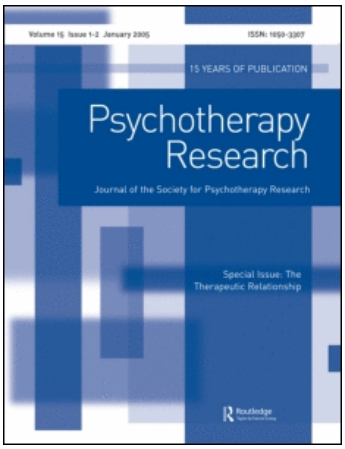


**Psychotherapy Research**
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713663589

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Mariane Krause [a]; Guillermo de la Parra [b]; Roberto Arístegui [a]; Paula Dagnino [b]; Alemka Tomicic [a]; Nelson Valdés [a]; Orietta Echávarri [b]; Katherine Strasser [a]; Lucía Reyes [b]; Carolina Altimir [a]; Ivonne Ramírez [a]; Oriana Vilches [a]; Perla Ben-Dov [a]
[a] Department of Psychology, Pontificia Universidad Católica de Chile, Santiago, Chile [b] Department of Psychiatry, Pontifcia Universidad Católica de Chile, Santiago, Chile

Online Publication Date: 01 November 2007

**To cite this Article** Krause, Mariane, de la Parra, Guillermo, Arístegui, Roberto, Dagnino, Paula, Tomicic, Alemka, Valdés, Nelson, Echávarri, Orietta, Strasser, Katherine, Reyes, Lucía, Altimir, Carolina, Ramírez, Ivonne, Vilches, Oriana and Ben-Dov, Perla(2007)'The evolution of therapeutic change studied through generic change indicators',Psychotherapy Research,17:6,673 — 689

**To link to this Article: DOI:** 10.1080/10503300601158814

**URL:** http://dx.doi.org/10.1080/10503300601158814

*Psychotherapy Research*, November 2007; 17(6): 673–689



# The evolution of therapeutic change studied through generic change indicators

MARIANE KRAUSE[1], GUILLERMO DE LA PARRA[2], ROBERTO ARÍSTEGUI[1], PAULA DAGNINO[2], ALEMKA TOMICIC[1], NELSON VALDÉS[1], ORIETTA ECHÁVARRI[2], KATHERINE STRASSER[1], LUCÍA REYES[2], CAROLINA ALTIMIR[1], IVONNE RAMÍREZ[1], ORIANA VILCHES[1], & PERLA BEN-DOV[1]

[1]*Department of Psychology, Pontificia Universidad Católica de Chile, Santiago, Chile, and* [2]*Department of Psychiatry, Pontifcia Universidad Católica de Chile, Santiago, Chile*

*(Received 4 January 2006; revised 20 September 2006; accepted 17 October 2006)*



**Abstract**
Ongoing change and therapeutic outcome were studied in five psychotherapeutic processes: three brief psychodynamic therapies, one social constructionist family therapy, and one group therapy of a comprehensive nature for drug abuse patients. Using qualitative methodology, in-session and extrasession change moments were identified and classified in a hierarchy of generic change indicators. Additionally, all patients were administered Lambert's Outcome Questionnaire. Results show that (a) extrasession change moments are more frequent toward the end of therapy, (b) therapy types differ in the frequency of some change indicators but not others, and (c) change indicators observed at the beginning of therapy are of lower level than those occurring at the end.

Because the effectiveness of psychotherapy, in general, is no longer questioned (Asay & Lambert, 1999; Shadish, Matt, Navarro, & Phillips, 2000), research efforts are being focused on identifying changes that occur during the therapeutic process and on establishing the relationship of change events with the final outcome. There also is continued interest in the study of nonspecific or common factors, given that the "equivalency paradox" (Meyer, 1990) still holds true (i.e., the general effectiveness of the various therapeutic systems does not vary; Bozok & Bühler, 1988). This study is concerned with both lines of inquiry.

Of the research that has been conducted on the therapeutic process (Bastine, Fiedler, & Kommer, 1989; Goldfried, Greenberg, & Marmar, 1990; Hill, 1990; Rees et al., 2001; Tschuschke & Czogalik, 1990), the area that is most relevant to our efforts is the abandonment of the premise of the homogeneity of the therapeutic process (Mergenthaler, 1998) for an understanding of therapy as a variable series of segments, periods, or phases (Bastine et al., 1989). Of particular importance is the study of "significant change events or episodes" (Bastine et al., 1989; Elliott, 1984; Elliott & Shapiro, 1992; Fiedler & Rogge, 1989; Marmar, 1990; Martin & Stelmaczonek, 1988; Rice & Greenberg, 1984; Wiser & Goldfried, 1996). Qualitative research methods are used extensively to identify and define these change events, especially in efforts to discover these episodes or their components (Hill, Thompson, & Williams, 1997; Stiles, 1997).

The goal of the methodological approach to the episode is the identification and exhaustive description of "moments that, in accordance with specific criteria, stand out in the therapeutic process as 'significant,' 'noteworthy' or 'relevant for change'" (Fiedler & Rogge, 1989, p. 46 [our translation]). We are particularly interested in "the period of time, the segment or sequence within one or various therapeutic sessions in which significant change is expected to occur with the intention of submitting these moments to a profound analysis of the changes themselves as well as of the period prior to them and of their effects" (Bastine et al., 1989, p. 11 [our translation]). Elliott and Shapiro (1992) describe change moments as windows on the inner workings of the process of change in psychotherapy.

However, methodologically it is not easy to isolate a change episode. It has been argued that these

Correspondence concerning this article should be addressed to Mariane Krause, Department of Psychology, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4860, Macul, Santiago, Chile. E-mail: mkrause@uc.cl

ISSN 1050-3307 print/ISSN 1468-4381 online 
DOI: 10.1080/10503300601158814

episodes have variable temporal limits and may last anywhere from a couple of therapeutic interactions to 20 to 40 min (Rice & Greenberg, 1984) or even more than one session (Bastine et al., 1989). They also may be defined from various perspectives: that of the client, the therapist, or an external observer, with frequent discrepancies among these sources (Elliott & Shapiro, 1992; Orlinsky, 1994). Given these difficulties, for the effects of the present study, we have adopted a temporally strict definition in which we determine a change event (Elliott, 1984) or change moment rather than an episode. We also have opted to use the external perspective and identify these moments on the basis of observations of therapy and the analysis of video recordings and transcripts. Finally, a methodological approach to the study of change moments should address the possibility that the outcome of therapy does not depend on isolated episodes but rather on the connection and concatenation of several different episodes (Fiedler & Rogge, 1989) or the connection between the episodes happening within therapy and those that happen outside in daily life. To address both conditions, we consider interrelated change moments through a sequential organization, and we relate the change that occurs during a session with change that takes place during the extrasession period.

In regard to the content of change, and although studies on episodes demonstrate that these changes "exist" from the subjective points of view of the patient and the therapist (i.e., they should not be considered a mere construct of the research; Hill, 1990; Hill et al., 1997; Stiles, 1997), a conceptual definition of change is indeed required, should there be an interest in identifying it through observation. Empirical data on the nature of change may aid us in approaching such a conceptual definition.

For example, Goldfried et al. (1990) identify cognitive processes as particularly important for explaining therapeutic change, viewing them as a possible point of contact for the integration of different therapeutic systems, an interest that they share with Bastine et al. (1989) and Barton and Morley (1999). Turning to older works, Kelly (1955) underscores the potential of concepts such as "core cognitive structures" or "schemes" and "cognitive representations," which do not merely reflect change but are the "place" where such changes happen (Barton & Morley, 1999).

