

Article

Patients' and Therapists' Reports of Psychotherapy Outcomes: Similarities and Differences

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ABSTRACT

Correction Notice: An Erratum for this article was reported in Vol 36(3) of Psicothema. These changes may not be applied on the printed versions. **Background:** Discrepancies between therapists' and patients' measures regarding therapeutic results indicate the need to analyze which symptoms and processes are being taken into consideration when reporting clinical change. This study analyzes the concordance between patient and therapist, at pre- and post-treatment, when reporting about anxiety, depression, Experiential Avoidance (EA), Cognitive Fusion (CF) and Activation (A). **Method:** Convergence was examined between information obtained by means of standardized measures and visual analogical scales (VAS) in 94 patients with anxiety and/or depression who participated in a controlled clinical study (TRANSACTIVA study). **Results:** Statistically significant correlation ($p < .05$) was found between all the measures of anxiety and depression, regardless of the source, timepoint, and measures procedure at 95% confidence. In the VAS, patient and therapist agreed ($p < .05$) in their evaluation of specific symptoms. For EA, CF and A, the therapists' measures demonstrated stronger correlations than those of the patients, although, in each condition, all the patients' measures correlated with each other ($p < .05$). **Conclusions:** Suitable agreement was found between therapist and patient when reporting clinical change. One-item VAS appeared to be suitable for identifying anxiety, depression and the transdiagnostic patterns of EA, CF and A.

Informes de Pacientes y Terapeutas Sobre el Resultado de la Psicoterapia: Similitudes y Diferencias

RESUMEN

Nota de corrección: se comunicó una erratum para este artículo en el Vol 36(3) de Psicothema. Estos cambios pueden no verse reflejados en las versiones impresas. **Antecedentes:** Las discrepancias entre terapeutas y pacientes sobre los resultados terapéuticos indican la necesidad de analizar qué síntomas y procesos se tienen en cuenta al evaluar el cambio clínico. Se analizó la correspondencia entre paciente y terapeuta, en pre y post tratamiento, al informar sobre ansiedad, depresión, Evitación Experiencial (EA), Fusión Cognitiva (FC) y Activación (A). **Método:** Se examinó la convergencia entre la información obtenida mediante cuestionarios estandarizados y escalas analógicas visuales (EVA) en 94 pacientes con ansiedad y/o depresión que participaron en un estudio clínico controlado (estudio TRANSACTIVA). **Resultados:** Se encontró correlación significativa ($p < .05$) entre todas las medidas de ansiedad y depresión, independientemente de la fuente, momento y procedimiento de medida al 95% de confianza. En la EVA, paciente y terapeuta coincidieron ($p < .05$) al valorar síntomas específicos. Respecto a EA, CF y A, las medidas del terapeuta mostraron correlaciones más altas y significativas que las del paciente, aunque, en cada condición, todas las medidas del paciente se correlacionaron entre sí ($p < .05$). **Conclusiones:** Se observó adecuada correspondencia entre terapeuta y paciente al informar sobre el cambio clínico. La EVA de un ítem parece adecuada para identificar ansiedad, depresión y patrones transdiagnósticos de EA, CF y A.

Palabras clave:

Trastornos emocionales
Activación
Evitación experiencial
Fusión cognitiva
Escala analógica visual

Self-report instruments are habitually used as measures of diagnostic assessment, for evaluation of clinical results, and for research, as they comply with scientific standards and provide psychometric assurances. This means that the effect size of the differences between scores has been adopted as a result criterion. Furthermore, there is adequate correspondence between data offered by patient self-reports and therapists', suggesting that the two measures could be interchangeable when evaluating mental disorders, functionality and quality of life (Guo et al., 2015; Hershenberg et al., 2020; Zimmerman et al., 2018). Nevertheless, there are also cases where the two differ, differences which are believed to be related to educational attainment, personality factors, and patients' understanding of their disorder (Cuijpers et al., 2010; Franklin & Raines, 2019; Hershenberg et al., 2020; Kendrick et al., 2016).

Patients are often asked for information about clinical improvement by means of one-item analogical scales. Although therapist-patient agreement is also assumed to be acceptable in this measure, the degrees of agreement and the calculations of sensitivity to change are influenced both by the interventions and by events in the patient's life between evaluations (Hobbs et al., 2021; Price et al., 2022; Robinson et al., 2017). In particular, patients' responses and their favorable progression could largely be explained by changes in quality of life, social support, and/or particular life events occurring at the same time as the treatment (Bandelow et al., 2018; Bowling et al., 2012).

