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The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression

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Abstract
A study was conducted to test the effects of adding emotion-focused interventions to the empathic relationship. The authors compared client-centered therapy, which provides an empathic relationship based on the relational attitudes of empathy, positive regard, and congruence, and emotion-focused therapy (EFT), which integrates process-guiding emotion-focused interventions that focus on depressogenic affective–cognitive problems with a client-centered supportive relationship. Thirty-eight patients meeting *DSM–IV* criteria for major depressive disorder were randomly assigned to 16 to 20 sessions of 1 of the 2 treatments. Clients' level of depressive symptoms, general symptom distress, interpersonal distress, and self-esteem improved in each condition, but improvement on symptomatology was superior in the EFT condition. An empathic relationship appears to be enhanced by the addition of specific emotion-focused interventions.

Empirical support for the effectiveness of psychotherapeutic approaches for specific disorders has become a central concern (Chambless & Hollon, 1998). There also has been a strong claim that the common factors have strong empirical support and that they probably account for the majority of effects of most treatments (Ahn & Wampold, 2001; Goldfried, 1980; Norcross, 2002). Alliance and empathy have been identified as efficacious relational factors with strong empirical support (Norcross, 2002). Although the relative contribution of specific versus common factors has been identified as an important issue, very few studies have investigated the relative contributions of both factors.

Studies of emotion-focused therapy (EFT) have demonstrated its effectiveness in the treatment of depression (Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). EFT treatment consists of an empathic relationship plus specific emotion-focused interventions at particular points (Elliott, Watson, Goldman, & Greenberg, 2003; Greenberg, Rice, & Elliott, 1993). In this study, the effects of adding emotion-focused interventions to the empathic relationship are investigated. The relational treatment involved the provision of a supportive therapeutic relationship based on the client-centered relational conditions of empathy, genuineness, and unconditional positive regard (Rogers, 1959) in order to create a safe, validating environment and involved following the client in moment-by-moment empathic attunement. EFT (Greenberg et al., 1993, Greenberg, Watson, & Goldman, 1998) builds on the client-centered relational framework by adding the use of particular process-guiding interventions to resolve particular types of emotional processing difficulties thought to underlie depressive symptoms. EFT combines the two therapeutic styles of following and leading.

Client-centered therapy (CCT) is thought to be effective for the treatment of depression as a validating relationship, and exploration promoted by empathy is seen as allowing clients to attend to and validate their own experience and learn to value and use their emotions to guide them and solve problems. This helps strengthen the self and promotes self-acceptance, and these processes combat depression. CCT has been shown to be effective for depression in two previous studies (Greenberg & Watson, 1998; King et al., 2000). EFT is seen as helpful in the treatment of depression because it provides this same validating relationship and empathic exploration but additionally targets maladaptive emotional processes of self-criticism and dependence (Blatt & Maroudas, 1992) that have

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been shown to relate to depression. EFT works to facilitate change by accessing adaptive emotions. This study replicates an earlier study (Greenberg & Watson, 1998) that compared CCT and EFT (previously called process-experiential therapy) for depression. Both treatments were found to be effective, and although there was no significant difference in reduction of depression on the Beck Depression Inventory (BDI), EFT was found to be superior in the reduction of overall symptoms (Symptom Checklist-90-Revised [SCL-90-R]) and interpersonal problems (Inventory of Interpersonal Problems [IIP]), and in increasing self-esteem (Rosenberg Self-Esteem Scale [RSE]). More recently, EFT was shown to be as effective as cognitive–behavioral therapy (CBT) in the treatment of depression on measures of depressive symptom reduction and superior in the alleviation of interpersonal problems (Watson et al., 2003). Additionally, EFT has been shown to deepen emotional processing (Watson & Greenberg, 1996), and deeper emotional processing has been shown to predict the alleviation of depressive symptoms (Goldman, Greenberg, & Pos, 2005; Pos, Greenberg, Goldman, & Korman, 2003).

The major question addressed in this study is whether the addition of specific emotion-focused interventions to the client-centered relationship common to both treatments enhances outcome in the treatment of depression. A randomized controlled trial in which 38 clients were assigned to one of the two conditions for 16 to 20 weeks of treatment was completed. The same therapists offered both treatments. This design was used specifically to control for the therapist personality and manner, which have been shown to be factors affecting outcome (Lambert & Bergin, 1994).

Method

Clients

A total of 38 clients, 14 men and 24 women, who met formal criteria for a major depressive disorder, based on a Structured Clinical Interview for *DSM–IV* (SCID; Spitzer, Williams, Gibbons, & First, 1995) completed the treatment. Clients who were currently in treatment or on medication for depression were excluded from the study. Additional exclusion criteria included a current diagnosis of one of the following *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychiatric Association, 1994) disorders: bipolar I; panic disorder; substance dependence; eating disorders; psychotic disorder; two or more schizotypal features; and paranoid, borderline, or antisocial personality disorders. Clients were also excluded if they were regarded as in need of treatment focusing on other problems (e.g., recent suicide attempt or active suicidal state) or in need of immediate crisis intervention, had a loss of a significant other in the last year, had recently been or currently was a victim of incest or sexual abuse, or were currently involved in a physically abusive relationship.

Clients were between the ages of 22 and 60 years ($M = 39.5$, $SD = 9.71$). Thirteen (34%) clients were never married, 12 (32%) were married or living common-law, and 13 (34%) were separated or divorced. Clients' level of education ranged from secondary to graduate school: 17 (45%) had completed high school, 17 (45%) had graduated from college, and 4 (10%) had a postgraduate degree. Thirty-four (89%) clients were European, 2 (5%) were Asian, 1 (3%) was Latino, and 1 (3%) was Caribbean Canadian.

