Psychotherapy Research, January 2005; 15(1): 1–8

Routledge
Taylor & Francis Group

ORIGINAL ARTICLE

The relation among the relationship conditions, working alliance, and outcome in both process–experiential and cognitive–behavioral psychotherapy

JEANNE C. WATSON[1], & SHARI M. GELLER[2]

[1]*University of Toronto, Toronto, Ontario, Canada and* [2]*York University, Toronto, Ontario, Canada*

(Received 18 April 2002; revised 18 August 2003; accepted 16 September 2003)

Abstract
This study investigated the relation among clients' ratings of the relationship conditions (Relationship Inventory), outcome, and working alliance (Working Alliance Inventory) in both cognitive–behavioral and process–experiential psychotherapy. It was hypothesized that the working alliance mediates the relation between the relationship conditions and outcome. The RI was predictive of treatment outcome on 4 different measures, and the impact of the relationship conditions was mediated through the therapeutic alliance on 3 of 4 measures of outcome. No significant differences were found between the 2 psychotherapies on the RI in terms of therapists' empathy, acceptance, and congruence. However, process–experiential therapists were rated as more highly regarding of their clients than cognitive–behavioral therapists.

AQ1 **Keywords:**

Research suggests that therapists show different levels of effectiveness irrespective of their treatment approach (Asay & Lambert, 2001; Beutler, Crago, & Arizmendi, 1986; Burns & Nolen-Hoeksma, 1992; Henry, Schacht, & Strupp, 1986; Lafferty, Beutler, & Crago, 1989; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). A major mediating variable of therapists' effectiveness is their ability to establish good therapeutic alliances (Luborsky et al., 1997). The therapeutic alliance, defined as agreement on the tasks and goals of therapy and the bond that develops between the participants, has been found to be a robust predictor of therapy outcome across diverse perspectives (Alexander & Luborsky, AQ2 1986; Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Krupnick et al., 1996; Martin, Garske, & Davis, 2000). However, little attention has been paid to therapist factors that contribute to the development and maintenance of a good working alliance. Horvath and Bedi (2002) suggested that more attention needs to be paid to understand the mediating and moderating factors that influence the alliance, especially therapist factors.

A number of authors have suggested that therapists who are perceived as empathic, accepting, nonjudgmental, and congruent in their interactions with their clients are more likely to facilitate agreement about the goals and tasks of therapy (Lietaer, 1992; Safran & Segal, 1990; Stiles, Honos-Webb, & Suko, 1998; Watson & Greenberg, 1994). Stiles et al (1998) suggested that a positive working alliance is the product of a responsive process, defined as the ability of therapists to fit specific therapeutic interventions and tasks to their clients' goals. Watson and Greenberg (1994) suggested that the implementation of specific tasks in process–experiential therapy (PET) that fit with clients' goals is an instantiation of the relationship conditions to the extent that it demonstrates therapists' empathy, acceptance, and understanding of clients' objectives in therapy.

Early research in humanistic therapies showed that the therapist qualities of empathy, acceptance, and congruence were positively related to outcome (Asay

Correspondence: Jeanne C. Watson, Department of Adult Education, and Counselling Psychology, OISE/University of Toronto, 252 Bloor Street West, 7th floor, Toronto, Ontario M5S 1V6, Canada. Tel: 416-923-6641, ext. 2555; Fax: 416-923-4749. E-mail: jewatson@oise.utoronto.ca

ISSN 1050-3307 print/ISSN 1360-046X online
DOI: 10.1080/10503300512331327010

& Lambert, 2001; Bohart, Elliott, Greenberg, & Watson, 2002; Orlinsky, Grawe, & Parks, 1994). More recently, Lafferty et al. (1989) found that less effective therapists have lower levels of empathic understanding. Lietaer (1992) found that successful clients characterized their therapists as warm, interested, involved, empathic, accepting, respecting, and patient. Similarly, Henry et al. (1986) found that therapist behaviors in good outcome cases were characterized as helping, teaching, protecting, affirming, and understanding. This was in contrast to therapist behavior in poor outcome cases, which included more blaming and belittling behaviors.

