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EMPIRICAL PAPER

An investigation of client mood in the initial and final sessions of cognitive-behavioral therapy and psychodynamic-interpersonal therapy

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Abstract

Objective: Our aim was to examine client mood in the initial and final sessions of cognitive-behavioral therapy (CBT) and psychodynamic-interpersonal therapy (PIT) and to determine how client mood is related to therapy outcomes. Methods: Hierarchical linear modeling was applied to data from a clinical trial comparing CBT with PIT. In this trial, client mood was assessed before and after sessions with the Session Evaluation Questionnaire-Positivity Subscale (SEQ-P). Results: In the initial sessions, CBT clients had higher pre-session and post-session SEQ-P ratings and greater pre-to-post session mood change than did clients in PIT. In the final sessions, these pre, post, and change scores were generally equivalent across CBT and PIT. CBT outcome was predicted by pre- and post-session SEQ-P ratings from both the initial sessions and the final sessions of CBT. However, PIT outcome was predicted by pre- and post-session SEQ-P ratings from the final sessions only. Pre-to-post session mood change was unrelated to outcome in both treatments. Conclusions: These results suggest different change processes are at work in CBT and PIT.

Keywords: cognitive-behavioral therapy; psychodynamic-interpersonal therapy; change process; client mood; session mood

Although the efficacy of psychological treatments has been clearly established for decades, much less is known about the process of change in these treatments (Kazdin, 2007, 2008). In the current study, we sought to better understand the change process by focusing on client mood—how positive or negative it is before and after treatment sessions and how much it changes during the session. Ratings of session mood may reflect the client’s progress in overcoming symptoms and distress and might be more responsive than traditional outcome measures to the effects of individual treatment sessions (Pesale, Hilsenroth, & Owen, 2012; Stiles, 1980). In this way, session mood ratings collected at different stages of treatment could illuminate the precise moments of therapeutic change.

One of the most widely used, self-report measures of session mood is the Positivity Subscale of the Session Evaluation Questionnaire-Positivity Subscale (SEQ-P; Stiles, 1980; Stiles et al., 1994). The SEQ-P assesses mood on a scale ranging from very negative to very positive (Stiles, 1980). Although the SEQ-P can be administered before sessions (SEQ-P-Pre) or after sessions (SEQ-P-Post), empirical findings to date pertain exclusively to SEQ-P-Post.

Client mood (e.g., as measured by SEQ-P-Post) may follow a different course in psychodynamic-interpersonal therapy (PIT) than in cognitive-behavioral therapy (CBT). Theoretically, in PIT, problems are uncovered and explored in the early stages of treatment and are then understood and assimilated in the later stages of treatment (see Reynolds et al., 1996). Because clients in the early sessions of PIT have yet to assimilate problematic material, their early mood ratings are unlikely to be very positive or prognostic of their eventual
outcome. On the other hand, successful PIT clients should experience positive mood in the later, assimilation phase of treatment. If this emergence of positive mood in the later sessions of PIT indicates the client’s symptomatic and functional improvements, then positive mood in the later sessions of PIT should be associated with good outcomes.

The theorized process of change in CBT is different (see Reynolds et al., 1996). In the early stages of CBT, the therapist introduces cognitive-behavioral skills and assigns homework to facilitate skill development and alleviate distress (Beck, 2011). That is, unlike in PIT, the goal in CBT is to initiate mood improvements from the outset. From this, we reasoned that client mood in the early stages of CBT would be more positive than client mood in the early stages of PIT. Insofar as early success begets and predicts later success, positive mood achieved in the early sessions of CBT should be maintained over the course of therapy and be predictive of post-treatment outcomes.

Previously reported SEQ-P-Post results have supported elements of this theoretical understanding of contrasting patterns of change in CBT and PIT. Reynolds et al. (1996) used data from the Second Sheffield Psychotherapy Project (Shapiro et al., 1994) to show that SEQ-P-Post scores were significantly higher in the early sessions of CBT than in the early sessions of PIT but did not differ between the two treatments in the final sessions (see also Stiles, Shapiro, & Firth-Cozens, 1988). Three studies have investigated the relation between SEQ-P-Post and treatment outcome, and all were conducted with clients in psychodynamic and/or interpersonal treatments; taken together, results imply that SEQ-P-Post ratings consistently predict psychodynamic/interpersonal treatment outcomes but only when SEQ-P-Post ratings are made in the final sessions of treatment (Joyce & Piper, 1990; Mallinckrodt, 1993; Pesale et al., 2012). Research is needed to verify these results and to explore the relation between session mood and treatment outcome in CBT.

