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Distinctive activities of cognitive–behavioral therapy A review of the comparative psychotherapy process literature

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Abstract

The present review examined the comparative psychotherapy process literature in order to identify the distinctive activities of cognitive–behavioral (CB) treatment. Six techniques and interventions were found to distinguish CB from psychodynamic–interpersonal (PI) therapy: (1) use of homework and outside-of-session activities; (2) direction of session activity; (3) teaching of skills used by patients to cope with symptoms; (4) emphasis on patients' future experiences; (5) providing patients with information about their treatment, disorder, or symptoms; and (6) an intrapersonal/cognitive (C) focus. Identifying the distinctive features of CB therapy can improve the measurement of process–outcome correlations by more accurately specifying and operationalizing the treatment-specific processes of CB treatment, help researchers differentiate between common and treatment-specific factors, and aid in development of more psychometrically sound instruments assessing adherence and competence in CB therapy. In addition, this review can improve training of CB therapists by providing a guide for clinical practice. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Cognitive-behavioral; Therapist activity; Distinctive features

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1. Introduction

Recent psychotherapy process research investigating the relationship between cognitive–behavioral (CB) interventions and patient outcome has yielded discrepant results. While some authors have demonstrated a favorable relationship between specific CB processes and patient improvement (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Tang & DeRubeis, 1999a, 1999b; Whisman, 1993), other researchers have reported a lack of (or negative) relationship between specific CB interventions and outcome. First, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) examined the effect of unique CB processes (such as a focus on distorted cognitions) and common factors (such as the therapeutic alliance and a patient's emotional investment in treatment) on treatment outcome. The authors reported that common treatment factors measured in the study predicted patient improvement while a focus on unique cognitive interventions was negatively correlated with treatment outcome. Second, Jacobson et al. (1996) reported that the behavioral activation component of a CB treatment for depression was just as effective as a full CB treatment package that included a specific focus on identification and modification of maladaptive cognitive errors and restructuring of core schemata. This suggests that change in CB treatments may be primarily the result of the specific behavioral strategies designed to activate patients in their environment rather than the cognitive procedures utilized to bring about schematic change. Finally, Ablon and Jones (1998) and Jones and Pulos (1993) examined the relationship between specific CB or psychodynamic (PD) activities and patient outcome. In each study, PD technique employed in a CB treatment, albeit a small amount, was significantly related to patient improvement rather than specific CB interventions. In addition, a focus on a patient's historical experiences (an area emphasized significantly more in psychodynamic–interpersonal (PI) therapy than CB treatment; Blagys & Hilsenroth, 2000) has been shown to be related to outcome in a CB treatment rather than specific CB interventions (Hayes, Castonguay, & Goldfried, 1996; Hayes & Strauss, 1998).

Taken together, these recent findings suggest that several different processes and interventions may be at least partially responsible for patient change in CB treatments. As such, further research is needed in order to understand the treatment-specific processes and mechanism of change in CB therapy. In order to determine the relative contributions of specific CB and PD techniques for facilitating change in CB treatments, researchers must first identify the distinctive activities and interventions of CB treatments.

In a recent review of the comparative psychotherapy process literature, Blagys and Hilsenroth (2000) sought to identify the activities and techniques that distinguish PI form CB treatments. The authors identified seven therapist activities that distinguished PI from CB treatment. These techniques included a focus on affect and the expression of emotion, an exploration of attempts to avoid topics or engage in activities that may hinder the progress of therapy, identification and exploration of patterns in patients' experiences and relationships, an emphasis on past experiences, a focus on patients' interpersonal experiences, a focus on the therapeutic relationship/alliance, and an exploration of patients' wishes, dreams, or fantasies. These seven activities were also noted as overlapping with theoretically important mechanisms in the process of change in PD psychotherapy as outlined by Luborsky, Barber,

and Crits-Christoph (1990). Specifically, the authors indicated that an emphasis on the therapeutic relationship and transference, a focus on patients' interpersonal interactions with current and historical figures, and a recognition and exploration of salient themes in various aspects of patients' functioning were key elements in the process of change in PD treatment. The present review of the comparative psychotherapy process literature endeavors to identify techniques and activities that distinguish CB from PI therapy.

The empirical documentation of the distinctive activities of CB treatment is an important line of research for several reasons. First, description of the distinguishing techniques of this approach may aid in measurement of process–outcome correlations by more accurately specifying and operationalizing the treatment-specific processes of CB treatment. Second, identifying distinctive interventions may help clinicians and researchers differentiate between common and specific factors associated with change across treatments. Third, Waltz, Addis, Koerner, and Jacobson (1993) suggested that adherence measures should assess activities that are unique and prescribed by a treatment approach as well as those interventions that are avoided or proscribed by that treatment approach. Identification of the distinctive activities of CB treatments may aid in the development of more psychometrically sound instruments to assess adherence and competence in CB therapy. In addition, identification of distinctive techniques may have implications for training and clinical practice. Identifying distinctive CB activities can help therapists develop skills that are distinctive to CB treatment and provide them with a guide for session activity.

Current treatments labeled CB have arisen from a foundation in behavioral and cognitive models of psychopathology and treatment. The behavioral model proposes that an individual's actions (both adaptive and maladaptive) are developed and maintained largely by basic learning principles (Craighead, Craighead, Kazdin, & Mahoney, 1994; Goldfried & Davison, 1994; Masters, Burish, Hollon, & Rimm, 1987). Through the principles of classical conditioning, a previously neutral stimulus may come to elicit an unhealthy affective, physiological, or behavioral response. Through the principles of operant conditioning, behavior is controlled by the consequences that follow it (Craighead et al., 1994; Hill & O'Brien, 1999; Kazdin, 1994). Individuals can also learn to behave in problematic ways by observing others engage in some behavior, without necessarily being reinforced or punished, through the principles of social learning (Bandura, 1986; Craighead et al., 1994; Kazdin, 1994). Since the behavioral approach conceptualizes psychological difficulties as developing according to basic contiguity and contingency principles, behavioral treatments and interventions are based, at least in part, on these learning mechanisms (Craighead et al., 1994; Goldfried & Davison, 1994; Masters et al., 1987).

While behavioral treatments emphasize the importance of basic learning principles in developing, maintaining, and treating maladaptive behaviors, cognitive treatments tend to focus more on the potentially mediating role that cognitions play in the development of psychological and behavioral difficulties (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). From a cognitive perspective, an individual's interpretation or construal of an event is a more important determinant of behavior than the stimulus itself or the consequences of a particular action. Since cognitive theory conceptualizes problematic behavior as resulting from dysfunctional, unhelpful, or distorted thinking, treatment focuses more on cognitions than

overt behaviors. Cognitive interventions, then, are based at least in part upon the cognitive mediation hypothesis—the belief that a decrease in symptomatic distress occurs via a reduction in dysfunctional, unhelpful, or distorted thinking (Beck, 1976; Beck et al., 1979, 1990; Ilardi & Craighead, 1994; Whisman, 1993).

Today, treatments referred to as CB are often an amalgamation of cognitive and behavioral procedures. While some treatments may emphasize cognitive more than behavioral techniques, and vice versa, these interventions typically share an appreciation for both basic learning principles and the role that cognitions play in human behavior and affective experience (Goldfried & Davison, 1994; Hill & O'Brien, 1999). One such intervention is imaginal or in vivo exposure. Exposure methods emerged from classical and operant conditioning theories of the acquisition and reduction of fear. Extending Lang's (1979) bioinformational theory of emotion, Foa and Kozak (1985, 1986, 1998), Foa and Meadows (1997), and Riggs and Foa (1993) suggest that exposure interventions correct erroneous associations between stimuli, responses, and the meanings attached to them in an individual's emotional memory network. Correction of these mistaken evaluations requires both activation of the fear structure (by presenting the feared stimulus) and the presentation of corrective information that is inconsistent with the learned, pathological associations. From this perspective, cognitive representations of stimuli, responses, and their relationship interact with behavioral learning principles to evoke pathological levels of fear and anxiety. Exposure is a central aspect of contemporary CB treatments for obsessive–compulsive disorder, panic disorder, and posttraumatic stress disorder (Calhoun & Resick, 1993; Craske & Barlow, 1993; Foa & Kozak, 1985, 1986, 1998; Foa & Meadows, 1997; Riggs & Foa, 1993).

The present review is an attempt to identify therapist activities and techniques that make CB therapy distinct from short-term PI treatment. In order to obtain the articles used in this review, a computer search of the Psych Lit database was conducted. Studies specifically comparing the techniques, interventions, and therapist activities of CB and PI therapies were identified and obtained. Reference sections of these articles were also examined and any additional articles deemed potentially relevant were retrieved. It is important to note that studies comparing interventions of cognitive (C), behavioral (B), or CB therapy with those of PD, interpersonal, or PI approaches to treatment were included in this study. Articles that investigated interventions of only one of the above forms of treatment or that focused only on treatment outcome were not included in this review. In addition, recent research focusing on potential differences between CB and PI in the development and quality of the therapeutic alliance was also excluded from the present study. This review focused specifically on differences in technique and therapist activity between the two treatment approaches.