Much of the research on the impact of therapist qualities has been conducted on humanistic approaches beginning with Rogers's (1959) observation that empathy, acceptance, and congruence were the necessary and sufficient conditions of therapeutic change (Asay & Lambert, 2001; Bohart et al., 2002). However, research indicates that the relationship conditions may be important in the delivery of cognitive–behavior therapy (CBT). A number of studies have found a positive relation between the therapist conditions and outcome in the development of assertiveness skills (Chiappone, McCarrey, Piccinin, Schmidtgoessling, 1981) and the treatment of anxiety disorders (Arts, Hoogduin, Keijsers, Severeijns, & Schaap, 1994) in CBT. Miller, Taylor, and West (1980) observed that empathy accounted for 67% of the variance in outcome in their comparative treatment study of problem drinkers. In another study, Burns and Nolen-Hoeksma (1990) found that therapists' empathy contributed significantly to successful outcome in CBT. More recently, Keijsers, Schaap, and Hoogduin (2000) observed that only the relationship conditions and the therapeutic alliance showed a consistent moderate relationship to outcome in CBT for a number of different disorders, including depression and anxiety. Further support for the importance of the role of empathy in CBT therapy is provided by Bohart et al.'s (2002) meta-analysis examining the relationship between empathy and outcome, which indicated that empathy may be more important in CBT than other therapies.

Originally, CBT emphasized technical skills with less emphasis on the quality of the therapeutic relationship compared with other approaches (DeRubeis & Feeley, 1990; Safran & Wallner, 1991). However, there has been a shift in emphasis; more authors stress the importance of focusing on the therapeutic relationship in a more systematic fashion in cognitive therapy (Goldfried & Castonguay, 1993; Mahoney 1991; Safran & Segal, 1990). This shift highlights the need for more empirical research on the quality of the therapeutic relationship and its relationship to outcome in cognitive therapy.

The first objective in this study was to provide a more differentiated picture of the link among the therapeutic alliance, therapist relationship conditions, and outcome in CBT and PET. Clarification of the relation between the relationship conditions and the alliance is important to better understand the factors that contribute to the development and maintenance of a positive alliance. To illuminate the distinct and interdependent role of the therapist relationship conditions in the development of working alliance and positive outcomes in therapy, it was hypothesized that working alliance would mediate the correlation between the relationship conditions and outcome.

The second objective was to compare clients' perceptions of the relationship conditions in CBT and PET. Few studies have compared the relationship conditions across different approaches, and no study has compared clients' perceptions of the relationship conditions in both CBT and PET. Most of the studies that have examined the role of the relationship conditions in successful outcome have focused on humanistic approaches to therapy. More research is necessary to reveal similarities and differences across orientations using current diagnostic criteria (Asay & Lambert, 2001; Krupnick et al., 1996; Raue & Goldfried, 1994; Safran & Wallner, 1991).

PET is an emotionally focused therapy that integrates client-centered and gestalt techniques. This approach emphasizes that therapists be empathic, accepting, congruent, and positively regarding of their clients while they work to facilitate clients' emotional arousal, differentiation, and expression of emotion in the session to resolve specific cognitive–affective tasks. In contrast, CBT focuses on helping clients' identify the cognitions and dysfunctional attitudes that may be contributing to their depression so that these can be challenged and reexamined in the light of other evidence. PET emphasizes empathy, acceptance, positive regard, and congruence as essential to the change process in therapy. In contrast, cognitive–behavioral approaches see empathy and the other relationship conditions as essential background conditions. Given the extent to which the relationship conditions are a cornerstone of treatment in PET, it was expected that clients would rate the therapists in the PET group higher on the relationship conditions than the CBT therapists.

Method

Participants

Clients. Data from 66 clients who participated in a comparative treatment study on depression (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003) were included in this study. Clients were included in the study if they were diagnosed with major depression according to *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition [*DSM-IV*]; American Psychiatric Association, 1994) criteria and had a Global Assessment of Functioning score of 50 or more ($M = 59.92$, $SD = 5.92$). Clients were excluded from the study if they were diagnosed with psychosis, substance abuse, disordered eating, or bipolar mood on Axis I or antisocial, schizotypal, or borderline personality disorder on Axis II. Other conditions for exclusion were suicide attempt within the last 3 years, loss of a significant other within the last year, history of incest, or current treatment or medication to treat depression. Clients who participated in the study received 16 sessions of either CBT or PET. Clients ranged in age from 21 to 65 years ($M = 41.70$, $SD = 10.78$).

