ABSTRACT

Title of Dissertation:	WHEN THERAPY RELATIONSHIPS MAKE A DIFFERENCE: CORRECTIVE RELATIONAL EXPERIENCES OF ADULT CLIENTS IN OPEN-ENDED INDIVIDUAL PSYCHOTHERAPY.
	Teresa Chen-Chieh Huang, Doctor of Philosophy, 2015.
Dissertation Directed By:	Professor Clara E. Hill Department of Psychology

The present study examined the antecedents, types, and consequences of Corrective Relational Experiences (CREs), as well as whether these aspects of CREs (antecedents, types, and consequences) differ depending on client attachment anxiety and avoidance. Clients completed a measure of adult attachment (Experiences in Close Relationships scale; ECR; Brennan, Clark, & Shaver, 1998) before starting open-ended, individual psychotherapy at a psychodynamic-interpersonal therapy clinic. After completion of therapy, 31 clients completed post-therapy interviews assessing their therapy experience, including the occurrence and nature of CREs. Interviews were analyzed qualitatively using CQR (Hill, Thompson, & Williams, 1997; Hill et al., 2005; Hill, 2012). Results indicated that CRE antecedents typically included both positive client-therapist relationships as well as difficulties in therapeutic relationships. Therapists typically facilitated CREs by identifying or questioning client behavior patterns, as well as

conveying profound trustworthiness (deep care, understanding, nonjudgmentalness, or credibility). Types of corrective shifts typically involved clients gaining a new understanding of behavior patterns or the therapist/therapy. Consequences of CREs generally included improvements in the therapy relationship, and improvements in the clients' intrapersonal well-being. Clients who did not have CREs variantly wished their therapist's theoretical orientation was a better match, while none of the clients who had CREs did so. Non-CRE clients had lower pre-therapy attachment anxiety and avoidance in comparison to clients who reported CREs. Antecedents, types, and consequences of CREs differed depending on client attachment anxiety and avoidance. Clients with high attachment anxiety seemed to have a greater interpersonal focus (e.g., indicated enacting their maladaptive behavior patterns with therapists prior to the CRE, had CREs focused on understanding clients' behavior patterns) while clients high in attachment avoidance seemed to have a greater intrapersonal focus (reported more client facilitators of CREs, especially deep disclosure prior to CREs, and more reduction in unwanted feelings after CREs). Implications for practice and research are discussed.

WHEN THERAPY RELATIONSHIPS MAKE A DIFFERENCE: CORRECTIVE RELATIONAL EXPERIENCES OF ADULT CLIENTS IN OPEN-ENDED INDIVIDUAL PSYCHOTHERAPY

By

Teresa Chen-Chieh Huang.

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Advisory Committee:

Professor Clara E. Hill, Chair
Professor Jude A. Cassidy
Professor Charles J. Gelso
Professor Mary Ann Hoffman
Professor Matthew J. Miller

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Introduction

Corrective experiences (CEs) are considered a key mechanism of therapeutic change from a wide variety of theoretical perspectives (Alexander & French, 1946; Christian, Safran, & Muran, 2012; Constantino & Westra, 2012; Goldfried, 2012; Hayes, Beck, & Yasinski, 2012; Hill et al., 2012; Sharpless & Barber, 2012). Yet, only a handful of studies have examined CEs, most of which have utilized a broad definition of CEs ("a person comes to understand or experience affectively an event or relationship in a different and unexpected way;" Castonguay & Hill, 2012, p. 5). However, as Sharpless and Barber (2012) pointed out, this definition is so broad that it impinges on other therapeutic constructs, and runs the risk of meaning "everything" (therefore, meaning nothing), resulting in a loss of explanatory power. In order for the meta-construct of CEs to maximize clinical utility, specific mechanisms and strategies for its facilitation must be identified.

Some researchers have suggested that one way to narrow the concept of CEs is to focus on those resulting from or related to therapeutic relationships. The term corrective relational experiences (CREs) has thus been used to denote research on CEs "that occur within the context of, and because of, the therapeutic relationship" (Knox, Hess, Hill, Burkhard, & Crook-Lyon, 2012, p. 191). CREs are defined as specific times in psychotherapy "when the client feels a distinct shift, such that she or he comes to understand or experience affectively the relationship with the therapist in a different and unexpected way, and is thereby [positively] transformed in some manner" (Knox et al., 2012; p. 191). Focusing specifically on CREs rather than CEs allows greater explanatory power (e.g., greater specificity into the mechanisms and predicted outcomes) regarding

the role of the therapeutic relationship in corrective experiences. In the present study, we focus on CREs, particularly the antecedents, nature, and consequences of CREs, as well as whether these aspects of CREs (antecedents, nature, and consequences) differ depending on client attachment type.

Empirical Studies of CREs

Four studies have found that therapist immediacy is associated with clients reporting CREs, although CREs were not the primary focus of these studies (Hill et al., 2008; Hill et al., 2014; Kasper, Hill, & Kivlighan, 2008; Mayotte-Blum et al., 2012). Three of these were case studies (Hill et al., 2008; Kasper et al., 2008; Mayotte-Blum et al., 2012), and the other examined 16 cases (Hill et al., 2014). Immediacy appeared to be an antecedent, characteristic, or consequence of CREs, depending on the clinical context (Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012).

Thus far, only one study (Knox et al., 2012) has focused primarily on examining CREs in therapy, and another study (Ladany et al., 2012a) examined CREs in clinical supervision. Both studies were qualitative, and both interviewed therapists-in-training about their CREs. In the following subsections, I summarize findings across the two CRE studies.

Antecedents of CREs. One important antecedent to CREs is the therapeutic alliance. Knox et al. (2012) found that, most often, CREs occur in the context of positive therapeutic relationships, but sometimes occurred when problems or frustrations had arisen in the therapeutic relationship. Similar findings emerged in Ladany et al. (2012a) with CREs in clinical supervision, but with a more equal balance of both good and negative supervisory relationships providing the backdrop for the occurrence of CREs.

Other antecedents to CREs have focused on the concerns of the client. Prior to a CRE, discussion of professional or personal concerns were typical of clients who were also therapists-in-training (Knox et al., 2012). In contrast, Ladany et al. (2012a) found that CREs in supervision were typically preceded by trainee concerns about supervision or the supervisor, and only sometimes preceded by the trainees' professional or personal concerns.

Nature of CREs. Knox et al. (2012) found that clients typically explored thoughts and feelings but sometimes felt vulnerable during CREs. Similarly, Ladany et al. (2012a) found that supervisees opened up during CREs but sometimes did not like the supervisor's intervention(s).

Therapists on the other hand, typically empathized/reflected/accepted during CREs, but sometimes became active/directive, used immediacy, invited exploration, responded to the rupture, or reassured/normalized (Knox et al., 2012). During CREs in clinical supervision, supervisors typically supported/normalized/validated, were open, processed the supervisory relationship, pointed out the parallel process, focused on feelings about the clinical situation, and sometimes encouraged trainees to trust their instincts/find their own answer (Ladany et al., 2012a).

Consequences of CREs. Consequences of CREs in Knox et al. (2012) typically included a deeper therapeutic relationship as well as improvements in the client's own professional work as a therapist. Similarly in Ladany et al. (2012a), consequences generally included strengthening or transformation of the supervisory relationship, and typically had a positive impact on the trainee's work with clients.

Additional consequences of CREs in therapy generally included positive intrapersonal changes in the client, and typically resulted in positive interpersonal changes in the participant's relationships with others (Knox et al., 2012). In contrast, additional consequences for CREs in supervision typically involved increased self-efficacy as a professional and the supervisor evaluating the trainee more positively (Ladany et al., 2012a).

Limitations of CRE studies. We found only a few studies related to CREs, and the two studies directly assessing CREs involved clients who were therapists-in-training. In addition, none of the prior studies on CREs categorized CREs based on the type of corrective shift, rather, prior studies categorized CREs in terms of participant actions (Ladany et al., 2012a) or types of client-therapist dynamics (Knox et al., 2012); thus a gap in the literature exists for identifying types of corrective relational shifts. Furthermore, a broad range of theoretical orientations of the therapists was represented in these studies, possibly obscuring results coming from therapists of specific orientations. Thus, further research is needed on CREs utilizing clients who are not therapists-in-training as well as utilizing therapists from more clearly demarcated theoretical orientations. In addition, the role of client attachment has yet to be examined in empirical studies of CREs.

Attachment and CREs

Given the importance and prevalence of attachment expectations and behaviors in interpersonal relationships (see Levy, Ellison, Scott, & Bernecker, 2011), client attachment would be a key area in which client relational expectations may need to be transformed by CREs. When clients have had difficulties in the past with having

relational needs met by caregivers and significant others, clients may develop hyperactive and/or dismissive coping strategies for trying to have their relational needs met in interpersonal relationships (Mikulincer, Shaver, & Berant, 2012). CREs may disconfirm clients' maladaptive relational expectations and help clients to have more adaptive relational expectations and/or behaviors. Indeed, theorists have proposed that what CEs correct are negative object attachments (Sharpless & Barber, 2012), and maladaptive internal working models of self and other (Levenson, 2003). Anxiously attached clients may have their fears of abandonment or other relational anxieties transformed through CREs with their therapists, whereas avoidantly attached clients may have their fear of intimacy or other fears of having unmet relational needs transformed through CREs. Clients with insecure attachment might, over time, view effective therapists as important attachment figures and thus become more securely attached through the development of a new self-other internal working model (Constantino & Westra, 2012). This "correction" of the client's maladaptive interpersonal expectations meets the criteria for counting as a CRE because it involves both parts of the definition of CREs: (a) the disconfirmation of the client's expectations and (b) a resulting positive shift in the client's psychological functioning.

Although we did not find any existing empirical studies examining the relationship between client attachment and CREs, a meta-analysis found that higher client attachment anxiety was associated with negative treatment outcomes, higher client attachment security was associated with better therapy outcomes, and client attachment avoidance was not associated with therapy outcome (Levy et al., 2011). In light of these meta-analytic findings and lack of prior empirical inquiry, it would be valuable to

investigate whether client attachment anxiety and avoidance are associated with the occurrence of CREs, the antecedents of CREs, the types of CREs, and the consequences of CREs (see Appendix A for full literature review).

The Present Study

The purposes of the present study are to investigate the antecedents, characteristics, and consequences of CREs for adults in individual psychotherapy, as well as whether the antecedents, characteristics, and consequences differ depending on client attachment types. Given that minimal empirical investigation exists on CREs, I pose research questions rather than hypotheses (see rationale for questions in Appendix A):

Research Question 1: What are the antecedents in therapy prior to the occurrence of a CRE?

Research Question 2: What occurs during CREs in therapy?

Research Question 3: What are the consequences of CREs?

Research Question 4: Do the antecedents, characteristics, and consequences of CREs differ depending on client attachment type?

In the present study, we focus on psychodynamic/interpersonal psychotherapy in order to avoid confusion due to possible alternative explanations (i.e., theoretical orientation) for the findings. The psychodynamic/interpersonal theoretical orientation was a logical choice given its emphasis on the use of the therapeutic relationship as a microcosm of the client's interpersonal relationships (Gelso & Fretz, 2001). Furthermore, we used a qualitative method in this investigation of CREs based on the precedent in the existing literature on CREs (e.g., Knox et al., 2012; Ladany et al., 2012a). Qualitative methods are "ideal for studying in depth the inner experiences, attitudes, and beliefs of

individuals because it allows researchers to gain a rich, detailed understanding that is not usually possible with quantitative methods" (Hill, 2012, p. 14). Qualitative methodology is ideal for studying complicated psychotherapy processes and internal experiences, and the in-depth results are ideal for building hypotheses and theory for better informed quantitative research.

Method

Design and Setting

The design of the present study is a qualitative, descriptive field design using CQR (Hill, Thompson, & Williams, 1997; Hill et al., 2005; Hill, 2012). The study used data collected at the Maryland Psychotherapy Clinic and Research Lab (MPCRL), a mental health clinic providing individual psychodynamic/interpersonal psychotherapy to adults from the local community. Therapists were counseling psychology doctoral students with at least two years of prior supervised clinical training. The therapy was open-ended with no maximum number of sessions clients could attend (although there were limits on how long they could see a particular therapist, depending on therapist length of participation in the clinic). Therapy sessions were typically 45 to 60 minutes in length and were videotaped with client consent for participating in the research.

Participants

Clients. Data from 31 (16 female, 15 male; age M = 34.8 years, SD = 13.5 years; 21 White American, 4 African American, 4 International, 1 Hispanic American, 1 unknown) clients who completed the pre-therapy attachment measure (i.e., the ECR) and post-therapy interview were used in this study. Of these 31 cases, 18 (8 female, 10 male; age M = 34.3 years, SD = 12.4 years; 14 White American, 2 African American, 1 International, 1 unknown) clients reported a CRE, whereas 13 (8 females, 5 males; age M = 35.6 years, SD = 14.3 years; 7 White American, 2 African American, 3 International, 1 Hispanic American) clients did not report a CRE.

The 18 CRE clients completed an average of 33.8 therapy sessions (not counting the intake session), ranging from 7 to 93 sessions (SD =21.3). The 13 non-CRE clients

completed an average of 17.2 sessions (not including the intake session), ranging from 3 to 61 sessions (SD = 15.8). A one-way ANOVA revealed that clients who reported CREs completed more therapy sessions than clients who did not report CREs, $F(1, 29) = 5.66$, $p = 0.02$.

In order for clients to participate in therapy at the MPCRL, they could not be in concurrent individual psychotherapy elsewhere, could not have current alcohol/drug abuse, could not be psychotic, and must have presented with at least one interpersonal issue. If a client was taking medication prior to starting services at the MPCRL, s/he must have been stabilized on psychotropic medication (i.e. taking it for over 2 months) in order to participate in the research.

It should be noted that only those clients who completed at least three sessions were asked to participate in post-therapy interviews. In addition, clients who dropped out rarely consented to participate in a post-therapy interview. Hence, the post-therapy interviews were most often conducted with clients who terminated from therapy rather than dropping out of therapy. Hence, this sample may have had more CREs than did drop-outs.

Therapists. 13 therapists (9 female, 4 male; age M = 30.2 years, SD = 6.4 years; 6 Asian Internationals, 3 White Americans, 2 Hispanics, 1 African American, 1 European International) at the MPCRL had clients who met criteria for participation in the present study. Therapists were counseling psychology doctoral students who had received at least one semester of pre-practicum training in the Hill (2009) helping skills model, two semesters of practicum training with a minimum of 50 hours of direct client contact, and training on using immediacy (as part of the clinic orientation process).

Interviewers. Post-termination interviews were conducted by a therapist at the clinic other than the therapist the client had seen. Thus, interviewers were counseling psychology doctoral students with therapy training as described above.

Judges. Three female undergraduates majoring in psychology (age M = 19.33, SD = 0.94; 2 White American, 1 Asian American), in addition to the primary investigator (aged 28, Asian American), served as judges for the qualitative analyses. A European-American female professor (aged 65) served as the auditor.

Measures

Demographics. A questionnaire asked clients about age, sex, race/ethnicity, highest educational level, current job, and whether they had ever consulted a mental health practitioner for any problem. A separate questionnaire asked therapists about age, sex, race/ethnicity, year in doctoral program, and number of years providing psychotherapy. Another questionnaire asked CQR judges about age, sex, race/ethnicity, educational level, and year in school.

Post-therapy interview protocol (Appendix B). Semi-structured post-therapy interview questions were developed by the clinic directors, then piloted by therapists/interviewers and revised accordingly. For the analyses, we focused on the questions pertaining to CREs, but we examined the entire post-therapy interviews for client responses that might be relevant to CREs.

Client attachment. The Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998; Appendix C) is a 36-item self-report measure assessing adult romantic attachment style. The ECR uses a 7-point Likert scale (1 = disagree strongly, 7 = agree strongly) and is currently the most widely used paper-and-pencil

measure of adult attachment style. The Avoidance subscale measures an individual's level of discomfort with emotional closeness, openness, and interdependence in romantic relationships. The Anxiety subscale measures the extent to which a person fears being rejected, neglected, or abandoned by romantic partners. The ECR was created through factor analysis of 482 items, revealing two major factors (Anxiety and Avoidance). Construct validity was demonstrated using hierarchical and non-hierarchical clustering procedures to derive four attachment categories (Secure, Fearful, Preoccupied, Dismissing) based on the responses of 1,086 participants to the Anxiety and Avoidance items. Convergent validity was demonstrated with the related constructs of affectionate touch and romantic sexuality: as predicted, secure and preoccupied groups scored high on using affectionate touch to express affection and low on aversion to affectionate touch, whereas fearful and dismissing groups showed a deficit in the use of touch to express affection (Brennan et al., 1998). Also as predicted, Secure and Preoccupied participants were significantly more likely than other participants to endorse romantic/affectionate sexual behavior (i.e., cuddling, kissing, and gazing), whereas Dismissing participants were the most likely to endorse "promiscuous" sexual behavior (i.e., "one-night stands") (Brennan et al., 1998). Both the Anxiety and Avoidance subscales have had high internal consistency estimates (.90 to .94 for Avoidance, .88 to .91 for Anxiety; Brennan et al., 1998; Mohr, Gelso, & Hill, 2005) and high 6-month test-retest reliabilities (.68 for anxiety and .71 for avoidance; Lopez & Gormley, 2002). High internal consistency was found in the present sample for Avoidance ($\alpha = .94$) and Anxiety ($\alpha = .92$).

Procedures: Data Collection

Client recruitment. Clients were recruited from the community for the research clinic through advertisements in local newspapers, flyers on campus and in the local community, referrals from professionals in the local area, word of mouth, online referral links, and the clinic's website. Clients were screened to determine if they met the eligibility criteria. If so, they were scheduled for an intake session with one of the therapists. If not, they were given a referral to another mental health provider. Clients were not provided with any additional compensation beyond low-fee psychotherapy (typically, $10 to $50 per session), because our target population was the outpatient population and we were looking for clients motivated to seek therapy.