Once all seemingly relevant studies were obtained, each article was evaluated independently by the authors to determine its inclusion or exclusion from the current review based on the above criteria. After reaching a consensus on which studies would be included in the present review, each author independently made a list of reported significant differences between the two treatment approaches. In order to be included in the current review, however, differences between treatment approaches had to satisfy two inclusion criteria. Specifically, only therapist activities and interventions that differentiated CB from PI treatments in at least two different studies and at least two different research sites were included in this review. The

six significant differences that satisfied these criteria were (arranged according to the amount of evidence that the technique or activity distinguished CB from PI therapy): (1) use of homework and outside-of-session activities; (2) direction of session activity; (3) teaching of skills used by patients to cope with symptoms; (4) emphasis on patients' future experiences; (5) providing patients with information about their treatment, disorder, or symptoms; and (6) an intrapersonal/cognitive focus. For each of these activities, a brief description of the theoretical importance of the intervention is presented before proceeding to the review of the empirical research in that domain. Following the review of the literature in each section, a brief summary and discussion of the findings in that content area is included.[1]

2. Literature review

2.1. Use of homework and outside-of-session activities

According to theory, CB treatments are more likely to include homework and outside-of-session activities than PI treatments. Homework provides an opportunity for the patient to practice skills learned in therapy. Practice is designed to make the work of treatment more concrete and helps a patient generalize skills learned in therapy to the real world (Alford & Beck, 1994; Beck, 1976; Beck et al., 1979; Burns, Adams, & Anastopoulos, 1985; Burns & Spangler, 2000; Goldfried & Davison, 1994; Hollon & Beck, 1994; Kazantzis, 2000; Thase, 1996). Homework also is assumed to equip a patient with a way of reducing or coping with his or her problematic symptoms outside of the therapy room and is considered an important ingredient for maintaining gains after treatment termination (Beck et al., 1979). For example, a patient who is taught progressive muscle relaxation during a session may be encouraged to utilize or practice this coping skill outside of the therapy room when he or she is experiencing anxiety. The ultimate goal of this outside-of-session task, then, is to reduce or decrease the patient's anxiety when he or she is not in the therapy room and transfer gains made in treatment to the patient's everyday life. This goal is very consistent with the symptom reduction focus of CB treatments. In contrast, theory suggests that more psychodynamically oriented treatments do not typically assign homework or outside-of-session tasks (Luborsky, 1984; Strupp & Binder, 1984).

After reviewing the comparative psychotherapy process literature, it appears that CB and PI therapy do differ in terms of the importance each places on outside-of-session activities (see Table 1). Using the Psychotherapy Process Q-set (PQS; Jones, 1985), a 100-item instrument assessing therapist–patient interactions, Ablon and Jones (1998, 1999) and Jones and Pulos (1993) reported that CB therapy was rated significantly higher than PD and IP treatment on the PQS item, "There is a discussion of specific activities or tasks for the patient to attempt outside of session." Using the Coding System of Therapeutic Focus (CSTF;

[1] The abbreviations used in the text correspond to the type of therapy employed in a given study with the exception of the summary sections, where the CB and PI abbreviations are used as aggregate terms.

Table 1
Homework and outside of session activities in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS Item 38:* "There is a discussion of specific activities or tasks for the patient to attempt outside of session." CB therapy (M=7.5) was rated significantly higher than PD therapy (M=4.3; P<.001) on this item. **PD therapy:** No PQS items regarding the use of homework or outside-of-session activities were found to be characteristic of PD therapy.
Ablon and Jones (1998)	A panel of expert PD (n=11) and CB (n=10) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians.	**CB therapy:** *PQS Item 38:* "There is a discussion of specific activities or tasks for the patient to attempt outside of session." This item was rated as highly characteristic of CB therapy (factor score=1.93, the highest factor score). **PD therapy:** No PQS items regarding the use of homework or outside-of-session activities were found to be characteristic of PD therapy.
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the National Institute of Mental Health Treatment of Depression Collaborative Research Project (NIMH-TDCRP). 35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed by nine trained research-oriented psychologists and master's-level graduate students.	**CB therapy:** *PQS Item 38:* "There is a discussion of specific activities or tasks for the patient to attempt outside of session." This item was rated as significantly more characteristic of CB therapy (M=8.09) than IP therapy (M=4.87; P<.001). **IP therapy:** No PQS items regarding the use of homework or outside-of-session activities were

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Table 1 (*continued*)

Study	Participants	Instruments and raters	Findings
			found to be characteristic of IP therapy.
Goldfried et al. (1997)	27 patients receiving PI therapy diagnosed with major depressive disorder. 30 patients receiving CB therapy diagnosed with major depressive disorder.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .98. Ratings performed by groups of trained raters that included advanced graduate and undergraduate students.	**CB therapy:** CB therapy placed more emphasis on between-session activities than PD therapy (F=74.87, P=.001). **PI therapy:** No items regarding an emphasis on between-session experiences were found to be characteristic of PI therapy.
Goldfried et al. (1998)	14 patients treated by master PI therapists presenting with anxiety, depression, or both. 22 patients treated by master CB therapists presenting with anxiety, depression, or both.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .99. Ratings performed by groups of trained raters that included advanced graduate students.	**CB therapy:** Master CB therapists placed significantly more emphasis on between-session activities than PD therapists (F=9.21, P=.005). **PI therapy:** No items regarding an emphasis on between-session experiences were found to be characteristic of PI therapy.
Hill et al. (1992)	180 patients from the NIMH-TDCRP diagnosed with major depressive disorder.	**Collaborative Study Psychotherapy Rating Scale** (**CSPRS**; Hollon et al., 1988) Reliability correlations ranged from .91 to .98. Ratings were completed by two trained coders.	**CB therapy:** CB therapists (M=2.39) scored significantly higher on the Cognitive-Behavior Therapy (CBT) scale, which included items reportedly measuring the use of homework than IP therapists (M=1.29, P<.01).
Startup and Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project.	**Sheffield Psychotherapy Rating Scale** (**SPRS**; Shapiro & Startup, 1990) ICC ranged from .78 to .85. Ratings were completed by eight trained coders that included clinical psychologists, graduate	**CB therapy:** Prescriptive therapists (M=26.8) scored significantly higher on the Prescriptive Therapy (P) scale, which included items reportedly measuring the use of homework than exploratory therapists (M=5.3, P<.0001).

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Table 1 (*continued*)

Study	Participants	Instruments and raters	Findings
		students, and psychological assistants working in the adult mental health field.	
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions.	**Minnesota Therapy Rating Scale (MTRS)** Pearson product–moment correlations ranged from .92 to − .29 (mode of .70). 19% of the items were reported as performing in the poor range ($r < .30$). Raters were four professionals (including clinical psychologists, social workers, and psychiatric nurses) and eight graduate students from diverse theoretical orientations.	**CB therapy:** *Item 11:* Did the therapist and client discuss activities or tasks agreed upon in earlier sessions for the client to attempt? This item was part of the CB technique factor (factor loading = .71) and was negatively related to the IP psychotherapy technique factor (factor loading = − .33). *Item 42:* The therapist assigned specific tasks to be attempted between sessions. This item loaded on a CB technique factor (factor loading = .60) and loaded at .30 on the IP psychotherapy technique factor.
Stiles et al. (1988)	33 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment from the Sheffield Psychotherapy Project.	**Verbal Response Modes (VRM)** ICC ranged from .20 to .98. Raters were five trained social sciences graduates.	**CB therapy:** Therapists used significantly more *general advisements* (attempts to guide client behavior outside of the session with commands, suggestions, or prohibitions) when providing prescriptive therapy ($M = 6.98$) than when providing exploratory therapy ($M = 0.84$, $P < .001$).
Stiles et al. (1989)	33 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the	**VRM** ICC ranged from .42 to .98. Raters were five trained university graduates.	**CB therapy:** Therapists used significantly more *general advisements* (attempts to guide client behavior outside of the

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Table 1 (*continued*)

Study	Participants	Instruments and raters	Findings
	other treatment from the Sheffield Psychotherapy Project.		session with commands, suggestions, or prohibitions) when providing prescriptive therapy ($M=6.92$) than when providing exploratory therapy ($M=0.99$, $P<.01$).
Stiles and Shapiro (1995)	39 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment from the Sheffield Psychotherapy Project.	**VRM** ICC ranged from .42 to .98. Raters were five trained females with undergraduate degrees in psychology or related fields.	**CB therapy:** Factor analysis revealed that a *prescribing* factor (therapists direct outside of session activities; eigenvalue = 2.34) distinguished CB from PI therapy.

Goldfried, Newman, & Hayes, 1989), a measure of in-session therapeutic process, Goldfried, Castoguay, Hayes, Drozd, and Shapiro (1997) and Goldfried, Raue, and Castonguay (1998) also found differences between CB and PI therapy in their respective use of homework and tasks to be completed outside of session. Both studies reported that CB therapists encouraged patients to act, think, or feel between sessions significantly more than PI therapists.

