Abstract

Objective: Debates continue over shared factors in therapy processes between different theoretical orientations. By seeking the opinions of practicing clinicians, this study aimed to elucidate the similarities and differences between cognitive-behavioural (CBT), psychodynamic (PDT), and schema therapy (ST) approaches. **Method:** Forty-eight practitioners aligning with one of the three approaches were asked to identify crucial processes in their therapy using a modified online version of the Psychotherapy Process Q-set. **Results:** Distinct differences between each theoretical orientation with few shared common factors were found. A comparison with ratings from previous studies indicated that CBT therapists have not changed over the last 20 years, whereas PDT therapists have changed and the differences appeared consistent with modern PDT theory. **Conclusions:** The differences between the therapy approaches were consistent with theories underlying each model. PDT therapists valued a neutral relationship, CBT therapists emphasized a didactic interaction, and therapists form a ST orientation placed a greater emphasis on emotional involvement.

Keywords: Cognitive-Behavioural Therapy, Psychodynamic Therapy, Schema Therapy, Psychotherapy Process Q-Set

Introduction

Considerable psychotherapy research has been focused on identifying the active ingredients of the therapeutic process (Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Goldfried & Davila, 2005; Jones & Pulos, 1993). Two therapies that have been compared extensively are Cognitive-Behavioural Therapy (CBT) and Psychodynamic Therapy (PDT) (Ablon & Jones, 1998). CBT and PDT have often been used in research due to the contrasting and at times contradictory nature of their underlying theory, mechanisms of change and techniques (Blagys & Hilsenroth, 2000; Jones & Pulos, 1993).

CBT applies the principles of cognitive and behavioural interventions in the treatment of psychological distress (Foreman, 2011; Watzke, Rueddel, Koch, Rudolph, & Schulz, 2008). The short-term nature and symptom focused approach of CBT makes it a popular choice of therapy and it has been shown to be efficacious for a wide variety of psychological issues (Butler, Chapman, Forman, & Beck, 2006; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006). CBT interventions target unhelpful patterns, in thinking and behaving, in order to help individuals feel better (Foreman, 2011). This is based on the assumption that emotions, behaviour, and cognitions are interrelated. Another fundamental assumption of CBT is that patients can access all the necessary information for change (Abrams & Abrams, 1997). Therapists take an active stance during therapy to guide the interaction, challenge negative cognitions, and encourage the patient to develop new ways of behaving (Ablon & Jones, 1999; Osatuke, Glick, Stiles, Greenberg, Shapiro, & Barkham, 2005). Practical exercises are often set between sessions to change cognitions and behaviour (Foreman, 2011).

The premise of PDT is that certain memories, feelings, and desires are hidden in our unconscious and are deliberately kept there by defence mechanisms (Abrams & Abrams,

1997). Therefore therapy endeavours to help the patient achieve insight through the exploration of unconscious processes or ideas of self that influence behaviour (Shedler, 2010). Past experiences, such as highly significant relationships or unresolved conflicts are emphasised because these can impact on the patient's current situation. Through the focus on interpersonal relations, affect, and expression of emotions the patient gains mastery over their unconscious or repressed desires, wishes, or anxieties (Blagys & Hilsenroth, 2000). The therapy relationship can become an important interpersonal relationship, which the therapist uses to identify themes and draw connections to the patient's other relationships (Trijsburg, Semeniuk, & Perry, 2004). Thus the therapy relationship becomes a topic of discussion and is considered the vehicle of change (Shedler, 2010).

Research has supported the idea that different therapies "borrow" a portion of techniques and strategies from other theoretical orientations (Ablon, Levy, & Katzenstein, 2006; Bambery, Porcerelli, & Ablon, 2007). The therapeutic alliance has been identified as a common factor in therapy approaches which accounts for improvement in the client (Goldfried & Davila, 2005; Price & Jones, 1998). As a result it has been suggested that the nature of the interaction between therapist and client could be more similar across different therapies than expected (Ablon & Jones, 2002).

Research that has explored processes in PDT and CBT to test for therapy-specific versus common factors has found mixed results. Trijsburg et al. (2004) conducted a study comparing the intervention process in PDT and CBT, and found just over half of the interventions employed by clinicians were theoretically specific. Another study conducted by Ablon and Jones (1998) developed PQS prototypes for CBT and PDT based on the most conceptually associated items identified for each therapy. They found there was a high correlation between CBT and PDT intervention processes to the CBT prototype. These

results suggest that PDT therapists employ not only psychodynamic but also a high amount of cognitive-behavioural strategies in treatment.

It could be argued that the reason for the similarities between these two distinct theoretical orientations is that they have evolved over time to help meet the needs of patients, not only in approach but also technique (James, 2001). With the introduction of brief PDT the focus of treatment has shifted to a focus on relief from symptoms (Watzke et al., 2008). Based on the same theoretical foundation, PDT interventions have become more active and utilise many similar techniques to those used in CBT (Abrams & Abrams, 1997, Serralta, Pole, Tiellet Nunes, Laks Eizirik, & Olsen, 2010). Conversely, although asserting the importance of empiricism, CBT has adopted other efficacious techniques and strategies from other theoretical orientations (James, 2001). In a review of therapeutic interventions, Perris (2000) posited that there has been a noticeable shift in the emphasis and focus of CBT over time. The approach that he termed 1st generation CBT was task and goal oriented working with surface level structures, whereas 2nd generation CBT focuses on the underlying cognitions and places greater emphasis on the therapeutic bond. Other researchers have argued that CBT has then evolved to incorporate affective processes to further enhance long-term effectiveness (Samoilov & Goldfried, 2000).

