Client Perceptions of Helpfulness: A Therapy Process Study

A thesis submitted to the University of Manchester for fulfilment of the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

2014

Alexandra Cocklin

School of Psychological Sciences
Section of Clinical and Health Psychology
## LIST OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of appendices</td>
<td>3</td>
</tr>
<tr>
<td>List of tables</td>
<td>4</td>
</tr>
<tr>
<td>List of figures</td>
<td>4</td>
</tr>
<tr>
<td>Word count</td>
<td>5</td>
</tr>
<tr>
<td>Thesis abstract</td>
<td>6</td>
</tr>
<tr>
<td>Declaration</td>
<td>7</td>
</tr>
<tr>
<td>Copyright Statement</td>
<td>8</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>9</td>
</tr>
<tr>
<td><strong>Paper 1: Client Perceptions of Helpful Therapeutic Process: A Systemic Review</strong></td>
<td></td>
</tr>
<tr>
<td>Preface</td>
<td>11</td>
</tr>
<tr>
<td>Abstract</td>
<td>12</td>
</tr>
<tr>
<td>Introduction</td>
<td>13</td>
</tr>
<tr>
<td>Method</td>
<td>22</td>
</tr>
<tr>
<td>Results</td>
<td>26</td>
</tr>
<tr>
<td>Discussion</td>
<td>45</td>
</tr>
<tr>
<td><strong>Paper 2: Client Perceptions of Helpfulness: A Therapy Process Study</strong></td>
<td></td>
</tr>
<tr>
<td>Preface</td>
<td>49</td>
</tr>
<tr>
<td>Abstract</td>
<td>50</td>
</tr>
<tr>
<td>Introduction</td>
<td>51</td>
</tr>
<tr>
<td>Method</td>
<td>63</td>
</tr>
<tr>
<td>Results</td>
<td>73</td>
</tr>
<tr>
<td>Discussion</td>
<td>83</td>
</tr>
</tbody>
</table>
**Paper 3: Critical Evaluation**

Overview  

Paper 1: Literature Review  

Paper 2: Empirical Paper  

References for Paper 1  

References for Paper 2  

References for Paper 3  


**List of appendices**

Appendix 1. Author guidelines for Psychotherapy Research  

Appendix 2. Author guidelines for Journal of Clinical and Consulting Psychology  

Appendix 3. Approval letter from Research Ethics Committee  

Appendix 4. Table of Studies (Paper 1)  

Appendix 5. Symptom measures: PHQ9 and GAD7 (Paper 2)  

Appendix 6. Novel client measures including Session Rating Scale (Paper 2)  

Appendix 7. Novel therapist measures  

Appendix 8. Therapist adherence measures: MOLAS, CTSR  

Appendix 9. Client Participation Information Sheet  

Appendix 10. Client Consent Form  

Appendix 11. Therapist Participation Information Sheet  

Appendix 12. Therapist Consent Form  

Appendix 13. Recruitment Poster for display within site office  

Appendix 14. Therapist feedback questionnaire  

Appendix 15. Table of inter-correlations (Paper 2)
Appendix 16. Therapist Adherence Scores (MOLAS, CTS-R)  177
Appendix 17. Annotated line graphs for client scores  178
Appendix 18. Invitation letter from BABCP Conference  185

List of tables

Paper 1

Table 1 Categories of client perceived experience in therapy in previous reviews.  16

Paper 2

Table 1 Means and standard deviations for client symptom scores  74
Table 2 Summary statistics for scores on client variables  75
Table 3 Summary of Regression Co-efficients for Client Variables  78

List of figures

Figure 1 Study Selection Procedure  26
Figure 2 Scores for perceived levels of Helpfulness and Control (Client 7)  79
Figure 3 Scores for perceived levels of Helpfulness and Control (Client 1)  79
Figure 4 Scores for perceived levels of Helpfulness and Control (Client 3)  80
Figure 5 Scores for perceived levels of Helpfulness and Control (Client 2)  81
Figure 6 Scores for perceived levels of Helpfulness and Control (Client 4)  81
Figure 7 Scores for perceived levels of Helpfulness and Control (Client 16)  82
Figure 8 Scores for perceived levels of Helpfulness and Control (Client 15)  83
<table>
<thead>
<tr>
<th>Thesis Section</th>
<th>Text</th>
<th>Tables and figures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thesis Abstract</td>
<td>506</td>
<td>0</td>
<td>506</td>
</tr>
<tr>
<td>Literature Review</td>
<td>10,580</td>
<td>104</td>
<td>10,684</td>
</tr>
<tr>
<td>Empirical Paper</td>
<td>11,242</td>
<td>345</td>
<td>11,587</td>
</tr>
<tr>
<td>Critical Review</td>
<td>4,833</td>
<td>0</td>
<td>4,833</td>
</tr>
<tr>
<td>Total</td>
<td>27,161</td>
<td>400</td>
<td>27,561</td>
</tr>
</tbody>
</table>
Thesis Abstract

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in June 2014
Candidate: Alexandra Cocklin
Title: Client Perceptions of Helpfulness: A Therapy Process Study

Client reports of perceived helpfulness in therapy may provide valuable information to clinicians and researchers about what makes therapy therapeutic for individuals. This may help us to understand more about common factors in effective psychotherapies, to explain the processes through which these factors might operate and to understand how the therapeutic relationship contributes to change for different clients. However, the methodological complexity involved in the design of experimental studies has so far prevented research from being able to fully utilise what clients can tell us about their experience of change. This thesis aimed to address some of these challenges in client centred psychotherapy process research.

Paper 1 presented a systemic literature review on studies that have investigated client perceptions of helpfulness in therapy. The methodology employed by the studies was critically evaluated by applying a set of criteria that was proposed by the current review to represent effective study design. The findings revealed that methods and measures remain largely driven by researcher perspectives. There are few studies that have been effective in looking specifically at internal client process over the course of an entire session. This supports the need for more intensive process studies that also employ continuous quantitative measures to test hypotheses within an overarching theory of change.

Paper 2 described a study which devised a novel methodology with quantitative measures to capture clients’ self-reported perceptions of what was helpful about the therapeutic environment created by the therapist during a single session of transdiagnostic CBT - Method of Levels Therapy. The study employed process measures of the client/therapist experience, informed by Perceptual Control Theory, and standardised measures of the therapeutic relationship (Session Rating Scale (SRS)). Eighteen therapy sessions were video recorded and both clients (N=18) and therapists (N=7) were asked to rate a twenty-minute section of therapy at two-minute intervals using repeated measures (ten ratings in total). A mixed-effects multi-level analysis was used to test for correlations between perceived levels of helpfulness and client process variables. The current study provides a valid and reliable method for investigating continuous measures of process that are client-orientated, internally driven and dynamic. The client’s perceived sense of control is shown to be an important process during therapy that is closely related to the client’s perceptions of helpfulness, the ability to talk freely in session and see their problem in new ways. This is suggested as a client centred, theory driven multifactor pathway that may describe the therapeutic change process.

Paper 3 critically evaluates the systemic review (Paper 1) and empirical paper (Paper 2). The methodological strengths and limitations are discussed as well as the implications for future research and the plans for dissemination. This study involved establishing a Practice Research Network (PRN) within a primary care service that encouraged collaborative networks between academics, researchers and clinicians. Research and practice links are discussed that have potential to improve clinical practice and enhance client experiences of service delivery and involvement. Some reflections are provided on the research process, as well as client and therapist reports of their experiences as participants.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trademarks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://www.campus.manchester.ac.uk/ media library/policies/intellectual- property.pdf), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/ regulations) and in The University’s policy on presentation of Theses.
Acknowledgements

I would like to thank my supervisors, Dr. Warren Mansell, Dr. Sara Tai and Dr. Phil McEvoy for their guidance and support. I would also like to thank all of the therapists and staff of Six Degrees Primary Care Mental Health Team for their energetic enthusiasm and involvement; as well as the service users who took the time to take part. Special thanks must go to my family and my partner Ian for being so supportive during my studies.

Word count: 10,580 (excluding references)
Preface

The following paper has been prepared for submission to ‘Psychotherapy Research’ in accordance with their requirements (Appendix 1). The authors will be Alex Cocklin, Dr. Warren Mansell and Dr. Sara Tai.

Objective: Client reports of perceived helpfulness in therapy may provide a valuable means of investigating micro-processes of change. To understand what makes therapy therapeutic for individual clients, it is necessary to consider how clients perceive and respond to the facilitative conditions provided by therapists in session. The methodological complexity involved in measuring this process has been recognised by numerous authors. In response, the current review gathers the data on methods and measures that have been employed by experimental studies from different disciplines to capture client perceptions of helpfulness in therapy. The review then critically evaluates the methods and measures used in these studies to identify key areas for future development. Method: A systematic literature search was conducted and a set of criteria proposed by the current review and drawn from previous research was applied to assess the methodological design of the selected studies. The criteria included the extent to which methods and measures are: i) client orientated ii) internally driven iii) incorporate the interpersonal context of therapy iv) focus on in-session activity and change over time v) applicable across therapeutic modalities and vi) naturalistic clinical settings and vii) linked to a theoretical framework of change. Results: Nineteen studies and six client measures of client perceived helpful experience in therapy were identified. Overall, findings revealed that methods and measures remain largely driven by researcher perspectives and there are few studies that have been effective in looking at internal client process over the course of an entire session. Conclusions: This review supports the need for more intensive process studies that employ continuous quantitative measures that are equipped to test hypotheses within an overarching theory of change. The analysis of data over the course of the session may help researchers to identify further mechanisms of change and to explain how they might operate. This will also help clinicians to enhance
their practice by understanding how the process of change occurs as a part of therapeutic interaction.

**Keywords:** client perceptions/experiences, psychotherapy, counselling, process, alliance/therapeutic relationship, systematic review

**Introduction**

The study of client perceptions of in-session experience during therapy may offer valuable opportunities for clinicians and researchers to enrich the current understanding of what makes psychotherapy therapeutic. A closer look at the helpful moments, events and aspects of therapy reported by clients may reveal greater insights into the active ingredients of therapy that facilitate internal change processes (Elliott & Shapiro, 1988; Greenberg & Rice, 1984; Vanaerschot & Lietaer, 2007). It is possible that helpful aspects of therapy may also represent common factors that apply across treatment modalities and which provide further evidence to support transdiagnostic approaches to therapy (Timulak, 2007; Ward, 2000). If we develop a greater understanding of what is working for clients ‘on the inside’ during episodes of helpful therapeutic interaction, then these processes could be maximised by therapists and tailored to individual needs (Elliott & James, 1989; McLeod, 2003; Norcross, 2011).

Clients may have ‘privileged access’ to specific aspects of the therapy process, including the felt quality of their relationship with the therapist (Gurman, 1977). Self-reported client perceptions in therapy may therefore capture certain aspects of the client’s experience that are not immediately accessible to the therapist or an outside observer. This offers the opportunity to identify the covert processes that direct and mediate the effectiveness of therapy that are closely related to client goals, values and relational schemas. In addition, the study of therapy through the client’s perspective may be an effective means of address-
ing the complex interaction of the intra-individual and interpersonal processes involved in therapeutic interaction. This reflects that clients perceive and respond to the interpersonal context of therapy and the responses of their therapist in different ways (Norcross, 2011).

It is also possible that the study of client experience offers the opportunity to generate theoretical explanations of therapy from data gathered in naturalistic clinical settings that operate in real time, as opposed to a ‘top-down’ theory-led approach where concepts may be super-imposed upon clinical practice (Castonguay et al., 2010). The inclusion of client perspectives on therapy process is key to conducting ethical research and practice; this is supported by the current growing emphasis on feedback informed treatment and service user involvement in the design and delivery of services (Duncan & Miller, 2006). A client led approach to intervention recognises the client as an active agent in therapy rather than a passive recipient of treatment. It further recognises that clients often come to therapy with self-healing capacities and personal resources that pre-exist and which may be scaffolded and enhanced by well attuned therapists.

Several previous reviews of the literature have made important contributions to the understanding of client perceptions of what is helpful in therapy. These include the review by Elliott and James (1979) on the varieties of client experience in therapy, Timulak’s analysis of client-identified helpful impacts and an update on the significant events literature (2007; 2010). Elliott and James identified nine categories of client experience in their broad overview of studies (1979). Five of these described clients’ experiences of their own psychological processes such as intentions, feelings, style of relatedness, style of relating and central concerns. Two described client experiences of therapist characteristics and intentions and the remaining two described the client’s experiences of change in therapy. It was noted that a methodological flaw in the majority of the selected studies was the confusion of client and therapist perspectives and the use of client measures that were derived from researcher perspectives. The most frequently cited helpful factors included: facilita-
tive therapist characteristics, client unburdening, supportive relationship, acquisition of hope, self-understanding, perceived therapist encouragement for practice, therapist intention to act as a catalyst to therapy and to give feedback and the therapist ability to be calm and objective. Alliance measures were reviewed briefly, however it was noted that these tended to capture partial aspects of client experience during therapy and were limited to the interpersonal bonding aspect of the alliance described by Bordin (1979). Recommendations for future research included further exploratory research into client interior processes such as intentions and the development of measures of client experience from the client perspective.

The review by Timulak (2010) revealed that client perceptions differ significantly from that of the therapist and tended to focus on relational and emotional aspects rather than the cognitive aspects of therapy that are often identified by therapists. Timulak (2010) also found that helpful significant events are therapeutically productive, although further evidence is needed to be able to establish this further as data gathered from the intensive qualitative studies was complex and ambiguous. Due to the use of different terminologies and descriptive labels, it was concluded that it has been difficult to gain an overview of what clients actually find helpful in therapy and to link these to the ways in which therapists can improve their practice. The earlier analysis was conducted by Timulak (2007) with the aim of developing a more comprehensive representation of client-identified helpful impacts. The review identified a further nine core categories which included: a) awareness/insight/self-understanding, b) behavioural change/problem solution, c) empowerment, d) relief, e) exploring feelings/emotional experiencing, f) feeling understood, g) client involvement h) reassurance/support/safety and i) personal contact. However, it was noted that the findings appeared to closely replicate earlier findings from primary studies. This suggests that the results of studies confirmed and consolidated what was already known in the field and that few new perspectives had emerged from the secondary analysis. Table 1
shows a summary of the categories of perceived client experience that have been identified by the previous reviews conducted by Elliot and James (1979) and Timulak (2007).

**Table 1** Categories of client perceived experience in therapy in previous reviews

<table>
<thead>
<tr>
<th>Review Study</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elliot &amp; James (1979)</td>
<td>Intentions, feelings, style of relatedness, style of relating to therapist, central concerns, therapist intentions, therapist characteristics, therapeutic aspects, helpful aspects of therapy.</td>
</tr>
</tbody>
</table>

**Defining Client Perceptions of Therapy**

The process of perceiving describes the act of constructing and representing a personal view of reality (Toukmanian, 1983). The study of clients’ perceptions in therapy therefore opens up a productive avenue for studying therapeutic change at the level of the client’s internal processes. Client perceptions are defined in this review as the client’s experience of external events as well as the internal processes that include private thoughts and feelings. This means that clients’ descriptions of their experiences include therapist actions and behaviours (external) as well as the client’s thoughts and interpretations of the event (internal). The definition extends to what is explicitly communicated as well as the covert processes that might not be shared with the therapist. This is reflected by Rennie’s (1992) suggestion that clients are often engaged in a number of covert processes throughout the session which may impact on how they respond and which are not readily observed by the therapist or third parties.
Rogers (1951) identified that the client’s perception of therapy plays a key role in how the client interprets and makes use of therapeutic interaction in his work on the facilitative conditions of therapy. This stemmed from Roger’s theory (1965) that described the facilitative conditions of therapy which suggested that the client’s perception of therapist empathy influences how the client benefits from the therapeutic encounter. This is echoed by Rennie (1992) who describes the client as a ‘self-aware agent of change’ who directs his or her own involvement with therapy. According to this interpretation, the client exerts their control over how they perceive, interpret and respond to therapeutic interaction. Toukmanian’s model of in-therapy perceptual functioning (2002) provides further explanation of this process by referring to the client perceptual system as the core element of change in Person Centred and Experiential therapies (Toukmanian, Jadaa & Armstrong, 2011). It emphasises how client perceptions during therapy moderate the client’s ability to explore their subjective experience and make sense of their difficulties. On the same basis, it is anticipated that client perceptions of the therapeutic environment, as they change from moment to moment, will also have a significant impact upon the within person processes that lead to change.

Despite the obvious potential for learning about what works in therapy that is offered by client reports, it has been suggested that client driven conceptualisations of the therapeutic alliance or relationship have been missing from research (Bachelor, 1995). The understanding of the relationship from the therapist’s perspective appears to have dominated the literature so far (Bedi, Davis & Williams, 2005). However, we now know that client and therapist perspectives on the experience of therapy and what makes it effective can be very different (Lysaker et al. 2011). A number of studies have reported low correlations between therapist and client ratings of the alliance (Cecero, Fenton, Frankforter, Nich & Carroll, 2001; Orlinsky & Howard, 1975; Bachelor, 1991; Bachelor & Salame, 2000; Hatcher, Barends, Hansell & Gutfreund, 1995; Horvath, 1994; Tichenor & Hill, 1989). This
strongly suggests that the effective study of therapy process requires measures which capture the internal experience of the client during therapy instead of standardised measures of alliance. The current review addresses this issue by looking at the range of studies that have attempted to capture the client’s phenomenological experience of therapy via client perceptions of helpfulness.

**Client Perceptions in Alliance Research**

The pan-theoretical model of the alliance (bond, task and collaboration) introduced by the work of Bordin (1979) and Luborsky (1984) provided some theoretical concepts on which to develop standardised measures of the alliance. This enabled researchers to test for associations between relationship factors and client outcomes. However, many of the subsequent studies that have applied alliance constructs have focused on data collected from observer or therapist ratings rather than client reports. In cases where alliance has been based on the perspective of the client, reports have still been viewed through the lens of global assessments and evaluative summaries more suggestive of client satisfaction than experienced process. Many client self-report measures used to assess the therapeutic relationship have been developed from existing observer measures based on theoretically informed conceptualisations (Bachelor, 1995). This is problematic in light of evidence that observer and client perspectives of the relationship differ significantly and that the client’s perception is the better predictor of positive outcome compared to the observer perspective (Bachelor & Horvath, 1999). Data has also been collected at fixed time points over the course of treatment (beginning, middle and end) and time points in-between sessions, rather than clients’ experience of in-session activity (Elvins & Green, 2009). Many of the standardised measures used in alliance studies are also not sufficiently dynamic to capture the evolving nature of a client’s subjective perception of the relationship as it unfolds during a session (Horvath & Symmonds, 1991; Strong, 1968; Castonguay et al., 2006; Fitz-
The common use of client or therapist rated alliance alongside patient or therapist derived measures of outcome is likely, therefore, to have introduced bias in the analysis of relationship between alliance and outcome (Klein et al., 2003).

There are further concerns that the alliance literature is based on overly generalised principles in contrast to client-identified relationship variables that lie outside the parameters of the predominant alliance theories (Safran & Muran, 2000). For example, it has been argued that clients mention collaboration and mutuality much less frequently than therapists (Hatcher, 1999; Horvath & Bedi, 2005). The most commonly used alliance measure is the Working Alliance Inventory (Horvath & Greenberg, 1989) but this reflects the mutual contributions of the client and therapist that form the basis of a generic alliance concept in contrast to the client’s individual perspective (Barret-Lennard, 1986). The California Psychotherapy Alliance Scale (Gaston & Marmar, 1994) also reflects the purposive mutual work of client and therapist although originally intended to capture their individual contributions.

Alliance studies appear to have focused on assessing the contributions made by individual therapists and client characteristics to the working alliance and outcome. This contrasts with the growing recognition amongst researchers that the dynamic processes of interpersonal interaction between client and therapist are not measurable in terms of static components (Elvins & Green, 2009; Carroll, 2001; Elkin, 1999). Therapist factors that have been studied include empathy, warmth, curiosity, experience and adherence. Client characteristics have been described in terms of readiness, expectation, satisfaction, severity of symptoms and interpersonal style (Norcross, 2011). However, different clients will react in varied ways to therapist characteristics such as empathy and positive regard (Farber & Lane, 2001). It has therefore been suggested that current alliance research needs to turn towards the analysis of therapy process including the interaction of therapist and client characteris-
tics in session and the collection of real-time feedback (Norcross, 2011). The current re-
view looks beyond studies that employ client ratings on core-standardised measures of alli-
ance in response to the primary concern that these measures may not correspond to the 
lived experienced of the client.

**Client Perceptions in Counselling Research**

Person centred research in Counselling offers a range of avenues for continued research 
into relationship factors from the client’s perspective at the micro-level (McLeod, 2003).
Some of these studies include intensive methodologies that can be employed to analyse the 
subjective and dynamic aspects of the client’s experience in therapy. One such method is 
the study of significant events, described as a part of the broader ‘events paradigm’ that 
covers research that looks at specific episodes of therapy process (Arnkoff, Victor, & 
Glass, 1993; Elliott, Slatick & Urman, 2001; Timulak, 2010). The rationale behind this ap-
proach is that the events which stand out to clients are most likely to provide useful infor-
mation about therapy process. Events are selected by clients and then rated using the ses-
sion transcript, quantitative process measures or qualitative interview. In this way, clin-
icians may gather more information on how clients act as agents of change and how they as 
therapists can facilitate this process. A number of different types of events have been stud-
ied; helpful events, disengaged moments, client silences, client events signifying the ex-
perience of high emotion, insight and moments of awareness, hope or problem clarification 
(Timulak, 2010). However, the difficulty within the significant events literature is how to 
quantify and connect the detailed and subjective data on client experience with more global 
variables such as outcome (Elliot & James, 1989). The significant events literature is rele-
vant here as it has included the study of helpful events and processes (Paulson, Truscott & 
Stuart, 1999) and helpful therapists’ interventions (Elliott et al, 1985).
Client Perceptions of Helpfulness

The aim of the current review is to examine the evidence on the methods and measures that have been used to capture clients’ perceptions of helpful experiences during therapy and what this evidence can tell us about mechanisms of change in therapy. The review acknowledges that a diversity of constructs, terminology and methods has been used to capture what clients find fruitful about their experiences in session. The current review uses the term first provided by Rogers (1965), ‘the facilitative conditions of therapy’ as an integrative concept to bring the ‘helpful aspects of therapy’ that clients experience (e.g. therapist characteristics, behaviours, responses) together under one umbrella. The concept of the ‘helping relationship’ describes the creation of an interpersonal environment for the client that will facilitate change (Orlinsky & Howard, 1986). The construct of ‘helpfulness’ has therefore been suggested to be an effective means of operationalising Roger’s original concept of the ‘facilitative conditions of therapy’. It is suggested here that ‘the facilitative conditions of therapy’ construed as client perceived helpfulness offers a more useful construct for future research than the concept of the alliance or the therapeutic relationship. The construct of perceived helpfulness allows for the fact that the alliance is made up of numerous components, the nature and quality of which differs significantly between individual clients who have unique relational and cultural schemas.

Scope and Aims of the Current Review

Previous reviews have tended to focus on identifying and labelling the core categories of client-identified helpful impacts and experiences in therapy across studies. It is possible however, that this categorical approach to understanding what works for clients may be replicating what is already known by creating new combinations of core components that are still heavily influenced by researcher perspectives. It was reported that six out of the nine categories identified by the analysis conducted by Timulak (2007) were
present in Elliott’s much earlier study of significant impacts (1985). Helpful impacts across all of the studies were described as fitting into the general areas of new perspective (awareness/insight/self-understanding), new behaviour (behavioural change/problem solution) and new experiencing and motivation (exploring feelings/emotional experiencing, empowerment and relief). The aim of the current review is therefore to identify and critically evaluate the key methodological and theoretical themes that currently exist in the field of client-identified helpfulness in therapy. This is to help us understand what kinds of novel designs might enrich the study of client perceptions of therapy process in the future. The current review therefore focuses on the methodological aspects of the studies in preference to the further categorisation of descriptive labels by generating and applying a set of criteria that we propose is representative of effective study design in this field.

**Method**

Systematic Review is defined by the Cochrane Collaboration as a review of a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant research from studies included in the review (Green et al., 2008). It is important to be entirely transparent in reporting the methods employed in the review to enable replication (Grant & Booth, 2009). Search strategies may be complex, especially when a researcher investigates a topic that covers different fields of research (Liberati, 2009). It is therefore very important that systematic reviews include a detailed description of the search strategy that has been followed (Golder, Duffy & Glanville, 2006). The following section provides information on the comprehensiveness, completeness and sensitivity of the search conducted for this review.

The electronic databases MEDLINE, EMBASE and PsychINFO were systematically searched to identify peer reviewed journals that could be included in the review. The databases were searched between January and March 2014. All of the articles searched were
from English language journals. The key words used in the search strategy included: *client perception* or *client rating* or *client experience* (limited to title and abstract) and *therapy and helpful* or *significant*. The search was then limited further to include *Psycho-therapy* as the subject heading. All abstracts identified from the search were individually compared to the inclusion criteria for the current review. Studies not meeting inclusion criteria were removed, including duplicates generated from different databases. Reference lists from all remaining articles were hand searched for further studies that potentially met inclusion criteria. Citation searches for each of the included articles were carried out.

