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**EMPIRICAL PAPER**

# Developing a prototype for short-term psychodynamic (supportive-expressive) therapy: An empirical study with the psychotherapy process Q-set

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**Abstract**
**Objective**: A Psychotherapy Process Q-set (PQS) prototype characteristic of short-term psychodynamic therapy (STPP) does not yet exist. **Method**: Experts in supportive-expressive (SE) therapy used the 100-Item PQS questionnaire to rate an ideal short-term SE therapy. **Results**: Agreement between raters was high (Cronbach's alpha = 0.94). The prototype for SE therapy showed a significant correlation with the psychoanalytic prototype, but with 28% of variance explained, the majority of variance of the former was not explained by the latter or vice versa. Furthermore, the SE prototype showed significant correlations with the cognitive-behavioral prototype and the prototype of interpersonal therapy by Ablon and Jones ($r = 0.69$, 0.43). **Conclusions**: We recommend using the PQS prototype presented here for future process research on STPP.

**Keywords:** supportive-expressive therapy; short-term psychodynamic psychotherapy; psychotherapy process Q-sort; psychotherapeutic processes; mechanisms of change

Evidence has emerged that even in studies of manual-guided therapies a considerable overlap exists between interventions (Ablon & Jones, 1998, 2002; Ablon, Levy, & Katzenstein, 2006). Cognitive-behavioral therapists, for example, were found to use interpretations or clarifications as often as psychodynamic therapists (Luborsky, Woody, McLellan, O'Brien, & Rosenzweig, 1982). When prototypes of psychodynamic and cognitive-behavioral therapies were used, psychodynamic therapists were found to adhere to a cognitive-behavioral therapy prototype to the same degree as they adhered to a psychodynamic prototype (Ablon & Jones, 1998). Ablon and Jones reported that the interpersonal therapies in the National Institute of Mental Health Treatment of Depression Collaborative Research Program showed a stronger correlation to the prototype of an ideal cognitive-behavioral therapy than to the prototype of interpersonal therapy and that the degree of correlation of the interpersonal therapies to the cognitive-behavioral therapy prototype yielded more positive correlations with outcome measures than the degree of correlation to the interpersonal prototype (Ablon & Jones, 2002). For this reason, Ablon

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and Jones (2002, p. 780) concluded: "Brand names of therapy can be misleading."

Using the Psychotherapy Process Q-set (PQS), Ablon and Jones developed prototypes for CBT, interpersonal therapy (IPT), and psychoanalysis (Ablon & Jones, 2002, 2005). In addition, a prototype for control mastery therapy (CMT) was developed (Pole, Ablon, & ÓConnor, 2008). Ablon and colleagues computed correlations between PQS profiles of actual therapies with these prototypes (congruence) and related these correlations to outcome with mixed results: For cognitive-behavioral therapy some studies found correspondence to the cognitive-behavioral model to be positively related to outcome in depressed patients (Ablon & Jones, 2002), whereas others reported only a few correlations (Ablon & Jones, 1998) or no correlations (Jones & Pulos, 1993). Other studies of CBT found more correlations with outcome for correspondence with the psychoanalytic prototype (Ablon & Jones, 1998). For psychodynamic psychotherapy results are heterogeneous as well (Ablon & Jones, 1998; Ablon et al., 2006; Jones & Pulos, 1993). Correspondence to the psychoanalytic prototype, for example, was significantly correlated with outcome in some, but not in all studies of short-term psychodynamic therapy (STPP) (Ablon & Jones, 1998; Ablon et al., 2006). This may be due to the fact that in these studies a prototype for psychoanalysis was used (Ablon & Jones, 1998; Ablon et al., 2006). The psychoanalytic prototype refers to long-term non-manualized psychoanalysis (Ablon & Jones, 2005). PQS ratings of actual psychoanalytic sessions showed a significantly higher correlation with this prototype than PQS ratings of long-term psychodynamic therapy which in turn showed a higher correlation with this prototype than actual STPP (Ablon & Jones, 2005). Thus, the psychoanalytic prototype developed by Ablon and Jones (2005) is not fully representative of long-term psychodynamic therapy and even less representative of (manual-guided) STPP. STPP is usually more structured and goal-oriented, especially if manual-guided versions are used (Crits-Christoph & Barber, 1991; Messer & Warren, 1995). Deviations between the psychoanalytic prototype from an ideal STPP may contribute to explaining some of the heterogeneous results reported above. This may apply, for example, to the finding that STPP did not show a higher correlation to the psychoanalytic prototype than to the CBT prototype (Ablon & Jones, 1998) and an even significantly higher correlation (0.50 vs. 0.35) to the CBT prototype (Ablon et al., 2006). As reported above, only in some of these studies, congruence of actual STPP with the psychoanalytic prototype showed correlations with outcome (Ablon & Jones, 2005; Ablon et al., 2006).

Thus, it seems useful to develop a prototype specifically for (manual-guided) STPP. This prototype can be compared with the psychoanalytic prototype, as well as with the prototypes reported by Ablon and Jones (2002) for CBT and IPT. In a next step, the new prototype may be related to outcome, both in studies for which data are already available and in new studies.

