

Client Perceptions of Corrective Experiences in Cognitive Behavioral Therapy and Motivational Interviewing for Generalized Anxiety Disorder: An Exploratory Pilot Study

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The purpose of the present study was to qualitatively investigate clients' posttherapy accounts of corrective experiences—a proposed common factor and integrative principle of therapeutic change (Castonguay & Hill, 2012)—after completion of either a brief cognitive behavioral therapy (CBT) or motivational interviewing (MI) integrated with CBT (MI–CBT) for generalized anxiety disorder (GAD; Westra, Constantino, & Antony, 2016). Patients' Perceptions of Corrective Experiences in Individual Therapy (PPCEIT; Constantino, Angus, Friedlander, Messer, & Heatherington, 2011) semistructured interviews were completed at therapy termination with 1 MI–CBT client and 1 CBT-only client who met the criteria for recovery. The PPCEIT interviews were audiorecorded, transcribed, and subjected to a grounded theory analysis using qualitative research methods software (ATLAS.ti). Findings indicated that both clients reported positive shifts in their experience of anxiety and increased agency in interpersonal relationships. In particular, the client undergoing integrative MI–CBT treatment reported increased confidence in her own ability to maintain positive changes posttherapy, while the CBT-only client expressed confidence in her application of CBT tools and skills to maintain therapy outcomes. The MI–CBT client attributed the shifts she experienced in therapy to an increased awareness and confidence in her own agency, indicating a potential corrective experience of self, whereas the CBT-only client attributed the positive shifts she experienced to the expertise provided by the therapist. Future research directions are discussed, in addition to implications of integrative CBT approaches, for enhanced clinical outcomes.

Keywords: corrective experience, cognitive behavioral therapy, motivational interviewing, generalized anxiety disorder, shifts in therapy

Alexander and French (1946) introduced the therapeutic principle of corrective emotional experience to describe how patients repair maladaptive interpersonal patterns in the context of

transference-focused, psychodynamic therapy sessions. Specifically, they posited that when psychodynamic therapists provide an opportunity to reexperience and understand early emotional conflicts in the context of a safe, responsive therapeutic relationship, clients begin to challenge and revise negative beliefs and expectations about themselves and others. The definition and nature of corrective emotional experiences has been extensively debated and theorized (Palvarini, 2010) since Alexander and French's original publication in 1946. A shared consensus on what is corrective, what gets corrected, and the mechanisms that underlie meaningful corrective shifts for clients in psychother-

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apy has nonetheless eluded psychotherapy researchers and practitioners, perhaps because the construct has traditionally been framed in psychodynamic terms, limiting the scope of research inquiry into the nature of corrective experiences (CEs) in therapy.

In a recent effort to address this gap in the psychotherapy research and practice literature, Castonguay and Hill (2012) proposed a pantheoretical, integrative definition of CEs in psychotherapy: “ones in which a person comes to understand or experience affectively an event or a relationship in a different or unexpected way” (p. 5).

Throughout the remainder of this paper, we use the term *corrective experience* to indicate this broader, pantheoretical definition proposed by Castonguay and Hill (2012). The purpose of arriving at this broader definition was to invite future psychotherapy research studies addressing client CEs from differing theoretical orientations and psychotherapy models (Castonguay & Hill, 2012). CEs differ from positive outcomes of therapy in that CEs are novel, personally significant, surprising, disconfirming of past experiences, and/or can have a significant impact on the clients’ understanding of the self, the world, and intra- and interpersonal patterns, along with concrete shifts in their thoughts, feelings, and behaviors. There may be overlap in clients’ accounts of positive outcomes of therapy and CEs, given that both can be emotional, cognitive, behavioral, or relational in nature. However, further research on clients’ perspectives of CEs can clarify the current conceptualization of CEs, which to date includes mostly psychotherapists’—rather than clients’—understanding of CEs.

Building on this integrative research initiative, the primary goal of the present exploratory study was to investigate the presence and nature of CEs in two clients’ firsthand accounts of their experience of cognitive behavioral therapy (CBT) and CBT integrated with motivational interviewing (MI) for generalized anxiety disorder (GAD; Westra, Constantino, & Antony, 2016). Specifically, the present study aimed to identify preliminary evidence for the validity of the updated, integrative, pantheoretical definition of CE and potential themes to inform a future larger study on CEs in the same clinical sample.