Perhaps consistent with these purported changes in CBT is the emergence of Schema Therapy (ST) which, although based on CBT, has more of an emphasis on affect and core underlying cognitions (de Groot, Verheul, & Trijsburg, 2008; James, 2001). ST is an integrative therapy developed by Young (1990). A central concept in ST is early maladaptive schemas, which are the result of an individual's core needs not being met in childhood (Lobbestael, van Vreeswijk, & Arntz, 2007; Young, Klosko, & Weishaar, 2003). This implies that more time during therapy should be spent on exploring the origins of patients schemas which Young believed was particularly relevant to the treatment of more complex

patients such as those with personality disorders (Cecero, Nelson, & Gillie, 2004; Nysæter & Nordahl, 2008). A strong therapeutic bond is necessary due to the high level of negative affect caused by addressing early maladaptive schemas but also as the therapist attempts to meet the core needs of the patient (Hoffart, Sexton, Nordahl, & Stiles, 2005). The systematic approach to treatment used in ST integrates techniques and strategies from several different theoretical orientations (Young et al., 2003). ST has established itself as an efficacious treatment intervention for patients with more chronic characterological issues (Kellogg & Young, 2006; Nysæter & Nordahl, 2008). However, more recently, it has been applied with positive outcomes in the treatment of mood and anxiety disorders (Cecero et al., 2004; Hawke & Provencher, 2011).

The incorporation of elements from other therapeutic approaches makes ST a unifying theory with a structured approach to the conceptualisation and treatment of individuals (Cecero & Young, 2001; Greenwald & Young, 1998; Lobbestael et al., 2007). Considering its origins ST shares similarities with CBT (Nysæter & Nordahl, 2008; Young et al, 2003). Both therapies use cognitive and behavioural intervention strategies as a means to facilitate change within the patient (Bernstein, 2005; McGinn, Young, & Sanderson, 1995). Also both therapies view the therapeutic relationship as a productive collaboration between the therapist and patient that is characterised by supportive communication, encouragement, and interpersonal contact (Kellogg & Young, 2006; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). The differences between these approaches predominantly relate to degree of emphasis placed on aspects of treatment (Young et al., 2003). ST can be considered a ‘top down’ approach whereas traditional CBT is ‘bottom up’. ST starts at the core level which results in a more distinct shift of focus earlier in treatment. The ‘here and now’ approach of CBT means a focus on surface level behaviours and cognitions with core beliefs addressed at later stages in the therapy intervention (James, 2001). By placing more

importance on the therapeutic relationship, discussion of experiences in early life and affective experience, ST elaborates on traditional CBT (Young, 1990; Young et al., 2003).

ST is similar to PDT in that childhood experiences are seen as important in the origins of a patient's life problems (McGinn et al., 1995). Another similarity with PDT is the focus on the therapy relationship, concepts such as limited reparenting and empathic confrontation are compatible with the modern psychodynamic focus on expressing empathy and building a therapeutic alliance (Bernstein, 2005; Kellogg & Young, 2006). The two approaches emphasise the need for individuals to process emotions associated with traumatic experiences (Cecero & Young, 2001). The differences between these therapies relate to their underlying theory and therapy techniques. ST is not an unconscious drive theory, meaning instead of focusing on instinctual impulses i.e. sexual and aggression, ST emphasises core emotional needs (Young et al., 2003). The therapist's approach in PDT is one of neutrality whereas in ST the therapist is likely to be more active and directive using techniques such as limited reparenting with the goal being to help meet unmet emotional needs of the patient in order to heal schemas (Nysæter & Nordahl, 2008).

Given that ST at a theoretical level incorporates elements of both PDT and CBT it is of interest to look at the degree to which there are similarities between the approaches in practise. Further distilling common and separate factors is important in understanding the active ingredients of the therapeutic process (Jones & Pulos, 1993). The potential of process research enables better understanding of client change, helps with development of theory, and bridge the gap between research efficacy and clinical practice effectiveness (Godfrey et al., 2007; Hill, 1990).

The Present Study

Using practitioners from three therapy orientations the broad purpose of this research was to explore common and unique therapeutic process of each perspective. This study did not aim to look at the effectiveness of each therapy approach but to explore clinicians' views on the treatment process. Using a modified version of the PQS, the aim was to elucidate the key therapy processes of CBT, PDT and ST approaches.

The second aim was to compare the most characteristic items of CBT and PDT in the present time to a previous study (Jones & Pulos, 1993) to examine whether therapy processes have changed over the last 20 years. This will enable an empirical test of the proposal that CBT and PDT are evolving and intervention processes have become more similar over time (James, 2001, Bambery, Porcerelli, & Ablon, 2009).