Different methods of STPP are available (Crits-Christoph & Barber, 1991; Messer & Warren, 1995). Supportive-expressive (SE) therapy is among the empirically best supported methods of manual-guided (short-term) psychodynamic therapy (Barber & Crits-Christoph, 1995; Leichsenring & Leibing, 2007). Barber, Barrett, Gallop, Rynn, and Rickels (2012), for example, recently compared SE therapy to pharmacotherapy for depression. A version of STPP based on SE therapy has been applied in a large-scale randomized controlled trial comparing STPP and CBT in social anxiety disorder (Leichsenring et al., 2013; 2014). However, because it is questionable whether the psychoanalytic prototype reported by Ablon and Jones (1998, 2005) and Ablon et al. (2006) is valid for STPP, we developed a PQS prototype for short-term SE therapy.

The following questions were addressed: (i) Does a PQS prototype specific to manual-guided STPP (SE therapy) differ from a psychoanalytic prototype? (ii) What are the correlations of this prototype with the prototypes of CBT, IPT and CMT? and (iii) In the study by Leichsenring et al. (2013) SE therapy was specifically tailored to the treatment of social phobia. It is interesting to see whether the prototype of generic SE therapy is consistent with the form of SE therapy specifically tailored to the treatment of social anxiety disorder used.

## Hypotheses

(1) We expected the SE prototype to differ from the psychoanalytic prototype. In other words, although the SE prototype was expected to correlate with the psychoanalytic prototype, the majority of variance of the SE prototype should not be explained by the psychoanalytic prototype.

(2) The SE prototype was expected to show a moderate correlation to other forms of psychotherapy, that is to the CBT prototype, the IPT prototype, and the CMT prototype. Again, we expected the majority of variance of the SE prototype to be independent from the CBT, the IPT, and the CMT.

(3) We expected the general SE prototype to be highly correlated to the prototypical rating of

STPP based on SE therapy specifically tailored to the treatment of social anxiety disorder (Leichsenring, Beutel, & Leibing, 2007).

## Methods

### Psychotherapy Process Q-sort

The PQS (Jones, 2000) consists of 100 items that can be grouped into 3 areas, items describing (i) the attitude, the behavior or the experiences of patients; (ii) attitudes and behaviors of therapists; and (iii) the interaction between patients and therapists or the atmosphere of the exchange between patient and therapist. The PQS uses an entire session as the unit of observation. Having listened to an audio or video tape of the session, clinical judges sort the 100 items in the Q-set on a continuum from least characteristic or negatively salient (category 1) to most characteristic or salient (category 9). The middle pile (category 5) is used for items deemed either neutral or irrelevant to the particular session being rated. The number of cards sorted into each category of the Q-sort conforms to a normal distribution (forced choice), requiring judges to make multiple evaluations among items, and thereby avoiding Halo-effects and response sets (Ablon & Jones, 2002). Judges rate the frequency, intensity, and estimated importance of each of the 100 items. A detailed coding manual provides the Q-items and their description as well as operational examples. The PQS was developed pantheoretically to assess therapist actions in different types of therapy so it is especially useful for comparing the process of different forms of therapy (Ablon & Jones, 2002; Fonagy, 2005; Jones, Cumming, & Horowitz, 1988). It has demonstrated both reliability and discriminant validity across a variety of studies and treatment samples (Ablon & Jones, 2002; Ablon et al., 2006; Jones et al., 1988; Jones & Pulos, 1993). In addition, Ablon and Jones (2002) developed prototypic ratings of different forms of psychotherapy by asking expert therapists to rate each of the 100 items of the Q-set in form of a PQS questionnaire according to how characteristic each item was of their understanding of an ideally conducted course of therapy that adheres to the principles of their theoretical perspective. In the studies by Ablon and Jones, 10 experts were included to give a prototypic rating for CBT, 11 for interpersonal therapy (Ablon & Jones, 2002), and 11 for psychoanalytic therapy (Ablon & Jones, 1998). A high agreement among raters was demonstrated (Cronbach´s alpha: CBT: 0.95, IPT: 0.96, and psychoanalytic: 0.94) (Ablon & Jones, 2002, 2005). In a next step, the expert ratings were analyzed by principal component factor analysis using the Q technique correlating a smaller number of subjects over a larger number of items (the 100 items of the PQS) (Ablon & Jones, 1998). For this purpose, the data matrix was transposed in a way that the experts represented the variables to be correlated over the 100 items of the PQS, so that $N = 100$ (Ablon & Jones, 1998). Using the transposed data matrix, a principal component factor analysis was performed and factor scores were calculated indicating to which degree each PQS item contributes to the factor (Ablon & Jones, 2002). These factor scores represent the prototype the respective therapy. Thus, the PQS can be used to rate actual therapies administered and to study their correspondence to therapy-specific prototypes (Ablon & Jones, 2002).