Investigating Client CEs in CBT

Heatherington, Constantino, Friedlander, Angus, and Messer (2012) conducted a multisite study to investigate clients’ ($N = 76$) first-person accounts of CEs immediately after every fourth therapy session. Clients were asked to describe *what* changed (“Have there been any times since you started the present therapy that you have become aware of an important or meaningful change[s] in your thinking, feeling, behavior, or relationships?”) and *how* they thought the change had occurred (“If yes, what do you believe took place during or between your therapy sessions that led to such change[s]?”). For clients engaged in CBT, five key themes emerged from the qualitative analysis of postsession accounts addressing *what* changed in therapy sessions: acquisition and use of new skills, recognition of hope, a more positive sense of self, specific changes in behavior (such as reduction in psychological symptoms or a shift in interpersonal patterns), and new cognitive perspectives on life and interpersonal relationships. In terms of perceptions of *how* change happens, the most commonly cited CBT therapist interventions were providing a new understanding of the client’s problems; giving advice; teaching specific techniques; and observing client patterns of thoughts, feelings, and behaviors. Themes pertaining to clients’ contributions to the change process included greater awareness and self-reflection, implementing specific techniques learned in therapy to daily life, and cooperating with the therapist (Heatherington et al., 2012). While these findings provided an interesting window into clients’ perceptions of postsession change in CBT, the analyses were limited by the brevity of postsession written accounts and the absence of information regarding client pretreatment diagnosis and outcome status at treatment termination and follow-up.

In order to help address these methodological gaps in future studies, Constantino, Angus, Friedlander, Messer, and Heatherington (2011) codeveloped a posttreatment interview protocol called Patients’ Perceptions of Corrective Experiences in Individual Therapy (PPCEIT). The PPCEIT interview protocol is a semistructured interview containing 10 open-ended questions divided into four sections. The sections ask clients to identify and elaborate on (a) the primary

reasons that they sought out therapy; (b) what significant shifts the client experienced in his or her view of self, life, interpersonal relationships, and problematic patterns; (c) the client's attributions for meaningful shifts in therapy, focusing on specific significant or unexpected incidents or therapist interactions; and (d) any other meaningful experiences in therapy and their overall experience of participating in the interview.

While previous posttherapy interview protocols have investigated clients' retrospective perceptions of psychotherapy (change interview: Elliott, Slatick, & Urman, 2001; narrative assessment interview: Hardtke & Angus, 2004; Kertes, Westra, Angus, & Marcus, 2011), the PPCEIT interview protocol (Constantino et al., 2011) is unique in that it addresses not only *what* clients perceive to be corrective about their experiences in psychotherapy but also inquires about their own personal understanding of *how* those changes occurred. Specifically, questions posed in the *what* shifted domain provide clients with an opportunity to identify meaningful shifts in multiple areas of their lives, such as their view of self, outlook on life, interpersonal relationships, thoughts, feelings, behaviors, and problematic patterns. Similarly, questions in the *how* shifts occur domain probe for specific moments within therapy and the therapeutic relationship that lead to shifts, which is unique to the PPCEIT interview protocol. This additional element appears to contribute important information to our understanding of CEs. For example, Friedlander and colleagues (2012) administered the PPCEIT interview protocol to investigate client CEs in one good-outcome client engaged in short-term dynamic psychotherapy. In terms of therapeutic change, the client identified resolution of unfinished business from childhood and more adaptive interpersonal relationships as CEs at therapy termination and attributed these shifts to the motivation, safety, and acceptance provided by her psychodynamic therapist.

To date, no studies have investigated client posttherapy accounts of CEs in mainstream therapy approaches such as CBT for depression or GAD. While research evidence generally supports the efficacy of CBT for GAD (see Covin, Ouimet, Seeds, & Dozois, 2008), a substantial number of clients fail to fully recover by treatment termination and follow-up (Westen &

Morrison, 2001). As such, many questions still remain as to the specific relational or treatment factors in brief CBT treatment protocols that contribute to clients' sustained recovery from GAD. For example, it may be the case that recovered clients experience shifts in their understanding of the self or in relation to the therapist (i.e., a CE) above and beyond learning and applying CBT skills for managing worry and anxiety. The randomized controlled trial (RCT) from which the present study's participants were drawn included clients who received CBT alone and clients who received MI integrated with CBT (Westra et al., 2016). Importantly, MI emphasizes the importance of the therapeutic relationship, empathic exploration of client values and identity, and heightening client collaboration and agency in the change process (Westra, 2012). As such, this study sample thus represents an opportunity to elucidate key distinctions between the types of changes clients experienced in therapy, such as distinctions between symptom level and gaining expertise in CBT skills changes, versus higher order shifts in experience or understanding of the self, events, or relationships (i.e., CEs).