Method

Participants

The participants consisted of an international sample of experienced clinicians recruited through professional associations. Participation in this study was anonymous and on a voluntary basis. Membership to the professional organisations required recognised tertiary qualifications in psychology, psychiatry, or social work with further qualifications and training within that particular theoretical orientation. Participants represented three therapy approaches ST, CBT, and PDT. In total there were 48 participants, CBT 16 (33.3%), PDT 14 (29.2%), and ST 18 (37.5%). An additional 12 surveys (4 CBT, 1 PDT, 7 ST) were commenced however they were not completed.

Participants were asked to identify the country in which they practice. Participants included Australia 13 (27.1%), USA 5 (10.4%), Europe 19 (39.6%), and other 11 (22.9%). Other locations included South Africa, Asia, and Canada.

Measures

Psychotherapy Process Q-Set (PQS)

The Psychotherapy Process Q-Set (PQS) developed by Jones (2000) was designed to help explain what takes place in the therapy process in terms that are clinically relevant. It is a widely published instrument composed of 100 items related to specific behaviours and actions (Sirigatti, 2004). The general purpose of the instrument is to provide a meaningful index of the therapeutic elements that may be suitable for quantitative analysis. A coding manual provides instructions for the Q-items and their definitions, and also the Q-sorting process (Ablon & Jones, 1999). The use of standard language and rating procedure provides a means for systematically characterising the therapist-patient interaction (Jones, 2000).

The PQS was intended to be largely neutral with respect to any particular theory of intervention, and should permit portrayal of a wide range of therapeutic interactions (Ablon et al, 2006; Jones & Windholz, 1990). The efficacy of the PQS in revealing the therapy process has been consistently demonstrated across a variety of psychotherapy studies and patient populations (Jones & Pulos, 1993; Sirigatti, 2004). Testing of the discriminant validity of the PQS has indicated that it is able to distinguish between types of therapy by correctly surmising the nature of differing theoretical orientations and also the number of significant differences (Price & Jones, 1998). Thus, it has allowed for researchers to develop prototypes for ideal psychotherapy treatments based on theoretical perspectives (Ablon et al., 2006).

Schema Therapist Competency Scale (STCS)

The Schema Therapist Competency Scale (STCS; Young & Fosse, 2008) was designed to measure the competency of a schema therapist during individual therapy sessions. This scale reflects the main characteristics which define ST and the approach used

by therapists. There are fourteen subscales which have been categorised into three groups. The groups incorporate key components of ST treatment and are distinguished by the skills required by the therapist and the different stages of the therapy process. The first group is general therapeutic skills, the second group explores the therapist conceptualisation of the patient's issues and the approach to educating the patient in schema terms and the third group focuses on techniques of schema change such as application of cognitive, emotion-focused, and behavioural pattern-breaking techniques.

Design

The PQS was modified in three ways (PQSM). Modifications included the elimination of the Q-sort process and using an online rating scale, a reduction in the number of PQS items and the inclusion of ten additional items characteristic to ST. This bought the total number of questions on the PQSM used in this survey to 67.

Traditionally the procedure for using the PQS is a process of sorting and categorising 100 cards. The 100 statement cards are allocated into one of nine categories, ranging from *most characteristic* to *most uncharacteristic*, with respect to the PQS item being analysed (Jones & Windholz, 1990). For the purpose of this study the PQSM was adapted to an online format, eliminating the need for card sorting.

Due to the nature of this research participants were asked to generalise their responses to each question by relevance to their therapeutic technique or approach as opposed to responding for an individual patient.

The selection of which items to remove from the survey was conducted through a comparison of several journal articles (Ablon & Jones, 1998; Ablon & Jones, 1999; Ablon et al., 2006; Bambery et al., 2007; Bambery et al., 2009; Jones & Pulos, 1993; Pole, Ablon, &

O'Connor, 2008). Each article explored facets of either psychotherapy, CBT or PDT and used the PQS as the measure. Researchers collated results from each article using only the PQS items which were ranked as characteristic for each therapy. Eight articles were compared in total. Of the articles used six pertained to CBT, five articles were for PDT, and two explored psychotherapy. A comparison between CBT and PDT therapy approaches using the PQS was related to five articles, two of the articles related specifically to psychotherapy, and one article explored the elements of CBT. Items were eliminated on the basis of total number of presentation across the articles. Only items which appeared more than twice were included. This bought the total number of items in the PQSM to 57.

An additional ten items were added to address areas of ST which the researchers believed were not adequately represented in the PQS. The PQS was assessed to see if all 14 subscales of the STCS were represented. Two research assistants examined the STCS and the PQS and agreement was reached that four subscales of the STCS were already represented in the PQS. Ten items from the remaining ten subscales were then written to ensure the PQSM would adequately cover all aspects of the ST process. These items covered topics such as: limited reparenting, therapist's approach to collaboration, feedback and session focus, therapist balance and flexibility, conceptualisation, education, linking schema-driven situations, application of emotion-focused change techniques, and application of behavioural pattern breaking.

Procedure

To ensure credibility of the results participants were recruited from associations for each of the therapy approaches. Organisations were approached including the International Society of Schema Therapy (ISST), Australian Association for Cognitive Behavioural

Therapy (AACBT), and the International Association of Psychodynamic Psychotherapists (INTAPSY).