All clients were diagnosed with major depression according to SCID-IV criteria (Spitzer et al., 1995). Three (8%) fell into the mild to moderate range (16–18) on the BDI (Beck et al, 1961), 23 (60%) in the moderate to severe range (19–29), and 12 (32%) in the extremely severe range (30–44). Before treatment, clients had a mean BDI score of 26.24 ($SD = 7.23$). Five (13%) of the clients were concurrently diagnosed with generalized anxiety disorder. Overall, 12 (32%) clients were diagnosed with an Axis II personality disorder. Eight were diagnosed with avoidant, 1 with narcissistic, 1 with dependent, 1 with obsessive–compulsive, and 1 with negativistic behavior. Clients' Global Assessment of Functioning Scores on the SCID ranged from 51 to 70 ($M = 62.89$, $SD = 5.35$). There were no significant differences between treatment groups on any of these variables.

Participants

Therapists. There were 14 therapists in the study. Twelve women and 2 men provided treatment in both conditions. All therapists were Caucasian. Therapists ranged in age from 28 to 53 years ($M = 39.21$, $SD = 7.11$). Three of the therapists were licensed clinical psychologists, 2 were doctorate-level clinical psychologists, and 9 were advanced doctoral students in clinical psychology. Therapists' therapy experience ranged from 2 to 20 years ($M = 6$, $SD = 5.79$). In this study, therapists were used as their own controls. Therapists saw equal numbers of clients in each condition. In total, 1 therapist saw 3 clients in each condition, 4 saw 2 clients in each condition, and 8 saw 1 client in each condition.

Assessors and judges. Two licensed clinical psychologists, 1 doctorate-level psychologist, and 6 clinical psychology graduate students performed assess-

ments. All assessors were Caucasian women. The mean age of the assessors was 41.43 years ($SD = 5.97$). The judges who performed adherence ratings on the Truax Accurate Empathy Scale were 2 female Caucasian advanced doctoral students, ages 42 and 48 years. The 2 judges who performed adherence ratings on the Task-Specific Intervention Adherence Measure were two advanced doctoral students, one a 35-year-old man and the other a 37-year-old woman.

Measures

SCID-IV was used to assess the presence of Axis I and II disorders before treatment. The depression module of the SCID-IV was used after therapy to evaluate the presence of depression. An outcome battery of self-report measures was administered to assess change in specific domains. Additionally, session measures were administered to assess the ongoing process of the therapy and specific measures were used to test adherence.

Structured Clinical Interview for DSM–IV (Spitzer et al., 1995). The SCID is a structured diagnostic interview based instrument designed to assess *DSM–IV* Axis I and II disorders. The SCID yields highly reliable diagnoses for most Axis I and Axis II disorders (Segal, Hersen, & Van Hasselt, 1994). Test–retest interrater reliability for current Axis I diagnoses for patient samples has been reported at an overall weighted $\kappa = .61$. Interrater agreement on the SCID-II has been reported to be satisfactory, and results support the use of the SCID-II as a diagnostic instrument for clinical and research purposes (Dressen & Arntz, 1998).

BDI. This 21-item inventory is highly sensitive to clinical change and is the instrument of choice for assessing self-reports of depression (Beck, Steer, & Garbin, 1987). Tests have revealed high correlations with other self-report measures of depression and clinicians ratings of depression ($r = .60–.90$; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Internal consistency in this sample was $\alpha = .92$. Scores higher than 16 were regarded as showing depression and less than 9 as falling into the normal population range.

SCL-90-R (Derogatis, Rickels, & Roch, 1976). The SCL-90-R is a widely used 90-item questionnaire that measures general symptom distress. Derogatis et al. (1976) reports test–retest reliability between .80 and .90 over a 1-week interval. The Global Symptom Index (GSI) was used as an outcome measure in this study. Internal consistency on the GSI in this study was $\alpha = .80$.

Rosenberg Self-Esteem Inventory. A 10-item form of this scale (Bachman & O'Malley, 1977) was used to assess self-esteem. This is one of the most widely used measures of self-esteem (Rosenberg, 1965). It measures respondents' attitudes about themselves. Internal consistency for this sample was $\alpha = .85$.

IIP (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988). This measure is designed to measure the severity of distress in interpersonal functioning. The IIP is composed of 127 items describing different interpersonal situations, 49 of which describe "things I do too much" and 78 describe "things I find hard to do" (Horowitz et al., 1988). Test–retest reliability has been reported at .98. Alpha values across subscales for this sample ranged from .86 to .95. In terms of validity, the IIP has been found to be highly sensitive to clinical change and agrees well with other measures of clinical improvement, including the SCL-90-R (Horowitz et al., 1988). The global scores were used in the outcome analyses.

Barrett-Lennard Relationship Inventory (BLRI) Perceived Empathy Scale. This self-report measure of clients' perception of therapist empathy asks clients to rate their therapists on a 7-point scale regarding the extent to which they experience them as empathic, congruent, prizing, and accepting. The short form (40 items) of the Relationship Inventory (RI; Barrett-Lennard, 1978) was used for this study. Clients indicate degree of agreement or disagreement on a 7-point scale. Interitem reliability on the Perceived Empathy Scale in this sample was $\alpha = .93$. The BLRI has been shown to have good predictive validity (Barrett-Lennard, 1986).

Truax Accurate Empathy Scale (Truax, 1967). This 9-point anchored rating scale measures tape-rated empathy. Raters assess the degree to which the content of the therapist's response detracts from the client's response, is interchangeable with it, or adds to or carries it forward by responding to feeling. A score of 5 indicates that the therapist's response is interchangeable with the clients, whereas scores of 6 and above indicate that the therapist's statement adds or carries forward the client's statement with increasing accuracy and attunement. This measure has shown good interrater reliability (range = .73–.86) and predictive validity in CCT (Kiesler, 1973).

