Journal of Rational-Emotive & Cognitive-Behavior Therapy
https://doi.org/10.1007/s10942-024-00560-3

Exploring the Resistance Factors within Cognitive Behavioral Therapy (CBT) and Strategies to Overcome them among Therapist: An Exploratory Study

Alexis Vancappel[1,2] · Camille Raysseguier[3] · Eline Jansen[1] · Anna Mangolini[1] · Cinzia Dicosimo[1]

Accepted: 20 June 2024

Abstract

The efficacy of CBT is now well-established, and CBT is recommended by multiple academic societies. However, not every patient responds well to CBT and little is known about the resistance factors of the therapy. This study aims to identify predictive factors of CBT success and failure and the techniques used by clinicians to overcome resistance. We recruited 43 French therapists (31 women) who filled out sociodemographic information and answered open questions related to the predictive factors of CBT and the way they overcome resistance in therapy. Thematic analysis was used to treat the data. Six themes related to the predictive factors were identified as follows, "Influence of motivation on the therapy"; "Influence of certain psychopathological processes"; "Influence of patient/therapist match"; "Certain psychopathological profiles are harder to treat"; "Influence of environmental and biological factors"; "Other factors of influence" and three themes related to the strategies to overcome resistance, namely "Adaptation of therapy content to overcome difficulties", "Adaptation of the therapeutic framework", "Environmental intervention to overcome the difficulties". Multiple factors influence the success or the failure of CBT such as motivation, alliance, negative beliefs about the therapy or complex symptomatic profiles. Some solutions have already been identified by the therapists to overcome such difficulties. However, it would be useful to conduct further research on CBT resistance and ways to overcome it.

Keywords CBT · Predictive factors · Thematic analysis · Psychotherapy · Psychiatric disorders

Extended author information available on the last page of the article

Published online: 16 July 2024

Introduction

It is now well-established that psychotherapies and psychological treatments have proved their efficacy (Barlow, 2004). Among these therapies, Cognitive Behavioral Therapies (CBT) may be one of the most famous evidence-based interventions. CBT is a structured psychotherapy that focuses on the interaction between thoughts, behavior and emotions within the different problematic situations (Cottraux, 2011). It aims to change the interaction using structured exercises (e.g., exposure, Socratic questioning). The scientific culture is important within CBT. Lots of evidence-based cognitive behavioral models have consistently been developed to understand multiple psychiatric disorders such as depression (Beck, 1979, 2008), social anxiety (Clark & Wells, 1995), Post Traumatic Stress Disorder (PTSD) (Ehlers & Clark, 2000), eating disorders (Fairburn et al., 2003) or dissociative disorders (Vancappel & El-Hage, 2023). Following this approach CBT has provided multiple interventions to treat psychiatric disorders. Their efficacy has been evaluated through controlled-randomized studies and meta-analysis, setting out the efficacy of such treatment for multiple disorders such as PTSD (McLean & Foa, 2011; Powers et al., 2010); depression (Dobson, 1989) or anxiety disorders (Carpenter et al., 2018). This resulted in the integration of CBT as gold standard treatments for multiple psychiatric disorders (Haute autorité de Santé, 2007, 2009, 2019; Phoenix Australia Centre for Posttraumatic Mental Health, 2020). In that sense, the efficacy of CBT is now well-established. However, some patients seem to not benefit from CBT. Therefore, the new challenge now for CBT is to understand why some patients do not respond to this treatment and how we can overcome these difficulties.

Based mostly on their clinical practice, some authors have put forward several resistance factors to CBT efficacy (Ellis, 2007; Leahy, 2003), such as the presence of negative beliefs about the therapy (e.g. "I can not change"), low tolerance to frustration or cognitive/neurological impairments. Previous studies have tended to empirically identify predictive factors of CBT efficacy. Some meta-analyses have already been performed on this subject. The first meta-analysis performed on 32 trials found that a higher severity of the symptoms, a higher functional impairment, the presence of secondary benefits and a longer duration of the psychiatric symptoms all constitute negative moderators of psychotherapy (Sarter et al., 2022). Then, another meta-analysis focused on the moderators of CBT efficacy among 52 trials for patients suffering from agoraphobia or panic disorder (Porter & Chambless, 2015). The authors identified that a lower success in psychotherapy is associated with a higher level of avoidance, low expectations of change, functional impairment and cluster C personality disorders. Another meta-analysis focused on the CBT trials for children and adolescents suffering from anxiety and depression (Kunas et al., 2021). The results indicated that the presence of psychopathology in parents, low coping abilities and the presence of non-suicidal self-harmed behavior, were all associated with a poorer response to the treatment. A meta-analysis performed on CBT and Interpersonal Psychotherapy trials found among 137 studies that a higher level of baseline depression and being of a younger age were both associated with a higher response to psychotherapy (Whiston et al., 2019). A further meta-analysis related to trials performed among those with Obsessive Compulsive Disorder (OCD) found