With consent from the organisations, participants were contacted through various electronic mediums including email, online member newsletters, and advertisements on organisation websites. Information was provided regarding the purpose of the study and a link was attached to the online survey. Each participant was only allowed to complete the survey once. For convenience, the opportunity to complete the questionnaire in several sittings was provided. Responses, once completed, could not be changed.

Results

Theoretical Differences

A 3 (Therapy approach) x 67 (PQSM-items) multivariate analysis of variance (MANOVA) was used to determine whether there was an effect of theoretical orientation on responses to the PQSM.

Testing to examine the underlying assumptions was conducted prior to conducting a MANOVA. The assumption of multivariate normality was met as there were no multivariate outliers in the data. The assumptions for multicollinearity, linearity, and homogeneity of variance-covariance matrices however were not satisfied. This was most likely related to the ratio of dependent variables to participants. An alternative approach to determine if items differentiated between the three orientations was to apply a Bonferroni correction to ensure that the cumulative Type 1 error is below .05. Given there were 67 ANOVAS, we applied a Bonferroni procedure, using $\alpha = .001$ (0.05/67, rounded to three places). 31-PQSM items were found to have a significant effect on theoretical orientation. Using Pillai's Trace, the MANOVA revealed there was a significant effect of theoretical orientation on the PQSM items, V = 1.991, F (90, 4) = 9.745, p <.05, partial $\eta^2 = .1$. Using the ANOVA results, the top

ten items for each therapy were then rank-ordered according to their discriminant value [Table 1, 2, and 3 near here].

Most Characteristic PQSM Items

Tables 4, 5, and 6, display the most characteristic aspects of each therapy approach based on the most frequent PQSM items as identified by the clinicians from each perspective.

Cognitive Behavioural Therapy: Table 4 displays the most frequent PQSM items identified by clinicians. As can be seen by comparing tables 1 and 4, five items were both most characteristic and most discriminating of CBT, and therefore appear central to the CBT approach. Clinicians perceived that there was a focus on patients' cognitive themes (Q30), that specific tasks and activities for the patients were scheduled outside of session (Q38), encouraging the patient to try new ways of behaving (Q85), conveying positive expectations about treatment (Q55), and discussion on the goals of treatment (Q4) [Table 4 near here].

A study of differences in items listed in tables 1 and 4 suggest that other items unique to CBT, but that did not make the top ten in terms of most characteristic, reflect a directive therapeutic stance. Clinicians identified the therapist as behaving in a teacher-like manner (Q37), giving explicit advice and guidance (Q27), having a specific focus (Q23), and actively exerting control over the interaction (Q17).

Items found to be most characteristic of CBT but also shared something in common with the other approaches reflect that CBT therapists focus on relationship building through collaboration (Q105), attuning to the patient's feelings (Q6), and being sure the patient understands the process of change (Q110).

Psychodynamic Therapy: Table 5 displays the most frequent PQSM items identified by the clinicians. A comparison of table 5 with table 2 revealed four common items that were both most characteristic and most discriminating of PDT. These items represent core

components to the PDT process, for example exploration into major themes related to the patient's interpersonal relationships (Q63), that the discussion is focused on the therapy relationship (Q98), that there are interpretations by the therapist of warded-off or unconscious wishes, feelings, or ideas (Q67), and that there is a discussion of scheduling or fees (Q96) [Table 5 near here].

Based on therapists' perceptions items found to be most characteristic of PDT but which shared something in common with the other approaches focused on relationship building including that the therapist was empathic (Q6), conveying a sense of non-judgemental acceptance (Q18), and accurately perceives the processes in the relationship (Q28). Other items in common with one of the other two approaches were identifying recurrent themes in the patient's experience (Q62) and a focus on achieving new insight and understanding (Q32).

A study of differences in tables 2 and 5 indicates two items to PDT that did not make the top ten most characteristic. These items were the therapist maintaining neutrality (Q93) and that the patient experiences ambivalence or conflict about their feelings towards the therapist (Q49).

Schema Therapy: Comparison between most frequent items and those that discriminate ST, revealed a high level of agreement, with seven items in common. These items reflect the collaborative nature of the therapy relationship (Q105 and Q110), a focus on core needs (Q103), and the conceptualising of the patient's problems and themes in schema terms (Q108). Other key items based on clinicians' perceptions reflect strategies used in the change process such as emotion-focused techniques (Q109) and imagery (Q102). Finally schema therapists identified that confrontation of dysfunctional behaviours (Q104) was highly characteristic and this item discriminated between the three approaches.

A study of differences in items listed in tables 3 and 6 suggest that items also unique to ST but not highly characteristic were that the therapist is responsive and affectively involved, such as might allow extra time (Q101), educates the patient on core issues and defence mechanisms (Q106) and self-discloses (Q21).

Items found to be most characteristic of ST but which shared something in common with the other two approaches were that the therapist is attuned to the patient, empathic (Q6), that the therapist draws attention to the mood or affect of the patient (Q79), and to link feelings and perceptions to situations or behaviours of the past (Q92) [Table 6 near here].