Therapist/interviewer recruitment. Therapists/interviewers were recruited through email announcements in the counseling psychology doctoral program at the university where the study was conducted.

Judge recruitment. Judges were recruited from upper-level psychology classes. All judges had at least a 3.2 grade point average, and all were individually interviewed for their appropriateness and motivation to serve as judges on the present study.

Pre-therapy and post-session assessment. Prior to the intake session, clients completed the ECR, along with other measures not included in the present study. After every session, clients completed measures not included in the present study (one post-session measure asked clients about CREs, but the post-session CRE data did not seem to be valid; clients reported events that did not seem to be related to CREs which brought into question whether they understood the construct based on the written instructions in the post-session measure).

Post-therapy interview procedures. After clients completed therapy, clinic staff scheduled post-termination testing and interviews for as soon as logistically feasible, typically within 2 weeks. Clients were interviewed for approximately 60 minutes.

Procedures: Qualitative Data Analysis

Transcripts. Client and interviewer statements were transcribed verbatim. Any identifying information was removed from the transcripts. All clients were assigned code numbers to protect confidentiality. Transcripts were double-checked for accuracy and completeness prior to qualitative analysis.

Training judges. Judges completed about 25 hours of training, which consisted of instruction (e.g., explaining the CQR process, defining CREs), assigned readings (relevant chapters in Hill [2012] about CQR and the two CRE studies Knox et al., 2012; Ladany et al., 2012a), written exercises (e.g., please describe an example of a CRE), discussion (e.g., questions about CQR tasks or identifying CREs), and practice (e.g., practice identifying CREs in post-therapy interviews).

Recording biases and expectations. Prior to qualitative analyses, judges wrote about and discussed their biases (i.e., "personal issues that make it difficult for researchers to respond objectively to the data," Hill et al., 1997, p. 539) and expectations (i.e., "beliefs that researchers have formed based on reading the literature and thinking about and developing the research questions," Hill et al., 1997, p. 538) about CREs. Judges independently wrote down their biases and expectations about CREs. Regarding the therapy relationship prior to CREs, four researchers mentioned that CREs are facilitated by positive therapy relationships, while three researchers mentioned that negative aspects of the therapy relationship could be facilitative when CREs resolve

problems in the therapy relationship. Regarding client and therapist facilitators of CREs, researchers tended to emphasize therapist contributions (e.g., four researchers mentioned that their therapists helping them gain insight or new perspectives on their problems were facilitative of CREs). Regarding types of CREs, all judges believed that CREs consisted of positive shifts in the client-therapist relationship (e.g., greater intimacy, trust), while three researchers mentioned that CREs can involve shifts in interpersonal paradigms/schemas when the therapist behaved in a positive, unexpected manner. Regarding consequences of CREs, all researchers expected some kind of improvement in the therapy relationship, while none of the researchers expected negative consequences from CREs. Judges were asked to try to set aside (bracket) their expectations so as to not unduly influence the data analysis. They were also asked to openly discuss their biases and expectations during the data analysis process to minimize the influence of their biases and expectations. Author biases and expectations are reported in Appendix D.

Protecting confidentiality. Judges were instructed to not analyze interviews when they recognized the client. Judges did not know any of the clients.

Determining whether a case had a CRE. After watching the DVD of each interview, the research team consensually determined whether the case had a CRE based on: (a) whether the client reported a CRE, and (b) whether the event fit the definition ("times when you felt a distinct shift, such that you came to understand or experience your relationship with your therapist in a way that was ultimately very positive"). More specifically, the event had to be: (a) corrective (a positive shift of some kind from past experiences; see Castonguay & Hill, 2012), (b) relational (in the context of or caused by the therapy relationship; see Knox et al., 2012), and (c) an experience (not only an

external event, the client must experience the event internally; Sharpless & Barber, 2012). We dropped one case in which the interviewer provided an inaccurate explanation of the definition of CREs.

An example of a case that we did not count as a CRE was when a client described an interesting suggestion that the therapist made, but stated that nothing had changed as a result of the experience (thus we considered that the event was neither corrective nor relational). Another example of a case that we did not count as a CRE was where one client reported getting his story out but stated that the therapy relationship was not helpful (thus we considered that the event was not relational). Yet another example of a case that we did not count was when a client reported the therapist pointed out conflicting feelings within the client about the client's family members, but the client did not experience a shift in the therapy relationship (thus we did not consider the event as relational).

Alternatively, when the client did not claim to have had a CRE (perhaps due to confusion about the construct), we looked for any examples that matched our definition of a CRE. We would have counted such a case as having a CRE had this scenario occurred, but we found no such evidence.

For cases in which multiple CREs were present (of the 18 cases, 11 cases had 1 CRE, 6 cases had 2 CREs, and 1 case had 5 CREs), the research team consensually chose the most salient CRE. We considered the most salient CRE to be the one that most clearly fit the definition, for which the client provided the most detail, and if all else was equal, was mentioned first.

The auditor reviewed all the cases to determine whether she agreed with the team's consensual decisions. In cases of discrepancies (about 5 cases were ambiguous), the team and auditor discussed extensively until agreement was reached.

Domains. Based on reading the transcripts and watching the DVDs, judges independently coded sections of the interviews into domains (i.e., topic areas). They then met and consensually decided upon the coding into the final domains: antecedents, types and characteristics of corrective relational shifts, and consequences.

Core ideas. Judges read the interview transcripts and watched the DVDs to independently construct core ideas (i.e., summaries or abstracts of what the client said, in clearer and more concise terms, taking into account the context of the entire case), and then discussed and consensually decided on the final wording of the core ideas. Judges kept as close to the clients' actual words as possible, reduced redundancy within the core ideas, and eliminated any non-relevant information. Prior to cross analyses, each case was reviewed to ensure thoroughness of inclusion of all data and consistency of assignment of domains to core ideas.

Auditing domains and core ideas. The auditor read the consensus version (raw data within domains with core ideas attached) of each case and checked the domain coding and the accuracy of the core ideas. The judges discussed the auditor's suggestions, revised as they judged best according to consensus, and sent their revisions back to the auditor. This revision process continued until everyone agreed that the core ideas reflected the clients' statements as closely as possible.

Cross-analysis. Judges then independently constructed categories that reflected themes within each domain across cases. Judges discussed their ideas and reached

consensus about a final list of categories. The auditor reviewed the categories and provided feedback, which the judges considered and revised according to consensus. Judges then independently assigned each core idea to one or more categories, and then discussed categorizations until they reached consensus. Again, the auditor provided feedback, which the team incorporated based on discussion. The feedback process continued until everyone was satisfied with the cross analyses.

Additional qualitative analyses. Additional information was available in the post-therapy interviews that we thought might shed light on the results. Therefore, we considered information related to possible reasons why non-CRE cases lacked CREs and what clients wished their therapists had done differently for CRE versus non-CRE cases. We followed the same CQR procedures outlined above.

Results

To situate and provide context for interpreting findings of the present study, we compare our CRE sample to other samples. Table 1 shows means and standard deviations of the scores on the Anxiety and Avoidance subscales of the ECR attachment measure for clients in the present study, all clients in the research clinic where the current study was conducted, and Marmarosh et al. (2009). Effect size analyses (Cohen's *d*, i.e., differences between means divided by the pooled standard deviations) were used to compare samples, where $d > .20$ indicates a small effect, $d > .50$ indicates medium effect, and $d > .80$ indicates a large effect. The effect size for the difference between the CRE clients ($N = 18$) compared to all clients in the research clinic where the study was conducted ($N = 155$) was small for Attachment Anxiety ($d = 0.35$) and nonsignificant for Attachment Avoidance ($d = 0.13$), indicating that clients who had CREs were more anxious in their attachment styles than the total sample of clients in the research clinic. The effect size for the difference between the CRE clients in the current sample ($N = 18$) and the 31 clients in Marmarosh et al. (2009) was large for Attachment Anxiety ($d = .64$) and small for Attachment Avoidance ($d = .26$), indicating that clients who had CREs in the current study were more anxious and less avoidant in their attachment styles than clients in Marmarosh et al. (2009).

Table 2 displays qualitative findings of the present study regarding antecedents, types, and consequences of CREs. For all qualitative analyses, labels indicating category frequencies followed CQR guidelines: "general" was used for categories that emerged for all or all but one case, "typical" for categories that emerged for more than half and up to the cut-off for general, and "variant" for categories that emerged for at least two cases but

fewer than the cut-off for typical. Thus, for the 18 CRE cases, the label "general" was used for 17-18 cases, "typical" for 10-16 cases, and "variant" for 2-9 cases; whereas for the 13 non-CRE cases, "general" was used for 12-13 cases, "typical" for 7-11 cases, and "variant" for 2-6 cases.

For each category, we provide quotes from the interviews to illustrate the results. Quotes were slightly edited for efficiency and clarity in presenting the findings. We used ellipses (. . .) to indicate where less-essential parts of quotes were omitted, and deleted non-essential colloquial filler words (e.g., "um," "like," "you know," "I mean").

Therapy Relationship Prior to CREs

Prior to CREs, clients typically had a positive therapy relationship with their therapists. Clients variantly had either experienced this positive relationship from the beginning of therapy (e.g., "I want to say that [the therapist] and I were a good match from the beginning"), or had experienced a progression from a neutral to a positive relationship before the CRE occurred (e.g., "I had to get used to [the therapist] . . . [the therapist] tried to have me open up to, to tell [the therapist] what happened, but it took me a while because it was just something that I don't easily share . . . I took a chance and I'm glad I did because I was able to learn things about myself").

Prior to CREs, participants also typically mentioned some difficulties in the therapy relationship, although these seemed to be minor difficulties. Variantly, these difficulties related to client re-enactments of problematic interpersonal patterns related to their CRE (e.g., a client "held back in therapy and with other people . . . being cautious of what I say, and not being able to fully open up") or were unrelated to client patterns addressed by the CRE (e.g., "It took me a little while to just settle in and just realize how

this was gonna go . . . It felt like we went through several sessions where I just wasn't sure what this was . . . sort of had to get my bearings").

Therapist Actions Facilitating CREs

CRE clients generally identified therapist actions that facilitated the occurrence of the CREs, and these actions fell into two subcategories. The first, typical, action involved the therapist identifying or questioning problematic client behavior patterns, typically enacted in relationships outside of the therapy session. For example, one client explained that the therapist, "helped me see how I was . . . not being straight with people about how I was feeling in stressful situations . . . in situations involving conflict." The behavior patterns identified by the therapist variantly occurred with the therapist in the therapy session(s). For example, a client stated, "I know these weren't her words but my translation of them, I seem to over prepare things a little bit and she [the therapist] pointed out that in this experience through therapy that I tend to set a lot of goals for myself and she was noticing me doing that for some of the sessions coming in."

The second, also typical, action involved the therapist conveying profound supportiveness (deep care, understanding, and nonjudgmentality) or conveying credibility to the client. The clients seemed to be saying that the therapists conveyed trustworthiness and expertise. For example, one client stated:

> She [the therapist] told me that . . . she'd been working with me and she can tell that I'm a really great person and that any person should be lucky to have me, to know me. And she said that just because of the person that I am, she believes . . . that good things are going to come my way. That I'm definitely going to get better, and that she will always be there to help me even if . . . she said even if I

stop the sessions, she will always be there, I can always return to her if I need help.

Another example of the therapist conveying credibility to the client occurred when "he [the therapist] said something . . . that conveyed that (client's son) was taking advantage of me [the client]." This was significant to the client, who stated, "I appreciated having a man say that, because I don't have a husband to say, 'Look, your son is taking advantage of his mother.' . . . I quickly came to respect him [the therapist] a lot and didn't see him [the therapist] [as someone] my son's [age] anymore."

Client Actions Prior to CREs

Although no typical categories emerged in this domain, three variant categories were found. First, clients did not mention any client contributions to the CRE. Second, clients engaged in the problematic interpersonal behavior with their therapist prior to the CRE (e.g., "I say I'm sorry a lot and even in my therapy . . . . I remember saying I'm sorry"). Third, clients indicated that they had engaged in actions facilitative of the CREs, such as opening up deeply to the therapist (e.g., disclosing something previously withheld), or expressing their relational needs to the therapist. An example of client disclosure facilitating the occurrence of a CRE was in a case where the client "decided to bring up the subject [of the client's sexual practices]" despite prior hesitancy to do so with the therapist. An example of a client expressing relational needs that facilitated the occurrence of a CRE was a client who expressed her need to know more about the therapist: "I remember finally telling her [the therapist] that I wanted to know [more] about her."

Types of Corrective Relational Shifts

Corrective shifts typically took the form of gaining a new understanding of the therapist, the therapy relationship, or the therapy. One client describes her corrective shift: “I realized that she [the therapist] really was there for me and she really wasn’t trying to judge me. All she was trying to do was help me.” This was corrective for this client given that the client had felt unable to share at a very deep level with family and friends (“They knew exactly everything I’ve been through, but the other details that I could not really share with them because they’re already feeling bad/sad for me, and worried, so I didn’t want to make them feel any worse”). Another client described the corrective shift, “I became aware that we weren’t just having conversations [in therapy], that [the therapist] was kind of doing homework and then coming back with ideas. And I liked that a lot . . . that was the biggest CRE, was when I realized how [the therapist] was working to be useful . . . It brought kind of a different level of respect for her professionalism.” A third client described the corrective relational shift as “[the] therapist giv[ing] me something new to think about, or that I never thought of before or noticed about my behavior before . . . [therapy was] more productive. I was getting a lot more out of it than just venting. I was more comfortable coming here.”

A variant type of CRE consisted of the therapist helping the client gain a new understanding of and/or breakthrough in changing behavior patterns. For example, a client said that the therapist pointed out the client’s pattern of holding back from opening up in therapy and with others outside of therapy. The client described this CRE as “realiz[ing] why I was holding back somewhat;” namely, “I guess I didn’t have a very supportive family when I was younger, and I was always afraid to be ridiculed, so I always have a little protection up.” This helped the client change the client’s behavior

pattern of withholding disclosure. Another example is of a client who gained a new understanding and breakthrough in changing a behavior pattern of deceiving others:

> I hadn’t been fully honest with her [the therapist] and I hadn’t been opening up completely. And I’d been lying to her about various things. And one day I just came in and told her “I want to talk to you about this. I haven’t been honest; I haven’t been open with you. This is what’s really going on and everything else I told you isn’t true.” . . . Normally I would just continue to lie or continue to avoid it. That was the first time I sat down and really confronted reality, you know and it was a huge step.

Consequences of CREs

Consequences for the therapeutic relationship. Clients generally expressed improvements in the therapeutic relationship after the CRE, with these improvements falling into one typical and two variant subcategories. A first type (typical) involved improvement in the client-therapist relationship with the client trusting the therapist more, opening up more, and/or feeling a deeper connection with the therapist. For example, one client stated, “It just felt like I was able to drop my guard more than I have before with [the therapist], and able to have that greater level of intimacy and feeling very open and trusting. Being vulnerable I guess.” Another client explained that as a result of the CRE, “I viewed her [the therapist] and my [therapy] relationship more favorably because I felt like she [the therapist] understood me.” A third client felt greater respect for and trust in the therapist after her CRE: “I gained respect, not that I didn’t respect [the therapist] beforehand but it was kind of a moment where I trusted her that she could lead

me in the right direction, that she was intelligent and could pick up things that I couldn't see."

A second type (variant) of improvement in the therapeutic relationship consisted of the client gaining greater respect for the therapist's professional abilities or credibility. For example, a client stated that she "quickly came to respect him [the therapist] a lot and didn't see him like my son's [age] anymore."

A third type (variant) of improvement in the therapy relationship involved greater awareness of or changes in interpersonal patterns in the therapy relationship (e.g., the client who struggled with honesty stated, "I wasn't hiding anything anymore; I was being completely open [with the therapist]" to the point that the therapist "became very, very significant in my life because I felt like she was the one person who saw who I was").

Consequences for client intrapersonal functioning. Clients typically indicated improvements in intra-personal well-being after the CREs. Intrapersonal improvements typically took the form of greater self-awareness, new ways of thinking about oneself, or new ways of relating to oneself. For example, a client who struggled with being assertive with others stated, "I feel less like I'm a burden, like I'm a problem, like I feel more like I have the right to be, to say what I want, think what I want." For another client, "It's [the CRE has] made me more aware of these things I do that are negative and harmful to myself." Variantly, intrapersonal improvements involved increased positive feelings (e.g., "a new sense of hope that [my] problems can be addressed"), reductions in unwanted feelings (e.g.s, "it [the CRE] was almost like a liberating experience," "it [the CRE] felt like a burden being lifted," "it released the pressure [of client's interpersonal concerns]"), and discomfort due to changing their typical behavior pattern (e.g., "On the

one hand it did feel really good to get it [the truth] out there but I was also stressed and kind of nervous about . . . what is it gonna be like now to have to tell the truth. For her [the therapist] to know that I have these [dishonest] tendencies and for her to call me on them, am I going to be able to be honest?").

Consequences for client interpersonal functioning. Clients variantly mentioned consequences of the CRE on their interpersonal functioning. For example, the client struggling with dishonesty stated that being honest with the therapist "made a huge difference and I was able to take that and apply it to my friends and family and other people who I'd been dishonest with and really saw progress after that." Another client indicated that as a result of the CRE, "I felt a lot more in control of . . . how I see relationships, I feel like I actually have more control in relationships and I kind of realized that a lot of my actions are out of guilt and that's irrational and that guilt shouldn't be a reason why you do something for somebody."

Therapy productivity after the CRE. Clients variantly described increased productivity in therapy after the CRE, namely, having more productive attitudes towards therapy or engaging in more productive behaviors in therapy. For example, a client stated that after the CRE, "I gained greater respect for the whole [therapy] process -- there's more than just venting." As another example, a client remarked that after the CRE, "I stopped telling stories a lot. I started being a little more focused on myself being more useful . . . getting to the root of problems, talking about what was really going on in my head and my heart."