These differences between sources make it necessary to ask whether a statistically significant difference in a given clinical condition adequately reflects the client's insight into improvement or deterioration. This is an important question, since the clinical significance of the results is not merely a statistical one, but also has important implications regarding therapeutic decisions (Bauer-Staeb et al. 2021; Hopko et al., 2000; Malpass et al., 2016; Robinson et al., 2017). Furthermore, any reference to therapeutic effects alludes directly to a measure of the therapeutic ingredients. Consequently, discrepancies between evaluators indicate (amongst other things) the need to identify the extent to which, when reporting clinical change, patient and therapist are referring specifically to changes in those conditions and/or processes the therapy focuses on.

To be able to identify the mechanisms through which psychological treatments produce results is important for the empirical validation of the therapies and is essential in order to validate the explanatory model proposed by each therapy regarding the nature of psychological problems. Transdiagnostic approaches are currently investigating precisely those common conditions which could play a part in the onset and maintenance of the psychological disorders. Using a contextual transdiagnostic approach, therapies such as the Acceptance and Commitment Therapy (ACT, Hayes et al., 2011) and Behavioral Activation (BA, Martell et al., 2013) have demonstrated their efficiency and effectivity, both in reducing symptoms and in changing transdiagnostic mechanisms. In controlled clinical studies and, more recently, in mediation studies, evidence has been found to show that clinical results are consistent with the model of psychological flexibility proposed by ACT (Coto-Lesmes et al.,

2020a; Gloster et al., 2020; González-Fernández & Fernández-Rodríguez, 2019; Stockton et al., 2019) and with the model of activation defended by BA (Coto-Lesmes et al., 2020b; González-Fernández et al., 2019; Martin & Oliver, 2019; Santos et al., 2017). However, before these conclusions can be confirmed it is necessary to ensure that the measures of evaluation are accurate and the most appropriate ones for examining the processes to which the clinical change is attributed.

The psychometric robustness of the questionnaires to measure the model of Activation developed by BA (for a review, see Manos et al., 2010) and the patterns of psychological inflexibility focused on by ACT (for a review, see Barney et al., 2019; Cherry et al., 2021) justifies their use as result measures for these therapies. They are instruments which measure the frequency or intensity of behaviors, interpersonal actions and/or specific events, and which, in accordance with previous correlational studies, make it possible to understand these data as indicative of transdiagnostic processes. Nevertheless, the suitability of these standardized instruments as measures of the processes of change depends on their capacity to explain the functionality of the behavior. From a contextual point of view, a functional analysis of the relationships of the person with others and with him/herself is essential in explaining the functionality of the problem. Indeed, both BA and ACT base the design of the intervention on a functional analysis of the behavior of each patient carried out by the therapist (with the involvement of the patient) and which requires observations of the behavior in the contexts in which this takes place over a period of time. This is obviously difficult to standardize but is feasible with measures of symptoms or of constructs (Ong et al., 2020; Rogge et al., 2019). In the light of these idiosyncrasies, knowing the degree of congruence between the patient's self-report (whether through standardized measures or analogical scales) and the therapist's report (as an expert) regarding the processes and conditions on which the contextual therapy focuses, could shed light on the suitability of the patient's assessments as measures of the processes of change and, consequently, as result criteria of the therapies.

TRANSACTIVA (Fernández-Rodríguez et al., 2022a) is a controlled trial study with the objective of comparing the post-treatment and follow-up effects of BA, ACT and Cognitive-Behavioral Transdiagnostic Therapy (TD-CBT) on emotional symptomatology, and analyses the role played by Experiential Avoidance, Cognitive Fusion, Activation and Emotion Regulation in the clinical change. With this objective in mind, measures of the therapeutic processes and of the results of the therapy were obtained through standardized measures and visual analogical scales (EVA), completed by both the patient and the therapist at different moments of the intervention. In this research context, this study seeks to analyze the correspondence between all the measures of the patient and therapist both prior to and following the intervention. Ultimately, it is hoped that these data will contribute to improving our knowledge regarding the conditions associated with the therapeutic process and clinical change associated with the transdiagnostic therapies tested in the TRANSACTIVA study.

Method

Participants

Of the 128 who fulfilled the inclusion criteria (i.e., being of 18-65 years of age and scoring ≥ 10 in either subscale of the Hospital Anxiety and Depression Scale), the current study includes 94 patients, of whom 73 (77.66%) completed the treatment. The exclusion criteria were: (a) receiving another type of psychological therapy; (b) suffering physical or cognitive deterioration which might hinder participation in the therapy; (c) presenting either a substance use disorder, a severe mental disorder or communication problems.

