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Research in Psychotherapy Sciences

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by means of the research project

Are there equivalent ways of achieving psychotherapeutic outcome? A comparative process-outcome study in an outpatient clinic

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Data on the project

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1.2 Data on the research project

Working title
Are there different ways of achieving psychotherapeutic outcome?
A comparative process-outcome study in an outpatient clinic

Area of Expertise
Psychotherapy Science

Expected time frame
Total time of the research intent: 24 months
Beginning of the project: November 2008
End of the project: November 2010

1.3 Scientific cooperation

Prof. Dr. Wolfgang Tschacher (University of Bern) has friendly offered his theoretical and methodological support for the present project.

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1 Introduction

Psychotherapy can be roughly defined as a primarily interpersonal context aimed at aiding clients who suffer from mental disorders, problems, or complaints. Despite this general common aim, a large number of therapies exist (e.g., psychoanalytic, psychodynamic, cognitive-behavioral, person-centred, systemic, humanistic), each containing its own rationale and specific techniques. Empirical (outcome) research has shown the *general* efficacy of psychotherapy, i.e., that the general effects of psychotherapeutic treatments are superior to no treatments or placebo (Smith & Glass, 1977; Smith et al., 1980; Landman & Daws, 1982; Lipsey & Wilson, 1993; Lambert & Bergin, 1994). However, concerning the *relative* efficacy of psychotherapy (i.e., the relative effects produced by the comparison of two or more treatments), it has not been possible for comparative outcome research to show that one therapeutic approach is clearly superior to another (Smith & Glass, 1977; Smith et al., 1980; Shapiro & Shapiro, 1982; Wampold et al., 1997) [1]. In other words, psychotherapy is effective, but no substantial differential effectiveness has been demonstrated (for a systematic review and discussion see Bergin & Ogles, 2004 and Wampold, 2001).

The paradox of "no differential effectiveness despite of technical diversity" – also called *equivalence paradox*[2] (see Stiles, Shapiro & Elliot, 1986) – represents a serious dilemma, because it implies that no matter what a therapist does, the end result is the same (Stiles & al., 1986). Moreover, it is quite remarkable, given the claims of unique therapeutic properties made by advocates of the various treatments available today (see Karasu, 1986). ((In fact, comparative process research has shown that the different therapeutic orientations are characterized by different "ingredients", i.e., the constitutive elements and characteristics which allow to describe each therapeutic orientation (Stiles et al., 1986).))

How can we explain this contradiction? According to Lamber & Ohles (2004), the general finding of no difference in the outcome of therapy for clients who have participated in highly diverse therapies has a number of alternatives explanations: (a) different outcomes do occur but are not detected by past research strategies because of methodological weaknesses; (b) different therapies can achieve similar goals through different processes; (c) different therapies embody common factors that are curative, though not emphasized by the theory of change central to a particular school.

At this time, any of the above proposed explanations can be absolutely advocated and defended because there is not enough evidence to rule out evidence available to reject

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[1] There seem to be some evidence that different therapeutic approaches lead to different outcomes (e.g., Chambless & Hollon, 1998; Crits-Christoph, 1997). However, these results are generally considered to reflect methodological biases (Wampold, 2001.

[2] The equivalence paradox is also known as Dodo Bird verdict from *Alice in Wonderland*, "Everybody has won and all must have prizes", which vividly characterizes the supposed equivalence of the different therapies. Used in this context for the first time by Rosenzweig (1936), it has been retrieved as a subtitle by Luborsky et al. (1975), and is nowadays commonly used within current literature.

alternative explanations. Anyway, as we will describe later, preferential lines of empirical investigation may be drawn.

Actually a debate exists about the possibility that methodological weaknesses could be responsible for the equivalence paradox – explanation (a). The inadequacy of past comparative outcome research is sustained by several authors. For example, Kazdin and Bass (1989) PG 187 BERGIN have questioned the value of the majority of past comparative studies on the basis of a "lack of statistical power". Stiles et al. (1986) summarized some of the methodological biases of past research: lack of sensitivity of meta-analytic procedures, inadequacy of common research designs in order to assess specificity of effectiveness, shortcomings in the operationalization of treatment variables for research, and the need of differentiation of outcome measures. On the other side, some other authors (e.g., Wampold, 2001) assert that, although some methodological biases can be sporadically observed, the result of the actual comparative outcome research can be trusted.