Client Attachment and CREs

Following precedents in the literature (e.g., Huang, Hill, & Gelso, 2013; Levy et al., 2011; Marmarosh et al., 2009), we focused separately on the dimensions of attachment anxiety and attachment avoidance. We used the means from the larger clinic sample ($N = 155$; see Table 1) as dividing points for high versus low attachment anxiety and high versus low attachment avoidance (note that Attachment Anxiety and Avoidance were not significantly correlated in the $N = 155$ sample, $r = 0.10$, $p = .20$). Of the 18 CRE clients, 6 were low in attachment anxiety and 12 were high in attachment anxiety; 12 were in the low attachment avoidance group and 6 were in the high attachment avoidance group (note that four were in both the high attachment anxiety and avoidance groups, and another four were in both the low attachment anxiety and avoidance groups).

Table 3 indicates the percentages from each attachment subsample (low attachment anxiety, high attachment anxiety, low attachment avoidance, high attachment avoidance) for the various CRE antecedents, types, and consequences. We used the criterion that the subsamples had to differ by at least 30% of cases (Ladany, Thompson, & Hill, 2012b). In the following section, we report on only those results that differed across subsamples. Illustrative quotes can be found in Appendix E.

Attachment anxiety and CREs. The high and low attachment anxiety groups differed on 8 of 29 categories. Compared to clients with low attachment anxiety, clients with high attachment anxiety were more likely to have enacted their maladaptive behavior patterns with their therapist, less likely to have indicated their therapist facilitated CREs by conveying profound trustworthiness, more likely to have reported CREs focused on changing behavior patterns, less likely to have reported CREs focused on a new understanding of the therapist/therapy, less likely to have indicated gaining a

greater respect for their therapist's professional abilities or credibility following their CREs, more likely to have indicated improved interpersonal functioning (specifically, gaining awareness of and/or changing interpersonal behavior patterns outside of therapy) from their CREs, more likely to have improved intrapersonal functioning from their CREs, and more likely to have increased positive feelings of well-being (a subcategory under intrapersonal improvements) following their CREs.

Attachment avoidance and CREs. The high and low attachment avoidance groups differed from each other on 10 of 29 categories. Compared with clients low in attachment avoidance, clients high in attachment avoidance were more likely to have had positive therapy relationships preceding their CREs, more likely to have had positive relationships that formed in the beginning of therapy, less likely to have had difficulties in their therapy relationship preceding their CREs (especially those unrelated to client patterns addressed by their CREs), more likely to mention client facilitators of CREs, more likely to have disclosed deeply prior to their CREs, less likely to have indicated that therapists facilitated CREs by identifying/questioning client behavior patterns (especially those enacted outside of therapy), more likely to have had a reduction in unwanted feelings after their CRE, and less likely to have engaged in more productive behaviors/attitude towards therapy after their CRE.

Additional Analyses of CRE vs. Non-CRE Cases

We conducted additional analyses to look for clues for the lack of CREs in the non-CRE cases. Firstly, we examined whether CRE and non-CRE cases differed on pre-therapy client attachment. Secondly, we looked at what clients said they had wished the therapist had done differently in the therapy for CRE vs. non-CRE cases.

Client pre-therapy attachment: CRE versus non-CRE cases. Table 1 reports means and standard deviations of client pre-therapy attachment for CRE versus non-CRE cases. The effect size for the difference between the clients who had a CRE ($N = 18$) and those who did not ($N = 13$) was large for attachment anxiety ($d = .79$) and small for attachment avoidance ($d = .22$), suggesting that clients with high attachment anxiety or avoidance had more CREs than did those with low attachment anxiety or avoidance.

What clients wished therapists had done differently. Table 4 reports qualitative findings about what clients wished their therapist had done differently in their therapies for clients who had a CRE versus clients who did not, as reported in post-therapy interviews. Applying the 30% criterion (Ladany et al., 2012b), one difference emerged: Clients who lacked CREs (N =13) were more likely than clients who had CREs (N = 18) to indicate that they wished their therapist's theoretical orientation was a better match.

Discussion

It is important to situate the sample again at the beginning of this section. Participants in this study were community clients engaging in open-ended psychotherapy with doctoral student therapists. The data were collected during post-therapy interviews and only included clients who came in for post-therapy interviews after their therapy experience (only 31 out of 105 clients who had more than 3 sessions participated in this interview), so this was a select sample.

The findings suggest that therapists did specific things to facilitate CREs. Furthermore, client attachment was related to differences in the antecedents, types, and outcome of CREs. In the following sections, I discuss the CRE antecedents, types of corrective shifts, and consequences. I then discuss CREs in relation to client attachment, and finally compare differences between the CRE cases and non-CRE cases that might explain the occurrence or lack of occurrence of CREs.

CRE Antecedent: Therapy Relationship Prior to CREs

Clients in this study who had CREs typically indicated having positive therapy relationships (61%) as well as minor difficulties in their therapy relationships prior to the CRE (61%). Of the difficulties, 22% involved re-enactments of interpersonal patterns addressed by the CRE, whereas 39% involved other difficulties in the therapy relationship. Some theorists have suggested that a positive therapy relationship needs to be established for a corrective experience to occur (e.g., Goldfried, 2012), whereas others have suggested the importance of difficulties being re-enacted in the therapy relationship as a precursor to corrective experiences (e.g., Levenson, 2003). Knox et al. (2012) found that CREs generally occurred in the context of positive therapeutic relationships, but

variantly occurred when problems or frustrations arose in the therapeutic relationship. Ladany et al. (2012a) found that a roughly equal balance of both good and negative supervisory relationships preceded CREs in clinical supervision. Taken together, the findings on therapy relationships preceding CREs in the present study as well as prior literature suggests that good enough therapy relationships can allow for CREs—perhaps the difficulties in the therapy relationship not addressed by the CRE were either resolved prior to the CRE or outweighed by the positive aspects of the therapy relationship. The idea of a "good enough" therapy relationship being a pre-requisite for therapeutic success is supported by a recent meta-analytic review, which concluded that the development of a sound or "good enough" alliance early in therapy is crucial for therapy success (Horvath, Del Re, Flukiger, & Symonds, 2011).

CRE Antecedent: Therapist Actions Facilitating CREs

Clients typically indicated that their therapists facilitated CREs was by identifying or questioning client behavior patterns (whether the pattern was being enacted outside therapy or with the therapist). In one example with a client who had a tendency to apologize unnecessarily, the therapist asked why the client was apologizing given that therapy is a place where the client is allowed to share anything. Another client reported that her therapist helped her to recognize her pattern of dissociating during stressful situations or situations that involved conflict.

The finding about the helpfulness of identifying/questioning client patterns is similar to Heatherington, Constantino, Friedlander, Angus, and Messer's (2012) finding that therapist observation of client's patterns of thoughts, feelings, or behavior facilitated corrective experiences, although 72% of clients in the current study endorsed this

therapist behavior whereas only 3% of the client responses in Heatherington et al. (2012) indicated a similar type of therapist action. This difference might be because we counted percentages of clients who made at least one statement about therapists facilitating CREs by pointing out client patterns, whereas Heatherington et al. counted the percentage of coded meaning units from client responses. Alternatively, differences could be because our therapists were psychodynamic/interpersonal in orientation and working in a community clinic whereas the therapists in the Heatherington study were from a mix of different treatment settings and from a range of theoretical orientations.

Re-enactment of a client's maladaptive patterns with the therapist can be viewed as a type of transference (i.e., displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier relationships, Gelso & Bhatia, 2012). Through the identification and transformative 'correction' of client maladaptive patterns being enacted with the therapist, clients may learn to have more adaptive perceptions, feelings, and/or behaviors towards the therapist. Thus, CREs related to the transformation of client maladaptive patterns enacted with the therapist can be considered a type of resolution of transference (see Gelso, Hill, Mohr, Rochlen, & Zack, 1999).

Clients also typically indicated that therapists facilitated CREs by conveying trustworthiness (care, understanding, nonjudgmentalness and/or credibility) towards the client. Examples include the therapist saying that the client was a really great person, the therapist conveying understanding of the client's point of view and listening impartially to the client, and the therapist's positive, nonjudgmental response to the client's disclosures.

Similarly, Knox et al. (2012) found that therapists typically facilitated CREs through empathizing, reflecting, or accepting (e.g., accepting the participant exactly as s/he was, which was a new experience for the participant). Ladany et al. (2012a) also found that supervisors typically facilitated CREs through supporting, normalizing, and validating. Thus, themes across the three studies indicate that a key mechanism of transformative change is conveying trustworthiness and nonjudgmentality through the therapeutic relationship, which supports Rogers's (1957) notion of the importance of unconditional positive regard for the client.

CRE Antecedent: Client Actions Facilitating CREs

Clients variantly indicated that they had some role in facilitating CREs by taking a risk in being vulnerable and disclosing deeply to the therapist. One client revealed something about her/himself that s/he did not normally disclose for fear of being judged. Another client who had a pattern of dishonesty disclosed that he had been dishonest with the therapist. Similarly, Knox et al. (2012) found that clients variantly felt vulnerable during their CRE interaction, and Ladany et al. (2012a) found that supervisees typically disclosed or were otherwise open or vulnerable during CREs in supervision. Themes across the three CRE studies indicate that client actions prior to CREs involve a deep level of disclosure.

Another variant client action involved expressing relational needs to the therapist. For example, one client presenting with romantic relationship concerns was unsure about whether her therapist would be a credible source of help and expressed that she wanted to know more about the therapist's romantic relationship status. Although not examined nor

found in previous studies, it makes sense that clients expressing their needs to their therapist would facilitate them having their needs met.

Types of Corrective Relational Shifts

In the present study, two broad categories of types of corrective relational shifts emerged. The first type (typical) involved the client gaining a new understanding of the therapist or therapy. Thus, some clients realized that therapy could be useful or productive in unexpected ways, whereas other clients realized that the therapist understood the client more than the client was accustomed to in interpersonal relationships. Relatedly, Knox et al. (2012) found that clients variantly saw therapists in a new way, and Anderson, Ogles, Heckman, and MacFarlane (2012) found that five clients (out of 27 clients) discovered a new experience of therapist warmth. This type of shift fits in with Alexander and French's original (1946) formulation about corrective experiences, as well as psychoanalytic theories of change (e.g., Levenson, 2003), wherein positive shifts in the therapy relationship are a mechanism by which clients learn new ways of thinking, feeling, behaving, and/or relating, and then generalize the learning outside of therapy.

The second type of corrective shift (variant), involved the client gaining a new understanding of and/or breakthrough in changing the client's behavior patterns. For example, a client realized he was holding back in therapy as well as in interpersonal relationships outside of therapy because he was afraid of judgment and wanted to protect himself. Similarly, Heatherington et al. (2012) had a subcategory of new experiential awareness of patterns in interpersonal relationships. Furthermore, psychodynamic and

interpersonal theories (e.g., Levenson, 2003; Teyber, 2006) support the importance of attending to and collaboratively identifying client maladaptive patterns.

Consequences of CREs

All clients who had CREs mentioned improvements in the therapeutic relationship following their CRE. Clients typically trusted their therapists more, opened up more, and/or felt a deeper connection with their therapist. These findings make sense given that corrective experiences are defined as being positive and transformative for clients (Alexander & French, 1946; Goldfried, 2012). Similarly, Knox et al. (2012) and Ladany et al. (2012a) found that therapy and supervision relationships, respectively, typically deepened after CREs.

In addition, clients typically reported positive intrapersonal consequences (e.g., new ways of relating to self, reduction of unwanted feelings, increased positive feelings) after CREs, which fits with the theory of CREs "correcting" maladaptive internal working models of self and other (see Levenson, 2003). Similarly, Knox et al. (2012) found that CREs generally resulted in positive intrapersonal changes for therapists in training undergoing personal therapy.

Clients in the present study only variantly indicated positive interpersonal consequences of their CREs, indicating that not all clients were able to generalize the results beyond their current psychotherapy. Given that the CREs are thought to correct maladaptive working models of self and others (e.g., Levenson, 2003), it would follow that positive interpersonal changes should result from the positive changes in working models of others. Indeed, Knox et al. (2012) found that participants typically experienced interpersonal improvements resulting from their CREs. Perhaps participants in Knox et

al. (2012), who were therapists-in-training, had greater interpersonal awareness or attentiveness for reporting interpersonal consequences of CREs than did clients in the present study.

Participants also variantly described more productive attitudes towards therapy and engaging in more productive behaviors in therapy as a result of CREs. Given the transformative nature of CREs (Alexander & French, 1946; Castonguay & Hill, 2012; Christian et al., 2012; Goldfried, 2012; Hayes et al., 2012; Hill et al., 2012; Sharpless & Barber, 2012), it is not surprising that clients would have an improved outlook about therapy and apply the adaptive changes achieved in their CRE to the therapeutic endeavor. Indeed, Castonguay et al. (2012) mentioned improved productivity in therapy resulting from a CRE, and Ladany et al. (2012a) found that CREs led to improvements in the supervision.

Client Attachment and CREs

CRE antecedents, types, and consequences varied based on client pre-therapy attachment anxiety and avoidance. Prior research has shown considerable differences in therapy outcome related to client attachment anxiety (e.g., negatively associated with therapy outcome and psychotherapy dropout; Levy et al., 2011; Huang et al., 2013), but the findings about attachment avoidance are particularly interesting given prior findings that attachment avoidance has been unrelated to therapy outcome (Levy et al., 2011), or psychotherapy dropout (e.g., Huang et al., 2013). In the following subsections, we highlight the most salient findings for clients with high versus low attachment anxiety and high versus low attachment avoidance.

Attachment anxiety and CREs. Clients with high attachment anxiety, as opposed to client with low attachment anxiety, were more likely to have indicated that therapists facilitated CREs by identifying client behavior patterns being enacted with the therapist, that CREs focused on changing behavior patterns, and that CREs resulted in improved interpersonal functioning (specifically, gaining awareness of and/or changing interpersonal behavior patterns outside of therapy). Thus, when clients had high levels of attachment anxiety, CREs tended to focus on interpersonal (as opposed to intrapersonal) aspects. Levenson (2003) proposed that corrective experiences "correct" maladaptive internal working models of self and other, but in the case of highly attachment-anxious clients it appears to be primarily maladaptive internal working models of others. Given that attachment anxiety involves a tendency to worry in relationships and fear abandonment (Brennan et al., 1998), highly attachment-anxious clients might be predisposed to being concerned about how they are relating to others rather than how they relate to themselves. Relatedly, perhaps clients high in attachment anxiety develop the presence of more maladaptive interpersonal behavior patterns in pre-emptive attempts to avoid abandonment (clients with high attachment anxiety tend to hyperactivate their attachment system and engage in exaggerated expressions of fear, need, and doubt in close relationships; Mikulincer & Shaver, 2007). As internal working models of others can include a continuum from high to low dependability, caring, and reliability (Gelso, Palma, & Bhatia, 2013), perhaps the interpersonal improvements following CREs may be the result of adaptive modifications to internal working models of others as more dependable, caring, and reliable.

Attachment avoidance and CREs. Clients who had high attachment avoidance, as opposed to client with low attachment avoidance, reported more client facilitators of CREs (especially deep disclosure prior to CREs), less facilitative therapist actions focused on identifying/questioning client behavior patterns, and more reduction in unwanted feelings after CREs. Thus, high attachment avoidance appeared to be related to a greater intra-personal (rather than interpersonal) focus of CREs. Accordingly, in Levenson's (2003) proposal that corrective experiences "correct" maladaptive internal working models of self and other, the "correction" for highly attachment-avoidant clients appears to focus primarily on changing maladaptive internal working models of self. Internal working models of self tend to involve one's perception of oneself as lovable and worthy (Gelso, Palma, & Bhatia, 2013). Perhaps clients high in attachment avoidance are predisposed to be more concerned about how they are relating to themselves rather than how they relate to others because they avoid others.

Unexpectedly, clients with high attachment avoidance were more likely than clients with low attachment avoidance to report positive therapy relationships from the start of therapy. This finding was surprising given that clients with higher attachment avoidance tend to avoid intimacy (Brennan et al., 1998) and would thus be expected to have greater difficulties establishing healthy attachment to their therapists. Perhaps therapists were responsive to client attachment needs and helped the clients high in attachment avoidance feel at ease, or perhaps clients high in attachment avoidance were more likely to avoid discussion of difficulties in the therapy relationship in the post-therapy interviews. From a psychoanalytic perspective, one possible explanation may be

that clients' idealized positive transference (see Baker & Baker, 1987) distorted the accuracy of memory of the initial ups and downs of their therapy relationships.

Possible Clues about the Lack of CREs in Non-CRE Cases

Pre-therapy client attachment anxiety and avoidance. Clients who had CREs in therapy had higher pre-therapy attachment anxiety and avoidance than did the non-CRE clients. This finding has an interesting parallel in empirical literature on the psychoanalytic concept of transference (consider greater levels of attachment anxiety and avoidance to be related to greater levels of transference in the therapy relationship; Gelso & Bhatia, 2012; Gelso, Palma, & Bhatia, 2013; Marmarosh et al., 2009): the most improved clients in some studies have a great deal of negative transference resolved in the course of therapy (e.g., Gelso et al., 1997), while the less improved clients never seem to have extremely high negative transference (never reaching 3 on a 5-point scale) in several studies (Gelso et al., 1991, 1997; 2005; Marmarosh et al., 2009; Woodhouse et al., 2003). Perhaps the clients with greater attachment difficulties were in greater need of CREs, and therapists responded to these needs with behaviors facilitative of CREs. Alternatively, perhaps any positive shifts are less striking for clients with less attachment difficulties to begin with, making it more difficult for these clients to consider positive shifts to be large enough to qualify as 'corrective.'

What clients wished therapists had done differently. Clients who lacked CREs were more likely than clients who had CREs to make statement(s) in their post-therapy interview indicating that they wished their therapist's theoretical orientation was a better match. Perhaps therapists were too rigidly adherent to their theoretical approach and were not responsive to client needs in therapy, hampering the facilitation of CREs.