In theoretical terms, such changes in the representational sphere (Fonagy, 2001) could be conceptualized as changes in subjective theories (Groeben, Wahl, Schlee, & Scheele, 1988; Krause, 1991, 1992a, 1992b, 1998, 2005; Krause & Cornejo, 1997; Krause & Winkler, 1995), in frames of reference (Duncan & Moynihan, 1994), and in personal constructs (Anderson, 1997b). From the perspective of approaches that emphasize the narrative aspects of psychotherapy, these changes would be conceptualized as a rewriting of aspects of one's life story (McLeod, 1998; McLeod & Balamoutsou, 1996) or, in the postmodern vein, as changes in language and communication systems (Anderson, 1997a). Regardless of the term used to describe them or their epistemological status, these changes enjoy abundant empirical and theoretical support.

In our line of research, we adhere to the concept of subjective theory to understand change. This theoretical concept is defined as "cognitions of the vision of one's self and the world that can be understood as a complete set that has an argumentative structure, at least implicitly, and which fulfills the functions of explanation, prediction and technology that are also contained in scientific theories" (Groeben et al., 1988, p. 19, [author'stranslation]). Subjective change is, then, a change in the subjective patterns of interpretation and explanation that leads to the development of new subjective theories (Krause, 2005). This subjective change is generic, in the sense in which Orlinsky and Howard (1987) apply the term; that is, it is transversal to different psychotherapeutic modes and schools.

Nonetheless, these generic changes, which occur in the sphere of the representational or of subjective theories, evolve throughout the therapeutic process. It is, therefore, important to review their sequential nature.

Therapeutic processes tend to include a help-seeking stage, which occurs before therapy begins. Changes frequently commence during this stage, and if this is not the case, such changes are a key task for the first sessions of psychotherapy. These initial changes can be summarized as the acceptance of one's own limits and the awareness of the need for help (Krause, 1993, 2005; Krause, Uribe, Winkler, & Avendaño, 1994).

Once therapy has begun, a series of additional changes take place. Frank (1982), one of the pioneers in the field of generic psychotherapeutic change, notes that all clients begin therapy in a state of "demoralization," which involves feelings of helplessness, loss of control, low self-esteem, and difficulty making sense of daily life. According to Frank, an initial change in any successful therapy is the diminishment of this demoralization, which is achieved through the development of the hope or expectation of being helped. This approach is supported by later research (Elliott, 1984; Joyce & Piper, 1998; Snyder, Michael, & Cheavens, 1999) and by the work of Howard, Lueger, Maling, and Martinovich (1993), particularly their theory on the

phases of change, which describes consecutive phases of remoralization, improvement, and rehabilitation.

However, along with these emotionally reconstructive changes, the initial psychotherapeutic sessions also require the client to undergo cognitive changes such as critical self-perception (Krause, 1992b) and the "unfreezing" of patterns of interpretation and cognitive schemes (Märtens, 1991). Critical self-perception implies beginning to doubt what one had assumed to be true, correct, or unchangeable. It opens the door to an initial questioning of the explanatory models used up until that point. The process of unfreezing, on the other hand, allows for cognitive preparation for new therapeutic changes (Karasu, 1986).

The representational changes that follow create a need to build a realm of shared meanings between patient and therapist, particularly regarding the interpretation of the problems or symptoms about which the former is inquiring. Given that the client is in a position of needing help, which defines the asymmetry of the relationship, this need for shared meaning leads the client to resignify problems and symptoms so that they match the therapeutic theory and the definition of the therapist's professional competence (Krause, 2005). When this does not occur, patients frequently abandon therapy or are referred to another therapist (Krause et al., 1994). In very general terms, this stage involves an acceptance by the client that the problems must be psychologically interpreted (and are not, e.g., the product of a physical malady). The patient must accept the "context of psychological meaning" as the appropriate context for the treatment of his or her problems (Krause, 1991, 2005).

Two additional changes derive from the resignification of problems and symptoms: the redefinition of therapeutic expectations and goals and the acceptance of the therapist as a competent professional who can treat the patient's problem (Krause, 2005; Thompson & Hill, 1993). Parallel to the latter, and as the basis of the therapeutic work to follow, the client must accept his or her own participation or responsibility in various life situations, particularly those that are related to the problems being considered (Bittner, 1981).

Once the therapeutic process has moved forward, new representations, both cognitive (Krause, 1992b) and affective (Greenberg, Rice, & Elliott, 1993), play an important role in generic therapeutic change with the attending changes in the expression of feelings in the therapeutic context and the valorization of aspects of personal life, including those related to the problems and symptoms. Thus, for example, a symptom that originally was perceived and defined as corporal dysfunction may now be redefined and revalorized as a "corporal signal that is useful because it helps me not subject myself to overwork" (Krause, 1992a), which may lead to a different emotional expression. Other researchers mention related constructs such as insight, gaining a new perspective, or becoming aware of a problem (Hanna & Ritchie, 1995). In particular, the definition of insight that includes cognitive and affective elements, as well as those related to valorization, has received abundant empirical support (Elliott et al., 1994).

Another change that is common to different types of therapy is the perception of self-efficacy (Bandura, 1977), which forms part of self-representation. This change also has been studied recently as the construction of a feeling of competence (Berg & De Jong, 1996) or being able to manage one's own problems (Shilkret & Shilkret, 1993).

Finally, concepts or theories that name and explain the client's symptoms and problems (Polkinghorne, 1988) are key. New concepts and theories lead to greater changes in that they allow the client to have successful experiences through insights, the expression of feelings, new behaviors, or other developments that, in the context of the respective therapeutic theory, represent progress. Three successive moments can be identified in the construction of concepts and theories (Krause, 1992b, 1998, 2005):

1. The establishment of associations among symptoms, life experiences (current and past), motivations, emotions, and behaviors;
2. The creation of subjective constructs about oneself, one's biography, and one's relation to others; and
3. The construction of theories about oneself and one's relationship to the world, including one's life story.

In sum, results regarding the content of psychotherapeutic change show that generic psychotherapeutic change is related to the subjective perspective of the client regarding him- or herself, personal problems and symptoms, and the relationship of these with the environment in which they occur. It is a process of constructing new forms of interpretation and representation and of subjective theories of a psychological nature. On the other hand, results regarding the evolution of subjective change show that psychotherapeutic change is a process with successive stages, which begin before therapy starts and end afterward. It is, in essence, subjective, even though some steps are not subjective by themselves but lead to subjective change. It

combines intra- and extratherapeutic factors and evolves in stages that are built on one another and in which the level of complexity of the patterns of explanation and interpretation increases progressively. Also, it implies a successive "psychologization" (an increase in psychological mindedness) of the patterns of explanation and interpretation. This is, of course, the ideal sequence of change, which occurs in therapies defined by patients and therapists as successful.

From this ideal sequence of successive changes, we can derive a hierarchy of change indicators that are generic in the sense that they can be found in different psychotherapy models (Krause et al., 2005). These generic change indicators, used in the present study and described in the Method section, can be applied in the evaluation of the therapeutic process while it is taking place, in the prognosis of the final results, and also in the retrospective analysis of the therapy. Nonetheless, for this study, the greatest relevance of these indicators lies in their role of establishing content criteria that, in conjunction with other criteria related to the way in which these indicators are expressed, allow us to detect change moments through observation.

The four research questions that set the framework for this study on change indicators address (a) the frequency of in-session and extrasession change moments during the therapeutic process; (b) the predominant types of change indicators that occur during the therapeutic process; (c) whether these indicators are indeed generic in the sense that they can be observed in different forms of therapy and whether some of them are less generic than others and thus more characteristic of certain forms of therapy; (d) whether the change indicators indeed occur in the theoretically established sequence (i.e., from those of less hierarchy in the early therapeutic process to those more highly ranked toward the end) and whether this evolution can be related to therapeutic success.