The Current Study

The present study conducted a qualitative analysis of client accounts of meaningful shifts experienced in the context of an RCT of CBT versus Motivational Interviewing integrated with CBT (MI-CBT) for GAD (Westra et al., 2016) using the PPCEIT interview protocol (Constantino et al., 2011). Qualitative analyses of the protocol were guided by the following exploratory research questions: (a) What core themes emerge from clients' verbal accounts of perceived meaningful and significant shifts in CBT and MI-CBT for GAD? and (b) What core themes emerge from clients' verbal accounts of how those shifts occurred?

In order to investigate client accounts of meaningful shifts in CBT and MI-CBT, the PPCEIT interview protocol (Constantino et al., 2011) was administered to one recovered CBT client and one recovered MI-CBT client who completed the semistructured interview protocol at treatment termination. The interviews were audiorecorded, transcribed, and subjected to a grounded theory analysis using qualitative research methods software, ATLAS.ti (Muhr,

1997), to generate themes. Selecting a client from each treatment condition for this pilot study allowed an initial comparison of the impact of treatment differences that emerged in the results to be explored in future larger samples.

Method

Participants

Selection pool. Client posttreatment accounts were solicited in the context of a larger RCT (Westra et al., 2016) of CBT versus CBT integrated with MI for GAD. Participants had a principal diagnosis of GAD as assessed by a modified Structured Clinical Interview for *DSM-IV-TR* Axis I Disorders (SCID-IP; First, Spitzer, Gibbon, & Williams, 2002) and a score above the cutoff for high-severity GAD on the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990). Participants ($N = 85$) were randomly assigned to either receive 15 weekly sessions of CBT or four individual MI sessions prior to receiving 11 weekly CBT sessions (MI-CBT), integrated with MI as needed. A total of 19 posttherapy interviews were randomly conducted by two of the authors who were trained in the administration of the PPCEIT interview protocol (Constantino et al., 2011). The two clients included in the current study were selected because they were the first pair (i.e., one from each treatment condition) of interviewees who met the recovered status at treatment termination and had thorough interviews.

Reliable change index (Jacobson & Truax, 1991) analyses of the PSWQ (Meyer et al., 1990) scores at posttreatment were conducted to determine the outcome status categorization of the CBT-only and MI-CBT client for inclusion in the current study. Both clients were considered recovered at treatment termination. However, the CBT client relapsed, while the MI-CBT client was still considered recovered at 12 months follow-up. It should be noted that the 12-month follow-up scores were made available to the authors after the qualitative analyses of the current study had already been completed. The trend in PSWQ scores of the two clients is consistent with the overall RCT results that show a consistent, significant pattern across self-report and diagnostic measures, indicating increasing improvement for the MI-CBT group

over the follow-up period and either no change or a slight worsening over time for the CBT-alone group (Westra et al., 2016). See Table 1 for clients' pretreatment, posttreatment, and 12-month follow-up PSWQ scores.

The pseudonym "Deb" was given to the client who completed CBT-only treatment and the pseudonym "Martha" was given to the client who completed MI-CBT treatment to preserve confidentiality and anonymity. Deb was a 28-year-old Caucasian female with a postsecondary degree who had a comorbid diagnosis of major depression, panic disorder, and social phobia at baseline. Martha was a 53-year-old Caucasian female with a master's degree who had no other comorbid conditions at baseline. Both Deb and Martha had had previous experience with psychotherapy treatment (Deb: 17 CBT sessions with a psychologist; Martha: 10 therapy sessions with a social worker).

Therapists

Deb's therapist was a 28-year-old Caucasian female who was a master's-level trainee in supervised practicum training. Martha's therapist was a 32-year-old Caucasian female who had recently completed her PhD. Therapists in the RCT self-selected the training and delivery of the treatment condition to enhance their fidelity to the MI-CBT or CBT treatment protocols. Training consisted of readings, 4-day-long workshops including discussion and role-play, and at least one practice case with intensive feedback and video review of therapy sessions.

Treatment

The CBT-only client (Deb) received 15 weekly sessions of CBT, which included the following components: psychoeducation for

Table 1
Client PSWQ Scores at Pretreatment, Posttreatment, and 12 Months Follow-Up

Client	Pretreatment	Posttreatment	12 months follow-up
Deb (CBT)	80	51	75
Martha (MI-CBT)	68	32	20

Note. PSWQ = Penn State Worry Questionnaire; CBT = cognitive behavioral therapy; MI-CBT = Motivational Interviewing integrated with CBT.

anxiety and worry, self-monitoring, progressive muscle relaxation training, discrimination training, cognitive restructuring, behavioral experiments, imagined and in vivo exposure to worry cues, prevention of worry-related behaviors, discussion of sleep strategies, and relapse prevention planning.