Alternatively, perhaps the clients were not good candidates for the psychodynamic therapy offered at the clinic, or may not have been good candidates for the occurrence of CREs. Yet another explanation might be that there was an underlying difficulty with client-therapist agreement on the goals and tasks of therapy due to a mediocre client-therapist match, which reduced the likelihood of adequately meeting facilitative conditions for the occurrence of CREs.

Limitations

One limitation is the limited generalizability of findings and low statistical power for quantitative analyses on the ECR due to the small sample size. However, although the sample size of 31 clients (18 with CREs, 13 without CREs) is small by quantitative standards, it is considered large for a qualitative study (Hill, 2012).

Secondly, the present study was limited to those who provided usable post-therapy interview responses (31 of 105 clients, which is about 30%). Relatedly, the quality of the post-therapy interview data was affected because some clients did not seem to fully understand the definition of CREs.

A third limitation is that by focusing on CREs, we excluded other types of CEs or other helpful aspects of therapy. In other words, other types of events (e.g., insight, immediacy) may have been the causal mechanisms of change rather than CREs.

A fourth limitation of the present study is all of the research assistants, the principal investigator, and the auditor were female from one large public mid-Atlantic US university, which may have caused some bias in the way the results were interpreted (e.g., they may have had a bias toward wanting interpersonal changes). Relatedly, other biases/expectations of the team undoubtedly played a role in how the data were

interpreted. Although these biases/expectations were discussed and an auditor was used, another research team would probably have somewhat different results, as was true in Ladany et al. (2012a). One particularly relevant aspect of the research team is that other than the principal investigator they were all undergraduates with limited training in psychotherapy. A group of seasoned psychotherapists may have seen other things in the data.

A fifth limitation is that our data collection method involved interviews conducted after therapy had ended. Although clients answered questions about CREs after every session, these data proved to be untrustworthy because clients did not seem to understand the definition of CRE and because there could have been a demand for clients to respond to the question even though they had not had a CRE. We eventually realized that post-session measurement was not appropriate given that CREs by definition do not happen that frequently.

Finally, although possessing at least a master's degree and two years of training, our graduate student therapists did not have as much experience as therapists who have been practicing for years. It may be that experienced therapists would be able to facilitate more CREs.

Implications for Practice, Training and Research

From the beginning of therapy, therapists may want to facilitate positive therapeutic relationships, as the present study indicated that CREs were typically preceded by positive therapy relationships. Strategies for fostering positive therapy relationships might include assessing and addressing client therapy goals, client needs in terms of the therapy process, and client expectations about therapy. In addition,

conveying positive, nonjudgmental regard of clients (e.g., responding with nonjudgmental positive reactions to client disclosures) is another relationship-building strategy that may help clients (especially those high in attachment avoidance) feel comfortable engaging in the riskier, more vulnerable disclosures that may facilitate CREs.

Perhaps the most obvious implication for practice and training from the present study is that therapists in the present study facilitated CREs by: (a) identifying or questioning client behavior patterns, and (b) conveying care, understanding, nonjudgmentalness and/or credibility towards their clients. Although these therapist behaviors do not guarantee CREs, they were identified as facilitating factors by clients in post-therapy interviews.

Given that client attachment moderated the antecedents, types, and consequences of CREs, and in line with Levy and colleagues' recommendation to assess (formally or informally) client attachment types, therapists may want to assess client attachment formally using measures such as the ECR (Brennan et al., 1998) or the Adult Attachment Interview (George, Kaplan, & Main, 1984, 1985), or informally by observing signs of client attachment anxiety (e.g., does the client tend to worry about relationships and show signs of a fear of abandonment?) and avoidance (e.g., does the client come across as dismissive or avoid closeness?). Applying Levy and colleagues' recommendations to tailor therapeutic interventions to work more effectively with client attachment styles, clinicians may want to tailor their interventions to their client's attachment style using the present study's findings by focusing on noticing and addressing maladaptive behavior patterns being enacted with the therapist for high attachment anxiety clients and patterns

being enacted outside of therapy for low attachment avoidant clients, focusing on conveying profound trustworthiness for low attachment anxiety clients, and either pointing out client patterns or conveying profound trustworthiness to high attachment avoidant clients. Researchers may consider assessing the extent to which avoidantly attached clients grow in engagement with their therapist using the Therapeutic Distance Scale (TDS; Mallinckrodt, Choi, & Daly, 2014) and anxiously attached clients reduce attachment hyperactivation behaviors (see Mikulincer & Shaver, 2007).

Further research is needed with new samples of clients and therapists to determine whether the present findings are robust. Additional research could further illuminate therapist strategies and skills for facilitating the occurrence of CREs. Empirical investigation is needed to determine effective training techniques for the training and teaching of therapist actions aimed at facilitating CREs. Given the varying types of CEs, future researchers could examine all the various types of corrective experiences (e.g., both CREs and CEs) within the same study to compare CREs to other types of CEs. Further empirical study of client attachment in relation to CREs is needed, especially with a sample large enough to investigate each of the four types of client attachment (secure, fearful, dismissing, preoccupied) in relation to CREs, as well as test the robustness of the present study’s findings on attachment anxiety and avoidance. Furthermore, given the dearth of research on why CREs do not occur, future research studies may want to incorporate in the qualitative interview protocol questions asking clients, therapists, and observers why corrective experiences did not occur.

Table 1

Means and Standard Deviations for Pre-Therapy ECR Attachment Anxiety and Avoidance for Clients in Current Study, All Clients in Research Clinic Where Study was Conducted, and Marmarosh et al. (2009)

	ECR-Anx		ECR-Avoid	
Sample	*M*	*SD*	*M*	*SD*
All clients in current study, *N* = 31	4.28	1.12	2.83	1.22
CRE clients in current study, *N* = 18	4.64	0.93	2.94	1.21
Non-CRE cases in current study, *N* = 13	3.79	1.21	2.67	1.26
All clients in clinic (including clients in study), *N* = 155	4.27	1.20	3.10	1.20
Marmarosh et al. (2009), *N* = 31	3.91	1.32	3.27	1.37

Note. ECR = Experiences in Close Relationships Scale (Brennan, Clark, & Shaver, 1998). ECR-Anx = Anxiety subscale of ECR. ECR-Avoid = Avoidance subscale of ECR. High scores on ECR-Anx indicate high levels of attachment anxiety; high scores on ECR-Avoid indicate high levels of attachment avoidance. The Marmarosh et al. (2009) sample included 31 adults (Age *M* = 24.6 years, *SD* = 9.2, ranging from 18 to 53 years old; 27 Caucasians, 2 Asian Americans, 1 African American, and 1 Latin American).

Table 2

Frequency of Cases for CRE Antecedents, Types, and Consequences

*Domain/*Category/Subcategories	All CRE *N* = 18	AvoidLo *n* =12	AvoidHi *n* = 6	AnxLo *n* = 6	AnxHi *n* =12
Therapy Relationship Prior to CRE					
Positive therapy relationship prior to the CRE	T (11)	V (5)	G (6)	V (3)	T (8)
Positive relationship from the beginning of therapy	V (8)	V (4)	T (4)	V (2)	V (6)
Progressed from Neutral to Positive prior to the CRE	V (3)	V (1)	V (2)	V (1)	V (2)
Difficulties in therapy relationship prior to CRE	T (11)	T (9)	V (2)	T (4)	T (7)
Difficulties were re-enactment of client patterns	V (4)	V (3)	V (1)	V (1)	V (3)
Other difficulties	V (7)	V (6)	V (1)	V (3)	V (4)
Immediate Antecedents of CREs					
Therapist actions facilitating CRE	G (18)	G (12)	G (6)	G (6)	G (12)
Therapist identified/questioned client behavior pattern	T (13)	T (10)	V (3)	T (4)	T (9)
Pattern was being enacted outside therapy	T (10)	T (8)	V (2)	T (4)	V (6)
Pattern was being enacted with the therapist	V (6)	V (4)	V (2)	N (0)	V (6)
Therapist conveyed profound trustworthiness (deep care, understanding, nonjudgmentalness, or credibility)	T (10)	T (7)	V (3)	G (6)	V (4)
No therapist actions facilitating CRE mentioned	N (0)	N (0)	N (0)	N (0)	N (0)
Client actions preceding CRE					
Client engaged in problematic interpersonal behavior	V (4)	V (3)	V (1)	V (1)	V (3)
Client facilitators of CREs	V (6)	V (2)	T (4)	V (2)	V (4)
Client disclosed something previously withheld or opened up deeply	V (4)	V (1)	V (3)	V (2)	V (2)
Client expressed his/her relational needs to the therapist	V (2)	V (1)	V (1)	N (0)	V (2)
No client contributions preceding CRE mentioned	V (8)	T (7)	T (1)	V (3)	V (5)
CRE Description (types of corrective shifts)					
Client had a new understanding of the therapist, therapy relationship and/or therapy and valued therapy more	T (10)	V (6)	T (4)	G (6)	V (4)
Therapist helped client gain a new understanding of and/or breakthrough in changing behavior patterns	V (8)	V (6)	V (2)	N (0)	T (8)
Consequences of CREs					
Therapy relationship after CRE					
Improvements in the therapy relationship after CRE	G (18)	G (12)	G (6)	G (6)	G (12)
Client trusted therapist more, opened up more, and/or felt a deeper connection with the therapist	T (15)	T (10)	G (5)	G (5)	T (10)

Client gained greater respect for therapist's professional abilities and/or credibility	V (8)	V (6)	V (2)	T (4)	V (4)
Client gained greater awareness of or changed interpersonal patterns in the therapy relationship	V (6)	V (4)	V (2)	V (1)	V (5)
No mention of therapy relationship consequences of CRE	N (0)	N (0)	N (0)	N (0)	N (0)
Intrapersonal functioning after CRE					
Improvements in client's intrapersonal well-being	T (13)	T (9)	T (4)	V (3)	T (10)
Greater self-awareness, new ways of thinking about self and/or new ways of relating to self	T (10)	T (7)	V (3)	V (3)	T (7)
Increased positive feelings	V (7)	V (5)	V (2)	N (0)	T (7)
Reduction of unwanted feelings	V (4)	V (1)	V (3)	V (1)	V (3)
Client felt discomfort due to changing client's typical behavior pattern	V (2)	V (1)	V (1)	N (0)	V (2)
No mention of intrapersonal improvements from CRE	V (5)	V (3)	V (2)	V (3)	V (2)
Interpersonal functioning after CRE					
Client gained awareness of and/or began changing interpersonal behavior patterns outside of therapy	V (8)	V (6)	V (2)	V (1)	T (7)
No mention of interpersonal consequences of CRE	T (10)	V (6)	T (4)	G (5)	V (5)
Therapy productivity after the CRE					
Client engaged in more productive behaviors in or attitudes towards therapy after the CRE	V (9)	T (8)	V (1)	V (3)	V (6)
No mention of therapy productivity consequences of CRE	V (9)	V (4)	G (5)	V (3)	V (6)

Note. Total Cases with CREs *N* = 18. Total Low Avoidant CRE Cases *n* = 12. Total High Avoidant CRE Cases *n* = 6. Total Low Anxiety CRE Cases *n* = 6. Total High Anxiety CRE Cases *n* = 12. G = General (17-18 of the 18 CRE cases; 11-12 of the 12 low avoidant or 12 high anxiety cases; 5-6 of the 6 high avoidant or 6 low anxiety cases). T = Typical (10-16 of the 18 CRE cases; 7-10 of the 12 low avoidant or 12 high anxiety cases; 4 of the 6 high avoidant or 6 low anxiety cases). V = Variant (below 9 of the 18 CRE cases; below 6 of the 12 low avoidant or 12 high anxiety cases; below 3 of the 6 high avoidant or 6 low anxiety cases). Double-coding was allowed; e.g., if a client mentioned both positive aspects and difficulties in the therapy relationship prior to the CRE, both were valid in our coding scheme. Mutually exclusive categories emerged as well. Attachment anxiety and avoidance were measured by the ECR (Brennan et al., 1998) prior to intake sessions and divided into high and low groups based on whether scores were above or below a normative average (i.e., 155 clients in research clinic, see Table 1).

Table 3

Percentage of Cases for CRE Antecedents, Types, and Consequences for CRE cases

Domain/Category/Subcategories	All CRE	AvoidLo	AvoidHi	AnxLo	AnxHi
Therapy relationship prior to CRE					
Positive therapy relationship prior to the CRE	T (61)	V (42)	G (100)*	V (50)	T (67)
Positive relationship from the beginning of therapy	V (44)	V (33)	T (67)*	V (33)	V (50)
Progressed from Neutral to Positive prior to the CRE	V (17)	V (08)	V (33)	V (17)	V (17)
Difficulties in therapy relationship prior to CRE	T (61)	T (75)*	V (33)	T (67)	T (58)
Difficulties were re-enactment of client patterns	V (22)	V (25)	V (17)	V (17)	V (25)
Other difficulties	V (39)	V (50)*	V (17)	V (50)	V (33)
Immediate Antecedents of CREs					
Therapist actions facilitating CRE	G (100)	G (100)	G (100)	G (100)	G (100)
Therapist identified/questioned client behavior pattern	T (72)	T (83)*	V (50)	T (67)	T (75)
Pattern was being enacted outside therapy	T (56)	T (67)*	V (33)	T (67)	V (50)
Pattern was being enacted with the therapist	V (33)	V (33)	V (33)	N (0)	V (50)*
Therapist conveyed profound trustworthiness (deep care, understanding, nonjudgmentalness, or credibility)	T (56)	T (58)	V (50)	G(100)*	V (33)
No therapist actions facilitating CRE mentioned	N (0)	N (0)	N (0)	N (0)	N (0)
Client actions preceding CRE					
Client engaged in problematic interpersonal behavior	V (22)	V (25)	V (17)	V (17)	V (25)
Client facilitators of CREs	V (33)	V (17)	T (67)*	V (33)	V (33)
Client disclosed something previously withheld or opened up deeply	V (22)	V (08)	V (50)*	V (33)	V (17)
Client expressed his/her relational needs to the therapist	V (11)	V (08)	V (17)	N (0)	V (17)
No client contributions preceding CRE mentioned	V (44)	T (58)*	V (17)	V (50)	V (42)
CRE Description (types of corrective shifts)					
Client had a new understanding of the therapist, therapy relationship and/or therapy and valued therapy more	T (56)	V (50)	T (67)	G(100)*	V (33)
Therapist helped client gain a new understanding of and/or breakthrough in changing behavior patterns	V (44)	V (50)	V (33)	N (0)	T (67)*
Consequences of CREs					
Therapy relationship after CRE					
Improvements in the therapy relationship after CRE	G (100)	G (100)	G (100)	G (100)	G (100)
Client trusted therapist more, opened up more, and/or felt a deeper connection with the therapist	T (83)	T (83)	T (83)	T (83)	T (83)
Client gained greater respect for therapist's					

professional abilities and/or credibility	V (44)	V (50)	V (33)	T (67)*	V (33)
Client gained greater awareness of or changed interpersonal patterns in the therapy relationship	V (33)	V (33)	V (33)	V (17)	V (42)
No mention of therapy relationship consequences of CRE	N (0)	N (0)	N (0)	N (0)	N (0)
Intrapersonal functioning after CRE					
Improvements in client's intrapersonal well-being	T (72)	T (75)	T (67)	V (50)	T (83)*
Greater self-awareness, new ways of thinking about self and/or new ways of relating to self	T (56)	T (58)	V (50)	V (50)	T (58)
Increased positive feelings	V (39)	V (42)	V (33)	N (0)	T (58)*
Reduction of unwanted feelings	V (22)	V (08)	V (50)*	V (17)	V (25)
Client felt discomfort due to changing client's typical behavior pattern	V (11)	V (08)	V (17)	N (0)	V (17)
No mention of intrapersonal improvements from CRE	V (28)	V (25)	V (33)	V (50)*	V (17)
Interpersonal functioning after CRE					
Client gained awareness of and/or began changing interpersonal behavior patterns outside of therapy	V (44)	V (50)	V (33)	V (17)	T (58)*
No mention of interpersonal consequences of CRE	T (56)	V (50)	T (67)	G (83)*	V (42)
Therapy productivity after the CRE					
Client engaged in more productive behaviors in or attitudes towards therapy after the CRE	V (50)	T (67)*	V (17)	V (50)	V (50)
No mention of therapy productivity consequences of CRE	V (50)	V (33)	G (83)*	V (50)	V (50)

Note. Total Cases with CREs $N = 18$. Total Low Avoidant CRE Cases $n = 12$. Total High Avoidant CRE Cases $n = 6$. Total Low Anxiety CRE Cases $n = 6$. Total High Anxiety CRE Cases $n = 12$. G = General (17-18 of the 18 CRE cases; 11-12 of the 12 low avoidant or 12 high anxiety cases; 5-6 of the 6 high avoidant or 6 low anxiety cases). T = Typical (10-16 of the 18 CRE cases; 7-10 of the 12 low avoidant or 12 high anxiety cases; 4 of the 6 high avoidant or 6 low anxiety cases). V = Variant (below 9 of the 18 CRE cases; below 6 of the 12 low avoidant or 12 high anxiety cases; below 3 of the 6 high avoidant or 6 low anxiety cases). Double-coding was allowed; e.g., if a client mentioned both positive aspects and difficulties in the therapy relationship prior to the CRE, both were valid in our coding scheme. Mutually exclusive categories emerged as well. Attachment anxiety and avoidance were measured by the ECR (Brennan et al., 1998) prior to intake sessions and divided into high and low groups based on whether scores were above or below a normative average (i.e., 155 clients in research clinic, see Table 1).

* = difference between high vs. low attachment avoidance or high vs. low attachment anxiety of at least 30%, with the asterisk next to the sample that scored the highest.