## Method

### Participants

The study sample included 100 psychotherapeutic sessions conducted in Chile, corresponding to five brief psychotherapeutic processes: three individual psychodynamic therapies (23 sessions, 18 sessions, and 21 sessions); a social constructionist family therapy (20 sessions)[1]; and one group therapy of a comprehensive nature (with behavioral–cognitive elements) for patients undergoing treatment for drug addiction (18 sessions).[2] In total, results from the therapeutic processes of 10 patients were collected. The therapists included women and men with 10 to 30 years of professional experience. Table I displays the basic data of the therapies studied.

### Instruments

*Indicators of generic psychotherapeutic change*. To qualify the changes observed in the therapy, we used the ideal sequence of successive changes described in the literature (see prior review) and transformed them into an ordered list, or hierarchy, of change indicators. This hierarchy was generated and validated in two of the authors' previous work (Arístegui

Table I. Analyzed Therapies: Patient Information

| Therapy | Sex | Age (yr) | Occupation | Marital status | Focus of therapy |
|---|---|---|---|---|---|
| I. Psychodynamic–individual | F | 29 | Med. tech | Married | Decrease anxiety stemming from separation; strengthen autonomy; favor the expression of emotional needs |
| II. Psychodynamic–individual | F | 38 | Teacher | Separated | Development of mourning for separation and recent losses |
| III. Social constructionist–family | F | 38 | Sales | Separated | Resolution of conflicts between mother and son and between the parents |
| IV. CB–drug abuse group | M | 19 | Student | Single | Recognition of addiction; strengthening ability to set limits; identification of situations of risk |
| | M | 23 | Unemployed | Single | |
| | M | 32 | Physician | Single | |
| | M | 34 | Sales | Single | |
| | M | 36 | Computer tech | Married | |
| | M | 52 | Professor | Married | |
| V. Psychodynamic–individual | F | 43 | School principal | Married | Expression of needs; strengthen autonomy; increase quality of relationships |

*Note.* CB = cognitive–behavioral.

et al., 2004; Krause, 2005). Empirical validation has been conducted with qualitative methodology, including triangulation and coding by multiple coders (for more details see Procedures section). Indicators are as follows (listed from lesser to greater hierarchical level):

1. Acceptance of the existence of a problem
2. Acceptance of his or her limits and of the need for help
3. Acceptance of the therapist as a competent professional
4. Expression of hope ("morale boost" or "remoralization," the expectation of being helped or being able to overcome the problems)
5. Questioning of habitual understanding, behavior, and emotions ("opening up"; may imply the recognition of problems previously ignored, self-criticism, and the redefinition of therapeutic expectations and goals)
6. Expression of the need for change
7. Recognition of his or her own participation in the problems
8. Discovery of new aspects of self
9. Manifestation of new behavior or emotions
10. Appearance of feelings of competence
11. Establishment of new connections among aspects of self (e.g., beliefs, behavior, emotions); aspects of self and the environment (persons or events); aspects of self and biographical elements
12. Reconceptualization of problems or symptoms
13. Transformation of valorizations and emotions in relation to self or others
14. Creation of subjective constructs of self through the interconnection of personal aspects and aspects of the surroundings, including problems and symptoms
15. Founding of the subjective constructs in own biography
16. Autonomous comprehension and use of the context of psychological meaning
17. Acknowledgment of help received
18. Decreased asymmetry between patient and therapist
19. Construction of a biographically grounded subjective theory of self and of his or her relationship with surroundings (global indicator)

*Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996)*. This instrument was developed, validated, and widely used in the United States and is able to register differences between population and psychopathological samples and among levels of psychopathology. Sensitivity to change has been demonstrated in United States, Germany, Canada, Chile, Argentina, and other countries. Patient progress is measured along three dimensions: subjective discomfort (SD), interpersonal relationships (IR), and social role performance (SR). The OQ-45.2 was adapted and validated for the Chilean context (de la Parra & von Bergen, 2001; de la Parra, von Bergen, & del Río, 2002; von Bergen, 2000).

## Procedures

*Qualitative process analysis*. Change moments were established through a two-step qualitative procedure. All raters were therapists with different theoretical orientations. On the basis of the hierarchy of generic CIs and their descriptions, two independent trained raters coded change moments by means of direct observation of each of the 100 psychotherapeutic sessions through a one-way mirror. At the end of each session, the raters compared their coding of change moments. If the two raters did not reach agreement, the session was taken to a second coding step. In this second step, each session was analyzed by a team of eight to 10 trained raters using videotapes and transcripts. The coding was conducted with all raters in the room at the same time. During these meetings, the team subjected change moments to intersubjective validation (i.e., reaching an agreement or consensus about the change moments and indicators through discussion, a procedure similar to the CQS method; Hill et al., 1997). To privilege possible false-negative results over false-positive results, change moments on which the group could not come to consensus were eliminated. Thus, a change moment was coded only when the complete team reached agreement on its existence and quality. No reliability coefficients were calculated because all sessions were at least double-coded, and agreement was a requisite for every CI registered.

During the initial coding stages, it became evident that some aspects of change moments produced greater disagreement between raters. To address these issues, some strict criteria for the identification of change moments were established. As a result, change moments had to fulfill the following criteria in order to be identified as such:

Theoretical correspondence: Change agrees with the contents of a generic change indicator.

Verifiability: Change is observed in the session (or, in the case of an extrasession change, it is mentioned during a session and an explicit reference is made to therapy).

Novelty: The specific content of change manifests for the first time.

Consistency: Change is consistent with nonverbal communication and is not denied later in the session or the therapy.

On the basis of these four criteria and on the descriptions of the CIs contained in the hierarchy, the research group identified and then coded all the in-session and extrasession change moments for each therapy under study, following the procedure described previously.

*Quantitative outcome analysis*. Lambert et al.'s (1996) OQ-45.2 was applied to all clients at the beginning and at the end of the process. The total and domain scores were calculated in accordance with Chilean norms. A high total score indicates that the patient reported a high discomfort in quality of life as expressed in symptoms, interpersonal relationships, and social role. In the Chilean validation process, the following normative data were established:

Cutoff score (CS = 73): derived by comparing a sample from the community (general population) and clinical samples; the CS separates the functional from the dysfunctional group.

Reliable change index (RCI = 17): indicates whether the change is reliable, which means that it is beyond the sample scoring error.

Change is considered clinically significant for a patient if the final score is below the CS and the difference between initial and final scoring is above the RCI (Jacobson & Truax, 1991).

## Results

### OQ and Change Indicators in the Different Therapies

Figure 1 through 6 show the evolution of in-session and extrasession change indicators during the therapeutic process. The *x*-axis of each scatter plot contains the session number. The *y*-axis represents the level of the change indicator in the hierarchy. For instance, Indicator 3 (acceptance of the therapist as a competent professional) is hierarchically low (i.e., expected to appear early in therapy), whereas Indicator 15 (founding of the subjective constructs in own biography) is hierarchically higher and is expected to appear later. The patient's initial and final OQ scores are reported in each figure.

### Outcome and Change Indicators in Therapy I

According to OQ score differences, the Therapy I patient shifts from the dysfunctional to the functional range under the cutoff score (73), showing a difference of 44 points between the first and the second assessments, far more than the RCI (17). Therefore, she presents a significant clinical change.