The MANOVA was followed up with a discriminant analysis using the most characteristic PQSM items. Based on therapists' perceptions 27-PQSM items in total were identified as being characteristic to either CBT, PDT or ST. One PQSM item was characteristic to all theoretical orientations (Q6) and 2-PQSM items were characteristic to both CBT and ST (Q105 and Q110). The analysis revealed two discriminant functions that in combination significantly differentiated the treatment groups, $\Lambda = .01$, χ^2 (54) = 168.83, p <.001, removing the first function indicated that the second function also significantly differentiated the treatment groups, $\Lambda = .17$, χ^2 (26) = 57.31, p <.001.

The correlations between items that differentiated each theoretical orientation and the discriminant functions revealed that function 1, which explained 86.4% of the variance, canonical correlation = .99, discriminated PDT from CBT and ST. This is defined by negative loadings on PDT characteristic items in the structure matrix and positive loadings for CBT and ST items. Specifically, this function discriminated PDT, function at the group centroid = -8.39, from CBT and ST, function at group centroid = 2.44 and 4.36, respectively. The second function only explained 13.6% of the variance, canonical correlation= .91, however this indicated the ability to discriminate CBT, function at group centroid = -2.9,

from ST, and to a lesser extent PDT, function at group centroid = 2.19 and = .5, respectively. Figure 1 depicts the identified PQSM items that were most characteristic to the theoretical orientations and the differences between the two functions [Figure 1 near here].

Comparison of CBT and PDT over time

Jones and Pulos (1993) conducted a direct comparison on the Q-sort items for CBT and PDT therapy sessions. They found 31-PQS items that were more characteristic of PDT and 26-PQS items more characteristic of CBT. Using these results, an independent sample t-test was conducted to compare the average scores of the more characteristic items between Jones and Pulos study and the findings of this study.

A direct comparison of CBT was made using the Mann-Whitney *U* test. The Shapiro-Wilk test indicated the assumption of normality had been violated for the PQS CBT group and therefore the nonparametric equivalent on an independent samples *t* test was used. The results of the Mann-Whitney *U* test indicated that the PQS items in this study (*Mean Rank* = 22.18, *n* = 20) were not significantly higher than those of Jones and Pulos' (1993) study (*Mean Rank* = 18.83, *n* = 20), *U* = 166.50, *p* = .369 (exact probability), two-tailed, and small effect size, *r* = .14. Not only was there no significant difference in ratings, all but 3-PQS items were within two points of the original ratings. The 3-PQS items which were above two were therapists commenting on changes in patients' mood (Q79), therapist encouraging patient to try new ways of behaving with others (Q85), and the use of humour (Q74).

A two-tailed, independent samples *t* test was used to compare the PDT-PQS item responses of this study (M = 7.98, SD = .50) with findings from Jones and Pulos' (1993) study (*M* = 5.87, *SD* = .74). Levene's test for equality of variance was significant (*F* = 4.677, *p* <.05), indicating that the homogeneity of variance assumption was violated. Consequently, Welch's *t* test was used to compare PQS items between the two studies. The *t* test was

statistically significant, $t(36.75) = -11.05$, $p < .001$, two-tailed, $d = 3.33$ and which can be described as large. Table 7 displays the 11-PQS items with the highest change in mean scores (change score >2) [Table 7 near here].

Discussion

The purpose of this study was to examine the key therapy process variables that are in common with and distinguish between CBT, PDT, and ST based on practitioners' perceptions. The results indicated a striking difference in the perception of therapists in the key processes between the three therapy approaches. Regardless to claims of "borrowing" from other therapies, distinct profiles for each theoretical orientation were identified, supporting differences in intervention repertoires and assumptions about the sources and nature of patients' psychopathology (Godfrey et al., 2007; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006).

Orientation Unique Therapy Factors

We found that CBT therapists rated themselves differently from the other therapists in that their style was more directive, focused on behaviour, and had a more problem solving approach. For example the ratings on the PQSM by CBT therapists that were both highly characteristic and discriminated them from the other two approaches included items that showed a focus on behaviour and being goal oriented. This is consistent with previous views of CBT that places an emphasis on structure and goal setting (Foreman, 2011).

Another key difference between CBT therapist self-ratings and the other two approaches is that the therapist tends to be actively controlling or teacher-like in the relationship. This was evident from several items that significantly differentiated CBT such as that the therapist exerts control, gives advice, and behaves in a teacher-like role. This was

consistent with previous analyses where the therapists rated ‘actively exerting control’ over the interaction as highly characteristic of CBT (Pole et al., 2008).

Psychodynamic therapist self-ratings were found to be different from CBT and ST in that there was a greater emphasis on relational issues including the patients’ interpersonal relations, the therapy relationship itself, and particular aspects of the therapy relationship such as fees. This is consistent with PDT theory where the patient’s interpersonal and therapeutic relationships, have been identified as a core component to the PDT intervention process (Blagys & Hilsenroth, 2000; Shedler, 2010).

The level of engagement with the patient is another distinguishing feature of PDT, our findings suggest that PDT therapists perceive themselves as remaining neutral, in contrast to ST and CBT therapists who work collaboratively with their patients (Jones & Windholz, 1990). Other themes that emerged from the items that discriminated PDT from ST and CBT was a focus on unconscious processes and defensive styles. Other writers have identified this as unique aspect in PDT (Abrams & Abrams, 1997).