Another debate in psychotherapy research is the so called *specificity versus nonspecificity controversy* (Karasu, 1986). In its simplest descriptive form, it pertains to the question of whether *unique* (i.e., specific) or *common* (i.e., nonspecific) factors are responsible for therapeutic effectiveness. The efficacy of each school of psychotherapy has been attributed by its respective founders and followers to features that distinguish their particular treatment or type of cure. Within this context, certain special techniques or processes, such as for example the analysis of transference, catharsis, systematic desensitization, and relaxation, have been considered a crucial component of the therapeutic endeavor. This position would account for the explanation (b), i.e., that different therapies can achieve similar goals through different processes. Anyway, we still do not have enough empirical results to discuss this explanation and its merits (for an exception see Grawe, Casper, & Ambühl, 1990).

Alternatively, especially in the light of the proliferation of diverse and often contrasting treatments of apparently equal efficacy, some investigators are seeking to locate underlying similarities or common factors across therapies. This position would account for the explanation (c), i.e., that there are general factors that cut across the different modalities and that these are more important than are factors unique to specific treatments. Actually, review of empirical evidence (Lambert, 1992_CONT_FAM_THER; Lambert & Ogles, 2004) is firmly suggesting that common factors across treatments account for a substantial amount of improvement found in psychotherapy patients. The so-called common factors may even account for most of the advances that result from psychotherapeutic interventions (Lambert & Ogles, 2004). So, while we do not necessarily rule out the possibility that variables specific to one school or technique might be found to make an additional contribution, at this point it is important to recognize that common factors are contributing a great deal to positive outcome. Therefore, future empirical research should try to answer the question if it is crucial for therapists to intentionally incorporate them.

1.1 Common factors

The idea that there are common therapeutic agents and that they are activated in diverse treatments is not a new one. Through the years, probably beginning with Rosenzweig (1936_WEINBERGER), many thinkers have offered their views of what these factors might be, and Goldfried (1982) has reprinted many of these seminal works. Until recently however, these efforts have been few and non-systematic. The one exception has been the work of Frank (1973, 1982). On the contrary, since the 1980s there has been a systematic effort in order to describe and discuss therapeutic common factors. Karasu (1986) – whose paper represents a milestone in the common factors literature – has examined common factors from a theoretical perspective, arguing that three factors can be identified: *affective experiencing*, *cognitive mastery*, and *behavioral regulation*. He suggests that these factors can be activated in diverse ways via the techniques central to particular treatment orientations, advocating that each therapy employs specific techniques to elicit similar goals or processes in patients (e.g., psychoanalytic free association, psychodrama role playing, behavioral therapy flooding in relation to affective experiencing; psychoanalysis interpretation and cognitive therapy correcting false beliefs in relation to cognitive mastery; and behaviour therapy conditioning, psychoanalysis identification, and assertiveness training teaching skills in relation to behavioral regulation). There is a limited number of important therapeutic goals or processes but an unlimited number of ways how these processes can be activated.

Since then, common factors have been conceptualized in several ways (e.g, Stiles et al., 1986; Lambert, 1992_CONT_FAM_THER; Weinberger, 1993, 1995_WEINBERGER; Grawe, 2000).

In an effort to make sense of this wide array of proposed mechanisms, Grencavage and Norcross (1990) collected articles dealing with common factors to discern commonalities among proposed therapeutic factors across these contributions. According to the identified commonalities they found the following superordinate categories: *client characteristics* (e.g., client's positive expectancies and hope for improvement), *therapist qualities* (e.g., therapist's ability of cultivating hope and enhancing expectancies, warmth and positive regards, and empathic understanding), *change processes* (e.g., opportunity for catharsis, acquisition and practice of new behaviours, provision for rationale, fostering insight, emotional and internersonal learning), *treatment structure* (e.g., use of concrete techniques and rituals, focus on "inner world" and exploration of emotional issues, adherence to theory), and *therapeutic relationship* (e.g., development of a working alliance between patient and therapist, engagement, transference). As these authors pointed out, however, most of the papers they reviewed were not empirically based. What they established was a consensus on factors that have yet to be empirically validated.