Table 4

Frequency of CRE Versus Non-CRE Cases for Things Clients Wished Therapists Would Have Done Differently

Category	CRE (*N* = 18)	Non-CRE (*N* = 13)
Wished therapist was more active/directive and/or used more therapeutic techniques	Variant (9)	Variant (6)
Disliked something the therapist did or wished therapist would have been more helpful	Variant (6)	Variant (6)
Wished therapist's theoretical orientation was a better match	None (0)	Variant (4)*
Wished CRE had occurred earlier in therapy	Variant (3)	N/A
Client did not wish therapist would have done anything differently	Variant (4)	Variant (3)

Note. Total Cases with CREs *N* = 18. Total Cases with CREs *N* = 13. The label "General" was used if finding applied to all or all but one case (17-18 of the 18 CRE cases; 12-13 of the 13 non-CRE cases). "Typical" refers to finding that applies to more than half the cases but up to the cut off for general (10-16 of the 18 CRE cases; 7-12 of the 13 non-CRE cases). "Variant" refers to findings that apply to at least two but fewer than the cut-off for typical (2-9 of the 18 CRE cases; 2-6 of the 13 non-CRE cases).

* = difference between CRE and non-CRE samples of at least 30%, with the asterisk next to the sample that scored the highest.

Appendix A: Chapters 2 and 3

Chapter 2: Review of the Literature

In this chapter, I review the literature on corrective experiences and corrective relational experiences. The first subsection discusses the definition and theoretical background of CEs, including a subsection on how corrective experiences compare to other types of helpful events in therapy. The second subsection discusses the rationale, definition, and theories for CREs. The third subsection summarizes the handful of empirical investigations conducted thus far on CEs and the even smaller handful of empirical investigations conducted on CREs. The fourth subsection presents a brief introduction to adult attachment theory as it relates to corrective experiences and highlights recent literature on adult attachment as it relates to psychotherapy.

Definitions and Theories of Corrective Experiences

Definition of corrective experiences. A corrective experience (CE) is considered a key mechanism of psychotherapeutic change in a wide variety of theoretical perspectives (e.g., Alexander & French, 1946; Christian et al., 2012; Constantino & Westra, 2012; Goldfried, 2012; Hayes et al., 2012; Sharpless & Barber, 2012) and involves "a disconfirmation of a client's conscious or unconscious expectations … as well as an emotional, interpersonal, cognitive, and/or behavioral shift" (Hill et al., 2012, p. 355-356). CEs typically involve clients "reencounter[ing] previously unresolved conflicts … or previously feared situations (whether internal or external) … [and] reach[ing] a new outcome in terms of their own responses, the reactions of others, or new ways of interacting with others" (Hill et al., 2012, p. 356). Anderson et al. (2012) operationally defined CEs to "include a recognizable contrast with the client's prior

experiences" (p. 284). CEs may occur as discrete events (e.g., a particular part of a therapy session) or an accretion based on an overall therapeutic relationship (e.g., a corrective experience taking place over 2 years of therapy; Hill et al., 2012). CEs can occur without client insight into the new reactions or previously feared situations (and insight can occur without CEs; Hill et al., 2012). CEs can be "an outcome of therapy, a mechanism of change leading to an outcome, or simply the process of successful treatment, such that good therapy is a succession of CEs" (Hill et al., 2012, p. 357).

A definition of CEs was determined by consensus after 12 hours of discussion at the Penn State University (Castonguay & Hill, 2012) as follows:

> CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way. Note that this definition allows for events that are emotional, relational, behavioral, or cognitive. This definition stresses, however, that such events are not just typical helpful events in therapy but that they are surprising or disconfirming of past experiences and often have a profound effect. (pp. 5-6)

CEs can also occur in a client's relationships outside of therapy (Castonguay & Hill, 2012). However, given our interest in examining how therapy can be helpful for clients, we focus primarily on CEs that have occurred during therapy and as a result of therapeutic intervention.

Variations on the definition of corrective experience. Although the basic elements of the definition of corrective experiences are common across all –or almost all– theoretical perspectives (e.g., involving a disconfirmation of the client's expectations in a way that helps the client), many aspects of the definition of corrective experiences

vary across differing theoretical stances. The concept of corrective experiences originated as ‘corrective emotional experiences’ (Alexander & French, 1946), and required an emotional component to the problematic situation addressed by the corrective experience. Although the emotional component of the definition of corrective experience is regarded as an important aspect from a number of theoretical stances (e.g., psychodynamic therapy, relational therapy, person-centered therapy; Castonguay & Hill, 2012), the definition has been expanded to include therapies that emphasize the cognitive, behavioral, and/or interpersonal aspects of change (Castonguay & Hill, 2012). Indeed, some even argue that the correction in CEs must include new behaviors, while others argue that the correction can consist only of new internal experiences (Hill et al., 2012). Hill et al. (2012) suggest that both definitions be included and distinguished two types of CEs. Type 1 CEs involve new thoughts, emotions, sensations, or behaviors that disconfirm the client’s expectations and do not need to include generalization of newly learned behavior (e.g., when Carl Rogers said to Gloria that she “would make a pretty good daughter,” this disconfirmed Gloria’s expectations of men and seemed very meaningful for her; Shostrom, 1965, Hill et al., 2012). Type 2 CEs involve the client learning new behaviors and generalizing the behaviors outside of therapy (Hill et al., 2012). These two types can be interrelated—Type 1 CEs may lead to Type 2 CEs, and Type 2 CEs may lead to Type 1 CEs (e.g., by disconfirming a client’s negative expectations of self or others; Hill et al., 2012).

How do CEs differ from similar constructs in psychotherapy? Corrective experiences are similar to but distinct from: a) new experiences, b) insight, c) immediacy, and d) helpful events in psychotherapy. Compared to new experiences, CEs are a subtype

of new experience that are helpful (since new experiences can either be helpful or not), and focus on reducing or eliminating suffering due to previously unresolved conflicts or previously feared situations (see Alexander & French, 1946). Compared to insight, although CEs are similar in that the client has a shift in thinking, feeling, and/or behaving, CEs differ from insight in the new way of thinking, feeling, or behaving must involve a disconfirmation of the client's expectations, and may occur without client insight into the new reactions or previously feared situations (Hill et al., 2012). I would add that CEs must 'correct' something maladaptive while insights are not restricted in this way (insights can simply add to a client's existing knowledge without 'correcting' anything). Compared to immediacy, CEs may occur without explicit discussion of the CE, without the therapist's awareness, and without client insight as to the previously feared situations (see Castonguay & Hill, 2012). Immediacy can facilitate a CE, produce a CE, or follow the CE (e.g., the client reports having the CE during discussion of the therapeutic relationship) (Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012).

Compared to helpful events in psychotherapy, CEs are a particular type of helpful event in psychotherapy—specifically, CEs are helpful events in therapy that involve a) a disconfirmation of a client's expectations, and b) lead to a positive shift for the client. In order to better situate the phenomenon of CEs within other helpful events in therapy, I compare CEs to client-identified helpful events from a qualitative meta-analysis by Timulak (2007). Timulak's qualitative meta-analysis examined seven primary studies containing more than 590 events from 94 different cases (in one study, the number of events was not stated). Preliminary meta-categories were developed by one researcher

dividing data (categories, category descriptions, and examples) from the results sections of primary studies into meaning units and then examining similarities in meanings contained in them. Final meta-categories and meta-descriptions incorporated observations from two independent auditors. Nine meta-categories of helpful events emerged from the analysis. The first category, awareness/insight/self-understanding, included events ranging from different levels of becoming aware of aspects of an experience to a deeper contextual (including past influence) understanding of a life situation. The second category, behavioral change/problem solution, included events in which the client developed a new strategy to attain desired goals. The third category, empowerment, consisted of impacts in which the client (a) experienced a fresh sense of personal strength; (b) had a sense of personal development; (c) experienced interpersonal validation; or (d) experienced recognition of self-development. The fourth category, relief, included events of client experiential relaxation resulting from the experience of safety with the therapist or in which therapist input (empathy, affirmation, and hopefulness) may have played a role. The fifth category, exploring feelings/emotional experiencing, consisted of events in which the client experienced emotions freshly, possibly in a new way. The sixth category, feeling understood, involved clients feeling deeply understood, which brought them a unique interpersonal experience. In the seventh category, client involvement, an event was significant because it made the client actively participate in the therapeutic process and allowed space for the client to come up with what was important in his or her current judgment of therapeutic process. The eighth category, reassurance/support/safety, contained events in which clients experienced reassurance provided by the therapist with and without explicit verbal reassurance, and

acceptance by the therapist. The ninth category, personal contact, was characterized by the client experiences of the therapist being not like a doctor but rather like a (close) fellow human being (Timulak, 2007).

In comparison to these nine categories of helpful events, since each of the nine categories involves a positive shift for the client, a CE is distinguished in comparison by the additional criteria that the event must involve a disconfirmation of the client's expectations. Thus, a CE can be considered a special - even privileged - type of helpful event due to the 'corrective' power of transforming a previously maladaptive aspect of the client's experience into a positive aspect (rather than taking a neutral or positive aspect and making it more positive). As emphasized in the Penn State University definition, CEs "are not just typical helpful events in therapy but … are surprising or disconfirming of past experiences and often have a profound effect" (p. 6, Castonguay & Hill, 2012).

However, the definition of the term "corrective experience" is complicated by the fact that many different techniques and aspects of therapy may be involved in producing CEs. For example, the therapeutic framework (e.g., empathic conversation focused on the client) may in itself be a corrective experience if a client had previously never experienced a conversation focused solely on helping the client. Or, CEs may be confused with the therapeutic relationship (alliance) if a client had previously never experienced a relationship in which conversations focused solely on taking care of the client's needs. In these two examples, the therapeutic framework and the alliance facilitate and provide the CE, but the terms 'alliance' and 'therapeutic framework' do not always constitute a CE—they must disconfirm a client's expectations in some way, and

lead to a positive shift for the client. Thus, although various techniques, interventions, and characteristics of therapy can facilitate and/or provide CEs, such aspects of therapy are not always CEs, and CEs do not always have to involve a certain technique/aspect of therapy. What is important to the definition of a CE is that something (whether it be a technique, intervention, or some other aspect of therapy) disconfirmed a client's conscious or unconscious expectations in a way that allowed the client to have a positive shift.

Theoretical background for CEs. Alexander and French (1946) are credited to propose the original concept of corrective experiences, and theorized about corrective experiences thus:

> In all forms of etiological psychotherapy, the basic therapeutic principle is the same: to reexpose the client, under more favourable circumstances, to emotional situations which he [sic] could not handle in the past. The client, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experiences. It is of secondary importance whether this corrective experience takes place during treatment in the transference relationship or parallel with the treatment in the daily life of the client. (p. 66)

Alexander and French's (1946) formulation of corrective experiences can be examined to specify the necessary conditions for a CE. Sharpless and Barber (2012, p. 34) identify the following 12 components and specifications based on Alexander and French's (1946) formulation:

1. The client must have experienced traumatic events (construed fairly broadly) or

events that caused a traumatic influence which were not successfully/adaptively dealt with in the past (Alexander & French, 1946, p. 66).

2. The client must be re-exposed to these emotional situations which were not successfully/adaptively dealt with (Alexander & French, 1946, p. 66).
3. This re-exposure must occur in more favorable circumstances than the original situation allowed (Alexander & French, 1946, p. 66).
4. The client must be able and willing to face the re-exposure (implied in definition).
5. This re-exposure does not necessarily need to take place with the therapist or within typical session confines (Alexander & French, 1946, p. 66).
6. The therapist (or another person in the client's life) must assume or express an attitude different from that of the individual(s) involved in the original traumatic event (Alexander & French, 1946, p. 66).
7. Building on 6, with CEEs specifically involving the therapist, the therapist may or may not *self-consciously* assume a particular role or attitude (or, similar to Kierkegaard [1844/1980], facilitate a particular emotional atmosphere) to elicit the emotional situation (i.e., manipulation may be present, but not necessarily; Alexander, 1961; Alexander & Selesnick, 1966). (Alexander & French, 1946, pp. 66-67)
8. The client must handle/react to this novel situation (#6) in a manner different from before (Alexander & French, 1946, p. 67).
9. Such a result often takes repetition of the conflicts before a new ending occurs (i.e., it seems unlikely that CEEs occur with a single re-exposure). (Alexander & French, 1946, p. 67).

10. Patient insight into these patterns may accompany a CEE, but is neither necessary nor sufficient to cause the CEE, and the experiential component holds predominance (Alexander & French, 1946, p. 67).
11. As a result of the above, the trauma becomes "repaired" in some way (Alexander & French, 1946, p. 66).
12. The results of the CEE should generalize to other situations/experiences (implied). (Sharpless & Barber, 2012, p. 34)

Sharpless and Barber (2012) point out that the Penn State University consensus definition ("CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way") differs in at least five ways from Alexander and French's original formulation:

> First, there is no explicit requirement that the CE takes place in an interpersonal context. Second, there is no direct indication that the therapist needs to behave in a way different from normal procedure. Thus, in contrast to some of Alexander and French's (e.g., 1946) writings, no direct manipulation of the therapeutic encounter deviating from standard psychoanalytic procedures is required. In fact, a therapist/other individual need not be required at all. Third, … there is no implicit requirement that CEs take place within the confines of psychoanalysis, psychoanalytic psychotherapy, or any type of psychotherapy. Fourth, there appears to be no requirement that the client has been unable to handle a past conflict or difficulty. What seems to be changed is an understanding or experience,

> and the consensus definition does not require a previous incapacity or lack of understanding (i.e., a "repair" need not take place). Finally, and perhaps most fundamentally, CEs are not necessarily limited to emotional content, but could consist of behavioral, cognitive, or relational experiences. For example, if a client is worried that his friend is indifferent, then later learns that the friend was merely preoccupied with other matters, this change within the client would presumably fall under the rubric of a CE. (p. 39)

Thus, the current formulation of CEs is much broader than Alexander and French's (1946) original formulation. This discrepancy is problematic since the broadness of the definition a) impinges on other therapeutic constructs, and b) runs the risk of meaning "everything" (therefore, meaning nothing), thus losing explanatory power (Sharpless & Barber, 2012).

Definition and Theoretical Background for Corrective Relational Experiences

Rationale and definition for CREs. In order to maximize explanatory power and minimize the problems that plague a broad formulation of CEs, we focus our investigation specifically on corrective relational experiences (CREs). A corrective relational experience (CRE) is a CE that has the therapeutic relationship as the vehicle of change, and is defined as a specific time in psychotherapy "when the client feels a distinct shift, such that she or he comes to understand or experience affectively the relationship with the therapist in a different and unexpected way, and is thereby transformed in some manner" (Knox et al., 2012; p. 191). The focus is "only on those experiences that occur within the

context of, and because of, the therapeutic relationship" (Knox et al., 2012, p. 191).

The importance of the therapeutic relationship has been repeatedly and robustly demonstrated to be of great importance to therapy process and outcome (see Norcross, 2002), and is a "potent, and as yet relatively empirically unexamined" source of corrective experiences (Knox et al., 2012, p. 192). The therapy relationship can allow and experientially correct maladaptive internal working models of self and other (Levenson, 2003). Focusing specifically on CREs rather than CEs not only allows greater explanatory power (e.g., greater specificity into the mechanisms and predicted outcomes) regarding the role of the therapeutic relationship in corrective experiences, but also advances an important line of research in psychotherapy process and outcome.

Theoretical background for CREs. CREs are "based on the assumption that the therapy relationship itself serves as the source of the corrective experience," and "rely on therapists responding differently (e.g., more supportively) to clients than have others in clients' pasts" (Knox et al., 2012, p. 192). This results in positive changes in clients' relational schemas, improvements in clients interpersonal behaviors as clients realize that they do not need to react in previously problematic ways, and ultimately resolution (rather than repetition) or earlier maladaptive behavior patterns (Knox et al., 2012; Teyber, 2006).

Levenson (2003) articulates several assumptions for Time-Limited Dynamic Psychotherapy (TLDP) that can be viewed as theoretical assumptions underlying CREs. First, maladaptive interpersonal patterns were learned in the

past. Problems with caregivers early on in life can result in maladaptive mental representations and interpersonal schemas (e.g., Bowlby, 1973). Second, the maladaptive interpersonal patterns learned in the past occur in the client's current life. Third, the maladaptive interpersonal patterns are re-enacted in vivo in therapy. The therapist is "invited repeatedly by the patient (unconsciously) to become a partner in a well-rehearsed, maladaptive [pattern]" (Levenson, 2003, p. 305). Fourth,

> For therapists to become unhooked, it is essential that they realize how they are fostering a replication of the dysfunctional pattern and use this information to attempt to change the nature of the interaction in a more positive way, thereby engaging patients in a healthier mode of relating. (Levenson, 2003, p. 305)

Immediacy may play an important role in the facilitation of CREs. Meta-communication about what is happening between the therapist and client can facilitate CREs by "either highlighting the dysfunctional reenactment while it is occurring or solidifying new experiential learning following a more functionally adaptive interactive process" (Levenson, 2003, p. 305).

Levenson (2003) warned that some may take Alexander and French's (1946) concept of corrective experiences too far by promoting the manipulation of transference such that "the therapist should respond in a way diametrically opposite to that expected by the patient" (p. 307-308). Therapists do not have to become manipulative in this way; "a therapist can help provide a new experience by selectively choosing, from all of the helpful, mature, and respectful ways of

being present in a session, those particular aspects that would most effectively undermine a specific patient's dysfunctional style" (Levenson, 2003, p. 308).

Thus, the role of the therapeutic relationship in CREs is to allow, identify, and experientially correct the re-enactment of maladaptive interpersonal patterns and schemas (see Levenson, 2003). The therapist's role is "to provide opportunities for the patient to have new experiences of himself or herself and/or the therapist that are designed to help disrupt, revise, and improve the patient's [maladaptive schemas, mental representations, and/or interpersonal patterns]" (Levenson, 2003, p. 314). CREs are considered to be mechanisms of change (Christian et al., 2012; Constantino & Westra, 2012; Goldfried, 2012; Hayes et al., 2012; Sharpless & Barber, 2012) that explain how the therapeutic relationship can be a vehicle of effective therapy. However, CREs can also be considered outcomes of therapy or parts of the process of effective treatment (Hill et al., 2012), among other helpful experiences, understandings, schemas, mental representations, thoughts, feelings, and behaviors.