Hill, O'Grady, and Elkin (1992) and Startup and Shapiro (1993) reported that CB therapy scored significantly higher than IP or PI treatment on scales assessing adherence to CB therapy that included items assessing an emphasis on homework. DeRubeis, Hollon, Evans, and Bemis (1982) also reported a greater focus on homework in CB treatment than in IP therapy. Stiles, Shapiro, and Firth-Cozens (1988, 1989), investigating verbal response modes, revealed that CB therapists used significantly more general advisements (attempts to guide client behavior outside of the session with commands, suggestions, or prohibitions) than PI therapy. More recently, Stiles and Shapiro (1995) found that a factor labeled "Prescribing" (therapist directs outside-of-session activities) was characteristic of CB treatment rather than PI treatment.

The research findings presented in this section offer strong support for the theoretical assumption that CB therapy focuses more than PI treatment on the use of homework and between-session activities. Of the 11 articles reviewed for this section, each confirmed this assumed theoretical and practical difference. Future research may wish to examine types of homework being utilized in CB treatments (written, verbal/thought exercise, behavioral activity) and their outcome correlates. In addition, we believe homework assignments may often vary along a general–specific dimension. Some homework may be very general in nature such as "I'd like you to watch and see if there are certain situations in which you are more likely to feel depressed than others" or "I'd like you to watch how people respond to you over this next week when you act in an assertive manner." The utility of this type of

general suggestion for a between-session activity may be very different than a more specific assignment such as "I'd like you to keep a log showing how frequently you engage in catastrophizing" or "I'd like you to perform the progressive muscle relaxation exercise we reviewed and practiced in session today once per day over the next week."

2.2. Direction of session activity

A second area in which CB and PI therapists are presumed to differ is in the amount of control they exhibit over the process of therapy. Theory suggests that CB therapists typically direct session activity by setting an agenda, utilizing preplanned techniques at specific times during sessions, deciding what will be discussed prior to the session, and actively directing the patient toward specific topics of discussion and tasks (Beck et al., 1979; Beck, Freeman & Associates, 1990; Craighead et al., 1994; Goldfried & Davison, 1994; Meichenbaum, 1977). CB therapists may be active in an attempt to stimulate and engage the patient in the process of therapy (Beck et al., 1979). In contrast, theory suggests that PI therapists are less directive during sessions, allowing patients to initiate discussions and supply topics for exploration (Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984).

The empirical psychotherapy process research reviewed for this section appears to support this theoretical difference between CB and PI therapy (see Table 2). Early work in this area by Staples, Sloane, Whipple, Cristol, and Yorkston (1975) indicated that behavioral therapists tended to initiate topics of discussion and make directive statements (defined as statements that imply imperatives such as "do this" or "try that") significantly more than PD therapists. In addition, behavioral therapists spent almost twice as much time talking in a session as PD therapists, suggestive of a more active and directive orientation. Brunink and Schroeder (1979) indicated that behavioral therapists used direct guidance techniques significantly more than PD therapists. DeRubeis et al. (1982) examined CB and IP treatments for depression and reported a tendency for CB therapy to focus on topics in an orderly fashion (as opposed to flowing from topic to topic), to keep the focus of treatment on issues decided upon in setting the agenda for the session (as opposed to not setting an agenda), and to talk more during the session than IP therapists. Luborsky, Woody, McLellan, O'Brien, and Rosenzweig (1982) reported that CB therapists spoke significantly more, made significantly more directive statements, and were rated higher on a scale measuring therapist directiveness than PD therapists. Stiles et al. (1988), investigating verbal response modes, reported that CB therapists averaged 50% more utterances per session than PI therapists, also indicative of the more directive role taken by CB therapists.

More recently, Hill et al. (1992) reported that CB therapists scored significantly higher than IP therapists on a nonmodality-specific scale labeled "Explicit Directiveness." Wiser and Goldfried (1996) reported that CB therapists advised their patients and attempted to guide patient behavior by using commands, permission, or prohibitions significantly more than PI therapists. In addition, Ablon and Jones (1999) and Jones and Pulos (1993) indicated that CB therapists exerted a more active influence over therapeutic interactions and topics of discussion than PD and IP therapy. In both of these studies, patients were judged to be more passive in CB therapy than in PD or IP treatment. In contrast, PD and IP therapists were

Table 2
Direction of session activity in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Staples et al. (1975)	Three behavioral and three psychoanalytic therapists.	**Truax Therapist Variable, Lennard and Bernstein Therapist Informational Specificity Scale, Nonlexical Speech Patterns, Temple Content Scale** Correlations ranged from .58 to .97 across measures. Raters were two individuals who were not described.	**B therapy:** Behavior therapists spent approximately twice as much time talking in the therapeutic hour than PD therapists.
Brunink and Schroeder (1979)	18 expert psychoanalytically oriented, gestalt, and behavior therapists	**System for Assessing Therapist Communications (SATC)** Average product–moment correlations between raters were reported to range from .81 to .82. Raters were three PhD clinical psychologists blind to the theoretical orientations of the therapists and the purpose of the research.	**B therapy:** Behaviorists ($M = 27.2$) used direct guidance techniques significantly more than psychoanalytic therapists ($M = 14.0$, $P < .01$).
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions.	**MTRS** Pearson product–moment correlations ranged from .92 to − .29 (mode of .70). 19% of the items were reported as performing in the poor range ($r < .30$). Raters were four professionals (including clinical psychologists, social workers, and psychiatric nurses) and eight graduate students from diverse theoretical orientations.	**CB therapy:** *Item 11:* Did the therapist and client discuss activities or tasks agreed upon in earlier sessions for the client to attempt? This item was part of the CB technique factor (factor loading = .71) and was negatively related to the IP psychotherapy technique factor (factor loading = − .33). *Item 18:* The therapist guided the client to arrive at his/her own interpretations or conclusions *or* supplied conclusions and interpretations. This item was part of the CB technique factor (factor loading = − .63). *Item 26:* In general, the session focused on specific topics in an orderly fashion *or* flowed from topic to topic as the discussion progressed. This item was part of the CB technique factor (factor loading = − .83) and was positively related to the IP psychotherapy technique factor (factor loading = .31). *Item 38:* The therapist: kept

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Table 2 (*continued*)

Study	Participants	Instruments and raters	Findings
			the focus of the session on issues decided upon in setting the agenda *or* did not focus on those issues in the session (or no topics were preset). This item loaded on a CB technique factor (factor loading = − .97). *Item 13:* Who talked more during the session? (1) therapist (5) equivalent (9) client. This item loaded − .57 on a factor labeled therapist directiveness. It also loaded negatively (− .41) on the CB technique factor and positively on the IP psychotherapy technique factor (.47).
Luborsky et al. (1982)	Narcotic addicts treated by four Supportive–Expressive (SE) therapists and four CB therapists.	An unspecified rating form was used to code psychotherapy sessions. One other independent rater also coded speech content of sessions using the Temple Content Categories. No psychometric data were reported for the rating form. Raters were two individuals with experience in coding samples of psychotherapy sessions from other studies.	**CB therapy:** CB therapists (42%) had a significantly greater percentage of time speaking in sessions than SE therapists (20%; $P < .05$). CB therapists (M = 4.0) provided a significantly greater number of directive statements than SE therapists ($M = 0.5$, $P < 0.05$). CB sessions ($M = 3.3$) were rated significantly higher than SE sessions ($M = 1.3$) on a scale labeled *directiveness*.
Stiles et al. (1988)	33 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment from the Sheffield Psychotherapy Project.	**VRM** ICC ranged from .20 to .98. Raters were five trained social sciences graduates.	**CB therapy:** Therapists providing prescriptive therapy ($M = 576$) averaged almost 50% more utterances per session than when they provided exploratory therapy [$M = 370$; $F(1,37) = 210.45$, $P < .001$].
Hill et al. (1992)	180 patients from the NIMH-TDCRP.	**CSPRS** (Hollon et al., 1988) Correlations between mean ratings of different ratings groups were significant and ranged from .91 to .98.	**CB therapy:** CB therapists ($M = 4.62$) were rated significantly higher on a nonmodality specific scale labeled *Explicit Directiveness* than IP therapists ($M = 3.71$, $P < .01$).