**Study Design and Goals**

The aims of this study pertained to session mood in the initial and final sessions of CBT and PIT. Our analyses built on Reynolds et al.’s (1996) observation that SEQ-P-Post ratings were higher in CBT than in PIT in the initial, but not final, stages of treatment. We assessed whether these initial and final session ratings of SEQ-P-Post predict treatment outcomes in CBT and in PIT.

To advance our understanding of client mood, we examined pre-session mood as well as post-session mood. To the best of our knowledge, the Second Sheffield Psychotherapy Project (Shapiro et al., 1994) is the only study that has administered the SEQ-P to clients before sessions (SEQ-P-Pre; not previously analyzed/reported) and after sessions (SEQ-P-Post). Using these archival data, we further constructed an index that assesses the change in mood over the therapy session (SEQ-P-Change) by subtracting SEQ-P-Pre scores from SEQ-P-Post scores. Theoretically as well as arithmetically, clients’ post-session mood might be understood as their pre-session mood (which may, in part, reflect symptomatic relief achieved prior to that session) plus the change in mood attributable to in-session developments (i.e., SEQ-P-Pre + SEQ-P-Change = SEQ-P-Post).

Following the theoretical suggestion that CBT seeks mood enhancements from the beginning whereas PIT aims to first uncover and explore problems (Reynolds et al., 1996), we hypothesized that in early sessions: (1A) clients in CBT would report significantly higher SEQ-P scores (i.e., SEQ-P-Pre, SEQ-P-Change, SEQ-P-Post) than clients in PIT and (1B) SEQ-P scores from the early sessions of CBT would predict CBT outcomes, whereas SEQ-P scores from the early sessions of PIT would have little to no relationship with PIT outcomes. Following the further suggestion that both CBT and PIT (and, presumably, most treatments) seek improved moods by the final stages of treatment, we further hypothesized that in late sessions: (2A) SEQ-P scores of clients in CBT and PIT would not differ significantly and (2B) SEQ-P scores from the final sessions would predict outcomes in both treatments.

**Method**

We used data from the Second Sheffield Psychotherapy Project (Shapiro et al., 1994). Although this clinical trial was conducted over 20 years ago, it is the only study that we are aware of that collected SEQ-P data at pre-session and post-session allowing us to construct the SEQ-P-Change index. Shapiro et al. (1994) provided a detailed description of the methodology of the Second Sheffield Psychotherapy Project, which we summarize here.

**Clients**

In total, 540 professional, managerial, and other white-collar workers were recruited over a 6-year period for the Second Sheffield Psychotherapy Project. About 61% of these prospective participants
were self-referred (e.g., in response to advertisements) and the remaining 39% were referred by medical and mental health professionals. One hundred and seventeen participants met eligibility criteria (e.g., Beck Depression Inventory score > 15; see Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and completed the assigned treatment. Clients had a mean age of 40.5 years (SD = 9.5), were predominately White, and most (n = 61) were female. At intake, all clients met criteria for a major depressive episode, 59 met criteria for co-morbid generalized anxiety disorder and 39 met criteria for co-morbid generalized anxiety disorder and panic disorder. Twenty-five of the 117 clients were on psychiatric medication at intake. For the present study, 4 of the 117 clients were excluded because of missing outcome data (N = 113).

Treatments and Therapists
In the Second Sheffield Psychotherapy Project, clients were randomly assigned to one of four manualized treatments (sample size for current study; N = 113): 8-weekly sessions of PIT (n = 29), 16-weekly sessions of PIT (n = 29), or 16-weekly sessions of CBT (n = 27). Treatment adherence was demonstrated with a discriminant function analysis; trained judges classified sessions as either PIT or CBT with 97% accuracy. As reported by Shapiro et al. (1994), post-treatment outcomes were generally equivalent across treatment modality (PIT vs. CBT) and treatment duration (8-session treatment vs. 16-session treatment).