Empirical Studies of CEs and CREs

Empirical studies of CEs. Heatherington, Constantino, Friedlander, Angus, and Messer (2012) examined client perspectives on corrective experiences in psychotherapy. The study collected data simultaneously from five sites, with a total of 76 clients and 39 therapists with theoretical orientations ranging from cognitive behavioral, psychodynamic, client-centered, experiential, emotion-focused, to integrative and eclectic. Therapists' experience levels ranged from doctoral practicum trainees to highly experienced clinicians. Corrective experiences were defined using the 2007 Penn State

University consensus definition: “CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way” (Heatherington et al., 2012, p. 164). A two-item questionnaire was administered after every fourth session. The first question assessed the nature of the corrective experience (i.e., What changed?): “Have there been any times since you started the present therapy that you have become aware of an important or meaningful change (or changes) in your thinking, feeling, behavior, or relationships? This change may have occurred in the past four weeks or any time during the present therapy. Please describe such change (or changes) as fully and vividly as possible.” (Heatherington et al., 2012, p. 166). The second question assessed the mechanism of change (i.e., How did the change happen?): “If yes, what do you believe took place during or between your therapy sessions that led to such change (or changes)?” (Heatherington et al., 2012, p. 166-167). The system for categorizing client responses for each question were developed by each investigator and his/her research assistants, and final categories were determined by collaborative discussion when no new categories emerged across sites. Client responses were divided into meaning units and each complete thought was categorized separately.

Results from Heatherington et al. (2012) indicated that the most frequently mentioned categories of CEs were: new experiential awareness (32% of all meaning units in response to the question of what changed), new perspectives (more cognitive than experiential; 26% of responses), and change in behavior (26%). The category of new experiential awareness included 6 subcategories (new experiential awareness: that a problem exists, of personal strengths, of personal needs, of emotions, of patterns in interpersonal relationships, and of the need to change behavior). The category of new

perspectives (more cognitive than experiential) included 6 subcategories (new perspectives: on relationships with family members or romantic others, on relationships with friends or coworkers, on the relation between past and present, on oneself, on life, and on the therapeutic process). The category of changes in behavior had 5 subcategories (behaving in new ways with others, taking on new challenges, reacting differently to stress, reduction in psychological symptoms, and change in internal dialogue). Results from Heatherington et al. (2012) indicated that clients most attributed the change to: something the client did (42% of all meaning units in response to the question of how the change occurred), something the therapist did (29%), and something the client and therapist did together (17%). External factors were cited in only about 5% of the responses to the question of how the change occurred. A limitation of Heatherington et al. (2012) is the lack of control over ballot-box stuffing—some clients responded to the questions once while others completed the questionnaire as many as 11 times (after every fourth session or so). Thus, results may disproportionately represent clients who completed the questionnaire multiple times. Relatedly, another limitation is that clients completed the questionnaire at different points in therapy—a client who completed the questionnaire at session 44 may have a different perspective than a client who completed the questionnaire at session 4.

Friedlander et al. (2012) conducted a case study of one of the Heatherington et al. (2012) clients, investigating whether and how a CE occurred during the course of short-term dynamic psychotherapy (STDP; Davanloo, 1980) in a hospital-based practice. The case was selected due to the client describing her therapy experience as highly successful. The client was a 35-year-old White woman presenting with severe panic attacks and

inappropriate outbursts of anger. The therapist was a 61-year-old white male psychiatrist with 18 years of full-time clinical experience. Therapy was conducted for 31 sessions and ended by mutual agreement. The client completed a postsession questionnaire after sessions 16, 20, 24, and 28 about whether the client perceived a CE (as defined by the Penn State researchers) and how the CE came about. Both client and therapist participated in posttermination interviews that assessed perceived change mechanisms and CEs. Posttermination interviews and postsession questionnaires were analyzed qualitatively. Four judges derived themes based on reading transcripts of participants' responses to posttermination interviews. Results indicated that the client experienced resolution of unfinished business from childhood and more adaptive relationships; the client was able to have a new and different emotional and cognitive experience of her relationships with both parents. The client reported complete symptom relief, greater self-acceptance, improved relationships, and more emotional flexibility at termination. Thus, consequences of CEs may include resolution of unfinished business from childhood, symptom relief, greater self-acceptance, improved relationships, and more emotional flexibility. Change mechanisms that occurred in the therapy included gaining insight, experiencing disavowed affect, confrontation of character defenses. Change mechanisms not specific to STDP that occurred in the therapy included client motivation, mutual rapport, safety, and respect/acceptance/validation by the therapist. The authors concluded that addressing a client's resistance to emotional expression can facilitate the successful resolution of deep emotional distress, and that therapists need to be responsive and persistent in pursuing a therapeutic agenda. A limitation of the study was the reliance on

a single case, making it difficult to know whether the findings would generalize to other clients, therapists, client-therapist dyads, or treatment settings.

Castonguay et al. (2012) analyzed corrective experiences in a case study of a client who received cognitive-behavioral (CBT) and interpersonal-emotional processing (I-EP) therapies. The client was a 50-year-old European American married heterosexual man presenting with GAD, marital difficulties, and stress at work. The therapist was a European American female in her late 30s with 10 years of postdoctoral therapy experience. The therapist identified as primarily psychodynamic in theoretical orientation but had been trained in CBT. The client was provided with 50 minutes of CBT followed by 50 minutes of I-EP for a total of 14 sessions of each. Therapy outcome was measured by a composite outcome variable created by Newman et al. (2011) to examine GAD symptomatology. CEs were defined using the Penn State University consensus definition "CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way" (Castonguay et al., 2012, p. 246). Four judges coded CEs by discussion and consensus. Analyses found 2 CEs in the CBT therapy and 2 CEs in the I-EP therapy. Three of the four CEs occurred outside of session and one occurred during the course of the I-EP treatment (during session 8).

For the first CE in the CBT treatment in Castonguay et al., the CE consisted of the client's new experience of successfully managing anxiety (e.g., being able to relax instead of tailgating someone as the client would usually do, and the other was calming himself down at work when the presenter before him was going over time, cutting into the client's presentation time). The client stated that he's beginning to "shift a paradigm" (p. 253), and that this was a new experience for him. Antecedents consisted of the client

initially (sessions 1-4) having difficulty using and benefiting from the CBT techniques, then benefiting from treatment beginning at the end of session 4 (reporting a substantial decrease in anxiety after a guided relaxation exercise). Consequences of the CE included strengthening of the therapeutic alliance and enhanced productivity in the therapeutic work.

For the second CE in the CBT treatment in Castonguay et al., the CE episode involved a 2 hour discussion between the client and his wife in which the client had a paradigm shift ("I don't have to be defensive about this, but I have to be honest about it . . . not shut up and run away, but . . . be able to say, 'OK, let's talk about this.' I'm not good at that, but I'm getting better at it" p. 257-258). The client stated that he did not "crash inside" (i.e. become angry, overwhelmed, and withdraw) as he had in the past and explicitly and fully recognized that his wife loves him and has not given up on their relationship (p. 259). The client was able to take in the therapist's positive view of the event. Antecedents included the first CE, as well as discussion/exploration of the client's marital difficulties. The within-session consequences of the CE included providing a productive direction for tasks and goals in therapy, and deeper exploration of the client's fear of getting close to others.

For the first CE in the I-EP treatment in Castonguay et al., the presession antecedents included the client's reluctance to engage in I-EP, the client expressing fears that he would feel sexual attraction toward the therapist if he allowed closeness and/or be scrutinized by a cold and distant attitude of a doctor, the therapist reassuring the client of the possibility of closeness without coldness and would maintain appropriate boundaries, and an alliance rupture in session 2 when the therapist tried to focus on the client's

emotions. The in-session antecedents for the CE included the therapist asking the client what he wanted from the relationship with his daughter, the client intellectualizing, the therapist reiterating the original question, and the client stating again not answering the question. The CE episode included the therapist pointing out that the client had a pattern of failing to directly answer her questions and the distancing impact it had on her, regardless of whether she was asking about emotions or not. Upon discussion, the client realized that he put on a good front ("smoke screen") to control the conversation and avoid being hurt by discussing potentially painful emotions. The event seemed to positively strengthen the alliance and foster the client's awareness and insight. The postsession consequences included that the client and therapist processed their new way of relating in the following session; two sessions later, the therapist complimented the client for not smoke screening in the previous session, and apologized for not appreciating this as it was happening. This was a new experience for the client, who experienced acceptance and validation rather than criticism for opening up about his feelings. Productive exploration, insight, and action plans followed this experience (i.e., realization that he can trust and let his guard down with a woman, that the client had to take a chance in opening up in order to make this experience happen, that the client can choose which relationships are worthy and safe enough to let his guard down, and that the client can generalize this new way of relating to others; doing a role play to allow the client to practice expressing his feelings to his son, who had recently hurt the client's feelings).

For the second CE that occurred during the I-EP treatment in Castonguay et al., the presession antecedents included the postsession effects of the first CE as well as

additional productive exploration/insight and strengthening of the therapeutic bond (e.g., the therapist expressing care for the client when client was embarrassed). The in-session antecedents included the therapist asking the client at the beginning of the session how the client was doing with not smoke screening, to which the client reminded the therapist that the client destroys possessions that the client prizes and disclosed that it occurred to the client that the client does the same thing in relationships (trashes people by rejecting them or walking away from them when there is a conflict). The client reported the CE as an instance in which he felt rejected during the past week by a mentor and close friend, processed his feelings with his wife, and decided to disclose his feelings to this friend rather than "trashing" the relationship. The client's friend responded by saying he valued the relationship with the client and was not going to abandon the client. This experience with this mentor was the client's first time expressing feelings of rejection to any of his male friends.

Thus, antecedents of the CEs in Castonguay et al. (2012) included therapist factors (therapist techniques such as relaxation or cognitive restructuring or using metacommunication skills; and therapist relationship skills such as empathy, openness, tact, and timing of interventions), client factors (client motivation and engagement, client willingness to repeatedly face difficult situations, client willingness to take risks, client openness to tasks of the treatment, and client awareness of and willingness to report difficult interactions with others that occurred between sessions), relationship factors (collaboration, mutual respect, mutual attunement to each other's efforts), and social reinforcement of new ways of relating. Characteristics of CEs included the client purposefully behaving differently than he had in the past in the face of feared situations,

and a disconfirmation of his previous expectations/fears. The nature of the CEs differed between CBT and I-EP treatments: with CEs related to CBT, the client focused more on changing thoughts and behaviors, whereas with CEs related to I-EP, the client focused more on resisting the urge to engage in typical maladaptive responses to conflict, challenging his automatic thoughts that his wife was a source of threat, and attempting to pay attention to what his wife was saying. Consequences of the CEs included a strengthened therapeutic alliance, progressive increase in the client's self-efficacy for facing previously avoided/feared situations, and enhanced productivity in the therapeutic work. Consequences of the combined CBT/I-EP treatment overall included a significant reduction in the client's GAD symptoms and a significant reduction in interpersonal distress. The primary limitation of Castonguay et al. (2012) is the reliance on a single case; it is difficult to know whether the findings would apply to other clients, therapists, client-therapist pairings, or treatment settings.

Anderson, Ogles, Heckman, and MacFarlane (2012) examined the nature, types, and facilitating factors of CEs in successful cases of short-term psychotherapy with either trained or untrained therapists. CEs were defined using the Penn State University consensus definition: "CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way" (p. 284) and further operationally specified to be "experiences in which there is significant contrast to the client's set of prior experiences" (pp. 281-282). CEs were identified through termination interviews conducted by independent clinicians. A total of 14 cases were identified to have CEs associated with specific events (12 occurred during the therapy sessions, 2 occurred outside of therapy). CEs were located from the 1st to the 25th/last

session. Qualitative analyses revealed a number of subtypes of CEs occurring during therapy (1. relational enactment with therapist, 2. client discovery of new experience, 2a. client discovery of new experience: therapist warmth, 2b. client discovery of corrective anger, and 3. therapeutic framework/structure facilitate a CE) and outside of therapy (4. relational enactment outside of therapy, 5. self-directed CEs outside of therapy). Category 6, No Contrast or Environmental change, included 4 cases in which change was reported but lacked full explanation due to lack of identified contrast experiences. In terms of antecedents, therapist supportiveness and warmth facilitated client discovery of new experiences that had previously been unavailable to the client. Anderson et al.'s theoretical model included the assumption that a prerequisite for therapist facilitation of CEs is that the therapist must have an intimate awareness of the client's experiential world. In terms of characteristics of CEs, direct enactment with the therapist only occurred in a minority of cases, while the majority of CEs were more directed by the client in the context of therapist supportiveness. An interesting characteristic of CEs was that the therapeutic framework/structure itself can be a CE (for example, knowledge about confidentiality may itself serve as a new experience for the client). A main finding about the characteristics of CEs is that CEs can occur in a variety of contexts and relationships (e.g., can occur with trained therapists, untrained therapists, and with others outside of therapy), and can occur through both interpersonal and intrapersonal processes. The authors also propose that CEs are characterized as a mechanism for change, or at least are very closely related to the actual mechanism of change. Limitations of Anderson et al. (2012) include that the categories of CEs may have overlapped, and a broad definition of CE was utilized.

Holtforth and Flückiger (2012) investigated whether CEs are primarily singular events or gradual accumulations of smaller but incremental therapeutic episodes. The study was conducted in a psychotherapy outpatient clinic utilizing an integrative form of CBT that incorporates process-experiential and interpersonal interventions. Participants included 223 clients and 108 therapists (master's level psychologists). CEs were defined as being facilitated by two mechanisms of change: the clarification of the patient's motivation and the patient's mastery of his or her problem. CEs were measured by the Bern Post-Session Report (BPSR-P; Flückiger, Regli, Awahlen, Hostettler, & Caspar, 2010), which clients completed after each session. Results indicated that the average level of change experiences predicted positive outcome more strongly and consistently than did extremely intense change experiences (either high or low). Limitations included that the BPSR-P was not designed to assess CEs according to the Penn State University definition, the study lacked a lack of control group (so we do not know whether the trajectory of CEs is similar or dissimilar for clients in other therapies, clients who are seeing other therapists, or individuals who experience CEs while not in therapy), and the lack of standardized assessment of personality disorders in participating clients.

Summary of empirical studies on CEs. In sum, a small body of literature exists on CEs, with most studies using the Penn State University consensus definition of CEs. Regarding the nature of CEs, types of CEs identified included changes in feelings (Anderson et al., 2012; Castonguay et al., 2012; Friedlander et al., 2012; Heatherington et al., 2012), thoughts (Castonguay et al., 2012; Heatherington et al., 2012), and behaviors (Anderson et al., 2012; Castonguay et al., 2012; Friedlander et al., 2012; Heatherington et al., 2012), as well as intrapersonal (Anderson et al., 2012; Castonguay et al., 2012;

Friedlander et al., 2012; Heatherington et al., 2012; Holtforth & Flückiger, 2012) and interpersonal changes (Anderson et al., 2012; Castonguay et al., 2012; Friedlander et al., 2012; Heatherington et al., 2012). The nature of CEs can be such that they are composed of singular events or an accumulation of smaller events (Holtforth & Flückiger, 2012). Antecedents of CEs include client factors, therapist factors, and relationship factors (Anderson et al., 2012; Castonguay et al., 2012; Friedlander et al., 2012; Heatherington et al., 2012). Consequences of CEs identified include improvements in the process (e.g., stronger therapeutic alliance, enhanced productivity in therapy) as well as the outcome of therapy (e.g., symptom reduction, more positive sense of self, improved relationships) (Castonguay et al., 2012; Friedlander et al., 2012; Heatherington et al., 2012).

Empirical studies of CREs. Knox, Hess, Hill, Burkard, and Crook-Lyon (2012) investigated client perspectives on CREs. The 12 clients were all therapists-in-training at the time of the CRE. They reported their therapists to have a mix of theoretical orientations (Jungian, eclectic, humanistic, psychodynamic, cognitive behavioral, feminist). Participants were students who were currently in or had graduated from the primary researchers' academic programs as well as the researchers' colleagues. Interviewers did not interview anyone from their own institution. Two interviews were conducted with each participant. Each interview was transcribed and analyzed following the steps of CQR (Hill, Thompson, & Williams, 1997; Hill et al., 2005). Labels of general (all or all but one case), typical (more than half up to the cutoff for general), and variant (two to half of the cases) were used to describe the findings. Results indicated that the general background for the therapy included positive outcomes and positive elements of the therapy relationship. The CRE antecedent included the participant being deeply

involved in the therapy process (typical) and/or a rupture between the therapist and participant (variant). The type of CRE was variantly the resolution of a rupture, the rescuing of the client, and/or reassurance or normalization. During the CRE, participants explored thoughts and feelings (typical), asserted self or feelings (typical), or dissociated/avoided/felt vulnerable (variant). During the CRE, participants reported the therapists' actions to be empathizing/reflecting/accepting (typical), active/directive (variant), using immediacy (variant), inviting exploration (variant), responding to the rupture (variant), or reassuring/normalizing (variant). The consequences of the CRE included positive intrapersonal changes in the participant (general), a deeper therapy relationship (typical), seeing the therapist in a new way (variant), positive changes in the participant's relationships with others (typical), an improved ability to work with clients (typical), an improved ability to use CRE as a model for work with clients (variant), and an improved ability to attend more to therapy relationship with clients (variant). Limitations include that the results reflect the specific experiences of 12 therapists-in-training (may not generalize to other therapists-in-training, or clients who are not therapists-in-training), the interview responses may have been influenced by social desirability of the participants, all the participants and researchers were European American (may not generalize to non-European American clients and/or non-European American researchers), and it was difficult for participants to identify discrete events that constituted the CRE (for example, one event was described as lasting more than 2 years). Participants in Knox et al. may have had difficulty identifying discrete events due to the time elapsed since the time the CRE occurred, since the interviews were not conducted soon after the therapy had ended.