The MI–CBT client (Martha) received four sessions of MI followed by 11 sessions of CBT, integrated with MI techniques when markers of ambivalence and resistance emerged. The MI treatment consisted of principles and methods outlined by Miller and Rollnick (2002), targeting ambivalence about worry and worry-related behaviors. Core strategies and principles of MI (expressing empathy, rolling with resistance, developing discrepancy, and enhancing self-efficacy) are differentiated from the underlying MI spirit. The MI spirit is a client-centered relational stance involving empathic attunement, collaboration, evocation, and respect for the client's autonomy (Angus, Watson, Elliott, Schneider, & Timulak, 2015). CBT therapists actively take on the role of change advocate, whereas MI therapists facilitate the client to explore their own thoughts and feelings about change, helping the client become a more effective advocate for his or her own change. Although MI has several directive components aimed at increasing client self-change talk, the focus remains on increasing motivation for change instead of primarily employing change strategies.

Measures

PSWQ (Meyer et al., 1990). The PSWQ is a widely used measure in assessing trait worry. The 16 items on the PSWQ are rated on a 5-point Likert scale, with higher scores indicating higher levels of worry. The PSWQ has been found to hold high internal consistency, have good test–retest reliability, and have good convergent and discriminant validity (Brown, Antony, & Barlow, 1992).

PPCEIT (Constantino et al., 2011). Clients were interviewed at therapy termination using the PPCEIT interview protocol, which contains 10 open-ended questions that are divided into four sections. The interview protocol is outlined in an interview manual (Constantino, Angus, & Moertl, 2012). The first section asks clients to identify the primary reasons they

sought out therapy. The second and third sections invite clients to share their experiences of what shifted in therapy and how these meaningful shifts came about, respectively. The fourth and final section of the PPCEIT interview protocol inquires about any other meaningful experiences in therapy and the client's experience of participating in the interview.

Procedure

Data analysis. Interviews were audiorecorded, transcribed, and analyzed using ATLAS.ti (Muhr, 1997) scientific software that is designed to implement a grounded theory analysis (Angus & Rennie, 1988, 1989; Glaser & Strauss, 1967).

Grounded theory. The grounded theory approach is a “qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Strauss & Corbin, 1990, p. 24). Glaser and Strauss (1967) originally developed this approach as an alternative to deductive theorizing methods in which data are forced to fit into existing theories. The grounded theory method used in the current study is based on an integration of grounded theory methods outlined by Angus and Rennie (1988, 1989) and Glaser and Strauss (1967).

The interview transcripts were first divided into meaning units, which are text segments (usually a few lines to a paragraph) that convey a single topic or focus. The next step involves identifying properties in each meaning unit. The term *properties* refers to individual and new ideas conveyed by the client within a larger meaning unit. Property titles were kept descriptive and close to the client's language. As the analysis progressed, new meaning units were compared to existing properties. If no existing properties were representative of an individual idea within a meaning unit, a new property was developed. Properties were further clustered into categories, the titles of which shifted from being entirely descriptive when identifying properties to conceptual, abstract themes when labeling categories in order to explain the properties' descriptive content. Categories with relationships to multiple other categories were termed *central* or *core* categories (Angus & Rennie, 1988, 1989). The linked categories were then organized into a hierarchical structure

in which core categories subsumed lower order categories, defining the core category properties. In the present study, the transcripts were coded into meaning units and properties and clustered into categories by a single coder. A senior researcher and clinical psychologist verified the meaning units and properties against the raw language used by the client and audited the properties as well as their categorization into lower order categories and core categories.

Results

Tables 2 and 3 present the core themes and subcategories that emerged from the qualitative analysis of Deb and Martha's posttreatment accounts of their therapy experiences. The emergent core themes were grouped in terms of two domains—(a) client-identified shifts in therapy and (b) clients accounting how shifts occurred in therapy—to address Research Questions a and b, respectively.

Domain 1: Client-Identified Shifts in Therapy

Core Category 1: More adaptive interpersonal relationships due to therapy. This core category includes Deb and Martha's de-

Table 2
Taxonomy of Categories for the Domain of Client-Identified Shifts in Therapy

Category
Core Category 1: More adaptive interpersonal relationships due to therapy
(a) Experiencing old interpersonal patterns with a new outcome in the therapeutic relationship
(b) Increased independence in interpersonal relationships
Core Category 2: Positive shifts in the experience of anxiety
(a) New awareness about the nature of anxiety: From feeling stuck in a box to expanded perspectives
(b) Change in anxiety-related behaviors that are observable in everyday life: Feeling more calm and present centered
Core Category 3: Feeling a sense of hopefulness about changes accomplished in therapy
(a) Feeling confident in sustaining progress accomplished in therapy through reliance on inner self-efficacy
(b) Feeling confident in sustaining progress accomplished in therapy by learning and applying CBT tools

Note. CBT = cognitive behavioral therapy.