Therapists. Of the 15 therapists in the study, 8 implemented the CBT treatment and 7 the PET treatment. Therapists ranged in age from 26 to 43 years ($M = 32.73$, $SD = 6.08$). Thirteen therapists were master's or doctoral candidates in counseling psychology, and 2 were psychologists. Therapists' years of experience ranged from 1 to 15 years ($M = 5.23$, $SD = 4.74$).

Treatments

CBT. CBT treatment followed a model based on adaptations of Beck, Rush, Shaw, and Emery's (1979) treatment. The CBT treatment focused on accessing clients' cognitive schemes to facilitate change. Therapists used thought records, weekly activity and mood schedules, cognitive patterns, and dispute handles homework sheets to help clients identify their cognitive schemas.

PET. This treatment followed the model developed by Greenberg, Rice, and Elliott (1993), which identifies markers of clients' cognitive–affective problems and uses specific interventions or therapeutic tasks to help clients resolve them. The model emphasizes the importance of the therapeutic attitudes in facilitating change. The four treatment tasks included systematic evocative unfolding at a problematic reaction markers, two-chair work for conflict and self-evaluative splits, empty-chair work for unfinished business with a significant other, and focusing on an unclear felt sense.

Process measures

Relationship Inventory (RI; Barrett-Lennard, 1962, 1973). This is a self-report measure used to rate Rogers's relationship conditions. Using a 7-point scale, clients rate their therapists on the extent to which they experience them as empathic, congruent, prizing, and accepting. The RI short form (40 items; Barrett-Lennard, 1973) was used in this study. The RI has been shown to have split-half reliability; coefficients from the client data for the four scales range from .82 to .96. The corresponding reliability coefficients for the therapist data range from .88 to .96. The RI has been shown to have good predictive validity (Barrett-Lennard, 1986).

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). This 36-item self-report questionnaire was used to assess the working alliance on the dimensions of tasks, goals, and bonds. Using a 7-point scale, clients rate the extent to which there is agreement with their therapist on the tasks and goals of therapy and whether they feel liked by their therapist. The measure has been found to have good interitem reliability (Horvath & Greenberg, 1986). The total of the three subscales was used in the analysis.

Outcome measures

Four outcome measures from the original study were used to examine the association between the presence of the relationship conditions, the working alliance, and outcome.

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI is a 21-item inventory for assessing depression. Test–retest reliability has been reported at .65 (Ogles, Lambert, & Sawyer, 1995).

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988). The IIP is a self-report instrument consisting of 127 items to measure distress arising from interpersonal sources. The IIP has been shown to possess high internal consistency, reliability, and validity and high test–retest reliability ($r = .90$; Hansen & Lambert, 1996; Horowitz et al., 1988).

Rosenberg Self-Esteem Inventory (RSE; Rosenberg, 1965). A 10-item version of the RSE scale (Bachman & O'Malley, 1977) was used to assess clients' levels

of self-esteem. This instrument has shown good internal consistency and validity. Excellent internal reliability (.89–.94), test–retest reliability (.80–.90), and adequate sensitivity to change have been reported.

Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978). The DAS is a 40-item inventory of dysfunctional attitudes used to measure vulnerability to depression. It has high internal reliability coefficients and test–retest reliability coefficients (Kuiper & Olinger, 1989).

AQ4

Procedure

Clients received 16 sessions of psychotherapy once a week. They completed the outcome measures at the beginning of treatment and after Sessions 8 and 16. In addition, they completed the RI at Sessions 9 and 12 and the WAI after every session. Both treatments were checked for adherence.

Results

Data screening

The outcome variables, the WAI, and the RI were examined using SPSS for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analysis. Fifty clients completed the RI. Data for 16 clients were missing as a result of a photocopying error. The mean of Sessions 9 and 12 on the RI was used for clients who completed the measure after both sessions. For those clients with missing scores for one of the sessions, the score from the one session only was used. The total RI score was used in the mediation analysis after a preliminary principal-components analysis revealed that one factor accounted for 68.65% of the variance.