Clients received treatment from one of five therapists, three of whom were male. All therapists were UK clinical psychologists, and each received pre-qualification training in which CBT was the predominant approach. Only two of the five therapists had extensive post-qualification experience in PIT methods. Nevertheless, all therapists reported even-handed allegiances to CBT and PIT. The design of the study allowed therapists to be crossed with treatments. That is, each therapist treated clients in all four treatment conditions.

Measures
The Second Sheffield Psychotherapy Project employed six self-report indices of treatment outcome: the Beck Depression Inventory (BDI; Beck et al., 1961), the Depression Subscale and the Global Severity Index of the Revised Symptom Checklist (SCL-90R-D, SCL-90R-GSI; Derogatis, 1983), the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988), the Self-Esteem Measure (SE; O’Malley & Bachman, 1979), and the Social Subscale of the Social Adjustment Scale Self-Report (SAS-SOC; Cooper, Osborn, Gath, & Feggetter, 1982). These outcome measures have sound psychometric properties (see Shapiro et al., 1994). Note that on the BDI, SCL-90R-D, SCL-90R-GSI, IIP, and SAS-SOC, higher scores imply greater psychopathology/impairment. However, on SE, higher scores imply less psychopathology/impairment. We used data collected at pre-treatment (i.e., before the first session) and post-treatment (i.e., after the 8th session for 8-session clients and after the 16th session for 16-session clients).

The SEQ-P (Stiles, 1980; Stiles et al., 1994) was administered to clients immediately before (SEQ-P-Pre) and after (SEQ-P-Post) each session. The SEQ-P consists of five bipolar adjective items, which are prefaced by the stem “Right now I feel” and are rated on a 1 (e.g., sad) to 7 (e.g., happy) scale. In addition to happy/sad, the adjective pairs include: confident/afraid; pleased/angry; definite/uncertain; and friendly/unfriendly. As supported by factor analytic and psychometric studies (Stiles, 1980; Stiles & Snow, 1984; Stiles et al., 1994), SEQ-P measures mood on a dimension, which ranges from exclusively negative feelings to exclusively positive feelings. Positivity/negativity accounts for much of the rating variance on a wide variety of mood measures in a wide variety of circumstances (Larsen & Diener, 1992; Reisenzin, 1994; Watson, Clark, & Tellegen, 1988). In an analysis of the Second Sheffield Psychotherapy Project data, Reynolds et al. (1996) reported high internal consistency for the five SEQ-P items (coefficient α = .90). Consistent with past research, the mean of the five items was used as the index of mood (possible range is one to seven).

Plan of Analysis
There were three SEQ-P variables of interest: SEQ-P-Pre (i.e., SEQ-P at pre-session), SEQ-P-Post (i.e., SEQ-P at post-session), and SEQ-P-Change (i.e., the difference between SEQ-P-Post and SEQ-P-Pre). To assess client mood in the early stage of treatment (see Hypotheses 1A and 1B), mean scores for SEQ-P-Change and SEQ-P-Post were calculated using data from the first three sessions (referred to as Early SEQ-P-Change and Early SEQ-P-Post). Because we wished to interpret SEQ-P-Pre as reflecting (in part) effects of the early stage of treatment, we calculated mean scores from only Sessions 2 and 3 (referred to as Early SEQ-P-Change and Early SEQ-P-Post). Therefore, the SEQ-P-Pre ratings from Session 1 could not have been affected by early treatment sessions. Five clients were missing SEQ-P (Pre and/or Post) data from one of the first three sessions, and for these clients, mean scores were calculated from the
available data. Means and standard deviations for Early SEQ-P-Pre, Early SEQ-P-Change, and Early SEQ-P-Post are presented in Table I, and the correlations among these variables are presented in Table II.