that a lower response to CBT was associated with a higher baseline level of depression and OCD symptoms and a lower level of education. Some of the results are congruent and it seems quite well-established that a higher level of symptoms and a higher level of functional impairment is associated with a poorer response to CBT. However, all these studies have focused on the predictive aspects of baseline treatments. Therefore, it is expected that the results concern mainly the psychological level of patients at baseline as this is information that is always available in clinical trials. However, other factors may influence the course of the psychotherapy and may not be assessed during a clinical trial. Furthermore, even though some factors may have been identified, there is still a need for a solution to solve them.

Therefore, this study aims through a qualitative approach (*i*) to identify the predictive factors of CBT success and failure among clinicians and (*ii*) to identify the solutions they use to get past the hurdle of resistance to psychotherapy. To our knowledge, this is the first study that has presented such an aim. This tends to complete the identification of moderators among clinical trials through a quantitative approach.

Method

Participants

The study and consent procedures were approved by the ethics committee of our university (Comité d'Ethique de la Recherche Tours-Poitiers; 2022-07-05). We engaged French participants on professional social networks. Participation required reading a letter of information, ticking a box (or signing) to give consent to participate, and choosing to either continue with the study or decline to proceed. To take part in the study, the participants had to be cognitive behavioral therapists.

Measures

Participants were required to fill out socio-demographic and professional information (sex, age, profession and region of professional activity, amount of time of CBT practice, modality of clinical setting and education). Then, they were asked to respond to three open questions. The first one asked them to explain, according to them, which factors predict resistance to CBT. The second one focused on how they manage to overcome such resistance. The third one asked them to explain which factors predict a good response to CBT.

Data Analysis

We used thematic analysis to process the data (Braun & Clarke, 2006). A first reading of the data was carried out in order to become familiar with the answers, then these were re-read and coded. A code was created for each piece of information. The data were double-coded; initially by the first author and then proofread by the second author. Minor disagreements were resolved, and the codes were categorized in themes and sub-themes. Finally, as for the coding process, a second reading was

performed on the theme and sub-theme categorizations. Finally, we reviewed every code related to the negative predictors of CBT success and matched them with the response strategy identified in participants speech.

Results

Socio-demographic Information

We engaged 43 participants (31 women). The mean age was 36.72 (SD = 10.88). Among the participants, 35 were psychologists, 6 were psychiatrists, one was a researcher in psychology, and one was an advanced practitioner nurse (*Infirmier en Pratique Avancée*). On average they have been practicing CBT for 7.07 (6.89) years. Professional locations were spread all over the country. Among the participants, twenty five (58.14%) had a private practice, ten (23.26%) worked within a public psychiatric outpatient institute; four (9.3%) worked in a public trauma center; four (9.3%) worked within a public psychiatric inpatient institute; three (6.98%) worked in a public addictology center; three (6.98%) worked in somatic hospital centers; two (4.65%) worked in a private hospital and one (2.32%) worked in a nursing home. Among the participants, seventeen (39.5%) worked with children; twenty-four (55.8%) worked with teenagers and 39 (90.7%) worked with adults. The participants were trained in CBT either through a Master's degree ($N = 15$, 34.9%), a post-master university diploma ($N = 17$, 39.5%), a private association diploma ($N = 15$, 34.9%), supervision ($N = 2$; 4.65%) or online training ($N = 1$;2.32%).

Thematic Analysis

We identified nine themes in the participants speech. The details of the prevalence of the themes are presented in Table 1.

Six themes were related to the factors that influence the success of the therapy.