As seen in Figure 1, the patient shows a tendency to begin therapy with low-hierarchy CIs that grow to high-hierarchy CIs as the process develops. Furthermore, a high OQ score at the beginning of the therapy coincides with the appearance of early CIs in this period, whereas a lower OQ score at the end of therapy is accompanied by the appearance of higher level CIs. At the same time, in the later phase of therapy, we also see a greater frequency of extrasession change indicators.

### Outcome and Change Indicators in Therapy II

The Therapy II patient began therapy under the OQ cutoff score. This is consistent with the patient's history because, before psychotherapy, she had been taking medication for several weeks. Nevertheless, the patient shows an improvement over the RCI during therapy. Visual inspection of Figure 2 shows that this patient starts therapy with higher CIs than the Therapy I patient, which is consistent with a lower OQ score at the beginning of therapy. The hierarchical level of change indicators for this patient continues to

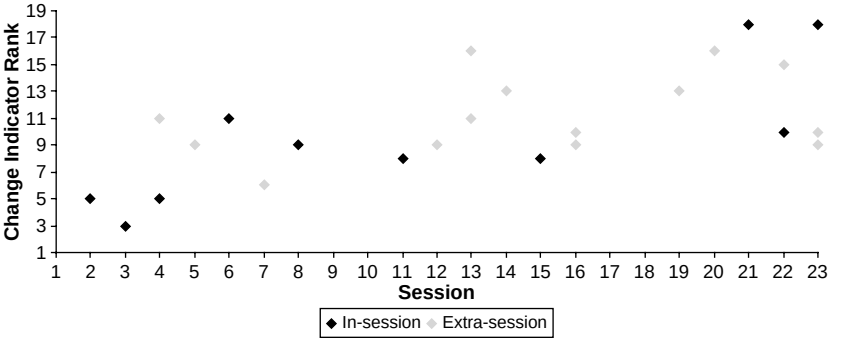


Figure 1. Evolution of change indicators for Therapy I: psychodynamic (beginning Outcome Questionnaire [OQ] = 115, final OQ = 71). Note that not all change indicators are visible because of overlapping of data points.

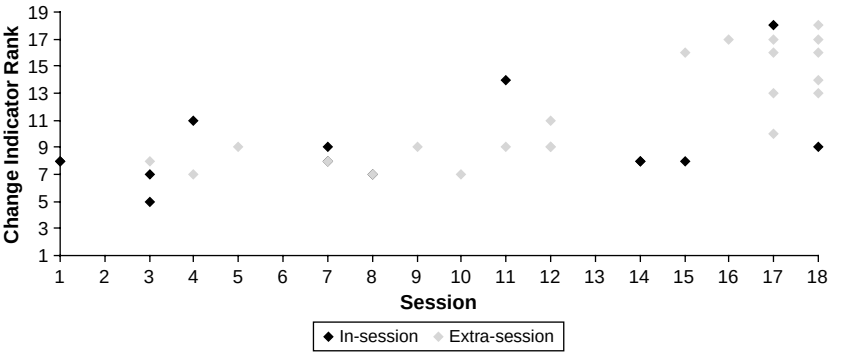


Figure 2. Evolution of change indicators for Therapy II: psychodynamic (beginning Outcome Questionnaire [OQ] =68, final OQ =48.4). Note that not all change indicators are visible because of overlapping of data points.

increase as therapy progresses, which is also consistent with the reliable OQ change. As in the previous therapy, there is also growing frequency of extrasession changes as therapy comes close to the end.

## Outcome and Change Indicators in Therapy III

Change indicators in Therapy III are shown in Figure 3. In this social constructionist family therapy, the mother, the father, and their 11-year-old son were treated. Because the boy and the father only attended the sessions intermittently and then abandoned therapy, only the OQ results of the mother are shown.

The patient began therapy far under the cutoff score, showing no significant change in the OQ. Although initial OQ score is high, the patient shows almost no change indicators in the first seven sessions (only one CI in Session 1). It is worth noting that, at the beginning, the patient came to therapy "because of her child's problems" without acknowledging herself as patient. She only explicitly assumes the role of patient in Session 8, in which two change indicators appear. The relatively high level of these two CIs is consistent with the patient's low starting OQ score.

## Outcome and Change Indicators in Therapy IV

The drug abuse therapy was an open group, and when observation was initiated, the patients were in different stages of their respective therapeutic processes. As a result, important differences in the OQ scores are seen in patients who have been under treatment longer versus those who have attended the group for only a couple of weeks (Figure 4).

Figures 4 and 5 show the evolution of change indicators in Therapy IV for individual patients and for the group as a whole, respectively. Despite the fact that it is an open group, Figure 5 shows the appearance of mostly in-session change indicators at the beginning of the observation period. Afterward, extrasession change indicators begin to appear, and the in-session indicators disappear. When looking at Figure 4, however, we can observe that the impression of more in-session CIs at the beginning of the observation period is driven mostly by Patient 4, whose entrance to the group coincided with the beginning of observation.

The overall low quantity of in-session indicators probably is due to the fact that patients attended other therapies at the same time. This eventually produced a dilution of indicators among therapies.

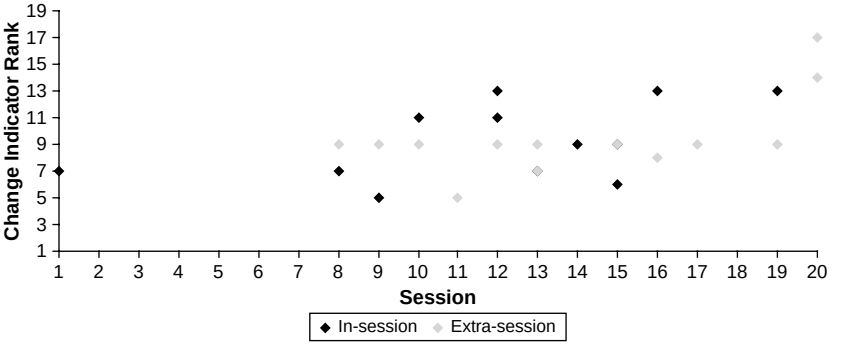


Figure 3. Evolution of change indicators for Therapy III: social constructionist family–mother (beginning Outcome Questionnaire [OQ] = 47, final OQ =55). Note that not all change indicators are visible because of overlapping of data points.