Table 3
Taxonomy of Properties for the Domain of Clients Accounting How Shifts Occurred in Therapy

Category
Core Category 4: Therapist's positive role in facilitating shifts in therapy
(a) Therapist as an expert and guide in therapy
(a1) Therapist provides helpful information and resources
(a2) Therapist helped facilitate new perspectives on anxious thoughts and self-reflection for the client
(b) Positive therapeutic relationship enhanced therapy experience
Core Category 5: New intrapersonal and interpersonal awareness derived from therapy
(a) Insight into previously unacknowledged thoughts and emotions in therapy
(b) Self-realization to give priority to one's own needs before others: Shift from other focused to self focused
Core Category 6: Learning helpful CBT exercises and tools to manage anxiety on an everyday basis
(a) Muscle relaxation exercises useful in recognizing bodily tension
(b) Thought records helpful due to their practical value in organizing anxious thoughts in stressful situations

Note. CBT = cognitive behavioral therapy.

scriptions of experiencing maladaptive interpersonal patterns with a new outcome within the therapeutic relationship as well as examples of improved interpersonal relationships outside the context of therapy.

(a) Experiencing old interpersonal patterns with a new outcome in the therapeutic relationship. Martha reported replaying her maladaptive interpersonal pattern of wanting to be perceived perfectly in the therapeutic relationship:

I slowly started to realize that I like to be perfect, I like to be friendly. So I was trying to be the perfect client, what if she (therapist) thinks I am crappy at this or that I am terrible?

After a discussion with her therapist, Martha reported that she came to understand this interpersonal pattern in a new way and apply this awareness within the therapeutic relationship and to relationships outside the therapeutic context:

I was trying to be perfect. I was trying to measure up to what I thought everyone else thought I should be. Now, it's okay to be who I am and do what I am doing . . . I am not so concerned about if they . . . are thinking

critically about me. . . . At Christmastime, I wanted to bake some cookies and bring them to her [therapist]. But I didn't because I didn't think it was totally necessary, which is a good thing.

Deb also reported becoming more aware of her interpersonal pattern of "worrying about the therapist being upset about something" and "apologizing too much" after the therapist pointed it out to her. After discussing this interpersonal pattern with the therapist, Deb noted the following: "There are situations now where I will be doing something, I think to myself, do I need to apologize for that? I try and like, go back to therapy."

(b) Increased independence in interpersonal relationships. This subcategory contains clients' responses in which they reported experiencing more adaptive interpersonal relationships characterized by an enhanced sense of agency and independence. For example:

- "I am trying to get myself a little less dependent. So I think my husband is happier and together we are a little bit better" (Deb).
- "I have always been very overprotective of my brother. But I am trying to . . . let him deal with his own issues. I would never have thought of doing that before" (Deb).
- "My mom has Alzheimer's and my dad is taking care of her. . . . He was angry and I got the brunt of it. . . . I would worry about my dad. . . . What should I be doing? Now, I am doing what I can and I am not . . . looking for more to compensate" (Martha).

Core Category 2: Positive shifts in the experience of anxiety. This core category includes Deb and Martha's reports of positive shifts in how they view and experience anxiety, which they attributed to their engagement in CBT and MI-CBT, respectively.

(a) New awareness about the nature of anxiety: From feeling stuck in a box to expanded perspectives. Deb described a transition in viewing her anxiety from "being stuck in a box" with a limited perspective to deriving a new perspective about the nature of anxiety by equating it to "bringing a new light" to it. Both clients described a meaningful shift such that instead of viewing their worry as unmanageable and overwhelming, they came to see it as something they could learn to work with. For example:

- "Before starting therapy, my worry was like a train, so it was thought after thought after thought. But now, it is easier for me to break that up" (Deb).
- "The more we talked about what was that thought? Why did you think that way? I started seeing, oh okay, I can stop, look at it, slow it down, and try to reframe it" (Martha).

Although Deb reported realizing that she would "always have anxiety," she noted being able to view her anxious thoughts in a more objective manner now, similar to Martha, who also noted being able to view her anxiety from "another person's point of view."