To assess client mood in the final stage of treatment (Hypotheses 2A and 2B), mean scores for SEQ-P-Pre, SEQ-P-Change, and SEQ-P-Post were calculated using data from the final two sessions (i.e., 7th and 8th sessions for 8-session clients and 15th and 16th sessions for 16-session clients); these means are referred to as Final SEQ-P-Pre, Final SEQ-P-Change, and Final SEQ-P-Post. There were two clients who were missing SEQ-P data from one of the final sessions, and for these clients, we used SEQ-P scores from the one session available. Means and standard deviations for Final SEQ-P-Pre, Final SEQ-P-Change, and Final SEQ-P-Post are presented in Table III, and the correlations between these variables are presented in Table IV.

To account for the nesting of clients within therapists, hierarchical linear modeling (HLM) was used to test Hypotheses 1A, 1B, 2A, and 2B using SAS 9.3 for Windows (SAS Institute Inc., Cary, NC, USA). Preliminary analyses showed that treatment duration (i.e., 8-sessions vs. 16-sessions) did not have an effect on Early or Final SEQ-P scores, so analyses included data from both treatment durations (i.e., \( n \) for PIT = 57; \( n \) for CBT = 56). Therapist effects are represented with intraclass correlation coefficients (ICCs; see Baldwin et al., 2011).

**Results**

### Hypothesis 1A: Are Early Session Mood Ratings Higher in CBT than in PIT?

Recall that Hypothesis 1A predicted that clients in the early stages of CBT would report higher SEQ-P scores (i.e., SEQ-P-Pre, SEQ-P-Change, SEQ-P-Post) than clients in the early stages of PIT. To test Hypothesis 1A, three HLM analyses were conducted: Early SEQ-P-Pre was the dependent variable (DV) in the first analysis, Early SEQ-P-Change was the DV in the second analysis, and Early SEQ-P-Post was the DV in the third analysis.
DV in the third analysis. In all three analyses, the independent variable (IV) was treatment (centered at PIT; positive β values imply higher SEQ-P scores for CBT).

Early SEQ-P-Pre was significantly higher in CBT than in PIT (β = 0.337, F(1, 107) = 5.58, p = 0.020, ICC = 0.019), Early SEQ-P-Change was significantly higher in CBT than in PIT (β = 0.453, F(1, 107) = 16.59, p < 0.0001, ICC = 0.047), and Early SEQ-P-Post was significantly higher in CBT than in PIT (β = 0.695, F(1, 107) = 23.76, p < 0.0001, ICC = 0.041).

Hypothesis 2A: Do Later Session Mood Ratings Differ between CBT and PIT?

Hypothesis 2A predicted that clients in the final stages of CBT would not differ in SEQ-P scores from clients in the final stages of PIT. To test Hypothesis 2A, three HLM analyses were conducted: Final SEQ-P-Pre was the DV in the first analysis, Final SEQ-P-Change was the DV in the second analysis, and Final SEQ-P-Post was the DV in the third analysis. In all three analyses, the IV was treatment (centered at PIT).

Final SEQ-P-Pre did not significantly differ between CBT and PIT, Final SEQ-P-Change did not significantly differ between CBT and PIT, and Final SEQ-P-Post did not significantly differ between CBT and PIT.

Table IV. Correlations of final SEQ-P variables.

<table>
<thead>
<tr>
<th></th>
<th>Final SEQ-P-Pre</th>
<th>Final SEQ-P-Change</th>
<th>Final SEQ-P-Resid</th>
<th>Final SEQ-P-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final SEQ-P-Pre</td>
<td>–</td>
<td>–0.179</td>
<td>0.141</td>
<td>0.791**</td>
</tr>
<tr>
<td>Final SEQ-P-Change</td>
<td>–</td>
<td>–</td>
<td>0.948**</td>
<td>0.460**</td>
</tr>
<tr>
<td>Final SEQ-P-Resid</td>
<td>–</td>
<td>–</td>
<td>0.717**</td>
<td>–</td>
</tr>
<tr>
<td>Final SEQ-P-Post</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>PIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final SEQ-P-Pre</td>
<td>–</td>
<td>–0.204</td>
<td>0.120</td>
<td>0.789**</td>
</tr>
<tr>
<td>Final SEQ-P-Change</td>
<td>–</td>
<td>–</td>
<td>0.947**</td>
<td>0.441**</td>
</tr>
<tr>
<td>Final SEQ-P-Resid</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Final SEQ-P-Post</td>
<td>–</td>
<td>–</td>
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</tr>
</tbody>
</table>

CBT, cognitive-behavioral therapy; PIT, psychodynamic-interpersonal therapy; SEQ-P, Session Evaluation Questionnaire-Positivity; SEQ-P-Pre, ratings at pre-session; SEQ-P-Change, raw difference between SEQ-P-Post and SEQ-P-Pre; SEQ-P-Resid, residualized difference between SEQ-P-Post and SEQ-P-Pre; SEQ-P-Post, ratings at post-session.