Task-Specific Intervention Adherence Measure (Greenberg & Watson, 1998). This is an adherence measure for both empty-chair work for unfinished business and two-chair work for self-evaluative split tasks. Each scale consists of a 7-point checklist of

specific therapist actions involved in the particular intervention that progressively lists the steps involved from initiation through to resolution for each of the tasks. Thus, for the two-chair scale, a rating of 1 indicates engagement in the dialogue between the two sides; 4, an assertion of feelings and needs to the critical self; and 6, a softening of the critic. For the empty-chair scale, a rating of 1 indicates evoking an image of the other in the empty chair; 4, an expression of underlying needs to the other; and 7, an expression of forgiveness or understanding to the other. Therapist responses are coded by raters as adhering or not to one of the steps in the task model while the therapist is engaged in the task. These measures have demonstrated interrater reliability (range = .76–.89) and have been found to discriminate EFT from CCT reliably (Greenberg & Watson, 1998).

Relational CCT. This treatment followed the manual for relational CCT (Greenberg & Goldman, 1999; Rice, Greenberg, & Watson 1994). Therapists in this condition adopt the three fundamental relational attitudes of empathy, positive regard, and congruence. The goal is to provide a genuinely empathic, validating environment to promote self-exploration and the strengthening of the self. Therapists consistently validate clients as worthwhile, letting them know they have been heard and encouraging further exploration. Therapists continually follow the clients' internal track, communicating empathic understanding and facilitating ongoing exploration. Therapists respond selectively to those parts of clients' messages that seem live and poignant. Symbolization of emotion and core meaning is encouraged to increase awareness of and access to healthier, more adaptive emotions (Greenberg, 2002; Greenberg et al., 1993).

In this treatment, depression is viewed as being alleviated through the empathic relationship and consistently communicated empathy that helps people deepen their experience and symbolize it in awareness. The therapist's validation and acceptance allows increased access to previously denied or blocked experience, encourages client's self-acceptance, and decreases negative self-evaluation. Empathic listening helps clients symbolize their own emotions both in and outside of the session and leads to greater exploration and congruence between self-concept and experience. Additionally, symbolization of emotions is seen as helping people to better orient toward needs and goals and strengthen the self.

EFT. This treatment followed the manual developed by Greenberg et al. (1993). Therapists work from within a client-centered relational framework, providing the relational conditions while integrating emotion-focused experiential and Gestalt techniques to resolve affective–cognitive problems in therapy. The objective of the therapy is to access and restructure habitual maladaptive emotional states that are seen as the source of the depression (Greenberg et al., 1998). These often involve feelings of shame-based worthlessness, anxious dependence, powerlessness, abandonment, and invalidation. Through the therapeutic process, adaptive emotions are accessed to transform maladaptive emotions and to organize the person for adaptive responses (Greenberg, 2002; Greenberg & Paivio, 1997).

The first three sessions are spent forming a safe, trusting bond and building a therapeutic alliance. Therapists listen to and observe clients' style of affective–cognitive processing and assess clients' capacity for emotional experiencing. When a safe bond and a strong working alliance have been established, therapists respond to particular markers or verbal indications from clients of various types of depressogenic processing problems such as self-criticism and suggest the use of appropriate interventions (Goldman & Greenberg, 1997). Interventions include the two-chair dialogue in response to self-critical conflicts and the empty-chair dialogue in response to unresolved feelings toward a significant other. In two-chair work, one part of the self is guided to express the harsh criticism or negative self-statements to another part of the self in order to evoke the emotional reactions to the criticisms. Empty-chair work for unfinished business involves expression of previously suppressed primary emotion such as hurt and anger to the imaginary significant other in the empty chair. In addition, focusing (Gendlin, 1996) is used to deepen experience and symbolize implicit experience, and systematic evocative unfolding is used to explore people's problematic reactions (Elliott et al., 2003; Greenberg et al., 1993). Therapists are responsive to clients' momentary states and do not plan or structure sessions in advance. However, in this study, therapists were encouraged to implement at least one experiential intervention every two to three sessions once an alliance had been established.

Assessment and Procedures

Clients for the study were recruited through local media, including television programs, radio announcements, and local newspapers. Treatment centers and clinics were informed of the study. All sources announced that a treatment study of depression was being conducted at the Psychotherapy Research Clinic and that people suffering from depression who were not currently in treatment or

on medication and wished to participate should call for more information. They were initially screened over the telephone and, if suitable, were invited to undergo further assessment to establish the suitability of the treatment. Approximately 458 people responded by telephone. Trained graduate students who administered a standard protocol over the telephone first assessed respondents. Of those respondents, 104 people participated in two assessment interviews. The majority of people who did not proceed beyond the telephone interview were not invited for an assessment interview because they were currently receiving other forms of treatment that disqualified them from entrance to the study, were currently in crisis, were currently abusing substances, or were involved in violent relationships.

The SCID-IV (Spitzer et al., 1995) was used to assess depression and rule out *DSM* disorders not appropriate for the study. The clinical psychologists and the doctoral-level psychologist (working toward licensure) were expert SCID interviewers and provided training and supervision on the SCID to the graduate students. Raters had prior SCID training and received careful training and supervision from the 2 experts. Before the study began, trainees trained 2 hr/week for 6 weeks. Reliability was established by checking 25% of the total assessments performed. Raters were not informed of treatment condition. Interrater reliability (intraclass correlation; ICC[2,1]) between the experts and the SCID raters was .92, based on the percentage of times the expert and the rater agreed on the primary diagnosis. Raters were unaware of which tapes the expert was rating.

In an initial interview, participants were assessed using the depression module of SCID-IV. Additionally, a brief clinical history was taken to determine suitability for the study and to rule out factors that automatically disqualified participants. At the end of the interview, clients completed a BDI as well as an SCID-II personality questionnaire. After the first assessment, the research team, including the supervisors, met and reviewed the clients' clinical history. If clients met criteria for an Axis I major depressive disorder, scored higher than 16 on the BDI, and did not initially indicate the presence of any other disorders that would make them unsuitable for treatment, they were invited back for a second interview. At the second interview, clients received a full multiaxial assessment using the SCID-IV.