(b) Change in anxiety-related behaviors that are observable in everyday life: Feeling more calm and present centered. Only Martha reported instances of taking action and changes in anxiety-related behaviors while noting a significant reduction in her anxiety. She noted:

I didn't like open time where there was nothing planned. I would get restless and feel like I should be productive. But now I am okay with downtime, like to spend a Sunday in my sweats, stay at home and watch movies, I never did that before. It feels good because I feel calmer. I am definitely less tired than I was.

She also noted: "My mind isn't racing as much. And I am sleeping better. I wake up in the morning and go, hmm, I don't feel tired. So that's nice! It's a surprise."

Core Category 3: Feeling a sense of hopefulness about changes accomplished in therapy. This core category includes clients' descriptions of deriving confidence from changes accomplished in therapy and growing optimism about the future.

(a) Feeling confident in sustaining progress accomplished in therapy through reliance on inner self-efficacy. This subcategory reflects Martha's responses; she reported increased confidence about the positive shifts she accomplished in therapy as well as taking responsibility in terms of creating and sustaining these shifts: "In the questionnaire that we fill out every session, that question of what percentage of your symptoms do you feel have improved, I would always say, 60% and then later on, I thought, maybe 80%." She also noted: "I was never skeptical that the therapy process was effective, it was more, could I do it? So more about myself than therapy itself." Although Martha described realistic concerns about keeping up with therapy progress, her responses

also indicated hopefulness and a belief in her own ability to continue moving forward:

I am a bit nervous because I have been dealing with it for 30 years. If I introduce more stress back, would I be able to keep it up? But I am thinking more and more that I can. I can think differently.

(b) Feeling confident in sustaining progress accomplished in therapy by learning and applying CBT tools. This subcategory contains Deb's responses; she described feeling equipped with various tools learned from therapy for application to outside situations: "At least I have all this information and tools that I can use when everything in my life returns to normal." She also noted: "Once life gets a little bit more back to normal, I can still do all this stuff that I have been doing in therapy." She also noted deriving confidence from applying CBT tools and observing the positive results: "Doing thought records, relaxation exercises, I have come into this brand-new profession with no experience and I am still there and they haven't fired me yet. So this is a good sign."

Domain 2: Clients Accounting How Shifts Occurred in Therapy

Core Category 4: Therapist's positive role in facilitating shifts in therapy. This core category includes Deb and Martha's descriptions of the positive role played by the therapist in facilitating shifts.

(a) Therapist as an expert and guide in therapy. The majority of the properties in this subcategory represented Deb's responses, which reflected the therapist actively guiding the therapy process and providing expertise.

(a1) Therapist provides helpful information and resources. All the properties in this subcategory came from Deb's responses in which she spoke about the therapist supplying her with resourceful information that provided her with clarity when "everything seemed cloudy." Her responses reflected the therapist being a knowledgeable guide who helped her overcome difficulties with therapy exercises: "Everything that she was asking me to do or ideas that she had, I agreed with everything she was suggesting because I felt like it was helpful."

(a2) Therapist helped facilitate new perspectives on anxious thoughts and self-reflection for the client. Martha spoke about the therapist "opening her mind" to new perspectives on her anxiety. Similarly, Deb noted:

The therapist asking me a lot of questions made me really think and gave me a chance to look at things from a different perspective. . . . She would come back with a question, which I would be like, whoa!, she stumped me. And I'd think wow, I never thought of it like that!

(b) Positive therapeutic relationship enhanced therapy experience. Both clients described the positive therapeutic relationship as providing them with a safe space to open up. During a particularly stressful week, Deb noted: "She said, today we are not going to have a schedule, I want you to talk about what you feel like you need to talk about. So she let me vent. I really needed it." Martha noted: "That was a surprise that I didn't expect to cry as much as I did." In addition, Deb reported that the therapist possessed a "very warm demeanor and personality," which helped increase her trust in the therapy process and relationship:

It felt like she truly cared. She wasn't just saying whatever because it's part of her job, it felt like a real sense of her personality came through, which is important because I didn't want to talk to a robot.

Core Category 5: New intrapersonal and interpersonal awareness derived from therapy. The majority of the properties in this core category represent Martha's responses in which she described how gaining awareness of her underlying beliefs and interpersonal patterns helped her accomplish meaningful shifts in therapy.

(a) Insight into previously unacknowledged thoughts and emotions in therapy. The properties in this subcategory emerged from Martha's account in which she spoke about realizing the extent to which she was "criticizing herself on the inside" and trying to "measure up to an unrealistic standard." She noted:

I always thought I should be able to do more, more, and more. It was never enough. Because of this, in the last 5 years, I realized that no matter what I did, I was exhausted. So mentally, I was burnt out.