### Procedure

To make results comparable, methodological and statistical procedures were analogous to the studies by Ablon and Jones (1998, 2002). For assessing a prototype for SE therapy, the PQS questionnaire developed by Ablon and Jones (1998, 2002) was used. Although containing the same 100 items, this questionnaire is not identical to the PQS as raters do not have to adhere to the normal distribution. Experts in SE therapy were asked to rate each of the 100 items of the PQS questionnaire according to how characteristic each item was of their understanding of an ideally conducted short-term SE therapy. They were given the following instructions:

> The following 100 statements describe things that may or may not go on during therapy. We are interested in your understanding of what should go on in an ideally conducted course of therapy that adheres to the principles of short-term Supportive Expressive (SE) Therapy. Please rate each item, on a scale from −4 to +4, according to how characteristic it is of an ideally conducted short-term Supportive Expressive (SE) Therapy.

Seven experts in SE therapy rated an (imagined) ideally conducted session of SE therapy. They are among the authors (JPB, PCC, MBCG, MB, JW, SS, and FL) of this article. They all provided major contributions to the development of and research on SE therapy (for an overview see, for example, Barber & Crits-Christoph, 1995; Leichsenring & Leibing, 2007; Leichsenring et al., 2013; Luborsky & Crits-Christoph, 1990). Due to their expertize in SE therapy, they were invited to participate in this project by the first author and agreed to do so. All expert ratings were carried out independently from each other.

As explained above, an (imagined) ideal SE therapy for social anxiety disorder (Leichsenring et al., 2007) was additionally rated by the same experts again using the PQS questionnaire in order to include a disorder-specific treatment based on SE therapy, four of them were involved in the development of the manual for social anxiety disorder (FL, MB, JW, and SS). This treatment was recently applied in a large-scale multicenter randomized-controlled trial comparing CBT to STPP (Leichsenring et al., 2013). All experts were familiar with the manual specifically tailored to the treatment of social anxiety disorder by Leichsenring et al. (2007).

### Statistical Analysis

Statistical analyses were carried out by SAS (9.2 Institute). In order to make results comparable with Ablon and Jones' work, we performed the same statistical analyses that they did (e.g., Ablon & Jones, 2002). Thus, inter-rater agreement was assessed by calculating Cronbach's alpha. For this purpose the data matrix was transposed in a way that the experts represented the variables to be correlated over the 100 items of the PQS, so that $N = 100$ (Ablon & Jones, 1998). Thus, Cronbach's alpha represents the agreement between the experts with regard to their prototypical ratings. To develop a prototype for SE therapy, we applied the SAS factor procedure to the transposed data matrix described above using a principal component analysis (Q) for factor extraction. Factor scores representing the contribution of each item to the prototypic profile of SE therapy were computed using the SAS factor procedure.

Ablon and Jones (2005) had applied the same procedure to develop a psychoanalytic prototype. Stuart Ablon made this psychoanalytic prototype available to us, that is, the factor scores of the 100 PQS items for the description of a prototypical psychoanalytic therapy. Using these data, we calculated Pearson correlations between the factor scores of the SE prototype we developed and those of the psychoanalytic prototype found by Ablon and Jones (2005). We also examined the correspondence between the new SE prototype and the existing prototypes for CBT, IPT, and CMT developed by Ablon and Jones (2002) and Pole et al. (2008). These prototypes (factor scores) were also made available to us by Stuart Ablon. We calculated Pearson correlations between the prototype for SE therapy and the prototypes for psychoanalysis, CBT and IPT, that is, between the factor scores of the respective prototypes. In addition, correlations between the generic SE prototype and the prototype for the psychodynamic treatment specific to social anxiety disorder (Leichsenring et al., 2007) were calculated.

## Results

### Inter-rater Agreement

The agreement between the expert ratings of an ideal SE therapy was high (Cronbach's alpha = 0.94).

### Principal Component Analysis

A principal component analysis yielded one factor explaining 75% of the variance (Eigenvalue: 5.23). The factor scores were calculated in order to gain a PQS-based prototype for SE therapy. The 20 PQS items most and least characteristic of this prototype are listed in Tables I and II.[1]

### Correlations Between Prototypes

The SE prototype showed a significant, but not perfect correlation to the psychoanalytic prototype ($r = 0.53$, $p < .0001$). Thus, 28% of variance of the SE prototype was explained by the psychoanalytic prototype corroborating hypothesis 1.

The SE prototype showed a significant correlation with both the CBT prototype ($r = 0.69$, $p < .0001$) and the IPT prototype ($r = 0.43$, $p < .0001$). Thus, hypothesis 2 was corroborated as well. The correlation between the SE prototype and the CBT prototype was somewhat higher than the correlation between the SE prototype and the psychoanalytic prototype (0.69 vs. 0.53), but the difference just failed to be statistically significant ($z = 1.63$, $p = .051$). The correlation between the SE prototype and the psychoanalytic prototype did not differ significantly from the correlation of the SE prototype with the IPT prototype ($z = 0.88$, $p = .19$). However, the SE prototype showed a significantly higher correlation to the CBT prototype than to the IPT prototype ($z = 2.51$, $p = .006$).

We applied the same procedures as described above to develop a prototype for the treatment specific to social anxiety disorder based on SE therapy (Leichsenring et al., 2007). Again, inter-rater agreement was high (Cronbach's alpha = 0.93). The factor analysis again yielded one factor for which the factor scores were calculated. The prototype for this treatment showed a high correlation to the prototype for SE therapy ($r = 0.98$, $p < .0001$). Hypothesis 3 was corroborated.