**Inclusion and exclusion criteria**

Studies were included in the review if they met all of the following criteria:

— An experimental study design.

— Any model of adult individual psychotherapy.

— Excluding group, family or couples therapy.

— Any adult client population (i.e. trans diagnostic; with a range of presenting issues that were clinically significant).

— Measures that are rated or coded by the client (excluding measures that have been adapted from observer or therapist measures).

— Includes the client’s perception of the facilitative conditions offered by the therapist during therapy (this is defined by the current review as helpful factors, aspects, events or impacts).

— That met quality criteria outlined by the QATSDD (Sirriyeh, Lawton, Gardner & Armitage, 2011).
Quality and Risk of Bias

Assessment of quality is important for establishing the reliability and validity of study design and results. It is essential that enough information is provided when reporting each study so that the reader may come to their own conclusions about the strengths and weaknesses of the evidence. A number of quality assessment tools are available that give each study a weighted score to indicate the risk of bias. However, using this method of aggregating quality assessment scores may not provide an accurate or balanced interpretation of the data; particularly so when studies in a systemic review include a range of mixed-methodological designs. The Quality Assessment Tool (QATSDD) was developed as a 16-item quality assessment tool to determine the quality of research studies in health care that have both qualitative and quantitative aspects to their designs (Sirriyeh, Lawton, Gardner & Armitage, 2011). The QATSDD has been shown to have good face validity, test-re-test reliability and inter-rater reliability when applying the tool to a set of research studies ($\kappa=71.5\%$). The quality criteria of the QATSDD is indicated by 16 separate items which include whether studies demonstrate: 1) an explicit theoretical framework, 2) a statement of aims or objectives in the main body of the report, 3) a clear description of the research setting, 4) evidence of the sample size considered in terms of the analysis 5) a representative sample of the target group and 6) of a reasonable size 7) a description of the data collection procedure 8) a rationale for the choice of data collection 9) detailed recruitment data 10) statistical assessment of the reliability and validity of assessment tools (quantitative only) 11) fit between stated research question, format and content of the data collection 12) fit between the research question and the analysis 13) good justification for analytical methods 14) assessment for reliability of analytical processes (qualitative only) 15) evidence of user involvement in the design 16) strengths and limitations critically discussed. The tool is scored by awarding a mark of 0 to 3 for each of the criteria (0=not at all, 1 = very slightly, 2= moderately, 3-complete.) 14 of the items apply to qualitative stud-
ies and 14 apply to quantitative studies whilst all 16 items can be applied to studies that employ mixed methods. The scores are then totalled to give an overall score for each paper (42 for quantitative and qualitative designs and 48 for mixed-method studies) which is expressed as a percentage. Sirriyeh et al., (2011) reported that applying the QATSDD is an iterative process that involves the exercise of careful judgement. The QATSDD is not generally used to exclude papers on the basis of a quality score due to a lack of literature in this area but rather as a means of assessing the scientific rigour of studies overall. Therefore, it was necessary for the researcher to use independent judgement to interpret the quality scores in the absence of threshold guidelines. A bi-polar scoring system was adopted (good quality vs. not good quality studies) where quality scores over 50% were interpreted as representing good quality and were therefore included in the review. To ensure that the method and the findings of the review were reported in a consistent and reliable format, the PRISMA guidelines were applied (Moher, Liberati, Tetzlaff & Altman, 2009).
Study Selection Process

Figure 1 provides a flow diagram illustrating the study selection process that was undertaken with details of how many results were identified and how many were excluded at different stages.

Results

Overview of Selected Studies

The initial search identified a total number of 183 studies from selected databases. A further 35 studies were identified via hand searching reference lists and searching for citations, providing a final total of 218 studies eligible for inclusion. After inspecting each article on the basis of title and abstract, 24 studies were retained to be included in the current review. Studies such as Hatcher, Barends et al., (1996) that included standardised measures of the alliance (e.g. the Working Alliance Inventory, WAI) were excluded. Although there
is evidence to suggest that it is also important to understand what can be problematic, hindering or even harmful about therapy this is beyond the scope of the current review (Paulson et al., 1999). Another study by Mackrill (2007) provided interesting data on client-identified helpful factors. This was excluded as the data came from diaries of events between sessions and did not apply exclusively to experience of therapy during treatment. Six studies were excluded on the basis of quality in that the sample did not represent a cross section of the target population (adult client in therapy or seeking therapy) or a size that was adequate to justify the chosen analysis.

A summary of the studies included in the current review is provided in Table 1 (Appendix 5). The table describes the sample characteristics, methodological design, measures and the main findings for each study. The primary construct of analysis (e.g. perceived alliance, critical incident of helpful aspect) is also identified in the table.

**Summary of Findings**

The current review organises the findings by first providing an overview of the aims, constructs, the methodological design and measures employed by the studies. A number of issues regarding the methodology of the studies were identified that are central to the current review. These issues were organised into clusters using the following criteria as terms and applied to the analysis of the selected studies. The current review proposes that these criteria may serve as guidance for evaluating previous studies on client perceptions of therapy process and to inform the future design of novel methodologies. The criteria includes the extent to which the methods and measures used are: i) client-orientated ii) internally driven iii) incorporate the interpersonal context of therapy iv) focus on in-session activity and capture change over time v) applicable across therapeutic modalities and vi) naturalistic clinical settings and vii) linked to a theoretical framework of change.
Study Aims.

The common aim of studies selected for review was to assess what clients and therapists found helpful during their sessions of individual psychotherapy. Further study aims included the investigation of whether clients and therapists were similar in the reports they provided (Castonguay et al., 2010) and to understand the extent that clients’ perceptions agreed with theoretician-derived views of the alliance. One study specifically focused on the replication of earlier findings (Castonguay et al., 2010) and a number of studies tested the psychometric properties of previously established measures (Stiles et al., 1994; Elliott & Wexler, 1994). A large number of the studies sought to identify an empirical taxonomy of change events that could be derived from client descriptions of helpful events or aspects.

Constructs of Helpfulness.

Across the literature reviewed, a variety of constructs were employed in the attempt to understand what clients report as helpful about their experiences in therapy and why. Perceived helpful factors were conceptualised as aspects of alliance formation and development (Bachelor 1995; Bedi, 2006; Owen et al., 2013; Simpson & Bedi, 2013) and by using the ‘events paradigm’ to include client reports of critical incidents, significant or positive moments and helpful events (Bedi, David & Meris, 2005; Castonguay et al., 2010; Elliott, 1985, Levitt, Butler & Hill, 2006; Llewelyn et al., 1988; Timulak & Lietaer, 2001). The majority of studies began by gathering client-identified significant events and then relating these either i) to the formation and strengthening of the alliance or ii) to the experience of therapeutic impacts. Overall, the findings offer a range of overlapping categorical systems and taxonomies. For example, many of the studies had more than one focus (for example helpful events and session impact or perceived alliance and therapist interventions). The studies further noted that there were difficulties inherent with attempting to establish mutually exclusive categories.
Study Design

A common approach to study design was the incorporation of qualitative and quantitative elements into a single method. Qualitative methods were used to gather descriptions of helpful events or factors from participants using semi-structured or open-ended interview. A large proportion of the studies used methods that were informed by the ‘events paradigm’ ($N=9$) (Elliot, James, Reimschuessel, Cislo & Slack, 1985). The ‘events paradigm’ involves the structured recall of therapy sessions with a trained interviewer. One study for example, used semi-structured interview, which asked participants to write down helpful and non-helpful aspects of therapy on index cards in response to the questions: ‘Did anything particularly helpful happen during this session?’ and ‘Did anything happen during this session that might have been hindering?’ taken from the Helpful Aspects of Therapy Form (Llewelyn, 1988).

A number of methods were employed in the selected studies to reduce the wealth of qualitative information to meaningful categories so that they could be interpreted and applied in a general context. Client-identified events were sorted and then rated by clients or by trained researchers to provide a taxonomy of helpful events using cluster analysis (Elliot, 1985), concept mapping (Paulson, Truscott & Stuart, 1999), Grounded Theory (Levitt, Butler & Hill, 2006), Phenomenological Analysis (Bachelor, 1995), Q-technique factor analysis (Mohr & Woodhouse, 2001) or by using pre-existing coding schemes such as the Therapeutic Impacts Content Analysis System (TICAS, Elliot et al.1985). The findings revealed a wide range in reliability estimates (0.49 to 0.97) when broken down into individual rating categories. The levels of inter rater agreement ranged from (0.60 to 0.84).

Overall, studies included in the current review employed exploratory means of assessing what the client views to be helpful about therapy. Client-identified factors and events were sometimes rated to test for associations with therapist in-session variables. Guiding principles or rules to aid therapist activity were also drawn from the resulting categories as
part of the secondary analyses. There were no studies that used measures to capture quantitative continuous data with regard to client process variables that could be used to test experimental hypotheses across a single session of therapy. Quantitative analyses were in the minority, although logistic regression was used to test for differences in the level of helpfulness and hindering between categories of events and their impact and content (Castañonguy et al., 2010; Elliot, 1985). Three studies included additional pre and post-outcome measure such as the WAI short form (Horvath & Greenberg, 1989), SCL-10 (Nguyen et al, 1983), Global Rating Scale (Green, Gleser, Stone & Seifert, 1975). However, the current review found that there was a significant lack of client rated measures of therapy process that were also validated in terms of therapeutic outcome.

**Client Process Measures of Helpfulness in Therapy**

Eight measures were used to capture and assess client perceptions of helpful in-session therapy process. This included two global ratings of helpfulness comprised of nominal categories to assess the general degree of perceived helpfulness (Helpfulness Rating Scale, Elliott, 1979; Helpful Aspects of Therapy Form, Llewelyn, 1988), ranging from extremely hindering (1) through neutral (5) to extremely helpful (9) with intervening scale points labelled slightly, moderately and greatly. These global rating scales are closely related to the Therapy Session Rating Form that was developed by Orlinsky & Howard (1986) and used in earlier studies.

- **Therapeutic Impacts Content Analysis System** (TICAS, Elliott, James, Reimscheuessel, Cislo & Sack, 1985). The TICAS has been designed to measure in-session client experience of therapy and can be rated by clients, therapists or researchers. However, it has most commonly been rated in studies by counselling academics or students. The categories for the therapeutic impact of events included Personal Insight, Awareness, Clarifica-
tion of Problem, Problem Solution, Understanding, Reassurance, Involvement and Personal Contact. There were further categories for Hindering Impacts including Unwanted Thoughts, Unwanted Responsibility, Misperception, Negative Therapist Reaction, Misdirection and Repetition. It has been reported that eight out of the fourteen categories have excellent reliability estimates with Awareness (.81), Reassurance (.89) and Personal Contact (.86) receiving excellent reliability ratings (Elliott, 1979, 1982). It has also been found that there is considerable overlap between the categories (Awareness, Unwanted Thoughts and Problem Solution). Authors suggest that the types of impacts tend to be used, added or subdivided according to the researchers’ interest (Timulak, 2008). The TICAS has been used to show that different techniques and therapist response modes achieve the same ends in therapy and can be interchangeable in different helping situations between individuals. It has also been commented that the TICAS simplifies the process of measuring therapeutic impacts so that data has been made easier to collect and analyse (Llewelyn, 1988).

- **Session Evaluation Questionnaire** (SEQ Version 4; Stiles & Snow, 1984). The SEQ is a twenty-four point scale that measures session evaluation, post-session mood and therapist evaluation. The items are presented as bipolar adjective scales for example, bad-good, relaxed-tense or unpleasant-pleasant. The most commonly used scales from the SEQ are the items on the Depth and Smoothness of sessions; these have been shown to be highly correlated with SEQ post session Positivity and Good Therapist indexes and to represent evaluative dimensions that had internal stability and stability across time, settings and therapeutic approaches (Stiles & Snow, 1984).

- **Session Impacts Scale** (SIS, Elliot, 1986; Elliot & Wexler, 1994) The SIS differs from the SEQ as it is claims to measure specific content rather than the general emotional quality of clients’ reactions to sessions. Each of the sixteen items include a phrase and a short
paragraph describing the following categories of session impact; realising something new about myself or someone else, more aware of or clearer about feelings and experiences, reaching a definition of problems for me to work on, progress towards knowing what to do about my problems, feel that my therapist understands me, feel supported or encouraged, feel relieved or more comfortable, feel more involved in therapy or inclined to work harder, feel closer to my therapist, more bothered by unpleasant thoughts or more likely to push them away, too much pressure or not enough direction from the therapist and other impacts. The use of multiple item scales has been suggested to be more accurate in capturing clients’ experiences than single items (Elliot & Wexler, 1994). Stiles et al., (1994) used the SIS to compare clients’ experience across different treatments (cognitive-behavioural and interpersonal-psychodynamic therapy) and found no significant differences for Problem Solving, Unwanted Thoughts or Hindering Impact scores.

- **Alliance in Action Form** (Owen, Reese, Quirk & Rodolfa, 2013). This measure assesses client’s perceptions of therapist behaviour related to fostering and maintaining the alliance, with four subscales of therapist behaviour: to monitor the relationship, the goals for therapy, the progress towards client goals and the therapist’s avoidance of eliciting feedback. The AiA subscales demonstrated alphas above .70 and were associated with client rated alliance and session outcomes. The AiA is suggested to be helpful in understanding how the alliance functions in therapy (Owen, Reese, Quirk & Rodolfa, 2013).

- **Helping Intention Rating Procedure** (Elliot & Feinstein, 1978) is used to categorise therapist responses according to intention in studies using the Interpersonal Process Recall method. There are ten categories of therapist intentions with separate versions for clients and therapists. The Helping Intention Rating Procedure has been used as a way of linking the client’s experience to the approach being taken by the therapist during the session. It
also parallels the Therapist Response Mode Rating System (Elliott, 1979) by using the therapist response as the unit of analysis.

- **Therapist Response Mode Rating System** (Elliott, 1979) measures helpful therapist actions with therapist response mode categories that include: Closed and Open Questioning, Reflection, Interpretation, Advice, Reassurance, Self-disclosure and Providing Information. Response modes are rated as independent, non-mutually exclusive rating dimensions. A 4-point scale is applied to each item (0=clearly absent, 1=probably absent, 2=probably present, 3=clearly present). The Helping Intention Rating Procedure and the Therapist Response Mode rating System have been used in research to explore the associations between obtained clusters of helpful/non-helpful events and therapist action variables (response modes and intentions). However, it has been suggested that these classification systems may oversimplify the complexity and variation of client experiences by imposing mutually exclusive categorisation. Rater bias may also be introduced when the coding is carried out by researchers, as is often the case (Elliot, 1985).

**Evaluation of Study Methods, Measures and Findings**

In the following section, the selected studies are critically evaluated by applying the criteria proposed by the current review to characterise effective study design in the investigation of client perceptions of therapy process.

**Client-orientated Methods and Measures**

An essential feature of studies designed to capture client perceptions of therapy process must be that the methods and measures they employ are client-orientated. It has been recognised that there is considerable divergence between client and therapist views of what
happens in therapy and what matters most; a suggestion that is supported by the findings of studies included by the current review.

A lack of agreement between client and therapist reports of the level of helpfulness was reported by Castonguay et al., (2010), Bedi, Davis and Williams (2005) and Bachelor (1995). Therapists appeared to be more concerned with alliance based concepts than clients. Therapists also tended to focus on what they had done when things went wrong which may mean that they were less aware of what the client was experiencing during these moments. Clients identified variables such as therapist friendliness and self-understanding that fall outside the boundaries of traditional alliance theories (Bedi, Davis & Meris, 2005). The term ‘alliance’ was also replaced by ‘working or therapeutic relationship’ in studies as clients were thought not to understand what alliance meant (Bachelor, 1995; Mohr & Woodhouse, 2001). One study identified three types of perceived alliance including Nurturant, Insight Orientated and Collaborative using content analysis (Bachelor, 1995). However, although three distinct types of perceived alliance were identified, it appears that there were significant overlap in the ways these types of alliance were achieved by therapists which may indicate that these are not mutually exclusive categories.

A clear finding across the studies was that clients cannot be classed as a homogenous group; they have different experiences of therapy and perceptions of therapeutic interaction whilst emphasising different aspects. Clients may also require different kinds of support in their therapeutic relationships with some feeling more comfortable with higher degrees of emotional connection and intimacy than others. Mohr and Woodhouse (2001) identified that clients prefer different types of relationship with 41% preferring a warm and personable alliance to facilitate self disclosure and 33% preferring a professional climate that was emotionally more distant but where challenge and collaboration was valued. This supports the evidence that client measures of experience need to capture the subjective nature of the client’s perceptions as they occur within the context of moments during therapy.
In the studies selected for review, the description of client-identified helpful events was often viewed through the lens of various coding schemes (e.g. SES, SIS, HAT and TI-CAS). This shows that researcher bias introduced through rating procedures (acknowledged by Elliott and James (1989) in their previous review of client experience) is still a significant limitation in this area of research. Rating scales included categories that were theoretically based such as ‘alliance strengthening’; despite evidence that suggests clients’ perceptions of therapeutic interaction do not match researchers’ theoretically based conceptions of the alliance. As with many of the coding schemes that are completed by researchers, they are limited in that client behaviours observed by trained third parties may not be relevant to the immediate therapeutic impact experienced by the client (feeling understood or listened to for example may not be easily observed). Low levels of agreement between client and observer perceptions of therapy process may be a result from this difficulty (Orlinsky & Howard, 1975).

A number of later studies recognised that earlier attempts to classify client’s qualitative reports may have led to researchers imposing their own categorical labels on clients’ experiences. One mentioned gathering ‘an inclusive set of statements to capture the essence of participant’s experiences’ of therapy whilst also retaining their language (Paulson, Truscott & Stuart, 1999; Bedi, 2006). Concept mapping and Grounded Theory were used to analyse transcribed interviews as a means of exploring the subjective experience of clients and to reduce the influence of researcher bias (Levitt, Butler & Hill, 2006). This included a non-metric scaling procedure that represented items along orthogonal axes so that the distance between any two points reflected the frequency with which the cards were sorted together. This allowed spatial representation of unknown latent relationships between variables (Fitzgerarld & Hubert, 1987) and a labelling of clusters that was statistically and conceptually determined. However, these studies tended to be discovery orien-
tated and exploratory and focused less on the identification of a multifactor pathway of change events related to outcomes.

**Intra-individual Processes**

In order for client reports of helpful experiences to provide valuable information about the micro-processes of change during therapy, it is necessary that they capture the internal processes occurring for the individual client (Toukmanian & Rennie, 1992). A number of methodological issues were acknowledged regarding the difficulty of capturing clients’ covert processes along with ethical issues regarding the level of intrusiveness the client experiences when attempting to assess them. Intrusiveness was a significant issue in two studies where the findings are limited by being observed by a non-participant, which may have influenced the interaction in the room (Elliott, 1985; Castonguay et al., 2010). However, studies employing video assisted recall such as IPR were well suited to reducing the level of intrusiveness for the client as much as possible.

There were issues with the process of client recollection when clients were asked to describe their experiences. It was reported that when interviewed without the aid of video or audio playback of therapy sessions, clients tended to report generalised memories of therapy session instead of recalling specific episodic memories. This is supported by other evidence that suggests retrospective review can be affected by false memories, interpretative bias and self presentation concerns if not handled very sensitively by the researcher (Hyman & Loftas, 1998; Timulak, 2008; McLeod, 2003). Again, it appeared that studies using video assisted recall such as IPR, were more robust in being able to capture client experience that was as close as possible to what they had experienced in-session.

All of the studies included in the review looked at the helpfulness of therapist personal characteristics and interventions, generally measured in terms of observable client and therapist behaviour and verbalisations. In Paulson, Truscott & Stuart (1999), Counsellor
Facilitative Interpersonal Style was rated highly (listening, being non-judgemental and supportive). These findings were generally supported across the studies with therapist acceptance, genuineness, attentiveness and empathic concern, emotional support and being non-judgemental consistently receiving high ratings (Levitt, Butler & Hill, 2006; Simpson & Bedi, 2013; Mohr & Woodhouse, 2001; Paulson et al., 1999; Bedi, 2006; Bachelor, 1995). However, it often appeared difficult to generalise the findings on therapist behaviours and characteristics as client responses to therapists appeared contingent upon contextual and individual factors. Therapist understanding, impartiality and reliability for example were viewed as important by clients but especially when these aspects were missing from current personal relationships.

Therapist interventions were also described by clients as helpful especially when they provided a structure within which clients could achieve a self-reflexive examination of their emotional, cognitive, relational and expressive patterns (Levitt, Butler & Hill, 2006). Some clients liked the structure of therapeutic tasks as they promoted confidence that they could make gains whilst other clients reported initial frustration with therapists who did not provide direct guidance. Some clients reported therapist self-disclosure as helpful (Bachelor, 1995) whilst others reported this as unhelpful (Simpson & Bedi, 2013). This may reflect how individual client expectations and relational patterns may affect the levels of intimacy that clients prefer in the therapeutic relationship.

Measuring what happens in therapy in terms of therapist behaviours and characteristics does not explain the process that determines the differential and contextually bound responses that clients demonstrate. The findings did suggest that therapists may be employing different interventions or activities that represent the same underlying therapeutic intentions due to cultural differences or professional backgrounds, which adds more strength to this argument (Castonguay et al., 2010). Studying subjective perceptions that incorpo-
rate interior elements such as attitudes, values and goals in therapy may provide more suitable variables with which to study client therapy process (Simpson & Bedi, 2013).

The evidence from the findings strongly suggests that clients need to be supported in different ways by their therapists at different times and that it is important the therapist is well attuned and flexible in meeting these needs. This was recognised by some of the studies included in the review where attempts to capture internal therapist and client processes were made. This included the assessment of therapist intentions (Elliott, 1985) and the impact of therapy as experienced by the client (Watson et al., 2012; Timulak & Lietaer, 2011; Llewelyn et al., 1988; Elliot & Wexler, 1994; Elliot, 1985; Castonguay et al., 2010). However, the study of client interior processes was limited by clients being asked to identify their experiences from categories of impacts that had been pre-determined by previous studies. The vast majority of client impact categories that were used in the studies were identified from the previous study conducted by Elliott (1985). This may mean that there may have been a degree of researcher bias that has influenced the labelling of constructs, the design of methods and measures as well as the interpretation of findings.

The studies that included processes of change experienced by the client in session perhaps provide the most valuable insight into the interior workings of therapy. The most commonly identified event impacts included the client gaining a new perspective, attitude or insight, the development of a new understanding of self or others or an increase in self awareness (Bachelor, 1995; Elliott, 1985; Watson et al., 2012; Paulson et al., 1999; Llewelyn, 1988). In several studies, insight or gaining a new perspective was the largest and most internally consistent change factor. This was associated with a therapeutic environment that facilitated client comfort (Bachelor, 1995), emotional support, personal contact and reassurance (Elliot, 1995; Mohr & Woodhouse, 2001). These findings may suggest that the task of therapy is to provide a therapeutic environment that enables the client to feel in control and remain comfortable in the session, yet to be able to express difficult feelings
and explore important issues freely. Clients frequently spoke about focusing awareness on a problem suggesting that the structuring of attention and attending to thoughts and feelings in the present moment is an important aspect of therapy.

Client Self Disclosure (having someone to talk to, telling someone about skeletons in the closet, speaking to someone neutral and feeling safe to say what the client wanted to say) was also rated highly by clients particularly in studies that did not employ predetermined coding schemes (Paulson et al., 1999 and Watson et al., 2012). However, findings demonstrated that meaningful disclosure is also facilitated by the interpersonal relationship with the therapist. Self-disclosure initiates emotional relief and increases the probability of developing new perspectives, which in turn leads to an increased probability of the client resolving their concerns. The remaining categories of helpful client processes included reaching a definition or the clarification of problems (Castonguay et al., 2010; Elliot, 1985; Elliott & Wexler, 1994) and problem solution (Castonguay et al., 2010; Elliot, 1985; Llewelyn, 1988; Paulson et al., 1988). It was interesting to find that in only one of the studies clients mentioned a change in behaviour (Bachelor, 1995) and that a change in attitudes or perspectives was mentioned much more often.

**Interpersonal Context of Therapy.** It is important that the design of studies in the field of therapy process incorporate the effect that each of the participants has on the interactive process. This requires the application of a theoretical framework that includes how clients and therapists respond to each other during therapy. The role of the therapist’s interpersonal style and the therapeutic relationship did emerge as a consistent finding across studies. Clients viewed the therapeutic relationship and its meaning, quality and structure as a central concern. However, many of the thoughts that clients had about the relationship were context specific; for example sometimes transgressing boundaries when therapists broke from professional roles was described as causing distress and at other times as a
helpful way of the therapist showing they cared. The emotional connection was described as a key part of the therapeutic relationship, however clients described that it was important for the therapist to care just the right amount to suit the individual.

