
Focusing the Therapist's Attention on the Patient's Strengths: A Preliminary Study to Foster a Mechanism of Change in Outpatient Psychotherapy



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Previous research has supported the immediate activation of patient's strengths (*resource activation*) as an important mechanism of change in psychotherapy. We designed a brief (10 min) priming procedure in which therapists' attention was focused on the patients' individual strengths before each therapy session (*resource priming*). In a preliminary study, the priming procedure was carried out before each of the first five sessions ($N = 20$). Preliminary results indicated that this brief preparatory intervention boosted resource activation as perceived by independent observers, fostered attachment and mastery experiences by the patient, and improved therapy outcome at Session 20. Improvement was assessed in comparison to a pairwise matched, nonrandomized control group of patients treated previously with the same treatment protocol at the same clinic. © 2008 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 64: 1–14, 2008.

Keywords: mechanism of change; process–outcome; resource activation; resource priming; patient strengths

Prospective studies on principles of change in psychotherapy are in demand (Castonguay & Beutler, 2006). In contrast to traditional, problem-focused concepts in psychotherapy, the importance of focusing on the patient's strengths has been

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emphasized frequently (Duckworth, Steen, & Seligman, 2005; Flückiger & Regli, 2007; Orlinsky, Rönnestad, & Willutzki, 2004; Snyder & Elliott, 2005; Willutzki, Neumann, Haas, Koban, & Schulte, 2004). According to Grawe (1997), psychotherapy can only work with what the patient brings to therapy—specifically, his or her motivational readiness and abilities. It has been argued that focusing on patients' strengths can initiate and maintain positive feedback circuits that potentially foster the therapeutic alliance, augment the patients' receptiveness, and support the implementation of adaptive coping strategies. Strengths that are helpful in psychotherapy are, for example: individual qualities (e.g., success at work), interactional qualities (e.g., relationship to a good friend), motivational preparedness (e.g., important life goals), and personal skills (e.g., cross-country skiing). These strengths can be either explicitly discussed with the patient or the therapist can help the patient to directly experience the consequences of using these strengths, for example, by experiencing the mood-lifting effects of a father-and-son weekend (Flückiger & Wüsten, 2008; Grawe, 1997, 1998/2004, 2004/2006).

One may argue that resource activation is merely an instance of *Positive Psychology* (Fredrickson, 2001; Seligman & Csikszentmihalyi, 2000). Obviously, there are theoretical connections to this programmatic framework: Both focus on positive perspectives; however, the resource activation approach articulated by Grawe (1997, 1998/2004, 2004/2006) was formulated on the basis of meta-analyses controlled efficacy studies (Grawe, Donati, & Bernauer, 1994), and resource orientation is considered one important mechanism of change that develops its influence in complex interactions with other mechanisms of change (e.g., therapeutic bond, problem activation, mastery experiences, and clarification experiences/insight). Interventions that focus on patients' strengths seem to have an impact particularly at the beginning of therapy (Regli, Bieber, Mathier, & Grawe, 2000). Before patients start psychotherapy, they are usually in a demoralized state and experience failure of their usual coping strategies (Frank, 1974; Howard, Lueger, Maling, & Martinovich, 1993; Hubble, Duncan, & Miller, 1999; Snyder & Taylor, 2002). Studies on early therapy responders show that improvements take place even before specific problem-focused techniques are implemented and that these improvements tend to remain stable over time (Haas, Hill, Lambert, & Morrell, 2002; Ilardi & Craighead, 1994; Tang & DeRubeis, 1999). Such early gains may be considered effects of expectations about treatment. Note that these effects do not need to be "nonspecific" but might occur differentially in different treatment conditions and thus interfere with the protocol of an experimental trial. Such a position was taken, for example, by Renaud et al. (1998), who found that rapid responders treated in a control group with a nondirective, supportive therapy showed a more stable improvement compared to rapid responders treated with cognitive behavioral therapy or systemic-behavioral family therapy. The authors discussed these differential effects rather as a nuisance that needs to be "washed out." In contrast to that position, various reviews of empirical studies have stressed the relevance of positive expectations for change and have advocated their intentional and proactive implementation in the therapists' repertoire of interventions (Arnkoff, Glass, & Shapiro, 2002; Greenberg, Constantino, & Bruce, 2006). With resource-activating interventions, therapists actively reinforce patients' positive expectations as well as their individual abilities and use them as a catalyst for therapeutic change. Examples of such interventions are lauding the patient's openness, complimenting the patient on his or her motivated participation in treatment, or emphasizing patients' already existing abilities for change and growth (Grawe, 1998/2004).