It is of interest to compare the items most characteristic of the SE prototype with those most characteristic

Table I. Rank ordering of Q-items by factor scores on SE psychodynamic technique factor.

| 20 most characteristic items of ideal supportive-expressive psychodynamic therapy | | |
|---|---|---|
| #PQS | Item description | Factor score |
| 31 | Therapist asks for more information or elaboration | 1.58 |
| 62 | Therapist identifies a recurrent theme in the patient's experience or conduct | 1.48 |
| 69 | Patient's current or recent life situation is emphasized in discussion | 1.40 |
| 75 | Termination of therapy is discussed | 1.39 |
| 46 | Therapist communicates with patient in a clear, coherent style | 1.39 |
| 63 | Patient's interpersonal relationships are a major theme | 1.39 |
| 18 | Therapist conveys a sense of non-judgmental acceptance | 1.37 |
| 6 | Therapist is sensitive to the patient's feelings, attuned to the patient; empathic | 1.36 |
| 45 | Therapist adopts supportive stance | 1.32 |
| 4 | The patient's treatment goals are discussed | 1.30 |
| 3 | Therapist's remarks are aimed at facilitating patient speech | 1.24 |
| 28 | Therapist accurately perceives the therapeutic process | 1.15 |
| 79 | Therapist comments on changes in patient's mood or affect | 1.13 |
| 57 | Therapist explains rationale behind his or her technique or approach to treatment | 1.07 |
| 48 | The therapist encourages independence of action or opinion in the patient | 1.06 |
| 23 | Dialogue has a specific focus | 1.05 |
| 32 | Patient achieves a new understanding or insight | 1.02 |
| 85 | Therapist encourages patient to try new ways of behaving with others | 1.02 |
| 86 | Therapist is confident or self-assure | 1.02 |
| 50 | Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, etc.) | 0.97 |

*Note.* Factor scores derived from expert SE psychodynamic therapists' ($N = 7$) ratings on the PQS questionnaire.

of the psychoanalytic prototype reported by Ablon and Jones (2005). These items are listed in Table III. Of the 20 items most characteristic of SE therapy (Table I), only 8 items are among the items most characteristic of the psychoanalytic prototype (items 62, 46, 18, 6, 3, 79, 32, 50). Accordingly, most of the items either most characteristic of SE therapy or psychoanalysis are not common to both prototypes (12/20). Thus, to a substantial degree the prototypes of psychoanalysis and the SE therapy do not overlap. For the items shared by the two prototypes, the factor scores are at least partly different showing that

Table II. Rank ordering of Q-items by factor scores on the SE psychodynamic technique factor.

| 20 least characteristic items of an ideal SE psychodynamic therapy | | |
|---|---|---|
| #PQS | Item description | Factor score |
| 51 | Therapist condescends to, or patronizes the patient | −2.83 |
| 77 | Therapist is tactless | −2.73 |
| 24 | Therapist's own emotional conflicts intrude into the relationship | −2.57 |
| 9 | Therapist is distant, aloof (vs. responsive and affectively involved) | −2.34 |
| 39 | There is a competitive quality to the relationship | −2.04 |
| 37 | Therapist behaves in a teacher-like (didactic) manner | −1.81 |
| 19 | There is an erotic quality to the therapy relationship | −1.66 |
| 21 | Therapist self-discloses | −1.34 |
| 5 | Patient has difficulty understanding the therapist's comments | −1.26 |
| 44 | Patient feels wary or suspicious (vs. trusting and secure) | −1.25 |
| 87 | Patient is controlling | −1.25 |
| 42 | Patient rejects vs. accepts therapist's comments and observations | −1.07 |
| 58 | Patient resists examining thoughts, reactions, or motivations related to problems | −1.07 |
| 83 | Patient is demanding | −1.04 |
| 12 | Silences occur during the hour | −0.98 |
| 10 | Patient seeks greater intimacy with the therapist | −0.93 |
| 94 | Patient feels sad or depressed | −0.92 |
| 14 | Patient does not feel understood by therapist | −0.79 |
| 52 | Patient relies upon therapist to solve his/her problems | −0.77 |
| 25 | Patient has difficulty beginning the hour | −0.77 |

*Note.* Factor scores derived from expert SE psychodynamic therapists' ($N = 7$) ratings on the PQS questionnaire.