She noted a specific incident in therapy when experiencing emotions acted as a cue to her underlying fears:

It was around the fourth session when the therapist started to get to me and I felt emotional. . . . It started with her asking me questions and then I felt like crying. . . . And then I started to realize some of my fears and how much they were part of me, like people

not liking me, getting old, and fat. I realized how much they mean to me.

(b) Self-realization to give priority to one's own needs before others: Shift from other focused to self focused. Both clients came to the realization that they were investing more into their interpersonal relationships instead of focusing on their own needs and priorities. For example, Deb stated: "I realized I was paying way too much attention to everyone else and not doing enough for myself. . . . I am realizing to step back and disconnect a little bit to keep myself sane." Martha noted:

I would go for a massage and then chat through the whole thing about their life and then I come to the end of the thing and go, that was not the point. . . . I notice now when other people do not ask about me. So it's a one-sided relationship. . . . So I realized, being nice and polite is good but not to go too far.

Core Category 6: Learning helpful CBT exercises and tools to manage anxiety on an everyday basis. This core category emerged from Deb's description of helpful CBT exercises and tools that she learned from therapy.

(a) Muscle relaxation exercises useful in recognizing bodily tension. Deb spoke about the helpful aspects of learning progressive muscle relaxation in therapy and incorporating it into her daily life. She mentioned now being able to identify tension in her body and being able to use it as a "sign to relax."

(b) Thought records helpful due to their practical value in organizing anxious thoughts in stressful situations. Deb noted that the thought records were her "favorite part" of therapy in terms of their value in helping her "break down and analyze" her worries in everyday situations. She also spoke about utilizing the thought records during and after therapy, which helped her "recognize the underlying cause of negative thoughts."

Discussion

This pilot study utilized a grounded theory analysis to identify core themes in clients' post-therapy accounts of shifts experienced in CBT or MI-CBT for GAD. Our goal was to identify core themes about what shifted and how it shifted and to identify whether any of those shifts might constitute a CE (i.e., a new understanding or unexpected, novel emotional experience of an event, the self, or a relationship;

Castonguay & Hill, 2012). Two recovered clients were solicited from an RCT of CBT versus MI-CBT (Westra et al., 2016) and interviewed at posttreatment using the PCEIT interview protocol (Constantino et al., 2011). The small sample size limits generalization, and systematic differences in age, education level, and comorbid diagnoses at baseline between the CBT and MI-CBT clients, as well as therapist differences, may have partially accounted for the findings. However, our findings are promising in terms of implications for future research with a larger sample and for clinical practice.

The emergent core themes and subcategories in the domain of client-identified shifts in therapy indicated that Martha and Deb reported several meaningful shifts in their therapy process, a few of which were congruent with the following pantheoretical, transdiagnostic definition of CEs: "ones in which a person comes to understand or experience affectively an event or a relationship in a different or unexpected way" (Castonguay & Hill, 2012, p. 5).

Specifically, the two subcategories in the core theme of more adaptive interpersonal relationships due to therapy are consistent with the conceptualization of CEs (Castonguay & Hill, 2012). The subcategory of experiencing old interpersonal patterns with a new outcome in the therapeutic relationship highlighted that both clients identified a meaningful interpersonal shift or CE within the therapeutic relationship, which is in agreement with the transtheoretical definition (Castonguay & Hill, 2012) and original conceptualization of CEs (Alexander & French, 1946). Both clients came to replay as well as understand and experience their old maladaptive interpersonal pattern with a new solution within the context of the therapeutic relationship. In both instances, instead of reaffirming their interpersonal pattern as others had done before, the therapist facilitated a new corrective interpersonal experience through an open discussion within the context of warmth, genuineness, and safety of the therapeutic space. The subcategory of increased independence in interpersonal relationships included Deb and Martha's examples of specific shifts in the way they experienced interpersonal relationships with significant others outside the context of the therapeutic relationship due to therapy, which is also consistent with Castonguay and Hill's (2012) conceptualization of CEs.

The core theme of positive shifts in the experience of anxiety highlighted that both clients indicated cognitive and experiential shifts in relation to their anxiety and worry. Although these responses were evoked in response to questions that pull for significant and personally meaningful shifts within therapy in the PPCEIT interview protocol (Constantino et al., 2011), these shifts do not meet the definition of CEs (Castonguay & Hill, 2012).