In a further attempt, Lambert & Bergin (1994) proposed a set of common factors derived from their review of empirical research: *support* (e.g., catharsis, identification with therapist, positive relationship, therapist warmth, respect, empathy and acceptance), *learning* (e.g., advice, affective experiencing, cognitive learning, feedback, insight), and *action* (e.g., behavioral regulation, cognitive mastery, modelling, working through) factors. These categories were chosen to represent a sequence that according to the authors operates in many psychotherapies: supportive factors precede changes in learning factors, which precede the therapist's attempts to encourage patient action (Lambert & Bergin, 1994). However, these factors were derived by taking into consideration empirical psychotherapy research in general, and not studies which directly addressed the issue of defining and assessing common factors in different therapies.

An interesting step forward has been made by Castonguay and Beutler (2006). Their work aims at identifying evidence-based principles of change, and is based on the integration of the work of the Empirically Supported Treatment movement (EST) – which produced a compilation of psychotherapeutic treatments and interventions found to be most effective (see Gorman, 2002) – and of the APA's Division of Psychotherapy on (Division 29) – whose work focused on the identification of Empirically Supported Therapeutic Relationships (ESTR; see Norcross, 2002). They describe three major factors which empirical research has demonstrated to be positively related to outcome: participant characteristics (divided in observed and inferred characteristics), therapeutic relationship (i.e., quality of therapeutic relationship, therapist interpersonal and clinical skills), and technique factors (i.e., therapeutic stance and general interpersonal style, framework of intervention, interpersonal/systemic vs. intrapersonal/individual procedures, abreactive vs. supportive procedures.

The perspectives described above are quite promising, and offer a plausible explanation for the failure to find differences in outcome between different therapies. Emphasizing the investigation of common factors in addition to specific factors will encourage a greater harmony between competing approaches, ultimately increasing the effectiveness of psychotherapy. However, direct empirical evidence is still needed to examine the importance of common factors.

As we have seen, proponents of a common factor or set of common factors usually review the history of the factor, point to its ubiquitous presence in all form of therapy, cite the relevant research (if there is any) to that specific factor, and move on, confident that his or her case has been proved. What is actually missing is direct empirical evidence that (a) specific common factors and not others do exist, and that (b) this factors are positively related to therapeutic outcome. One exception is that of therapeutic alliance, which many of the conceptualizations described above have proposed, and that has been extensively investigated on an empirical level.

Therapeutic alliance

The alliance between the client and the therapist is the most frequently mentioned common factor in the psychotherapy literature (Grencavage & Norcross, 1990). The concept of therapeutic alliance between therapist and client originated in the psychoanalytic tradition and was conceptualized as the healthy, affectionate, and trusting feelings toward the therapist, as differentiated from the neurotic component (i.e., transference) of the relationship. Over the years, the concept of alliance has been defined pantheoretically to include other aspects of the relationship, including (a) the client's affective relationship with the therapist, (b) the client's motivation and ability to accomplish work collaboratively with the therapist, (c) the therapist's emphatic responding to and involvement with the client, and (d) client and therapist agreement about the goals and tasks of therapy (Gaston, 1990). There are a number of reasons for selecting the alliance as a common factor to examine. First, the alliance is mentioned prominently in the psychotherapy literature and draws attention from theorists and clinicians across many disparate approaches. Second, there are a sufficient numbers of studies that have investigated the association between alliance and outcome using a variety of well-developed and accepted measures.