Client experiences of helpful aspects were shown by one study, to appear to move along a continuum from interpersonal-affective to task-impact aspects. Two super-clusters of helpful events were identified which included task related events (n=50, sim=.14) and interpersonal related events (n=37, sim = .12) (Elliot & Wexler, 1994). However, the distinction between task orientated and interpersonal may be more of a reflection of the theoretical distinction made by traditional alliance and process experiential therapy theories. It is unclear whether the task/interpersonal distinction is a result of the theoretical interpretations imposed by researchers when categorising client descriptions, or whether this was a real distinction that was experienced by clients. Other research suggests that relationship and technical factors are not easy to separate in therapy and that therapist interventions are indistinguishable from the impact of the relationship (Mohr & Woodhouse, 2001; Bedi, Davis & Meris, 2005).

The approach to studying the interpersonal context of the relationship in the studies tended to label and categorise distinctive therapist characteristics or contributions to the relationship. The studies that employed IPR and investigated sequences of therapy episodes did allow for more consideration of the reciprocal and dynamic features of the interaction. Descriptions of client-identified helpful aspects were compared to pre-determined therapist response and action mode categories (Elliot, 1985). However, this approach did not reflect the flow of the interaction as it occurred between the client and therapist in real time over the course of the whole session.

**Within Session Processes and Change over Time.** The extent to which the studies focused on within session processes varied considerably. The study of within session proc-
esses is particularly important in the attempt to identify the micro-processes of change that take place during therapeutic interaction. Studies tended to either investigate a short sequence of events occurring during a single session or a whole course of treatment retrospectively which made it difficult to compare findings. The unit of analysis ranged from the review of a single ‘mock session’ lasting 20 minutes (Elliot, 1985) to the retrospective review of an 8 session course of treatment (Levitt, Butler & Hill, 2006). Another study involved a telephone interview within 3 weeks of termination of therapy which leads us to question the extent to which it was possible for clients to recall specific moments and experiences as they occurred in therapy (Paulson et al., 1999). Some of the studies also included global client perceptions of treatment and service delivery alongside client perceptions of in-session therapeutic interaction.

The client measures identified by the current review also varied in the extent to which they focused on in-session processes. The SEQ was reported to be regarded a more evaluative measure. The SIS was developed to go beyond global evaluation and asks clients to identify the extent to which each of the event-derived specific impacts is experienced within a session. However, Stiles et al., (1994) found that evaluation aspects were prominent and there was a high degree of overlap between indexes. The predictive validity of the SIS has not been established which suggests that the SIS may be unrelated to outcome and may represent a consumer satisfaction measure rather than a measure that predicts change at the session level (Whiston & Sexton, 1993).

The extent to which the studies were able to investigate change over time also varied considerably. Change was not very often studied over the course of a whole session, due to the intensive nature of the analysis, although segments of change over a shorter time period were analysed using IPR. The comparison of data gathered at different time points during treatment was included. However, the random sampling methods used to identify helpful aspects from client interviews did not allow for the unfolding process of therapy to be ob-
served. Without the use of continuous measures, this was very difficult to achieve and did not appear to have been accounted for by the qualitative methods used by studies selected for review.

Applicability across Therapeutic Modalities and Diagnoses. The findings on the helpful processes reported by clients appear to be consistent with a pan-theoretical model of psychotherapy process (Lambert, 1992). Clients’ understandings of what is important in therapy may be understood as independent of the therapist’s theoretical orientation (Horvath, 2001; Horvath & Bedi, 2002; Horvath & Luborsky, 1993). Studies investigated client perceptions of therapy across a wide range of therapies and counselling approaches including Cognitive Behavioural, Humanist, Behavioural and Psychodynamic Interpersonal approaches, Psychoanalytic and Gestalt therapy. The population samples covered a range of common presenting problems e.g. adjustment issues, anxiety, interpersonal problems, psychosomatic problems, depression, self-esteem and other client concerns. These findings support previous suggestions that the investigation of client-identified helpful events has the potential to inform transdiagnostic and integrative approaches to therapy (Beutler, 1983; Castonguay & Beutler, 2006; Ward, 2000). However, it did appear that the majority of studies excluded participants with serious emotional or mental health problems; just one study recorded the inclusion of clients with psychotic spectrum disorders (Castonguay et al., 2010). Further studies investigating inpatient samples and clients with severe and enduring mental health issues are needed to understand what clients from these populations might perceive as helpful in therapy and whether this differs from clients who present with moderate to mild levels of distress. It was also noted that there was a significant lack of male participants in two of the studies and so it is unclear from these studies the extent to which gender may affect how clients perceive therapy.
Applicability to Naturalistic Clinical Settings. Studies were conducted in naturalistic clinical settings (including private and individual psychotherapy and counselling or university counselling services). They were therefore largely representative of clinical populations that would be seen in everyday practice. Overall, participants were individuals seeking psychotherapeutic input from outpatient services. However, the participants in earlier studies included a large percentage of university students. Elliot’s study (1985) which provided the data for the development of the Therapeutic Impacts Content Analysis System used in subsequent studies (Castonguay et al, 2010), took place in a research lab and recruited university students on psychology courses for ‘mock counselling sessions’ where volunteers were asked to identify a personal problem that they would like to talk about. It was further noted that the study of client perceptions in therapy also provided both the clinician and the researcher with opportunities to engage in productive collaboration; the setting up of a Research Practice Network in one study served as a particularly active example of this (Castonguay et al., 2010).

Links to a Theoretical Framework of Change. Overall, the findings of these studies may confirm what we already suspect is helpful about therapy. Many of the helpful factors identified correspond to current models of therapy. For example, client-identified processes of gaining insight and a new perspective is supported by aspects of Psychodynamic, Cognitive Behavioural and Experiential theories. Many of the therapist characteristics cited by clients such as empathy, warmth and being non-judgemental agree with Roger’s findings on what constitutes the facilitative conditions of therapy (1957). However, the fact that clients perceive these therapeutic elements as helpful, perhaps, provides the most useful source of evidence. The key aspects of change highlighted across the studies include the development of insight/understanding/self awareness, behavioural change/problem solution and reassurance/personal contact.
There have been few attempts to map out the pathway of change in therapy that may involve a string of multiple factors. However, the central finding of Levitt, Butler & Hill (2006) with regard to the structure of the therapeutic environment may provide a useful framework for conceptualising this pathway. Clients overall described a tension between sustaining reflexive exploration of threatening internal processes and the relational dynamics in the room with a tendency to avoid these processes to seek safety. Clients also described employing covert processes with the aim of controlling the direction of the session and drawing therapists’ attention away from threatening topics so that they could avoid difficult emotions. Clients described therapy as a caring and compassionate relationship that promoted reflexivity as important in contrast to symptom focused techniques and interventions. This is consistent with Rennie’s (1992) findings that the encouragement and structuring of reflexivity is the central task of therapy. The alliance was defined less as the presence of individual facilitative attitudes or behaviours than a distinctive therapy climate which was the essential therapeutic agent (Levit, Butler & Hill, 2006). This requires the therapist to monitor the degree of structure needed by clients to engage in reflexive exploration accompanied by the right amount of compassion and positive regard so that clients feel safe when exposing their vulnerabilities. This may help us to understand the mechanism by which therapist warmth, unconditional positive regard and empathy contribute to internal change and therapeutic outcomes for the client (Carey et al., 2012). The warmth, positive regard and empathy that the therapist offers may be seen to having an effect on internal change and perceived as helpful by allowing the client to experience a safe environment in which to explore their problem freely.
Discussion

The findings of the studies selected for review are limited by the extent to which they present overlapping constructs. In several studies, participants were asked to identify the therapeutic impact of helpful events. However, it is not clear how helpfulness and therapeutic impact are distinct from each other, as it stated in the literature that ‘helpfulness’ may be defined as ‘general therapeutic impact’ (Elliot et al., 1982). Overall, the findings have continued to result in the further creation of taxonomies, drawn from different theoretical orientations. This means that the study of psychotherapy process has not been able to move forward towards the clearer identification of change mechanisms. There was little evidence showing designs that were flexible and innovative enough to track the interaction of client and therapist processes as they unfold over time, as previously suggested in the recommendations by Rennie (1992). The current review suggests that a high degree of overlap will always exist between categories as one event will necessarily have several different impacts that vary between clients. Another approach to study design that contrasts with the descriptive categorical approach that has dominated this area of research so far, might be using quantitative continuous measures which may be more closely related to the dynamic, process orientated composition of underlying change mechanisms (Wiseman, 1992). It appears that a wealth of discovery orientated qualitative studies have been conducted and now perhaps there is a greater need for experimental studies that can test hypotheses that are informed by conceptual frameworks of change.

Elliott suggests that the method of Interpersonal Recall (IPR) acknowledges the complexity of experiences described by clients and that resulting taxonomies provide a means of quantifying the important elements. The Interpersonal Recall method employed by the selected studies in the current review has shown that there is further potential in the design to be maximised. However, scales such as the Helpfulness Rating Scale used in IPR (Elliot, 1979, 1975) have so far been presented as ordinal scales and so lack the specificity of
quantitative continuous measures. Overall, it was noted that very few of the studies in the current review employed client rated measures of therapy that were linked to therapeutic outcome measures of change. When quantitative methods were employed, statistical issues were raised when trying to establish associations between helpful and non-helpful events and therapist action variables. For example, the data points taken from helpful and non-helpful events were often non-independent and it was recognised that the high number of correlations performed on the data may have resulted in a Type 1 error. However, the studies often included an insufficient number of ratings drawn from events to conduct more complex multivariate statistics.

**Strengths and Limitations of Current Review**

It was noted that many of the measures identified as part of this review were from the same author who is a leader in the field of Process Experiential Psychotherapy research. It is therefore possible that the findings may have been slightly biased towards this theoretical interpretation. The selected studies investigated client perceptions of helpfulness by using a diversity of constructs (perceived alliance, client experience and helpful aspects). It was a challenge to achieve the right balance between providing a comprehensive and yet detailed review that could provide some synthesis of the findings. It is therefore possible that the review may not have included all of the studies that have focused on aspects, events and features that clients experience as helpful. There are further studies on ‘good moments’ and other event types that may have warranted inclusion. There are also new and interesting studies investigating dialogic exchanges between client and therapist dyads using methods such as conversational transaction analysis that may have added to the findings of the current review (Ribeiro et al., 2013). The current review also excluded the consideration of unhelpful factors. However, it has been suggested that helpful and hindering
aspects of therapy do not represent distinct categories and one cannot be considered without the other (Paulson et al., 1999).

**Concluding Summary**

The current review supports the suggestion that client-identified helpful processes during therapy can be used to improve the effectiveness of treatments (e.g. help clinicians develop awareness of clients’ internal experience and adapt the therapeutic relationship to individual needs). One possibility for future research could be to include more intensive and in-depth process studies that look at the relative importance of helpful aspects and their relationship to immediate and long-term outcomes within an overarching theory of change. This requires the further design of novel experimental studies that employ theoretically sound methods and measures that are client-orientated and internally driven, designed to capture change over time and that may be applied to the dynamic interpersonal context of therapy. The current review has made some helpful suggestions on what the future priorities of research into the perceived experience of clients in therapy might be and how they might be achieved.
Paper 2: Client Perceptions of Helpfulness: A Therapy Process Study

Word count: 11,242 (excluding references)
The following paper has been prepared for submission to the ‘Journal of Consulting and Clinical Psychology’ in accordance with their requirements (Appendix 2). The authors will be Alex Cocklin, Dr. Warren Mansell and Dr. Sara Tai.
**Paper 2: Client Perceptions of Helpfulness: A Therapy Process Study**

**Objective:** This study devised a novel methodology with quantitative measures to capture clients’ self-reported perceptions of what was helpful about the therapeutic environment created by the therapist during a single session of transdiagnostic CBT - Method of Levels Therapy. The study employed process measures of the client/therapist experience, informed by Perceptual Control Theory and standardised measures of the therapeutic relationship (Session Rating Scale (SRS). We predicted that helpfulness would involve clients being able to talk freely about an important problem whilst experiencing a degree of difficult emotions; and yet, importantly, feeling in control over this process. This experience may be more important than believing the therapist to be empathic and knowledgeable, and allow them to think and talk about their problem from more than one perspective, leading them to generate their own solutions. **Method:** Eighteen therapy sessions were video recorded, clients (N=18) and therapists (N=7) were asked to rate a twenty-minute section of therapy at two-minute intervals using repeated measures (ten ratings using a Likert scale) on separate occasions. A mixed-effects multi-level analysis was used to test for correlations between perceived levels of helpfulness and client process variables (perceived control, ability to experience emotion, talk freely and to see new perspectives). **Results:** Multi-level regression revealed that client perceived control ($b = -0.39, p = 0.027, 95\% CI (.05, 0.73)$) and the ability to talk freely ($b = 0.30, SE = 0.11, p = 0.005, 95\% CI (.09, 0.51)$) predicted client rated helpfulness. **Conclusions:** The current study provides a valid and reliable method for investigating continuous measures of process that are client orientated, internally driven and dynamic. The client’s perceived sense of control is shown to be an important process during therapy that is closely related to the client’s perceptions of helpfulness, the ability to talk freely in session and see their problem in new ways.
Keywords: therapeutic alliance, client perceptions, helpfulness, perceptual control theory

Introduction

Client reports of experiences during therapy offer valuable information to researchers and clinicians on how to maximise the effectiveness of psychotherapy (Castonguay et al., 2010; Bedi, Cook & Domene, 2012; Lambert & Cattani, 2012). It seems very likely that events described by clients as being helpful also incorporate the active ingredients that are closely related to key processes of change. Clients may therefore be the most valuable source of information that we can learn from on what makes therapy therapeutic. It is also possible that investigating how clients perceive therapeutic interactions may provide us with a greater understanding of intra and interpersonal processes of change (Norcross, 2011). The research questions addressed in this paper included i) whether it was possible to design and test a valid and reliable novel method that used client-orientated quantitative measures of client perceived process over the course of a single session of therapy ii) to see how Perceptual Control Theory (Powers, 1973) could be applied as a theory of change to explain the mechanisms operating as part of therapeutic interaction iii) to explore the extent to which client perceived control over what is happening in the session is experienced as helpful or ‘therapeutic’ by the client.

Clients perceive the therapy relationship in complex and multidimensional ways; this makes it necessary to focus on within patient processes if we are to make therapy and therapeutic relationships more effective for individual clients in clinical settings (Falkenstrom, Granstrom & Holmqvist, 2013). This is supported by findings that show client perceptions not only impact significantly on outcome but may also be more strongly related to success than the therapist’s perspective (Horvath & Bedi, 2002; Bedi, Davis & Meris, 2005; Horvath & Symmonds, 1991).
It has been widely recognised that client perceptions of therapy are distinct from therapist and observer perspectives. However, the majority of research on relational factors in psychotherapy has focused on therapist’s experiences and assessments (Bachelor, 1995; Ward, 2000). This leads us to wonder why the study of client perspectives has not occupied a more central position in research on the therapeutic relationship and working alliance (Bachelor, 1991; Hatcher, Barends, Hansell & Gutfreund, 1995; Horvath, 1994; Tichenor & Hill, 1989; Fitzpatrick, Iwakabe & Stalikas, 2005). Many of the variables that are identified by clients as important in therapy have not been given much consideration by researchers perhaps because they do not lie within the frameworks of traditional alliance theory (Bachelor, 1995).

The few studies that have looked specifically at client perceptions of therapy have generated a wealth of descriptive information on the phenomenological experience of the client. However, many of the numerous categorical labels and taxonomies that have been created are still lacking a theoretical basis with which to explain the process of change (Timulak, 2010). The linking of client-identified experiences to mechanisms of change has been suggested to be one of the next steps for psychotherapy research; so that we are able to apply our understanding of how clients experience therapy to maximise therapeutic effectiveness across modalities.

The current study included: a) the design and pilot of a novel method using quantitative process measures to capture client perceptions of therapy as they unfold during a single session b) the utilisation of this novel method in an experimental study within a naturalistic clinical setting to test hypotheses about therapy process. The experimental method was specifically designed to address methodological limitations of previous studies on client perceptions of therapy. This included the use of ‘helpfulness’ as the main construct instead of alliance to ensure that measures were client oriented. The measures were designed to capture interior client processes and be dynamic in an interpersonal sense through the ap-
lication of Perceptual Control Theory (PCT; Powers, 1973); a framework that we propose is useful for understanding not only what is helpful in therapy but also how and why. A PCT framework allowed for the investigation of therapy processes within the context of a specific theory of change that may also be applied across disciplines. In the following introduction, the rationale for studying client perceptions of therapy and the current literature in this field is presented along with the limitations of previous studies. It is then shown how Perceptual Control Theory (Powers et al., 1960; Powers, 1973) might be applied to address these limitations and further develop the study and practice of effective psychotherapy.

1:1 The Importance of Client Perceptions in Therapy

Client perceptions of the change process within therapy are already fundamental to informing treatments, theories, the organisation and delivery of services in many settings (Levitt, Butler & Hill, 2006). Policy guidelines on promoting patient choice, service user feedback and person centred care all support the notion that incorporating client perspectives is of ethical, social and economic importance (Department of Health and NHS Institute for Innovation and Improvement, 2011). The current drive to encourage clinicians to carry out feedback informed treatment is backed by evidence that suggests using measures of progress and the therapeutic alliance may double the effectiveness of therapy while decreasing the costs, levels of deterioration and drop-out rates (Miller at al., 2006). As a consequence, client satisfaction measures, such as the Client Satisfaction Questionnaire (Larsen et al., 1979; Greenfield, 1983), have become popular in clinical practice. However, these measures have been limited in the extent to which they reflect the phenomenological experience of the client and capture therapeutic processes. Client satisfaction tends to be measured in terms of standardised criteria and static components such as therapist characteristics and behaviours rather than the change that was experienced by the client. This
perhaps ignores the fact that different clients may find different therapist responses helpful at different times. It is evident that the detailed study of how the client perceives their in-session therapy experience is important however, it also appears that there is some way to go before these findings can be applied to research and practice in a meaningful way (Hill, Churi & Bauman, 2013).

The subjective experience of the client has been a key feature in Humanistic and Experiential approaches to therapy for a long time (Patterson, 1984). Carl Rogers first identified that the client’s perception of the ‘facilitative conditions’ that are offered by the therapist are means to understanding the mechanisms of change in 1951. Rogers conducted a series of studies to investigate the relationship as experienced by the client by using diaries and open-ended interviews. This work was pivotal in generating curiosity amongst researchers about what clients find helpful regarding their experiences in therapy and why (McLeod, 2003). A number of different research strands investigating client-identified factors in therapy have developed including studies on the alliance, therapeutic relationship and process orientated studies using the ‘events paradigm’ in Person Centred Counselling. The following section presents an overview of how client perceptions of therapy have been studied in the Alliance literature which represents the largest body of evidence on relational factors in therapy. A more extensive review of studies investigating client perceptions of the therapeutic environment across disciplines can be found in Paper 1: Client Perceptions of Helpful Therapy Process: A Systemic Review.

1:2 Client Perceptions of Therapy in Alliance Research

A huge number of studies have looked at the association between client ratings of the alliance and outcomes. It is established that rater-perspective is a key moderator of the association between alliance/relationship factors and outcome (Norcross, 2011). However, the specificity of findings from research on alliance has been limited by the use of global
measures developed from the researchers’ theoretical understanding of the relationship and pre-existing observer measures (Bachelor, 1995; Elliott & James, 1989; Orlinsky & Howard, 1986). The standardised scales most commonly used to capture client ratings of the alliance/relationship include the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989); California Therapeutic Alliance Rating Scales (CALPAS; Gaston & Marmar, 1994); Pensylvania Scales (PEN; Luborsky et al., 1983) and the Vanderbuilt Scales (VTAS; Hartley & Strupp, 1983). These measures have been shown to be strong predictors of outcome and to measure a series of common underlying features of the alliance such as the quality and strength of the alliance and the interpersonal or affective bond between client and therapist (Martin et al., 2000; Fenton et al., 2000). However, it is unclear to what extent these alliance measures are representative of clients’ own perceptions of the relationship and their experiences in therapy.

Client rated measures in alliance research have been limited by focusing on a conceptualisation of the therapeutic relationship based on static components rather than client-orientated process (Elvin & Green, 2008). The pan-theoretical alliance construct proposed by Bordin (1979) emphasises three key components: agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings (Ardito & Rabellino, 2010). However, it has been suggested that the relational factors identified by clients do not reflect the same components of the dominant alliance theories. For example, Hatcher and Barends (1999) and Levitt, Butler and Hill (2006) found that clients mention theoretical alliance constructs such as collaboration and mutuality much less frequently than therapists. This has led to some authors suggesting that the alliance has perhaps outlived its usefulness as a construct for investigating the therapeutic environment (Safran & Muran, 2006). Clients have identified change processes (for example developing insight, awareness and reflexivity through exploration and self-disclosure) that have not been covered by traditional conceptualisations of the alliance.
(Levitt, Butler & Hill, 2006). It appears that the client’s perspective is less likely to be defined by theoretical views and may in fact be much better placed to judge what may act as healing factors (Murphy, Cramer & Lillie, 1984). Process measures need first to relate directly to the internal experiences of the client and therapist as they occur in the session if they are to represent valid constructs (Llewelyn & Hardy, 2001). Until now, the majority of client ratings have also tended to be collected at fixed time points over the duration of treatment, for example at the beginning, middle and end (Hardy, Cahill, Barkham, 2007). However, this does not allow for enough data points to provide a detailed analysis of within subject effects and to see how client processes unfold over the course of a therapy session.

Alliance studies have often focused on client ratings of therapist behaviours and characteristics such as warmth, genuineness or respect and empathy (Friedlander & Tuason, 2000; Bohart, Elliott, Greenberg & Watson, 2002). This may stem from Roger’s primary concern with the client’s perception of therapist attitudinal qualities (1957). However, it has now been recognised that clients respond in unique and individual ways to therapist characteristics such as empathy (Greenberg et al., 2001; Elliott et al., 2011). Patterns of the relationship also vary between individuals and within subjects over the course of therapy in a non-linear fashion (Safran & Muran, 2000).

Novel designs that employ more sensitive client-orientated measures are needed to capture the process of therapy experienced by the client as it unfolds over time during the dynamic interaction between client and therapist. Overall, the methods and measures in alliance research have provided a means of capturing quantitative data but have fallen short in the extent to which they are i) truly client-orientated ii) able to reflect the internal processes occurring as part of the client’s experience iii) reflect the dynamic interpersonal context of therapy and iv) fit within an overarching theoretical framework of change.
**1:3 Client Perceptions of Helpfulness**

Client ratings of helpfulness have been proposed as an alternative construct to the alliance that reflects the subjectivity of the client’s perspective. The construct of helpfulness can be construed as a pan-theoretical factor that describes the therapeutic climate as it is created by the therapist and perceived by the client in session. This provides a useful way of understanding the association between therapeutic process and outcome (Paulson, Truscott & Stuart, 1999). The helping process has been employed in a number of studies to pinpoint the active ingredients of therapy sessions which contribute to change (Gelso & Carter, 1994; Greenberg & Pinsof, 1986; Gurman, 1977; Rogers, 1951; Bachelor, 1995; Castonguay et al., 2010.) A significant overlap may therefore been seen to exist between client perceptions of helpfulness, the therapeutic relationship and common factors in therapy (Ward, 2000). The study of helpfulness including helpful events, aspects and factors in psychotherapy process research is discussed in more detail in Paper 1.

**1:4 Client Perceptions of Therapy in Person Centred Counselling**

Client perceptions of therapy have played a much more central role in Person Centred Counselling and Experiential Process therapy than in research on the alliance (Ward, 2000). The methods and measures used have generally been more client-orientated and have focused more intensively on process. A number of studies have also employed the construct of helpfulness. Qualitative methods have been employed to gather client descriptions of helpful events or factors using semi-structured or open-ended interview (sometimes using audio or video-taped session material to aid recall). A list of client-identified helpful events and impacts have been identified from this research, which appear to map on to aspects of therapy across different disciplines (Timulak, 2007). However, the generalisability and the practical application of the findings have been limited by the diversity of constructs, measures and methodologies. The extent of the intrusion into the ongoing flow
of therapy has also presented ethical dilemmas and has made it difficult to capture client experiences. In response, many of the studies have focused on client reports of therapist behaviour or spoken turn as the unit of analysis. However, client and therapist behaviours that are observable in session may not reveal the full extent of the internal experience that is driving the therapeutic interaction. There are a number of covert therapist and client processes that go on during therapy sessions that are not accessible to an outside observer of the interaction (Rennie, 1992). Different clients also show a predisposition to different tasks and goals in therapy as a meaningful expression of their developmental histories and cognitive schemas (Safran & Muran, 2006). Whereas therapists are likely to be using different processes or interventions to express the same intentions due to differences in personal style, culture or experience (Castonguay et al., 2010). Studies that have used Interpersonal Process Recall (IPR, Kagan, 1984) have investigated significant events in therapy using a video recall procedure designed to capture the micro-processes of therapy. However, it appears that they tend to focus on short segments of therapy rather than the whole session due to the intensive nature of the analysis. Many of the existing studies also use measures that include ordinal data instead of quantitative measures that are capable of hypothesis testing (Timulak, 2010).