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Table 2 (*continued*)

Study	Participants	Instruments and raters	Findings
		Ratings were completed by two trained coders.	
Wiser and Goldfried (1996)	31 significant sessions from 13 PI and 18 CB therapists.	**VRM** Cohen's κ was reported as .75. Raters were six VRM trained advanced undergraduates.	**CB therapy:** CB therapists advised their clients using commands, permission, or prohibition significantly more than PI therapists ($F=6.44$, $P=.02$).
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems. 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS item 15:* "Patient does not initiate topics; is passive". CB therapy ($M=3.4$) was rated significantly higher than PD therapy ($M=1.9$, $P<.001$) on this item. *PQS Item 17:* "Therapist actively exerts control over the interaction." CB therapy ($M=8.0$) was rated significantly higher than PD therapy ($M=4.9$, $P<.001$) on this item. *PQS Item 25:* "Patient has difficulty beginning the hour." CB therapy ($M=3.0$) was rated significantly higher than PD therapy ($M=2.1$, $P<.001$). *PQS Item 93:* "Therapist is neutral." This item received a mean rating of 2.56 and was among the least characteristic items of CB therapy. **PD therapy:** *PQS Item 15:* "Patient does not initiate topics; is passive." This item was rated as the least characteristic items of PD therapy ($M=1.88$). *PQS Item 25:* "Patient has difficulty beginning the hour." This item was rated as the second least characteristic item of PD therapy ($M=2.09$). *PQS Item 88:* "Patient brings up significant issues and materials." PD therapy ($M=6.9$) was rated significantly higher than CB therapy ($M=6.3$, $P<.01$) on this item.
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed	**CB therapy:** *PQS Item 17:* "Therapist actively exerts control over the interaction." This item was rated as significantly more characteristic of CB therapy ($M=8.44$) than IP

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Table 2 (*continued*)

Study	Participants	Instruments and raters	Findings
	35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	by nine trained research-oriented psychologists and master's-level graduate students.	therapy ($M=5.72$, $P<.001$). *PQS Item 93:* "Therapist is neutral." This item was rated as significantly more characteristic of IP ($M=4.09$) than CB ($M=2.22$, $P<.001$). **IP therapy:** *PQS Item 93:* "Therapist is neutral." This item was rated as significantly more characteristic of interpersonal therapy ($M=4.09$) than CB therapy ($M=2.22$, $P<.001$).
Crits-Christoph et al. (1999)	72 patients receiving either CB or IP therapy from the NIMH-TDCRP.	Ratings were based on relational episodes (narratives told by patients describing interpersonal interactions). ICC ranged from .48 to .88. Raters were one advanced undergraduate student and one recent college graduate research assistant.	**CB therapy:** CB therapists talked more than IP therapists during patient narratives ($r=-.56$, $P<.001$).
Ablon and Jones (1998)	A panel of expert PD ($n=11$) and CB ($n=10$) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians	**CB therapy:** *PQS Item 17:* "Therapist actively exerts control over the interaction." This item was rated as highly characteristic of CB therapy (factor score = 1.45). *PQS Item 88:* "Patient brings up significant issues and materials." This item was rated as highly characteristic of CB therapy (factor score = 1.09). **PD therapy:** *PQS Item 93:* "Therapist is neutral." This item was rated as highly characteristic of PD therapy (factor score = 1.57).

rated as allowing patients to introduce important issues and topics for discussion significantly more than CB therapy. Crits-Christoph et al. (1999) also reported that CB therapy was characterized by a higher proportion of words spoken within relational episodes indicating a more directive role in treatment than IP therapists.

Psychotherapy process research by Ablon and Jones (1998) using the PQS also investigated the direction and control of session activity in ideal PD and CB treatments conducted by expert therapists. The authors reported that expert CB therapists rated the PQS item "Therapist actively exerts control over the interaction" to be characteristic of CB therapy. Expert PD therapists, in contrast, rated the PQS item, "Therapist is neutral" as part of an ideal PD treatment. Surprisingly, however, expert PD therapists did not judge a patient's initiation

of significant material and issues to be among the most characteristic items of PD therapy. Instead, the PQS item, "Patient brings up significant issues and material" was rated as 1 of the 20 items most characteristic of CB treatment by expert CB therapists. This finding suggests that expert CB therapists may be more willing to let patients introduce significant topics and issues for discussion than CB therapists with less experience.

Research presented in this section offers strong support for the theoretical contention that CB treatment attempts to direct and control session activity more than PI therapy. Of the 11 articles reviewed in this section, each found that CB therapists were significantly more likely than PI therapists to direct session activity. This greater control suggests that CB therapists take a more directive role in treatment. CB therapists appear to speak more frequently in sessions and initiate the discussion of specific topics and tasks significantly more than PI therapists. It should be noted, however, that assessment of the direction of session activity may overlap with a similar concept such as the therapist's amount of activity during a session. While similar in nature, these two processes are not necessarily synonymous. For example, a CB therapist can presumably direct session activity without being extremely active (i.e., talking a great deal and dominating the session). Future adherence, process, and outcome research must differentiate between the direction of session activity (as in setting and maintaining an agenda) and the purely quantitative measurement of a therapist's activity level during a treatment.

2.3. Teaching skills to patient

Another area in which CB and PI therapy theoretically differ is in the importance each places on teaching skills to patients. Theory suggests that CB therapists teach a patient skills in order to help him or her cope more effectively with problematic situations and experiences (Beck et al., 1979, 1990; Craighead et al., 1994; Goldfried & Davison, 1994; Meichenbaum, 1977). In theory, CB therapists espouse a psychoeducational approach, teaching patients new ways of coping with stressful situations. PI theory, in contrast, suggests that therapists are not as overtly instructive. Rather, patients are presumed to be able to manage their difficulties more effectively through a greater understanding, awareness, and insight about their difficulties (Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984).

Empirical treatment process research has supported this theoretical and practical difference (see Table 3). Ablon and Jones (1998, 1999) and Jones and Pulos (1993) reported that CB therapy scored significantly higher than PI/IP therapy on the PQS item "Therapist behaves in a teacher-like (didactic) manner." Hill et al. (1992) and Startup and Shapiro (1993) investigated treatment fidelity in CB and PI/IP therapy. The authors reported that CB therapists scored significantly higher than IP/PI therapists on scales measuring adherence to CB treatment that included items assessing a focus on behavioral skills. Luborsky et al. (1982) also found differences between CB and PD therapy in terms of their focus on skills training. CB sessions contained a significantly greater focus on behavioral techniques than PD therapy sessions. The above findings are similar to those of an earlier study by Silove, Parker, and Manicavasagar (1990) investigating patients' perceptions of therapist activity. In

Table 3
Teaching skills in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems. 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS Item 37:* "Therapist behaves in a teacher-like (didactic) manner." CB therapy ($M = 7.8$) was rated significantly higher than PD therapy ($M = 3.9$, $P < .001$) on this item. **PD therapy:** No PQS items regarding teaching patients skills in therapy were found to be characteristic of PD therapy.
Ablon and Jones (1998)	A panel of expert PD ($n = 11$) and CB ($n = 10$) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians.	**CB therapy:** *PQS Item 37:* "Therapist behaves in a teacher-like (didactic) manner." This item was rated as highly characteristic of CB therapy (factor score = 1.17). **PD therapy:** No PQS items regarding teaching patients skills in therapy were found to be characteristic of PD therapy.
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the NIMH-TDCRP. 35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed by nine trained research-oriented psychologists and master's-level graduate students.	**CB therapy:** *PQS Item 37:* "Therapist behaves in a teacher-like (didactic) manner." This item was rated as significantly more characteristic of CB therapy ($M = 8.06$) than IP therapy ($M = 5.04$, $P < .01$). **IP therapy:** No PQS items regarding teaching patients skills in therapy were found to be characteristic of IP therapy.
Hill et al. (1992)	180 patients from the NIMH-TDCRP.	**CSPRS** (Hollon et al., 1988) Correlations between mean ratings of different ratings groups were significant and ranged from .91 to .98. Ratings were completed by two trained coders.	**CB therapy:** CB therapists ($M = 2.39$) scored significantly higher than IP therapists ($M = 1.29$, $P < .01$) on the CBT scale, which included items reportedly measuring a focus on behavioral skills.
Startup and Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project.	**SPRS** (Shapiro & Startup, 1990) ICC ranged from .78 to .85. Ratings were completed	**CB therapy:** Prescriptive therapists ($M = 26.8$) scored significantly higher than exploratory therapists ($M = 12.1$, $P < .0001$) on the P scale, which included items reportedly

(continued on next page)

Table 3 (*continued*)

Study	Participants	Instruments and raters	Findings
		by eight trained coders that included clinical psychologists, graduate students, and psychological assistants working in the adult mental health field.	measuring a focus on behavioral skills, operant approaches, and the rationale for behavioral procedures.
Luborsky et al. (1982)	Narcotic addicts treated by four SE therapists and four CB therapists.	An unspecified rating form was used to code psychotherapy sessions. No psychometric data were reported for the rating form. Raters were two individuals with experience in coding samples of psychotherapy sessions from other studies. One other independent rater also coded speech content of sessions using the Temple Content Categories.	**CB therapy:** CB therapists ($M = 1.80$) focused significantly more than SE therapists ($M = 1.1$, $P < .05$) on behavioral techniques.
Silove et al. (1990)	81 subjects (38% receiving PD therapy, 28% cognitive therapy, 17% behavior therapy, and 7% CB therapy) seeking services for anxiety and depression	Two unnamed questionnaires measuring therapist activities. Cronbach's α for subscales of the questionnaires ranged from .79 to .96. Raters were patients who completed the questionnaires.	**CB therapy:** Patients who received CB therapy rated their therapists ($M = 30.6$, S.D. = 3.9) significantly higher on a behavioral task dimension than patients who received PD treatment rated their therapists ($M = 15.1$, S.D. = 8.0, $F = 87.38$, $P < .01$). **PD therapy:** Patients who received PD therapy rated their therapists ($M = 29.3$, S.D. = 8.2) as focusing significantly more on inner conflict than patients who received CB treatment rated their therapists ($M = 16.4$, S.D. = 5.3, $F = 50.74$, $P < .01$).

this study, patients who had been treated with CB therapy rated their therapists high on a construct of behavioral task orientation (the degree to which specific strategies for changing behavior were outlined in therapy) and low on a dimension assessing their therapists' focus on internal conflicts (the extent to which the therapist attempted to elicit and examine deep, hidden, or conflictual emotions). Patients who received PD therapy, conversely, characterized their therapists as low on the behavioral task dimension and high on the assessment of their inner conflicts.