The idea of a therapeutic alliance was first enunciated within *psychoanalysis*. Freud (1910) described it as having two complementary aspects: the therapist's understanding and feeling well-disposed toward the patient and the therapist's encouragement of the patient's warm feeling toward the therapist. Freud considered this positive, reality-based component of the therapeutic relationship a positive force in treatment the patient's neurosis, and the therapist was enjoined to actively try to foster it. This work has been expanded upon in the psychoanalytic literature most especially by Greenson (1967), who coined the term *working alliance*. Bordin (1979) wrote an often-cited paper reviewing this concept, in which he declares the working alliance to be a major, if not the major, common factor across various forms of psychotherapy. Gaston has written a more recent review, describing the core components of the therapeutic alliance which are considered in many of the conceptual and research articles published nowadays. Clearly, the therapeutic alliance is central to *psychodynamic* therapies as well. Its importance ranges from asserting the absolute centrality of the relationship to positing the therapeutic alliance as necessary for other, more critical, processes to take place. Thus Yalom (1980) argues that the relationship is the vehicle for cure, and Kohut (1984) presents a model wherein empathy moves psychological development forward.

A notion very similar to that of therapeutic alliance was also developed by the *humanistic/experiential* school. Thus Rogers (1951, 1957) argued that the therapist's offering of unconditional positive regard, accurate empathy, and genuineness were both necessary and sufficient for therapeutic progress, provided that the patient senses these qualities. Non-Rogerian humanistic/experiential approaches also accord critical importance to the

therapeutic relationship (Greenberg, Elliot, & Lietaer, 1994). In contrast to Rogerian nondirective approach however, non-Rogerian approaches see the therapeutic relationship not as sufficient for change, but as a mean in order to deepening experiencing (Greenberg et al., 1994).

Other schools of psychotherapy accord differing levels of importance to the therapeutic alliance but do not see it as central. Thus, Beck, Rush, Shaw, and Emery (1979) devote a chapter of their manual on *cognitive therapy* to the relevance of the therapeutic relationship but see it as facilitator of the specific techniques of cognitive therapy and not as ameliorative in its own right. Some cognitive therapists (e.g., Ellis & Dryden, 1987) even warn of overvaluing the therapeutic alliance. The empirical research in cognitive therapy reflects this lack of emphasis. However, this picture is beginning to change. For example, Guidano and Liotti (1983) as well as Safran and Segal (1990) have all discussed the importance of the therapeutic relationship within cognitive therapy with direct reference to psychoanalytic and psychodynamic literature. *Learning-based behavioral treatments* also do not typically view relationship factors as central, except for seeing the therapist as a potent source of reinforcement (cf. Gelso & Carter, 1985).

A great deal of empirical data strongly support the therapeutic efficacy of the therapeutic alliance (see Wampold, 2001 for a review of the most significant results). This support is most clearly evidenced in a meta-analysis conduced by Horvath and Symonds (1991). They reviewd 24 studies and found a reliable effect of the therapeutic alliance on therapeutic outcome. Moreover, the effect of the therapeutic alliance was similar in psychodynamic, cognitive, and eclectic/mixed therapies and across a wide range of diagnostic categories. In another study, Krupnick et al. (1996) investigated the relationship between therapeutic alliance and outcome across four treatments for depression: cognitive-behavioral therapy, interpersonal psychotherapy, imipramine plus clinical management, and pill-placebo plus clinical management. Although no effects concerning the relative efficacy of the four treatment conditions could be observed, the results of this study showed a consistency of alliance-outcome relationship across treatments. First, there were no statistically significant differences among the mean alliance ratings for the four treatments. Second, the therapeutic alliance assessed at an early session (session 3) explained a relatively high amount of variance (8%) in the outcome scores, and the mean therapeutic alliance scores (over all the sessions) explained an even higher amount of variance of outcome (21%). Third, there were virtually no significant treatment group differences in the relationship between therapeutic alliance and outcome in the four treatments considered.