Correlative process–outcome studies have shown that psychotherapy sessions after which the patients reported strong mastery experiences are characterized by high levels of resource-activating interventions as well as a stronger focus on change (Gassmann & Grawe, 2006; Regli et al., 2000; Smith & Grawe, 2003, 2005). In contrast, inadequate activation of the patients' resources has been shown to have undesired side effects (Grawe & Grawe-Gerber, 1999; Willutzki, 2000). For example, if the therapist focuses on goals that are too difficult to achieve, patients may experience strong discrepancies between their wishes and the perceived reality. This may lead to negative emotions and to defensive reactions by the patient (Grawe & Grawe-Gerber, 1999). Similarly, explicitly mentioning what the patient perceives as self-evident might be perceived as a devaluation. In addition, delayed interventions to activate resources in combination with a weak therapeutic alliance are characteristics of unsuccessful therapies (Gassmann & Grawe, 2006). While the quality of the early alliance itself has been shown to be a reliable predictor of therapeutic success (Horvath & Bedi, 2002; Orlinsky et al., 2004), there is some evidence that it is difficult to influence the therapeutic alliance deliberately (Crits-Christoph et al., 2006; Holloway & Neufeldt, 1995).

Although these correlational studies do provide evidence for the therapeutic importance of resource-activating strategies, they do not directly support the causal impact of these superordinate strategies on the patient change. To arrive at causal interpretations of mechanisms of change, it is necessary to experimentally modulate mechanisms of change, explore the influence of this modulation on relevant process variables, and demonstrate the influence of these process variables on therapy outcome (Grosse Holtforth, Castonguay, & Borkovec, 2004). Following this research strategy, the study presented here investigates to which degree a systematic focusing of therapists' awareness on the patients' strengths at the beginning of psychotherapy influences process and outcome of therapy. We tested the following hypotheses:

H1: Systematically focusing the therapists' attention on the patients' strengths results in a higher degree of resource-activating interventions.

H2: A higher degree of resource-activating interventions leads to a better therapeutic alliance and to better session outcomes with regard to the patients' experience of mastery and therapy progress.

H3: A higher degree of resource-activating interventions leads to larger symptom reductions and augments well-being as measured after 20 sessions.

We tested these hypotheses within an open trial, in which an intervention group with systematic focus on patients' strengths was compared to a pairwise matched control group extracted from archival data obtained in the same setting and with the same treatment protocol (Lutz, 2002).

Method

Patients and Therapists

Twenty-six patients who were successively admitted for psychotherapy in a Swiss university outpatient clinic between Spring 2004 and Spring 2005 entered the preliminary study. Patients with psychotic and substance abuse disorders were excluded from the study. Patients were not informed about the therapists' specific

priming procedure. Therapists were postgraduate psychotherapy trainees, and participation in the study was part of their training. Six of 26 therapies had missing data at Session 20 and were removed from the statistical analyses [23%; including 2 of the total 3 dropouts (11.5%)], which is slightly less than the longtime mean of missings (27.2%) and dropouts (16.3%) in the clinic (Grosse Holtforth, Znoj, Fries, & Grawe, in press). Patients in the nonrandomized control group were selected from a pool of 201 patients who were admitted between 2002 and the beginning of the priming intervention. The institutional context was the same for these 201 therapies (i.e., setting, case formulations, curriculum of postgraduate training, treatment rationale). For each of the 20 patients in the experimental group, 1 corresponding patient was selected from this pool, matching the respective patient most closely according to the following criteria (Lutz, 2002, 2005): (a) years of therapist's postgraduate training, (b) *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*; American Psychiatric Association, 1994) diagnosis (SKID-I; Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997; $\kappa > .75$), (c) sex and age of the patient, (d) interpersonal problems (mean of the four IIP-64-D scales: too dominating, too vindictive, too cold, too introverted; Horowitz, Strauß, & Kordy, 2000), and (e) sex and age of the therapist. If there were missing data in the postsession questionnaires of the "matching" patient, we conducted a second drawing. The matching procedure was performed without awareness of the therapist's identity or treatment outcome. The descriptive qualities of the priming group and the control group are documented in Table 1.

Table 1
Descriptives of the Priming and Control Group

	Priming group	Control group
Patient sex	9 males/11 females	9 males/11 females
Patient age (<i>SD</i>)	36.1 (15.6)	33.7 (13.1)
	DSM-IV diagnoses	
Affective	Major Depression: 6 Dysthymia: 1	Major Depression: 6* Dysthymia: 1
Anxiety	Social phobia: 2 Panic: 2 Other anxiety: 3	Social phobia: 2 Panic: 2 Other anxiety: 3
Other diagnoses	2	2
No diagnosis on Axis I	4	4
Global assessment of functioning (GAF)	70 (10.6)	70 (12.5)
Interpersonal Problems (IIP)	1.5 (.63)	1.3 (.54)
Global Severity Index (GSI)	1.02 (.53)	1.08 (.56)
Emotionality (EMI-B)	31.3 (6.0)	31.1 (6.0)
Therapist sex	7 males/13 females	8 males/12 females
Therapist age (<i>SD</i>)	35.6 (6.5)	35.1 (5.4)
Therapists experience I	2.7 (1.6)	2.8 (1.7)
Therapists experience II	6.8 (7.5)	6.0 (7.4)
Dropouts	1	1

Note. Therapists experience I = sessions outside of the outpatient clinic (1 = 0–50; 2 = 51–100; 3 = 101–500; 4 = 501–1,000; 5 = over 1,001); Therapists experience II = number of therapies at the outpatient clinic;

*1 adjustment disorder with depressed mood; all differences $p > .2$.