Table III. Rank ordering of Q-items by factor scores on the ideal psychoanalytic process factor.

| 20 most characteristic items of ideal psychoanalytic treatment | | |
|---|---|---|
| #PQS | Item description | Factor score |
| 90 | Patient's dreams or fantasies are discussed | 1.71 |
| 93 | Analyst is neutral | 1.57 |
| 36 | Analyst points out P's use of defensive maneuvers (e.g., undoing and denial) | 1.53 |
| 100 | Analyst draws connections between the therapeutic relationship and other relationships | 1.47 |
| 6 | Analyst is sensitive to the P's feelings, attuned to the P; empathic | 1.46 |
| 67 | Analyst interprets warded-off or unconscious wishes, feelings, or ideas | 1.43 |
| 18 | Analyst conveys a sense of non-judgmental acceptance | 1.38 |
| 32 | Patient achieves a new understanding or insight | 1.32 |
| 98 | The therapy relationship is a focus of discussion | 1.28 |
| 46 | Analyst communicates with patient in a clear, coherent style | 1.24 |
| 50 | Analyst draws attention to feelings regarded by patient as unacceptable (e.g., anger, envy, and excitement) | 1.17 |
| 11 | Sexual feelings and experiences are discussed | 1.12 |
| 82 | Patient's behavior during the hour is reformulated by analyst in a way not explicitly recognized previously | 1.12 |
| 35 | Self-image is a focus of discussion | 1.11 |
| 91 | Memories or reconstructions of infancy and childhood are topics of discussion | 1.08 |
| 92 | Patient's feelings or perceptions are linked to situations or behavior of the past | 1.05 |
| 62 | Analyst identifies a recurrent theme in patient's experience or conduct | 0.95 |
| 3 | Analyst's remarks are aimed at facilitating patient's speech | 0.92 |
| 79 | Analyst comments on changes in patient's mood or affect | 0.88 |
| 22 | Analyst focuses on patient's feelings of guilt | 0.87 |

*Note.* Factor scores derived from expert psychodynamic therapists' ($N = 11$) ratings of thePQS.



the items contribute differently to the respective prototype. The item 62 ("Therapist identifies a recurrent theme in patient's experience or conduct"), for example, has a higher factor loading (1.48) on the SE prototype than on the psychoanalytic prototype (0.95). In sum, psychoanalysis and SE therapy are regarded by the respective experts as characterized by predominantly distinct interventions.

The items most characteristic to the psychoanalytic prototype (Ablon & Jones, 2005) which are not included by the SE prototype refer to (Tables I and III): the discussion of dreams and fantasies, therapist being neutral, addressing defense mechanisms, drawing connections between the therapeutic relationship and other relationships (transference interpretation), interpreting warded-off or unconscious wishes, feelings or ideas, focusing on the therapeutic relationship, addressing sexual experiences, reformulating patient's behavior in a way not explicitly recognized previously, addressing self-image, addressing childhood, linking patient's perception to situations of the past, and focusing on feelings of guilt.

These items refer to therapist activities. These activities are usually regarded as characteristic of the specific techniques and processes of psychoanalysis (e.g., Greenson, 1967).

On the other hand, the items most characteristic of the SE prototype which are not included by the psychoanalytic prototype refer to (Tables I and III): therapist asking for information, discussing current life situations, addressing termination, discussion patient's interpersonal relationships, adopting a supportive stance, discussing patient's goals, accurately perceiving the therapeutic process, explaining the rationale behind the approach, encouraging patients' independence of action or opinion, addressing a specific focus, encouraging the patient to try new ways of behaving with others, and being confident.

These items are consistent with techniques and processes of SE therapy as described by Luborsky (1984) with an emphasis on supporting the patient and establishing a helping alliance, addressing a specific focus, setting treatment goals and discussing termination issues. Whereas in psychoanalysis proper insight-oriented components are more prominent, supportive factors remain implicit, but are the "silent force" also of psychoanalysis (de Jonghe, 1994, p. 439; Wallerstein, 1989).

The techniques and processes common to both psychoanalysis and SE therapy refer to the therapist identifying a recurrent theme in the patient's experience, communicating in a clear, coherent style, conveying a sense of non-judgemental acceptance, being empathic, facilitating patient speech, commenting on changes in patient's mood or affect, drawing attention to feelings regarded by the patient as unacceptable (e.g., anger or envy), and patient achieving a new understanding.

In sum there are both plausible differences and similarities between the psychoanalytic and the SE prototype (Tables I and III).

In addition, it is of interest to compare the SE prototype to both the CBT and the IPT prototype reported by (Ablon & Jones, 2002). The SE prototype and both the CBT and the IPT prototype have 10 items in common. For CBT these are the items 4, 85, 45, 23, 31, 69, 86, 57, 28, and 48. These items refer to therapist activities or attitudes. Of the items least characteristic of SE therapy, only one item (item 37: therapist behaves in a teacher-like (didactic) manner) is among the items rated as most characteristic for the CBT model. The 10 items common to the SE and IPT prototype are the items 69, 75, 63, 45, 4, 3, 28, 79, 57, and 23. Only five items are common to the three prototypes (SE, CBT, and IPT): 69, 45, 4, 28, and 57.

In order to show the realms of overlap and non-overlap between psychoanalysis, SE therapy, CBT, and IPT, the prototypic items of the four approaches are presented in the form of a Venn diagram (Figure 1).

Whereas psychoanalysis does not share any prototypic item with CBT (Figure 1), SE therapy shares 10 items with CBT, 10 items with IPT, and 8 items with psychoanalysis. All prototypic items of SE therapy are among the prototypic items of the other three methods of psychotherapy. A list of all PQS items is presented in Table IV.