Comparison of CBT and PE therapists on RI

Regarding clients' self-report ratings, differences between groups on the four dimensions of the RI were examined using an SPSS multivariate analysis of variance. The means and standard deviations are presented in Table I. PET psychotherapists were rated significantly higher on positive regard than CBT psychotherapists. Contrary to expectations, there were no significant differences between PET and CBT therapists in terms of unconditional acceptance and congruence, whereas empathy approached significance.

Relationship conditions, working alliance, and outcome

To test whether the correlation between the relationship conditions and outcome is mediated by the working alliance, the procedures outlined by Baron and Kenny (1986) were followed. Three different analyses are required to test mediation: First, the relationship conditions should predict alliance; second, the relationship conditions should predict outcome; third, the alliance should predict outcome when entered into the equation with the relationship conditions. Mediation is observed if all these conditions are met and the inclusion of the working alliance in the regression equation renders the correlation between the relationship conditions and outcome insignificant.

The first condition for mediation requires that the independent variable, the relationship conditions, predict the mediator, the total working alliance score. The clients' self-report scores from the RI significantly predicted their working alliance scores, $F(1, 48) = 52.94$, $p < .01$. The second condition of mediation requires that the independent variable predict the dependent variable. The dependent variable was outcome as measured by each of the outcome measures. In the first analysis, clients' posttherapy scores on the BDI was the dependent variable. To control for clients' pretherapy status on the BDI, their pretreatment scores were entered first, followed by clients ratings on the RI in a hierarchical multiple regression analysis. As expected, clients' ratings of the relationship conditions significantly predicted outcome, $R^2 = .10$, $F(1, 47) = 5.67$, $p < .05$. The third condition requires that the mediator (the working alliance score) predict the dependent variable, BDI, in a third equation when

AQ5

Table I. Client ratings on Barrett-Lennard Relationship Inventory.[a]

	CBT (23)		PET (27)			
RI scale	*M*	*SD*	*M*	*SD*	$F(1, 48)$	*p*
Empathy	49.90	6.40	52.78	5.08	3.14	.08
Regard	47.07	6.67	50.98	4.89	5.70	.02*
Acceptance	46.23	6.37	46.12	7.11	0.003	.96
Congruence	44.69	12.41	47.77	6.65	1.25	.27

[a]RI = Relationship Inventory; CBT = cognitive–behavioral therapy; PET = process–experiential therapy.

both the independent variable and the mediator are entered together. Clients' pretreatment BDI was entered first followed by their midtreatment BDI to ensure that the alliance scores were making independent, additive contributions to outcome over and above initial in-treatment improvement. This was followed by clients' ratings on the RI, and then their WAI score was entered. As expected, the alliance did significantly predict outcome over pretherapy status and initial in-treatment improvement, $\Delta R^2 = .13$, $F(1, 43) = 9.71$, $p < .01$. However, the therapist relationship conditions were no longer significant, indicating that the working alliance mediates the relation between the therapists' conditions and outcome. The regression analyses are presented in Table II.

The same analyses were repeated with each of the other outcome measures. As expected, clients' ratings of the relationship conditions significantly predicted outcome using clients' DAS scores, $\Delta R^2 = .16$, $F(1, 40) = 14.18$, $p < .01$; their RSE scores, $\Delta R^2 = .10$, $F(1, 43) = 7.91$, $p < .01$, and their IIP scores, $\Delta R^2 = .07$, $F(1, 42) = 7.19$, $p < .01$. As expected, clients' ratings of the working alliance significantly predicted outcome over and above clients' midtreatment change scores on the DAS, $\Delta R^2 = .05$, $F(1, 35) = 5.19$, $p < .05$, and RSE, $\Delta R^2 = .08$, $F(1, 40) = 7.51$, $p < .01$, and the relationship conditions were no longer a significant predictor of outcome, indicating that they were mediated by the working alliance. Contrary to expectation, the working alliance did not predict outcome on the IIP, $\Delta R^2 = .01$, $F(1, 39) = 0.96$, $p < .34$. The most significant predictor of clients' posttherapy IIP scores when all four variables were entered was clients' midtreatment change score.