Theme 1: Influence of Motivation on the Therapy

Most of the participants ($N = 36$, 83.7%) mentioned that motivation positively influenced the success of the therapy. They mentioned that low motivation was associated with poorer success. The participants explained that patients with low motivation used therapeutic techniques less and do not carry out their assigned therapeutic tasks. One participant explained that some patients have a "*Lack of motivation*, *or wait for a magic response*, *leading to a lack of personal engagement within their homework task*.")

Theme 2: Influence of Certain Psychopathological Processes

Lots of participants ($N = 35$, 81.4%) mentioned that the presence of certain psychopathological processes makes the therapy harder. They mentioned the detrimental effect of cognitive alterations, explaining that people with a poorer ability have more

Table 1 Prevalence and percentage of themes and subthemes

Number	Theme	Subtheme	*N*	Percentage
	Factors influencing the therapy			
1	Influence of motivation on the therapy		36	83.7%
2	Influence of certain psychopathological processes		35	81.4%
		Cognitive and understanding abilities	22	51.2%
		Acceptation and consciousness of the disorder	12	27.9%
		Exacerbation of certain psychopathological process	11	25.6%
		Negative attitude and beliefs about the therapy	9	20.9%
		Lack of psychic availability	8	18.6%
3	Influence of patient/therapist match		32	74.4%
4	Certain psychopathological profiles are harder to treat		20	46.5%
		Certain specific symptoms are harder to treat	15	34.9%
		Complex profiles are harder to treat	11	25.6%
5	Influence of environmental and biological factors		14	32.6%
		Environmental factors	12	27.9%
		Biological factors	2	4.7%
6	Other factors of influence		9	20.9%
	Strategies to overcome the difficulties			
7	Adaptation of therapy content to overcome difficulties		39	90.7%
8	Adaptation of the therapeutic framework		32	74.4%
9	Intervention on the environment to overcome the difficulties		4	9.3%

difficulties in progressing with the therapy. One participant said for instance that some patients may "*lack the mental resources to apply the strategies*, *and they cannot inhibit their automatic response*". The lack of consciousness of the disorder was also mentioned as an influential factor (e.g. "*Some patients can not put their difficulties into perspective*."). The participants explained that the exacerbation of certain specific mechanisms (e.g. perfectionism or experiential avoidance) may predict a poorer response towards the therapy. Negative attitudes or beliefs about the therapy (e.g. "*It works better if the patient believes in CBT*, *it motivates him/her"*) and a lack of mental capacity (e.g. "*The patient is too instable*, *emotionally/cognitively distant*") were also reported as negative predictors.

Theme 3: Influence of Patient/therapist Match

Lots of participants ($N=32$, 74.4%) mentioned the influence of patient/therapist match. Lots of them mentioned the influence of the therapeutic alliance. They explained that the patient and the therapist need to agree on the objectives and the

way to meet them. They said how some patients are not looking for CBT but instead just want someone to talk to. One participant explained that "*some patients just need to talk and do not want structured therapy*".

Theme 4: Certain Psychopathological Profiles are Harder to Treat

Some participants ($N=20$, 46.5%) cited that certain profiles are harder to treat. Firstly, they explained that some specific symptoms are harder to treat. Among these symptoms, they mentioned severe depression, conversion symptoms, complex Post-Traumatic Stress Disorder (PTSD) and personality disorders. Secondly, they mentioned that patients with more severe symptoms and higher comorbidity are harder to treat than patients suffering from one isolated disorder.

Theme 5: Influence of Environmental and Biological Factors

Participants ($N=14$, 32.6%) mentioned the influence of both biological and environmental factors. They explained that endogenous symptoms are harder to treat and that patients suffering from biological impairments (e.g. sensorial disabilities) responded less to the therapy. Environmental factors were also identified as predictors. Overall, the lack of social support or the presence of secondary reinforcement was reported as detrimental. For instance, it was said that "some *patients do progress*, *but are not encouraged or supported by their family which means the disorder continues*".

Theme 6: Other Factors of Influence. Other Factors were also Reported ($N=9$, 20.9%)

Other factors that do not fit in the previous thematic were also reported such as the good initial conceptualization of the patient or the fear of the therapist of using certain techniques such as exposure therapy.

Three themes were related to the way therapists overcome the difficulties.