Research presented in this section strongly supports the theoretical differences between PI and CB therapy in terms of their emphasis on teaching specific skills to help patients cope

more effectively with their symptoms. The notion that CB therapists are more likely than PI therapists to adopt a psychoeducational role and teach patients skills was found in each of the seven studies reviewed. Like homework and outside-of-sessions activities, in-sessions skills training is intended to help the patient learn to reduce, manage, or control their symptoms. From this perspective, therapy is seen as a psychoeducational, learning process requiring a patient to acquire and practice new ways of thinking and behaving in order to cope more effectively with his or her symptoms.

2.4. Emphasis on future experiences

CB and PI therapy are also assumed to differ in their emphasis on a patient's current and future functioning. Theory suggests that CB treatment focuses on the impact a patient's present illogical thoughts have on his or her current and future functioning (Beck et al., 1979; Meichenbaum, 1977). In addition, skills learned in therapy are designed to promote more effective future functioning (Goldfried & Davison, 1994). In contrast, PI theory suggests that therapy concentrates more on a patient's past, unresolved conflicts, historical relationships, and the impact these have on a patient's present functioning (Blagys & Hilsenroth, 2000; Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984).

A patient's present life experiences may be a focus of both short-term manualized approaches. However, short-term CB and PI therapy may conceptualize a patient's current difficulties very differently. Support for this equivalent focus on a patient's present life situation can be seen in research conducted by Ablon and Jones (1998) and Jones and Pulos (1993), in which both PD and CB approaches were characterized by an emphasis on a patient's current or recent life situation. Similarly, Goldfried et al. (1997) revealed no significant differences between the two approaches in therapists' emphasis on current (since the start of therapy) events. However, Samoilov, Goldfried, and Shapiro (2000) found that CB therapy focused significantly more than PI therapy on a scale that included items regarding a focus on a patient's current life situation. One possible explanation for the equivalent focus on a patient's current life situation by short-term CB and PI therapies might be the nature of the treatment being provided. In the studies reviewed, treatments being given were short-term in nature and manualized. Employing a shorter-term treatment may require PI therapists to focus more on what can be changed or improved in the present rather than focusing on the patient's past and childhood experiences. The pressure of fewer sessions with which to make significant patient gains may force therapists (PI in particular) to focus more on the present causes of an individual's difficulties rather than exploring his or her past for potential influences on his or her current behavior.

Recent empirical research supports the notion that differences exist between the CB and PI treatments in their emphasis on future events and time frames (see Table 4). In the Ablon and Jones (1998) and Jones and Pulos (1993) studies, CB therapists were rated as encouraging patients to try new ways of behaving with others in the future significantly more than PD therapists. Ablon and Jones (1999), however, did not report a significantly greater focus on a patient's future behavior in CB than IP therapy. On a single-case, single-session basis,

Table 4
Emphasis on future experiences in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems. 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS Item 85:* "Therapist encourages patient to try new ways of behaving with others." CB therapy ($M = 5.8$) was rated significantly higher than PD therapy ($M = 4.8$, $P < .001$) on this item.
Ablon and Jones (1998)	A panel of expert PD ($n = 11$) and CB ($n = 10$) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians.	**CB therapy:** *PQS Item 85:* "Therapist encourages patient to try new ways of behaving with others." This item was rated as one of the 20 most characteristic items of CB therapy (factor score = 1.49).
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the NIMH-TDCRP. 35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed by nine trained research-oriented psychologists and master's-level graduate students.	**CB and IP therapy:** No items regarding a focus on a patient's past experiences were found to differentiate IP from CB therapy.
Goldsamt et al. (1992)	1 patient seen in a 45-min demonstration session by three master therapists (Beck, Meichenbaum, and Strupp).	**CSTF** (Goldfried et al., 1989) Average Cohen's κ values ranged from .23 to .79. Raters were three advanced graduate students with 2 years of experience/training using the CSTF.	**CB therapy:** Beck ($\chi^2 = 13.43$, $P < .001$) and Meichenbaum ($\chi^2 = 17.96$, $P < .001$) focused more than Strupp on future time frames.
Samoilov et al. (2000)	28 patients receiving CB treatment and 29 patients treated with PI therapy from the Second Sheffield Psychotherapy Project.	**Therapeutic Focus on Action and Insight (TFAI)** ICC ranged from .88 to .94. Raters were two trained undergraduates.	**CB therapy:** CB therapy scored significantly higher than PI therapy on a scale that included items measuring a focus on the future [$F(1,49) = 29.30$, $P < .001$].

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Table 4 (*continued*)

Study	Participants	Instruments and raters	Findings
Goldfried et al. (1997)	27 patients receiving PI therapy diagnosed with major depressive disorder. 30 patients receiving CB therapy diagnosed with major depressive disorder.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .98. Ratings performed by groups of trained raters that included advanced graduate and undergraduate students.	**CB therapy:** CB therapy was significantly more likely than PI therapy to focus on future time frames ($F=16.19$, $P=.001$). **CB and PI therapy:** No significant differences were found between CB therapy ($M=9.9$) and PI therapy ($M=10.7$, $F<1$) in terms of their focus on the patient's expectations for the future. No significant differences were found between CB ($M=10.5$) and PI therapy ($M=12.6$, $F=1.29$, $P=.26$) in terms of their focus on a patient's future-oriented volition such as wishes, desires, motivations, or needs.
Goldfried et al. (1998)	14 patients treated by master PI therapists presenting with anxiety, depression, or both. 22 patients treated by master CB therapists presenting with anxiety, depression, or both.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .99. Ratings performed by groups of trained raters that included advanced graduate students.	**CB and PI therapy:** Both approaches to therapy emphasized future events ($F=3.96$, $P=.005$) during important portions of sessions significantly more than in insignificant portions of sessions. **CB therapy:** CB therapy was significantly more likely than PI therapy to focus on a patient's future ($F=10.09$, $P=.003$).

Goldsamt, Goldfried, Hayes, and Kerr (1992) did find the expected therapy orientation differences in time frame emphasis as Beck and Meichenbaum focused significantly more on future events than Strupp. Samoilov et al. (2000) reported that CB therapists scored significantly higher than PI therapists on a scale labeled "Facilitating Action," which included items related to a focus on the patient's future.

Goldfried colleagues (1997, 1998) also provide evidence supporting a greater focus on future experiences in CB than PI therapy. In each study, the authors reported that CB therapists were significantly more likely than PI therapists to focus on a future time frame (after the present session). However, no significant differences were found in the amount each approach focused on a patient's expectations or future-oriented volition such as wishes, desires, and motivations. Rather, the authors found a main effect for session portion such that therapists of both orientations placed more of a focus on a patient's expectations during important parts of sessions. This finding suggests the importance of exploring a patient's expectations of and wishes for the future in both forms of therapy. PI therapy has been shown to focus on a patient's wishes, dreams, and fantasies significantly more than CB treatment in theory and empirical research (Blagys & Hilsenroth, 2000). Perhaps this focus on imagined or expected future events in PI therapy is reflected in the absence of significant differences between CB and PI therapy in terms of their focus on a patient's expectations for and actions of the future.

Research reviewed in this section lends strong support to the theoretical assumption that CB and PI treatments differ in terms of their emphasis on a patient's future experiences. Of the seven articles reviewed in this session, six reported a greater focus on a patient's future in CB treatment than in PI therapy. The lack of a significant difference between IP and CB therapy in the Ablon and Jones (1999) article is surprising. Perhaps IP therapy is more likely to focus on patients' future experiences than PD treatment. Future research may shed light on this subject.

The equivalent focus of the two alternative treatments on a patient's expectations and wishes in the Goldfried and colleagues (1997, 1998) studies may be a result of a tendency for PI therapy to focus on a patient fantasized, imagined, or expected thoughts (Blagys & Hilsenroth, 2000). These findings highlight a difficulty encountered in the interpretation of the results included in this section. The CSTF contains a coding category that deals specifically with the time frame in which an intervention or utterance was focused (i.e., past, current, in-session, future). In addition, the CSTF contains coding categories labeled "Expectation" and "Intention" that also have future-oriented components in their coding description. Care should be taken when conducting adherence, fidelity, and process research to ensure that any item or variable assessing the time frame in which an intervention is focused is not confounded with other categories of interest such as motivations for behavior and patients' ability to anticipate future problematic situations and events. While this might prove to be a difficult task due to overlap in the constructs of interest, item descriptions and scoring guidelines must be made explicit.

In addition, studies reviewed in this section suggest that a focus on a patient's present life situation and functioning is a significant part of both short-term CB and PI therapy. One possible reason for this equivalent focus on the patient's current functioning could be the use of short-term, manualized PI treatments in these studies. In comparison with more traditional, longer-term PI therapies, the time constraints of short-term treatment may compel PI therapists to focus on a patient's present experiences more frequently. In addition, when an individual's past is explored, the therapist may link experiences to a patient's present functioning more readily in shorter-term treatments. Consequently, short-term, manualized PI therapists may focus more than PI therapists utilizing longer-term treatment on a patient's current feelings and relationships, possibly accounting for the equivalent focus between CB and PI therapy in this review.