**p < .01.
Hypothesis 2B: Do Later Session Mood Ratings Predict Outcomes in CBT or PIT?

For Hypothesis 2B, we proposed that SEQ-P scores from the final sessions of CBT would predict CBT outcomes, and SEQ-P scores from the final sessions of PIT would predict PIT outcomes. Separate HLM analyses were conducted for CBT and PIT. Final SEQ-P variables were used as IVs, and post-treatment outcome variables were used as DVs. Each outcome variable was fitted with one HLM, using the corresponding pre-treatment outcome scores as a covariate. Since there were six different outcome variables, a Bonferroni adjusted $\alpha$ level of 0.008 was used.

For CBT, Final SEQ-P-Pre significantly predicted all six outcomes: BDI ($\beta = -3.074, F(1, 49) = 8.69, p = 0.005, ICC = 0.032$), SCL-90R-GSI ($\beta = -0.275, F(1, 49) = 19.07, p < 0.0001, ICC = 0$), SCL-90R-D ($\beta = -0.412, F(1, 49) = 14.98, p < 0.001, ICC = 0.016$), IIP ($\beta = -0.234, F(1, 49) = 9.98, p = 0.003, ICC = 0.020$), SE ($\beta = 0.646, F(1, 49) = 14.17, p < 0.001, ICC = 0$), and SAS-SOC ($\beta = -0.236, F(1, 49) = 9.26, p = 0.004, ICC = 0$). Final-P-Change did not predict treatment outcomes. Final SEQ-P-Post significantly predicted all six outcomes: BDI ($\beta = -2.555, F(1, 49) = 7.68, p = 0.0079, ICC = 0.006$), SCL-90R-GSI ($\beta = -0.217, F(1, 49) = 13.99, p < 0.001, ICC = 0$), SCL-90R-D ($\beta = -0.341, F(1, 49) = 12.89, p = 0.001, ICC = 0$), IIP ($\beta = -0.207, F(1, 49) = 9.83, p = 0.003, ICC = 0$), SE ($\beta = 0.599, F(1, 49) = 16.09, p < 0.001, ICC = 0$), and SAS-SOC ($\beta = -0.208, F(1, 49) = 9.29, p = 0.004, ICC = 0$).

For PIT, Final SEQ-P-Pre significantly predicted all six outcomes: BDI ($\beta = -4.238, F(1, 50) = 36.37, p < 0.0001, ICC = 0.018$), SCL-90R-GSI ($\beta = -0.238, F(1, 50) = 24.30, p < 0.0001, ICC = 0.033$), SCL-90R-D ($\beta = -0.390, F(1, 50) = 29.64, p < 0.0001, ICC = 0$), IIP ($\beta = -0.178, F(1, 50) = 10.10, p = 0.003, ICC = 0$), SE ($\beta = 0.648, F(1, 50) = 23.95, p < 0.0001, ICC = 0.153$), and SAS-SOC ($\beta = -0.206, F(1, 50) = 12.72, p = 0.001, ICC = 0$). Final SEQ-P-Change did not significantly predict any outcomes. Final SEQ-P-Post significantly predicted BDI ($\beta = -2.474, F(1, 50) = 10.59, p = 0.002, ICC = 0.091$), SCL-90R-D ($\beta = -0.247, F(1, 50) = 10.81, p = 0.002, ICC = 0.040$), SE ($\beta = 0.500, F(1, 50) = 16.04, p < 0.001, ICC = 0.240$), and SAS-SOC ($\beta = -0.176, F(1, 50) = 10.74, p = 0.002, ICC = 0$).