Instruments

Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983; Spanish adaptation, Quintana et al., 2003). The HADS is a 14-item scale with 2 subscales, Anxiety (HADS-A: $\alpha = .64-.87$) and Depression (HADS-D: $\alpha = .80-.86$), with subscales ranging from 0 to 21. The internal consistency was good at both assessments (anxiety: $\alpha = .64-.87$; depression: $\alpha = .80-.86$).

Generalized Anxiety Disorder-scale 7 (GAD-7) (Spitzer et al., 2006; Spanish adaptation, García-Campayo et al., 2010). The GAD-7 assesses symptoms of generalized anxiety disorder as referred to in the DSM-IV. Total scores range from 0 to 21. The GAD-7's internal consistency in the present sample ranged .79-.89.

Short form of the 1978 Beck Depression Inventory (BDI-IA-SCA) (Beck & Steer, 1993; Spanish adaptation, Sanz & García-Vera, 2007). It consists of the first thirteen items of the BDI-IA, referring to affective-cognitive symptoms of depression. The internal consistency in the study sample range was very good ($\alpha = .84-.92$).

Environmental Reward Observation Scale (EROS) (Armento & Hopko, 2007; Spanish adaptation, Barraca & Pérez-Álvarez, 2010). It consists of 10 items assessing the quantity and availability of reinforcement received from the patient's environment. The internal consistency in the study was good ($\alpha = .76-.87$).

Acceptance and Action Questionnaire-II (AAQ-II) (Bond et al., 2011; Spanish adaptation, Ruiz et al., 2013). The AAQ-II measures experiential avoidance and psychological inflexibility using 7 Likert-type items. The reliability as estimated by internal consistency was adequate ($\alpha = .86-.93$).

Cognitive Fusion Questionnaire (CFQ) (Gillanders et al., 2014; Spanish adaptation, Romero-Moreno et al., 2014). The CFQ is a seven-item scale assessing cognitive fusion. The internal consistency in the study sample ranges from .86 to .95.

Visual Analogue Scale (VAS). Designed ad hoc to enable patients (PAVAS) and therapists (TEVAS) to assess frequency

during the preceding week of anxiety, depression, A, EA and CF by means of 10-centimetre horizontal lines, the two ends of which represent the two extremes of the condition being evaluated. In each case, the evaluator is asked to "mark on the line the point which best corresponds to the situation being evaluated". Patients fulfilled the PAVAS weekly. For each pattern of behavior/condition, the measure corresponding to the first session is taken as the pre-treatment measure and that of the last session as the post-treatment measure. Therapists completed the TEVAS in the first, mid (session four) and last sessions. In the present study, and with the aim of comparing patients' and therapists' VAS, only pre- and post-treatment measures are used. The measure is based on the physical distance of the mark from the lines' left extreme (from 0 to 10).

Patient Visual Analogue Scale (PAVAS). PAVAS1(A): My activity level was... PAVAS2(CF): My worries interfered with the things that I wanted to do. PAVAS3(EA): I stopped/avoided doing things so as not to feel bad. PAVAS4(anxiety): I felt nervous. PAVAS5(depression): I felt sad.

Therapist Visual Analogue Scale (TEVAS). TEVAS1(A): The patient's day-to-day occupation in relevant activities was... TEVAS2(EA): The patient avoided activities as a strategy of fear/worry-control. TEVAS3(A): Friends and family maintained anxiety/depression behaviors in the patient. TEVAS4(A): Friends and family encouraged healthy behaviors in the patient. TEVAS5(EA): The patient avoided thoughts and emotions as a strategy for controlling distress. TEVAS6(EA): The patient's attempts to control/avoid worries interfered with the maintaining of his/her relevant activities. TEVAS7(CF): Rumination interfered in the patient's involvement in relevant activities. TEVAS8(CF): The patient's behavior remained focused on the present. TEVAS9(anxiety): Patient's anxiety. TEVAS10(depression): Patient's depression.

Procedure

This secondary study includes participants assigned to any of the experimental groups of the parent study (Fernández-Rodríguez et al., 2022a), which examined the efficacy of the abovementioned treatments for emotional disorders. Those who met study criteria were requested to fill out the informed consent form. Each person filled out the measures individually in an independent room without the presence of the researchers (see Table 1 for sample characteristics). The study was approved by Research Ethics Committee of the Principality of Asturias (Ref. 208/18).

Data Analysis

Of the initial 94 patients, eight participants (8.51%) presented missing data in the VAS at all sessions. Of the 73 participants completing the treatment, one presented missing data in the VAS at all sessions, two at session three, one at session three and two in PAVAS and TEVAS at session four. Due to the lack of differences in efficacy between treatments in the short-term (Fernández-Rodríguez et al., 2022a) and the study aims, the analyses were

performed without differentiating between groups. To test the convergence measurement instruments both at the baseline and post-treatment, Pearson zero-order correlations (95% confidence interval) were performed between all three sources (including the items of the questionnaires). Discrimination indices of those

items were calculated to explore the contribution of those items significantly correlated with the corresponding PAVAS/TEVAS to the total score. To test evidences of validity, Non-parametric 2-paired test were performed between pre- and post-treatment PAVAS/TEVAS.