Theme 7: Adaptation of the Therapy Content to Overcome the Difficulties

The first strategy used by the participants is to change the content of the therapy ($N=39$, 90.7%). This means that the therapist changed the topic of the sessions or the techniques he/she uses (e.g. a change from cognitive restructuring to behavioral activation). Among these techniques they mentioned motivational interviewing, cognitive remediation and psychoeducation. They also explained they turn the therapy into a game or that they do more tasks with the patient during the session.

Theme 8: Adaptation of the Therapeutic Framework

The second strategy used by the participants was to adapt the framework ($N=32$, 74.4%). This means that therapists keep the same technique (e.g. cognitive restructuring) but change the way they do it (e.g. going from Socratic questioning to the identification of cognitive distortions with a list.) As with theme 7, the process targeted is the same, but the way of targeting it changes. The participants mentioned that they

explain the framework to their patient and especially the need to do the exercises. Some of them explained that they take a break with the patient if he/she is not ready to embark on the therapy (e.g. "*I offer them a break and tell them to come back to me when they are ready to apply the techniques and commit themselves to a change"*). Some of the therapists ask the patients' friends and family to attend a session to define the framework with the patient and to help him/her to use the techniques. Some therapists also mentioned the need to minimize the initial objectives.

Theme 9: Intervention on the Environment to Overcome the Difficulties

Finally, a small amount of participants (N=4, 9.3%) explained that they change the environment to overcome the difficulties. Notably, they tend to solve the social problems of the patients, orienting them towards social workers. Some of them also discussed with the patients how to remove themselves from some detrimental relationships.

Matching Negative Predictors and Corresponding Strategies

We matched the different difficulties with the solutions proposed by the participants (see Table 2). Overall, we found that therapists have identified strategies for almost every difficult situation. Among the difficulties that did not have a solution to match it, we found the negative beliefs about the therapy, the presence of certain symptoms and high pessimism.

Discussion

The first aim of the study was to identify the predictors of CBT success among therapists. Consistently, we found that motivation, positive beliefs about the therapy and patient/therapist match were reported as good predictors of CBT success. This is congruent with studies performed on the common psychotherapeutic factors that suggest that motivation, positive expectations and alliance are essential factors of psychotherapy (Browne et al., 2021). We also identified the influence of complex profiles and secondary benefits on CBT success. This is congruent with previous research on predictive factors of CBT (Porter & Chambless, 2015; Sarter et al., 2022). We found certain factors that occurred less in the literature, namely the acceptation and consciousness of the disease, the presence of cognitive impairments and the negative influence of relatives. Altogether, these results tend to confirm Ellis' proposal (2007) that identified the influence of *i*) the match between the patient and the therapist, *ii*) beliefs about the therapy, *iii*) cognitive and neurological impairments, *iv*) negative influence of the relatives and *v*) high pessimism. Ellis (2007) also set out that complex profiles, such as patients suffering from borderline personality disorder may be less eligible for short term treatment such as CBT.

The second aim of this study was to identify the strategies used by the therapist to overcome the aforementioned difficulties. We found that therapists either change the content, the framework of the therapy or the patients' environment. To our knowl-

Table 2 Matching negative predictors and corresponding strategies

Negative predictors	Corresponding responses	Additional proposal
Influence of motivation on the therapy		
Lack of motivation/ The patient does not do the exercise	Motivation interviewing Redefining the framework Take a break in the therapy Do the exercise during session with the patient Make the therapy more fun/use games	Firstly fix the easy objectives
Influence of certain psychopathological process		
Non-acceptance of the disorder	Psychoeducation	Socratic questioning on the meaning of the disorder Write an acceptance letter with the patient
Lack of insight or meta-cognitive abilities	Psychoeducation Use group psychotherapy	Train the patient through observation
Cognitive impairments	Cognitive remediation Simplifying the exercises using the preserve function	
Beliefs that change is impossible (e.g. "The disorder is me, I can not change my personality")/ external locus of control		Socratic questioning on these thoughts Psychoeducation about the efficacy of CBT Perform a reality testing with the patient on an easy objective
High experiential avoidance	Reducing the objective of the therapy (lower exposure)	
High perfectionism	Change the approach	
High pessimism		Make the patient write some few positive things everyday Ask him/her to force himself/herself to produce positive thoughts, even if he/she doesn't believe it at the beginning
Complete adhesion to automatic negative thoughts	Change the approach Use Alternating Bilateral Stimulation Use group psychotherapy	Question the idea that the patient's thoughts are always right
Lack of psychic availability	Taking a break Change the environment Reduce the objectives of the therapy	
Influence of patient/therapist match		
CBT does not match the patient demand	Reorientation of the patient	
Lack of alliance	Reinforce the alliance through Rogerian/ humanist techniques	
Objectives poorly defined	Redefine the objectives the patients	
Certain psychopathological profiles are harder to treat		