Discussion

The current study examined the differences in clients' perceptions of the relationship conditions of empathy, acceptance, positive regard, and congruence in CBT and PET and illuminated the association among these conditions, the working alliance, and outcome. As expected, and consistent with earlier studies, clients' ratings of the relationship conditions were predictive of outcome in both PET and CBT (Bohart et al., 2002; Krupnick et al., 1996) on measures of depression, dysfunctional attitudes, and self-esteem. These findings support earlier studies that highlighted the importance of the relationship conditions in contributing to positive therapeutic outcome and illuminate the mediating role of the therapeutic alliance.

The mediating role that the alliance plays with respect to the relationship conditions and outcome

AQ6

Table II. Regression analyses for testing mediation hypothesis.[a]

DV Change	IV	R^2	ΔR^2	F	β	t
WAI	RI	.52	.52	52.94***	.72	7.28***
BDI-post	BDI-pre	.06	.06	3.19	−.28	−2.07*
	RI	.16	.10	5.68*	−.32	−2.38*
BDI-post	BDI-pre	.04	.04	2.32	.02	.17
	BDI-Mid	.21	.16	9.07**	.38	2.73**
	RI	.28	.07	4.42*	.12	.71
WAI		.41	.13	9.71**	−.54	−3.12**
DAS-post	DAS-pre	.40	.40	27.73***	.57	5.35***
	RI	.56	.16	14.18**	−.40	−3.77**
DAS-post	DAS-pre	.38	.38	23.51***	.42	3.19**
DAS-mid		.52	.14	10.59**	.31	2.15*
	RI	.60	.08	7.72**	−.03	−.21
WAI		.65	.05	5.19*	−.36	−2.28*
RSE-post	RSE-pre	.35	.35	24.00***	.59	5.20***
	RI	.45	.10	7.91**	.32	2.81**
RSE-post	RSE-pre	.36	.36	23.87***	.24	1.44
RSE-mid		.48	.13	10.29**	.49	2.95**
	RI	.53	.05	3.92*	−.61	−.55
WAI		.60	.08	7.51**	.42	2.74**
IIP-post	IIP-pre	.49	.49	41.41***	.66	6.40***
	RI	.57	.07	7.19**	−.28	−2.68**
IIP-post	IIP-pre	.48	.48	38.39***	.27	1.52
IIP-mid		.54	.06	5.31*	.46	2.60*
	RI	.61	.07	7.57**	−.16	−1.10
WAI		.62	.01	.96	−.15	−.98

***$p < .001$, **$p < .01$, *$p < .05$. [a]DV =; IV =; WAI = Working Alliance Inventory; BDI = Beck Depression Inventory; DAS = Dysfunctional Attitudes Scale; RI = Relationship Inventory; RES = Rosenberg Self-Esteem Inventory; IIP = Inventory of Interpersonal Problems.

indicates that the relationship conditions facilitate the development and maintenance of a good working alliance across different therapies with different theoretical assumptions (Lambert, 1983; Stiles et al., 1998; Watson & Greenberg, 1994). This supports the view that therapists who are empathic, accepting, congruent, and prizing of their clients, irrespective of the specific techniques they use, are better able to negotiate agreement about the tasks and goals of therapy and develop a positive therapeutic bond than therapists who are not. It may be that therapists who are more empathic, accepting, nonjudgmental, and congruent will be able to implement specific tasks and interventions that clients' view as fitting with their goals, thus increasing the likelihood of good outcome (Stiles et al., 1998). However, the alliance did not play a mediating role between the relationship conditions and outcome with respect to changes in clients' reports of their interpersonal difficulties. The most important predictor of change on the IIP was clients' midtreatment scores.

The finding that the two therapies were effective in treating depression and that the relationship conditions were predictive of outcome suggests that the question of the primacy of relationship over technique is not a simple either–or question. Rather, it is important that the techniques are implemented in a way that makes sense to the client and fits with their objectives. This requires sensitive negotiation and a good understanding of the other. Adherence to techniques alone does not seem to be enough to ensure positive outcomes; rather, competent delivery requires that clients perceive their therapists as empathic, accepting, nonjudgmental, and congruent. The findings suggest that therapists need to learn how to combine the relationship conditions and technical expertise to ensure competent delivery.

Contrary to prediction, there were no differences between PET and CBT therapists on clients' ratings of empathy, unconditional acceptance, and congruence. However, clients did report feeling more highly regarded by PET therapists than their CBT counterparts. The items that measure regard ask clients whether they experienced their therapist as friendly, warm, appreciative, and respectful of them. It is possible that the more active and didactic style of CBT therapists leaves clients feeling less highly regarded than those in PET, which is less didactic in its approach (Wiser & Goldfried, 1993). However, further research is needed to replicate this finding and to explore more fully what contributes to the difference in the experience of clients in the two psychotherapies.