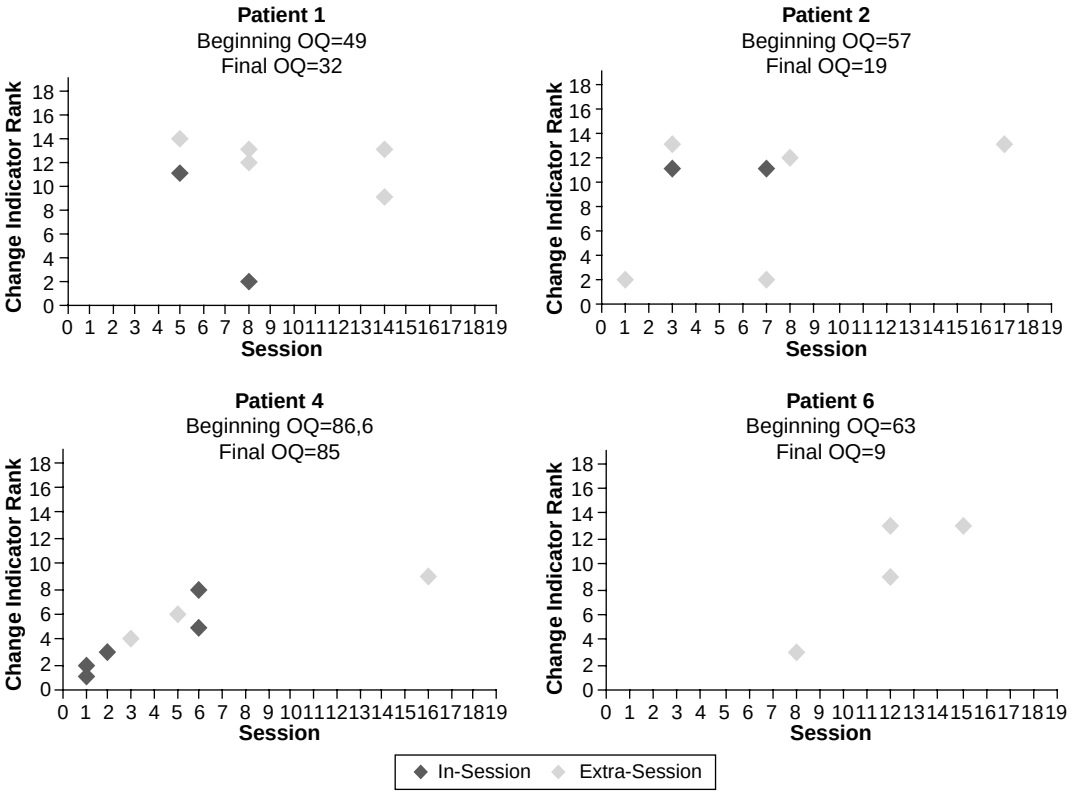


Figure 4. Evolution of change indicators (CI) for patients in Therapy IV: drug abuse group. Only patients with more than one CI are shown. Patient 3 showed an extrasession CI of Level 1 in Session 10, and Patient 5 showed an extrasession CI of Level 13 in Session 2. Not all change indicators are visible because of overlapping of data points.

Figure 5 also suggests a progression from lower level CIs at the beginning of the observation period toward higher level CIs at the end. Part of this is driven mainly by Patient 4, because the first two sessions included the hierarchically low change indicators of this patient, who had been recently incorporated into the group when observation started.

## Outcome and Change Indicators for Individual Patients in Therapy IV

Both the OQ scores and the hierarchical levels of the CI appear to be related to the length of time the patients have been in therapy. A newer patient, such as Patient 4, who had only been participating in the group for 2 weeks when observation commenced, displays lower change indicators and a higher OQ score in comparison with Patient 1, who had been in therapy for a year.

With regard to the results for each individual patient, we note that Patient 1, who had begun therapy a year before the observation period commenced, shows an initial OQ score under the cutoff but improvement above the RCI. This result is coherent with the appearance of hierarchically higher CIs. In this case, once again, extrasession

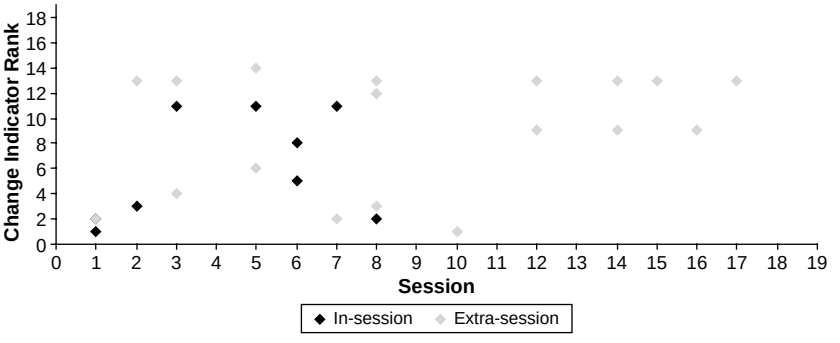


Figure 5. Evolution of change indicators for Therapy IV as a whole: drug abuse group. Note that not all change indicators are visible because of overlapping of data points.

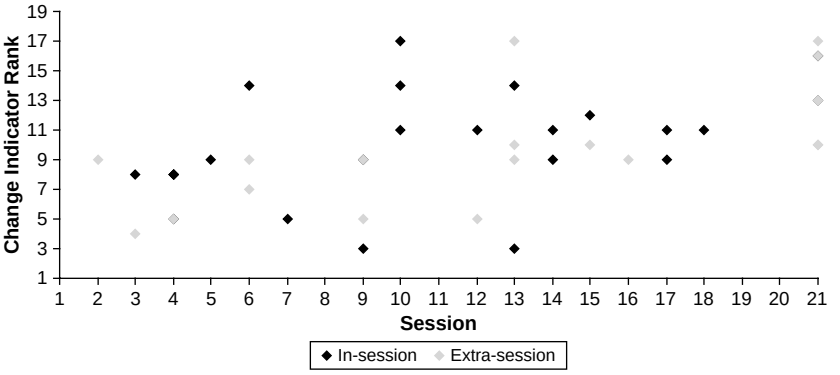


Figure 6. Evolution of change indicators for Therapy V: psychodynamic (beginning OQ = 111, final OQ = 91). Note that not all change indicators are visible because of overlapping of data points.

indicators are more frequent in later stages of therapy.

In the case of Patient 2, who had been participating in the group therapy for 8 months when observation commenced, the OQ scores are in the functional range, but they show a difference above the RCI. This demonstrates, at the beginning of the observation, the positive effects of a treatment already underway, which are further complemented by a process of change during the period observed. Once again, indicators higher in the hierarchy appear in these later stages of treatment, along with a low OQ score.

Patient 4 had been in therapy for only 2 weeks before the observation started. Regarding the OQ scores, he began and ended the observation period in the dysfunctional range without a significant change. Consequently, he shows mostly early, low-hierarchy CIs. Late in the observation period, an extrasession CI appears. High OQ scores and low-hierarchy CI in this patient are consistent with a therapeutic process that is just beginning.

Finally, Patients 3, 5, and 6 show recovery rates above the RCI, but only Patient 3, recently included in the group, changes from a dysfunctional to a functional range. Because they had been in therapy longer, the other two patients show OQ scores under the cutoff score at the beginning of the observation period.

It is also noteworthy that Patient 6 displays two higher CIs—Indicator 9 (manifestation of new behavior or emotions) and Indicator 13 (transformation of valorizations and emotions in relation to self or others)—and Patient 3, the new participant, shows an early extrasession change moment, corresponding to Indicator 3 (acceptance of the therapist as a competent professional). For Patient 5, who had a low OQ score comparable to the normal population, only an extrasession CI was registered during this period.

## Outcome and Change Indicators in Therapy V

The patient in Therapy 5 began her process with OQ scores above the cutoff, and even though this score did not decrease enough to fall within normal limits, the difference between the initial score and the final score (20 points) is greater than the RCI (17 points).

With regard to CIs, Figure 6 shows two moments in which the hierarchical level of the indicators increase: one toward the middle of the therapy (Session 13) and another toward the end. As in the other cases studied, the extrasession indicators are concentrated closer to the conclusion of therapy.

## Distribution of In-Session and Extrasession Change Indicators Throughout the Therapy

To examine the occurrence of change throughout the therapy, the number of change indicators at the beginning and end of therapy was compared using *t* tests. Beginning and end of therapy were defined as the first and last three sessions, respectively, and the average number of CIs in the beginning and end periods was compared separately for in-session and extrasession CIs. In this analysis, the cases correspond to the sessions, and the number of CIs present in sessions belonging to either beginning or end of therapy is the score being compared. Sessions in which no change had occurred received a score of 0. Table II shows the mean number of in- and extrasession CIs observed at the beginning and end of therapy. As observed in Table II, the difference in the number of extrasession change indicators is significant, $t(28) = -2.4$, $p = .023$, with more extrasession change indicators occurring toward the end of therapy. The number of in-session change indicators, on the other hand, is lower at the end of the therapy than at the beginning, but this difference is not statistically significant.