2.5. Providing patients with information about their treatment, disorder, or symptoms

A fifth area in which CB and PI therapy appear to theoretically differ is in their respective emphasis on providing patients with information regarding their symptoms, disorder, or treatment. Theory suggests that CB therapists typically discuss with their patients the explicit rationale for their treatment or the specific techniques being used and may provide them with detailed information such as books or handouts about their symptoms (Beck et al., 1979; Dobson & Shaw, 1995). Providing information may serve to orient patients to the technique being used and increase their hope that his or her difficulties can be alleviated (Fennell & Teasdale, 1987). Imparting knowledge may also

Table 5
Provision of information in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems. 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS Item 57:* "Therapist explains rationale behind his/her technique or approach to treatment." CB therapy ($M = 6.9$) was rated significantly higher than PD therapy ($M = 4.0$, $P < .001$). **PD therapy:** No items regarding the provision of information to patients was found to be significantly characteristic of PD therapy.
Ablon and Jones (1998)	A panel of expert PD ($n = 11$) and CB ($n = 10$) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians.	**CB therapy:** *PQS Item 57:* "Therapist explains rationale behind his/her technique or approach to treatment." This item was rated as highly characteristic of CB therapy (factor score = 1.13). **PD therapy:** No items regarding the provision of information to patients was found to be significantly characteristic of PD therapy.
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the NIMH-TDCRP. 35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed by nine trained research-oriented psychologists and master's-level graduate students.	**CB therapy:** *PQS Item 57:* "Therapist explains rationale behind his/her technique or approach to treatment." This item was rated as significantly more characteristic of CB therapy ($M = 6.34$) than IP therapy ($M = 5.0$, $P < .001$). **IP therapy:** No items regarding the provision of information to patients was found to be significantly characteristic of IP therapy.

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Table 5 (*continued*)

Study	Participants	Instruments and raters	Findings
Goldfried et al. (1997)	27 patients receiving PI therapy diagnosed with major depressive disorder. 30 patients receiving CB therapy diagnosed with major depressive disorder.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .98. Ratings performed by groups of trained raters that included advanced graduate and undergraduate students.	**CB therapy:** CB therapists were significantly more likely to provide patients with therapeutically relevant information than PI therapists ($F=10.62$, $P=.002$).
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions.	**MTRS** Pearson product–moment correlations ranged from .92 to −.29 (mode of .70). 19% of the items were reported as performing in the poor range ($r<.30$). Raters were four professionals (including clinical psychologists, social workers, and psychiatric nurses) and eight graduate students from diverse theoretical orientations.	**CB therapy:** *Item 44:* Did the therapist attempt to explain the rationale behind the nature of the therapy to the client? (1) therapist offered explicit rationale (9) therapist offered no rationale. This item loaded negatively on a CB technique factor (factor loading = −.60) and loaded positively on an IP technique factor (factor loading = .31).
Goldfried et al. (1998)	14 patients treated by master PI therapists presenting with anxiety, depression, or both. 22 patients treated by master CB therapists presenting with anxiety, depression, or both.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .99. Ratings performed by groups of trained raters that included advanced graduate students.	**CB and PI therapy:** Master therapists of both orientations were significantly more likely to provide patients with therapeutically relevant information during significant portions of sessions than in nonsignificant portions of session ($F=7.87$, $P<.008$). **CB therapy:** No coding categories regarding the provision of information to patients were found to be characteristic of CB therapy alone. **PI therapy:** No coding categories regarding the provision

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Table 5 (*continued*)

Study	Participants	Instruments and raters	Findings
			of information to patients were found to be characteristic of PI therapy alone.
Goldsamt et al. (1992)	1 patient seen in a 45-min demonstration session by three master therapists (Beck, Meichenbaum, and Strupp).	**CSTF** (Goldfried et al., 1989) Average Cohen's κ values ranged from .23 to .79. Raters were three advanced graduate students with 2 years of experience/training using the CSTF.	**CB and PD therapy:** No significant differences were found between the three mastertherapists with regards to their provision of therapeutically relevant information to patients.

enhance a patient's ability to cope with problematic external, environmental situations. In contrast, PI theory suggests that therapists offer comparatively little information to patients about their treatment or disorder (Fenichel, 1945; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984).

Recent psychotherapy process research has found empirical differences between CB and PI therapy in their emphasis on providing patients with specific information about their treatment, disorder, or symptoms (see Table 5). Ablon and Jones (1998, 1999) and Jones and Pulos (1993) reported that CB therapists were significantly more likely than PD or IP therapists to explain the rationale behind their techniques or approach to treatment. Similarly, Goldfried et al. (1997) found that CB therapists were significantly more likely than PD therapists to provide patients with information relevant to the therapeutic process. DeRubeis et al. (1982) also reported that CB therapists explained the rationale for their treatment to their clients significantly more than IP therapy.

Some other studies utilizing more experienced therapists of each orientation have reported results contradictory to the notion that CB therapy emphasizes the dissemination of information about a patient's treatment, disorder, or symptoms to patients more than PI therapy. On a single-case, single-session basis, Goldsamt et al. (1992) revealed no significant differences between master C (Beck), CB (Meichenbaum), and PD (Strupp) therapists' provision of therapeutically relevant information. In addition, Goldfried et al. (1998) found no significant differences between master therapists in the provision of general facts and knowledge that have therapeutic implications for the patient. Instead, the authors noted that therapists of both orientations were more likely to provide patients with information regarding their treatment in important portions of sessions.

Results described in this section offer moderate support for the notion that CB therapy emphasizes the provision of information to patients about their symptoms, disorder, or treatment significantly more than PI therapy. Of the seven studies reviewed in this section, five found the theoretically assumed differences. The contradictory findings reported in the Goldfried et al. (1998) and Goldsamt et al. (1992) studies may reflect a deviation from the

prescribed guidelines of an approach to therapy on the part of the master therapists used in each study. The discrepancy between the Goldfried et al. (1997) and (1998) studies may also be the result of the experience level of the master therapists used in the 1998 study. That is, an examination of the mean CSTF category ratings in the Goldfried and colleagues (1997, 1998) studies suggest that the master PI therapists were more likely to disseminate information to patients than PI therapists with less experience. In addition, the conflicting results of the studies by Goldfried and colleagues may also be the result of one study being conducted in a controlled clinical trial and the other in a naturalistic setting.

Future research may attempt to better describe what providing a patient with information means. For example, the CSTF defines its "Information Giving" category broadly as "providing general facts and knowledge that have therapeutic implications for the patient/client (Goldfried et al., 1997)." In addition, future research should better define the type information being provided. Better explanation of the coding category may perhaps lead to different empirical findings in this area.

2.6. Cognitive/intrapersonal focus

A sixth area in which CB and PI therapy differ theoretically is in their focus on a patient's cognitive/intrapersonal functioning. As stated previously, CB theory is based, at least in part, upon the notion that a patient's emotions and behavior are influenced by his or her beliefs or thoughts about the world. By evaluating, challenging, and modifying a patient's irrational or illogical beliefs, he or she presumably gains control over problems previously believed to be insurmountable and progress is made (Beck et al., 1979; Ellis, 1995; Goldfried & Davison, 1994; Meichenbaum, 1977). PI theory also suggests that therapy contains an intrapersonal focus with its emphasis on inner impulses, conflicts, wishes, expectations, and fantasies (Fenichel, 1945; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984). However, this focus is believed to be qualitatively different from CB therapy's focus on irrational and illogical beliefs that are directly related to psychiatric symptoms and maladaptive behaviors.

Some empirical psychotherapy process research has shown that this theoretical difference is also evident at the level of clinical practice. Ablon and Jones (1998, 1999) and Jones and Pulos (1993) reported that the PQS item, "Discussion centers on cognitive themes (i.e., about ideas or belief systems)" was significantly more characteristic of CB than PD or IP therapy. Silove et al. (1990) also revealed differences between PD and CB therapy in their emphasis on a patient's cognitive functioning from a patient's perspective. Patients who received CB therapy noted that their therapists emphasized the cognitive change of attitudes significantly more than patients treated with PD therapy.

Hill et al. (1992) and Startup and Shapiro (1993) investigated treatment fidelity in PI/IP and CB therapy. In these studies, CB therapists scored significantly higher than PI and IP therapists on a scale measuring adherence to prescriptive (CB) therapy. This scale included items assessing cognitive rationale and cognitive processes in addition to the evaluation and changing of beliefs. DeRubeis et al. (1982) and Luborsky et al. (1982) also reported that CB therapists focused significantly more than PD and IP therapists on finding, examining,

testing, and challenging the validity of the patient's distorted beliefs. Similarly, Samoilov et al. (2000) reported that CB therapy scored significantly higher than PI therapy on a scale that included items related to a focus on a patient's thinking and thought process.