1.2 Comparative process-outcome research

The equivalence of the effectiveness between different psychotherapy is a paradox because, although it has been shown that psychotherapy is effective (*outcome* research), and that different psychotherapeutic orientations are different from a theoretical and technical point of view (*process* research), no reliable results have been found concerning the relative efficacy of the different psychotherapeutic schools (*comparative outcome* research). We propose that, in order to shed light on this paradox, *comparative process-outcome* research should be conducted, which consists of systematically investigating the relationship between therapeutic process and outcome in different therapeutic orientations[3]. Although a great deal of empirical literature concerning the relationship between therapeutic process and outcome (*process-outcome* research) exists (see Orlinsky, Rønnestad & Willutzky, 2004 for a comprehensive review), relatively little exists concerning the systematic comparisons of such relationships between different treatments. An exception is the study of Grawe, Caspar, & Ambühl (1990), who investigated classical behavioral therapy, interactional behavioral therapy in individual and group settings, and client-centred psychotherapy. Their findings show that, although the four treatment modalities do not differ in their outcome, a different relationship exists between therapeutic outcome and process in each therapy form considered.

With regard to what we described in the previous paragraphs, it emerges that in order to comprehensively compare different psychotherapeutic treatments, we need:

a) to accurately describe the different processes which characterize the different forms of psychotherapy/psychotherapeutic treatments (both in terms of common factors and therapeutic alliance as well as of specific factors).
b) to identify which features of these different processes predict the therapeutic outcome in each treatment form and compare them to each other.

[3] This kind of research has been conceptualized by Grawe (1989) as *differential process analysis*.

2 Research Project

2.1 Research questions and hypotheses

Research questions

The main research question is to investigate the relationship between process and outcome parameters comparing different psychotherapeutic schools, in this case psychoanalysis, systemic and client-centered psychotherapy. Two clinical groups, patients suffering from Depression or Personality Disorders, will be taken into account. Referring to the state of the art of comparative psychotherapy research we expect no (or slight but statistically non-significant) differences in general efficacy between the different therapeutic schools. In an exploratory way we aim to parameterize courses of the so-called “common factors”, mainly the therapeutic bond, and several symptom-oriented measures and relate them to therapy outcome. We expect that psychotherapeutic schools can be differentiated as to the manner through which they achieve the (approximately) same effects, that means the weights, interactions, and courses of process and outcome parameters during psychotherapy. We are especially interested in understanding these differences.

Hypotheses

1. The parameters, calculated based upon the course of common factors and symptom-oriented parameters, allow prediction of therapy outcome.
2. The parameterized courses differ depending on the psychotherapeutic schools. Therefore different equations of prediction can be set up.

3.2 Statistical Analysis

The statistical analyses will mainly be accomplished by using multivariate regression models including path analysis and will in addition focus on parameterization of the therapeutic process by means of fitting time series models. All statistical analyses will consider the whole sample as well as the six subgroups, defined by the three different psychotherapeutic schools and two mental disorders being treated. The arising parameters will be used to compute specific equations which allow the prediction of outcome achieved by the psychotherapeutic approaches, respectively. The predictive equations will then be tested for significant differences.

3.3 Methods

3.3.1 Sample

Overall N = 300 patients will be recruited for participation in the project. We aspire to obtain subgroup numbers of n = 100 patients per psychotherapeutic school which again are

subdivided into the clinical groups Depression and Personality Disorders (each n = 50). The following criteria of inclusion and exclusion will be realized:

Inclusion criteria

Patients meeting the following criteria will be included:

- Age between 18 to 65 years
- Diagnosis of a depressive disorder or personality disorder based upon DSM-IV criteria
- Informed consent
- Sufficient German language attainment

Exclusion criteria

Patients meeting the following criteria will be excluded:

- acute psychotic symptomatology
- high comorbidity (more than five diagnoses based upon DSM-IV criteria)
- brain disorder
- acute suicidal tendency
- acute dependency on psychotropic substances
- constraint of intellectual capacity
- Beck Depression Inventory (BDI) - Total Score under 18
- General Assessment of Functioning (GAF) – Score above 70

The fixation of BDI minimum and GAF maximum is conducted to achieve homogenity of the sample and avoid ceiling and ground effects which might contort the research results.

3.3.2 Research design

A prospective single-site longitudinal research design will be implemented. All participants will be recruited in the Outpatient Clinic of the Sigmund Freud University, Vienna.