CMT integrates elements of CBT and psychodynamic therapy (Pole et al., 2008). Thus, it is of interest to compare the CMT prototype with the SE prototype. The correlation between the two prototypes was significant ($r = 0.40$, $p < .0001$). The two prototypes were found to have seven items in common (46, 18, 6, 45, 3, 28, and 86). However, the factor scores of these items are at least partly different showing that the items contribute differently to the respective prototype. The most characteristic CMT item (#28 "therapist accurately perceives the therapeutic process"), for example, contributes more strongly to the CMT prototype (2.11) than to the SE prototype (1.15). The correlation of the CMT prototype with the CBT prototype is significant, but modest as well ($r = 0.37$, $p < .001$).

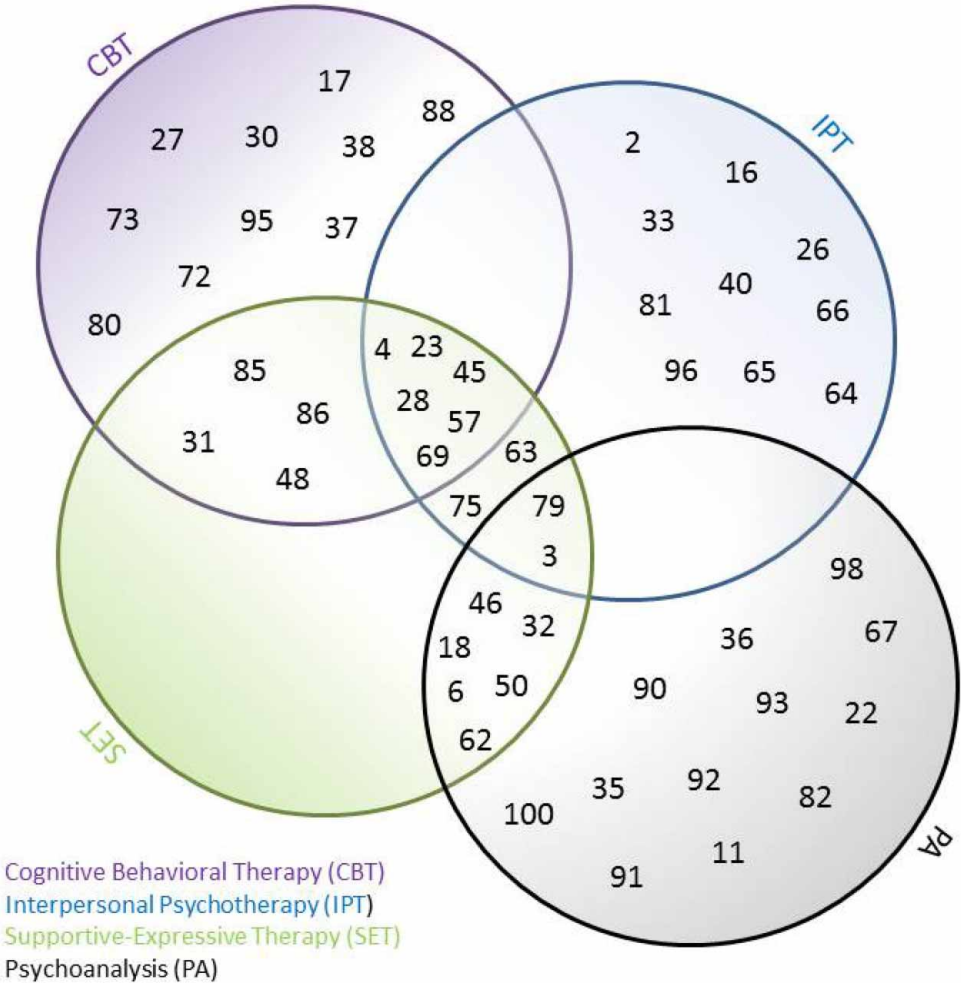


Figure 1. Overlap between psychoanalysis, SE therapy, CBT, and IPT with regard to the prototypic PQS items.

Table IV. The 100 items of the PQS.