There are a number of limitations with the current study. These include the small number of participants in each group, therapists' level of expertise (most were students), and the exclusive use of client self-report data. It is important to replicate these findings with a larger group using expert therapists treating other disorders to determine whether the findings generalize to other populations. The use of self-report data only may have underestimated the effects. In future studies, it will be important to use data from multiple sources. In the current study, the relationship conditions were measured relatively late to ensure their reliability. This may have contributed to a halo effect, so that clients' ratings of their therapists' attitudes may reflect their positive feelings about the effects of therapy. Future studies might benefit from rating the therapists' attitudes early and at midpoints in therapy to better control for the presence of a halo effect and to investigate their relation to the development and maintenance of the working alliance and more specific treatment effects at different phases of therapy.

Acknowledgements

This research was supported by Social Sciences and Humanities Research Council of Canada Research Grant 410-97-0525 to Jeanne C. Watson.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (fourth ed.). Washington, DC: Author.

Arts, W., Hoogduin, K. A. L., Keijsers, G., Severeijns, R., & Schaap, C. (1994). A quasi-experimental study into the effect of enhancing the quality of the patient-therapist relationship in the outpatient treatment of obsessive-compulsive neurosis. In S. Borgo & L. Sibilia (Eds.), *The therapist-patient relationship: Its many dimensions* (pp. 25–31). Rome: Cosiglio Nazionale della Ricerche.

Asay, T. P., & Lambert, M. J. (2001). Therapist relational variables. In D. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 531–558). Washington, DC: American Psychological Association.

Bachman, J., & O'Malley, P. (1977). Self-esteem in young men: A longitudinal analysis of the impact of educational and occupational attainment. *Journal of Personality and Social Psychology*, *35*, 365–380.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, *51*, 1173–1182.

Barrett-Lennard, G. T. (1962). Dimensions of therapy response as causal factors in therapeutic change. *Psychological Monographs*, *76*, 1–33.

Barrett-Lennard, G. T. (1973). *Relationship Inventory*. Unpublished manuscript, University of Waterloo, Ontario, Canada.

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method and use. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 439–476). New York: Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression: A treatment manual*. New York: Guilford Press.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 257–310). New York: Wiley.

Bohart, A., Elliott, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.

Burns, D. D., & Nolen-Hoeksma, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology*, *60*, 441–449.

Chiappone, D. V., McCarrey, M., Piccinin, S., & Schmidtgoessling, N. (1981). Relationship of client-perceived facilitative conditions on outcome of behaviorally oriented assertiveness training. *Psychological Reports*, *49*, 251–256.

AQ8 Derogatis, L. R., Rickels, K., & Roch, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Psychiatry*, *128*, 280–289.

DeRubeis, R. J., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research*, *14*, 469–482.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., et al. (1989). NIMH treatment of depression collaborative research program: General effectiveness of treatments. *Archives of General Psychiatry*, *46*, 971–982.

Goldfried, M. R., & Castonguay, L. G. (1993). Behavior therapy: Redefining strengths and limitations. *Behavior Therapy*, *24*, 505–526.

Greenberg, L. S., Elliott, R., & Lietaer, G. (1994). Research on humanistic and experiential psychotherapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 509–539). New York: Wiley.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.

Greenberg, L. S., & Watson, J. C. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy-Research*, *8*, 210–224.

Hansen, N. B., & Lambert, M. J. (1996). Brief report: Assessing clinical significance using the inventory of interpersonal problems. *Assessment*, *3*, 133–136.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behaviour: Application to a study of interpersonal process in differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology*, *54*, 27–31.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical application. *Journal of Consulting and Clinical Psychology*, *56*, 885–892.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1986). Development of the working alliance. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*, 223–233.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149.

Hoyt, W. T. (2002). Bias in participant ratings of psychotherapy process: An initial generalizability study. *Journal of Counseling Psychology*, *49*, 35–46.