1:5 Perceptual Control Theory: A Useful Framework for Understanding Therapy

The current study proposes that Perceptual Control Theory (PCT) offers a useful framework for understanding what is helpful in therapy. PCT allows us to understand the therapeutic alliance/relationship from the client’s perspective in a dynamic sense that is anchored in the present and internally driven. PCT (Powers et al., 1960; Powers, 1973) originates from the field of engineering and has the benefit of not being allied to a specific therapeutic orientation. PCT can therefore be applied across disciplines and research fields whilst providing an integrating theory of human functioning (Higginson, 2011). As PCT is
an open-ended theory that focuses on the client’s perception of their intrapersonal and interpersonal environment; it does not need to impose a static model of the therapeutic relationship. The theory also allows for the quantitative measurement of process variables and the subsequent testing of hypotheses using scaled items that capture continuous client and therapist perceptions.

PCT states that all individual actions are goal-serving attempts to control experiences. This means that people adapt to their everyday environments by regulating their perceptions of what is happening around them. The process operates through a hierarchy of negative feedback control systems that detect the discrepancies between a ‘just right’ internal standard of how the person would like or needs things to be (e.g. a goal or value) and what the individual perceives to be happening. This guides the individual’s interaction with their environment so that they may adapt to change and learn more efficiently. Distress is caused when a conflict between goals arises which is signalled by an emotional response (Mansell, 2005; Powers, 1973).

Through the application of PCT, the therapeutic relationship can be seen to be a highly specific cognitive-interpersonal process (Mansell, 2012, p.261) during which the balance of control affects the way the client and therapist relate to their own thoughts and feelings. Matches and mismatches in client and therapist goals have a significant impact on how the therapeutic relationship unfolds (Carey et al., 2012). The conflict that arises between therapist and client goals in therapy serves as a potential threat to the client’s experience of control in the session. The level of control that is experienced by the client will then affect the extent to which they feel able to talk freely about their problem, experience emotion and broaden their awareness in session, which we believe are the key processes that result in therapeutic change (Mansell, Carey & Tai, 2012).

The full exploration of the client’s problem enables them to broaden their awareness and focus on areas of conflict so that they may problem solve effectively. Clients also con-
sider the freedom to self disclose as a key component of the therapeutic relationship that has been shown to be closely linked to outcome (Farber, 2004). This is emphasised by the questioning used in Method of Levels Therapy (Mansell, Carey & Tai, 2012) which is a transdiagnostic form of cognitive therapy informed by PCT, so that background thoughts may be brought into awareness and explored in the process of resolving conflicts. The extent to which the client feels able to explore their internal experience and talk about their problem freely has been shown to predict change following a therapy session over and above the client’s perception of the therapeutic relationship (Carey et al., 2012). In another study, a rating of therapist adherence and a client rating of working alliance predicted client readiness to talk about their problem at the beginning of the next session (Kelly, 2011).

The central task of therapy is to enable the client to feel in control whilst being supported to tolerate a degree of uncertainty and emotional distress so that they may broaden their awareness of internal conflict (Carey et al., 2012). This interpretation is supported by Levitt, Butler and Hill in their study of client perceptions of therapy (2006). Clients overall described a tension between sustaining the reflexive exploration of threatening internal processes and the relational dynamics in the room with a tendency to avoid these processes to seek safety. Clients also said that they employed covert processes with the aim of controlling the direction of the session and drawing therapists’ attention away from threatening topics so that they could avoid difficult emotions.

From a PCT perspective, having a sense of control, the opportunity to experience emotion and to talk freely are key elements that therapists need to provide in creating the most therapeutic climate to foster change (Carey 2006, 2008; Mansell, 2009; Carey et al., 2012). The therapist will pursue their own goals (to maintain a good therapeutic relationship, be adherent to the therapeutic model, to show warmth and empathy) by various means. However, ultimately, they are striving to facilitate the best balance of control and exploration for the individual client. In this way, the therapist creates an intrapersonal (cognitive) and
interpersonal (social) environment balanced around the perception of control that can be tailored to the needs of the individual (Mansell, 2012).

The client and therapist can be seen to operate as two control systems that interact and respond to each other via their individualised perceptions of each other and their own internal experiences (Carey et al., 2012). This is further illustrated by the model described by McCabe & Priebe (2008) that describes how care professionals and clients balance contrasting personal goals during their interactions.

Whilst the establishment of warmth and trust are important goals in therapy, from a PCT perspective they are a means to an end; therapist goals to be warm and empathic or to develop trust in the relationship are designed to help the client feel in control and able to explore their problem freely (Carey et al., 2012). The way in which the client responds to the therapist in session reflects the extent to which the client needs to exert control over reducing the gap between a number of goals and their perception of what is happening. At times, when a client is feeling out of control (vulnerable, angry or frustrated) during therapy, client attempts at ‘arbitrary control’ may occur as the client seeks to restore a sense of equilibrium and regulate their emotions. Examples of client arbitrary control during therapy might include attempts to conceal hidden feelings through changes of topic and moments of disengagement or resistance. A therapist who attempts to pursue a different agenda to the client may also exhibit arbitrary control and may fail to respond to important client cues. This in turn may further challenge the client’s sense of control and lead to client resistance or even a rupture in the relationship.

A PCT framework helps us to map out the contribution of therapist and client factors along a pathway to change. There is however, a lack of research evidence that identifies whether the combination of these therapeutic factors (control, ability to experience emotion and talk freely) are subjectively experienced as helpful by clients themselves. The current study aimed to address this issue and to investigate whether clients’ perceived levels of
control, emotion and being able to talk freely were more closely related to client ratings of helpfullness than a standardised measure of therapeutic relationship using an adapted version of the Session Rating Scale (Duncan et al., 2003).

**Primary and Secondary Hypotheses**

Hypotheses were made that predicted an association between client ratings of perceived therapist helpfulness and client perceived levels of control, the ability to talk freely and the opportunity to focus on salient emotion. The primary hypotheses for this study were the following: H1) client ratings of perceived control during therapy will be positively correlated with perceived helpfulness H2) client ratings of perceived opportunity to talk freely will be positively correlated with perceived helpfulness H3) client ratings of perceived opportunity to focus on emotion will be positively correlated with perceived helpfulness H4) clients’ perceived levels of control, opportunity to experience emotion and to talk freely will predict perceived helpfulness over and above an established measure of the therapeutic relationship i.e. the relationship item on the Session Rating Scale (Duncan et al., 2003).

Secondary research aims were to compare client and therapist ratings of perceived helpfulness and to explore the client’s capacity to talk and think about a problem from different perspectives. From the qualitative data collected, we also anticipated being able to track client and therapist goals at each time interval.
Method

The current study was based upon a single case series design, which is well suited to psychotherapy research (Barkham & Mellor-Clark, 2000). Single case studies usually include the repeated collection of quantifiable data on a single clinical case to understand within subject variability and the causes of this variation (Morely, 2007; Barlow et al., 2008). However, the findings may be replicated over a number of cases to form a case series which allows investigation of the ‘intra-individual process of change’ across a single session of therapy and the comparison against other subjects (Hoffart, Oktedalen, Lang-kaas & Wampold, 2013).

The current design takes inspiration from time-dependent observational methodologies used in research on social referencing and interpersonal emotion regulation (Simons & Parkinson, 2009). The video recording and subsequent rating of interactions between partners in a close relationship has been shown to provide an effective means of obtaining self reports of perceptions and emotions experienced during the interaction (Gottman & Notarius, 2000). Video-assisted review using helpfulness ratings has been shown to be a valid method of studying the experiences of clients and therapists during therapy sessions (Hill et al., 1994; Elliott: 1985, 1986; Hill et al., 1992; Kivlighan, 1990; Thompson & Hill, 1991). This method enables clients to provide subjective data about what happens in therapy without the session being interrupted. Client and therapist helpfulness ratings, therapist intentions and client reactions have been shown to be highly consistent between sessions and reviews, as long as review sessions are held within two weeks (Hill et al., 1994; Katx & Resnikoff, 1977). These findings suggest that the stimulus of the video is enough to enable participants to re-experience sessions.

Further findings from studies using the method of Interpersonal Process Recall (IPR) (Kagan, 1984) support the valid use of video assisted recall to investigate therapy process. IPR has been used to analyse client experiences of therapy (Levitt, 2001; McLeod, 2001;
The current study differs from the majority of previous IPR studies by covering the course of an entire session and including quantitative measures of process that test theory-driven hypotheses about the process of change.

**Ethical Considerations**

The research was approved by the Greater Manchester Central Ethics and the local R&D Committees (ref: 13/NW/0366). Copies of the approval letters are available in Appendices 3 and 4. Client participants were given at least a week to consider their participation and were told that the research would in no way affect their normal treatment. Clients were first approached by a member of the primary care staff team, so that they did not feel under any pressure to participate. Clients were given a copy of the Participant Information Sheet to read in their own time. This detailed the procedure of the study, the level of their involvement, confidentiality and the benefits and risks of participation to the client (Appendix 11). Clients were also made aware that participation was voluntary and that they could withdraw at any time. Written consent was collected from participants by a member of the service staff team using a consent form (Appendix 10). Written consent was also provided by therapists using a consent form by the chief researcher (Appendix 12).

**Participants**

Seven therapists participated in the study from the same primary care service in Salford. Six of the therapists were female and one was male. They were all qualified in delivering psychological therapies and had varying levels of experience. One therapist had just qualified as a Clinical Psychologist, another therapist was a qualified Mental Health Nurse with training in Psychodynamic and Cognitive therapy, the remaining therapists had all completed training to be a Psychological Wellbeing Practitioner. The length of service in mental health services ranged from 20 to 5 years. Five therapists described their main theoretical
orientation as being within the cognitive behavioural tradition and two therapists reporting a preference for Psychodynamic therapy. The therapists were initially approached by the Service Manager who informed them about the study and distributed a participant information sheet (Appendix 11).

Client participants were recruited via the participating primary care service. A target of 23 client participants was identified for recruitment, in order to estimate a correlation coefficient of 0.5 (medium effect size) between the explanatory variables and perceived helpfulness with 80% power at a significance level of 0.05. The 2-minute measures were recognised as not being independent within person, and so this was reflected in the number of participants recruited. Clients were included if they met the following criteria: in treatment at the participating primary care service, who could identify a problem that they would like to work on and met service criteria for mild/moderate depression or mild/moderate anxiety disorder on GADS-7 (Spitzer, Kroenke, Williams & Lowe, 2006) and PQH-9 (Kroenke, Spitzer & Williams, 2001), with sufficient English language skills to understand the therapist and the materials. Clients with current suicidal intentions, severe self-injury, psychotic symptomology, current substance dependence, organic brain impairment (e.g. dementia) were excluded from the study.

**Measures**

**The following battery of measures were used:**

i) *The Session Rating Scale* (SRS, Duncan et al., 2003) was selected as a brief measure that represented a standardised measure of the relationship

ii) Novel client measures were designed to measure degrees of client perceived helpfulness and the components of therapy process that had been identified as important by the current study (perceived control, talking freely, experience of emotion and ability to see new perspectives). Therapist novel measures were included to capture therapist’s perceptions of the extent to which they were being helpful and their level of adher-
ence to the model. Finally, the Patient Health Questionnaire Depression Scale (PHQ9; Kroenke, Spitzer, & Williams, 2001) and the Generalised Anxiety Disorder Questionnaire (GAD7; Spitzer, Kroenke, Williams, & Lowe, 2006) were used as symptom measures, primarily to describe the sample and to track levels of distress.

**Standardised Measure of Relationship: Session Rating Scale (SRS)**

The Session Rating Scale (SRS, Duncan et al., 2003) was developed as a clinical tool for therapists to use in everyday practice. It is an ultra brief measure designed for practical use. The SRS has been shown to have a moderate relation to the gold standard measures of the relationship such as the Working Alliance Inventory (Horvath & Greenberg, 1989) and the Revised Helping Alliance Questionnaire (HAQ II; Luborsky et al., 1996). It also has good test-retest reliability ($r = .64-.70$) convergent validity with the HAQ II (.39-.44) and feasibility (participant compliance of 96%) according to Duncan et al., (2003). The SRS is based on Bordin’s description of the alliance (1979) and is supported by evidence that suggests it represents the single underlying factor of the ‘strength of the alliance’. The items included i) a measure of the relationship (feeling heard, understood and respected: Not at all vs. Completely), goals and topics (whether the client worked on and talked about what they wanted to: Not at all vs. Entirely) and the approach of the therapist (whether it was a good fit for the client: Not at all vs. Completely). The measure is usually administered post-session and so it was adapted to be administered at two minute intervals, dropping the last item which asks the client if there was anything that was missing overall from the session.

The novel client and therapist ratings were novel measures that were designed for the current study. The Likert scale format with bipolar adjectives at each end was adapted for use from the format of the SRS (Duncan et al., 2003). The wording was changed to reflect the components of therapy that were being investigated as part of the current study. The
measures were piloted with a single client and several therapists before administration to ensure that they could be clearly understood and used reliably.

**Novel Client Ratings**

Five process items were presented to the client as a series of bipolar Likert scales, labelled with adjectives at each end (Appendix 6). These included a measure of i) the extent of perceived therapist helpfulness (Not helpful at all vs. Extremely helpful) ii) the client’s perceived sense of control over what was happening in therapy (No control at all vs. Complete Control) iii) the client’s perceived ability to talk freely about their problem without filtering what first came to mind (Not able at all vs. Entirely Able) iv) the client’s perceived ability to experience emotion connected to the problem (Not able at all vs. Entirely Able). All of the items were presented as a series of 10 cm lines on a single page with the standardised measure of relationship (Session Rating Scale, SRS) at the bottom, making a total of eight measures for the client to complete at each time interval. Clients completed these items as repeated measures for every two minute section of the therapy session watched on video.

**Therapist Ratings**

The following two items were presented to the therapist as 10cm Likert scales: a measure of i) the extent of helpfulness that the client experiences, as perceived by the therapist (Not helpful at all vs. Extremely helpful) and ii) a measure of the therapist’s perceived level of adherence to the therapeutic model (Method of Levels). Three further items from the SRS were presented on each page at the bottom, making a total of 5 measures to be completed by the therapists for every two minute section of the video recorded therapy session (Appendix 7). The therapist rating session was held separately to the client rating session. The wording of the items on relationship, goals and topics and the therapist’s approach...
were adapted from the Session Rating Scale (Duncan et al., 2003) to provide a standardised rating of the alliance from the therapist’s point of view.

**Symptom Measures**

The *Patient Health Questionnaire Depression Scale* (PHQ9; Kroenke, Spitzer, & Williams, 2001) and the *Generalised Anxiety Disorder Questionnaire* (GAD7; Spitzer, Kroenke, Williams, & Lowe, 2006) were used as symptom measures. The PHQ9 is a reliable and valid brief measure of depression severity that is commonly used in guiding treatment decisions and in research. The measure consists of 9 items with a total possible score of 27. A score above a threshold of 10 indicates the threshold for clinical intervention. The GAD7 is a standardised measure of anxiety related disorders including post-traumatic stress disorder that has good psychometric properties (Spitzer et al., 2006). The GAD7 is a 7-item measure with possible scores ranging from 0-21, with a threshold of 8 indicating the threshold for a clinical intervention. Client symptom scores (PHQ-9 and GAD-7) were calculated at three time points; Time 1 (T1) at the point of referral, Time 2 (T2) at start of the rating session and Time 3 (T3) prior to discharge (Table 1).

**Therapist Adherence**

To establish a baseline adherence level for each therapist, two raters from within the research team rated therapist adherence to the Method of Levels therapy model using the Method of Levels Adherence Scale (MOLAS V2) and the Cognitive Therapy Scale Revised (CTS-R). The therapists were rated on both of these measures so that the scores could be seen within the context of the therapy model being used (MOL) and the wider context of Cognitive Behavioural Therapy (CBT). The CTS-R is a 12-item scale to assess competence of therapists conducting cognitive therapy with good reliability and internal consistency (Blackburn et al., 2001). The Likert scale items are scored from 0 (non-
adherence) to 6 (very high skill). For the purposes of the current study, items 1 and 12 were omitted as agenda setting and homework were not relevant to the sessions being recorded for research. The MOLAS (V2) is a validated six item measures that is based on the format of the CTS-R (Mansell, Carey, Bird, Tai, Mullan & Sprat, 2011). Please see Appendix 8 for the full range of items on which therapists were assessed. Ratings were based on review of the video material collected. One video per therapist was selected at random by the chief researcher to be rated. Inter-rater reliability for adherence was also calculated using Cohen’s Kappa. The final scores for therapist adherence from raters 1 and 2 are included in Appendix 16. The level of inter rate agreement for therapist scores on the MOLAS was .58 and .60 on the CTS-R which represents a good level of inter-rater agreement. The majority of the item scores that were not agreed upon between raters were within a single point of each other on the scale.

Supervision and Training

This study was designed with the intention of establishing a Practice Research Network (PRN) that would involve collaboration between researchers and clinicians in an active primary care setting (Castonguay et al., 2010). This involved recruiting therapists who were active in clinical work and videotaping therapy sessions within the normal clinical setting of the primary care service. A network of participating professionals was established that included academics, researchers and clinicians.

All of the therapists selected for the study attended an initial workshop day in Method of Levels Cognitive therapy (MOL) run by experienced qualified clinicians. Throughout the study, a further series of training workshops (N=4) and peer supervision sessions (N=4) were held. During these sessions the therapists also completed ratings of therapy video tapes using measures of adherence and helpfulness which gave them further opportunities to review and reflect on their own practice. The chief investigator attended a
weekly supervision session for researchers and clinicians involved in MOL related projects. The therapists participating in the study received a regular newsletter updating them on the progress of the study and to enhance the collaborative spirit within the team. The chief researcher visited the participating service on weekly basis over a period of four months and sat within the team to further good research/practice links.

**Procedure**

Clients met with a therapist at an arranged appointment and first completed service measures of risk and distress. The therapist then conducted a 30-minute session of MOL therapy which was video-recorded. There was a five-minute period at the beginning and five minutes afterwards to bring the session to a close. The therapist then arranged a time for the client participant to attend a session to review the therapy video and complete ratings with the researcher on another day.

Clients were asked to complete risk and distress measures before commencing with the ratings session. The client was then asked to watch the video of the session on a laptop. The researcher read through the measures and offered to answer any questions. It was made clear to the client that their responses would not be passed on as feedback to their therapist. The researcher paused the video playback every two minutes and asked the participant to complete the series of measures. The researcher asked the participant to pay attention to any subtle changes in the measures in-between sections. They were asked to think carefully about how they had thought and felt at the time. The researcher then ended the session by going through confidentiality and any other client concerns. Clients were thanked for their participation and asked if they would like to receive a further information sheet on the results of the study at a later date.

A time was arranged with the therapist to review the video recording of the therapy session on a separate occasion from the client. The therapist was asked to complete ratings of
each two-minute section of the session. Before the ratings began, the therapist was asked to focus on what they thought was most helpful for the client and to resist the urge to focus on what they would like to have changed about how the session was conducted. It was made clear that their comments would remain confidential and would not be passed on to clients or any other staff at the primary care service. The ratings of clients were kept confidential and were not passed on to therapists however, clients often chose voluntarily to engage in informal discussion with therapists about their participation in the research project. Finally, a short questionnaire was distributed to the therapists involved, asking for their reflections on their participation and how this might have informed their practice (Appendix 14).

**Piloting Phase**

Piloting of both phases of the design was carried out. This was initially with two pairs of therapists not participating in the study and then with two participating therapists prior to commencement. Feedback on the measures and the procedure of the design was collected and further amendments were made. This included reducing the length of the recorded therapy session from 30 to 20 minutes so that participants did not become weary of completing the measures. The wording of the idiosyncratic items was changed so that their meaning was more accessible. Headphones were introduced to increase the sense of privacy for therapists and clients completing the ratings. Informal service user feedback was also provided from a community liaison group from a single representative via interview regarding the acceptability of the measures and the design. This helped to inform the distress protocol that was included in the ethics proposal and led to the incorporation of a short de-briefing session after the ratings for clients and therapists.
Statistical Analyses

A descriptive analysis was conducted on the client data in SPSS (2007). This included histograms, box plot and stem and leaf graphs for each of the scores on client items. Overall, the data showed a non-normal distribution with a negative skew (the mass of the distribution was concentrated on the right). The data was found to be significantly skewed using the command *sktest* in the statistics programme Stata (2011). The descriptive statistics also revealed that there was sufficient variation in the sample scores for a multi-level analysis to be conducted. This follows guidelines set out by Heck & Thomas (2009) that multi-level modelling requires more than 5% variation in outcomes across groups (in this case across subjects).

Data collected from therapist and client ratings were entered into Stata in long format so that a multi-level longitudinal analysis could be conducted (Rabe-Heskeths & Skrondal, 2008). The statistical analysis was designed to account for the longitudinal data made up of repeated measures at different time points nested within subjects. The structure of the data suggested that a two-level mixed-effects model was most suitable to capture individual change over time within the context of the sample.

The statistical analysis was planned in line with the research question informing the current study (Singer & Willett, 2003). Multi-level modelling techniques allow for the incorporation of substantive theory about change processes into repeated measures designs (Heck & Thomas, 2009). The current analysis therefore aimed to use a multi-level analysis to deconstruct the proportion of variance in outcomes on the client process measures, so that a multifactor pathway of change occurring in session could be identified. A linear mixed-effects model was used in the analysis to explore the hierarchical structure of the data following the hypotheses made by the current study (H1-4).

Each of the 18 client participants were required to complete 180 question items for the study (eight items at 10 time points over a 20 minute session). This meant that there was a
potential total of 3,240 client recorded observations for the entire study. Missing data was recorded for two clients who completed 9/10 pages of the answer booklet (forgetting to fill out the last page) and one client (Client 2) missed out a further two items at time two. It is recommended that bootstrapping and other methods for dealing with missing data in multi level analyses should only be used if missing data exceeds 5% of the total data collected (Heck & Thomas, 2009). A total of 3,222 client recorded observations were recorded which is equivalent to 99.4% of the total number. The missing data was left blank as there was such a small number of missing items (items that the client had overlooked whilst turning the pages) that it was thought that this would not affect the results.

Results

Demographic Information

A total of 38 clients consented to participation and 15 participants withdrew before videotaping a therapy session. Many of the clients initially approached for the study said that they had declined because they felt anxious about videotaping a session. A total of 23 client participants recorded a therapy session with a therapist at one of three local clinic sites attached to the primary care service. Three clients decided to withdraw when contacted to complete the ratings session due to changes in their personal circumstances. Clients were recruited from different stages of their treatment including those who were within a week of discharge (but not in the initial two weeks of treatment). Four of the therapists saw one client each, one therapist met with two clients and the two remaining therapists met with six clients each.

A final total of 18 client and therapist pairs completed the video assisted rating session giving a total of 36 individually rated sessions of 20 minutes. The 18 clients who completed both the video and the ratings sessions included 12 males and 6 females. Age ranged
from 26 to 70 years (M=43, SD=14), and two thirds were male, mostly White British (88.89%). Overall, clients’ presenting problems were categorised by primary care staff during screening as i) mixed anxiety and depression disorder (N=11) ii) depressive episode (N=3) or iii) mental disorder not otherwise specified (N=4). The latter tended to describe clients who were referred for issues related to loss and difficulties with adjustment.

The current study was conducted in a primary care service that offered guided self-help interventions, with normal treatment including six 30-minute sessions. Clients were usually either discharged or referred on to other services after the completion of six sessions. To increase recruitment opportunities, participants were referred from the wider therapy team as well as by therapists participating in the current study. This meant that some of the clients met with the therapist that they were already seeing for routine treatment (N= 9) and others met with a new therapist that they had never met before (N=9).

**Table 1** Means and standard deviations for client symptom scores at three time points during the study

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (SD)</th>
<th>Time 1 (at referral)</th>
<th>Time 2 (start of rating session)</th>
<th>Time 3 (discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ9</td>
<td>13.61 (6.22)</td>
<td>8.47 (5.57)</td>
<td>6.617 (5.76)</td>
<td></td>
</tr>
<tr>
<td>GAD7</td>
<td>13.22 (4.33)</td>
<td>7.94 (5.36)</td>
<td>6.34 (4.90)</td>
<td></td>
</tr>
</tbody>
</table>
Table 1 shows the mean symptom scores for the sample at each of the three time points that they were collected. A paired samples t-test (2 tailed) was conducted to compare the symptom scores on the GAD-7 and the PHQ-9 at the time of referral (T1) and at the time of discharge (T3) and at the time of referral (T1) and after the rating session (T2). There was a highly significant difference in GAD-7 scores at T1 (M = 13.61, SD = 6.22) and T3 (M = 6.61, SD=5.75), t (17) = 4.32, p = 0.0005. There was also a highly significant difference found between PHQ-9 scores at T1 (M = 13.61, SD = 6.22) and T3 (M=6.61, SD = 5.75), t (17) = 4.30, p = 0.0005. No significant difference found for GAD-7 scores at T2 (M=8.00, SD= 4.08) and T3 (M = 8.15, SD = 5.40), t (12), 0.28, p=0.79). No significant difference was found for PHQ-9 scores at T2 (M = 8.15, SD = 5.40) and T3 (M = 6.61, SD = 0.57), t (12) = 0.58, p = 0.57.