Supplementary Analyses

In addition to the raw change SEQ-P index (i.e., SEQ-P-Change), we constructed a residualized change index (SEQ-P-Resid; standardized residuals from regressing SEQ-P-Post on SEQ-P-Pre). The primary analyses were conducted with SEQ-P-Change because raw change scores are more easily interpretable and thus have more practical utility. Nevertheless, results using SEQ-P-Resid are reported here. Early SEQ-P-Resid was significantly higher in CBT than in PIT ($\beta = 0.640, F(1, 107) = 25.99, p < 0.0001, ICC = 0$) but was unrelated to treatment outcomes in CBT and PIT. Final SEQ-P-Resid did not significantly differ between CBT and PIT and was unrelated to treatment outcomes in CBT and PIT. Thus, when analyzed in lieu of SEQ-P-Change, SEQ-P-Resid produced the same pattern of results.

Discussion

Results were consistent with the theoretical understanding that the early sessions of CBT profoundly benefit the client’s immediate mood as well as ultimate outcome, and that in contrast, the early sessions of PIT are less positive but may provide the foundation for gains made in later stages of treatment. These findings underscore and extend previous research on session mood and have direct implications for psychotherapy theory and practice. Reynolds et al. (1996) found that clients in the early sessions of CBT reported higher post-session mood ratings (i.e., SEQ-P-Post) than clients in the early sessions of PIT. Previously, however, it was unclear whether these treatment differences were due to the client’s mood coming into session or the change in the client’s mood within session. Our analyses of SEQ-P-Pre and SEQ-P-Change revealed that both interpretations might be valid; clients in the early sessions of CBT reported more positive mood at pre-session (i.e., SEQ-P-Pre) and greater improvements in their mood from pre-to post-session (i.e., SEQ-P-Change), as compared to clients in the early sessions of PIT. These treatment differences on early ratings of SEQ-P-Pre, SEQ-P-Change, and SEQ-P-Post provide compelling evidence that the early sessions of CBT uplift the client’s mood better than the early sessions of PIT. Nevertheless, we also discovered that session mood ratings (i.e., SEQ-P-Pre, SEQ-P-Change, SEQ-P-Post) were roughly equivalent across the final sessions of CBT and the final sessions of PIT.

Other analyses showed that, as similar to previous results (Joyce & Piper, 1990; Mallinckrodt, 1993), PIT outcomes were predicted by SEQ-P-Pre and SEQ-P-Post ratings from the final, but not early, sessions of treatment. In comparison, CBT outcomes were predicted by SEQ-P-Pre and SEQ-P-Post ratings from the early and final sessions of
treatment. Although the current study is the first to investigate and discover a relation between early SEQ-P ratings and outcomes in CBT, our results dovetail with an extensive body of research that has identified sudden gains in the early sessions of CBT, as well as the link between these early, sudden gains and post-CBT outcomes (Aderka, Nickerson, Boe, & Hofmann, 2011; Busch, Kankter, Landes, & Kohlenberg, 2006; Ildari & Craighead, 1994; Tang & DeRubeis, 1999; Watson, Schein, & McMullen, 2010).

Interestingly, regardless of treatment approach and stage of treatment, SEQ-P-Change ratings did not predict outcomes. Because SEQ-P-Post is simply the sum of SEQ-P-Pre and SEQ-P-Change, these results may suggest that the reason why SEQ-P-Post was linked to outcome in the current study and in past studies (e.g., see Mallinckrodt, 1993) is largely because of the client’s mood coming into session (i.e., SEQ-P-Pre), rather than within-session mood change (i.e., SEQ-P-Change). Of note, SEQ-P-Pre was inversely related to SEQ-P-Change in the early sessions of PIT (see Table II). This is not surprising, however, because PIT clients who reported more negative mood coming into session (i.e., lower SEQ-P-Pre scores) may have had a larger range of possible mood improvements within-session (i.e., higher SEQ-P-Change scores).