Keijsers, G., Schaap, C., & Hoogduin, C. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy: A review of empirical studies. *Behavior Modificiation*, *24*, 264–297.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, *64*, 532–539.

Lafferty, P., Beutler, L. E., & Crago, M. (1989). Differences between more and less effective psychotherapists: A study of select therapist variables. *Journal of Consulting and Clinical Psychology*, *57*, 76–80.

Lietaer, G. (1992). Helpful and hindering processes in client-centered-experiential psychotherapy: A content analysis of client and therapist post therapy perceptions. In S. Toukmanian & D. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. xx–xx). Newbury Park, CA: Sage. AQ9

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, *4*, 53–65.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450.

Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broad spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, *48*, 590–601.

Ogles, B. M., Lambert, M. J., & Sawyer, J. D. (1995). Clinical significance of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Journal of Consulting and Clinical Psychology*, *63*, 321–326.

Orlinsky, D., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. xx–xx). New York: Wiley.

Raue, P., & Goldfried, M. R. (1994). The therapeutic alliance in cognitive-behavior therapy. In A. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 131–152). Oxford, England: Wiley.

Rogers, C. R. (1959). *Client-centered therapy: Its current practice, implications, and theory*. Boston, MA: Houghton Mifflin.

Rosenberg, M. (1965). *Society and the adolescent self image*. Princeton, NJ: Princeton University Press.

Safran, J. D., & Wallner, L. K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Journal of Consulting and Clinical Psychology*, *59*, 188–195.

Salvio, M., Beutler, L. E., Wood, J. M., & Engle, D. (1992). The strength of the therapeutic alliance in three treatments for depression. *Psychotherapy research*, *2*, 31–36.

Spitzer, R., Williams, J., Gibbon, M., & First, M. (1995). *Structured Clinical Interview for DSM-IV*. New York: American Psychiatric Press.

Stiles, W. B., Honos-Webb, L., & Suko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology; Science and Practice*, *5*, 439–458.

Watson, J. C., Gordon, L. B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, *71*, 773–781.

Watson, J. C., & Greenberg, L. S. (1994). The working alliance in experiential therapy: Enacting the relationship conditions. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. xx–xx). New York: Wiley.

Weissman, A. N., & Beck, A. T. (1978, August–September). *Development and validation of the Dysfunctional Attitudes Scale: A preliminary investigation*. Paper presented at the 86th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

Wiser, S., & Goldfried, M. R. (1993). Comparative study of emotional experiencing in expert psychodynamic-interpersonal and cognitive-behavioural therapies. *Journal of Consulting and Clinical Psychology*, *61*, 892–895.

AUTHOR'S QUERY SHEET

Author(s): J. C. Watson & S. M. Geller TPSR 100010
Article title:
Article no:

Dear Author

Some questions have arisen during the preparation of your manuscript for typesetting. Please consider each of the following points below and make any corrections required in the proofs.

Please do not give answers to the questions on *this* sheet. All corrections should be made directly in the printed proofs.

AQ1 Please supply keywords.

AQ2 P. 2, please cite Alexander & Luborsky, 1986; Horvath & Greenberg, 1994; Safran & Segal, 1990; in reference list.

AQ3 p. 4, please cite in reference list: Burns and Nolen-Hoeksma (1990), Mahoney 1991;

AQ4 p. 9, please cite in reference list: Kuiper & Olinger, 1989

AQ5 Table I: Please supply footnote for * symbol in table.

AQ6 Table II: Please spell out DV and IV. Also, Row 1 contains the heading "Change." To what does this refer? Please clarify.

AQ7 p. 12, please cite in reference list: Lambert, 1983

AQ8 In reference list, please cite the following in text or delete from reference list: Derogatis, L. R., Rickels, K., & Roch, A. F. (1976); Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., et al. (1989); Greenberg, L. S., Elliott, R., & Lietaer, G. (1994); Greenberg, L. S., & Watson, J. C. (1998); Hoyt, W. T. (2002); Salvio, M., Beutler, L. E., Wood, J. M., & Engle, D. (1992); Spitzer, R., Williams, J., Gibbon, M., & First, M. (1995).

AQ9 In reference list, please supply chapter pages for Lietaer, G. (1992); Orlinsky, D., Grawe, K., & Parks, B. K. (1994); and Watson, J. C., & Greenberg, L. S. (1994).