Treatment

Individual sessions typically took 50 min. The therapists practiced an integrative form of psychotherapy, which is based on available empirical evidence in psychotherapy research (Grawe, 1997). The therapists differentially combined cognitive-behavioral, process-experiential, and interpersonal interventions following a case formulation based on consistency theory (Grawe, 1998/2004). In the first five sessions, therapists in the priming as well as in the control group had to make an individual case formulation (5–10 pages). Case formulations included therapeutic strategies for fostering a custom-tailored therapeutic alliance based on the patient's motivational and interpersonal characteristics (Grosse Holtforth & Castonguay, 2005). The assessment of patients' strengths was integrated within the functional analysis of patient problems (Grawe, 1998/2004). The therapists were supervised biweekly in small groups over time units of 100 min. Before the beginning of each therapy, there was an intake and assessment phase consisting of four sessions (i.e., intake interviews with the patient and with a significant other, completion of questionnaires, structured *DSM-IV* interview).

Priming Intervention

The following two strategies were used to implement resource activating interventions: (a) Preparation: After the intake/assessment phase, therapists were systematically interviewed by three trained master's students and discussed the individual strengths of the patient as measured by the core battery and as inferred from the videotapes of the intake interviews. For interview preparation, the master's students had full access to the data collected in the intake/assessment phase. To detect patients' strengths, we also used the Bern Resource Inventory (BRI; Trösken & Grawe, 2003), which is described later. (b) Priming: Immediately before Sessions 1 to 5, the therapists had a 5-min conversation with the same master's student about ways to implement resource-activating interventions in the forthcoming session. After each of the first five sessions, there was a short (5-min) conversation about how the therapist had succeeded in activating the patient's strengths. With this priming intervention, we intended to activate therapists' preexisting knowledge about resource-activating interventions (Flückiger & Wüsten, 2008). The implementation of the priming intervention was evaluated by the master's students as conforming to the preparation guideline [mean adherence score of 1.84 ($SD = 1.1$) on a 7-point Likert scale ranging from -3 (*not at all*) to 3 (*yes, exactly*)].

Instruments

The self-report BRI-SR (Trösken & Grawe, 2003) was constructed by cluster and factor analyses and includes eight categories of personal strengths: (a) Well-being, (b) Coping with daily hassles, (c) Social support, (d) Former coping within crises, (e) Recent experiences boosting self-esteem, (f) Personal strengths and skills, (g) Interpersonal relationships, and (h) Commitment to personal growth, and was administered before treatment.

The therapeutic process was assessed using the short forms of the Bern-Post-Session Reports for Patients (BPSR-P) and Therapists (BPSR-T) by Regli and Grawe (2000). These scales were constructed by factor analyses of data collected using previous versions of these measures (Grawe & Braun, 1994). Implementation of the resource-activating interventions was assessed by the BPSR-T subscale

“Resource Activation” [$\alpha = .86$; 5-point Likert scale ranging from 0 (*not at all*) to 4 (*completely right*)]. A sample item of the BPSR-T is: “Today, I systematically let the patient experience his own strengths.” Additionally, two trained (systematic 7-day training) and monthly supervised advanced master’s students watched videorecordings of Sessions 2, 5, and 8, and then rated the verbalization and experience of patient’s strengths minute by minute ($\kappa = .65$, $\gamma = .94$; Gassmann & Grawe, 2006).

To evaluate the quality of the therapeutic interaction, the BPSR-P subscale “Bond” [e.g., “The therapist should pay more attention to my feelings. (–)”] as well as the corresponding BPSR-T subscales “Global Alliance” (e.g., “The patient and I appreciate each other.”) and “Patient’s Openness to Procedures” (e.g., “Today the patient spontaneously shared his feelings and wishes with me.”) were used. Session outcome was assessed using the subscales “Mastery Experiences” of both BPSR-P (e.g., “Now I feel better prepared for situations that I could not handle before.”) and the “Session Progress” (e.g., “Today, we made substantial progress in the therapy session.”) of the BPSR-T [$\alpha s > .78$; 7-point Likert scales, ranging from –3 (*not at all*) to 3 (*yes, exactly*)].