Table II. Number of Change Indicators at the Beginning and End of Therapy

| | Beginning of therapy[a] | | | End of therapy[b] | | | |
|---|---|---|---|---|---|---|---|
| Variable | *M* | *SD* | No. sessions | *M* | *SD* | No. sessions | *t* |
| In-session change indicators | 0.87 | 0.74 | 15 | 0.53 | 0.64 | 15 | 1.03 |
| Extrasession change indicators | 0.47 | 0.64 | 15 | 1.53 | 1.59 | 15 | −2.40* |

[a]First three sessions. [b]Last three sessions.
*$p < .05$.

## Frequency of Each Type of Change Indicator

The frequency of each CI in each type of therapy and across all three types is shown in Tables III and IV. According to Table III, the most common in-session change indicators across therapies are Indicator 8 (discovery of new aspects of self) and Indicator 11 (establishment of new connections among aspects of self [e.g., beliefs, behavior, emotions), aspects of self and the environment [persons or events], and aspects of self and biographical elements). The most frequent extrasession indicators are Indicator 9 (manifestation of new behavior or emotions) and Indicator 13 (transformation of valorizations and emotions in relation to self or others). Indicators 4, 15, and 19 were never observed in any session of these five therapies, whereas Indicators 3 and 19 were absent outside of the session.

## Distribution of Change Indicators in the Different Types of Therapy

As shown in Tables III and IV, the different types of CIs do not seem to be distributed randomly across the three types of therapy. With regard to the in-session CIs (see Table III), in the psychodynamic therapies, the following indicators predominate: 8 (discovery of new aspects of self), 9 (manifestation of new behavior or emotions), and 11 (establishment of new connections). In the constructionist therapy, the most frequent change indicators are 7 (recognition of own participation in the problems) and 13 (transformation of valorizations and emotions in relation to self or others) in addition to 9 and 11. In the group therapy, Indicators 11 (establishment of new connections among aspects of self, aspects of self and the environment, aspects of self and

Table III. Frequency of the Type of In-Session Change Indicators in Different Types of Therapy and Across All Therapy Types

| Change indicator | PD | SC | GT | Total |
|---|---|---|---|---|
| 1. Acceptance of the existence of a problem | 0 | 0 | 1 (11%) | 1 (1.45%) |
| 2. Acceptance of "limits" and of the need for help | 0 | 0 | 2 (22%) | 2 (2.90%) |
| 3. Acceptance of the therapist as a competent professional | 3 (6%) | 0 | 1 (11%) | 4 (5.80%) |
| 4. Expression of hope | 0 | 0 | 0 | 0 |
| 5. Questioning of habitual understanding, behavior, and emotions ("opening up") | 5 (11%) | 1 (8%) | 1 (11%) | 7 (10.14%) |
| 6. Expression of the need for change | 0 | 1 (8%) | 0 | 1 (1.45%) |
| 7. Recognition of own participation in the "problems" | 2 (4%) | 3 (25%) | 0 | 5 (7.25%) |
| 8. Discovery of new aspects of self | 12 (25%) | 0 | 1 (11%) | 13 (18.84%) |
| 9. Manifestation of new behavior or emotions | 7 (15%) | 2 (17%) | 0 | 9 (13.04%) |
| 10. Appearance of feelings of competence | 1 (2%) | 0 | 0 | 1 (1.45%) |
| 11. Establishment of new connections | 7 (15%) | 2 (17%) | 3 (34%) | 12 (17.39%) |
| 12. Reconceptualization of problems and/or symptoms | 1 (2%) | 0 | 0 | 1 (1.45%) |
| 13. Transformation of valorizations and emotions | 1 (2%) | 3 (25%) | 0 | 4 (5.80%) |
| 14. Creation of subjective constructs of self | 4 (8%) | 0 | 0 | 4 (5.80%) |
| 15. Founding of the subjective constructs in own biography | 0 | 0 | 0 | 0 |
| 16. Autonomous comprehension and use of the context of psychological meaning | 1 (2%) | 0 | 0 | 1 (1.45%) |
| 17. Acknowledgment of help received | 1 (2%) | 0 | 0 | 1 (1.45%) |
| 18. Decreased asymmetry between patient and therapist | 3 (6%) | 0 | 0 | 3 (4.34%) |
| 19. Construction of a biographically grounded subjective theory of self | 0 | 0 | 0 | 0 |
| Total | 48 (70%) | 12 (17%) | 9 (13%) | 69 (100%) |

*Note.* PD = psychodynamic; SC = social constructionist; GT = group therapy.

Table IV. Frequency of Extrasession Change Indicators in Different Types of Therapy and Across All Therapy Types

| Change indicator | PD | SC | GT | Total |
|---|---|---|---|---|
| 1. Acceptance of the existence of a problem | 0 | 0 | 1 (5.6%) | 1 (1.16%) |
| 2. Acceptance of "limits" and of the need for help | 0 | 0 | 3 (16.6%) | 3 (3.49%) |
| 3. Acceptance of the therapist as a competent professional | 0 | 0 | 0 | 0 |
| 4. Expression of hope | 1 (1.8%) | 0 | 1 (5.6%) | 2 (2.32%) |
| 5. Questioning of habitual understanding, behavior, and emotions ("opening up") | 3 (5.5%) | 1 (7.6%) | 0 | 4 (4.65%) |
| 6. Expression of the need for change | 1 (1.8%) | 0 | 1 (5.6%) | 2 (2.32%) |
| 7. Recognition of own participation in the "problems" | 4 (7.3%) | 1 (7.6%) | 0 | 5 (5.81%) |
| 8. Discovery of new aspects of self | 2 (3.6%) | 1 (7.6%) | 0 | 3 (3.49%) |
| 9. Manifestation of new behavior or emotions | 14 (25.0%) | 8 (62.0%) | 3 (16.6%) | 25 (29.10%) |
| 10. Appearance of feelings of competence | 7 (13.0%) | 0 | 0 | 7 (8.14%) |
| 11. Establishment of new connections | 3 (5.5%) | 0 | 0 | 3 (3.49%) |
| 12. Reconceptualization of problems and/or symptoms | 0 | 0 | 1 (5.6%) | 1 (1.16%) |
| 13. Transformation of valorizations and emotions | 6 (11.0%) | 0 | 7 (38.8%) | 13 (15.12%) |
| 14. Creation of subjective constructs of self | 1 (1.8%) | 1 (7.6%) | 1 (5.6%) | 3 (3.49%) |
| 15. Founding of the subjective constructs in own biography | 1 (1.8%) | 0 | 0 | 1 (1.16%) |
| 16. Autonomous comprehension and "use" of the context of psychological meaning | 6 (11.0%) | 0 | 0 | 6 (6.97%) |
| 17. Acknowledgment of help received | 5 (9.1%) | 1 (7.6%) | 0 | 6 (6.97%) |
| 18. Decreased asymmetry between patient and therapist | 1 (1.8%) | 0 | 0 | 1 (1.16%) |
| 19. Construction of a biographically grounded subjective theory of self | 0 | 0 | 0 | 0 |
| Total | 55 (63.0%) | 13 (15.0%) | 18 (21.0%) | 86 (100%) |

*Note.* PD = psychodynamic; SC = social constructionist; GT = group therapy.



biographical elements) and 2 (acceptance of "limits" and of the need for help) are the most common. Clearly, Indicator 11 is the most generic in that it appears the most often among the three types of therapy.