At the time of referral (T1), 13 out of the 18 client participants (72%) had scores that were over the clinical threshold for depression on the PHQ-9 and 15 out of the 18 clients (83%) met the clinical threshold on the GAD-7 for anxiety disorder. At the time of the rating session (T2) 7 out of the 18 clients (39%) met the clinical threshold for depression on the PHQ9 and 9 out of the 18 clients (50%) met the clinical threshold for anxiety disorder on the GAD7. At the time of discharge (T3) 3 of the 18 clients (17%) met the clinical threshold for depression (PHQ9) and 4 of the 18 clients (22%) met the clinical threshold for anxiety disorder on the GAD7.
Table 2 Summary statistics for scores on client variables

<table>
<thead>
<tr>
<th>Client variable (novel measures)</th>
<th>No of obs*</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpfulness</td>
<td>177</td>
<td>84.40</td>
<td>17.04</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>178</td>
<td>81.08</td>
<td>21.84</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Emotion</td>
<td>178</td>
<td>83.87</td>
<td>18.83</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Talk Freely</td>
<td>178</td>
<td>80.63</td>
<td>23.17</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Perspectives</td>
<td>178</td>
<td>75.48</td>
<td>23.62</td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Variable (SRS)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>178</td>
<td>86.84</td>
<td>14.60</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Goals &amp; Topics</td>
<td>178</td>
<td>80.31</td>
<td>14.60</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Therapist Approach</td>
<td>177</td>
<td>86.11</td>
<td>12.89</td>
<td>28</td>
<td>100</td>
</tr>
</tbody>
</table>

*Obs. = observation

Table 2 shows the summary statistics for mean client scores on the dependent variable (helpfulness) and the seven client process variables. The measure labelled ‘Perspectives’ represents the extent to which the client perceived that they were able to see their problem in new ways. Overall the mean scores for the client process variables were at the higher end of the scale and in the last quartile, suggesting that clients perceived their experience of therapy to be very positive. This was the case for majority of clients except for one (Client 15) who reported consistently low scores (See Appendix 17).

Primary Hypotheses

A series of separate multi-level mixed-effects regression analyses were used to test the primary hypotheses (H1-4), with ‘Helpfulness’ as the dependent variable. This was conducted using Stata command `xtmixed` using a correction with robust standard errors to account for the non-normal distribution of the data. Zero order correlations were also calculated for all seven variables to test for inter-correlation between the variables. As this was
not directly linked to hypothesis testing, the results are included in Appendix 16. This showed that all client variables were correlated with Helpfulness and with each other. However, correlations were not very high (above 0.8), with the exception of Relationship and Approach that were highly correlated with a correlation coefficient of 0.81.

Confirming H1, a significant positive correlation was found between helpfulness and control $b = -0.39, SE = 0.17, p = 0.027, 95\% CI (.05, 0.73)$. In support of H2, a highly significant positive correlation was found between helpfulness and the ability to talk freely $b = 0.30, SE = 0.11, p = 0.005, 95\% CI (.09, 0.51)$. H3 was not supported as the positive correlation between helpfulness and emotion was at trend level $b = -0.36, SE = 0.20, p = 0.070, 95\% CI (-.029, 0.75)$.

A highly significant positive correlation was found between the measure of the therapeutic relationship (Relationship) and helpfulness $b = 0.65, SE=0.14, p = 0.0, 95\% CI (.37, .94)$. To enable further comparison between the contributions made by all of the client variables in predicting client perceived helpfulness, the seven client variables were then entered into the mixed-effects regression analysis. This followed the planned strategy for the main analysis referred to in the previous Statistical Analysis section. The correlations that remain significant (where the confidence interval did not include 0) are shown in bold.
The findings provided partial confirmation for H4, as the independent contributions of Control and Talking Freely to Helpfulness remained significant, when Relationship was no longer significant. The independent contribution of Emotion (as well as Perspectives and Goals and Topics) were found to be non-significant at the significance level of p>0.05.

**Change in Client Perceived Helpfulness and Control**

Line graphs were produced for each of the clients to show the change in ratings of perceived helpfulness and sense of control over the whole session (Appendix 17). These were categorised by into 3 subsets for the purposes of referring to them in the current study. These were represented by subset A: Low Variability (a range in scores of 0-50), B: Moderate Variability (a range in scores of 50-100) and C: High Variability (100-150). The differences between the highest and lowest scores for the control and helpfulness variable were calculated for each graph and added together to produce a composite variability score.
Subset A

One subset of clients ($N=8$) were identified who showed a relatively flat profile where scores for control and helpfulness had a tendency to increase over the course of the first 6 minutes and then stabilise to remain consistently high over time until the end of the session. From these profiles, control appeared to track helpfulness very closely. Scores for control and helpfulness were in the range of 60-100 over the whole course of the session. Figure 2 shows the change over time in helpfulness and control for Client 7 (composite variability score: 37), this profile was typical for clients assigned to Subset A.

![Figure 2. Scores for perceived levels of Helpfulness and Control over the course of a single session (Client 7)](image)

Subset B

The graphs for client scores in subset B showed a moderate amount of variability ($N=5$).

![Figure 3. Scores for perceived levels of Helpfulness and Control over the course of a single session (Client 1)](image)
Figure 3 shows that Client 1 gave scores for Control and Helpfulness that were consistently in the higher range (composite variability score: 53). Helpfulness scores showed a slight increase towards the end of the session and Control showed an interesting dip around 14 minutes into the session, which recovered to match ratings of control at 18 minutes. This pattern of variability is representative of subset B.

Figure 4 shows the profile for Client 3 (control variability score 65) in scores for Helpfulness and Control. Helpfulness stays steady and produces a flat line, whereas we can see two distinct fluctuations in Control at 6 and 12 minutes. This was an unusual profile for subset B because the variability in Control was high, yet Helpfulness remained constant.

Subset C

A subset of client rating profiles was identified showing a much clearer variation in scores of perceived Helpfulness and Control over time (N=5). These results are of particular interest and shall be discussed in more detail.
Figure 5. Scores for perceived levels of Helpfulness and Control over the course of a single session (Client 2)

Figure 5 shows the fluctuations in scores for helpfulness and control over the course of the session for Client 2 (composite variability score: 150). Scores for helpfulness and control are roughly similar until the 6 minute mark, there is then a decline in control which is shortly followed by a sharp fall in the level of helpfulness, and both variables then rise together to levels slightly higher than previously. At 16 minutes there is a fall in control once again, which is followed by a less dramatic decrease in helpfulness. This might suggest that a fall in control for this client precedes a decrease in helpfulness. A similar trajectory was found for Client 4 (Figure 6, composite variability score: 120), where levels of control are again the first to decline, followed by a slight decrease in helpfulness.

Figure 6. Scores for perceived levels of Helpfulness and Control over the course of a single session (Client 4)
Figure 6 shows the scores on levels of helpfulness and control reported by Client 4 (composite variability score: 120). The levels of Helpfulness were reported as consistently high with slight drops in Helpfulness following more significant drops in reported Control. Client 4 experienced a dramatic reduction in Control around the 6 minutes. However, this appears to have been reflected by only a slight drop in perceived Helpfulness.

Figure 7 shows the scores on Helpfulness and Control reported by Client 16 (composite variability score: 104). Control and Helpfulness appear to diverge and mirror each other, so that when control rises, helpfulness declines at the same point (6 minutes). There is a significant drop in Control at 16 minutes, which is reflected by a very slight decline in Helpfulness in the following 2 minutes.
Only one client (15) reported consistently low scores for Helpfulness and Control over the course of the session (Figure 8, composite variability score: 124). However, levels of Helpfulness and Control tracked each other closely over the duration, with a steep rise in both in the last four minutes.

**Discussion**

Self-reported client perceptions of helpfulness were found to be positively correlated with client ratings of perceived control and the perceived ability to talk freely in line with our hypotheses. The results from the separate fixed effects regression analysis initially indicated that there was a slightly stronger correlation between the ability to talk freely and helpfulness than between control and helpfulness. Using a general rule of thumb, the correlations between helpfulness and control (.39) and talking freely (.30) represent a positive relationship of moderate effect size (Field, 2013). However, the correlation for talking freely reduced to below significance when all of the seven client variables were entered at the same time. This may be explained by the significant overlap between talking freely and some of the other client variables.

A positive association between client perceived levels of the opportunity to focus on emotion in session and helpfulness was found at trend level. This suggests that having a sense of control and being able to talk freely may be more important for the clients in this sample than the opportunity to experience emotion. This finding might suggest that although the experience of emotion is an important process in therapy, clients may show different levels of comfort with regard to the amount of emotion that they are able to tolerate and are willing to express during sessions. Some clients may prefer a therapeutic relation-
ship that allows for a high degree of intimacy, yet others may prefer to remain more distant (Mohr & Woodhouse, 2001). Similarly, clients may recognise that talking about emotive subjects may be useful and necessary in different degrees and in different contexts. Clients in general may therefore be more likely to agree that being able to talk freely and have a sense of control over what is happening is of primary importance. Control may represent a client process variable that occupies a higher, more fundamental position in the hierarchy that then impacts upon other experiences such as the perceived ability to talk freely and to focus on emotion connected to the problem. In this case, it would make sense for therapists to be attuned to the client’s sense of control as a primary goal throughout the session as a way of facilitating their engagement and exploration.

The item that represented client perceptions of the therapeutic relationship (Relationship) was one of the items adapted from the Session Rating Scale (Duncan et al., 2003). This item was used in the main analysis to test the hypothesis that the variables Control, Talk Freely and Emotion would predict Helpfulness above a standardised measure of the therapeutic relationship (H4). The other two items from the SRS (Goals and Topics and Therapist Approach) were included on a speculative basis to maintain the construct validity of the SRS and were not directly related to the research question being investigated. It was interesting to find that Relationship was highly correlated with perceived Helpfulness when a separate mixed-effects regression analysis was conducted. However, the strength of the correlation reduced to below significance when all seven client variables were entered into the analysis. In the final mixed-effects regression analysis, only Therapist Approach, Control and Talking Freely remained as significant predictors of Helpfulness. This may indicate that Control and Talking Freely but not Emotion predicts Helpfulness over a standardised measure of Relationship. However, Relationship was also shown to be highly correlated with Therapist Approach which may explain why the correlation between Relationship and Helpfulness was no longer significant when Therapist Approach was added. It
may be that Relationship and Therapist Approach measure similar processes. Control and Talk Freely emerged as robust predictors of client perceived helpfulness in the session. The construct of relationship may perhaps be viewed as a more global measure of the interaction than measures of control and being able to talk freely, which may be more descriptive and have greater specificity. However, this remains speculative as it was not possible to include a comprehensive measure of the therapeutic relationship at each time point and requires further investigation.

The multi-level analysis used in the current study and the high number of observations per client meant that there was enough variation in scores for correlations with moderate effect sizes to be found. It may also be possible that the multi-level analysis did lack power due to the number of participants that were finally recruited. This was because the original parameters estimated for a moderate effect size called for the inclusion of 23 client participants instead of the 18 that were recruited. The multi-level analysis with 18 participants was still possible and therefore suggests that the final number of clients that were included was sufficient for this exploratory study. If there had been more data collected, then it might have been possible to detect an effect for Emotion and Relationship may have remained significant. Other aspects of the design may have also introduced bias into the results. For example, the number of sessions that clients engaged in prior to taking part in the study might have influenced what participants were able to identify as helpful. This was especially when clients were close to discharge and may have been experiencing less distress. There may also have been some systematic bias introduced into the sample of client participants as there were twice the number of males to females and a lack of participants from ethnic and cultural minorities.

The results from the t-tests conducted on the symptom scores pre and post the video review and rating session and at discharge should also be interpreted with caution. Client participants had varying lengths of treatment and were not matched with controls. There-
fore the conclusion from this outcome data suggests that there was a significant difference in scores from the beginning to the end of the participant’s therapy, however this does not provide information on what contributed to this difference. As this was a process study, the main focus was on the quantitative data collected whilst clients rated the course of a single session. The results on symptom scores may also have been affected by some missing data.

It has been noted in previous studies that clients tend to rate the helpfulness of the therapist very highly and that clients do not show dissatisfaction or identify hindering aspects of therapy as often (Lieater, 1992). The findings of this study appear to support this, with the vast majority of clients (17/18) reporting scores of helpfulness that were consistently in the range of 70-100. However, it is difficult in the current study to disentangle how the ratings of therapist helpfulness may have been related to the specific approach being used, i.e. Method of Levels Therapy. It would be worthwhile for this to be explored in more detail with the replication of the current study design across different types of treatments (e.g. including CBT, Interpersonal Dynamic Therapy). The consistently high scores may also suggest self-presentation effects or reveal perceived power differentials present between clients and therapists. It is also possible that the clients who reported less variation in scores may have been fatigued by the intensive method of data collection, or may have been taking less time to make considered judgements. If we consider the proposition made by PCT that all individual actions are goal-serving attempts to control experiences (Powers, 1973), participating clients might have also been attempting to regulate their perceptions of what was happening during the rating session with the researcher. This makes it important to also consider the match and mismatch between the goals of the researcher conducting the interview and the client when interpreting the findings of this study. This is explored in more detail as part of the critical reflections in Paper 3.

The results of this study provide some intriguing insights into how clients perceive their experience of therapy, what they consider to be helpful and what might lead to intra-
individual change. A measurement of control may allow us to pinpoint significant moments or exchanges in therapeutic interaction that might be closely connected to the experience of positive change or have a capacity to reveal moments of client disengagement and resistance. On a case-by-case basis, this kind of information may be particularly useful in guiding therapists in how they attune to their clients. In contrast, if we look at the line graphs showing scores of helpfulness and control for each of the clients we may be able to get a closer look at the interior of therapy (Gurman, 1977; McLeod, 2003). Fluctuations in measures of control were often evident despite client reports of consistently high levels of helpfulness (e.g. Figure 3 and 4). Levels of control seem to provide some insight into the specific occurrence of client covert processes that Rennie (1992) refers to at the micro-level against a background of general feeling that the therapist was being very helpful throughout the session.

In summary, this study has shown that client reports of their perceptions during therapy do offer valuable information to researchers and clinicians on how to maximise the effectiveness of psychotherapy (Castonguay et al., 2010; Bedi, Cook & Domene, 2012; Lambert & Cattani, 2012). This study has proposed a novel method that has been successful in addressing specific limitations of previous studies regarding client perceptions of therapy process. It has shown that it is possible to design studies that are capable of investigating how clients perceive therapeutic interactions may provide us with a greater understanding of intra and interpersonal processes of change (Norcross, 2011). This exploratory study has shown that the design has potential for measuring the complexity of client experience during therapy in a client-oriented way, whilst capturing internal processes and the interpersonal dynamics of interaction (Toukmanian & Lieater, 1992). The application of PCT as a framework for therapeutic interaction has also supported the use of conceptually based and theory driven process measures of change, that it has been claimed are missing from psychotherapy research (Timulak, 2010).
The role that client perceived control plays in therapy is both recognised by clients as being helpful and it is supported by theory. The findings from this study lend support to the proposal that establishing a sense of control for the client in therapy may be the therapist’s primary task (Carey et al., 2012; Mansell, 2012). The current study makes the tentative proposal that this could be one of the primary mechanisms that underlies therapist attempts to establish and maintain a therapeutic relationship with their clients. It may help us to understand more about what the therapist is ultimately aiming to achieve when they strive to be warm, empathic and genuine during therapeutic encounters (Rogers, 1951). These findings indicate that with the right methodology, it could be possible to link client processes together to form a multifactor change pathway. An example of one such pathway could start with the client experience of control that is facilitated by the therapist in-session, which then leads to the client’s increased ability to talk freely whilst experiencing difficult emotion. This then results in the generation of new perspectives that clients perceive to be helpful.

It should be noted that the current study presents preliminary findings from the early stages in developing a novel exploratory method. Therefore, the results need to be interpreted with some caution before wide reaching conclusions regarding the implications for clinical practice and process research are made. Further research is required if we are able to capture more accurate and specific measures of perceived control in therapy from the client and therapist perspective and to see how levels of perceived control are reported across different stages in treatment, populations and treatment modalities.
Paper 3 Critical Evaluation

Word Count: 4,833
Overview

The work undertaken as part of this thesis has involved the analysis of client perceptions of helpful experiences in therapy with a view to identifying and developing micro-theories of change. This approach has been taken by a number of previous authors, although the findings have as yet been methodologically limited (Rice & Greenberg, 1984; Toukmanian & Rennie, 1992; Wiseman, 1985; Timulak, 2008; McLeod, 2003). The first part of the thesis included a systematic literature review of studies specifically designed to capture client self-reported perceptions of helpful processes in therapy.

The aim of the review was to draw attention to the key methodological issues that have challenged researchers in this field and to make recommendations to guide future research. In the second part, an empirical paper was presented that detailed a therapy process study designed to address the issues raised in the literature review. This study devised a novel methodology with quantitative measures to capture clients’ self-reported perceptions of what was helpful about the therapeutic environment created by the therapist during a single session of transdiagnostic CBT - Method of Levels Therapy.

The study employed process measures of the client/therapist experience, informed by Perceptual Control Theory (Powers, 1973) and standardised measures of the therapeutic relationship (Session Rating Scale (SRS: Duncan et al., 2003). In the third part of this thesis, the work involved in papers 1 and 2 is critically evaluated. The methodological strengths and limitations are discussed as well as the implications for future research and the plans that have been made for disseminating the findings. Further limitations are included in the discussion sections of Paper 1 and 2. During the process of conducting the research, a number of different research and practice links were revealed that have potential to improve clinical practice and enhance client experiences of service delivery and involvement. This study also involved establishing a Practice Research Network (PRN) within a primary care service that encouraged collaborative networks between academics, researchers and
clinicians, similar to the network described by Castonguay et al., (2010). Some reflections are provided on this process as well as client and therapist reports of their experiences as participants in the research.

**Paper 1: Client Perceptions of Helpful Therapeutic Process: A Systemic Review**

**Scope and Focus**

A number of key decisions influenced the selection of the topic and identification of the primary research question. The original motivation behind the research was to gain a better understanding of how therapeutic interaction operates during therapy and what makes therapy therapeutic for the client. The dynamic interpersonal context of therapy emerged as very important aspect of psychotherapy research that previous researchers have had difficulty in addressing (Elvin & Green, 2008; Cahill et al., 2008; Norcross, 2011) from the very early stages of this investigation. This generated an initial idea for the literature review that included an assessment of how the process of interpersonal affect regulation has been studied within the context of therapeutic encounters. Affect regulation is a well established concept in a number of research fields (Eisenberg, Fabes, Guthrie & Reiser, 2000) and it was thought that it might be interesting to see how therapists’ attempts to regulate clients’ emotions in therapy as part of the therapeutic relationship have been explored. After an initial search, some studies were identified that looked at helpful and unhelpful interpersonal affect regulation strategies used by couples in close relationships (Niven, Trotterdell & Holman, 2009). Interpersonal affect regulation did not appear to have been investigated very widely with the context of therapy using these terms. This may provide an interesting avenue for future research. However, it was decided for the purposes of the current study to adopt a research focus on client perceived aspects of the therapeutic relationship that was more closely related to the aims of the empirical paper.
In preparing to carry out the literature search, common areas of consensus about what is already known and supported by the evidence base were identified in the wider literature on the alliance and therapeutic relationship. It soon became evident that a huge wealth of studies exist providing evidence of a robust association between relational factors and outcome (Horvath & Symonds, 1991; Horvath, Fluckger & Symonds, 2011). However, less is known about the client’s contribution to what happens in therapy from their own perspective (Norcross, 2011). This narrowed the focus of the current investigation towards psychotherapy process studies as opposed to outcome research which in turn opened up to other related areas of research such as the ‘events paradigm’ in Person Centred Counselling. A construct of helpfulness was proposed as a useful alternative to the therapeutic relationship and the working alliance for the investigation as it appeared more closely allied to the client’s perspective and more broadly applicable to the study of process.

It remained a significant challenge through the search and review of the literature to achieve a balance between being comprehensive and still being able to provide a narrow enough focus to present meaningful conclusions. The search terms were made broad enough to include client perceptions of therapy, experience in therapy and the alliance/therapeutic relationship due to the overlap between these areas of research that had been discovered early on. Client ratings or measures of therapy were included in the initial search. However, views or opinions were not included in the search as these were thought to represent evaluative judgements rather than specific experience.

**Assessment of quality**

The Quality Assessment Tool (QATSDD) was chosen to assess quality, as it provided a flexible yet comprehensive means of screening. However it should be noted that the QATSDD is a relatively new tool that requires further validation (Sirriyeh, Lawton, Gardner & Armitage, 2011). Quality and inclusion criteria suggested that the key study con-
ducted by Elliot (1985) could have been excluded on the basis that the sample included psychology students for a mock session of therapy rather than clients from a naturalistic clinical setting. However, it was felt that as this is such as key study in this area, upon which many of the subsequent measures of client experience (SEQ, SIS) are based, that it should be included in the review. To ensure that the method and the findings of the review were reported in a consistent and reliable format, the PRISMA guidelines were applied (Moher, Liberati, Tetzlaff & Altman, 2009). These are intended to ensure quality in the reporting of systemic reviews.

**Evaluation of Findings**

It appeared that a number of previous reviews on client-identified helpful aspects of therapy have focused on the identifying and aggregating the contents of descriptive categories derived from client reports. However, it was established from reading previous reviews and the wider psychotherapy process literature that the design of studies capable of tracking therapy process over time remained as a challenge for research (Elliot & James, 1979; Timulak, 2007, 2010). It was therefore decided that a review of the methodological issues raised by studies might make a more valuable contribution to future research in this area. A set of criteria was proposed by the current review to indicate good quality design in the study of client reports of therapy process. The findings also helped to provide the rationale for the novel method that was designed for the empirical study. It may be that because the researcher already had aspects of the novel design for the empirical study in mind, which may have influenced the creation of the criteria proposed in the literature review. However, the criteria were drawn from the wider literature and it is suggested that they would be supported by many other researchers in this field. Further discussion and dialogue with other researchers perhaps through the use of a Delphi Poll (Fish & Busby, 1996) would improve the reliability and validity of the criteria.
It was necessary to exclude some interesting studies on different types of client experience from the review. Studies of this kind are likely to make a significant contribution to the understanding of how micro theories of change can be identified and developed from the reports of client experience. Wiseman’s (1992) study on client-identified problematic experiences using Interpersonal Process Recall provides an interesting example that is particularly relevant to the design of the current study. Wiseman designed the study to track therapist and client interactions over a course of therapy using conceptually based continuous measures and mood ratings as the dependent variable. Other interesting event types that were not included in the current review include moments of innovation where the client expresses an exception to a dominant self-narrative (Gonçalves et al., 2009), experiencing empathy (Vanaerschot & Lietaer, 2007) and moments of achieving insight (Elliott et al., 1994).

The comprehensiveness of the review was limited by the fact that the researcher did not make an earlier attempt to contact other researchers who are active in the field of psychotherapy process for unpublished material. This is likely to have improved the breadth and depth of the findings, whilst perhaps revealing more about the novel methodologies that are currently being used to explore client perceptions of therapy process across the course of a single session. The findings of the review should also be seen in the context of other studies that have included observer measures of client process during therapy. Although this study emphasised the importance of the client’s perspective as a key component of how the experience of therapy impacts upon internal change for the client, observer measures of therapy process may still be useful for different purposes. For example, the study by Ribeiro et al., (2013) provides an interesting example of this with a method designed to track the moment to moment interaction in session by applying a conceptual framework to the study of the dialectical work that fosters collaboration in session. It is recognised by the
current study that the triangulation of observer, client and research perspectives are impor-
tant to the study of psychotherapy (Norcross, 2002).