Therapy outcome was measured by computing pre–post differences of the global means of the following three self-report measures: (a) the Global Severity Index (GSI) of the German short version of the Brief Symptom Inventory (BSI; Franke, 2000); (b) the German version of the Inventory of Interpersonal Problems (IIP-64-D; Horowitz et al., 2000), and (c) the Emotionality Inventory (EMI-B; Ullrich de Muynck & Ullrich, 1978; bipolar rating scale; e.g., ranging from “nervous” to “well-balanced”). In addition to these measures, three retrospectively rated change measures were employed at Sessions 10 and 20: (a) the global scale of the revised Questionnaire for the Assessment of Changes in Experiencing and Behavior (QCEB-VW; Willutzki, 1999; e.g., “In comparison to the beginning of my therapy, I feel more self-confident now”); (b) the subscale “Changes in the Social Environment” of the Change in Life Domains questionnaire [CLD, Itten & Grawe, 2002; e.g., “satisfactory leisure time;” global ratings from –4 (*deterioration*) to 4 (*improvement*)]; and (c) the revised Goal Attainment Scale (GAS-R, Kiresuk & Lund, 1979; global rating of the individual therapy goals from –2 to 4). The reliabilities and validities of these full-reported outcome assessments were considered satisfactory in our sample (Flückiger, Regli, Lutz, & Grawe, 2007).

Statistical Analyses

First, using growth curve modeling (HLM, Bryk & Raudenbush, 1992; Raudenbush, Bryk, Cheong, & Congdon, 2004), each patient’s progress over the course of 20 psychotherapy sessions was modeled as a linear function of the log of session number (Level 1). The intercept π_0 was centered to the mean session of the first five primed sessions and indicates the estimated mean differences between priming and control group at Session 3. The slope π_1 indicates the progress over the course of 20 sessions (i.e., increase, decrease, no change) (Bryk & Raudenbush, 1992). Second, intercept π_0 and slope π_1 are predicted by treatment membership [priming vs. control group (Level 2)]. Unstandardized β s were used [for intercept: $\beta_{01}(\text{EXP})$; for slope: $\beta_{11}(\text{EXP})$]. Differences of the intercept are equivalent to the treatment main effects within a “traditional” ANOVA design, and the differences of the slopes are equivalent to the general Time \times Treatment interaction (Bryk & Raudenbush, 1992). Additionally Cohen’s d s were computed.

All therapies were examined up to Session 20 (maximally 40 therapies \times 20 sessions = 800 sessions). Eleven of the 40 therapies were terminated before Session 20 (70 sessions from therapies with regular termination and 27 sessions from the two dropout therapies; $p > .05$ between priming and control group). Of these 703 sessions, 97.9% ($n = 688$ sessions) were documented by the BPSR-T and 93.5% ($n = 657$ sessions) by the BPSR-P. The benefit of HLM in contrast to traditional repeated measures ANOVA lies especially in the individual parametrization of the process variables; therefore datasets with missing values can be used (repeated measures as random variable). To test the impact of the resource-activating interventions on the therapeutic alliance and mastery experiences within the first five sessions with priming interventions, cross correlations ($n = \pm 2$) of the five priming sessions (centered at Session 3) were computed. The impact of the priming intervention on the therapy success at Session 20 was examined by ANOVAs, with time as the repeated factor, treatment condition as the fixed factor, and a Time \times Treatment Condition interaction).

The general effectiveness of the therapies independent of the treatment condition was demonstrated by analyzing the main effect for time. Treatment effects were analyzed differently for pre- and postassessments and retrospective assessments. For pre- and postassessments, the Time \times Treatment interaction was analyzed. Time represented assessments at preassessment and at Session 20. For retrospective assessments, the main effect for treatment was analyzed. Time here represented assessments at Sessions 10 and 20 since there is no preassessment for retrospective measures. If a therapy was completed before Session 20, data from the assessment posttreatment were analyzed. To detect a meaningful main effect within a repeated 2×2 design (Treatment Conditions \times Assessments) and assuming a β -error of .2, an optimal sample size for each group is 20 therapies (Bortz, 2005). Nevertheless, because of the heterogeneity of the sample, a larger sample would be preferable.

Results

Impact of the Priming Intervention on Resource Activation (H1)

Therapist ratings. In comparison to the control group, the therapists in the priming group rated an increased degree of resource-activating interventions in the priming group during the five intervention sessions, Intercept treatment main effect centered to Session 3: $\beta_{01}(\text{EXP}) = .57$, $t = 3.8$, $p < .001$, $d = .63$. Descriptively, there was a decrease of resource activation of over 1 *SD* of the slope variance after these sessions. To demonstrate this decrease, Figure 1 depicts the development of resource activation from Sessions 1 to 10. This decrease is represented in the differences of the slopes over the 20 sessions, Slope general Time \times Treatment interaction: $\beta_{11}(\text{EXP}) = -.46$, $t = 2.0$, $p < .01$, $d = -.46$.