In the core theme of feeling a sense of hopefulness about changes accomplished in therapy, both clients noted a shift from feeling hopeless about the future to enhanced optimism in maintaining changes accomplished in therapy. While this core theme is representative of a positive outcome of the clients' therapeutic experiences, the subcategories within the theme do not comply with the pantheoretical definition of CEs (Castonguay & Hill, 2012). What is notable here is that while there were many commonalities in Deb and Martha's accounts of increased hopefulness, differences were apparent in their perceptions of what their roles were in maintaining shifts from therapy. Martha expressed confidence about maintaining changes through a belief in her own inner resources, whereas Deb expressed similar optimism but through the application of CBT tools learned from therapy. This difference was also paralleled in their descriptions of how they perceived CEs to have occurred. The bulk of Deb's responses fell under the core themes of therapist's positive role in facilitating shifts in therapy and learning helpful CBT exercises and tools to manage anxiety on an everyday basis. Salient in Deb's responses was a sense that she experienced the therapist as the expert and guide who acted as the primary manager of the therapy sessions (e.g., agreeing with the therapist's suggestions, complying with homework and exercises). Deb also attributed her shifts in therapy to thought records and muscle relaxation.

In contrast, Martha's descriptions of attributions for shifts mainly fell under the core theme of new intrapersonal and interpersonal awareness derived from therapy. In Martha's accounts of how CEs occurred, she noted working hard at gaining a deeper understanding of herself and finding her own answers. This difference may reflect key elements of the MI spirit, which emphasizes the view that resources and motiva-

tion for change reside within the client (Miller & Rollnick, 2002).

The aforementioned findings are also consistent with the theoretical rationale for integrating MI with more directive therapeutic approaches such as CBT to increase clients' active engagement and motivation for change in treatment (Miller & Rollnick, 2002). Specifically, CBT requires that the client engage in several tasks and exercises with a clear orientation toward changing one's thinking and behaviors, which can be a potent breeding ground for resistance (Westra, 2012). MI is then added to mobilize the client's intrinsic motivation for movement toward change, which is thought to inherently increase engagement in treatment. Increased treatment engagement as a function of receiving MI was observable in Martha's accounts of how shifts occurred; she attributed them to the awareness and insights derived by her agentic self, whereas Deb attributed her CEs to the therapist's guidance and CBT tools, which is congruent with the didactic nature of CBT.

In addition to enhanced engagement in treatment, Martha's (MI-CBT) PSWQ scores indicated an enhanced treatment outcome compared to Deb (CBT only) at 12 months follow-up—that is, although both clients were considered to have recovered from GAD at posttreatment, Martha retained her treatment status of recovered at 12 months follow-up, while Deb relapsed at 12 months follow-up. If these two cases are representative of the treatment conditions from which they were sampled, then these findings indicate that MI integrated with CBT might improve treatment outcomes through the pathway of the MI spirit and client-as-expert nature, which engenders clients with an agency and trust in themselves, as observed in Martha's posttreatment. In contrast, Deb's account suggested her dependence on therapist guidance. This distinction might be particularly relevant once treatment ends and clients have to rely on themselves. In addition to capturing the nature and attributions of meaningful shifts from the clients' perspectives, the results of the present study also provide preliminary evidence that CEs are experienced by clients undergoing MI and CBT for GAD. Finally, our findings tentatively suggest that the theoretically intended mechanisms of change in MI and CBT are consistent with clients' subsequent accounts of shifts experienced in therapy, and these may

point to pathways through which MI may exert better long-term benefits than CBT alone.

Limitations and Future Directions

An important limitation of this pilot study was the small sample size. It should also be noted that differences in age, education, comorbid diagnoses at baseline, and therapist differences between the CBT-only client and MI-CBT client could have contributed to systematic differences in long-term outcome as well as the clients' understanding and reporting of their therapy experiences.

In future studies, it will be important to explore if key differences in agency and self-efficacy, as noted in the MI-CBT client's descriptions of meaningful shifts, also arise in a larger sample of clients engaging in CBT and MI-CBT for GAD, which may add to the growing understanding of how MI may increase receptivity to more action-oriented treatments such as CBT. It would also be informative to examine how verbal accounts compare between psychotherapy clients who achieve recovery versus those clients who do not achieve recovery in order to further elucidate how differences in clients' understanding and attributions for their CEs and shifts may contribute to their therapy outcome status at posttreatment and follow-up. Overall, a growing understanding of CEs and meaningful shifts holds the potential of providing therapists with knowledge of how to create favorable conditions to facilitate such shifts for clients in therapy. Most importantly, the present study adds to the understanding of clients' experiences of personally significant shifts in psychotherapy that ultimately belong to the clients and are worthy of studying in their own right.

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