If clients met criteria after the second interview, the research team met and approved their entrance to the study. In the assessment interview, participants were told that, if accepted to the study, they would be randomly assigned to one of two treatments. If the therapist was unable to meet with the person because of scheduling conflict, the client was randomly assigned to the next therapist in that treatment group. Both client and therapist were unaware of which condition the clients were assigned until therapy began.

Clients were offered 16 to 20 sessions of individual psychotherapy once a week. Before participating, clients were provided with information about the study and signed an informed consent form documenting their understanding of the treatment and their research participation. All sessions were audio- and videotaped. The Barrett-Lennard Perceived Empathy Scale was administered after Sessions 2 and 8. Clients completed the outcome measures before the beginning, after Session 8, and at the end of therapy.

Client characteristics. A total of 42 clients met study criteria and were randomized into treatment. Dropouts were defined as clients who withdrew or terminated treatment prematurely because of a change in life circumstances, illness, a sudden move, beginning another treatment, or terminating before Session 8. There were 2 dropouts in each treatment condition, who were subsequently excluded from this study. All others were considered completers and included in this investigation. The length of treatment for completers ranged from 9 to 20 sessions ($M = 17.6$, $SD = 2.60$). The average length of treatment in the EFT condition was 17. 5 ($SD = 3.25$) sessions and in the relational CCT condition, 16.84 ($SD = 1.74$) sessions.

Therapist training. All therapists had received prior training of at least 1 year in both CCT and EFT and received an additional 48 hr of training before participation in the study. Training was 2 hr weekly for 24 weeks. This involved training in the relational conditions and in the specific interventions. Therapists were trained according to the manuals for EFT (Greenberg et al., 1993) and CCT (Greenberg & Goldman, 1999; Rice et al., 1994). They received training in the provision of the relational conditions for 8 weeks as well as an additional 8 weeks each in two-chair and empty-chair work. Training involved didactic instruction, viewing videos, live demonstrations, and in vivo practice in dyads.

Therapists in both conditions received weekly supervision throughout the study, which allowed supervisors to monitor treatment adherence. At this time, therapists were encouraged to discuss ambiguities regarding adherence to protocol issues that they had identified as well as any anticipated treatment integrity issues.

Adherence Procedures

Relational CCT. Adherence in the relational condition was measured through empathy adherence, nonadherence to the EFT protocol, and adherence to the protocol for the relational CCT. To measure adherence in the provision of empathy, 20 min of two sessions of each CC treatment was rated on the Truax Accurate Empathy Scale. One session was randomly chosen from each half of treatment. Twenty minutes of each session was then randomly extracted from each designated session, further divided into 5-min segments, and randomly mixed for rating. Thus, a total of 152 segments were extracted for rating. Each rater rated two thirds of the segments (101/rater), overlapping on one third on which reliability was calculated. The interrater reliability on the Truax Accurate Empathy Scale was significant, ICC(3,1) = .81, $p < .05$, $n = 51$. To adhere to the relationship condition, the average empathy level on the 9-point Truax scale needed to exceed 5 and no sessions drop below 4. Therapists were sufficiently high on average tape-rated empathy in 20-min segments from two sessions across therapy to meet adherence criterion. None of the sessions dropped below 4 on the Truax scale. A comparison of sessions from the first and second halves of each treatment showed no significant difference between the groups (Table I).

The 20-min segments were also rated on the Task-Specific Intervention Adherence Measure to ensure nonadherence to the EFT treatment. The therapist responses in the client-centered empathy sessions did not show adherence to the task intervention scales ($M = 11.5\%$). This small overlap is due to the common use of responses that inquire into current feelings and needs. That is, in addition to different types of empathic responses, client-centered therapists typically ask questions designed to further emotional exploration, and these fit the access feeling or access needs categories on the EFT adherence measures.

After each session, therapists completed a form stating whether or not they adhered to the treatment protocol for that condition. The form asked therapists to indicate whether or not adherence was achieved with a simple "yes" or "no" response, and if they had deviated, they were asked to describe what out-of-mode interventions were used, such as process directive experiential interventions, cognitive–behavioral interventions, or interpretations of the transference. Adherence was further corroborated by the supervisor who listened to all sessions. No deviations from mode were reported by either the therapist or supervisor; thus, no cases were eliminated from the study.

Table I. Adherence Ratings on Truax Accurate Empathy Scale, Task-Specific Intervention Adherence Measure, and Barrett-Lennard Relationship Inventory.

Time[a]	1 ($n = 19$)	2 ($n = 19$)	*M*
Truax Accurate Empathy Scale			
CCT			
M	6.85	6.75	6.80
SD	0.86	1.10	0.97
EFT			
M	6.30	6.7	6.50
SD	0.88	0.94	0.91
Task-Specific Intervention Adherence Scale			
CCT (%)	14	10	11.5
EFT (%)	87	93	90
Barrett-Lennard Relationship Inventory			
CCT			
M	5.07	5.24	5.15
SD	0.61	0.47	0.54
EFT			
M	5.01	5.05	5.03
SD	0.61	0.46	0.54

Note. CCT = client-centered therapy; EFT = emotion-focused therapy.
[a]Session samples selected from first and second halves of treatment.

EFT. Adherence in the EFT condition was measured based on empathy adherence and adherence to the EFT protocol. To measure empathy adherence, two sessions that did not contain a task intervention were randomly selected from each half of treatment and rated as in the CCT condition. Each rater rated two thirds of the segments (101/rater), overlapping on one third. Reliability on the Truax Accurate Empathy Scale was significant, ICC(3,1) = .78, $p < .05$, $n = 51$. Therapists in the EFT condition also were sufficiently high on average tape-rated empathy, and none of the therapists fell below 4 on the Truax scale. A comparison of sessions from the first and second halves of each treatment yielded no significant difference between groups on empathy. Table I additionally illustrates that client-perceived empathy, as measured by the BLRI, was high both early and late in treatment and not significantly different in the two groups. The *t* tests comparing means for the BLRI revealed no differences between groups.