On the other hand, as shown in Table IV, in the way of extrasession changes, among the psychodynamic therapies, the most common change indicators are 9 and 10 (manifestation of new behavior or emotions and appearance of feelings of competence, respectively) and 13 and 16 (transformation of valorizations and emotions in relation to self or others and autonomous comprehension and use of the context of psychological meaning, respectively). In the constructionist therapy, Indicator 9, and in the group therapy with drug addicts, Indicators 2, 9, and 13 are most common.

Therefore, the most clearly generic indicator in extrasession changes is Indicator 9 (manifestation of new behavior or emotions). Finally, Indicators 2, 9, and 13 predominate as indicators in both the in- and extrasession changes, whereas Indicators 10 and 16 only appear in the extrasession changes.

## Distribution of the Level of Change Indicators in Different Stages of the Therapeutic Process

To test our hypothesis regarding the evolution of the level of CIs from the beginning to the end of therapy, two approaches were used. In the first approach, we compared the level of CIs in the beginning and end periods of therapy (as in the previous analysis, beginning and end of therapy were defined as the first and last three sessions, respectively). In the second approach, Spearman correlation coefficients were computed between session and level of CI for each therapy.

For the first analysis, nonparametric tests for ordered data (Mann-Whitney *U*) were used to test

Table V. Level of Change Indicators at the Beginning and End of Therapy

| | Rank | | | | | | |
|---|---|---|---|---|---|---|---|
| | Beginning of therapy[a] | | | End of therapy[b] | | | |
| Variable | *M* | Sum | *N* | *M* | Sum | *N* | *U* |
| Level of in-session change indicators | 6.67 | 80 | 12 | 16.25 | 130 | 8 | 2.00*** |
| Level of extrasession change indicators | 6.57 | 46 | 7 | 18.22 | 419 | 23 | 18.00*** |

[a]First three sessions. [b]Last three sessions.
***$p < .001$.

Table VI. Spearman's ρ Between Session and Change Indicator Rank in Four of the Five Therapies[a]

| Therapy | In session[b] | *N* | Extrasession[b] | *N* |
|---|---|---|---|---|
| I. Psychodynamic | 0.783** | 10 | 0.255 | 14 |
| II. Psychodynamic | 0.439 | 14 | 0.834*** | 22 |
| III. Social constructionist | 0.450 | 12 | 0.655* | 12 |
| V. Psychodynamic | 0.525** | 24 | 0.775*** | 19 |

[a]Therapy IV was excluded because of lack of sufficient change indicators per patient. [b]Spearman ρ between session and change indicator. *$p < .05$. **$p < .01$. ***$p < .001$.

the hypothesis that change indicators were of a higher level at the end than at the beginning of therapy. Comparisons were conducted taking into account only those sessions in which change indicators were registered. Table V shows mean ranks for in-session and extrasession change indicators. As shown in Table V, in both cases change indicators are of significantly higher levels at the end than at the beginning of therapy ($U_{\text{in session}} = 2.00$, $p = .000$; $U_{\text{extrasession}} = 18.00$, $p = .001$).

For our second approach, we computed the Spearman correlation coefficient between the session number and the level of CIs observed. Table VI shows the results from this analysis. All therapies show significant Spearman correlation coefficients between CI level and session. However, only for Therapy V is this correlation significant for both in-session and extrasession CIs. In Therapy I only the correlation between in-session CI level and session is significant, whereas in Therapies II and III only the coefficient for extrasession CIs is significant (Therapy IV was excluded because of lack of sufficient CIs per patient).

## Discussion

Four research questions guided our study: What is the frequency of in-session and extrasession change moments during the therapeutic process? What are the predominant change indicators observed during the therapeutic process? Are the change indicators generic, or are there significant differences in the frequency of each change indicator across the different therapies? How do change indicators evolve over the course of treatment, and how is this evolution related to therapeutic outcome?

Our first research question was related to the frequency of change moments, identified and then labeled with the corresponding change indicator. Results revealed 69 in-session change moments and 86 extrasession change moments during the period studied (100 sessions). The rigorous methodology used to include the change moments should be kept in mind: Possible change moments that were questioned to any degree were not included to minimize the chance of false-positive results.

There was at least one observable moment of change in every other session in addition to nearly two other extrasession change moments. As well as supporting the long-standing notion that the therapeutic process is not homogenous (Bastine et al., 1989), this finding sheds light regarding how many of these special moments of discontinuity—small qualitative surges forward in the process of change—we can expect to occur. In this regard, it is also interesting to examine when they do not occur. The case of the Therapy III patient is a particularly intriguing example. During the first third of the therapy, this patient demonstrated almost no change moments, and only when the therapeutic contract changed—when the patient consciously accepted her role as a patient, which she had previously reserved for her son alone—did she evidence change moments.

With regard to the distribution of the change indicators throughout the therapy, in general, we observed a homogenous distribution of these indicators throughout the processes, with the exception of Therapy III. Nonetheless, when this study commenced, we wondered whether there was a difference between the early stages of therapy versus the final stages with regard to the frequencies of the change moments in session and those that took place out of session. Specifically, we hypothesized that the extrasession change moments would increase toward the conclusion of therapy, at least in successful therapeutic processes. The number of extrasession indicators reveals not only the well-known fact that the therapeutic process also takes place beyond the therapeutic setting, but that this phenomenon increases as therapy progresses. Our hypothesis was based on earlier findings demonstrating that this evolution progresses toward greater autonomy (Krause, 2005), which also would be reflected in internalized representations from the therapist to which the patient would have recourse during problematic situations (Geller & Farber, 1993). Indeed, the results of the present study suggest that, in the final stages of therapy, there is a

predominance of extrasession indicators compared with the earlier stages, which also supports our earlier findings.

As for our second research question—the identification of the predominant type of change indicator—this is a theoretically relevant issue, because some of these indicators have greater conceptual significance than others in the theory of subjective change on which this study is based. Our findings revealed the most common in-session change indicators to be 8, (discovery of new aspects of self) and 11 (establishment of new connections among aspects of self [e.g., beliefs, behavior, emotions], aspects of self and the environment [persons or events], and aspects of self and biographical elements). Clearly, these indicators are central to the theory of subjective change, which proposes that the essence of psychotherapeutic change is a transformation in the subjective patterns of interpretation and explanation that leads to the development of new subjective theories (Krause, 2005) and that these subjective theories are composed of sets of interconnected elements and refer essentially to oneself. These change indicators also are in keeping with other theoretical positions that use different concepts, such as frames of reference (Duncan & Moynihan, 1994), personal constructs (Anderson, 1997b), or rewriting of aspects of one's own life story (McLeod, 1998; McLeod & Balamoutsou, 1996), to address similar changes.

With regard to the extrasession indicators, the most frequent are Indicators 9 (manifestation of new behavior or emotions) and 13 (transformation of valorizations and emotions in relation to self or others). The former is a behavioral change and, therefore, quite fitting in an extrasession context; indeed, this change indicator would be much less likely to appear in session because of the conditions inherent in the clinical setting. We can hypothesize, however, that this change indicator reveals the repercussion of what happens in therapy. On the other hand, the latter change indicator is more appropriately described as representational (Fonagy, 2001) and, therefore, is in keeping with the theory of subjective change (Krause, 2005).