Observer-rated patient behavior. Observer ratings confirmed the intercept main effect; there are enhanced ratings of patient's immediate resource-activating experiences, intercept: $\beta_{01}(\text{EXP}) = .13$, $t = 2.94$, $p < .001$, $d = .56$. The Time \times Treatment interaction by therapists' evaluation could not be replicated by observer ratings, slope: $\beta_{11}(\text{EXP}) = .01$, $t = .06$, $p > .2$; in the priming group, there was no decrease of resource activation over the three time points (i.e., Sessions 2, 5, and 8).

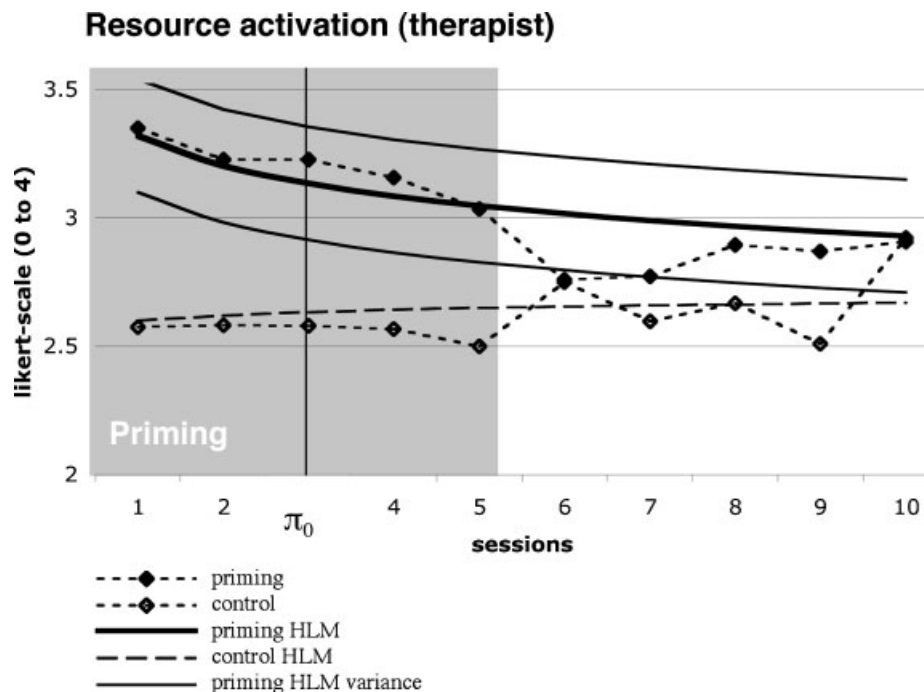


Figure 1. Impact of the priming intervention to the early resource activation (therapist) from Sessions 1 to 10; priming = observed averaged course of the priming group; control = observed averaged course of the control group; priming HLM = HLM estimated course_{sess 20} of the priming group; control HLM = HLM estimated course_{sess 20} of the control group

Higher Quality of Therapeutic Bond and Mastery Experiences (H2)

Short-term influences (therapists). The short-term influences of resource activation on therapeutic bond and mastery experiences were analyzed by computing cross correlations of the BPSR-T scales “Resource Activation” with “Therapeutic Alliance” and with “Mastery Experiences” over the first five priming sessions. Resource activation correlated highly with the therapeutic bond one session later (Fig. 2). The cross correlations were constantly significant over time for mastery experiences, CCF: $\text{lag}_{-2} = .20$, $\text{lag}_{-1} = .21$, $\text{lag}_0 = .20$, $\text{lag}_{+1} = .22$, $\text{lag}_{+2} = .10$.

Long-term effects on therapeutic alliance (therapists). Therapists rated the therapeutic alliance in the priming group as higher than in the control group, intercept: $\beta_{01}(\text{EXP}) = .49$, $t = 3.75$, $p < .01$, $d = .63$, and the slope differences did not reach statistical significance, slope: $\beta_{11}(\text{EXP}) = -.14$, $t = .6$, $p < .2$. Comparable effects occurred regarding the therapists’ rating of patient openness to procedure, intercept: $\beta_{01}(\text{EXP}) = .43$, $t = 2.9$, $p < .01$, $d = .55$; slope: $\beta_{11}(\text{EXP}) = .06$, $t = .3$, $p < .2$.