The approach and strategies identified by schema therapists as being highly characteristic were consistent with its theoretical framework (Young et al., 2003). Schema therapists identified predominantly with items that were related to the content of a scale to assess adherence to a schema therapy approach (Young & Fosse, 2008). Items that were unique and characteristic of schema therapy included a focus on experiential techniques that involved affect and imagery.

The other items that differentiated ST from the other two approaches referred to behaving more like a parent than teacher (CBT), or neutral (PDT). The term limited re-parenting has been developed by schema therapists to describe the therapists’ attempt to meet, in a limited way, the core needs of the patient (Young et al., 2003). Items that relate to

this theme include more personal affective involvement such as using self-disclosure and being affectively responsive. Also, like a parent, the therapist focuses on providing for the needs of the patient as well as confronting the patient when necessary. This is also in contrast to PDT where the focus is on the transferential aspects of the therapy relationship which can also be confrontational and emotionally charged however the therapist remains neutral (Blagys & Hilsenroth, 2000; de Groot et al., 2008).

Partially Shared Therapy Factors

The CBT clinicians' self-ratings identified two PQSM items in common with ST, working collaboratively with the patient and explicit communication of the change process. Although these are shared elements, they may appear differently in the intervention. For example in ST, the therapist listens rather than gives advice (Hoffart et al., 2005) and tends to be explorative rather than directive (de Groot et al., 2008; McGinn et al., 1995).

Exploration of past events was similar in both PDT and ST. However in ST, the therapist uses this information to conceptualise and educate the patient regarding their core issues and defence mechanisms, for the purpose of cognitive restructuring, experiential relearning, and behavioural pattern breaking (Kellogg & Young, 2006; Young et al., 2003). In PDT this exploration is used to help the patient gain a better understanding of how their problems have manifested in their lifetime and to help them relieve their intrapsychic conflicts (Blagys & Hilsenroth, 2000).

There were no shared highly characteristic items between PDT and CBT apart from the single item that was rated as highly characteristic by therapists from each of the three approaches, as discussed below.

Common Therapy Factors

Identification of the most characteristic items for each of the theoretical orientations revealed very few commonalities. The one common item between the three approaches was "therapist is sensitive to patient's feelings, attuned to patient, empathic". This behaviour has been identified as essential to all therapies as awareness of the patient is necessary for the change process to occur (Sexton et al., 2005). The empathic understanding of the patient's position within the relationship has been viewed as critical to the intervention process (Swift & Callahan, 2010). This item also suggests that a focus on affect is important which facilitates the patient in exploring their full range of emotions, making them feel understood and supported (Lingiardi, Colli, Gentile, & Tanzilli, 2011).

Comparison of CBT and PDT Over Time

The second aim of this study was to compare and contrast the responses given from CBT and PDT clinicians to a previous study as a means to explore changes in therapy processes within each orientation over time.

Despite many writers arguing that CBT has evolved over time (e.g. James, 2001), in this study there were no significant differences in mean ratings on items from the PQS rated by therapists 20 years ago compared to self-ratings now. Although there were no significant differences, three items showed some tendency towards change. They suggest that CBT therapists use more humour, comment on changes in patients' mood, and are more likely to encourage the patient to try new behaviours. These last two items are consistent with observations that contemporary CBT therapists might be more involved with affect compared to the past (Samoilov & Goldfried, 2000) and that there has been an increased focus on changing behaviour (Perris, 2000).

PDT therapists rated the PQS items significantly differently in this study compared to those in the Jones and Pulos' (1993) study. These item scores are consistent with PDT

therapists over time being more encouraging of the patient to talk. The differences were also consistent with PDT therapists having a greater focus on exploration, interpretation, and linking of situations and behaviours to help the patient achieve new understanding. Previous research has identified these as distinctive features of modern PDT approach (Shedler, 2010).

Limitations, Strengths, and Suggestions for Future Research.

Caution is encouraged when drawing conclusions from the findings of this study. The complexity of the PQSM combined with the number of participants meant that the options for analysis were limited. The sample size was also small. These issues however were somewhat mitigated by the fact that the current findings were consistent with previous research and even using the most rigorous Bonferroni corrections, significant differences emerged.

Any conclusions based on comparing the current findings with previous data need to take into account that this study used a modified version of the PQS. Although identical items were compared in this study with the Jones and Pulos' (1993) data, the rating system was different. The Q-sort system was adapted to an online version that asked people to rate the degree to which each item was characteristic. Therefore it is possible that differences in the ratings were not due to changes over time but to the different rating methodology or even to the different context in which the data was collected for example, the earlier data was based on therapy experiences during a randomised control trial (RCT), whereas the current data reflects therapists' views of their every day practise. This could be tested by a replication of the current study with the original rating system and in an RCT context. Some confidence in the generalizability of the findings can be taken from the fact that there were no significant differences in the ratings for the CBT therapists between the two studies.

The design of this study meant that the participants were in fact judging themselves in their approach to treatment. This could be subject to bias and it is noted that these self-

perceptions may not reflect what therapists actually do (Roussos, Lissin, & de Duarte, 2007). It is an empirical question as to the degree that self-ratings correlate with observer ratings in assessing characteristic processes. Such a question is another area for future research.