However, to fully address the theoretical coherence of these finding, we must address our third question regarding the generic nature of the indicators, as Orlinsky and Howard (1987) have used this term, or their commonality, in keeping with the study of common factors (Maione & Chenail, 1999). Which indicators appear most often and, at the same time, are shared by the different therapies? Or do therapy types differ regarding the indicators that appear more frequently? Although it may at first appear contradictory, our results provided evidence supporting both of these questions. Therapy types indeed differ in the frequency of different changes indicators; some in-session and extrasession indicators are more common for some types of therapy. However, despite the differences among the therapies, we found some change indicators that are extremely frequent in all three types of therapy studied. From these, the most common (i.e., most generic) change indicator for in-session change was Indicator 11, (establishment of new connections among aspects of self [e.g., beliefs, behavior, emotions], aspects of self and the environment [persons or events], and aspects of self and biographical elements), whereas the most generic extrasession indicators (for the three types of therapy) was Indicator 9 (manifestation of new behavior or emotions). The common in-session indicator provides significant support for the theory of subjective change as a generic model of psychotherapeutic change. However, because of its behavioral nature, the generic extrasession indicator is less closely linked to this theoretical model.

With regard to differences among the therapies, given that in two types of therapy we only had data for one patient, it would be premature to draw conclusions about the specific indicators for these therapies. Furthermore, many change indicators had overall low frequencies, which limited our possibility of testing the significance of frequency differences between the three therapeutic approaches. Thus, the matter of the distribution of change indicators in different types of therapies deserves further exploration in future research.

Finally, we addressed the issue of the evolution of the indicators through the therapeutic process and its relation to the therapeutic outcome. Our original query, based on an understanding of change as the progressive evolution of change moments of increasing complexity, was "To what extent do the data from the real therapies, of different types, follow the theoretically ideal sequence for successful therapy?" Given the limited number of therapeutic processes available for study at this time, we simplified our question and examined only whether the hierarchic level of the change indicators from the beginning of the processes differed from those that appear toward the end of therapy.

As discussed in detail in the Results section, low-hierarchy change indicators appeared in the initial stages of therapy, whereas those higher in the hierarchy appeared in the final stages regardless of whether they manifested during the therapeutic session or outside of it. In other words, the hierarchical level of the change indicators depends on the moment in the evolution of the therapeutic process observed: the later the moment, the higher

the indicator. Nonetheless, a qualitative analysis of each therapy reveals that this evolution is not linear; rather, we see "advances and retreats," which can be explained by specific contingencies in the therapy.

Triangulation of the results of the OQ with the change indicators suggests that high OQ scores at the beginning of the therapy are associated with the appearance of low CIs in this period. On the other hand, lower OQ scores at the beginning of the therapy are accompanied by hierarchically higher CI. At the end of therapy, when in most cases we find lower OQ scores, we also find higher change indicators. However, in this study, it is impossible to establish a systematic relationship between therapeutic success measured with OQ scores and progression in CI level throughout the therapy because of the small number of therapies observed. Furthermore, the variability of therapeutic outcomes in this study was rather small, because only one patient in the sample started and ended therapy in the dysfunctional range (Patient 4 from the drug abuse group therapy). A study of the relationship between CI evolution and therapeutic outcome measured through OQ scores will require a wider range of therapeutic outcomes.

If we analyze the content of change, we find that in the initial stages of the therapeutic processes, the most frequent change indicator in the various types of therapy is Indicator 5, (questioning of habitual understanding, behavior, and emotions ["opening up"]). In relation to the theoretical foundation of the present study, this indicator marks the beginning of therapeutic change as such, because it constitutes the first step in the much later construction of new subjective theories regarding oneself, a process that demands an initial questioning of one's own understanding, as evidenced in earlier works by Karasu (1986), Krause (1992b), and Märtens (1991). Also appearing in the different types of therapies, but much less frequently, is Indicator 7 (recognition of own participation in the problems). This shift in the locus of control also is evident in the statements of the patients during the change moments, which are notable for their self-referential content, as described in the study by Arístegui et al. (2004).

Other indicators that appear frequently at the beginning of therapy, but in particular in the drug abuse group therapy, are Indicators 1 (acceptance of the existence of a problem), 2 (acceptance of "limits" and of the need for help), and, to a lesser degree, 3 (acceptance of the therapist as a competent professional). It should be kept in mind that, because this is an open group, these indicators do appear in the beginning of the period of observation, but they correspond, specifically, to patients who have recently joined the group. That these very low-hierarchy change indicators only appeared in this therapy is consistent with the fact that the patients of the group therapy, unlike many of those undergoing individual therapy, have no prior experience with or understanding of psychotherapy and often are brought to therapy by close family members, somehow against their own will. So it is not unusual that, in their case, we see indicators during therapy that other patients have already experienced before beginning the therapeutic relationship, as reported elsewhere (Krause, 1993, 2005; Krause et al., 1994; Yokopenic, Clark, & Aneshensel, 1983). Finally, exclusively in Therapy V, in the first sessions, we note the early appearance of Indicator 8 (discovery of new aspects of self), which was one of the central issues addressed in this therapy regarding the patient's tendency toward denial or to forget difficult experiences.

In sum, these findings can be interpreted as revealing two conditions under which therapy begins: one in which certain requirements already have been met and, therefore, the therapy can begin immediately with the patient questioning his or her understanding of the problems, including the locus of control that emphasizes the patient's participation in the problems or the discovery of new aspects of self; and another for patients who have less experience with or understanding of therapy and who are more reluctant participants, which means first creating the conditions for the realization of representational changes, such as accepting that one has a problem, that the possibilities of confronting the problem oneself have been exhausted (Krause, 2005), and that the therapist is a competent professional, capable of providing help.

In the middle stage of the therapies, a greater variety of indicators appear. Nonetheless, the two most recurrent indicators are 7 (recognition of own participation in the "problems") and 9 (manifestation of new behavior or emotions), both of which are not exclusive to this stage, because the first is frequent in the beginning stages and the latter in the final stages. This allows us to hypothesize that the middle stage of the therapies is less specific than both the beginning and the conclusion of therapy, as revealed by the type of indicator that appears most frequently.

In the final stage, the most recurrent indicators, in the different types of therapy, are 9 (manifestation of new behavior or emotions) and 3 (transformation of valorizations and emotions in relation to self or others). Somewhat less frequent are Indicators 17 (acknowledgment of help received) and 18 (decreased asymmetry between patient and therapist). The frequency of the first two is due to the predominance of the extrasession indicators in the

final stages of the therapies (as discussed previously). The other indicators are related directly to the conclusion of successful therapeutic processes, in which the patient expresses thanks for the help received (although not all of them manifest this as the sudden acknowledgment implied in a change moment) and gains greater autonomy, with the result being a less asymmetric relationship.

Indicator 19 (construction of a biographically grounded subjective theory of self and of his or her relationship with surroundings [global indicator]), which would be the final and highest ranking indicator in the hierarchy, does not appear in any of the therapies. This is theoretically congruent, because, as a global indicator, inclusive of the prior indicators, such a change would be difficult, if not impossible, to observe in session. To evaluate whether or not this global change is manifested, follow-up interviews would need to be conducted, as shown elsewhere (Krause, 2005), and included in later studies on this topic.

In conclusion, this study shows that generic change indicators are tools that can be applied to study the evolution of therapeutic processes. Generic change indictors also may have a practical use in efforts to monitor ongoing therapies by providing the therapist with feedback on the evolution of change. In this regard, future studies should examine more fully the evolution of change indicators step by step; analyze the therapeutic actions associated with these indicators; undertake further comparisons of different types of therapies and between successful and failed therapies; and, with regard to the practical use of change indicators, evaluate their usefulness as a tool for monitoring the therapeutic process or as self-monitoring instrument for therapists.



## Notes

[1] In this therapy, only the mother's data were used because attendance by the son and the father was minimal and irregular. However, it is worth noting that, despite desertion by two members, the therapy maintained a family focus, because it was centered around family relationships, mostly the relation between the mother and son. Thus, we will continue to refer to it as a "family" therapy.

[2] The group was composed of six patients; individual data were collected for each.

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