Table 1
Sample Characteristics

Variables	Total sample (<i>n</i> = 94)	BA (<i>n</i> = 34)	ACT (<i>n</i> = 27)	CBT (<i>n</i> = 33)	χ^2/F
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	
Sex					2.29
Females	78 (83.0)	27 (79.4)a	21 (77.8)a	30 (90.9)a	
Males	16 (17.0)	7 (20.6)a	6 (22.2)a	3 (9.1)a	
Age^a	40.96 (12.34)	45.12 (12.15)a	42.44 (10.89)ab	35.45 (11.93)b	5.99
Marital status					7.08
Single	49 (52.1)	14 (41.2)	13 (48.1)	22 (66.7)	
Married/couple	28 (29.8)	11 (32.4)	9 (33.3)	8 (24.2)	
Divorced	14 (14.9)	7 (20.6)	5 (18.5)	2 (6.1)	
Widowed	3 (3.2)	2 (5.9)	0 (0.0)	1 (3.0)	
Employment status					9.65
Working	47 (50.0)	19 (55.9)	14 (51.9)	14 (42.4)	
TD	7 (7.4)	3 (8.8)	1 (3.7)	3 (9.1)	
PD	2 (2.1)	2 (5.9)	0 (0.0)	0 (0.0)	
Unemployed	35 (37.2)	8 (23.5)	11 (40.7)	16 (48.5)	
Retired	3 (3.2)	2 (5.9)	1 (3.7)	0 (0.0)	
Educational level					4.56
Master/PhD	9 (9.6)	2 (5.9)	3 (11.1)	4 (12.1)	
University	51 (54.3)	20 (58.8)	14 (51.9)	17 (51.5)	
Vocational	20 (21.3)	5 (14.7)	7 (25.9)	8 (24.2)	
High school	8 (8.5)	3 (8.8)	2 (7.4)	3 (9.1)	
Elementary	6 (6.4)	4 (11.8)	1 (3.7)	1 (3.0)	
HADS^a					
Anxiety	15.3 (3.13)	15.21 (3.31)	15.44 (3.92)	15.30 (2.16)	0.03
Depression	11.87 (3.99)	12.82(3.87)a	12.74(3.61)a	10.18(3.96)b	4.96
BDI^a	15.40 (6.25)	14.35 (5.44)	16.96 (6.26)	15.21(6.93)	1.35
GAD^a	14.33 (4.29)	13.65 (3.94)	13.92 (5.77)	12.48 (4.19)	0.43
EROS^a	20.12 (5.19)	19.88 (5.28)	20.56 (5.02)	20 (5.38)	0.14
AAQ-II^a	36.60 (8.52)	36.82 (9.25)	36.81 (8.50)	36.18 (8.00)	0.06
CFQ^a	39.59 (6.99)	39.38 (7.25)	41.48 (6.42)	38.18 (7.01)	1.70

Note. ^a mean (standard deviation). Subscripts indicate between-group differences. Groups with the same subscript did not differ significantly from each other

BA: Behavioural Activation; ACT: Acceptance and Commitment Therapy; CBT: Cognitive-Behavioural Therapy; TD: Temporary disability; PD: Permanent disability; HADS: Hospital Anxiety and Depression Scale; BDI: Beck's Depression Inventory; GAD: Generalized Anxiety Disorder scale; EROS: Environmental Reinforcement Schedule; AAQ-II: Acceptance and Action Questionnaire; CFQ: Cognitive Failures Questionnaire

Results

Relationship Between Measurement Instruments

Activation

Two out of three activation-related TEVAS [1(occupation) and 4(healthy behaviors)] and PAVAS1(A) at baseline were significantly correlated with EROS total score (all $p < .05$; see Table 2). Although the PAVAS1(A) was significantly correlated only with TEVAS1(Occupation), the latter and the TEVAS4(healthy behaviors) were highly correlated. Regarding specific items and besides other statistically significant associations, the three clinical measures at baseline were significantly correlated with items 1 and 3 from the EROS. Correlations between the PAVAS and other measures at post-treatment increased their magnitude dramatically (see Table 2 for all correlations at 95% confidence interval).

