some evidence counter to our expectations: higher-than-usual psychodynamic therapy techniques were associated with less helpful sessions when supervisors were highly psychodynamically-oriented.

It would appear, therefore, that doing more techniques is not always better. Given that process-experiential and psychodynamic therapy techniques

share a focus of emotional eliciting and intensifying of experience, it is possible that these techniques might be problematic when performed in excess. Considering that clients completed the session questionnaires immediately following sessions, it is possible that if the session focus or material had been highly emotional, they may be left feeling somewhat shaken or unsettled, which may cause lower ratings of session quality. These lower ratings may or may not be related to eventual improvements due to the difficult session material, for instance if the client was able to productively process the material after the session. Such gains, however, would not be observed in the current study. Buttressing this interpretation, perhaps the trainee therapists in this study may have been particularly prone to use either their preferred or their supervisors' preferred techniques beyond the point of productivity. Given that high adherence to techniques has sometimes been associated with negative therapy processes (e.g. Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996; Piper et al., 1999), it is conceivable that these negative results reflect novice therapists 'overusing' techniques at the expense of being fully attuned to their clients' needs or optimally managing their sessions.

However, there was some support for the suggestion that a match between therapist and supervisor is important in conjunction with the specific techniques used, though only for CT techniques. The therapist-supervisor match on CT orientation was an important moderator of the helpfulness of CT techniques. The significant 3-way interaction suggested that increased CT technique use may be helpful when it is consistent with both the therapist's own views as well as the supervisor's. However, sessions higher in CT techniques than usual were associated with poorer session quality when either the therapist or the supervisor was not particularly CT-oriented, and was essentially unrelated to session quality when neither the therapist nor supervisor was particularly CT-oriented. This phenomenon seems to indicate that a greater emphasis on CT techniques can be helpful, but only when therapist and supervisor are both competent in and/or comfortable with them. This may indicate that CT techniques, which are generally directive, explicit, and at times didactic, are quite potent in their own way. Though they seem to be helpful when they are performed by therapists who believe in their efficacy and when it is consistent with the model of psychotherapy being trained, they can also be

associated with less helpful sessions if they are out of step with either the treatment type or the therapist's own beliefs and identity. That is to say, though it is promising that CT techniques do seem to be associated with helpfulness for some therapists, a categorical recommendation to 'do more CT techniques' in sessions may lead to some less helpful sessions, and possibly less productive treatments.

We must also stress the importance of the training environment in the present study, and the assumption that therapist orientation is linked with competence or comfort with a given orientation, as well as the use of session helpfulness as a marker of outcome. Therapists who identified themselves as highly CT-oriented may have had more positive experiences with CBT in general, and so may be expected to perform these techniques with more skill than other therapists. If this was the sole cause of increases in session quality, however, it would be difficult to explain why CT techniques were not helpful if the supervisor was not CT-oriented (moreover, this would not explain the previous contrary findings, in which therapists identifying themselves as humanistic had lower quality ratings when using high levels of process-experiential therapy techniques). We thus conclude that, at least for one family of techniques (i.e. CT), the degree of orientation match between therapist and supervisor may have a meaningful effect on the helpfulness of psychotherapy sessions.

Despite the presence of some interesting and unexpected findings, the weight of the evidence from this study was negative. The most consistent and simple explanation is that orientation-specific techniques and theoretical orientation do not explain much variance of the helpfulness of psychotherapy sessions. This conclusion was essentially found to be true across all five orientation technique scales measured on the MULTI, given that there were no unqualified main effects for techniques, therapist orientation, or supervisor orientation on session helpfulness. In general, therefore, one major conclusion of this study, consistent with the bulk of past research, is that such variables used as main effects without interactions are generally not expected to be related to outcomes at the session level.

It is worth noting that by conducting this study in a PRN, we were able to collect information on several hundred sessions of psychotherapy without unduly impacting the ongoing therapy process. This is facilitated by the strong collaborative nature of a PRN, which in this study was evidenced by the high

recruitment rate of therapists despite the lack of an external incentive. It also shows that both clients and therapists who are already engaged in long-term psychotherapy are willing to participate in research studies, even when (or perhaps partially because) they require some time to complete treatment-relevant measures. This active collaboration of clinicians and clients not only allows for, but may also be facilitated by the evaluation of real-world psychotherapy. In the case of this study, collection of data is likely to have benefitted from the fact that structured interviews for the purpose of initial assessment and diagnosis are routine aspects of training and treatment, not additional tasks beyond daily clinical work in this community mental health centre. In addition, PRN studies in training clinics may present an efficient and unobtrusive way to collect data on psychotherapy training without altering the supervisory process.

There are, of course, several important limitations to this study. One of the most important is our reliance on self-report data, especially in assessing technique use in sessions. It is also the case that with so few clients and therapists, the power to detect differences with statistical analyses was lower than we would have liked. Though the total number of sessions used and the session per client ratio were both relatively high, this likely only helped to detect differences between sessions. In order to have more power to detect differences between therapists and supervisors, more therapists and supervisors would be necessary. Future studies should include a larger number of therapists and supervisors than we were able to recruit in this PRN at this time.

In conclusion, results from this study suggest that the imposition of treatment type on a given therapist may not be the optimal method to improve care. Indeed, in the way that we examined outcome here – session helpfulness rated by clients – techniques and orientations do not seem to be notably strong predictors at all.

Note

- Such difficulties have been noted in similar situations (e.g. Reese, Toland, & Hopkins, 2011) and, following the suggestion by Hox (2010), we did not include a random effect for therapists.

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