Adherence to the EFT protocol was rated after each therapy session by the therapist and supervisor as in the CCT condition. Neither the therapists nor the supervisors reported any out-of-mode interventions occurring in the therapies. Protocol adherence to EFT also required that a minimum number of active intervention sessions occur across the therapy. All cases in the EFT condition were checked to ensure that tasks were being done for a minimum of

15 min in at least one quarter of the sessions after Session 3. Active interventions occurred in an average of 5.3 ($SD = 2.2$) sessions after Session 3.

Adherence to the EFT protocol was further measured through adherence to the EFT task intervention scales. Two sessions, one from each half of therapy in which the therapist was performing an active intervention (two chair or empty chair), were rated on a randomly chosen consecutive 20 min of the dialogue on the appropriate Task-Specific Intervention Adherence Measure. The percentage of therapist responses that fell into one of the seven categories on the scale was calculated. Both raters rated all 20-min segments of dialogue ($n = 34$). Reliability on the task scales was calculated as a mean ICC(3,1) of .83 across the two active intervention scales (.78 for two chair and .88 for empty chair). The two active intervention sessions extracted from the EFT cases showed a high percentage adherence of therapist responses to the EFT task adherence scales ($M = 90\%$). Overall, data indicate that the therapists in both groups adhered to treatment and were perceived as sufficiently empathic and understanding.

Results

Treatment Effects

A 2×14 analysis of variance was performed comparing therapist effects on outcome. This yielded no significant main effects for therapist, and therapist was, therefore, not included in subsequent analyses.

Table II presents means, standard deviations, and treatment effect sizes for the four outcome measures. The primary treatment outcome analyses consisted of a 2 (Treatment Group) $\times$ 2 (Occasion) analysis of covariance (ANCOVA) performed for each measure in turn, with posttest BDI, SCL-90-R GSI, IIP, and RSE scores serving as dependent variables and pretest scores on the respective pretest measures serving as covariates. Significant group effects were found on the BDI, $F(1, 35) = 4.62$, $p = .039$, and the SCL-90-R GSI, $F(1, 35) = 5.08$, $p = .031$, suggesting a significant difference in favor of the EFT for the alleviation of symptoms. There were no significant group effects on the IIP or the RSE.

Effect sizes for each of the measures in each treatment condition were calculated by subtracting the pretreatment score from the posttreatment score and dividing by the standard deviation at pretest. Pre–post effect sizes on the symptom measures (range = 1.16–2.99) suggest that both treatments were highly effective in alleviating symptoms. Comparative effect sizes between groups were also calculated for the two symptom measures in which the difference score from one treatment was subtracted from the other and divided by the average standard deviation of the pretreatment score. The effect size for the BDI was .69 in favor of EFT and for the SCL-90-R GSI, .54 in favor of EFT. These differences are considered moderate to large effect sizes (Cohen, 1988).

Table II. Pre- and Posttreatment Means for All Outcome Measures in Two Treatment Conditions.

	CCT			EFT		
Measure	*n*	*M* ± *SD*	ES	*n*	*M* ± *SD*	ES
BDI			2.23			2.99
Pre	19	26.26 ± 7.35		19	26.21 ± 7.10	
Post	19	9.89 ± 9.10		19	4.95 ± 5.69*	
GSI			1.16			2.40
Pre	19	1.42 ± .60		19	1.43 ± 0.62	
Post	19	0.75 ± .61		19	0.42 ± 0.36*	
IIP			0.53			0.95
Pre	19	1.41 ± 0.56		19	1.47 ± 0.44	
Post	19	1.14 ± 0.65		19	1.05 ± 0.59	
RSE			0.81			1.21
Pre	19	22.34 ± 6.38		19	21.42 ± 5.62	
Post	19	27.35 ± 6.93		19	28.25 ± 5.36	

Note. CCT = client-centered therapy; EFT = emotion-focused therapy; ES = effect size; BDI = Beck Depression Inventory; GSI = Global Symptom Index; IIP = Inventory of Interpersonal Problems; RSE = Rosenberg Self-Esteem.
*$p < .05$.

Clinically Significant Change

At the end of treatment, the proportion of patients in each condition who were depressed, whose depression remitted but had not fully recovered, and who had recovered fully was tabulated (Jacobson et al., 1996). *Depressed* indicates that clients met criteria for major depressive disorder as measured by the SCID and had a score greater than 8 on the BDI. One client (5%) in the relational CCT and no clients in the EFT condition were depressed at posttest. *In remission but not recovered* indicates that clients no longer qualify as having a major depressive disorder but had a score greater than 8 on the BDI. Eighteen (95%) clients in the CCT condition and all 19 in the EFT condition were in remission at posttest. *Fully recovered* is defined as no major depressive disorder and a BDI score of 8 or less. Thirteen (68%) of clients in the CCT condition and 15 (79%) in the EFT condition were recovered at posttest. Chi-square analyses revealed no significant difference between the groups on any of the three categories.

The number of clients who changed reliably (Jacobson & Truax, 1991; Ogles, Lambert, & Sawyer, 1995) on the BDI was also calculated. Using a stringent .05 criteria, it was found that

89% (17) of clients in the relational CCT condition and 95% (18) in the EFT condition surpassed reliable change index (RCI) minimums for the BDI, suggesting that treatment moved these clients outside of the range of the dysfunctional population and into the range of the functional population.

Ancillary Analysis: Combined Samples

Discrepancies in the findings of this study (York 2) and the study that it replicated (York 1; Greenberg & Watson, 1998) were observed and hypothesized to be due to the lack of power owing to the small sample sizes used in each study (<20 in each group). In this study, significant differences were found between the treatment groups on the BDI and SCL-90-R measures but not on self-esteem or interpersonal dysfunction measures. The York 1 sample, in contrast, showed significant group effects on the IIP, RSE, and SCL-90-R but not on the BDI (Greenberg & Watson, 1998). The two samples were combined to increase power to detect differences between treatments.