An outcome battery of self-report inventories will be administered to assess change in specific domains. All symptom-oriented *outcome* measures will be completed by the patients one week before the beginning of treatment, every three months during therapy, and one week following treatment. In order to investigate the therapeutic *process* in detail participants will complete two additional instruments every session, measuring “common factors” and overall symptomatology. In addition therapists will evaluate the psychosocial functioning the week before and after therapy. Follow-up measurement will be realized at a six- and twelve-months interval.

Recruitment

Patients aspiring to receive psychotherapy and therefore seeking the Outpatient Clinic at Sigmund Freud University will be assessed with regard to the inclusion and exclusion criteria. The persons who meet the criteria will be comprehensively informed about the research project, its aims as well as anonymisation strategies. After informed consent patients will be assigned to the basic diagnostic sessions before entering the psychotherapeutic treatment.

The assignment to the different psychotherapeutic schools is accomplished with regard to the disposability of the therapists' time resources and the patients' disposable time-frames to attend psychotherapy. Although this this is not a randomization, this will not lead to a systematic assignment bias.

Ethics Committee

The project has been accepted by the responsible Ethics Committee.

3.3.3 Measures

Basic Diagnostics (Pre-Diagnostics)

Basic diagnostic sessions will comprise the application of the *Structured Clinical Interview for Mental Disorders* (SKID-I; Wittchen et al., 1997) *and for Personality Disorders* (SKID-II; Fydrich et al., 1997) which result in classifications of diagnoses on Axis I and Axis II of DSM-IV (American Psychiatric Association , 1994).

Specific measures for symptom severity (depending on clinical groups)

In the clinical subgroup 'Personality Disorders' the overall score of SKID-II will be dimensionally evaluated and regarded as severity of personality disorders.

The symptom severity in the clinical subgroup 'Depression' will be assessed by administering the *Beck Depression Inventory* which is described in the following paragraph dealing with outcome measures.

Outcome Measures

Beck Depression Inventory (BDI; Beck et al., 1988) is a very frequently used 21-item self-rating scale which measures the severity of depressive symptoms during the past seven days. Its internal consistency is indicated with $\alpha = .88$. Convergent and construct can be evaluated as satisfactory. The BDI is sensitive to symptom change and therefore appropriate for the measurement of symptom courses (Hautzinger, 1993).

Symptom-Checklist-90-Revised (SCL-90-R; Derogatis et al., 1976; Franke, 1995). The SCL-90-R is a widely used 90-item questionnaire which measures general symptom distress as consequence of physical and psychological symptoms during the past seven days. The

parameters of internal consistency are reported from .77 to .90, and test-retest reliability from .80 to .90 over one week interval. The scale allows discrimination between clinical and non-clinical groups and is sensitive to symptom change.

Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988). The IIP is a self-report instrument, consisting of 127 items. It measures distress arising from interpersonal resources. Test-retest reliability is reported between .89 and .98, and internal consistency ranges from .89 to .94. It consists of six subscales which identify if the patiens/clients have problems being assertive, sociable, or intimate with others, assuming too much responsibility for others' welfare, and being overly submissive or controlling. The global score is used for outcome analyses.

Ergebnis-Fragebogen (EB-45; Haug et al., 2004). The EB-45 is the German version of the Outcome Questionnaire (OQ-45.2; Lambert et al., 2004)**.** It is a brief 45-item self-report instrument and measures patient progress in therapy. It is designed to be repeatedly administered during the course of treatment and at termination. Patient progress is measured along several important dimensions, based on Lambert's (1983) conceptualization suggesting that three aspects of the patient's life be monitored: 1) Subjective discomfort (intrapsychic functioning), 2) Interpersonal relationships, and 3) Social role performance. These areas of functioning suggest a continuum covering how the persons feel inside, how they are getting along with significant others, and how they are doing in important life tasks, such as work and school. Convergent validity, calculated as correlations with the General Symptom Index of SCL-90-R is considered to be satisfying. Furthermore the scale allows discrimination between clinical and non-clinical groups and proved to be sensitive to change during psychotherapeutic courses. In the present project the EB-45 will be used for measuring the micro outcome each session.