Long-term effects on bond (patients). Descriptively, the establishment of a positive bond was observable on the respective subscale of the BPSR-P by an increase over the first three therapy sessions (Fig. 3a). Five of the 20 therapies in the priming group had a rapid gain in the Bond scale (1.25 scores of change in raw data over the first three sessions). In the control group, there was no rapid gain and one rapid loss. At Session 3, patients in the priming group rated the quality of the therapeutic bond as generally more positive than that in the control group, intercept:

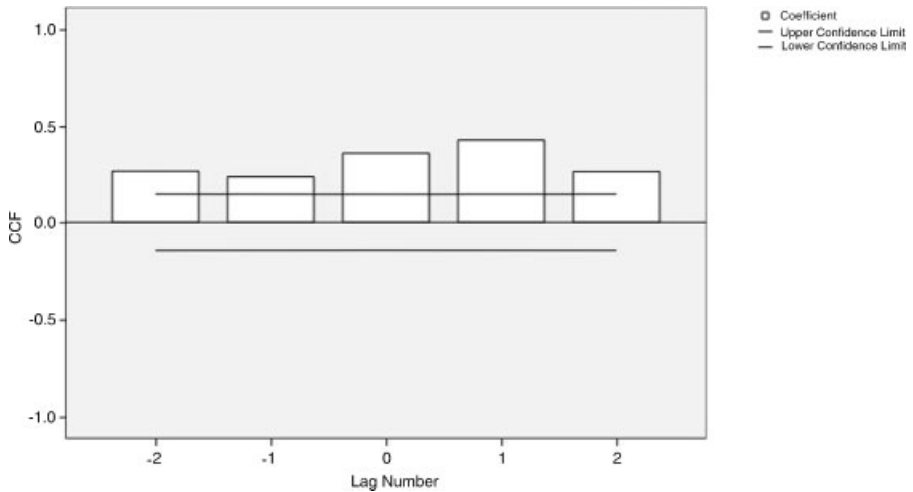


Figure 2. Cross correlations of the early resource activation with the global alliance (therapist).

$\beta_{01}(\text{EXP}) = .40$, $t = 1.7$, $p < .1$, $d = .42$. Over the course of 20 sessions, the slope differences were not significant, slope: $\beta_{11}(\text{EXP}) = -.14$, $t = .6$, $p < .2$.

Long-term effects on mastery (therapists). At Session 3, mastery experiences were rated higher in the priming group than they were in the control group, intercept: $\beta_{01}(\text{EXP}) = .57$, $t = 3.5$, $p < .01$; $d = .61$, and there were no significant slope differences, slope: $\beta_{11}(\text{EXP}) = -.21$, $t < 1.2$, $p > .1$. Comparable effects were found in the therapists' rating of session progress, intercept: $\beta_{01}(\text{EXP}) = .47$, $t = 3.0$, $p < .01$, $d = .56$; slope: $\beta_{11}(\text{EXP}) = .09$, $t < .37$, $p < .2$.

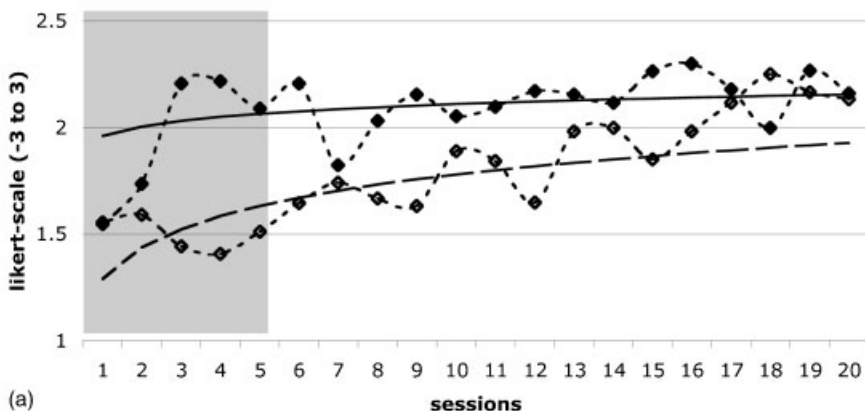
Long-term effects on mastery (patients). Descriptively, the differences between priming and control group were already apparent at the beginning of the therapies (Fig. 3b). These differences are recognizable in the intercept at Session 3, intercept: $\beta_{01}(\text{EXP}) = .57$, $t = 1.8$, $p < .05$, $d = .44$. There were no significant slope effects, slope: $\beta_{11}(\text{EXP}) = -.23$, $t = 1.1$, $p > .1$.