| | |
|---|---|
| 1. | Patient verbalizes negative feelings toward therapist |
| 2. | Therapist draws attention to patient's non-verbal behavior |
| 3. | Therapist's remarks are aimed at facilitating patient speech |
| 4. | The patient's treatment goals are discussed |
| 5. | Patient has difficulty understanding the therapist's comments |
| 6. | Therapist is sensitive to the patient's feelings, attuned to the patient; empathic |
| 7. | Patient is anxious or tense (vs. calm and relaxed) |
| 8. | Patient is concerned or conflicted about his or her dependence on the therapist |
| 9. | Therapist is distant, aloof (vs. responsive and affectively involved) |
| 10. | Patient seeks greater intimacy with the therapist |
| 11. | Sexual feelings and experiences are discussed |
| 12. | Silences occur during the hour |
| 13. | Patient is animated or excited |
| 14. | Patient does not feel understood by therapist |
| 15. | Patient does not initiate topics; is passive |
| 16. | There is discussion of body functions, physical symptoms, or health |
| 17. | Therapist actively exerts control over the interaction (e.g., structuring, introducing new topics) |
| 18. | Therapist conveys a sense of non-judgmental acceptance |
| 19. | There is an erotic quality to the therapy relationship |
| 20. | Patient is provocative, tests limits of the therapy relationship |
| 21. | Therapist self-discloses |
| 22. | Therapist focuses on patient's feelings of guilt |
| 23. | Dialogue has a specific focus |
| 24. | Therapist's own emotional conflicts intrude into the relationship |
| 25. | Patient has difficulty beginning the hour |
| 26. | Patient experiences discomforting or troublesome (painful) affect |
| 27. | Therapist gives explicit advice and guidance (vs. defers even when pressed to do so) |
| 28. | Therapist accurately perceives the therapeutic process |
| 29. | Patient talks of wanting to be separate or distant |
| 30. | Discussion centers on cognitive themes |
| 31. | Therapist asks for more information or elaboration |
| 32. | Patient achieves a new understanding or insight |
| 33. | Patient talks of feelings about being close to or needing someone |
| 34. | Patient blames others, or external forces for difficulties |
| 35. | Self-image is a focus of discussion |
| 36. | Therapist points out patient's use of defensive maneuvers, e.g. undoing, denial |
| 37. | Therapist behaves in a teacher-like (didactic) manner |
| 38. | There is discussion of specific activities or tasks for the patient to attempt outside of session |
| 39. | There is a competitive quality to the relationship |
| 40. | Therapist makes interpretations referring to actual people in the patient's life |
| 41. | Patient's aspirations or ambitions are topics of discussion |
| 42. | Patient rejects vs. accepts therapist's comments and observations |
| 43. | Therapist suggests the meaning of others' behavior |
| 44. | Patient feels wary or suspicious (vs. trusting and secure) |
| 45. | Therapist adopts supportive stance |
| 46. | Therapist communicates with patient in a clear, coherent style |
| 47. | When the interaction with the patients is difficult, the therapist accommodates in an effort to improve it |
| 48. | The therapist encourages independence of action or opinion in the patient |
| 49. | The patient experiences ambivalent or conflicted feelings about the therapist |
| 50. | Therapist draws attention to feelings regarded by the patient as unacceptable (e.g. anger, envy, … ) |
| 51. | Therapist condescends to, or patronizes the patient |
| 52. | Patient relies upon therapist to solve his/her problems |
| 53. | Patient is concerned about what therapist thinks of him or her |
| 54. | Patient is clear and organized in self-expression |
| 55. | Patient conveys positive expectations about therapy |
| 56. | Patient discusses experiences as if distant from his or her feelings |
| 57. | Therapist explains rationale behind his or her technique or approach to treatment |
| 58. | Patient resists examining thoughts, reactions, or motivations related to problems |
| 59. | Patient feels inadequate and inferior (vs. effective and superior) |
| 60. | Patient has cathartic experience |
| 61. | Patient feels shy and embarrassed |
| 62. | Therapist identifies a recurrent theme in the patient's experience or conduct |
| 63. | Patient's interpersonal relationships are a major theme |

(*Continued*)

Table IV. Continued.

| | |
|---|---|
| 64. | Love or romantic relationships are a topic of discussion |
| 65. | Therapist clarifies, restates, or rephrases patient's communication |
| 66. | Therapist is directly reassuring |
| 67. | Therapist interprets warded-off or unconscious wishes, feelings, or ideas |
| 68. | Real vs. fantasized meanings of experiences are actively differentiated |
| 69. | Patient's current or recent life situation is emphasized in discussion |
| 70. | Patient struggles to control feelings or impulses |
| 71. | Patient is self-accusatory, expresses shame or guilt |
| 72. | Patient understands the nature of therapy and what is expected |
| 73. | The patient is committed to the work of therapy |
| 74. | Humor is used |
| 75. | Termination of therapy is discussed |
| 76. | Therapist suggests that patients accept responsibility for his or her own problems |
| 77. | Therapist is tactless |
| 78. | Patient seeks therapist's approval, affection, or sympathy |
| 79. | Therapist comments on changes in patient's mood or affect |
| 80. | Therapist presents an experience or event in a different perspective |
| 81. | Therapist emphasizes patient feelings in order to help him or her experience them more deeply |
| 82. | The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously |
| 83. | Patient is demanding |
| 84. | Patient expresses angry or aggressive feelings |
| 85. | Therapist encourages patient to try new ways of behaving with others |
| 86. | Therapist is confident or self-assure |
| 87. | Patient is controlling |
| 88. | Patient brings up significant issues and material |
| 89. | Therapist acts to strengthen defenses |
| 90. | Patient's dreams or fantasies are discussed |
| 91. | Memories or reconstructions of infancy and childhood are topics of discussion |
| 92. | Patient's feelings or perceptions are linked to situations or behavior of the past |
| 93. | Therapist is neutral |
| 94. | Patient feels sad or depressed |
| 95. | Patient feels helped |
| 96. | There is discussion of scheduling of hours, or fees |
| 97. | Patient is introspective, readily explores inner thoughts and feelings |
| 98. | The therapy relationship is a focus of discussion |
| 99. | Therapist challenges the patient's view |
| 100. | Therapist draws connections between the therapeutic relationship and other relationships |



However, the CMT prototype correlates neither with the psychoanalytic prototype nor with the IPT prototype ($r = 0.15$, $p = .13$, $r = -0.03$, $p = .80$).