Experiential Avoidance

Although both TEVAS2 (avoid activities) and TEVAS6 (control/avoid worries) were statistically significant correlated with AAQ at baseline (all $p < .05$), only the latter was correlated with PAVAS3 (EA) (see Table 2). Regarding the AAQ items, TEVAS6 (control/avoid worries) showed the highest correlation with items 1 and 2, while PAVAS3 (EA) presented the highest correlations with items 7, 3 and 5 (all $p < .001$). Correlations at post-treatment followed the same pattern as in the case of activation.

Cognitive Fusion

CFQ total score correlated significantly with all clinical measures at baseline (all $p < .05$; see Table 2). Nonetheless, only TEVAS7(Rumination) was significantly correlated with PAVAS2(EA). Regarding the CFQ items, TEVAS7 (Rumination) showed the highest correlation with items 6 ($p < .001$), 2 ($p < .05$) and 1 ($p < .05$), while PAVAS2(EA) presented the highest correlations with items 3, 5, and 4 and 7 (all $p < .05$). At post-treatment, correlations between PAVAS2(EA) and other measures increased their magnitude (see Table 2).

Anxiety

HADS-A and GAD were significantly associated with PAVAS4(anxiety) and TEVAS9(anxiety) (all $p < .05$; see Table 2). Both PAVAS4 and TEVAS9 were also statistically significant associated. Regarding specific items, the PAVAS4 presented the highest association with item 5 from the HADS-A, and item 1 (all $p < .05$) from the GAD. On the other hand, TEVAS9 was significantly associated with all items from both questionnaires, presenting the highest correlations with 13, 3, and 11 and from the HADS-A, and items 1, 3, and 2 (all $p < .05$) from the GAD. As shown in Table 2, PAVAS4 at post-treatment showed greater correlation with TEVAS9, HADS-A and GAD than at baseline.

Depression

As in the case of anxiety, both HADS-D and BDI were significantly associated with PAVAS5(depression) and TE-

VAS10(depression) (all $p < .05$; see Table 2), and PAVAS5 and TEVAS10 were also significantly associated. Regarding specific items, the PAVAS5 presented the highest correlations with items 8, 6 and 12 from the HADS-D, and significant correlations with items 1, 10, 2 and 3 (all $p < .05$) from the BDI-IA-SCA. Regarding TEVAS10, the highest correlations with items from the HADS-D were shown for items 12, 6 and 10, and items 9, 12 and 7 (all $p < .001$) from the BDI-IA-SCA. As in other cases at post-treatment, PAVAS5 showed higher convergence with TEVAS10 and both questionnaires.

Table 3 shows items' discrimination indices of each related PAVAS/TEVAS. Those items presenting significant correlations with each PAVAS/TEVAS showed one of the highest discrimination values, hence further supporting the validity of the proposed PAVAS/TEVAS for assessing each process. All PAVAS/TEVAS significantly changed in the therapeutic direction after treatment (all $p < .001$), consistently with changes reported in questionnaires (Fernández-Rodríguez et al., 2022a).

Table 2
Correlations Between Clinical Measures and Validated Questionnaires per Transdiagnostic Component

	Activation				
	PAVAS1	TEVAS1	TEVAS3	TEVAS4	EROS
PAVAS1	1	.249*	.059	.178	.250*
TEVAS1	.487**	1	.024	.626**	.380**
TEVAS3	-.284*	-.408**	1	-.090	-.137
TEVAS4	.394**	.641**	-.310**	1	.254*
EROS	.412**	.598**	-.169	.559**	1
	Experiential avoidance				
	PAVAS3	TEVAS2	TEVAS5	TEVAS6	AAQ
PAVAS3	1	.144	.073	.212*	.405**
TEVAS2	.405**	1	.396**	.502**	.346*
TEVAS5	.336*	.533**	1	.346**	.182
TEVAS6	.481**	.841**	.581*	1	.305**
AAQ	.475**	.583*	.330*	.570**	1
	Cognitive fusion				
	PAVAS2	TEVAS7	TEVAS8	CFQ	-
PAVAS2	1	.323**	-.171	.309**	-
TEVAS7	.465**	1	-.340**	.402**	-
TEVAS8	-.488**	-.795**	1	-.358**	-
CFQ	.508**	.622**	-.588**	1	-
	Anxiety				
	PAVAS4	TEVAS9	HADS-A	GAD	-
PAVAS4	1	.299**	.286**	.276*	-
TEVAS9	.534**	1	.591**	.661**	-
HADS-A	.594**	.693**	1	.657**	-
GAD	.563**	.675**	.764**	1	-
	Depression				
	PAVAS5	TEVAS10	HADS-D	BDI	-
PAVAS5	1	.299**	.362**	.283**	-
TEVAS10	.542**	1	.694**	.595**	-
HADS-D	.560**	.788**	1	.550**	-
BDI	.567**	.668**	.719**	1	-

Note. Figures above the diagonal represent correlations at baseline and figures below the diagonal represent correlations at post-treatment.