Initial tests were conducted to ascertain whether the characteristics of the two samples differed in any substantial way. Exclusion and inclusion criteria for the two studies were the same. Chi-square analyses reveal no differences between groups on dimensions of gender, age, education, marital status, and ethnicity. Comparisons of the two populations at pretreatment on the frequency of comorbid generalized anxiety disorder, Axis II personality disorders, and Global Assessment of Functioning level revealed no significant differences. The two samples also were not significantly different on measures of symptomatology at pretreatment.

There was some degree of overlap of therapists between the earlier study and the current one (2 of the student therapists were the same), and the same two treatments manuals were used to treat depression. Training involved the same process in both studies and an equal amount of time. Therapists in both studies were supervised on a weekly basis, and treatments were judged as adherent on the same adherence criteria (Greenberg & Watson, 1998).

Results on Combined Samples

Table III shows means, standard deviations, and effect sizes for the four outcome measures for the combined sample. Before comparative analyses were performed on the combined sample, interaction effects were tested for each of the four outcome measures to ensure that the covariate was not behaving differently in the two cohorts. For each dependent variable (BDI, GSI, IIP, and RSE), three-way (Covariate $\times$ Cohort $\times$ Group) and two-way (Covariate $\times$ Cohort) interactions were checked, and no significant interactions were found.

Table III. Pre- and Posttreatment Means for All Outcome Measures in Each Treatment Condition for Combined Cohorts (York I and 2).

	CCT			EFT		
Measure	*n*	*M*±*SD*	ES	*n*	*M*±*SD*	ES
BDI			2.29			2.86
Pre	36	24.56±6.54		36	26.11±6.96	
Post	36	9.53±7.48		36	6.19±5.34*	
GSI			1.40			1.98
Pre	36	1.40±0.50		36	1.48±0.54	
Post	36	0.70±0.46		36	0.47±0.35**	
IIP			0.76			1.29
Pre	36	1.63±0.54		36	1.54±0.41	
Post	36	1.22±0.56		36	0.92±0.48**	
RSE			0.79			1.31
Pre	36	21.51±6.3		36	20.81±6.01	
Post	36	26.50±6.83		36	28.69±5.81**	

Note. CCT = client-centered therapy; EFT = emotion-focused therapy; ES = effect size; BDI = Beck Depression Inventory; GSI = Global Symptom Index; IIP = Inventory of Interpersonal Problems; RSE = Rosenberg Self-Esteem.
*p <.05. **p <.01.

The outcome analysis consisted of a 2 (Treatment Group) $\times$ 2 (Occasion) ANCOVA performed for each measure in turn, with posttest BDI, SCL-90-R GSI, IIP, and RSE serving as dependents variables and pretest scores serving as covariates. Statistically significant differences among treatments in favor of EFT were found at termination on all indexes of change, including the BDI, $F(1, 72) = 3.93$, $p = .05$, the SCL-90-R GSI, $F(1, 72) = 8.88$, $p = .004$, the IIP, $F(1, 72) = 25.70$, $p = .000$, and the RSE, $F(1, 72) = 45.26$, $p = .000$. No significant Cohort $\times$ Group interactions were found on any of the four outcome measures. Pre–post effect sizes on the outcome measures (range = 0.76–2.86) suggest that both treatments were effective in alleviating depression, although EFT effects were larger on all treatment indexes. Comparative effect sizes were .52 on the BDI, .56 on the SCL-90-R GSI, .64 on the IIP, and .35 on the RSE.

Assessments of clinical significance on the combined sample revealed that, in the CCT relational treatment, 8 (22%) clients were depressed at posttreatment, 28 (78%) were in remission (no longer qualifying as having a major depressive disorder but scoring higher than 8 on the BDI), whereas 19 (53%) were fully recovered (no major depressive disorder and a BDI score ≤ 8). In the EFT condition, 5 (14%) clients were depressed, 31 (86%) were in remission, and 25 (69%) were recovered. Chi-square analyses revealed no difference between the

groups on any of the three categories. The percentage of clients who changed reliably on the BDI (Jacobson & Truax, 1991; Ogles et al., 1995) when the two samples were combined was 86% in the CCT group and 89% in the EFT group.

Discussion

Treatment Efficacy

This investigation was designed to study the effects of adding emotion-focused interventions to the client-centered relationship in the treatment of depression. An examination of effect sizes (0.53–2.99 in this investigation and 0.76–2.86 when this sample was combined with the Greenberg & Watson, 1998 sample) suggests that both treatments are effective in reducing symptoms, increasing interpersonal functioning, and increasing self-esteem. Effect sizes fall within a range comparable to that of other studies of the treatment of depression with similar populations (Jacobson et al., 1996). A comparison of the magnitude of change shown by the patients in these studies is far larger than those reported for the no-treatment controls in other studies with comparable samples. The effect sizes at pre- and posttreatment for no-treatment controls range from .20 to .49 (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Taylor & Marshall, 1977). It is thus unlikely that the current findings are merely due to the remission of clients' depressive symptoms over time.

Pretreatment scores indicate that the sample studied in the current investigation had initial mean levels of symptomatology well into the clinical range of severity on the BDI. Comparisons with other studies that examined the clinical significance of treatment for depression show equal or superior results. Jacobson et al. (1996) report that 64% of patients receiving short-term cognitive therapy treatment were not depressed at the end of treatment. In the current York 2 study, a relatively large number of patients in each group were not depressed at the end of treatment: 100% in the EFT treatment and 95% in the relational CCT. Additionally, a significant portion was fully recovered (not depressed and a BDI $\leq$8) at the end of treatment: 79% in EFT and 68% in the relational CCT. Jacobson et al (1996) report a 56% recovery rate for patients in cognitive therapy at the end of treatment. These findings appear consistent across the current study and that which it replicated (Greenberg & Watson, 1998), with similar percentages calculated when the two samples were combined.