Table 2 (continued)

Negative predictors	Corresponding responses	Additional proposal
Addiction is harder to treat	Reorientation to a psychiatrist for medication	
Severe depression is harder to treat	Reorientation to a psychiatrist for medication	
Conversion symptoms are harder to treat		
Complex PTSD is harder to treat		
Personality disorder is harder to treat		
A patient with lots of comorbidities is harder to treat	Change for a transdiagnostic/processual approach	
Influence of environmental and biological factors		
Influence of biological mechanisms (e.g. endogenous disorder/physical disabilities)	Reorientation to a doctor for medication	
Negative influence of the relatives	Meet the relatives during session Encourage the patient to go away from certain people	
Negative influence of social context	Orientation to a social worker	
Other factors of influence		
Error in the initial conceptualization	Reperform the functional analysis and ask for supervision	
The therapist fears using certain techniques	Go for supervision	
The therapy is too academic	Make the therapy more fun/use games	

edge, no research has been done to date on strategies used by therapists to overcome difficulties encountered in therapy. Finally, we matched the different strategies with the different negative predictors. Overall, we found that the outcomes of our study lack propositions on possible solutions to overcome negative beliefs about therapy, high pessimism and the presence of certain disorders. This is of major importance. Particularly, the participants did not set out a way to solve the negative expectations about therapy. This may be explained by the fact they were not asked directly about it. Nevertheless, this concept is of major interest and might be related to self-fulfilling beliefs (Stukas & Snyder, 2016). In that sense, if patients are convinced that the therapy will not work, it may predict poor therapeutic results. It seems that such thoughts may be particularly relevant to the understanding of resistance factors. Ellis (2007) proposed several techniques to overcome these beliefs such as empirical or realistic disputing, using anti-catastrophizing or informing the patient about unrealistic thoughts. Further research should be conducted on such concepts.

Limitations

This study has some limitations. As a qualitative explorative study, the sample size is reduced, limiting the generalization of the conclusions drawn. Furthermore, the study was only performed among French therapists. An international study may offer

a deeper understanding of the different mechanisms, a more thorough identification of strategies, and may reveal different strategies than those mentioned in this study.

Implications

This study has some implications. Firstly, the mechanisms identified during this study should be assessed more often within clinical trials to ensure their role in a quantitative approach. Secondly, the list of negative predictors can be used by the clinicians to help in identifying the problems they may face with some patients, and they could be inspired by the solutions identified by the different therapists to try to overcome resistance.

Conclusion

Multiple factors influence the efficacy of CBT such as motivation, alliance, negative beliefs about therapy or complex symptomatic profiles. Some solutions have already been identified by therapists to overcome such difficulties. However, further research should be conducted on resistance to CBT and ways to overcome it.

Author Contributions All authors took part in the design of the study. The first two authors gathered the data and perform the coding. The first author wrote the first draft and all the authors add their comments and modifications.

Funding This work did not receive any specific grant from funding agencies in the public, commercial, or non-profit sectors.

Data Availability The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethical Approval and Consent to Participate The study received the ethical approval from the University ethical committee.

Consent for publication Not applicable.

Competing interests The authors declare that they have no competing interests related to this work.

References

Barlow, D. H. (2004). Psychological treatments. *The American Psychologist*, *59*(9), 869–878. https://doi.org/10.1037/0003-066X.59.9.869.

Beck, A. T. (1979). *Cognitive therapy of Depression*. Guilford Press.

Beck, A. T. (2008). The evolution of the cognitive model of Depression and its neurobiological correlates. *American Journal of Psychiatry*, *165*(8), 969–977. https://doi.org/10.1176/appi.ajp.2008.08050721.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191/1478088706qp063oa.

Browne, J., Cather, C., & Mueser, K. T. (2021). Common Factors in Psychotherapy. In *Oxford Research Encyclopedia of Psychology*. https://doi.org/10.1093/acrefore/9780190236557.013.79.

Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A. J., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, *35*(6), 502–514. https://doi.org/10.1002/da.22728.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. *Social phobia: Diagnosis, assessment, and treatment* (pp. 69–93). The Guilford Press.

Cottraux, J. (2011). *Les psychothérapies comportementales et cognitives* (5e édition). Elsevier Masson.

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, *57*(3), 414–419.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0.

Ellis, A. (2007). (Éd.). *Overcoming Resistance: A Rational Emotive Behavior Therapy Integrated Approach, Second Edition* (2nd edition). Springer Publishing Company.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A « transdiagnostic » theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/s0005-7967(02)00088-8.

Haute autorité de Santé (2007). *Affections psychiatriques de longue durée Troubles anxieux graves*.

Haute autorité de Santé (2019). *Boulimie et hyperphagie boulimique Repérage et éléments généraux de prise en charge*.

Haute autorité de Santé (2009). *Affections psychiatriques de longue durée Troubles dépressifs récurrents ou persistants de l'adulte*. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-04/gm_ald23_troubles_depressifs_webavril2009.pdf.

Kunas, S. L., Lautenbacher, L. M., Lueken, P. U., & Hilbert, K. (2021). Psychological predictors of cognitive-behavioral therapy outcomes for anxiety and depressive disorders in Children and adolescents: A systematic review and Meta-analysis. *Journal of Affective Disorders*, *278*, 614–626. https://doi.org/10.1016/j.jad.2020.09.092.

Leahy, R. L. (2003). *Overcoming resistance in cognitive therapy*. Guilford.

McLean, C. P., & Foa, E. B. (2011). Prolonged exposure therapy for post-traumatic stress disorder: A review of evidence and dissemination. *Expert Review of Neurotherapeutics*, *11*(8), 1151–1163. https://doi.org/10.1586/ern.11.94.

Phoenix Australia Centre for Posttraumatic Mental Health (2020). *Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD*.

Porter, E., & Chambless, D. L. (2015). A systematic review of predictors and moderators of improvement in cognitive-behavioral therapy for panic disorder and agoraphobia. *Clinical Psychology Review*, *42*, 179–192. https://doi.org/10.1016/j.cpr.2015.09.004.

Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review*, *30*(6), 635–641. https://doi.org/10.1016/j.cpr.2010.04.007.

Sarter, L., Heider, J., Witthöft, M., Rief, W., & Kleinstäuber, M. (2022). Using clinical patient characteristics to predict treatment outcome of cognitive behavior therapies for individuals with medically unexplained symptoms: A systematic review and meta-analysis. *General Hospital Psychiatry*, *77*, 11–20. https://doi.org/10.1016/j.genhosppsych.2022.03.001.

Stukas, A., & Snyder, M. (2016). Self-Fulfilling Prophecies. In *Encyclopedia of Mental Health: Second Edition* (pp. 92–100). https://doi.org/10.1016/B978-0-12-397045-9.00220-2.

Vancappel, A., & El-Hage, W. (2023). A cognitive behavioral model for dissociation: Conceptualization, empirical evidence and clinical implications. *Journal of Behavioral and Cognitive Therapy*. https://doi.org/10.1016/j.jbct.2023.05.003.

Whiston, A., Bockting, C. L. H., & Semkovska, M. (2019). Towards personalising treatment: A systematic review and meta-analysis of face-to-face efficacy moderators of cognitive-behavioral therapy and interpersonal psychotherapy for major depressive disorder. *Psychological Medicine*, *49*(16), 2657–2668. https://doi.org/10.1017/S0033291719002812.

Authors and Affiliations

Alexis Vancappel[1,2] · Camille Raysseguier[3] · Eline Jansen[1] · Anna Mangolini[1] · Cinzia Dicosimo[1]

✉ Alexis Vancappel
alexis.vancappel@univ-tours.fr

[1] CHRU de Tours, Pôle de Psychiatrie-Addictologie, Tours, France

[2] Département de Psychologie, UR 1901 QualiPsy, Qualité de vie et santé psychologique, Université de Tours, Tours, France

[3] Faculté de Psychologie, Laboratoire de psychologie LabPsy EA4139, Université de Bordeaux, Bordeaux, France