Ladany et al. (2012a) qualitatively investigated CREs in clinical supervision for 15 therapists-in-training. CREs were defined as occurring "when a trainee feels a distinct shift, such that he or she comes to understand or experience affectively the relationship with the supervisor in a different and unexpected way and is thereby transformed in some manner," (p. 335), with a focus on specific events within the supervisory relationship (see pp. 335-336). Supervisory interactions before CREs typically included both a good supervisory relationship and negative feelings about the supervisory relationship. Antecedents to CREs typically involved the trainees having concerns about supervision or the supervisor, and variantly included concerns about a challenging clinical situation or the trainees' concerns about him- or her-self. During the CRE event, supervisors typically: 1. supported, normalized, validated, 2. were open, 3. processed the supervisory relationship, 4. discussed parallel process, and 5. focused on feelings about the clinical situation. During the CRE even, trainees: 1. disclosed, were open or vulnerable (typical), and 2. did not like their supervisor's intervention (variant). Consequences of CREs generally involved strengthening or transformation of the supervisory relationship, and typically involved: the trainee feeling more comfortable disclosing, a positive impact on the trainee's work with clients, the trainee having increased self-efficacy as a professional, and supervisors evaluating trainees more positively. Limitations of Ladany et al. (2012a) include that the sample was self-selected and there were discrepancies between the interpretation of the data between the two data analysis teams (e.g., one team highlighted concepts related to immediacy more than the other team).

Immediacy as an antecedent to CREs. A number of studies suggest that immediacy (discussions about the here-and-now therapeutic relationship; Kasper et al.,

2008) contributes to CREs. Kasper, Hill, and Kivlighan (2008) examined immediacy in a 12-session case of individual interpersonal psychotherapy and found that immediacy sometimes led to a CRE for the client. Immediacy was defined as “disclosures within the therapy session of how the therapist is feeling about the client, him- or herself in relation to the client, or about the therapy relationship [and] involves discussing and processing what occurs in the here-and-now client–therapist relationship” (p. 281) and was measured by consensus among three judges. No definition of CREs was given in Kasper et al. The client suggested that a CRE occurred when the therapist expressed feeling hurt that it did not matter to the client how long they met:

> This was really an incredible session and I really feel much closer and more attached to Dr. N. It was knowing how disappointed he seemed at the thought of my distance (over discussing our ending) and I never would have realized this if he hadn't brought it up… It's amazing to know what a strong effect I can have on someone… This led to a very vulnerable discussion of how I relate to people and the negative effects of this (p. 289).

Thus, immediacy led to a CRE by exposing the client to a new kind of relationship that differed from the problematic patterns she had experienced in her life.

Hill and colleagues (2008) qualitatively examined immediacy in a 17-session case of brief psychotherapy and found that immediacy was associated with the client experiencing CREs (defined as “coming to understand or experience relationships in a different and unexpected way,” p. 312). CREs were determined by therapist report and conceptualization paragraphs written by the 5 researchers. For example, the client disagreed with the therapist about something (that the client’s mother felt threatened by

the client's successful presentation in class) and the therapist encouraged the client to disagree with him. This was corrective in that the client previously worried that the therapist would become angry and their relationship would be ruined if she disagreed with him. The therapist wrote that, "I thought it was very significant that Jo disagreed with me about something (her mother feeling threatened by Jo's successful presentation in class). … I thought it was a corrective experience for her" (p. 305). The research team noted that "Interestingly, Dr. W's countertransference (i.e., overprotectiveness and high activity level) and the client's idealization of the therapist might have actually facilitated the corrective relational experience, given that the client had experienced such impoverished interpersonal relationships previously" (p. 312).

Mayotte-Blum et al. (2012) qualitatively examined immediacy in a case of individual long-term psychotherapy, and found that immediacy was associated with CREs. Mayotte-Blum et al. provides an example: the therapist teared up while the client was tearing up, and the therapist used immediacy to openly acknowledge his feelings. This was corrective because the client's emotional experience was validated (this client had been viciously verbally attacked by her mother for crying). Although Mayotte-Blum et al. referred to it as a "corrective emotional experience," their description fits under the definition of a corrective relational experience as well.

Hill et al. (2014) examined the use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy, and found that one of the effects was to provide CREs. Immediacy was defined as "a discussion of the therapeutic relationship by both the therapist and client in the here-and-now, involving more than social chitchat (e.g., 'It's nice to see you.')" (p. 3) and determined by rater consensus upon watching

DVDs of the sessions. Consequences of immediacy, including CREs, were determined by teams of raters for each immediacy event and each client; more than one consequence could be coded. No definition of CREs was provided. Of the 234 immediacy events, 2% of those events on average (*SD* = 3%) were associated with CREs. Of the 16 cases examined, in 12% of the cases immediacy was associated with a corrective relational experience for the client.

Summary of studies of CREs. In sum, only one study (Knox et al., 2012) has focused on examining CREs in therapy, while another study (Ladany et al., 2012a) examined CREs in clinical supervision. However, both of these studies examined the CREs of therapists-in-training. These studies found that: antecedents to CREs often involve helping alliances that are going well but sometimes involve alliances that are having difficulties; during CRE events, both helper and helpee were deeply involved; and consequences of CREs include positive intrapersonal, interpersonal and professional changes. In addition, four studies on immediacy (Kasper et al., 2008; Hill et al., 2008; Mayotte-Blum et al., 2012; Hill et al., 2014) have found immediacy to be related to CREs. In these studies, immediacy appeared to be at times preceding the CRE, often occurring during the CRE, and other times occurring after the CRE (for example, a client explaining to the therapist that a CRE has occurred). The main limitation of research on CREs is the lack of studies thus far: no studies have focused on CREs for clients who are not therapists-in-training.

Attachment and Corrective Experiences

Client attachment style has been theorized to play an important role in the types of corrective experiences clients need (Bowlby, 1988; Miller, 1990). Miller (1990) argued

that what CEs correct are negative object attachments (Sharpless & Barber, 2012), and the ‘corrective’ part of CEs and CREs has been theorized to ‘correct’ maladaptive internal working models of self and other (Levenson, 2003). For example, a client with insecure attachment who comes to therapy might, over time, view an effective therapist as an important attachment figure and thus become more securely attached through the development of a new self-other internal working model (Constantino & Westra, 2012). The client in Kasper et al. (2008) appeared to report such a phenomenon when the therapist expressed feeling hurt that it didn’t matter to the client how long they met:

> This was really an incredible session and I really feel much closer and more attached to Dr. N. … I never would have realized this if he hadn't brought it up… It's amazing to know what a strong effect I can have on someone… This led to a very vulnerable discussion of how I relate to people and the negative effects of this. (p. 289)

For adults, attachment style is often measured using two underlying dimensions of attachment organization: anxiety and avoidance (Brennan et al., 1998). An anxiously attached adult tends to have fears of abandonment by and worries about significant interpersonal relationships in his/her life (Brennan et al., 1998). An avoidantly attached adult tends to avoid closeness with important people in his/her life, and does not like to depend on others (Brennan et al., 1998).

Levy, Ellison, Scott, and Bernecker (2011) conducted a recent meta-analysis of adult pre-treatment attachment style and psychotherapy outcome. Participants included 19 separate therapy samples from 14 studies, with a combined N of 1,467. Clients had a variety of presenting problems, including but not limited to: major depression, borderline

personality disorder, marital problems, and post-traumatic stress disorder. Average client ages in the samples ranged from 24.6 to 44.98 years. Percentages of females in individual studies ranged from 0 to 100. Therapist theoretical orientations varied, including cognitive-behavioral, psychodynamic/interpersonal, eclectic, and integrative orientations. The therapy treatment duration ranged from 6 to 52 weeks in individual studies used in the meta-analysis. Attachment scores in each study were coded for their degree of approximation to the two underlying dimensions of attachment avoidance and attachment anxiety since various measures of attachment had been used in the 14 studies. The mean effect sizes were computed as weighted averaged of each samples' correlation coefficient; weights consisted of two coefficients (one for sample size so that each sample's contribution to the overall mean would take into account the sample's size, and one for weighing sample's contributions to the overall mean based on how closely they approximated the constructs of interest; Levy et al., 2011). Results of the meta-analysis indicated that the relationship between attachment anxiety and psychotherapy outcome (various measures of outcome were used in the various studies) yielded a Cohen's weighted d of -0.460, with an 80% credibility interval of d = -0.320 to -0.608. Thus, attachment anxiety negatively affects psychotherapy outcome with a medium effect. The relationship between attachment avoidance and psychotherapy outcome yielded a Cohen's weighted d of -0.014, with an 80% credibility interval d = -0.165 to 0.275, indicating that attachment avoidance had little, if any, effect on psychotherapy outcomes. The relationship between attachment security and outcome was d = 0.370, with an 80% credibility interval of d = .084 to 0.678. Thus, higher attachment security predicted better psychotherapy outcomes (Levy et al., 2011). Limitations of the meta-analysis include that

treatment type was not controlled for (e.g., individual and group therapy were mixed together, long-term and short-term treatments were combined in the statistical analyses, inpatient and outpatient treatments were combined), and the lack of pre-treatment baseline data to compare to post-treatment outcome (which means the results may have an alternative explanation that clients with poorer outcomes began with poorer functioning pre-therapy, which could rule out the influence of attachment on outcome).

Levy et al. (2011) derived a number of implications for practice based on the attachment literature and their meta-analysis. First, practitioners might assess the patient's attachment style, either formally or informally, to inform their treatment strategies, given that client attachment style may influence the therapy outcome. Second, therapists might expect longer and more difficult treatment with anxiously attached patients but faster and more effective treatment with securely attached patients. Third, therapists may consider tailoring their intervention styles to work more effectively with their client's attachment style (e.g., being more engaged with clients with a dismissing attachment style, being more explicit about the treatment frame and/or provide more structure to clients with a preoccupied attachment style, and avoiding emotional/experiential techniques that may overwhelm clients who have preoccupied attachment styles). Fourth, therapists should not assume too much based on a client's attachment style. Fifth, therapists may consider using cognitive or interpretive treatments –as opposed to interpersonally focused treatments– with dismissing individuals, given preliminary evidence that such individuals seem to respond slightly better to these in short-term treatments, and attend to the structure of the internal working models of clients who score high on both the anxiety and avoidance attachment dimensions (research

suggests that much varies in this group's functioning in therapy and outcome). Sixth, therapists might keep in mind that attachment style can be modified with treatment, even in brief treatments and for patients with severe attachment difficulties (e.g., borderline personality disorder), and that change in attachment can be considered a treatment goal. For achieving this goal, preliminary research findings suggest that focusing on the relation between therapist and client and/or using interpretations may be helpful in changing attachment style, at least for severely disturbed clients with personality disorders (Levy et al., 2006), and that a range of treatments might be useful for changing attachments styles of less disturbed patients with neurotic or Axis I disorders (Levy et al., 2011).

Although theoretical literature espouses client attachment as an important factor in the types of corrective experiences clients need, no studies have systematically examined whether the nature of CREs (nor CEs for that matter) differ depending on client attachment type. Thus, a new line of research is needed for examining whether the process and outcome of CEs and/or CREs differ depending on client attachment types.

Chapter 3: Statement of the Problem

Corrective experiences are a key mechanism of therapeutic change (Alexander & French, 1946; Christian et al., 2012; Constantino & Westra, 2012; Goldfried, 2012; Hayes et al., 2012; Sharpless & Barber, 2012). The concept of corrective experiences holds a central place in theories of change in therapy and has a long history (Hayes et al., 2012; Hill et al., 2012). However, only a handful of studies have examined CEs and much remains to be done to understand the nature and facilitators of CEs. Most of these studies have utilized a broad definition of CEs: "CEs are ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way" (Castonguay & Hill, 2012, p. 5). However, as Sharpless and Barber (2012) point out, this definition is so broad that it impinges on other therapeutic constructs, and runs the risk of meaning "everything" (therefore, meaning nothing), resulting in a loss of explanatory power.

One mechanism that researchers have begun to examine focuses on the therapeutic relationship as the vehicle of change. The therapeutic relationship has been consistently and robustly demonstrated to be an important aspect of therapy process and outcome (see Norcross, 2002), and is a "potent, and as yet relatively empirically unexamined" source of corrective experiences (Knox et al., 2012, p. 192). The term corrective relational experiences (CREs) has been used to denote research on CEs "that occur within the context of, and because of, the therapeutic relationship" (Knox et al., 2012, p. 191). CREs are defined as specific times in psychotherapy "when the client feels a distinct shift, such that she or he comes to understand or experience affectively the relationship with the therapist in a different and unexpected way, and is thereby

transformed in some manner" (Knox et al., 2012; p. 191). Focusing specifically on CREs rather than CEs allows greater explanatory power (e.g., greater specificity into the mechanisms and predicted outcomes) regarding the role of the therapeutic relationship in corrective experiences, and advances an important line of research in psychotherapy process and outcome.

Only one study (Knox et al., 2012) has focused on examining CREs in therapy, while another study (Ladany et al., 2012a) examined CREs in clinical supervision. Both Knox et al. (2012) and Ladany et al. (2012a) were qualitative studies, and both examined the experiences of CREs by therapists-in-training in their personal therapies. These studies found that antecedents to CREs often involve helping alliances that are going well but sometimes involve helping alliances that are having difficulties. Also, these studies found that during CRE events, both helper and helpee were deeply involved. Finally, the studies found that consequences of CREs include positive intrapersonal, interpersonal and professional changes. In addition, four studies on immediacy (Kasper et al., 2008; Hill et al., 2008; Mayotte-Blum et al., 2012; Hill et al., 2014) have found immediacy to be related to CREs. In these four studies, immediacy sometimes preceded the CRE, often occurred during the CRE, and other times occurred after the CRE (Kasper et al., 2008; Hill et al., 2008; Mayotte-Blum et al., 2012; Hill et al., 2014).

Limitations of the research on CREs include the dearth of empirical studies directly on the topic, the lack of any studies utilizing clients who are not therapists-in-training, and the small sample size of participants in the only study on CREs in therapy. The present study addresses these limitations by investigating the CREs for community

clients rather than therapists-in-training, and utilizing a larger sample size than any existing studies on CREs.

Another limitation of both the research on CEs and CREs thus far is that no studies have examined attachment in relation to either CEs or CREs. Client attachment will be useful to examine since the types of corrective experiences clients need have been theorized to depend on attachment style (Bowlby, 1988; Miller, 1990) and the 'corrective' part in CEs and CREs has been theorized to 'correct' aspects of attachment (such as maladaptive internal working models of others; Levenson, 2003). A recent meta-analysis (Levy et al., 2011) indicated that client attachment anxiety had a negative impact on psychotherapy outcome while client attachment security had a positive impact on therapy outcome. Given that therapy outcome may relate to CREs, one possibility might be that anxiously-attached clients may have more difficulty having CREs and need CREs more than securely attached clients.

In the present study, we focused on psychodynamic/interpersonal psychotherapy in order to more cleanly specify the context of the CREs under examination, rather than a mix of theoretical orientations that would scatter the explanatory power. The psychodynamic/interpersonal theoretical orientation was a logical choice given its emphasis on the use of the therapeutic relationship as a microcosm of the client's interpersonal relationships (Gelso & Fretz, 2001).

Furthermore, we used a qualitative method in our investigation of CREs. Given that previous literature on CEs and CREs has primarily employed qualitative methods, the present study builds upon the precedent and existing knowledge in the literature. Specifically, we utilized consensual qualitative research (CQR; Hill, 2012; Hill et al.,

2005; Hill et al., 1997) methods, which allows researchers to use participants' own words and discover unanticipated findings given CQR's inductive nature (Knox et al., 2012). CQR is "ideal for studying in depth the inner experiences, attitudes, and beliefs of individuals because it allows researchers to gain a rich, detailed understanding that is not usually possible with quantitative methods" (Hill, 2012, p. 14).

Thus, we sought to advance knowledge on the topic of CREs by: a) utilizing a community sample of clients rather than therapists-in-training as clients, b) utilizing a larger sample of clients than has been included in CRE studies thus far, c) examining whether the aspects of CREs differ depending on client attachment types, and d) examining CREs in psychodynamic-interpersonal therapy with qualitative (CQR) methodology. Since minimal empirical investigation exists on CREs, we posed research questions rather than hypotheses.

Research Question 1: What are the antecedents in therapy prior to the occurrence of a CRE?

One important antecedent to CREs that has been investigated is the therapeutic alliance. Knox et al. (2012) found that, most often, CREs occur in the context of positive therapeutic relationships, but sometimes occur when problems or frustrations have arisen in the therapeutic relationship, when examining the experiences of 12 therapist-in-training about their experiences as clients in their own personal therapies. Similar findings emerged in Ladany et al. (2012a) with CREs in clinical supervision, but with a more equal balance of both good and negative supervisory relationships providing the backdrop for CREs to occur.

Other antecedents to CREs have focused on the concerns of the client. Prior to a CRE, discussion of professional or personal concerns were typical of clients who were also therapists-in-training (Knox et al., 2012). In contrast, Ladany et al. (2012a) found that typically CREs in supervision were preceded by trainee concerns about supervision or the supervisor, and only sometimes preceded by the trainees' professional or personal concerns.

Research Question 2: What occurs during CREs in therapy?

During CREs, clients typically explored thoughts and feelings but sometimes felt vulnerable (Knox et al., 2012). Similar findings emerged in Ladany et al.'s (2012a) study on CREs in supervision: trainees typically opened up during the CRE but sometimes did not like the supervisor's intervention.

Therapists on the other hand, typically empathized/reflected/accepted during CREs, but sometimes became active/directive, used immediacy, invited exploration, responded to the rupture, or reassured/normalized (Knox et al., 2012). Somewhat similar findings emerged in Ladany et al. (2012a): during CREs in supervision supervisors typically supported/normalized/validated, were open, processed the supervisory relationship, pointed out the parallel process, focused on feelings about the clinical situation, and sometimes encouraged trainees to trust their instincts/find their own answer.