An attempt was made throughout the review was to synthesise and integrate findings in
a way that would provide a meaningful summary for researchers investigating client proc-
ess variables in therapy. It is also noted that the review reflected some of the paradigm
shifts in the historical evolution of psychotherapy research that have informed the approach
to study design. A reading of the selected studies revealed a shift in the roles of the re-
searcher and the clinician towards becoming more closely integrated with each other as the
scientist practitioner model became more popular. It was evident that video recording and
audio taping of therapy session also became more acceptable over time and clients gradu-
ally appeared to gain more recognition as active participants in therapy and the research
process. Many of the early studies on therapy process relied on direct observation of be-
aviours, although the studies in the review demonstrated that there is still a need to design
studies that can address the complexity of intra-individual and interpersonal processes so
that it is possible to identify mechanisms of change. It was interesting to see how the
power relationship between clients and researchers had been addressed at the basic level of
the study design, through data collection, the analysis and the way in which the findings
were reported. It was often the case that researchers claimed to be representing the voices
of clients whilst also imposing their own ideas of what was important at different stages in
the research process. This reflects the need to remain constantly aware of how knowledge
is produced through various processes of exclusion which may lead to the maintenance of
certain discourses over others (Foucault, 1972). The established body of literature on the
alliance that has overshadowed client oriented descriptions of the relationship is perhaps a
good example of this.
Recruitment

Recruitment was carried out at the site of the primary care service participating in the study. Therapists employed by the service approached clients that they were seeing in therapy to see if they wanted to take part in the study. A number of reservations were expressed by clients about participating in a study that involved the video recording of therapy. Clients that were socially anxious may therefore have not been likely to volunteer. It was made very clear to potential participants that their participation was voluntary at each stage in the recruitment process. Recruitment was therefore quite challenging, took longer than was expected and resulted in the recruitment of 18 instead of 23 clients. The recruitment guidance for therapists was improved half way through data collection so that clients had a very detailed description of was involved. It was very important to ensure that clients felt positive and safe about their participation and every care was taken to ensure that they retained a sense of control over the process and were fully informed. Under these conditions, service users were much more likely to take part. Despite many clients expressing initial concerns about being videotaped, the reaction of participants once they had taken part was in the vast majority of cases very positive.

Sample

Due to some difficulties with recruitment, therapists from the service who were not recording sessions as part of the research were invited to approach their clients. This meant that half of the clients met the therapist that they were seeing for therapy and the other half met with a therapist that they had never met before. The number of therapy sessions that clients received before taking part in the research also varied which may have had an impact on what they chose to talk about and the extent to which they rated their session as helpful. One client received 3 sessions and two clients received 4. There were 4 clients
who received either 5, 6 and 7 sessions each. One client was referred on for a CBT intervention after receiving 1 session and another two clients extended their therapy sessions to 8. Most clients received between 5 - 7 sessions ($M=5.56$, $SD=1.79$). 72% of the sample completed therapy and were discharged, 11% were referred on to other services, 6% dropped out of therapy and 11% continued with therapy. The findings of Paper 2 would therefore be improved by further exploratory analysis of these factors. It might also have improved the validity of findings if each of the therapists had met with an equal number of clients each.

**Reliability and Validity of Study Design**

Client perspectives may not be particularly reliable as a source of information due to difficulties with the recollection of experience as well as performance and self-presentation biases. This may not reduce the value of client reports but simply suggest that means of reducing this bias needs to the carefully considered as part of methodological design. Overall, it appeared that clients were able to recollect and connect to their experience during therapy when watching the video. This was aided by the use of headphones that may have cut out other distractions and provided a sense of privacy and control over what was happening. However, 12 out of the 18 clients returned to view their therapy tape did so after a period of 2 weeks, which may have compromised their ability to re-experience and connect with what they observed to be happening on the video. It would be beneficial, if this study were replicated; to address this by having all clients return within two weeks to review their video, as suggested by Hill et al., (1994). Due to the timeframe available for data collection and the difficulties with recruitment, this was not possible in the current study.
Measures

There are a number of factors that may have affected data collection determined by the presentation of the measures employed by the study. It was noted that the study design was intensive and that in a few cases completion of the repeated measures did lead to participant fatigue. Also, as the same eight measures appeared on each page practice effects may also have occurred. This does not necessarily invalidate the design, as a good degree of variation was observed, which suggests that clients were thinking about the measures and applying them to their observed experience in a considered manner. The study design could be improved, however, by perhaps reducing the number of client items on each page. This could be done by excluding the SRS measures and focusing on the main process measures that are related to PCT (Control, Talk Freely, Emotion, Perspectives) in any further replication of the design (where the hypotheses were no longer comparing PCT process measures to the relationship). Clients may also need re-orientating to the proper use of the measures on a regular basis and reminders to look for subtle variations over the course of the video.

It was noted, as has been in other reports of psychotherapy process interview studies, that there was often a fine line between recall and re-experiencing for clients that bordered on therapy. Some clients were task focused whilst many others used the opportunity to further reflect on what had been bothering them. A number of clients made further disclosures about the covert processes that had been going on for them during the session. It would be interesting to investigate why some clients chose to engage in more reflection that others. This may indicate that clients come to therapy with different kinds of resources (Rice, 1992) and it may also indicate that the stage at which a client is at in assimilating their experience has an impact on the degree to which they are able to engage in reflection (Stiles et al., 1990). This is reflected by findings that show client readiness is an important factor in the outcome of therapy (Bohart, 2002; Kelly, 2011).
Data Collection

The client rating session brought up many issues regarding the process of data collection. One of these issues concerned the importance of the relationship between the researcher and the client when reviewing and rating the video material. The relationship between the participant and the researcher has been identified as a key feature of qualitative research that deserves careful consideration and explanation in the reporting of findings (McLeod, 2003). Many of the studies involving the Interpersonal Recall Method (IPR) involve researchers who have been trained specifically in interview techniques. It might have been beneficial with regard to the current study, if the chief investigator had been able to access similar training. However, it was found that the clinical interview skills that the chief investigator had already accumulated as part of doctoral training did support a productive approach to conducting the session. The researcher was also conscious of applying some of the principles that are fundamental to Method of Levels (enabling the client to feel in control over what is happening, able to talk freely and to focus on present moment perceptions) during the rating session (Carey et al., 2012).

Client and Therapist Experience of Research

A high number of clients reported that it has been a valuable and unique experience for them to see themselves talking about their problem. Some clients commented on their body language and their modes of expression and some reflected on how differently they felt since making progress which appeared to consolidate the gains that they had made in therapy. Others reached new insights into what it was that was really bothering them and what they needed to do about it. One participating client decided to end therapy after the rating session because he felt that he had gained a new perspective on his problem and no longer felt distressed. A couple of the client participants said that taking part in the research had been a demonstration of how they had grown in confidence. Their participation was de-
scribed by them as a personally rewarding achievement that made them feel good about helping others. Therapists described taking part in the research as interesting and productive. They commented on how it provided an invaluable opportunity to reflect on their practice and that through watching the video they became aware of things that had perhaps been helpful for the client that they had not been aware of in-session. Therapists did tend to undervalue their contribution and focus on what they had not been able to achieve in early reviews. However, it was noticeable that this became less of an issue for therapists in later sessions as they grew in confidence and focused more on the client experience.

**Ethical Considerations**

As part of the current study, live therapy sessions were video recorded and as a consequence involved a number of important ethical issues. It was especially important that participants did not feel under pressure to take part, in case this had a negative impact on their experience of treatment and their view of services. This meant that it was very important to keep checking with participants that they felt comfortable and in control of what was happening as part of their involvement. The fact that the researcher was also on a Clinical Psychology training course was an advantage, as it meant that they were able to monitor client’s levels of arousal and respond appropriately during the video review session. It could also be argued that incorporating service user feedback on the experience of therapy is of ethical importance in itself. Surely, collecting data on patient experience needs to happen at all levels of research and practice if we are going to provide truly person centred care. However, as the current study has shown the collection of data that could possibly impact upon the client’s experience of treatment needs to be carried out in a very sensitive way with the support of a knowledgeable and fully accountable supervisory network.
Statistical Analysis

A multi-level analysis was used in the design to account for the nested data, occurring within subjects at different points over time. The subtle and often slight change in scores recorded by clients across the sessions and the relatively high number of variables does mean that a larger sample size could have improved the findings. It may be that the effect sizes could have been improved by a larger sample size. This may have meant that the correlations for Relationship and Emotion may have remained significant when the mixed-effects regression that included all seven variables was performed. To enhance the analysis and to look more carefully at the structure of the data, it would be possible to conduct a Structural Equation Modelling analysis. This would have made it possible to estimate causal relations with the model that adhered to the theory driving the operation of the process variables selected. Due to time constraints, it was unfortunately not possible to conduct these further detailed analyses. As the therapist adherence ratings were completed by the chief investigator and the second author, it would also be a good idea to have these completed by a set of independent judges and inter-rater reliability re-calculated.

Novel Method Design

This study designed, piloted and applied a valid novel design in a naturalistic setting that was able to capture client perceptions of therapy process and which may be replicated to generate further findings. The design of the method met the criteria that outlined in Paper 1. The measures used were client-orientated and internally driven in that they captured client perceptions of processes occurring during therapy that were linked to an internal sense of the experience. This also incorporated the interpersonal context of therapy by using client responses in relation to the activity of the therapist and the differential perspectives of the client and the therapist. The findings provide evidence to suggest that clients and therapists may act to control their perceptions of what happens in therapy in line with
their goals and values (Carey et al., 2012). The study focused specifically on within session activity and was able to capture change over time by using quantitative continuous measures. The process measures were informed by Perceptual Control Theory (Powers, 1973), which is a theory of human functioning that is not restricted to one theoretical orientation. It is therefore anticipated that the method and measures could be applied to investigate client perceived control and the ability to talk freely across different therapeutic modalities (Psychodynamic Interpersonal, Cognitive Behavioural and Experiential Therapy) within naturalistic clinical settings. The use of process variables informed by a Perceptual Control Theory framework helped to link client measures of helpfulness to a theoretical framework of change. The novel method utilised in the current study therefore suggests new possibilities for experimental research design in the field of psychotherapy process research (e.g. the use of longitudinal designs to collect continuous quantitative data that can be analysed with multi-level statistics).

The video assisted review format has considerable therapeutic potential for application as part of clinical practice. However, it should be noted that it is not suitable for all clients and may be better used later on in therapy once they have grown in confidence and developed a good relationship with their therapist. The client also needs to be well supported during the review by a clinical professional that can remain well attuned to their levels of arousal and individual needs. Clients may need the clinician to check in with them at various points during the review so that they remain feeling in control of the process. It was also indicated by the responses of therapists who had reviewed the videos of sessions that this method can also be applied effectively to supervision in clinical practice. It was often quite difficult for therapists to remain focused on what they perceived to be helpful for clients during the review, as they showed a tendency to notice what they thought they had done wrong first. However, sometimes, therapists realised that they may have been being more helpful than they realised during the session. Therapists often described a sense of
anxiety around not knowing where the client was leading the conversation. However, often therapists could see from the video that clients were so absorbed in the exploration of their internal world during these moments, they were not aware of the therapists’ concerns. This might suggest that one task for the therapist in therapy is to acknowledge and tolerate any anxiety that arises when they feel they are not controlling the flow of the session for the client.

**Client Perceptions of Therapy Process**

The findings from the current study indicate that clients may be more likely to agree that being able to talk freely and having a sense of control over what they experience in therapy is of primary importance. This also provides a focus for therapists when carrying out interventions. Understanding the experience of control for the client may be a closer fit to the ‘just right’ needs of the individual client than ‘a one size fits all’ definition of the therapeutic relationship. It may be more useful for therapists to consider the different ways in which they can help the client experience control and yet talk freely whilst remaining focused on the problem rather than what they can do or say to show the client warmth, empathy or genuineness. This may be especially true considering the evidence that clients may experience these characteristics in different ways (Farber et al., 2004). A PCT explanation of the therapeutic relationship also helps us consider the importance of the balance of control between the therapist and client that results from the relative match and mismatch between the goals that direct their individual responses.

**Further Planned Analyses**

The current study gathered a large amount of rich data, which will make it possible to conduct a number of further analyses. This includes investigation of the qualitative data collected from audiotaped interviews with clients during the recall session and the analysis
of the therapist data (including how the adherence levels of therapists relate to client perceptions of helpfulness and a comparison of client and therapist perceptions of helpfulness). The qualitative data collected as part of audiotaping the rating session provides some interesting information that may also enrich our understanding of clients’ experiences and goals in therapy. This may provide some insight into client covert processes that may have been having an effect upon levels of perceived helpfulness and control during the session. The current study has also generated data that may enrich the understanding of Method of Levels cognitive therapy in clinical practice and provide further guidelines for therapists.

**Dissemination of Research**

The plan for disseminating the research findings from the current study acknowledges the value of the contributions made by all participants involved. This work has led to the preparation of two research papers for submission. The work will also be presented to the therapy team from the participating primary care service and in a letter to clients who have requested this information. An open paper submission has also been accepted by the BABCP for Paper 2, which will form part of a mini-symposium on Client Perceptions of Therapy Process, therefore supporting the timeliness of the current study (Appendix 18).
References for Paper 1


Elliott, R. & Feinstein, L. (1978). Helping intention rating procedures: overview and uses. (Unpublished manuscript), University of Toledo, Toledo: OH.


References for Paper 2


Hill, C.E., Churi, H. & Bauman, E. (2013). Revisiting and re-envisioning the outcome problem in psychotherapy: An argument to include individualized and qualitative measurement. Psychotherapy, 50(1), 68-76.


StataCorp. (2011). *Stata Statistical Software: Release 12*. College Station, TX: StataCorp LP.


References for Paper 3


Appendix 1 Psychotherapy Research: Submission Guidelines

- Manuscripts are accepted in English (for non-English submissions see Manuscript submission section below). Oxford English Dictionary or US spelling are preferred. Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Long quotations of 40 words or more should be indented without quotation marks.
- There is no word limit for articles but authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows:

- For single agency grants
  This work was supported by the <Funding Agency> under Grant <number xxxx>.

- For multiple agency grants
  This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.

- Abstracts of 100-200 words are required for all manuscripts submitted. The abstract should be structured with the following headings: Objective, Method, Results, Conclusions.
- Each manuscript should have 5 to 6 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

2. Style guidelines
- Description of the Journal’s reference style.
• An EndNote output style is available for this journal.
• Guide to using mathematical scripts and equations.
• Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures
• Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
• Figures must be saved separate to text. Please do not embed figures in the manuscript file.
• Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
• All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
• Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
• The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Last updated 13 March 2014
Length and Style of Manuscripts

Full-length manuscripts should not exceed 35 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double spaced.


Authors submitting manuscripts that report new data collection, especially randomized clinical trials (RCTs), should comply with the newly developed APA Journal Article Reporting Standards (PDF, 98KB) (JARS; see American Psychologist, 2008, 63, 839–851 or Appendix in the APA Publication Manual).

For papers that exceed 35 pages, authors must justify the extended length in their cover letter (e.g., reporting of multiple studies), and in no case should the paper exceed 45 pages total. Papers that do not conform to these guidelines may be returned without review.

The References section should immediately follow a page break.

Title of Manuscript

The title of a manuscript should be accurate, fully explanatory, and preferably no longer than 12 words. The title should reflect the content and population studied (e.g., “treatment of generalized anxiety disorders in adults”).

If the paper reports a randomized clinical trial (RCT), this should be indicated in the title. Note that JARS criteria must be used for reporting purposes.

Abstract and Keywords

Starting in 2010, all manuscripts published in the Journal of Consulting and Clinical Psychology will include a structured abstract of up to 250 words.

For studies that report randomized clinical trials or meta-analyses, the abstract also must be consistent with the guidelines set forth by JARS or MARS (Meta-Analysis Reporting Standards) guidelines, respectively. Thus, in preparing a manuscript, please ensure that it is consistent with the guidelines stated below.

Please include an Abstract of up to 250 words, presented in paragraph form. The Abstract should be typed on a separate page (page 2 of the manuscript), and must include each of the following sections:

- **Objective:** A brief statement of the purpose of the study
- **Method:** A detailed summary of the participants (N, age, gender, ethnicity) as well as descriptions of the study design, measures (including names of measures), and procedures
- **Results:** A detailed summary of the primary findings that clearly articulate comparison groups (if relevant), and that indicate significance or confidence intervals for the main findings
- **Conclusions:** A description of the research and clinical implications of the findings

After the abstract, please supply up to five keywords or short phrases.

Participants: Description and Informed Consent

The Method section of each empirical report must contain a detailed description of the study participants, including (but not limited to) the following: age, gender, ethnicity, SES, clinical diagnoses and comorbidities (as appropriate), and any other relevant demographics.
In the Discussion section of the manuscript, authors should discuss the diversity of their study samples and the generalizability of their findings. The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians) and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

**Measures**

The Method section of empirical reports must contain a sufficiently detailed description of the measures used so that the reader understands the item content, scoring procedures, and total scores or subscales. Evidence of reliability and validity with similar populations should be provided.

**Statistical Reporting of Clinical Significance**

*JCCP* requires the statistical reporting of measures that convey clinical significance. Authors should report means and standard deviations for all continuous study variables and the effect sizes for the primary study findings. (If effect sizes are not available for a particular test, authors should convey this in their cover letter at the time of submission.) *JCCP* also requires authors to report confidence intervals for any effect sizes involving principal outcomes (see Fidler et al., *Journal of Consulting and Clinical Psychology*, 2005, pp. 136–143 and Odgaard & Fowler, *Journal of Consulting and Clinical Psychology*, 2010, pp. 287–297).

In addition, when reporting the results of interventions, authors should include indicators of clinically significant change. Authors may use one of several approaches that have been recommended for capturing clinical significance, including (but not limited to) the reliable change index (i.e., whether the amount of change displayed by a treated individual is large enough to be meaningful; see Jacobson et al., *Journal of Consulting and Clinical Psychology*, 1999), the extent to which dysfunctional individuals show movement into the functional distribution (see Jacobson & Truax, *Journal of Consulting and Clinical Psychology*, 1991), or other normative comparisons (see Kendall et al., *Journal of Consulting and Clinical Psychology*, 1999).


**Discussion of Clinical Implications**

Articles must include a discussion of the clinical implications of the study findings or analytic review. The Discussion section should contain a clear statement of the extent of clinical application of the current assessment, prevention, or treatment methods. The extent of application to clinical practice may range from suggestions that the data are too preliminary to support widespread dissemination to descriptions of existing manuals available from the authors or archived materials that would allow full implementation at present.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (*6th* edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Below are additional instructions regarding the preparation of display equations, computer
code, and tables.

**Display Equations**

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0
(built into pre-2007 versions of Word) to construct your equations, rather than the equation
support that is built into Word 2007 and Word 2010. Equations composed with the built-in
Word 2007/Word 2010 equation support are converted to low-resolution graphics when
they enter the production process and must be rekeyed by the typesetter, which may intro-
duce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or
2010 and you have access to the full version of MathType 6.5 or later, you can convert this
equation to MathType by clicking on MathType Insert Equation. Copy the equation from
Microsoft Word and paste it into the MathType box. Verify that your equation is correct,
click File, and then click Update. Your equation has now been inserted into your Word file
as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be
produced as Word text using the Times or Symbol font.

**Computer Code**

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a
separate file with your code exactly as you want it to appear, using Courier New font with
a type size of 8 points. We will make an image of each segment of code in your article that
exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset
in Courier New and run in with the rest of the text.) If an appendix contains a mix of code
and explanatory text, please submit a file that contains the entire appendix, with the code
keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your ta-
ble will create problems when the table is typeset and may result in errors.

**Submitting Supplemental Materials**

APA can place supplemental materials online, available via the published article in the
PsycARTICLES® database. Please see Supplementing Your Article With Online Mate-
rial for more details.

**References**

List references in alphabetical order. Each listed reference should be cited in text, and each
text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and
  sensory attenuation: The role of temporal prediction, temporal control, identity prediction,

- **Authored Book:**

- **Chapter in an Edited Book:**
Appendix 3 Research Ethics Committee Approval Letter

06 August 2013

Miss A Cocklin
Trainee Clinical Psychologist
University of Manchester
Department of Clinical Psychology
2nd Floor, Zochonis Building
Brunswick Street
Manchester
M13 9PL

Dear Miss Cocklin

Study title: What’s therapeutic about therapy?: Client Perceptions of Therapist Helpfulness.

REC reference: 13/NW/0366
IRAS project ID: 122326

Thank you for your letter of 17 July 2013, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so.
Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Kath Osbourne, nrescommittee.northwest-gmcentral@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised subject to the conditions specified below.

A Research Ethics Committee established by the Health Research Authority
Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.recforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre") guidance should be sought from the R&D office on the information it requires to give permission for this activity.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>24 April 2013</td>
</tr>
<tr>
<td>Evidence of insurance or indemnity</td>
<td>Employers liability, MARSH letter, Zurich letter, University of Manchester letter</td>
<td></td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Alexandra Cocklin</td>
<td>25 February 2013</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>23 April 2013</td>
</tr>
<tr>
<td>Letter from Statistician</td>
<td></td>
<td>18 November 2012</td>
</tr>
<tr>
<td>Other: Letter of support Dr Phil McEvoy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: CV Academic Supervisor</td>
<td>Warren Mansell</td>
<td>25 February 2013</td>
</tr>
<tr>
<td>Other: CV Academic Supervisor</td>
<td>Dr Sara Tai</td>
<td>25 February 2013</td>
</tr>
<tr>
<td>Participant Consent Form: Therapist</td>
<td>2</td>
<td>12 July 2013</td>
</tr>
<tr>
<td>Participant Consent Form: Client</td>
<td>2</td>
<td>12 July 2013</td>
</tr>
</tbody>
</table>

A Research Ethics Committee established by the Health Research Authority
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

A Research Ethics Committee established by the Health Research Authority
13/NW/0366  Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/.

With the Committee's best wishes for the success of this project.

Yours sincerely

K. Osborne

Signed on behalf of
Professor S J Mitchell
Chair

Email: nrescommittee.northwest-gmcentral@nhs.net

Enclosures: "After ethical review – guidance for researchers"
Copy to: Ms L Macrae, University of Manchester
Ms L Dowell, Manchester Mental Health and Social Care Trust

A Research Ethics Committee established by the Health Research Authority
### Appendix 4

**Table of Study Characteristics: Client Perceptions of Helpfulness**

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Data Collection</th>
<th>Data Analysis</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor (1995)</td>
<td>Self referred clients University consultation service (N=34) Masters level Clinical Psychology trainees as therapists (N=23)</td>
<td>Post session questionnaire (3 time points during therapy) Clients asked to focus on event, verbalisations and feelings</td>
<td>Perceived alliance Coded by trained raters Phenomenological content analysis (Giorgi, 1985) of client descriptions</td>
<td>3 types of alliance: Nurturant, insight orientated, collaborative 10 facilitative therapist characteristics: discloses self and emotions, therapist respectful, non-judgemental, listens, understands, therapist competence, facilitates understanding, change in behaviours &amp; attitudes</td>
</tr>
<tr>
<td>Bedi, Davis and Meris (2005)</td>
<td>Adult clients (in therapy or recently completed in last 1yr) (N=40) Outpatient setting</td>
<td>Semi-structured interview and self report questionnaire (global evaluation of entire treatment) Focus on observed behaviours and events</td>
<td>Critical incidents in therapy contributing to alliance formation and strengthening Coded by first author using Critical Incident Technique (CIT; Flanagan, 1954)</td>
<td>25 helpful factors: 10 most common were technical activity, non-verbal communication, active listening, choices, psychotherapy environment, therapist personal charac.s, service beyond normal expectation, self disclosure, positive commentary</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Data Collection</td>
<td>Data Analysis (Construct/Coding/Rater)</td>
<td>Findings</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bedi (2006)</td>
<td>Adult clients (completed therapy, from prev study Bedi, Davis &amp; Meris, 2005) (N=40)</td>
<td>Transcripts of research interviews, relevant statements extracted by researchers</td>
<td>Helpful alliance formation factors, Clients (N=31) sorted statements Multivariate concept mapping</td>
<td>11 categories of helpful factors: nonverbal gestures, emotional support and care, presentation &amp; body language, setting, session admin., client personal responsibility, referrals &amp; materials, guidance &amp; honesty, validation</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Data Collection</td>
<td>Data Analysis (Construct/Coding/Rater)</td>
<td>Findings</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Elliott and Wexler (1994)</td>
<td>Adult clients with depression ((N=48))</td>
<td>Post session client questionnaire</td>
<td>Client experienced impact of therapy Factor Analysis to test psychometric properties of the SIS</td>
<td>Helpful and Hindering Impacts: divided into Task Impact (awareness and definition of problems) and Relationship Impact (feeling understood, closer to therapist) Good internal and convergent reliability for the SIS</td>
</tr>
<tr>
<td></td>
<td>Process Experiential therapy Therapists ((N=10))</td>
<td>The Session Impact Scale (SIS) (Elliott, 1985; Elliott &amp; James et al. 1985)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Session Evaluation Questionnaire (SEQ) (Stiles, 1980)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gershefski et al., (1996)</td>
<td>Adult Clients with Major Depressive Disorder ((N=154)) 4 treatment conditions: CBT, IPT, Medication + clinical management, Placebo + clinical management Therapists ((N=28))</td>
<td>Post treatment questionnaire using Evaluation of Therapy Form (not specified)</td>
<td>Helpful aspects of treatment Coded by research students (Kappas = .61-.93)</td>
<td>Frequent categories of helpful aspects: common aspects (therapist helped, learnt something new) therapist approach reported as helpful</td>
</tr>
<tr>
<td>Levitt, Butler &amp; Hill (2006)</td>
<td>Adult clients (completed therapy within 2-12 months) ((N=26))</td>
<td>Structured interview post session</td>
<td>Significant therapy moments Coded by researchers using Grounded Theory (Fassinger, 2005) included credibility check with clie</td>
<td>6 clusters: commitment to therapy, therapist’s care, self reflection, relationship, therapist characs, structuring reflexivity</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Data Collection</td>
<td>Data Analysis (Construct/Coding/Rater)</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lietaer and Neirinck (1986)</td>
<td>Adult clients ($N=41$) Therapists ($N=25$)</td>
<td>Semi-structured interview post session</td>
<td>Helping Processes Rating scale of 76 items constructed for the study by the author Content analysis Rated by chief researcher and other staff members</td>
<td>3 categories of helping processes: relational climate (basic attitudes of therapists and general characteristics of contact), specific therapist interventions, process aspects concerning the client.</td>
</tr>
<tr>
<td>Llewelyn et al., (1988)</td>
<td>Adult clients with Anxiety/Depression ($N=26$) RCT study (Shapiro &amp; Firth, 1987) Therapists ($N=22$)</td>
<td>Self reports of events post session and post treatment using Helpful Aspects of Therapy Form (HAT)</td>
<td>Helpful and Unhelpful events Coded by researcher using Therapeutic impact Content analysis System (Elliot, 1985)</td>
<td>Helpful event clusters: Experience of relief, positive view of self, resolution of specific problems, acquisition of insight, personal contact.</td>
</tr>
<tr>
<td>Mohr and Woodhouse (2001)</td>
<td>Undergraduate students (in or seeking therapy) ($N=47$)</td>
<td>Post session questionnaire (3 time points during therapy) Clients asked to focus on event, verbalisations and feelings Replication of Bachelor (1995)</td>
<td>Helpful and harmful aspects Therapy priorities Q sort (TPQ) Clients sorted self report cards</td>
<td>2 factor model of alliance, personal alliance (warm and highly personal) and professional (challenging and collaborative) trusting and respectful therapist optimal for both factors, client differences for emotional connection</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Data Collection</td>
<td>Data Analysis (Construct/Coding/Rater)</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Paulson, Truscott and Stuart (1999)</td>
<td>Adult clients on completion of therapy ($N=36$)</td>
<td>Qualitative telephone interview, 3 weeks prior to termination of therapy</td>
<td>Helpful experiences Client (N=19) returned to sort and rate reports into categories Concept Mapping</td>
<td>9 clusters of helpful experience: counselor facilitative interpersonal style, interventions, generating client resources, new perspectives, client self disclosure, emotional relief, gaining knowledge, accessibility and client resolution</td>
</tr>
<tr>
<td>Simpson and Bedi, (2013)</td>
<td>Adult clients (in therapy or terminated in the last 30 days) ($N=50$)</td>
<td>Clients sorted statements from previous study (Bedi &amp; Duff, 2012)</td>
<td>Factors helping to form or strengthen the therapy relationship Clients rated statements for helpfulness Concept mapping</td>
<td>Most helpful factors: emotional support, non-judgemental, effective listening</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Data Collection</td>
<td>Data Analysis</td>
<td>(Construct/Coding/Rater)</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Stiles et al., (1994)</td>
<td>Office workers referred for depression as part of Sheffield Psychotherapy Project (Shapiro et al. 1990) (N=218) Therapists (N=8)</td>
<td>Post session questionnaire (SEQ, SIS) and global helpfulness scale</td>
<td>Session evaluation and impact Researchers sorted responses Factor Analysis</td>
<td>High intercorrelations found between SEQ and SIS, suggesting SIS captures global assessment rather than differentiated client descriptions of impact</td>
</tr>
<tr>
<td>Watson et al., (2012)</td>
<td>Adult clients taking part in relationally oriented therapy (N=10)</td>
<td>Post session form with qualitative descriptions of helpful client and therapist activities and effects</td>
<td>Helpful therapeutic processes Coded by researchers Thematic analysis and process mapping</td>
<td>Helpful client activity: talking about emotions and experiences Helpful therapist activity Questioning, direction, relational qualities Helpful effects: insight, completion of therapeutic tasks, change in feelings</td>
</tr>
</tbody>
</table>
Appendix 5  Symptom Measures: PHQ-9 and GAD-7