A final limitation was that the findings of this research were not based on a random sample of the population of therapists, but instead based on therapists that were prepared to participate. It is not known to the extent to which therapists that volunteered are representative of their colleagues in each theoretical orientation.

The strengths of this research include directly comparing two extensively researched evidenced based approaches with ST which has only been subject to limited comparative studies (McGinn et al., 1995). In addition there was heterogeneity in therapists' backgrounds as therapists from four continents participated in the research. The benefits of developing an online version of the PQSM meant that the labour intensive Q-sort process could be simplified and the completion of the survey could be done at the convenience of participants.

Conclusion

This research explored the key therapy processes of CBT, PDT, and ST. It was the first to compare the therapy processes of ST with two evidence-based approaches using the PQSM. The findings did not support claims made by other researchers that there is overlap between interventions; instead we found very few shared factors between each of the therapy approaches. CBT interventions were seen to be directive and task oriented, in distinct contrast to PDT and ST which explore past events and place greater emphasis on relationships. In comparison to research published 20 years ago it appears that CBT seems to have changed little on items assessing therapy process, whereas PDT has evolved into an intervention based more on interpretation, exploration, focusing on relational issues. Regardless of the claims made towards integration and the adoption of techniques from other therapies, practicing

clinicians were found to still adhere to the framework and approach consistent with their theoretical orientation.

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Tables

Table 1. The ten most characteristic items of CBT ranked order according to discriminant value.

Item no.	PQS Item	F Value
38	There is discussion of specific tasks or activities for patients to attempt outside of session	212.04
17	Therapist actively exerts control over the interaction (e.g. Structuring, and/or introducing new topics)	68.83
27	Therapist gives explicit advice and guidance (vs. Defers even when pressed to do so)	41.15
85	Therapist encourages Patient to try new ways of behaving with others	35.04
23	Dialogue has a specific focus	28.26
37	Therapist behaves in a teacher-like or didactic manner	25.02
30	Discussion centers on cognitive themes, i.e. About ideas or belief systems	15.27
55	Patient conveys positive expectations about therapy	13.77
72	Patient understands the nature of therapy and what is expected	10.40
4	Patient’s treatment goals are discussed	8.15

Table 2. The ten most characteristic items of PDT ranked according to discriminant value.

Item no.	PQS Item	F Value
67	Therapist interprets warded-off or unconscious wishes, feelings, or ideas	29.27
100	Therapist draws connections between the therapeutic relationship and other relationships	20.65
91	Memories or reconstructions of infancy and childhood are topics of discussion	18.16
98	The therapy relationship is a focus of discussion	16.84
90	Patient's dreams or fantasies are discussed	16.76
36	Therapist points out Patient's use of defensive maneuvers (e.g., undoing and denial)	15.23
93	Therapist is neutral	14.78
49	Patient experiences ambivalent or conflicted feelings about Therapist	14.64
63	Patient's interpersonal relationships are a major theme	10.76
96	There is discussion of scheduling or fees	8.81

Table 3. The ten most characteristic items for ST ranked according to the discriminant value.

Item no.	PQS Item	F Value
21	Therapist self-discloses	43.63
108	Therapist conceptualises patient's problems and underlying themes in schema or mode terms	31.82
105	Therapist works collaboratively with the patient (eg., seeks feedback, checks how the patient is responding in session)	25.34
109	Therapist uses emotion-focused techniques	24.57
102	Therapist uses imagery in session	21.38
101	Therapist is responsive and affectively involved (e.g., gives extra time if needed)	17.64
110	Therapist communicates the change process to the patient in terms that they can understand	14.83
103	Therapy focuses on core needs of the patient	13.19
106	Therapist educates the patient on their core issues and defence mechanisms	11.33
104	Therapist confronts the patient's dysfunctional behaviour in an empathic way	9.84

Table 4. The ten most characteristic items for CBT according to the highest mean scores. Items that were also high on discrimination are indicated in bold type.

Item no.	PQS Item	M
4	**Patient's treatment goals are discussed**	8.88
105	Therapist works collaboratively with the patient (eg. seeks feedback, checks how the patient is responding in session)	8.88
31	Therapist asks for more information or elaboration	8.69
38	**There is discussion of specific tasks or activities for patients to attempt outside of session**	8.69
46	Therapist communicates with Patient in a clear, coherent style	8.69
55	**Patient conveys positive expectations about therapy**	8.69
110	Therapist communicates the change process to the patient in terms that they can understand	8.69
6	Therapist is sensitive to Patient's feelings, attuned to Patient, empathic	8.63
85	**Therapist encourages Patient to try new ways of behaving with others**	8.63
30	**Discussion centers on cognitive themes, i.e. About ideas or belief systems**	8.56

Table 5. The ten most characteristic items of PDT using the most frequent PQSM items. Items that were also high on discrimination are indicated in bold type.

Item no.	PQS Item	M
6	Therapist is sensitive to Patient's feelings, attuned to Patient, empathic	8.71
32	Patient achieves a new insight or understanding	8.71
75	Interruptions or breaks in the treatment, or termination of therapy discussed	8.71
98	**The therapy relationship is a focus of discussion**	8.64
62	Therapist identifies a recurrent theme in Patient's experience or conduct	8.57
18	Therapist conveys a sense of nonjudgmental acceptance	8.43
96	**There is discussion of scheduling or fees**	8.36
28	Therapist accurately perceives therapeutic process	8.29
63	**Patient's interpersonal relationships are a major theme**	8.29
67	**Therapist interprets warded-off or unconscious wishes, feelings, or ideas**	8.29

Table 6. The ten most characteristic items for ST according to the highest average scores. Items that were also high on discrimination are indicated in bold type.