The results on clinical significance of change were similar or better than those of other studies. Ogles et al. (1995), in a review of the Treatment of Depression Collaborative Research Program, found that of clients who completed at least 12 sessions and 15 weeks of treatment, 50% of patients in CBT and 64% of patients in interpersonal therapy met RCI criteria. Shapiro and Firth (1987) reported that 37% of their entire sample receiving exploratory and prescriptive psychotherapy met RCI criteria. In the current study, 84% of clients in the CCT condition and 95% of clients in the EFT condition met RCI criteria, suggesting that both were highly effective treatments for unipolar, nonsuicidal depressed patients with a 21% rate of Axis II disorders. Again, these results are consistent across this sample and that of Greenberg and Watson (1998). When the samples were combined, 86% of clients in the CCT and 89% in the EFT condition met RCI criteria for the BDI.

Differential Effectiveness of Components

Results of the analysis offer support for the hypothesis that the addition of EFT interventions to the relational conditions to some degree increases the effectiveness of treatment. Considering the sample studied in the current investigation, EFT showed superior effects on the measures of depressive symptom and general symptom distress. When the power to detect differences was increased by combining this sample with that from the earlier study that it replicated, EFT showed superior results on all outcome indexes, including symptom distress, interpersonal functioning, and self-esteem measures. It seems then that the combination of specific interventions with a solid empathic relationship may do better than the empathic relationship alone in the treatment of depression. Given the findings that both treatments are highly effective treatments of depression but that EFT promotes greater change on the outcome measures, it seems important to understand what is similar and different about the two treatments.

Findings suggest that a good empathic relationship was present in both treatments. We also know that emotion-focused tasks were performed in about 28% of sessions after Session 3. Previous studies of the EFT treatment process (Goldman et al., 2005) suggest that themes tend to emerge fairly early in treatment (typically around Session 4) and that they center around the two major therapeutic tasks: the two-chair task, which is designed to target the specific problem of self-criticism, and the empty-chair task, which targets unresolved dependence, injury, and loss. The specific interventions allow the therapist to set up a task-focused environment and provide a quicker way to identify core emotional processing difficulties related to depression. The

two-chair task helps clients identify self-criticisms, become aware of the emotional impact on the self of the criticisms, differentiate their feelings and needs, and use these to combat the negative cognitions. The empty-chair task helps clients resolve past losses, hurts, and anger toward significant others by expressing and processing their unresolved feelings. Watson and Greenberg (1996) found that these specific interventions are related to deeper in-session emotional process and stronger outcome.

The use of therapists as their own controls also is a unique feature of this study. This design feature eliminates between-subjects variance accounted for by therapist factors. In light of findings that the therapeutic relationship (as well as patient factors) accounts for a greater proportion of the outcome variance than technique (Lambert & Barley, 2002), by controlling for the therapists' personality and relationship, this design allowed a good test of the additive effect of the intervention. Both treatments use the empathic relationship as a core ingredient. Furthermore, therapists were equally trained in both approaches and, in fact, were initially trained in the CCT and had a strong belief that the relationship is the central ingredient of treatment. This study thus showed that these therapists, who believe in the relationship as the core ingredient of therapy, when they were doing the best they possibly could in each condition, were more effective when they used specific interventions in addition to their relationship skills.

Limitations

Therapist and researcher bias could have affected the results if therapists were biased toward seeing the CCT as less effective than the EFT. It is possible that the therapists in the EFT condition could have communicated a stronger belief in that therapy over the CCT. We recognize that, as authors of the EFT itself, it would seem to many that our allegiance would be with this treatment, and we acknowledge that this indeed might have influenced the outcome of this study. In actuality, however, we feel committed to both treatments, and the therapists felt committed to the outcomes of the clients regardless of the treatment being offered. Therapists trained in and committed only to CCT may, however, have had an even stronger belief in the relationship and might have conveyed an even stronger belief in this treatment. This remains to be tested.

Although the analysis of therapist effects did not yield significant results, this could be due to lack of power to detect differences. Furthermore, because of the small proportion of material used to check adherence, it is possible that the two 20-min segments were not representative of performance of the average 17 hr of treatment.

In conclusion, the findings from the present study provided empirical support for the effectiveness in the treatment of depression of both relational CCT and EFT, which combines the therapeutic relationship with specific process-guiding emotion-focused interventions. It is important to note that, although EFT showed superior effects in reducing depressive and general symptoms, relational CCT was still highly effective in reducing these symptoms, and there was no difference in the proportion of people who recovered from depression in each treatment. In relation to the debate on common and specific factors, it appears from this study that a large proportion of outcome variance is accounted for by the relational conditions. The addition of specific, more process-guiding emotion-focused methods, however, does appear to enhance this effect. Depth of experience (Goldman et al., 2005) has already been found to predict outcome in these treatments, but future research needs to work toward more precisely identifying the nature of the change processes in these treatments.

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Zusammenfassung

Die Effekte zusätzlicher emotions-fokussierter Interventionen auf die Bedingungen klientenzentrierter Beziehung bei der Behandlung von Depression

Es wurde eine Studie dazu durchgeführt, welche Effekte zusätzliche emotions-fokussierte Interventionen auf die empathische Beziehung haben. Die Autoren verglichen klientenzentrierte Therapie, die eine empathische Beziehung auf Grund von Beziehungseinstellungen von Empathie, positiver Zuwendung und persönlicher Kongruenz beinhaltet mit emotions-fokussierter Therapie (EFT), die prozessbegleitende emotions-fokussierte Interventionen umfasst, die auf depressionsgenetische Probleme affektiv-kognitiver Art mit einer klientenzentrierten unterstützenden Beziehung gerichtet sind. 38 Patienten, die nach den DSM-IV Kriterien an einer schweren Depressionsstörung litten, wurden dem Zufall nach 16 bis 20 Sitzungen in einer der Behandlungen zugewiesen. Das Niveau der depressiven Symptome, die allgemeine Belastung durch die Symptome, wie sowohl die interpersonale Belastung und der Selbstwert verbesserten sich in beiden Behandlungen, aber die Verbesserung der Symptomatologie war höher in der EFT Bedingung. Eine empathische Beziehung scheint durch zusätzliche spezifische emotionsfokussierte Interventionen verstärkt zu werden.