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself --- or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite --- being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: _____ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Appendix 5

Symptom Measures: PHQ-9 and GAD-7

<table>
<thead>
<tr>
<th>GAD-7</th>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Use &quot;✓&quot; to indicate your answer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(For office coding: Total Score $T = \text{___} + \text{___} + \text{___}$)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Appendix 6 Novel Client Measures (Page 1 of 10 repeated measures)

Instructions: Read the questions carefully below. Each time the video is stopped, think about the 2 minutes of interaction that has just taken place between you and the therapist. Try to recall how you perceived what was going on at that time. Mark with an X on each vertical line the level which describes your own experience of each item.

1) Therapist assistance
   Not helpful at all I----------------------------------------------I Extremely helpful

2) Sense of control over what is happening in therapy
   No control I-----------------------------------------------I Complete control

3) Talking freely about my problem
   (without filtering what comes into my mind)
   Not able at all I-----------------------------------------------I Entirely able

4) Feeling able to experience emotion connected to the problem
   Not able at all I-----------------------------------------------I Entirely able

5) Being able to see my problem in new ways
   Not able at all I-----------------------------------------------I Entirely able

6) Relationship
   I-----------------------------------------------I
   I did not feel heard, understood and respected at all
   I felt completely heard, understood and respected

7) Goals and Topics
   I-----------------------------------------------I
   We did not work on and talk about what I wanted to at all
   We worked on and talked about what I wanted to entirely

8) Approach and Methods
   I-----------------------------------------------I
   The therapist’s approach is not a good fit for me at all
   The therapist’s approach is an extremely good fit for me
Appendix 7 Novel Therapist Measures (Page 1 of 10 repeated measures)

Instructions: Read the questions carefully below. Each time the video is stopped, think about the 2 minutes of interaction that has just taken place between you and the client. Try to recall how you perceived what was going on at that time. Mark with an X on each vertical line the level which describes your own experience of each item.

1) the extent to which you think that you were being helpful to the client

| Not helpful | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |..
Appendix 8

Therapist Adherence Measures: MOLAS and CTS-R

METHOD OF LEVELS ADHERENCE SCALE – MOLAS v2.0


While the content of this scale is unique, the Format and Overview is directly based on:

COGNITIVE THERAPY SCALE – REVISED (CTS-R)
I.-M. Blackburn, I.A. James, D.L. Milne & F.K. Reichelt
Newcastle upon Tyne, UK, 2001

Name: _____ Scorer: _____ Date: ___ Session: __

MOL ADHERENCE SCALE – MOLAS v 2.0

The rating of the scale

The present seven point scale (i.e. a 0-6 Likert scale) extends from (0) where the therapist did not adhere to that aspect of therapy (non-adherence) to (6) where there is adherence and very high skill. Thus the scale assesses both adherence to therapy method and skill of the therapist. To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. A description of the various rating criteria is given in the right hand margin – see example below in Figure 1. Further details are provided in the accompanying manual.

The examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides.
Figure 1: Example of the scoring layout

Key features: this is an operationalised description of the item (see examples within the scale). Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incompetent</td>
<td>0 absence of feature, or highly inappropriate</td>
</tr>
<tr>
<td></td>
<td>performance</td>
</tr>
<tr>
<td>Novice</td>
<td>1 Inappropriate performance, with major problems</td>
</tr>
<tr>
<td></td>
<td>evident</td>
</tr>
<tr>
<td>Advanced</td>
<td>2 evidence of competence, but numerous problems and</td>
</tr>
<tr>
<td>Beginner</td>
<td>lack of consistency</td>
</tr>
<tr>
<td>Competent</td>
<td>3 competent, but some problems and/or inconsistencies</td>
</tr>
<tr>
<td>Proficient</td>
<td>4 good features, but minor problems and/or</td>
</tr>
<tr>
<td></td>
<td>inconsistencies</td>
</tr>
<tr>
<td>Expert</td>
<td>5 very good features, minimal problems and/or</td>
</tr>
<tr>
<td></td>
<td>inconsistencies</td>
</tr>
<tr>
<td></td>
<td>6 excellent performance, or very good even in the</td>
</tr>
<tr>
<td></td>
<td>face of patient difficulties</td>
</tr>
</tbody>
</table>

* The present scale has incorporated the Dreyfus system (Dreyfus, 1989) for denoting competence. Please note that the top marks (i.e. near the ‘expert’ end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

The ‘Key Features’ describe the important features that need to be considered when scoring each item. When rating the item, you must first identify whether some of the features are present. You must then consider whether the therapist should be regarded as competent with the features. If the therapist includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the therapist should be rated very highly.
The ‘Examples’ are only guidelines and should not be regarded as absolute rating criteria.


This overview is adapted and reproduced directly from:

COGNITIVE THERAPY SCALE – REVISED (CTS-R)
I.-M. Blackburn, I.A. James, D.L. Milne & F.K. Reichelt
Newcastle upon Tyne, UK , 2001
ITEM 1 – FOCUSING ON THE PROBLEM AT HAND

Key features: This refers to the degree to which the therapist allows the client to discuss their current problem, as they see it, right now, in the session. This requires the therapist to track the current problem and its associated goals, feelings and thoughts, and where necessary to help the client reprioritise and reprioritise the problem they talk about in an ongoing, sensitive manner.

These features need to be considered when scoring this item:
(i) To what degree are the problems those chosen by the client rather than the therapist
(ii) To what degree does the therapist track the problem and its features, as it is being described
(iii) To what degree does the therapist allow the client to reprioritise the choice of current problem in an ongoing manner

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled this goal. The descriptive features on the right are designed to guide your decision

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NB: Score according to features, not examples</td>
</tr>
<tr>
<td>0</td>
<td>The problems are always those decided upon by the therapist rather than the client</td>
</tr>
<tr>
<td>1</td>
<td>The problems are only occasionally those suggested by the client</td>
</tr>
<tr>
<td>2</td>
<td>The problems are sometimes those suggested by the client</td>
</tr>
<tr>
<td>3</td>
<td>The problems are often those suggested by the client but there are examples of where the therapist makes his or her own suggestions</td>
</tr>
<tr>
<td>4</td>
<td>The problems are nearly always those suggested by the client but the therapist struggles to follow how they change in an ongoing manner</td>
</tr>
<tr>
<td>5</td>
<td>The problems are nearly always those suggested by the client and the therapist follows how they change in an ongoing manner</td>
</tr>
<tr>
<td>6</td>
<td>The problems are always those suggested by the client and the therapist allows the client to readjust and reprioritise their problems in an ongoing, sensitive manner</td>
</tr>
</tbody>
</table>
**ITEM 2 – FOCUSING ON THE CLIENTS’ PRESENT PERCEPTION**

Key features: This item reflects the degree to which the therapist gears the client to talk about their present experience, in the moment as it is happening. This includes current thoughts, feelings, mental imagery, memories (as they are being *recalled* right now), and current perception of the environment, including the clients’ own voice and the interaction as it is occurring.

These features need to be considered when scoring this item:

(i) To what degree is the session focused on present perception, through whatever modality is relevant at the time

(ii) To what degree do the therapist’s questions help the client to notice the process and properties of current experience (e.g. vividness, location, timescale, pace of change)

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>All discussion is focused on the past or future</td>
</tr>
<tr>
<td>1</td>
<td>Only occasionally is the content of the session focused on the present experience</td>
</tr>
<tr>
<td>2</td>
<td>Some of the content of the session is focused on the present experience</td>
</tr>
<tr>
<td>3</td>
<td>At least half of the content of the session is focused on the present experience, but many opportunities to do so are missed</td>
</tr>
<tr>
<td>4</td>
<td>Most of the content of the session is focused on the present experience but several good opportunities to do so are missed</td>
</tr>
<tr>
<td>5</td>
<td>Most of the content of the session is focused on the present experience but occasionally opportunities to do so are missed</td>
</tr>
<tr>
<td>6</td>
<td>The therapist takes every appropriate opportunity to focus the content of the session on the present experience</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples.

---

**NB:** Score according to features, not examples.
ITEM 3 – NOTICING DISRUPTIONS AND BACKGROUND (HIGHER LEVEL) THOUGHTS

Key features: This item reflects the degree to which the therapist notices disruptions and/or facilitates the client’s awareness of higher level goals, thoughts and perceptions. Disruptions include changes in affect such as smiling or fearful expressions, changes in vocal output such as volume, pace, pausing, etc, behaviours such as gesturing or the process of eye movement. These are detected in order to facilitate the clients’ awareness of them, and the goals, thoughts and feelings related to them rather than to present the therapist’s interpretations. Questioning style can also be used to facilitate awareness of background thoughts as they occur.

These features need to be considered:

  To what degree does the therapist notice disruptions and indicators of background thoughts.
  To what degree is the therapist’s commenting and questioning appropriate in that it facilitates the client’s awareness of disruptions and the thoughts, feelings or goals relating to them.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The therapist never pays attention to disruptions or background thoughts</td>
</tr>
<tr>
<td>1</td>
<td>On rare occasions, the therapist asks about disruptions and background thoughts but insufficiently to allow their exploration</td>
</tr>
<tr>
<td>2</td>
<td>On occasions, the therapist asks about disruptions and background thoughts and some times this helps their exploration</td>
</tr>
<tr>
<td>3</td>
<td>The therapist asks about disruptions and elicits background thoughts some of the time but the way of doing so only sometimes facilitates further exploration of them</td>
</tr>
<tr>
<td>4</td>
<td>The therapist asks about disruptions and elicits background thoughts some of the time and on many occasions this facilitates further exploration of higher level goals and perceptions</td>
</tr>
<tr>
<td>5</td>
<td>The therapist asks about disruptions and elicits background thoughts regularly and on many occasions this facilitates further exploration of higher level goals and perceptions</td>
</tr>
<tr>
<td>6</td>
<td>The therapist regularly and sensitively asks about disruptions and elicits background thoughts wherever it seems appropriate and helpful to do so and this nearly always leads to further exploration of higher level goals and perceptions</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples
ITEM 4 – ASKING ABOUT PROCESS OVER CONTENT

Key features: This item reflects the extent to which the therapist’s questions relate to process rather than content. The processes of particular importance involve the temporal quality of perception (e.g. when does this stop and start), the nature of changes (e.g. quick to slow), the quality of perception (e.g. vivid to faint), and whether they involve sharp or gradual differences (e.g. categorical or continuous). The process of control of perception over different timescales (e.g. sensations through plans to self-ideals and values) and to different degrees is also important (e.g. feeling little control to feeling in complete control).

This feature needs to be considered:

(i) To what degree do the therapists questions guide the client to notice the process of their thinking, feeling and perception in contrast to the content of thought, feelings and perception.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The therapist focuses entirely on content and never asks about the processes of thinking, feeling and perceiving</td>
</tr>
<tr>
<td>1</td>
<td>The therapist typically asks about content but occasionally asks about the process of thinking, feeling and perceiving</td>
</tr>
<tr>
<td>2</td>
<td>The therapist typically asks about content but sometimes asks about the process of thinking, feeling and perceiving</td>
</tr>
<tr>
<td>3</td>
<td>The session is about equal in terms of process versus content</td>
</tr>
<tr>
<td>4</td>
<td>The therapist often asks about the process of thinking, feeling and perceiving but sometimes focuses on the content</td>
</tr>
<tr>
<td>5</td>
<td>The therapist nearly always asks about the process of thinking, feeling and perceiving but occasionally focuses on the content</td>
</tr>
<tr>
<td>6</td>
<td>The therapist takes every appropriate opportunity to ask about the process of thinking, feeling and perceiving</td>
</tr>
</tbody>
</table>
ITEM 5 – MAINTAINING CURIOSITY

Key features: This item reflects the general stance of the therapist as ‘curious’ in a way that facilitates the clients own exploration of their perceptions and goals.

These features need to be considered:

(i) The degree to which the therapists comes across as genuinely curious and open-minded about what the client reports
(ii) The degree to which the therapist is unbiased by their own assumptions, advice and interpretations

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The therapist is never curious, regularly makes assumptions and offers advice within an expert role</td>
</tr>
<tr>
<td>1</td>
<td>The therapist is occasionally curious, but mostly makes assumptions and offers advice</td>
</tr>
<tr>
<td>2</td>
<td>The therapist is sometimes curious, but often makes assumptions and offers advice</td>
</tr>
<tr>
<td>3</td>
<td>The therapist provides assumptions and advice and shows curiosity to about an equal degree.</td>
</tr>
<tr>
<td>4</td>
<td>The therapist maintains curiosity most of the time but sometimes makes assumptions and offers advice</td>
</tr>
<tr>
<td>5</td>
<td>The therapist maintains a natural curiosity nearly all of the time and only occasionally makes assumptions or offers advice</td>
</tr>
<tr>
<td>6</td>
<td>The therapist maintains empathic curiosity throughout, never offers advice and takes every appropriate opportunity to try to understand the client and help them to clarify their descriptions.</td>
</tr>
</tbody>
</table>
ITEM 6 – TREATING THE CLIENT WITH RESPECT AS A SOPHISTICATED, PURPOSEFUL, BEING WHO NEVERTHELESS EXPERIENCES PROBLEMS

Key features: This item reflects the degree to which the therapist purveys an understanding of the client as a person with their own goals, values and beliefs, which are respected and not oversimplified or ignored. In this context, the problems the client describes as seen as an potentially understandable consequence of the kind of life the client is experiencing, and the challenges inherent in managing conflicting values, beliefs and goals.

These features need to be considered:

- The degree to which the therapist seems to appreciate the purposefulness of living
  (i) The degree to which the therapist seems to understand that goals are hierarchically organised
  (ii) The degree to which the therapist seems to appreciate that internal conflict is a problem
  (iii) The degree to which the therapist seems to appreciate at a human level how control is being compromised for the client; this appears to emerge naturally rather than being assumed or suggested

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The therapist treats the client as an object to be influenced, controlled and manipulated</td>
</tr>
<tr>
<td>1</td>
<td>The therapist mostly expects the client to be compliant with demands or advice, but occasionally shows respect or consideration</td>
</tr>
<tr>
<td>2</td>
<td>On balance, the therapist is controlling, but shows some examples of stepping back and allowing the client to explore their own perspectives</td>
</tr>
<tr>
<td>3</td>
<td>The therapist is directive and makes some suggestions and interpretations, but only around half of the time</td>
</tr>
<tr>
<td>4</td>
<td>The therapist often respects the client’s autonomy and illustrates a consideration for their predicament but some of the time makes assumptions or offers advice</td>
</tr>
<tr>
<td>5</td>
<td>The therapist illustrates respect for the client throughout most of the session in the way that questions are asked</td>
</tr>
<tr>
<td>6</td>
<td>Through their interaction, the therapist shows a respect and compassion for the client that emerges from the way the therapist regards the self-determined and purposeful nature of the client at every level</td>
</tr>
</tbody>
</table>
COGNITIVE THERAPY SCALE - REVISED  
(CTS-R)

I.-M. Blackburn, I.A. James, D.L. Milne &  
F.K. Reichelt

Collaborators:  
A. Garland, C. Baker, S.H. Standart & A. Claydon

Newcastle upon Tyne, UK - August 2000
COGNITIVE THERAPY SCALE - REVISED (CTS-R)

The rating of the scale
The present seven point scale (i.e. a 0-6 Likert scale) extends from (0) where the therapist did not adhere to that aspect of therapy (non-adherence) to (6) where there is adherence and very high skill. Thus the scale assesses both adherence to therapy method and skill of the therapist. To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. A description of the various rating criteria is given in the right hand margin - see example below in Figure 1. Further details are provided in the accompanying manual.

The examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides.

Adjusting the scale in the presence of patient difficulties
The scale's dimensions were devised for patients assessed as being well/moderately suited for cognitive therapy (Safran & Segal, 1990). As such, adjustments may need to be made when patient difficulties are evident (e.g. excessive avoidance). Indeed, with problematic patients it is sometimes difficult to apply CT methods successfully; that is, with desirable change. In such circumstances the rater needs to assess the therapist's therapeutic skills in the application of the methods. Thus even though the therapist may be unsuccessful at promoting change, credit should be given for demonstrations of appropriate skillful therapy.


Figure 1: Example of the scoring layout

Key features: this is an operationalised description of the item (see examples within the CTS-R).
Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy and perceived patient difficulty.
### Competence Level Examples

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incompetent</td>
<td>0 absence of feature, or highly inappropriate performance</td>
</tr>
<tr>
<td>Novice</td>
<td>1 inappropriate performance, with major problems evident</td>
</tr>
<tr>
<td>Advanced</td>
<td>2 evidence of competence, but numerous problems and lack of consistency</td>
</tr>
<tr>
<td>Beginner</td>
<td>3 competent, but some problems and/or inconsistencies</td>
</tr>
<tr>
<td>Competent</td>
<td>4 good features, but minor problems and/or inconsistencies</td>
</tr>
<tr>
<td>Proficient</td>
<td>5 very good features, minimal problems and/or inconsistencies</td>
</tr>
<tr>
<td>Expert</td>
<td>6 excellent performance, even in the face of patient difficulties</td>
</tr>
</tbody>
</table>

* The present scale has incorporated the Dreyfus system (Dreyfus, 1989) for denoting competence, which is described fully in the manual. Please note that the 'top marks' (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

The 'Key Features' describe the important features that need to be considered when scoring each item. When rating the item, you must first identify whether some of the features are present. You must then consider whether the therapist should be regarded as competent with the features. If the therapist includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the therapist should be rated very highly.

The 'Examples' are only guidelines and should not be regarded as absolute rating criteria.

### Scoring Distribution

It is important to remember that the scoring profile for this scale should approximate to a normal distribution (i.e. mid-point 3), with relatively few therapists scoring at the extremes.

ITEM 2 - FEEDBACK

Key features: The patient’s and therapist’s understanding of key issues should be helped through the use of two-way feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient’s situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.

Three features need to be considered when scoring this item:

(i) presence and frequency, or absence, of feedback. Feedback should be given/elicted throughout the therapy - with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session;
(ii) appropriateness of the contents of the feedback;
(iii) manner of its delivery and elicitation (NB: can be written).

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Absence of feedback or highly inappropriate feedback.</td>
</tr>
<tr>
<td>1</td>
<td>Minimal appropriate feedback (verbal and/or written).</td>
</tr>
<tr>
<td>2</td>
<td>Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback, e.g. feedback too vague to provide opportunities for understanding and change.</td>
</tr>
<tr>
<td>3</td>
<td>Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.</td>
</tr>
<tr>
<td>4</td>
<td>Appropriate feedback given and elicited frequently, facilitating moderate therapeutic gains. Minor problems evident (e.g. inconsistent).</td>
</tr>
<tr>
<td>5</td>
<td>Highly appropriate feedback given and elicited regularly, facilitating shared understanding and enabling significant therapeutic gains. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent use of feedback, or highly effective feedback given and elicited regularly in the face of difficulties.</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples!
**ITEM 3 - COLLABORATION**

**Key features:** The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skillfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way.

Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of:

(i) verbal skills (e.g. non-hectoring);
(ii) non-verbal skills (e.g. attention and use of joint activities);
(iii) sharing of written summaries.

NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self discovery should be scored under Item 9 (Guided Discovery).

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>NB: Score according to features, not examples!</strong></td>
</tr>
<tr>
<td>0</td>
<td>Patient is actively prevented or discouraged from being collaborative.</td>
</tr>
<tr>
<td>1</td>
<td>The therapist is too controlling, dominating, or passive.</td>
</tr>
<tr>
<td>2</td>
<td>Some occasional attempt at collaboration, but didactic style or passivity of therapist encourages passivity or other problems in the therapeutic relationship.</td>
</tr>
<tr>
<td>3</td>
<td>Teamwork evident, but some problems with collaborative set (e.g. not enough time allowed for the patient to reflect and participate actively).</td>
</tr>
<tr>
<td>4</td>
<td>Effective teamwork is evident, but not consistent. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Effective teamwork evident throughout most of the session, both in terms of verbal content and use of written summaries. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent teamwork, or highly effective teamwork in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 4 - PACING AND EFFICIENT USE OF TIME

Key features: The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

Three features need to be considered:

(i) the degree to which the session flows smoothly through the discrete phases;
(ii) the appropriateness of the pacing throughout the session;
(iii) the degree of fit to the learning speed of the patient.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Poor time management leads either to an aimless or overly rigid session.</td>
</tr>
<tr>
<td>1</td>
<td>The session is too slow or too fast for the current needs and capacity of the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Reasonable pacing, but digression or repetitions from therapist and/or patient lead to inefficient use of time; unbalanced allocation of time, over time.</td>
</tr>
<tr>
<td>3</td>
<td>Good pacing evident some of the time, but diffuse at times. Some problems evident.</td>
</tr>
<tr>
<td>4</td>
<td>Balanced allocation of time with discrete start, middle and concluding phases evident. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent time management, or highly effective management evident in the face of difficulties.</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples!
ITEM 5 - INTERPERSONAL EFFECTIVENESS

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.