Item no.	PQS Item	M
6	Therapist is sensitive to Patient's feelings, attuned to Patient, empathic	8.94
108	**Therapist conceptualises patient’s problems and underlying themes in schema or mode terms**	8.94
105	**Therapist works collaboratively with the patient (e.g. seeks feedback, checks how the patient is responding in session)**	8.89
109	**Therapist uses emotion-focused techniques**	8.89
102	**Therapist uses imagery in session**	8.83
103	**Therapy focuses on core needs of the patient**	8.83
79	Therapist comments on changes in Patient's mood or affect	8.78
92	Patient's feelings and perceptions are linked to situations or behavior of the past	8.78
104	**Therapist confronts the patient’s dysfunctional behaviour in an empathic way**	8.78
110	**Therapist communicates the change process to the patient in terms that they can understand**	8.78

Figure 1: Scatter plot showing the 27-items identified by the PQSM as being able to discriminate between the three theoretical orientations.

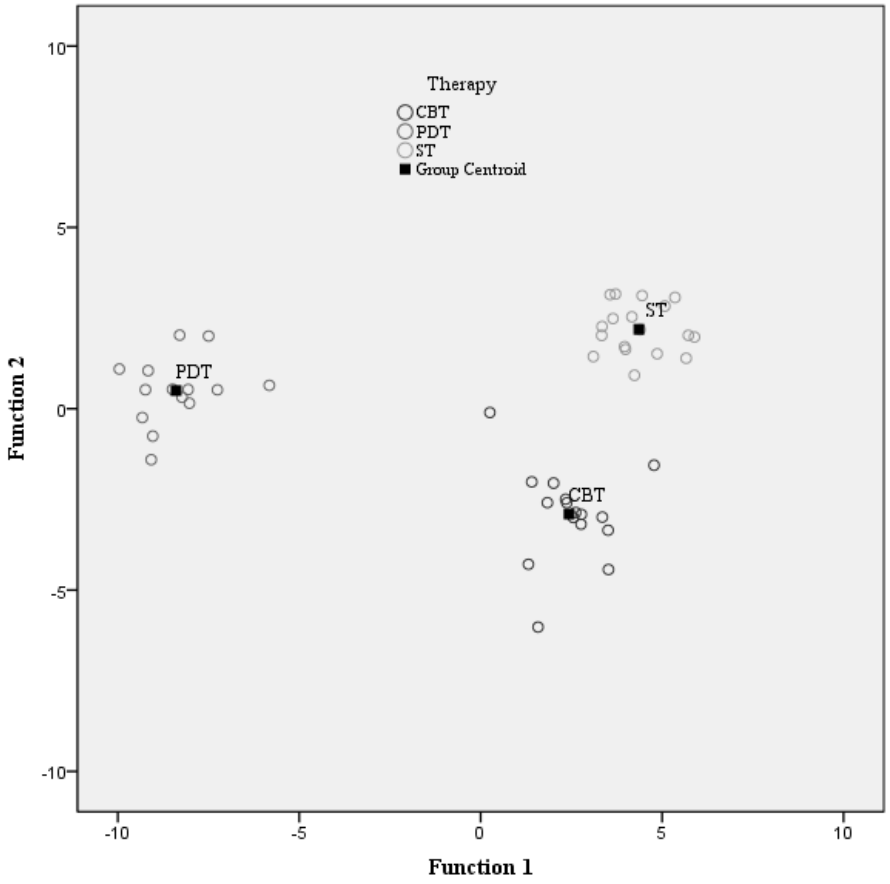

Table 7. Mean of the characteristic items for PDT identified by Jones and Pulos (1993), the means of this study and the difference between the groups.

Item no.	PQS Item	1993	2012	Difference
1	Patient verbalizes negative feelings (e.g., criticism, hostility) toward Therapist (vs. making approving or admiring remarks)	4.2	8	-3.8
98	The therapy relationship is a focus of discussion	5.3	8.64	-3.34
49	Patient experiences ambivalent or conflicted feelings about Therapist	4.8	7.93	-3.13
32	Patient achieves a new insight or understanding	5.6	8.71	-3.11
100	Therapist draws connections between the therapeutic relationship and other relationships	5.1	8.14	-3.04
11	Sexual experiences and feelings are discussed	5.3	7.71	-2.41
82	Patient's behavior during the hour is reformulated by Therapist in a way not explicitly recognized previously	5.3	7.57	-2.27
46	Therapist communicates with Patient in a clear, coherent style	5.9	8.07	-2.17

22	Therapist focuses on Patient's feelings of guilt	5.4	7.43	-2.03
36	Therapist points out Patient's use of defensive maneuvers (e.g., undoing and denial)	5.4	7.43	-2.03
3	Therapist's remarks are aimed at facilitating Patient's speech	6.2	8.21	-2.01