PAVAS: Patient Visual Analogue Scale; TEVAS: Therapist Visual Analogue Scale; EROS: Environmental Reward Observation Scale; AAQ: Acceptance and Action Questionnaire; CFQ: Cognitive Fusion Questionnaire; HADS-A: Hospital Anxiety and Depression Scale-Anxiety; GAD: Generalized Anxiety Disorder scale; HADS-D: Hospital Anxiety and Depression Scale-Depression; BDI: Beck Depression Inventory

* $p < .05$ ** $p < .001$

Table 3
Questionnaires' Items Discrimination Indices

Items	ID
Environmental Reward Observation Scale	
1. A lot of activities...	.520
2. Lately I have found that...	.418
3. In general, I am very satisfied...	.509
4. It is easy for me to find...	.440
5. Other people seem to have...	.458
6. Activities that used...	.308
7. I wish that I could find more hobbies...	.458
8. I am satisfied with my accomplishments	.441
9. My life is boring	.411
10. The activities I engage in usually...	.184
Acceptance and Action Questionnaire	
1. My painful experiences...	.728
2. I'm afraid of my feelings	.618
3. I'm worry about not being able...	.720
4. My painful memories prevent me from...	.699
5. Emotions cause....	.774
6. It seems like most people...	.646
7. Worries get in...	.659
Cognitive Fusion Questionnaire	
1. My thoughts cause...	.779
2. I get so caught up in my thoughts...	.661
3. I over-analyse situations to the point...	.585
4. I struggle with my thoughts	.597
5. I get upset with...	.658
6. I tend to get very entangled...	.746
7. Its such a struggle to let go...	.688
Generalized Anxiety Disorder scale	
1. Feeling nervous, anxious or on edge	.675
2. Not being able to stop or control worrying	.664
3. Worrying too much about different things	.700
4. Trouble relaxing	.628
5. Being so restless...	.609
6. Becoming easily...	.400
7. Feeling afraid as...	.365
Hospital Anxiety and Depression Scale-Anxiety	
1. I feel tense...	.509
3. I get sort of frightened...	.302
5. Worrying thoughts...	.422
7. I can sit at ease...	.420
9. I get sort of frightened...	.414
11. I feel restless...	.422
13. I get sudden...	.477
Beck Depression Inventory	
1. Sadness	.511
2. Pessimism	.555
3. Past failure	.630
4. Loss pleasure	.367
5. Guilt feelings	.614
6. Punishment feel	.387
7. Self-dislike	.537
8. Self-critical	.589
9. Suicidal	.402
10. Crying	.405
11. Irritability	.191
12. Loss interest	.434
13. Indecisive	.484

Table 3
Questionnaires' Items Discrimination Indices (Continuation)

Hospital Anxiety and Depression Scale-Depression	
2. I still enjoy...	.510
4. I can laugh...	.581
6. I feel cheerful	.562
8. I feel as if...	.475
10. I have lost interest...	.478
12. I look forward....	.661
14. I can enjoy...	.567

Note. ID: Discrimination index; Discrimination indices of items significant correlated with both EVA/TERA shown in bold

Discussion

In clinical studies, the scientific and psychometric guarantees of the psychological measurement instruments employed justify adopting, as criteria of therapeutic results, the statistical significance of change and effect size. However, this supposition would only allow us to attribute the results obtained to the treatment if the variables measured are those which are responsible for the therapeutic change and not simply measures of effects which could potentially be attributed to the treatment. A greater insight into the correspondence between the different sources (therapist and patient), procedures and moments of assessment during the therapeutic process would facilitate the calibration of the specificity of the measures and the reliability of the instruments. This secondary paper finds correspondence between the measures of the therapist and those of the patient. This occurs both regarding the measures of the psychological processes on which the therapies focus (and which are proposed as therapeutic ingredients) and to the measures of anxiety and depression which are conventionally taken as effect and criterion of clinical change.