Research Question 3: What are the consequences of CREs?

Consequences of CREs in therapy typically included a deeper therapeutic relationship as well as improvements in the client's own professional work as a therapist (Knox et al., 2012). Similar findings appear in Ladany et al.'s (2012a) study on CREs in

supervision: consequences of CREs generally included strengthening or transformation of the supervisory relationship, and typically had a positive impact on the trainee's work with clients.

Consequences of CREs in therapy also generally included positive intrapersonal changes in the client, and typically resulted in positive interpersonal changes in the participant's relationships with others (Knox et al., 2012). CREs in supervision have typically resulted in increased self-efficacy as a professional and the supervisor evaluating the trainee more positively (Ladany et al., 2012a).

Research Question 4: Do the antecedents, characteristics, and consequences of CREs differ depending on client attachment type?

Thus far, no studies have systematically examined whether the nature of CREs (nor CEs for that matter) differ depending on client attachment type. The 'corrective' part of CEs and CREs has been theorized to 'correct' maladaptive internal working models of self and other (Levenson, 2003). A client with insecure attachment who comes to therapy might, over time, view an effective therapist as an important attachment figure and thus become more securely attached through the development of a new self-other internal working model (Constantino & Westra, 2012). This 'correction' of the client's maladaptive interpersonal expectations meets the criteria for counting as a CRE because it involves both parts of the definition of CREs: a) the disconfirmation of the client's expectations and b) a resulting positive shift in the client's psychological functioning. A meta-analysis of client attachment and therapy outcome (Levy et al., 2011) found that higher client attachment anxiety predicted negative outcomes, client attachment avoidance did not affect therapy outcome, and higher client attachment security predicted

better therapy outcomes. Levy et al. (2011) suggest, in their review of the literature, that therapists may want to attend to the structure of the internal working models of clients who score high on both the anxiety and avoidance attachment dimensions, that change in attachment can be considered a treatment goal, that preliminary research findings suggest that focusing on the relation between therapist and client and/or using interpretations may be helpful in changing attachment style (at least for severely disturbed clients with personality disorders; Levy et al., 2006), and that a range of treatments might be useful for changing attachments styles of less disturbed patients with neurotic or Axis I disorders (Levy et al., 2011).

Appendix B: Post-Therapy Interview Questions

NOTE: For the present study, we primarily analyzed the data from questions 1-5 and 9, but the team read the whole interview to get a sense of the context.

1. Overall, how did you feel about your therapy experience?
2. What is your current understanding about your struggles in interpersonal relationships?
3. How did your understanding about your relationship struggles change over the course of your psychotherapy?
4. Now let's talk about corrective relational experiences, or CREs, which we define as times when you felt a distinct shift, such that you came to understand or experience your relationship with your ***therapist*** in a way that was ultimately very positive. Please tell me about the most meaningful or most salient CRE. (If none, go on to question #5) MAY NEED TO CLARIFY DEFINITION OF CRE
    a. Approximately when in the therapy did the CRE occur?
    b. What was going on in therapy prior to the CRE?
    c. What occurred during the CRE?
    d. What made the CRE positive?
    e. What changed for you as a result of the CRE?
    f. What happened in the therapy as a result of the CRE?
5. Did you and [therapist] ever talk about your relationship? [If no, go on to question #6. If yes, keep going] Pick the most meaningful or most salient time that this occurred and tell me about it.
    a. Approximately when in the therapy did this occur?
    b. What did you talk about? (probe for specific events)
    c. What was that like for you?
6. Did you work with dreams in your psychotherapy?
    a. If no, why not?
    b. If yes, What made you bring up dreams in the therapy?
        i. What were the effects of working with dreams in this therapy?
7. Did you have any dreams about [therapist] or the clinic during the therapy? Probe extensively here [If no, go to next questions; if yes, continue…]
    a. First dream: Approximately when in the therapy did this dream occur?
        i. Tell me the dream
        ii. Did you discuss this dream with [therapist]? Why or why not?
        iii. What is your best guess about what this dream means?
    b. Second dream: Approximately when in the therapy did this dream occur?
        i. Tell me the dream
        ii. Did you discuss this dream with [therapist]? Why or why not?
        iii. What is your best guess about what this dream means?
    c. Repeat the above questions for as many dreams as client had
8. What were your reasons for stopping therapy?
    a. How did you feel about the termination process?
9. What do you wish the therapist would have done differently in your therapy?
10. What was the impact of the research on you?
11. Anything else that you'd like to add about your experiences of this therapy?

Appendix C: Experiences in Close Relationships Scale

Experiences in Close Relationships Scale

(ECR; Brennan, Clark, & Shaver, 1998)

INSTRUCTIONS: The following statements concern how you feel in *romantic relationships*. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Please circle the number that best shows how much you agree or disagree with each item according to the scale given.

	Strongly Disagree	Mostly Disagree	Mildly Disagree	Neutral	Mildly Agree	Mostly Agree	Strongly Agree
1. I prefer not to show a partner how I feel deep down.	1	2	3	4	5	6	7
2. I worry about being abandoned.	1	2	3	4	5	6	7
3. I am very comfortable being close to romantic partners.	1	2	3	4	5	6	7
4. I worry a lot about my relationships.	1	2	3	4	5	6	7
5. Just when my partner starts to get close to me, I find myself pulling away.	1	2	3	4	5	6	7
6. I worry that romantic partners won't care about me as much as I care about them.	1	2	3	4	5	6	7
7. I get uncomfortable when a romantic partner wants to be very close.	1	2	3	4	5	6	7
8. I worry a fair amount about losing my partner.	1	2	3	4	5	6	7
9. I don't feel comfortable opening up to romantic partners.	1	2	3	4	5	6	7
10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.	1	2	3	4	5	6	7
11. I want to get close to my partner, but I keep pulling back.	1	2	3	4	5	6	7
12. I often want to merge completely with romantic partners, and this sometimes scares them away.	1	2	3	4	5	6	7
13. I am nervous when partners get too close to me.	1	2	3	4	5	6	7
14. I worry about being alone.	1	2	3	4	5	6	7

	Strongly Disagree	Mostly Disagree	Mildly Disagree	Neutral	Mildly Agree	Mostly Agree	Strongly Agree
15. I feel comfortable sharing my private thoughts and feelings with my partner.	1	2	3	4	5	6	7
16. My desire to be very close sometimes scares people away.	1	2	3	4	5	6	7
17. I try to avoid getting too close to my partner.	1	2	3	4	5	6	7
18. I need a lot of reassurance that I am loved by my partner.	1	2	3	4	5	6	7
19. I find it relatively easy to get close to my partner.	1	2	3	4	5	6	7
20. Sometimes I feel that I force my partners to show more feeling, more commitment.	1	2	3	4	5	6	7
21. I find it difficult to allow myself to depend on romantic partners.	1	2	3	4	5	6	7
22. I do not often worry about being abandoned.	1	2	3	4	5	6	7
23. I prefer not to be too close to romantic partners.	1	2	3	4	5	6	7
24. If I can’t get my partner to show interest in me, I get upset or angry.	1	2	3	4	5	6	7
25. I tell my partner just about everything.	1	2	3	4	5	6	7
26. I find that my partner(s) don’t want to get as close as I would like.	1	2	3	4	5	6	7
27. I usually discuss my problems and concerns with my partner.	1	2	3	4	5	6	7
28. When I’m not involved in a relationship, I feel somewhat anxious and insecure.	1	2	3	4	5	6	7
29. I feel comfortable depending on romantic partner	1	2	3	4	5	6	7
30. I get frustrated when my partner is not around as much as I would like.	1	2	3	4	5	6	7
31. I don’t mind asking romantic partners for comfort, advice, or help.	1	2	3	4	5	6	7
32. I get frustrated if romantic partners are not available when I need them.	1	2	3	4	5	6	7
33. It helps to turn to my romantic partner in times of need.	1	2	3	4	5	6	7

	Strongly Disagree	Mostly Disagree	Mildly Disagree	Neutral	Mildly Agree	Mostly Agree	Strongly Agree
34. When romantic partners disapprove of me, I feel really bad about myself.	1	2	3	4	5	6	7
35. I turn to my partner for many things, including comfort and reassurance.	1	2	3	4	5	6	7
36. I resent it when my partner spends time away from me.	1	2	3	4	5	6	7

Note: Avoidance subscale consists of the odd items; Anxiety subscale consists of the even items.

Appendix D: Author Biases and Expectations

In examining our biases and expectations, each author responded to the following questions: a) What has facilitated you in having CREs? How do you think the participants will typically respond?; b) What do you think has occurred during CREs for you? How do you think the participants will typically respond?; c) What have the consequences of CREs been for you? How do you think the participants will typically respond?; and d) What can you do to prevent biases and expectations from over-influencing your understanding of the data (post-therapy interviews)? We independently wrote our responses to these questions (described below), strived to openly discuss and address biases/expectations as appropriate, and on several occasions during the data analysis process did discuss our biases and expectations to better set aside and minimize any undue influences of our biases and expectations.

Four of us believed that CREs are facilitated by positive therapy relationships (e.g., openness, warmth, genuine care, unconditional positive regard, nonjudgmental attitude, emotional security, empathy, compassion, trust). Three researchers mentioned that negative aspects of the therapy relationship could be facilitative when CREs resolve problems in the therapy relationship. Four researchers mentioned that their therapists helping them gain insight or new perspectives on their problems were facilitative of CREs. Three researchers mentioned positive therapist responses to risking greater openness to the therapist as facilitative for CREs. Two researchers mentioned that the therapist's nonjudgmental response to client transference and encouraging client insight about the origin of the client's transference was facilitative of CREs. One researcher mentioned that therapist self-disclosure (e.g., learning about the therapist's experiences,

struggles, etc.) might facilitate CREs. One researcher believed that participants would typically indicate something the therapist did, rather than emphasizing client or client-therapist factors, as facilitators of CREs. For the latter part of the first three questions, all of us believed that participants would respond similarly as we did.

All of us believed that CREs consisted of positive shifts in the client-therapist relationship (e.g., greater intimacy, trust). Three researchers mentioned that CREs can involve shifts in interpersonal paradigms/schemas where the therapist behaved in a positive, unexpected manner. Two researchers mentioned that the shifts involved therapist demonstrating care and nonjudmentalness in response to client disclosures. Two researchers mentioned that the shifts involved insights into their interpersonal reactions. One researcher mentioned a CRE consisting of processing client's negative feelings about some of the therapist's behaviors.

All believed that consequences of CREs include improvements in the client-therapist relationship (e.g., felt more comfortable being open with therapist, more trusting of therapist, greater appreciation and respect for the therapist, felt closer to therapist, less awkward, less artificial). All mentioned positive consequences of CREs; none mentioned negative consequences of CREs. All mentioned being encouraged to continue or increase adaptive interpersonal behaviors as a result of their CREs (e.g., greater openness in self-disclosure towards others outside of therapy, less worried about being judged/punished if sharing more openly with others, improved love/compassion for others). Three researchers mentioned that insight/paradigm shifts were consequences of CREs. One mentioned continued and fruitful discussion of the CRE in therapy as a result of the CRE.

All believed that increased self-awareness of our biases and expectations through reflection and comparison with the data and noticing when our individual opinion differs from others' opinions would help prevent biases and expectations from over-influencing our understanding of the data. Three researchers mentioned openness to other's opinions as a way to keep biases and expectations from overly influencing data analyses. Two researchers mentioned open discussion of everyone's understanding of the data as a way to keep biases and expectations in check. One researcher mentioned modeling acknowledgement and correction of biases for other team members. One team member mentioned trying to create a nonjudgmental team environment for acknowledging and addressing biases.

Appendix E: Client Attachment Anxiety and Avoidance Example Excerpts

In this appendix, we present illustrative examples for the findings regarding client attachment and CREs from Table 3 that differed by at least 30% of subsamples (Ladany et al., 2012b). For efficiency and clarity, we omitted less essential parts of quotes as indicated by ellipses (. . .) and deleted colloquial filler words (e.g., "um," "like," "you know," and "I mean").

Therapy Relationship Prior to CRE

Positive therapy relationship prior to the CRE. High attachment avoidance: All clients high in attachment avoidance mentioned having had positive therapy relationship prior to their CRE, especially from the beginning of therapy. Example excerpts: "[therapy has] always been beneficial the first day till the last day," "I am an open individual; I am quick to volunteer information . . . so opening up to [therapist] and having genuine conversation was never a problem."

Difficulties in therapy relationship prior to CRE. Low attachment avoidance: Most clients with low attachment avoidance mentioned difficulties in the therapy relationship prior to CRE, especially those unrelated to re-enactment of client patterns. Example excerpt: "I was opening up but I don't think he [therapist] really understood me yet or I didn't really understand him yet."

Therapist Actions Facilitating CRE

Therapist identified/questioned client behavior pattern. Low attachment avoidance: Most clients with low attachment avoidance mentioned that therapists facilitated CREs by identifying/questioning client behavior patterns, especially patterns not being enacted with the therapist. Example excerpt: "[therapist] was doing a very good job of understanding what I was saying and helping me see . . . a pattern about behavior . . . doing something in one relationship and doing it in another."

Therapist identified/questioned client behavior pattern. High attachment anxiety: Most clients with high attachment anxiety indicated that their therapist facilitated their CRE by identifying/questioning the client behavior pattern(s), especially patterns being enacted with the therapist. Example excerpt: "I seem to over prepare things a little bit and she [the therapist] pointed out that in this experience through therapy that I tend to set a lot of goals for myself and she was noticing me doing that for some of the sessions coming in."

Therapist conveyed profound trustworthiness (care, understanding, etc.). Low attachment anxiety: All clients with low attachment anxiety indicated the therapist action facilitating CRE involved conveying care, understanding, nonjudgmentalness, or credibility. Example excerpt: "It was the realization that [the therapist] wasn't judgmental at all. This was very significant part of my life that I find very difficult to talk about. [The therapist's] body language, tone, response to it all [client deep

disclosure] were very positive for me." Another client explained, "I appreciated having a man [the therapist] say that [my son was taking advantage of me], because I don't have a husband to say, 'Look, your son is taking advantage of his mother.' . . . I quickly came to respect him [the therapist] a lot and didn't see him [the therapist] [as someone] my son's [age] anymore."

Client Facilitators of CREs: Deep Disclosure Prior to CRE

High attachment avoidance: Most clients high in attachment avoidance mentioned engaging in actions that facilitated their CRE, especially by opening up deeply. Example excerpts: "I told [therapist] everything I went through and what I dealt with," "I'd been lying to [therapist] . . . One day I just came in and told her 'I want to talk to you about this. I haven't been honest. . . This is what's really going on . . .'."

Type of Corrective Relational Shift

New understanding of therapist/therapy. Low attachment anxiety: All clients with low attachment anxiety had corrective relational shifts involving a new understanding of the therapist, therapy relationship, or therapy (none had the type of shift related to maladaptive behavior patterns). Example excerpts: "It was sort it was almost like a liberating experience. . . . the realization that he [the therapist] wasn't judgmental at all." Another client stated that the CRE "was sort of like the 'aha, now I understand what therapy is about.' . . . [the therapist] was doing a very good job of understanding what I was saying and helping me see [things] in a way that. . . . was just really illuminating."

New understanding of or breakthrough in changing behavior patterns. High attachment anxiety: Most clients with high attachment anxiety indicated their CRE involved a shift relating to their maladaptive behavior patterns. Example excerpts: the client recalls the therapist pointing out the client was apologizing unnecessarily in therapy, saying "This is a space you are allowed to share anything so why would you be sorry?", and as a result, the client "was able to be more open with [the] therapist about [the client's] feelings" and "feel less like I'm a burden, like I'm a problem, like I feel more like I have the right to be, to say what I want, think what I want." Another example: "we talked about . . . over preparing [client's tendency to over-prepare for therapy sessions and other situations outside oftherapy]. . . that was sort of a little bit of a revelation for me."

Consequences of CREs for the Therapy Relationship: Greater Respect for Therapist

Low attachment anxiety: Typically, clients with low attachment anxiety indicated that they gained greater respect for their therapist's professional abilities or credibility (compared to variantly for other attachment subgroups). Example excerpt: "[the therapist] was doing homework and then coming back with ideas. . . . that was the biggest CRE, was when I realized how [therapist] was working to be useful. . . . It brought a different level of respect for her professionalism."

Consequences of CREs on Intrapersonal Functioning

Increased positive feelings. High attachment anxiety: Most clients with high attachment anxiety mentioned increased positive feelings of well-being after their CRE. Example excerpts: "Everything all feels much better." Another client felt "empower[ed]" after the CRE.

Reduction of unwanted feelings. High attachment avoidance: Clients high in attachment avoidance were more likely than clients with low attachment avoidance to mention having reduction in unwanted feelings after their CRE. Example excerpts: "I felt relieved," "it felt like a burden being lifted."

Consequences of CREs on Interpersonal Functioning

High attachment anxiety: Most clients with high attachment anxiety indicated improvements in interpersonal functioning after their CRE, namely, increased awareness of or changing interpersonal behavior patterns outside of therapy. Example excerpt: The client who had a pattern of being dishonest stated, "I was able to take that [what I learned from the CRE] and apply it to my friends and family and other people who I'd been dishonest with and really saw progress after that."

Consequences of CREs on Therapy Productivity: Client Attitudes or Behaviors

Low attachment avoidance: Most clients with low attachment avoidance mentioned the CRE increasing productivity in therapy (i.e., engaging in more productive behavior in or attitudes towards therapy after the CRE). Example excerpts: "Our [therapy] conversations became more productive. As we got better at doing therapy together, our sessions got more productive." Another client low in attachment avoidance explains identifying similar instances of interpersonal patterns in therapy after the CRE: "I had volunteered that story [about my behavior] way back, but then here [the therapist] was, through our talking, not just him, it would be both of us sometimes, . . . [we] would see that behavior pattern in another situation and untangle that relationship."

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