Early therapy outcome. Descriptively, the priming group showed more goal attainment, symptom reduction, and well-being, both in the pre–post as well as in the retrospective assessments of outcome (Table 2); however, the differences between the priming and the control group were not always significant. The results of the statistical tests for pre- and postassessments (Time \times Treatment interaction) were GSI: $F(1, 38) = 2.84$, $p < .05$; EMI-B: $F(1, 38) = 2.65$, $p < .10$; IIP-64-D: $F(1, 38) = 1.5$, $p > .10$, and for retrospective assessments (treatment main effect), GAS-R: $F(1, 38) = 3.85$, $p < .05$; CLD: $F(1, 38) = 1.0$, $p > .10$; QCEB-VW: $F(1, 38) = 0.0$, $p > .10$. Both treatments showed a symptom reduction and an improvement of well-being (time main effect), GSI: $F(1, 38) = 15.8$, $p < .001$; EMI-B: $F(1, 38) = 36.1$, $p < .001$; IIP-64-D: $F(1, 38) = 17.9$, $p < .001$; GAS-R: $F(1, 38) = 9.7$, $p < .001$; CLD: $F(1, 38) = 4.5$, $p < .01$; QCEB-VW: $F(1, 38) = 5.3$, $p < .001$.

Discussion

In this preliminary process–outcome study, we investigated the consequences of directing the psychotherapists' attentional focus towards their patients' strengths (Grawe, 1998/2004; Snyder & Elliott, 2005). Previous correlative studies had

Therapeutic bond (patient)



Mastery experiences (patient)

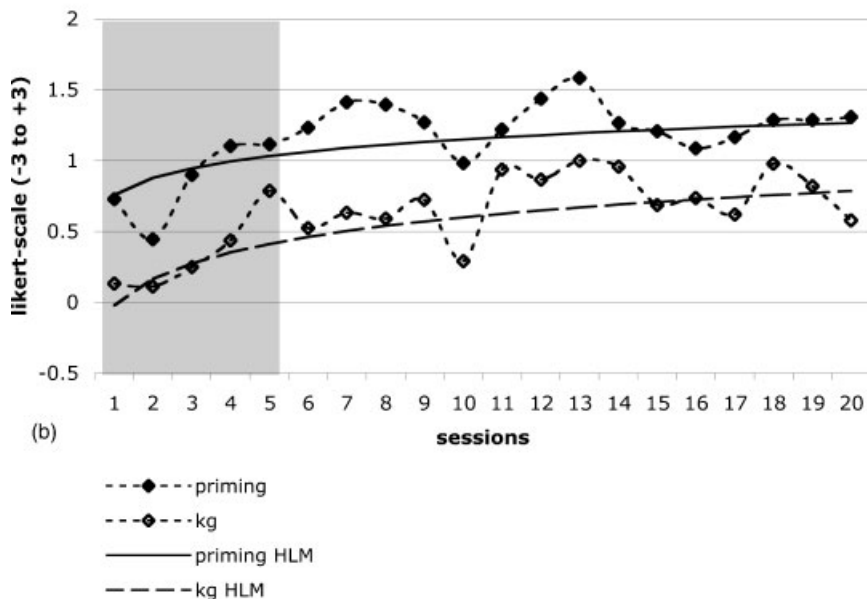


Figure 3. Run of the bond (a) and the mastery experiences (b) over 20 sessions (patient); priming = observed averaged course of the priming group; control = observed averaged course of the control group; priming HLM = HLM estimated course of the priming group; control HLM = HLM estimated course of the control group.

supported the predictive value of activating these strengths (resource activation) for therapy outcome (Gassmann & Grawe, 2006; Smith & Grawe, 2003, 2005). However, the question to what extent resource activation as a global intervention heuristic may be systematically manipulated had not been investigated. The results of this preliminary study indicate that resource activation was immediately enhanced after brief priming interventions before the beginning of therapy and before each of the first five sessions ($N = 20$). This main effect was observable in therapist ratings as well as in ratings by independent observers (H1). Interestingly, only therapist ratings of resource activation declined in the course of the first 10

Table 2
Impact of the Priming Intervention on Therapy Outcome at Session 20

	Priming		Control		<i>d</i>
	Pre <i>M (SD)</i>	Session 20 <i>M (SD)</i>	Pre <i>M (SD)</i>	Session 20 <i>M (SD)</i>	
<i>Pre-post assessments</i>					
GSI	1.03 (.53)	.53 (.41)	1.07 (.57)	.87 (.51)	.55*
EMI-B	3.8 (.79)	2.8 (.73)	3.8 (.80)	3.2 (.86)	.53 ⁺
IIP-64-D	1.68 (.50)	1.25 (.54)	1.60 (.37)	1.36 (.49)	.40
<i>Retrospective assessments</i>	Session 10 <i>M (SD)</i>	Session 20 <i>M (SD)</i>	Session 10 <i>M (SD)</i>	Session 20 <i>M (SD)</i>	
GAS-R	1.6 (1.2)	2.0 (1.1)	.87 (1.1)	1.5 (1.0)	.65*
CLD	1.0 (1.1)	1.4 (1.0)	.74 (1.4)	1.0 (1.1)	.32
QCEB-VW	130 (25)	139 (26)	133 (25)	137 (22)	.00

Note. GSI = Global Severity Index of the Brief Symptom Inventory; EMI-B = Emotionality Inventory; IIP-64-D = Inventory of Interpersonal Problems; GAS-R = revised Goal Attainment Scale; CLD = Change in Life Domains Questionnaire; QCEB-VW = Questionnaire for the Assessment of Changes in Experiencing and Behavior; Test statistic for pre-post assessments: Interaction Time Treatment; for retrospective assessments: treatment main effect.