Significant correlation is observed between all the measures of anxiety, regardless of the source of information, moment and measures procedure. The same is true for the measures of depression. The correspondence between the data obtained through standardized measures and the assessment of anxiety and depression carried out by the therapist is taken for granted. Some studies even consider the possibility of the two measures being interchangeable (Corruble et al., 1999; Guo et al., 2015; Hershenberg et al., 2020; Zimmerman et al., 2018). However, the question is whether the therapist's assessment of anxiety and depression using VAS and that of the patient can also be considered interchangeable. The same was the case with the measures of depression. It was, however, the relationship between the items of the standardized anxiety and depression measures and the observations made through a VAS that highlighted those symptoms in which there existed the greatest concordance between the two evaluators. In the case of anxiety, when informing through a VAS, patient and therapist appear to coincide in references to trouble relaxing, feeling nervous or on edge, sudden feelings of panic and not being able to stop or control worrying. In the case of depression, both appear to refer to the presence or absence of sadness, pessimism, past failure, crying or joy and optimism. However, only the therapist, when employing a VAS, appears to take into consideration all the conditions included in the standardized measures. Consequently, the information provided

by the patient through the VAS does not appear to be sufficient to be used as a diagnostic criterion of anxiety/depression. However, since patient and therapist do show a significant coincidence in their assessment of manifestations/symptoms which are specific to and define both disorders, these scales can be considered useful as criteria of clinical change. These findings are of great importance given the therapeutic implications of these measurement procedure.

Regarding Activation, the pretreatment measures showing the highest correlations are those offered by the therapist regarding the level of the patient's daily participation in relevant activities [TEVAS1(occupation)] and the frequency with which friends and family promote antidepressive behaviors [(TEVAS4(healthy behaviors))]. All the measures of A reported by the patient relate to each other and to the TEVAS1(occupation). An evaluation of the EROS items' discrimination indices and the correlations between these and the PAVAS1(A) and the TEVAS1(occupation) and 4 suggests that, when patient and therapist assess A using a VAS, what they principally pay attention to is satisfaction with how time has been occupied and how rewarding those occupations have been. In other words, both coincide in focusing on two of the principal conditions which define Activation (Manos et al, 2010), although the therapist, predictably given his/her expertise in the area, would pay attention to all the conditions/situations described in the EROS. The pretreatment data appear to support the suitability of self-report measures using VAS in the assessment of A.

At post-treatment, the measures of A show even greater significant correlations with each other, they continue to group together around a single dimension and do so with excellent consistency. This result can be attributed to the therapeutic process to which the group was subjected (Fernández-Rodríguez, 2022a). It is foreseeable that, during an intervention, the patient learns to discriminate the conditions focused on (Flückiger et al., 2018; Gelso et al., 2018; Meidlinger & Hope, 2017; Norcross & Lambert, 2018). In particular, the participants in this study who underwent a therapy of BA or ACT had the opportunity to learn to discriminate their Activation patterns. Both therapies focus on increasing this condition, although they each do so in a different way (Kanter et al., 2006). The results of the TRANSACTIVA study showed a statistically significant improvement of all the therapeutic groups at the end of the treatment. Furthermore, the results showed that the increase in relevant activities and in the degree of day-to-day rewards was a determining condition of the therapeutic benefit (Fernández-Rodríguez et al., 2022a). Activation as a process associated with therapeutic benefit has been widely reported in different populations (Fernández-Rodríguez et al., 2018; Jacobson et al., 2001; O'Mahen et al., 2017; Santos et al., 2017, 2019). This fact explains both the increase in the correlations in the post-treatment between all the measures of Activation.

However, what interests us here about this correspondence between measures is that it allows us to affirm that, when patients inform about their day-to-day activity using the PAVAS1(A), what is provided is reliable information regarding their satisfaction with those activities and with their rewards. Consequently, this single-item measure could be considered another additional reliable measure in the evaluation of the Activation response pattern (Manos et al, 2010). This procedure, despite being extremely useful, could by no means replace the functional analysis of behavior in the design and control of the therapeutic process. Indeed, we believe that functional analysis (used in the

TRANSACTIVA study) was key in the discrimination of the A patterns. This would explain the fact that, in the post-treatment, there was a statistically significant relationship between the patient's measure and the expert criterion of the therapist. Consequently, the PAVAS1(A) would also be a reliable measure of clinical change.

Regarding to EA, a greater relationship between pretreatment measures can also be observed between all those carried out by the therapist. That is, between the therapist's assessment of the frequency with which the patient avoids activities (TEVAS2) and/or thoughts/emotions (TEVAS5) as a strategy to control distress, the effects of that thought control in the maintaining of activities (TEVAS6), and also the total score of the AAQ-II, as would be expected given the therapist's expertise. There also exists significant correlation between all the EA measures informed by the patient, although the two patient measures only correlate significantly with the TEVAS6(control/avoid worries). In any case, the discrimination indices of these four measures [PAVAS3(EA), TEVAS2(avoid activities), TEVAS6(control/avoid worries) and AAQ-II] allow us to affirm that they all reliably measure the same condition. That condition is taken to be EA (Hayes et al, 1996). Indeed, the relationships between the responses to the items of the AAQ-II and all those provided through the VAS, would indicate that, when informing through a VAS, both the patient and the therapist are principally assessing how worries, memories and painful emotions prevent the person from leading the life that they would like to lead (AAQ-II, items 1,2, 4,6). This correspondence supports the suitability of VAS as complementary measures of EA.