When considered in total, our findings imply that CBT and PIT are characterized by different patterns of change; the early sessions of CBT may yield substantial mood improvements that are maintained over the course of treatment and reflected in post-treatment outcomes, whereas the early sessions of PIT may set the stage for the mood improvements that emerge in later sessions. These contrasting patterns of change could be explained, at least in part, by the techniques unique to each treatment (e.g., behavioral activation in early CBT sessions, problem exploration and then assimilation in PIT; see Startup & Shapiro, 1993).

Despite these contrasting patterns of change in CBT and PIT, post-treatment outcomes were reported to be roughly equivalent across CBT and PIT in the original study (Shapiro et al., 1994), as well as in other studies (see Baardseth et al., 2013; Imel & Wampold, 2008). It is possible, then, that the Dodo verdict is valid with regard to end-of-treatment outcomes but not session outcomes over the course of treatment. That is, CBT, PIT, and other bona fide psychotherapies might all work but in different ways (Crits-Christoph, Chambless, & Markell, 2014; Ulvenes et al., 2012; Wiser, Goldfried, Raue, & Vakoch, 1996).

Clinical Implications

It is interesting to speculate how the present findings may inform clinical practice. For clients who are at-risk and are in need of mood improvements at the outset of therapy (e.g., severely depressed, suicidal clients), therapists should consider implementing the early sessions of CBT so as to lift the client’s mood. If, on the other hand, the goal is to improve mood and symptoms over the longer-term, then it appears that CBT and PIT are both viable options.

The current research could also be extended and integrated into outcome-monitoring programs (see Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). The session mood ratings over the course of CBT and PIT, as well as the links between the session mood ratings and outcome, could inform and enhance the capacity of these programs for predicting client outcome. Our results imply that the trajectory of client change is not uniform across CBT and PIT, and so it may be prudent to develop expected treatment response curves that are unique to particular treatment modalities (see Lambert & Ogles, 2014).

Limitations and Directions for Future Research

To construct the new index of within-session mood change (SEQ-P-Change), we relied on a data-set that is over 20 years old (Shapiro et al., 1994). More recent data are needed to corroborate these results with CBT and PIT, as well as to examine the process of change in other therapeutic approaches (e.g., client-centered therapy).

There are several limitations associated with our client sample, which was exclusively composed of adult clients who met criteria for a depressive disorder. Shapiro et al. (1994) noted that these clients were predominately White, although the racial/ethnic status of clients was not officially recorded. This might obstruct efforts to compare the current sample to other outpatient samples. In addition, clients enrolled in the Second Sheffield Psychotherapy Project were professional, managerial, and other white-collar workers, who were likely of higher socioeconomic status (SES). A recent review (Bohart & Wade, 2013) concluded that lower SES predicts treatment nonattendance, and so our use of “completer” analyses could have further exacerbated the underrepresentation of lower SES clients. In light of the limitations associated with our client sample, it would be inappropriate at this time to generalize the current findings to non-depressed clients, non-White clients, and to clients of lower SES.
We also want to stress that our findings are in support of, and do not confirm, our hypotheses. In particular, there is inherent danger in construing null findings as confirmation of hypotheses (Kolden, 1996), and so the lack of a significant treatment difference, for example, on late session SEQ-P-Post ratings may not necessarily mean that post-session mood is in fact equivalent across the final sessions of these treatments. Moreover, because techniques were not isolated or measured in the present study, firm conclusions cannot be drawn about the role of specific techniques in facilitating client change. An avenue for future research is to use highly controlled methodologies (e.g., see McClintock & Anderson, 2015) to identify the techniques that have the greatest, positive impact on client mood.

Finally, given our small sample of therapists (n = 5), the therapist effects observed on SEQ-P ratings should not be generalized at this time to therapists at large. The possible influence of therapists on client mood is, however, a topic deserving of empirical attention.

Conclusions

According to our results, the early sessions of CBT have a relatively positive effect on the client’s mood before, during, and after sessions, as well as on their ultimate treatment outcome; in contrast, the early sessions of PIT are less positive but may lay the foundation for later gains. These results add to the growing body of knowledge about the change processes in CBT and PIT. Understanding how these treatments work may allow us to optimize the processes critical to change (Kazdin, 2008), thereby improving clinical work and client care.

Disclosure statement

No potential conflict of interest was reported by the authors.

References