Goldsamt et al. (1992) coded a single session of individual therapy with the same patient conducted by Beck (C), Meichenbaum (CB), and Strupp (PD) using the CSTF. On this individual case and session, master therapist level of examination, empirical differences were also identified between therapists with regard to their respective emphasis on intrapersonal elements of the patient's functioning. Beck was significantly more likely than Strupp to highlight the impact that one component of the patient's intrapersonal functioning was having on another component. However, Strupp was significantly more likely than either Beck or Meichenbaum to identify similarities or recurrences within the patient's intrapersonal functioning. Strupp's focus on similarities or recurrences in the patient's intrapersonal functioning may reflect PD therapy's greater emphasis on the identifications of patterns in a patient's experiences (Blagys & Hilsenroth, 2000). These findings underscore the intrapersonal focus of cognitive therapy and again highlight the emphasis on similarities in a patient's functioning in PD therapy. The lack of significant differences between Beck and Meichenbaum's sessions in the emphasis of intrapersonal factors is not surprising.

Some studies have not reported the expected greater focus on a patient's intrapersonal functioning in CB therapy. Kerr, Goldfried, Hayes, and Castonguay (1992) reported that CB therapist made more IP than intrapersonal links. However, this difference was not significant. The authors also noted that both CB and PI therapists tended to have an interpersonal rather than an intrapersonal focus. This finding is consistent with the interpersonal focus of PI therapy. However, the finding that CB therapists made more interpersonal than intrapersonal links was not expected as this appears to be inconsistent with the central intrapersonal focus of CB sessions. Kerr et al. (1992) noted that this finding is an indication that CB therapists deviated from what might be expected by traditional CB theory and suggest that CB therapy was closer to PD therapy than might be expected on a theoretical level (Kerr et al., 1992).

In addition to the findings of Kerr et al. (1992), Goldfried et al. (1997) reported a greater intrapersonal emphasis in PI than CB therapy. PI sessions were found to place significantly more emphasis than CB sessions on similarities and differences that may exist within aspects of patients' intrapersonal functioning. More recently, Samoilov et al. (2000) found that PI therapy scored significantly higher than CB therapy on a scale that included items focusing on intrapersonal links. Goldfried et al. (1998) found no significant differences between PI and CB therapy in their focus on a patient's intrapersonal experiences in sessions conducted by master therapists. Results of the Goldfried and colleagues (1997, 1998) and Samoilov et al. (2000) studies suggest that in some instances, PI therapists focus as much as CB therapists on intrapersonal aspects of a patient's functioning. However, PI therapy's greater focus on intrapersonal functioning in these studies may be due to the approaches' tendency to focus on patterns in this realm of an individual's functioning. Goldfried et al. (1997) included the identification of patterns and inconsistencies in a patient's functioning in their intrapersonal coding category. This general emphasis on the identification of themes and patterns in a patient's functioning is consistent with the PI approach (Blagys & Hilsenroth, 2000).

Table 6
Intrapersonal/cognitive focus in CB and PI therapy

Study	Participants	Instruments and raters	Findings
Jones and Pulos (1993)	30 patients (20 women, 10 men) receiving brief PD therapy for various problems. 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder receiving CB therapy and tricyclic pharmacotherapy, alone and in combination.	**PQS** (Jones, 1985) Pearson product–moment correlations ranging from .83 to .92. Ratings completed by 10 trained research-oriented clinicians and graduate students from a range of theoretical orientations.	**CB therapy:** *PQS Item 30:* "Discussion centers on cognitive themes, i.e., about ideas or belief systems." CB therapy ($M = 7.78$) was rated significantly higher than PD therapy ($M = 5.0$, $P < .001$) on this item. **PD therapy:** No items regarding a focus on cognitive themes were found to be characteristic of PD therapy.
Ablon and Jones (1998)	A panel of expert PD ($n = 11$) and CB ($n = 10$) therapists.	**PQS** (Jones, 1985) Coefficient α of .94 for expert PD clinicians and .95 for expert CB clinicians. Ratings completed by expert PD and CB clinicians.	**CB therapy:** *PQS Item 30:* "Discussion centers on cognitive themes, i.e., about ideas or belief systems." This item was found to be highly characteristic of CB therapy (factor score = 1.68, second highest). **PD therapy:** No items regarding a focus on cognitive themes were found to be characteristic of PD therapy.
Ablon and Jones (1999)	29 patients receiving CB treatment diagnosed with depression from the NIMH-TDCRP. 35 receiving IP therapy diagnosed with major depressive disorder from the NIMH-TDCRP.	**PQS** (Jones, 1985) Alpha coefficients ranging between .83 and .89. Ratings were completed by nine trained research-oriented psychologists and master's-level graduate students.	**CB therapy:** *PQS Item 30:* "Discussion centers on cognitive themes, i.e., about ideas or belief systems." This item was found to be significantly more characteristic of CB therapy ($M = 8.09$) than IP therapy. **IP therapy:** ($M = 4.29$, $P \leq .001$) No items regarding a focus on cognitive themes were found to be characteristic of IP therapy.
Silove et al. (1990)	81 subjects (38% receiving PD therapy, 28% cognitive therapy, 17% behavior therapy, and 7% CB therapy) seeking services for anxiety and depression.	Two unnamed questionnaires measuring therapist activities. Cronbach's α for subscales of the questionnaires ranged from .79 to .96. Raters were patients who completed the questionnaires.	**CB therapy:** Recipients of CB therapy rated their therapists ($M = 32.9$, S.D. = 9.3) as emphasizing cognitive focus and attitude change significantly more than those receiving PD ($M = 21.5$, S.D. = 10.0, $F = 20.00$, $P < .01$).

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Table 6 (*continued*)

Study	Participants	Instruments and raters	Findings
Startup and Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project.	**SPRS** (Shapiro & Startup, 1990) ICC ranged from .78 to .85. Ratings were completed by eight trained coders that included clinical psychologists, graduate students, and psychological assistants working in the adult mental health field.	**CB therapy:** Prescriptive therapists ($M=26.8$) scored significantly higher on the P scale, which included items reportedly measuring cognitive rationale, assessing cognitive processes, evaluating and changing beliefs than exploratory therapists ($M=12.1$, $P<.0001$).
Hill et al. (1992)	180 patients from the NIMH-TDCRP.	**CSPRS** (Hollon et al., 1988) Correlations between mean ratings of different ratings groups were significant and ranged from .91 to .98. Ratings were completed by two trained coders.	**CB therapy:** CB therapists ($M=2.39$) scored significantly higher on the CBT scale, which included items reportedly measuring cognitive rationale, assessing cognitive processes, evaluating and changing beliefs than IP therapists ($M=1.29$, $P<.01$).
Luborsky et al. (1982)	Narcotic addicts treated by four SE therapists and four CB therapists.	An unspecified rating form was used to code psychotherapy sessions. No psychometric data were reported for the rating form. Raters were two individuals with experience in coding samples of psychotherapy sessions from other studies. One other independent rater also coded speech content of sessions using the Temple Content Categories.	**CB therapy:** CB ($M=2.7$) focused significantly more than PD therapy ($M=1.1$, $P<.01$) on finding cognitive distortions. CB ($M=2.6$) focused significantly more than PD therapy ($M=1.2$, $P<.01$) on challenging cognitive beliefs.
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions.	**MTRS** Pearson product–moment correlations ranged from .92 to −.29 (mode of .70). 19% of the items were reported as performing in the poor range ($r<.30$). Raters were four professionals (including clinical psychologists, social workers, and psychiatric nurses)	**CB therapy:** *Item 5:* To what extent did the therapist examine (or encouraged the client to examine) the validity of the client's beliefs? This item was part of the CBT factor (factor loading = .59) and negatively related to IP psychotherapy technique (factor loading = −.19). *Item 23:* Did the therapist (and/or client) work to set up an experiment for the client to try (i.e., testing something he/she

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Table 6 (*continued*)

Study	Participants	Instruments and raters	Findings
		and eight graduate students from diverse theoretical orientations.	believes by gathering data relevant to the belief or behaving differently than he/she might typically do? This item was part of the CBT factor (factor loading = .72) and was negatively related to the IP therapy technique factor (factor loading = − .33).
Samoilov et al. (2000)	28 patients receiving CB treatment and 29 patients treated with PI therapy from the Second Sheffield Psychotherapy Project.	**TFAI** ICC ranged from .88 to .94. Raters were two trained undergraduates.	**CB therapy:** CB therapy scored significantly higher than PI therapy on a scale that included items measuring a focus on the patient's thoughts and making intrapersonal links [$F(1,49) = 29.30$, $P < .001$].
Goldsamt et al. (1992)	1 patient seen in a 45-min demonstration session by three master therapists (Beck, Meichenbaum, and Strupp).	**CSTF** (Goldfried et al., 1989) Average Cohen's κ values ranged from .23 to .79. Raters were three advanced graduate students with 2 years of experience/training using the CSTF.	**CB therapy:** Beck placed more emphasis on intrapersonal consequences than Strupp ($\chi^2 = 4.06$, $P < .05$). **PD therapy:** Strupp focused more on intrapersonal patterns than either Beck ($\chi^2 = 4.85$, $P < .05$) or Meichenbaum ($\chi^2 = 4.57$, $P < .05$).
Kerr et al. (1992)	13 patients receiving PI therapy and 14 patients receiving CB therapy presenting with depression and/or anxiety from the Sheffield I project.	**CSTF** (Goldfried et al., 1989) ICC were reported as .38 and .61. Raters were trained clinical graduate students from CB and PD orientations.	**CB therapy:** CB therapist made more interpersonal than intrapersonal links in their therapy [$t(13) = 1.68$, $P < .15$], but this difference was not significant. However, this intrapersonal focus was positively related to symptom improvement as measured by the SCL-90 ($r = .49$, $p < .05$).
Goldfried et al. (1997)	27 patients receiving PI therapy diagnosed with major depressive disorder. 30 patients receiving CB therapy diagnosed with major depressive disorder.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .98. Ratings performed by groups of trained raters that included advanced graduate and undergraduate students.	**CB therapy:** No differences between PI and CB therapy were found to favor CB therapy in the area of intrapersonal focus. **PI therapy:** PI therapists placed more of a therapeutic focus than CB therapists on similarities and patterns within a client's cognitive functioning ($F = 3.96$, $P = .05$) and incongruities that may exist between aspects of their intrapersonal functioning ($F = 22.9$, $P = .001$).