Global Assessment of Functioning (GAF; American Psychiatric Association, 2004). The GAF corresponds to Axis V of DSM-IV and allows the assessment of mental, social, and occupational functioning from an observer's point of view. The ratings are made on a hypothetical continuum from "mental health" to "mental illness" (0 to 100). The GAF scale is especially appropriate for the monitoring of clinical advancement by means of one single measure.

Process Measures

Bern Session Report (Berner Therapiesitzungsbogen; Tschacher & Endtner, 2007). The Bern Session Report is a self-rating instrument which was developed on the basis of works of Regli and Grawe (2000). It is administered every session and comprises one patient's and one therapist's version as well as additional items for group therapy settings. In our project the patient's version for single sessions consisting of 20 items will be applied. A factor analysis conducted during the developmental work on the scale resulted in four main factors: 1) therapeutic bond, 2) self-efficacy, 3) emotional regulation, 4) clarification, understood as state variables. The scale proved to be sensitive to change in clinical samples (Tschacher & Endtner, 2007).

Working Alliance Inventory (WAI-SR; Wilmers et al., 2008). The WAI-SR is a widely used self-rating instrument which measures three aspects of the therapeutic alliance mirrored by three sub scales: gaol, task, and bond. The internal consistency of the German version is considered high (α= .81 to .91). Factor analyses have confirmed the initial constructed subscales. Convergent validity is proven by positive correlations with instruments covering helping alliances in general. The main advantages of the scale are its theoretical funding, its economy and favourable psychometric properties as well as the fact that it is applicable independent of different psychotherapeutic approaches.

Final Measures (Post-Diagnostics)

As mentioned in the paragraph dealing with outcome measures all the self-ratings will be administered to the patients one week following therapy as final measures. In addition the *Change Interview* (Elliott, 1996) will be conducted aiming at comprehensively compassing psychotherapy outcome by means of quantitative as well as qualitative methods.

Change Interview (Elliott, 1996). The Change Interview is a promising method for collecting qualitative data on the general change process in psychotherapy. It is a partially structured post-therapy interview and consists of open-ended, exploratory questions. The Change Interview assesses three main kinds of information: 1) change perceived by clients over the course of therapy, 2) clients' understanding of the sources of the changes, including helpful aspects of their therapy, 3) hindering or difficult aspects of therapy. Its overall purpose is thus to obtain clients' understanding of what has changed and how the changes have come about, including factors which have interfered with change. Embedded in the interview is a general framework which allows researchers to access clients' explanatory models of the change process, both inside and outside of therapy (Elliott et al., 2006).

Table 1: Overview Measurements

Table 1: Overview Measurements						
Measures	**one week before therapy**	**every session**	**every three months**	**one week following therapy**	**follow-up 3 months**	**follow-up 6 months**
Outcome						
BDI	●		●	●	●	●
SKID-II-Score	●			●	●	●
GAF	●			●	●	●
SCL-90-R	●		●	●	●	●
IIP	●		●	●	●	●
EB-45 (micro outcome)	●	●	●	●	●	●
Change Interview				●		
Process						
Bern Session Report	●	●	●	●		
WAI	●	●	●	●		

3 Time Schedule and Cost Overview

Time schedule

First year of advancement

- Further theoretical preparation considering the psychotherapeutic process and its relation to therapy outcome
- Recruitment of participants
- Accomplishment of basic diagnostics (Classification of Diagnoses by means of clinical interviews, additional symptom severity by administration of self-rating scales, assignment of the participants to psychotherapists)
- Constitution of algorithms for precise administration of self-rating instruments
- Ongoing recruitment of participants and accomplishment of basic diagnostics
- Organization of process measurement
- Continuous data entry

Second year of advancement

- Organization of Process and Outcome measurement
- Accomplishment of final diagnostics (Change Interviews, self-rating instruments)
- Catamnestic data acquisition
- Continuous data entry
- Data analysis
- Written composition of results of the project

Cost overview

Acquisition of tests and test licenses	1500 €
Accomplishment of Change Interviews	2500 €
Organization and Administration of self-ratings per session	800 €
Data analysis	1000 €
Technical literature	600 €
Total costs	6400 €

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