## Discussion

STPP in general and SE therapy in particular differ from psychoanalysis with regard to characteristics of process and interventions (e.g., addressing a specific focus, therapist being less neutral and more active, restriction of regression and transference, setting goals, explaining the rationale behind the approach, and use of interpretive vs. supportive interventions). Thus, ratings of an ideal psychoanalysis and an ideal STPP/SE therapy by experts can be expected to differ in specific regards. In this study we tested this assumption empirically using expert prototypic ratings of STPP (SE therapy) which were compared to the prototypic ratings of psychoanalysis reported by Ablon and Jones (2005). The results of this study corroborated that assumption (hypothesis 1). The prototypic rating of SE therapy showed a significant correlation to the psychoanalytic prototype ($r = 0.53$), but the majority of variance of the SE prototype was not explained by the psychoanalytic prototype and vice versa. The SE prototype did not show a higher correlation with the psychoanalytic prototype than with the CBT or IPT prototype. This may be explained by the fact that the prototypes of both CBT and IPT refer to treatments that are manual-guided and short-term, features that are characteristic of STPP (SE therapy) as well. The STPP (SE) prototype showed a significantly higher correlation with the CBT prototype than with the IPT prototype, although both SE therapy and IPT focus on interpersonal relationships. SE therapy and CBT seem to share more features than SE therapy and IPT, at least as measured by the PQS.

The reported correlation between the SE and the CBT prototype indicates a relevant overlap between these two "brand name" treatments. One may ask

whether the representatives of these two approaches usually tend to overemphasize the differences between these two methods neglecting their similarities. In order to address this issue, it is necessary to examine what therapists are actually doing. For this reason, we are planning to apply the new disorder-specific SE prototype and the CBT prototype to a large multicenter study comparing STPP and CBT in social anxiety disorder (Leichsenring et al., 2013). Furthermore, it is important to note that SE therapy could be significantly discriminated from CBT by use of other measures applied to actual therapy sessions (Leichsenring et al., 2009; Leichsenring et al., 2013, 2014; Luborsky et al., 1982). Thus, one may wonder if it is possible that the PQS does not provide a good description of the actual differences between those two approaches (e.g., a focus on conflicts associated with social anxiety vs. a focus on cognitions, video-feedback and exposure in CBT), at least on the level of prototypic description by experts.

CMT integrates both psychodynamic and cognitive-behavioral elements. Thus, the (modest) overlap between the CMT prototype on the one hand and both the SE prototype and the CBT prototype are to be expected. However, the CMT prototype does not correlate with either the psychoanalytic prototype or the IPT prototype. Thus, according to the CMT expert ratings, CMT shows modest overlap with SE therapy and CBT, but no overlap with psychoanalysis and IPT. It would be of interest to compare the PQS ratings of actual CMT sessions with the PQS ratings of actual psychoanalytic and IPT sessions to see whether the expert opinions are confirmed by the data on actual treatments (empirical PQS profiles).

With regard to the interpretation of our results, some limitations should be mentioned. The raters were instructed to rate a prototypic SE therapy. However, various forms of STPP are available, for example, the methods by Mann (1973), Sifneos (1978), Strupp and Binder (1984), or Davanloo (1980). Thus, we do not know to what degree the identified SE prototype is representative for other forms of STPP. For this reason it would be of interest to develop prototypes of various forms of STPP and compare them with each other. However, it still remains unclear whether substantial differences between these forms of STPP can be empirically found. The overlap may outweigh the differences: For the empirically supported psychodynamic treatments of both anxiety and depressive disorders, a high degree of overlap was found suggesting to develop unified protocols (Leichsenring & Salzer, 2014; Leichsenring & Schauenburg, 2014). Furthermore, it is not yet clear whether it is possible to identify such potentially existing, but maybe small differences by the PQS.

For future process analyses of STPP using the PQS, the availability of a prototype for SE therapy may be of some use. In addition, the SE prototype can be applied to already existing data of studies on STPP, for example to the data by Ablon and Jones (1998, 2005) and Ablon et al. (2006). For these studies, using a prototype for SE therapy can be regarded as more appropriate than using a psychoanalytic prototype. For this reason, applying the SE prototype to the data may explain at least some of the heterogeneous results reported by Ablon and Jones (1998): whereas in one psychodynamic treatment sample correspondence to the psychoanalytic prototype showed significant correlations to outcome, in another psychodynamic treatment sample no such correlations were found (Ablon & Jones, 1998)—both psychodynamic treatments were short-term. It would be of interest to see whether a significant correlation to outcome results in the latter sample if the SE prototype is used which—despite of possible differences between the various forms of STPP—represents a method of STPP.

As a next step of research, the SE prototype can be used to assess both the overlap between actual treatments and prototypes and the correlation of adherence to the STPP prototype with outcome. Furthermore, an update of the CBT prototype may be useful that takes more recent developments in CBT into account (e.g., emphasizing affect regulation or the therapeutic relationship). This may also be true for the items of the PQS that aim to tap processes characteristic of CBT.

## Note

[1] The factor scores of all 100 items of the SE prototype are available on request from the first author.

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