* $p < .05$; ⁺ $p < .1$.

therapy sessions, although the therapists were instructed to actively foster resource activation also after the first five sessions. This provides preliminary evidence for a specific effect of the priming interventions; however, this effect does not seem to endure for very long. In contrast to resource activation, the quality of the therapeutic bond remained stable after the first five therapy sessions as perceived by therapists as well as by patients (H2). The observed decline of resource-activating interventions might be explained by a successful implementation of a positive feedback circuit of an enhanced therapeutic alliance and the patient's openness to the procedure (Grawe, 1998/2004). The slope differences between observer ratings (that remain stable after the five priming sessions) and therapists' self-report (substantial decrease after five priming sessions) speak for this interpretation; after the initial priming sessions, therapeutic work on patients' strengths seems to run more fluently (Smith & Grawe, 2003, 2005). Otherwise, social desirability could improve therapists' positive evaluations of resource-activating interventions during the first five priming sessions. Enhanced session outcomes (mastery experiences, progress) as well as better therapy outcome after 20 sessions (symptom reduction, goal attainment; H3) might be interpreted as indicators of a generalization of therapeutic gains (Fredrickson, 2001; Grawe, 1998/2004). Consistent with these results in previous research, early alliance has been shown to be a reliable predictor of therapy outcome (Horvath & Bedi, 2002), and is seen as a long-term prerequisite for successfully implementing problem-focused interventions later in the therapy process (Orlinsky et al., 2004). An interesting feature of our preliminary study is that the patients had no knowledge about the priming procedure; that is, patients' process and outcome evaluations were made without awareness of the treatment condition.

A representative heterogeneity of the samples is preferable for research of common principles of change. With small-sample RCT designs, potentially confounding variables such as therapist experience, psychopathological symptoms, and interpersonal difficulties could not be controlled in an optimal way (e.g., Kendall, Holmbeck, & Verduin, 2004). For these reasons, we pairwise matched the priming therapies with control therapies extracted from our archives from a sample of 201 reference therapies (Lutz, 2002, 2005). With this method, we achieved to control these confounding variables in our naturalistic sample without threatening the external validity, for example, by overselective patients' characteristics or overly restrictive therapists' instructions (e.g., De Maat, Dekker, Schoevers, & De Jonghe, 2007; Wolfe & Goldfried, 1998). Nevertheless, because of the lack of randomization, confounding variables must be considered, such as minimally varying training conditions or seasonal effects. As a next step, the results of the preliminary study should be replicated in a randomized design with a larger sample size; however, there are natural limits to the sample size of psychotherapy training studies due to the limited size of eligible training cohorts (Chrits-Christoph et al., 2006; Holloway & Neufeldt, 1995).

One may argue that the observed effects could be accounted for by patients in the priming condition receiving a higher dose of therapy; however, the dose of therapy sessions was comparable between the conditions. *Only the therapists* in the priming group spent more time in the additional priming sessions (+12%). As other authors (e.g., Holloway & Neufeldt, 1995) have shown, additional unspecific supervision alone does not lead to a higher quality in therapeutic alliance. Additionally, exploratory analyses of the data of other therapies in our clinic, in which therapists conducted comparatively brief but unspecific preparatory conversations with students, did not show a comparable early enhancement of the therapeutic alliance. Attractive features of the reported resource-priming procedures are that resource priming and resource activation are custom-tailored individually to patient characteristics and that the therapists' choice of specific interventions is not confined. These features meet the demand of investigating therapeutic strategies on a superordinate level as discussed by Castonguay and Beutler (2006), and also allow for research on therapeutic strategies based on individual case formulations (Eells, 2007).

The present study provides evidence for the influence of resource activation on the therapeutic process and outcome. This contradicts the conception of resource activation as an "unspecific" curative factor, which operates "automatically" in the phase of remoralization (Hubble et al., 1999; Renaud et al., 1998). In contrast, our study speaks for conceptualizing resource activation as a comprehensive mechanism of change, which can be actively influenced by therapist behavior (Castonguay & Beutler, 2006; Castonguay & Grosse Holtforth, 2005; Grawe, 1998/2004). The priming intervention can be seen as one effective way to foster this mechanism of change. Future studies need to investigate further which specific resource-activating therapist behaviors are most effective for which patients and for which specific therapist.

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