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Table 6 (*continued*)

Study	Participants	Instruments and raters	Findings
Goldfried et al. (1998)	14 patients treated by master PI therapists presenting with anxiety, depression, or both. 22 patients treated by master CB therapists presenting with anxiety, depression, or both.	**CSTF** (Goldfried et al., 1989) ICC ranged from .54 to .99. Ratings performed by groups of trained raters that included advanced graduate students.	**CB and PI therapy:** Master PI and CB therapists were more likely to highlight the intrapersonal consequence one aspect of clients' functioning had on another ($F = 17.26$, $P = .001$) in significant portions of sessions than in nonsignificant portions of sessions.
Gaston and Ring (1992)	16 depressed patients from a larger outcome study by Thompson et al. (1987) (10 receiving brief PD therapy; 6 in cognitive therapy).	**ITS** ICC ranged from .21 to .98 across treatments with a mean of .84 and .68. Raters were two postdoctoral fellows in clinical research with experience in behavioral, cognitive, and dynamic therapy.	**PD therapy:** PD therapists ($M = 1.45$, S.D. = 0.52) emphasized patients' problematic cognitions significantly more than cognitive therapists ($M = 0.62$, S.D. = 0.62, $t = 13.23$, $P < .005$).

Research on the Inventory of Therapeutic Strategies (ITS) by Gaston and Ring (1992) also reported that dynamic therapists tended to emphasize a patient's problematic cognitions significantly more than CB therapists. However, as the authors suggest, PD therapy strongly advocates the exploration of a patient's fantasized or imagined expectations of events and experiences. The cognitions category of the ITS included both a patient's cognitions and expectations. A PD therapist's exploration of a patient's imagined or fantasized expectations, then, may inflate his or her rating in this category and account for the findings reported in this study. Incorporating an additional subcategory focusing on a patient's wishes or expectations may have been helpful in differentiating the two aspects of the original cognitions category (Gaston & Ring, 1992).

The research reviewed in this section provides moderate support for the theoretical conjecture that CB treatment focuses more than PI therapy on a patient's cognitive functioning. Of the 15 articles included in this section, 10 found a significantly greater emphasis of a patient's cognitive/intrapersonal functioning in CB therapy than PI therapy (see Table 6). The greater emphasis on a patient's intrapersonal functioning in PI sessions as found in the Gaston and Ring (1992), Goldfried et al. (1997), and Samoilov et al. (2000) studies may possibly be attributed to the definition and operationalization of the intrapersonal coding categories used in these articles. "Intrapersonal" may be too broad a category for comparing PI and CB treatments on adherence, fidelity, and psychotherapy process measures. Future comparative process research should attempt a finer definition and discrimination between a cognitive focus on irrational/illogical thoughts and beliefs (more consistent with a CB approach) and an intrapersonal focus on wishes and expectations (perhaps more congruent with a PI approach). Overall, however, the articles reviewed in this section provided evidence for CB therapy's significantly greater focus on cognitive and intrapersonal experiences.

2.7. Conclusion

In order to determine the relative contributions of CB and PI techniques to treatment outcome, researchers must establish what interventions and activities are specific to and distinctive of each treatment approach. The current review was conducted in order to identify techniques and therapeutic activities that distinguish CB from PI therapy. Six activities discriminated the two treatments (see Table 7). The six empirically distinctive techniques reflect a set of interventions focused on changing dysfunctional thinking, offering psychoeducation, and developing skills for coping with symptoms both in the present and future.

In addition to the above distinctive features, CB therapy has begun to incorporate processes and interventions from other forms of treatments (Beck, 1991; Mahoney, 1991, 1993; Mahoney & Lyddon, 1988; Robins & Hayes, 1993). For example, some authors have discussed the integration of processes more PI in nature such as a greater emphasis of the therapeutic relationship (and a patient's IP relationships in general), an exploration of defensive processes, an emphasis on a patient's affect, an acknowledgment of unconscious processes in human experience, and an increased focus on a patient's developmental experiences (Hayes & Strauss, 1998; Mahoney, 1993; Robins & Hayes, 1993). Given recent research supporting the relationship between these PI activities and patient outcome in CB treatments (Ablon & Jones, 1998; Castonguay et al., 1996; Hayes et al., 1996; Hayes & Strauss, 1998; Jones & Pulos, 1993), this practical integration is encouraging. The broadening of existing CB interventions to include the above PI techniques may potentially make CB therapy a more powerful and viable treatment options for a wider range of patients and presenting problems.

Specific attention was paid in this review to the implication of these findings for the development of future adherence, competence, and psychotherapy process instruments. An examination of the articles reviewed in this study revealed several important methodological and scoring issues that require clarification in future research. First, it may be useful to include items assessing the different types of homework utilized in CB treatment (i.e., written, verbal/thought exercise vs. behavioral activity). It was also suggested that the specificity or generality of between-session activities also be taken into account and examined in future adherence, process, and outcome research. Second, adherence and process measures must take care to differentiate between the purely quantitative assessment of a therapist's activity

Table 7
Summary: Distinctive characteristic of CB treatment

(1)	Emphasizes homework and outside of session activities
(2)	Direction of session activity
(3)	Teaching skills to cope with symptoms
(4)	Focus on a patient's future experiences
(5)	Providing the patient with information about his or her treatment, disorder, or symptoms
(6)	Focuses on a patient's cognitive/intrapersonal experience (specifically illogical or irrational thoughts and beliefs)

level (e.g., how active a therapist was in a session or how much he or she spoke) and the actual direction of session activity (e.g., setting and maintaining an agenda). Activities identified in this review may provide a foundation for more psychometrically sound. Third, adherence and process measures must explicitly define and provide scoring guidelines to help differentiate between a focus on a future time frame, motivations for future behavior, and the patients' ability to anticipate future problematic situations and events. Fourth, future research should attempt to better define what is meant by providing a patient with information. Existing coding instruments such as the CSTF often do not define what type of information is given to patients. Developers of future adherence and psychotherapy process measures may wish to separate this category into several subcategories assessing potentially different types of presented information (such as general facts, treatment rationale, relationship between thoughts, feelings, and behavior, prevalence of disorder, or patient diagnosis). Finally, future adherence and competence research might benefit from a separation of items assessing intrapersonal components of a patient's functioning (such as wishes, fantasies, expectations, and intentions) from those specifically focusing on dysfunctional or distorted cognitions. Making some of these changes in our existing and future instruments may provide more accurate descriptions of the treatment process and lead to a greater understanding of the relationship between these treatment-specific activities and patient outcome.

In terms of the implications of this paper for training and clinical practice, identification of distinctive CB activities can provide therapists with a guide for session activity by specifying the techniques and interventions to be emphasized in treatment. Supervisors could also use this review as tool for training students and trainees in the distinctive features of CB treatment. We hope that this review serves as a useful heuristic for future psychotherapy process and outcome research as well as a tool for clinical practice and training.

Some potential limitations of the present review must be acknowledged. First, the research included in this review focused heavily on studies comparing CB and PI treatments for depression. While this was not our intention, the predominance of studies examining CB treatment for depression may be due in part to the fact that this disorder has received a large amount of empirical research relative to other psychological difficulties. Furthermore, CB treatment for depression may be the most open-ended of CB treatments (there is no extensive exposure component) which allows for the investigation of treatment process. While many of the articles included in this review focus on CB treatment for depression, we believe the distinctive features identified in this review would generalize to treatments considered more traditionally behavioral in nature. For example, activities such as assigning homework, directing session activity, teaching coping skills, and providing an explicit rationale for treatment are interventions that would likely be found in more specifically behavioral treatments for a variety of difficulties such phobias, panic, and other anxiety disorders.

A second limitation of this review is that ratings of the activities judged to be distinctive of CB therapy were conducted by a heterogeneous population of coders. Raters ranged from patients, to therapists with different levels of expertise in the provision of psychological treatments (i.e., experts vs. less experienced clinicians), to independent raters with varied amounts of expertise and training in the delicate process of coding psychotherapy sessions and psychotherapy process instruments. In addition to the perspective of the rater, the

psychometric properties of the instruments used in the articles under review were also of variable quality.

In conclusion, this review endeavored to identify the techniques that distinguish CB from PI treatment. Identifying the distinctive elements of alternative approaches to treatment may aid in the development of more psychometrically sound instruments with which to assess adherence and competence. We hope this review serves a heuristic function for future research on the relationship between treatment-specific activities and patient outcome.

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