Résumé

Les effets de l'intégration d'interventions focalisées sur les émotions dans les conditions relationnelles centrées sur le patient dans le traitement de la dépression

Nous avons conduit une étude pour tester les effets de l'intégration d'interventions focalisées sur les émotions dans la relation empathique. Les auteurs ont comparé la thérapie centrée sur le client qui crée une relation empathique sur la base des attitudes relationnelles de l'empathie, du regard positif et de la congruence, et la thérapie focalisée sur les émotions (EFT) qui intègre des interventions focalisées sur les émotions, guidant le processus, et qui focalisent sur des problèmes affectifs – cognitifs dépressiogènes par une relation de soutien, centrée sur le client. 38 patients suffisant aux critères *DSM-IV* pour la dépression majeure étaient attribués au hasard à 16-20 séances avec l'un des deux traitements. Le niveau de symptômes dépressifs, la détresse symptomatique générale, la souffrance interpersonnelle et l'estime de soi s'amélioraient dans les deux conditions, mais l'amélioration symptomatique était supérieure en condition EFT. Une relation empathique semble être favorisée par le rajout d'interventions spécifiques, focalisées sur les émotions.

Resumen

Se realizó un estudio para testear los efectos de agregar, a la relación empática, intervenciones focalizadas en la emoción. Los autores compararon la terapia centrada en el cliente, que provee una relación empática basada en las actitudes relacionales de la empatía, mirada positiva y congruencia, con la terapia focalizada en la emoción (EFT), que integra intervenciones focalizadas en la emoción que guía el proceso (process-guiding emotion-focused interventions) que se centran en problemas depresógenos afectivo-cognitivos en una relación de apoyo centrada en el cliente. Se asignaron al azar, para 16 a 20 sesiones de 1 de los 2 tratamientos, a treinta y ocho pacientes que reunían los criterios del DSM-IV para el desorden depresivo mayor. En cada condición, el nivel de síntomas depresivos, el distrés general de síntomas, el distrés interpersonal y la autoestima mejoraron, pero la mejoría fue superior en la condición EFT. La relación empática parece aumentar por la adición de intervenciones específicas focalizadas en la emoción.

Resumo

Os efeitos de adicionar intervenções focadas nas emoções às condições de relação centrada no cliente no tratamento da depressão

Este estudo foi conduzido para testar os efeitos de adicionar intervenções focadas nas emoções à relação empática. Os autores compararam a terapia centrada no cliente, que fornece uma relação empática baseada nas atitudes relacionais de empatia, aceitação positiva e congruência, e a terapia focada nas emoções (EFT), que integra intervenções focadas nas emoções e guiadas pelo processo, centradas nos problemas afectivo-cognitivo depressogénicos com uma relação de suporte centrada no cliente. Trinta e oito pacientes com critérios de diagnóstico do DSM-IV para perturbação depressiva major foram aleatoriamente distribuídos por um dos dois tratamentos, de duração de 16 a 20 semanas. O nível de sintomas depressivos do cliente, disfuncionamento sintomático geral, disfuncionamento interpessoal e auto-estima melhoraram em cada condição, mas a melhoria da sintomatologia foi superior na condição EFT. Uma relação empática parece ser melhorada pela adição de intervenções específicas focadas nas emoções.

Sommario

Gli effetti degli interventi aggiuntivi focalizzati sulle emozioni nella relazione centrata sul cliente, nel trattamento della depressione

E' stato condotto uno studio per valutare gli effetti degli interventi aggiuntivi focalizzati sulle emozioni nella relazione empatica.

Gli autori hanno confrontato la terapia centrata sul cliente, che offre una relazione empatica basata sulle attitudini relazionali dell'empatia, sulla stima positiva e sulla coerenza, con la terapia focalizzata sulle emozioni (EFT), che integra i processi che guidano gli interventi focalizzati sulle emozioni, che si focalizzano sui problemi depressogeni affettivo-cognitivi, con una relazione supportiva centrata sul cliente.

Trentotto pazienti con i criteri del DSM-IV del disturbo depressivo maggiore sono stati assegnati casualmente da 16 a 20 sedute di uno dei due trattamenti. I livelli dei clienti di sintomi depressivi, di sintomi generali di sofferenza, della sofferenza interpersonale e dell'autostima sono migliorati in ogni condizione, ma il miglioramento nella sintomatologia è stato superiore nella condizione EFT. Una relazione empatica sembra essere cresciuta attraverso l'aggiunta di interventi specifici focalizzati sulle emozioni.

案主中心的關係狀況加上以情緒為主的處遇對憂鬱症處遇的效果

摘要

本研究旨在探討同理的關係之外，再加上以情緒為主的處遇方式，其效果為何。研究者比較案主中心治療，亦即依據諸如同理、積極關注、真誠一致等同理的態度，加上以情緒為主（EFT），亦即統整以歷程來引導，重視憂鬱基因的情感-認知問題。38 位被診斷符合 DSM-IV 憂鬱症患者的案主被隨機分派到兩種治療法任一種的 16-20 次治療。二組案主的憂鬱症狀程度、一般沮喪的症狀情形、人際困擾與自重感均有所改善，不過 EFT 組的症狀改善程度優於另一組。同理的關係可以透過加強以情緒為主的處遇方式而有所增進。