All posttreatment measures of EA, regardless of the source of information, are significantly related to each other and in a more discriminating way around one single condition his result, as in the case of Activation, can be seen as an effect of the intervention which the participants underwent, and which led to greater discrimination and change regarding this behavioral pattern and clinical improvement in the posttreatment.

Regarding CF and following the same line of results and discussion, it is important to note that, at pretreatment, there was once again extremely significant correlation between all the therapist's measures and also between these and the standardized CF measure. The same occurs between all the patient's measures. The frequency with which patients inform of worries/thoughts which interfere with things that they wanted to do [PAVAS2(CF)], correlate significantly with the observations of the therapist regarding patient rumination (TEVAS7), but not with the therapist's assessment of the patient's attention to the present (TEVAS8). Based on the discrimination indices of those items of the CFQ which correlate most closely with the VAS (CFQ items 1, 3, 4, 5 and 7), it would appear that, when assessing CF through a VAS, both patient and therapist are providing reliable information about entrapment and a struggle with thoughts. These correlations between all the observations of the patient and the therapist increase in the post-treatment, even in the case of the TEVAS8(focused on present). Their participation in the TRANSACTIVA study provided this sample with the opportunity to practice focusing attention on the present and improved their ability to discriminate (and change) patterns of CF. As for the rest of the variables, the data support the value of VAS as a complementary measure of CF and as a results measure since CF has demonstrated its transdiagnostic and therapeutic value, in association with EA in particular (Bardeen & Fergus, 2011; Cookson et al., 2020).

It is of particular interest to highlight how patients, when informing about CF and EA through the PAVAS2(CF) and 3(EA), show excellent discrimination of these behaviors when they interfere with the maintaining of their activities, as can be seen in Table S2. The reliability of the patients' self-report observations regarding their EA and CF responses would appear to be greater when they perceive that these behaviors result in a lesser Activation. This could be attributed to participants' clinical characteristics, all patients with a clinical symptomatology of anxiety and depression. There exists specific research which gives evidence of the positive relationship and interaction between EA and CF and anxiety and depression and points to avoidance as a determining factor in the transit from anxiety to depression (Chawla & Ostafin, 2007; Cheng et al., 2022; Fergus, 2015; Fernández Rodríguez, et al., 2022b; Spinhoven, et al., 2017). Since avoidance provides short-term relief from worrying or stressing situations, it can become a rigid behavioral pattern. In this scenario, the person becomes distanced from self-relevant conditions of life and loses contact with the life contingencies or circumstances in which change could occur, thus being unlikely to resolve the worry, stress or overdemanding situations and, conversely, the distress will probably increase. These situations and their associated responses are generally characterized as anxiety. As the experiential avoidance strategy becomes the best resource the person has at his/her disposal to combat distress, the person will withdraw from his/her life context. As activities/experiences/relationships are reduced, the effects that maintain them will no longer be produced, leading progressively to a vicious circle of reduction of activity and loss of rewards. These situations and their associated responses are generally characterized as depression. To sum up, what is highlighted is not only the relationship between EA/CF and emotional distress, but the interaction between EA, CF and A. When investigating how these three response patterns modulate emotional distress, Fernández-Rodríguez et al. (2022b) found that the interaction EAxCF modulates the intensity of the symptomatology of anxiety but is not significant when trying to explain the symptomatology of depression, whereas (a decrease in) Activation is.

The study presents some limitations. Although there exist numerous references confirming the measures guarantees offered by the instruments used in this study, the evaluation of the transdiagnostic patterns examined is not problem-free (Armento, & Hopko, 2007; Manos et al., 2010; Ong, et al., 2020), particularly due to the many difficulties involved in evaluating behavioral processes which are, by definition, dynamic and changing. Also, the interpretations of results should be considered exploratory, noting the limited sample size. Nonetheless, the consistency between analyses and with theoretical interpretations supports their adequacy. Finally, although the analyses were performed without considering treatment options due to their similar efficacy, future studies should address this issue by exploring between treatment differences in self-reported clinical evolution. Nevertheless, we suggest that the inclusion of new measures like the VAS used in this study could make an economic and simple contribution towards improving the reliability of response pattern measure, the change in which, to a large extent, explains the efficacy of a therapy.

In conclusion, one-item VAS is suitable to identify specific patterns of anxiety, depression, CF, EA and A. These measures are simple to apply during the whole therapeutic process and could

consequently be of enormous use as complementary results criteria in psychological treatments.

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