Three features need to be considered:

(i) empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change;
(ii) genuineness - the therapist has established a trusting working relationship;
(iii) warmth - the patient seems to feel liked and accepted by the therapist.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
<th>NB: Score according to features, not examples!</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Therapist's manner and interventions make the patient disengage and become distrustful and/or hostile (absence of/or excessive i, ii, iii).</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Difficulty in showing empathy, genuineness and warmth.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Therapist's style (e.g. intellectualisation) at times impedes his/her empathic understanding of the patient's communications.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The therapist is able to understand explicit meanings of patient's communications, resulting in some trust developing. Some evidence of inconsistencies in sustaining relationship.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The therapist is able to understand the implicit, as well as the explicit meanings of the patient's communications and demonstrates it in his/ her manner. Minor problems evident (e.g. inconsistent).</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The therapist demonstrates very good interpersonal effectiveness. Patient appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Highly interpersonally effective, even in the face of difficulties.</td>
<td></td>
</tr>
</tbody>
</table>
ITEM 6 — ELICITING OF APPROPRIATE EMOTIONAL EXPRESSION

**Key features:** The therapist facilitates the processing of appropriate levels of emotion by the patient. Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered:

(i) facilitation of access to a range of emotions;
(ii) appropriate use and containment of emotional expression;
(iii) facilitation of emotional expression; encouraging appropriate access and differentiation of emotions.

<table>
<thead>
<tr>
<th>Competence Level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient is under- or over stimulated (e.g. his/her feelings are ignored or dismissed or allowed to reach an unmanaged pitch). Or the therapist’s own mood or strategies (e.g. intellectualization) adversely influences the session.</td>
</tr>
<tr>
<td>1</td>
<td>Failure to facilitate access to, and expression of, appropriate emotional expression.</td>
</tr>
<tr>
<td>2</td>
<td>Facilitation of appropriate emotional expression evident, but many relevant opportunities missed.</td>
</tr>
<tr>
<td>3</td>
<td>Some effective facilitation of appropriate emotional expression, created and/or maintained. Patient enabled to become slightly more aware.</td>
</tr>
<tr>
<td>4</td>
<td>Effective facilitation of appropriate emotional expression leading to the patient becoming more aware of relevant emotions. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Very effective facilitation of emotional expression, optimally arousing the patient’s motivation and awareness. Good expression of relevant emotions evident- done in an effective manner. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent facilitation of appropriate emotional expression, or effective facilitation in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 7 - ELICITING KEY COGNITIONS

**Key features:** To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs) and to understand the relationship between these and their distressing emotions. This can be done through the use of questioning, diaries and monitoring procedures.

Three features need to be considered:
(i) eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts);
(ii) the skillfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);
(iii) choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

**NB:** This item is concerned with the general work done with eliciting cognitions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Therapist fails to elicit relevant cognitions.</td>
</tr>
<tr>
<td>1</td>
<td>Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored.</td>
</tr>
<tr>
<td>2</td>
<td>Some cognitions/emotions (or one key cognition, e.g. core belief) elicited, but links between cognitions and emotions not made clear to patient.</td>
</tr>
<tr>
<td>3</td>
<td>Some cognitions/emotions (or one key cognition) elicited in a competent way, although some problems evident.</td>
</tr>
<tr>
<td>4</td>
<td>A number of cognitions and emotions (or one key cognition) elicited in verbal or written form, leading to a new understanding of their relationship. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Effective eliciting and selection of a number of cognitions/emotions (or one key cognition), which are generally dealt with appropriately. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent work done on key cognition(s) and emotion(s), even in the face of difficulties.</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples!
ITEM 8 - ELICITING AND PLANNING BEHAVIOURS

Key features: To help the patient gain insight into the effect of his/her behaviours with respect to the problems. This can be done through the use of questioning, diaries and monitoring procedures. The therapist works with the patient to plan strategies either to overcome or disrupt dysfunctional behavioural patterns.

Two features need to be considered:
(i) eliciting behaviours and plans that are associated with distressing emotions;
(ii) the skillfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);

NB: This item is concerned with the general work done with eliciting behaviours and plans. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Therapist fails to elicit relevant behaviours and plans.</td>
</tr>
<tr>
<td>1</td>
<td>Inappropriate behaviours focused on and/or plans generated.</td>
</tr>
<tr>
<td>2</td>
<td>Some behaviours and plans elicited, but links between behaviours, cognitions and emotions not made clear to patient.</td>
</tr>
<tr>
<td>3</td>
<td>Some behaviours and plans elicited in a competent way, although some problems evident.</td>
</tr>
<tr>
<td>4</td>
<td>A number of behaviours and plans elicited in verbal or written form, leading to a new understanding of their importance in maintaining problems. Minor difficulties evident.</td>
</tr>
<tr>
<td>5</td>
<td>Effective eliciting and selection of a number of behaviours and plans, which are generally dealt with appropriately. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent work done on behaviours and plans, even in the face of difficulties.</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples!
ITEM 9 - GUIDED DISCOVERY

Key features: The patient should be helped -to-develop hypotheses regarding his/her current situation and to generate potential solutions for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.

Two elements need to be considered:

(i) the style of the therapist - this should be open and inquisitive;
(ii) the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No attempt at guided discovery (e.g. hectoring and lecturing).</td>
</tr>
<tr>
<td>1</td>
<td>Little opportunity for discovery by patient. Persuasion and debate used excessively.</td>
</tr>
<tr>
<td>2</td>
<td>Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thoughts or emotions or to make connections between themes.</td>
</tr>
<tr>
<td>3</td>
<td>Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.</td>
</tr>
<tr>
<td>4</td>
<td>Moderate degree of discovery evident. Therapist uses a questioning style with skill, and this leads to some synthesis. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Effective reflection evident. Therapist uses skilful questioning style leading to reflection, discovery, and synthesis. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent guided discovery leading to a deep patient understanding. Highly effective discovery produced in the face of difficulties, with evidence of a deeper understanding having been developed.</td>
</tr>
</tbody>
</table>
**ITEM 10 - CONCEPTUAL INTEGRATION**

**Key features:** The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward.

Two features need to be considered:

(i) the presence/absence of an appropriate conceptualisation which is in line with goals of therapy;
(ii) the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.).

**NB:** This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions)

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The absence of an appropriate conceptualisation.</td>
</tr>
<tr>
<td></td>
<td>The lack, or inappropriateness or misapplication of a conceptualisation leads to a neutral impact (e.g. interferes with progress or leads to aimless application of procedures).</td>
</tr>
<tr>
<td>1</td>
<td>Some rudimentary conceptualisation arrived at, but not well integrated with goals of therapy. Does not lead to a clear rationale for interventions.</td>
</tr>
<tr>
<td>2</td>
<td>Cognitive conceptualisation partially developed with some integration, but some difficulties evident (e.g. in synthesising and in sharing it with the patient). Leads to coherent interventions.</td>
</tr>
<tr>
<td>3</td>
<td>Cognitive conceptualisation is moderately developed and integrated within the therapy. Minor problems evident.</td>
</tr>
<tr>
<td>4</td>
<td>Cognitive conceptualisation is very well developed and integrated within the therapy - there is a credible cognitive understanding leading to major therapeutic shifts. Minimal problems.</td>
</tr>
<tr>
<td>5</td>
<td>Excellent development and integration evident, or highly effective in the face of difficulties.</td>
</tr>
</tbody>
</table>

NB: Score according to features, not examples!
ITEM 11- APPLICATION OF CHANGE METHODS

Key features: Therapist skillfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to apply behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test-out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient’s level of understanding of prospective practical assignments (i.e. by the patient performing the task in-session).

Three features need to be considered:

(i) the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient’s work, modeling, applied relaxation, controlled breathing, etc.);
(ii) the skill in the application of the methods - however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;
(iii) the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex).

NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NB: Score according to features, not examples!</td>
</tr>
<tr>
<td>0</td>
<td>Therapist fails to use or misuses appropriate cognitive and behavioural methods.</td>
</tr>
<tr>
<td>1</td>
<td>Therapist applies either insufficient or inappropriate methods, and/or with limited skill or flexibility.</td>
</tr>
<tr>
<td>2</td>
<td>Therapist applies appropriate methods, but major difficulties evident.</td>
</tr>
<tr>
<td>3</td>
<td>Therapist applies a number of methods in competent ways, although some problems evident (e.g. the interventions are incomplete).</td>
</tr>
<tr>
<td>4</td>
<td>Therapist applies a range of methods with skill and flexibility, enabling the patient to develop new perspectives. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent range and application, or successful application in the face of difficulties.</td>
</tr>
</tbody>
</table>
Appendix 9

Client Participation Information Sheet

Division of Clinical Psychology
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester M13 9PL

Email: alexandra.cocklin@postgrad.manchester.ac.uk

PARTICIPANT INFORMATION SHEET Version 2.0 (July 2013)

A Study of What Makes Therapy Therapeutic for Service Users.

We would like to invite you to take part in a research study. Before you decide whether or not to take part, please read why the research is being done and what it would involve for you. Please take time to read the following information carefully and to speak to others about the study. The aim of the project is to evaluate what service users find helpful when talking about a problem in sessions of psychological therapy.

Why do the study?

The project focuses on what individual clients find helpful in therapy and what therapists can do to make interactions more positive. We believe that client perceptions of therapy are key to understanding how we can help people to get the most out of therapy. We hope that understanding the process that occurs during therapeutic sessions could help therapists to learn techniques and skills in training that may increase the client’s experience of positive change. This is further hoped to promote further client satisfaction with therapy, engagement and therapeutic outcomes over time.

Who is carrying out the research?

This project is being completed by Alex Cocklin, Trainee Clinical Psychologist, as part of the requirements for the Doctorate in Clinical Psychology programme. The project is being supervised by Dr Sara Tai and Dr Warren Mansell, who are both practicing Clinical Psychologists and senior researchers in Clinical Psychology at the University of Manchester.

What happens if I take part?
If you agree to take part, you would be invited to an initial appointment to discuss the study in more detail at Six Degrees Social Enterprise. This appointment will involve answering a few questionnaires about how you’ve been feeling over the last two weeks. You will also have the opportunity to ask any questions about the project and you will be asked to sign a consent form. An appointment for the first session of the study will then be agreed for a time that is convenient for you.

What does the study involve?

Before the first session you will meet the researcher and there will be some brief questionnaires to complete. The first session of the study will involve a 30 minute meeting with a therapist at Six Degrees Social Enterprise to talk about a problem of your choice. There will be some time at the start of the session to settle in and some time at the end to discuss any questions you may have. The therapist will use a type of cognitive therapy known as Method of Levels, which can be applied to a range of mental health problems. The session will be videotaped.

You will then be invited back for a further appointment to watch the video recording of your therapy session. You will be asked to rate your experiences at different time intervals using a paper and pencil rating form. This session will take about 1 hour and 15 minutes. The therapist from the session will not be present and everything discussed will be kept confidential. The only people watching the videotape during this session will be yourself and the researcher. The therapist from your session will be invited to watch and rate the videotape but this will take place on a separate occasion. The therapist will be asked to rate how they conducted the session at different time intervals.

Participation in this study is entirely voluntary

You are free to withdraw from the study at any point without giving a reason. If you do not take part in this study it will not affect your right to receive psychological therapy and be treated by your local NHS Trust (or indeed any other trust).

Will my information be kept confidential?

All questionnaires for the study will be anonymised and have a code rather than your name and will be kept in a locked cabinet at the University. It is planned that the results of this project will be written in a report, which may be published in a scientific journal; however your details will be removed and replaced with a code. It is also possible that this data may be used in further research studies in the future; however this information will still remain anonymous. We will send you a summary of the findings from this study when it is completed. Quotes from interviews and scores from questionnaires may be part of the final research report and used in research publications, but under no circumstances will names or identifying characteristics be included.

It is planned that the research therapy session will be video recorded. However this material will be kept confidential and will not be accessible by anyone other than the research team. The videotape of your therapy session will not be viewed by other members of the service staff team except for the therapist who has conducted your first session. Your videotape will be given a code number which is linked to your name. The list of names and codes are kept separately so that only the research team will be able to identify your video session tape if necessary.
All of the data including the video material will be kept for 10 years in a locked filing cabinet in Dr. Warren Mansell’s office at Manchester University until they are destroyed. Data obtained from this study may be used in future studies, however all details shall remain anonymous. We would like to keep the data for 10 years so that we may use it for further analyses, in light of new understanding and data that we collect from related studies.

The information that you discuss during your therapy session will be available to the researcher conducting this study and the rest of the research team. The researcher is required to inform your GP and other health professionals working with you that you are receiving psychological therapy as part of a research project. A letter will be sent to your G.P. stating that you are taking part in this research study and providing further details of what it involves. What you say in your therapy session and when watching the video of your therapy will remain confidential and will not be shared with anybody else without your consent. However, if you tell us anything that makes us think that you or anyone else is at risk of serious harm we will have to break confidentiality and share this information with other another person or services responsible for your care (e.g. with your GP). We would always discuss this with you before we spoke to anyone else.

Are there any potential risks?

The therapeutic techniques used in this study are no different to those used in standard everyday clinical practice. However, some people may find talking about their emotions and experiences upsetting. The researcher will routinely ask you about your level of distress and provide support as and when required.

Potential benefits of this study

This study will give the participant the immediate opportunity to reflect upon what they find helpful about therapy during the review of video material from their session. This may have benefits in terms of enabling the participant to become more aware of how they respond to the approach offered by a therapist. Participants may be able to develop a different perspective on their problem by watching the video playback. This study also encourages the involvement of service users in the evaluation of therapy sessions. We hope that this might create a positive impression of mental health research and service provision amongst participating clients, by showing how clients’ views about therapy are being actively used and valued.

Complaints

If you have a concern about any aspects of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.
Who do I contact?

If you have any questions about the study or would like to take part please contact Alex Cocklin, Trainee Clinical Psychologist at:

Division of Clinical Psychology
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester M13 9PL

Tel: 0161 306 0400
Email: alexandra.cocklin@postgrad.manchester.ac.uk

Alternatively you can contact:

Dr Sara Tai, Clinical Psychologist at:

School of Psychological Sciences
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester
M13 9PL

Tel: 0161 275 2595
sara.tai@manchester.ac.uk

Dr Warren Mansell
School of Psychological Sciences
Coupland Building
University of Manchester
Oxford Road
Manchester M13 9PL

Tel: 0161 275 8589
warren.mansell@manchester.ac.uk

If you have any concerns about the study that you prefer not to raise with the research team, please contact the University Research Office on 0161 275 7583 or at research.complaints@manchester.ac.uk.
Appendix 10

Client Consent Form

Division of Clinical Psychology
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester M13 9PL

Email: alexandra.cocklin@postgrad.manchester.ac.uk

Participant Consent Form Version 2

A Study of What Makes Therapy Therapeutic for Service Users.

The project is being sponsored by the University of Manchester. Please read the information sheet above before you sign the consent form.

Thank you for your willingness to take part in this research project. Your involvement is very much appreciated. We would like to reassure and remind you that as a participator in this project you have several very definite rights.

1. I confirm that I have read and understand the information sheet dated ......................... (version ............) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my ongoing therapy, medical care or legal rights being affected.

3. I understand that quotes from interviews and scores from questionnaires may be part of the final research report and used in research publications, but under no circumstances will names or identifying characteristics be included.

4. I give my consent for the therapy session to be video recorded and I understand that this material will only be used by the researcher and her supervisors.

5. I give my consent for the short interview with the researcher at the end of the video playback session to be audio taped. I understand that this material will only be used by the researcher and her supervisors.

6. I give consent for the researchers to contact me (either by telephone or in writing) to ask me to complete follow up questionnaires for a period of 3 months after the last research session.
7. I understand that there is a possibility that the information from interviews and questionnaires may be used in future research studies, however this information will remain confidential and anonymous.

8. I consent to my G.P. receiving a letter saying that I am taking part in this research study.

9. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data.

9. I agree to take part in the above study.

I would be grateful if you would sign this form to show that you have read, or have had read to you the contents of this information sheet and that you consent to take part in the study.

_________________________  ___________________________  ___________________________
Name of participant        Date                              Signature

_________________________
Name of Person taking consent  Date  Signature
(if different from researcher)

_________________________
Researcher                              Date                          Signature

Interviewer: Keep signed copy; leave a second signed copy with respondent on the day of the study. A third signed copy is kept in the medical notes.

Appendix 13 Therapist Participant Information

Division of Clinical Psychology
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester M13 9PL

Email: alexandra.cocklin@postgrad.manchester.ac.uk
Appendix 11

PARTICIPANT INFORMATION SHEET (Version 2, July 2013)

A Study of What Makes Therapy Therapeutic for Service Users.

We would like to invite you to take part in a research study. Before you decide whether or not to take part, please read why the research is being done and what it would involve for you. Please take time to read the following information carefully and to speak to others about the study. The aim of the project is to evaluate what service users find helpful when talking about a problem in sessions of psychological therapy.

Why do the study?

The project focuses on what individual clients find helpful in therapy and what therapists can do to foster a good therapeutic relationship. We believe that client perceptions of therapy are key to understanding how we can help people to get the most out of therapy. It is anticipated that a more detailed knowledge of the processes during therapeutic sessions could help therapists to learn techniques and skills in training that may increase the client’s experience of positive change. This is further hoped to promote client satisfaction with therapy, engagement and therapeutic outcomes over time.

Who is carrying out the research?

This project is being completed by Alex Cocklin, Trainee Clinical Psychologist, as part of the requirements for the Doctorate in Clinical Psychology programme. The project is being supervised by Dr Sara Tai and Dr Warren Mansell, who are both Clinical Psychologists and senior lecturers in Clinical Psychology at the University of Manchester.

What happens if I take part?

If you agree to take part, you would be invited to an initial appointment to discuss the study in more detail at Six Degrees Social Enterprise with the researcher. You will have the opportunity to ask any questions about the project and you will be asked to sign a consent form. You will then be invited to identify current service users from Six Degrees Social Enterprise that may be interested in participating in the study. When approaching the service user you have identified, who may be a current client you are engaging in therapy, you will be asked to go through the participant information sheet with them and check whether they meet inclusion and exclusion criteria for the study. All relevant materials including the client information sheets and inclusion/exclusion criteria will be made available to you at the initial appointment.

What does the study involve?

The first session of the study will involve a 30-minute meeting with a service user at Six Degrees Social Enterprise to talk about a problem of their choice. The researcher will meet with the service user briefly before the session to ask them a few questions and complete service distress measures. You will then be asked to conduct the session in the same way as you would normally conduct a therapy session. There will be 5 minutes at

168
the start of the therapy session for the client to settle in and at the end to discuss any questions they may have. The session will last for 30 minutes. As the therapist, you will be using a version of cognitive therapy known as Method of Levels. The session will be videotaped.

You will then be invited back for a further appointment to watch the video recording of your therapy session. You will be asked to rate your experiences at different time intervals using a paper and pencil rating form. This session will take about 1 hour and 15 minutes. The client from the session will not be present and everything discussed will be kept confidential. The only people watching the video tape during this session will be yourself and the researcher. The client from your session will be invited to watch and rate the video tape but this will take place on a separate occasion.

**Participation in this study is entirely voluntary**

You are free to withdraw from the study at any point without giving a reason and without your medical care or legal rights being affected.

**Will my information be kept confidential?**

All questionnaires for the study will be anonymised and have a code rather than your name and will be kept in a locked cabinet at the University. It is planned that the results of this project will be written in a report which may be published in a scientific journal; however your details will be removed and replaced with a code. It is also possible that this data may be used in further research studies in the future; however this information will still remain anonymous. Quotes from interviews and scores from questionnaires may be part of the final research report and used in research publications, but under no circumstances will names or identifying characteristics be included. We will send you a summary of the findings from this study when it is completed.

It is planned that the research therapy session will be video recorded. However this material will be kept confidential and will not be accessible by anyone other than the research team. Your video tape will be given a code number which is linked to your name. The list of names and codes are kept separately so that only the research team will be able to identify your video session tape if necessary. The video tape of your therapy session will not be viewed by other members of the service staff team except for the client who attended the session. What you say in the therapy session and when watching the video of the therapy will remain confidential and will not be shared with anybody else without your consent. However, if something is disclosed which poses harm this would be notified to line management.

All of the data including the video material will be kept for 10 years in a locked filing cabinet in Dr. Warren Mansell’s office at Manchester University until they are destroyed. Data obtained from this study may be used in future studies. We would like to keep the data for 10 years so that we may use it for further analyses, in light of new understanding and data that we collect from related studies.

**Are there any potential risks?**
Should any clinical issues arise that lead you to seek further support, you will be encouraged to share these with your clinical supervisor or the Service Manager at Six Degrees Social Enterprise. You will also be invited to share your concerns with the researcher who may seek further advice and guidance from Dr. Sara Tai and Dr. Warren Mansell at Manchester University.

In the event of any disclosures concerning significant risk of harm to the service user or other people, normal service protocol will be followed and it may be necessary to share this information with other services. The service user will be made aware of this exception to confidentiality in the client participation sheet.

Complaints

If you have a concern about any aspects of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

Who do I contact?

If you have any questions about the study or would like to take part please contact Alex Cocklin, Trainee Clinical Psychologist at:

Division of Clinical Psychology  
2nd Floor, Zochonis Building  
University of Manchester  
Brunswick Street  
Manchester M13 9PL  
Tel: 0161 306 0400  
Email:alexandra.cocklin@postgrad.manchester.ac.uk

Alternatively you can contact:

Dr Sara Tai, Clinical Psychologist at:

School of Psychological Sciences  
2nd Floor, Zochonis Building  
University of Manchester  
Brunswick Street  
Manchester  
M13 9PL  
Tel: 0161 275 2595  
sara.tai@manchester.ac.uk

Dr Warren Mansell  
School of Psychological Sciences

Coupland Building
University of Manchester
Oxford Road
Manchester M13 9PL

Tel: 0161 275 8589
warren.mansell@manchester.ac.uk

If you have any concerns about the study that you prefer not to raise with the research team, please contact the University Research Office on 0161 275 7583 or at research.complaints@manchester.ac.uk
Therapist Consent Form

Division of Clinical Psychology
2nd Floor, Zochonis Building
University of Manchester
Brunswick Street
Manchester M13 9PL

Email: alexandra.cocklin@postgrad.manchester.ac.uk

Participant Consent Form Version 2

A Study of What Makes Therapy Therapeutic for Service Users.

The project is being sponsored by the University of Manchester. Please read the information sheet above before you sign the consent form.

Thank you for your willingness to take part in this research project. Your involvement is very much appreciated. We would like to reassure and remind you that as a participator in this project you have several very definite rights.

1. I confirm that I have read and understood the information sheet dated ......................(version ............) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my job or legal rights being affected.

3. I understand that quotes from interviews and scores from questionnaires may be part of the final research report and used in research publications, but under no circumstances will names or identifying characteristics be included.

4. I give my consent for the therapy session to be video recorded and I understand that this material will only be used by the researcher and her supervisors.

5. I give my consent for the short interview with the researcher at the end of the video playback session to be audio taped. I understand that this material will only be used by the researcher and her supervisors.

6. I understand that there is a possibility that the information from interviews and questionnaires may be used in future research studies, however this information will remain confidential and anonymous.
I would be grateful if you would sign this form to show that you have read, or have had read to you the contents of this information sheet and that you consent to take part in the study.

_________________________  _____________________________________
Name of participant        Date                                    Signature

_________________________  _____________________________________
Researcher                 Date                                    Signature

Interviewer: Keep signed copy; leave a second signed copy with respondent on the day of the study.

7. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data.

8. I agree to take part in the above study.

I would be grateful if you would sign this form to show that you have read, or have had read to you the contents of this information sheet and that you consent to take part in the study.

_________________________  _____________________________________
Name of participant        Date                                    Signature

_________________________  _____________________________________
Researcher                 Date                                    Signature

Appendix 13

Recruitment Poster for display within site office
What’s Therapeutic about Therapy?
Research study
A study looking at what service users find helpful in a single session of Method of Levels Cognitive Therapy (MOL)

Do you know a client that would be interested in an additional session of MOL therapy as part of research?

This will offer the client an opportunity to:

- Talk freely about a problem of their choice
- Experience Method of Levels therapy
- Think about what is helpful to them in therapy
- Have a say about what helps them in therapy

Single sessions will be offered by therapists from Six Degrees, trained in MOL. The session will be video recorded and will last 30 minutes. Service users will be asked back to rate the video of their session with the researcher.

Contact .... or ..... for further details or email Alex Cocklin (chief investigator) at alexandra.cocklin@postgrad.manchester.ac.uk.
Alex

Appendix 14

Therapist Questionnaire

Name:
Age: 
Qualifications: 
Time employed by Six Degrees: 
Therapeutic Approach:  
(e.g. Guided Self-help, Cognitive therapy, 
Psychodynamic therapy, Person Centred Counselling) 

1. How many of the participants you saw for a recorded session were also your clients in therapy?

2. If you continued to see the participant for therapy after the session, did you talk to your client about how the rating session was for them? If so, what did they say?

3. Was having a discussion about the rating session useful for ongoing therapy?

4. Did taking part in the project help you to think differently about your clinical practice in any way?

5. What did you get out of the video rating session?

6. Any other comments about participating in a research project (e.g. feasibility, logistics)

Appendix 15

Zero Order Correlation Co-efficients between Client Variables with Significance Levels
### Appendix 16

**Table showing the adherence rating scores for therapists in the study using the MOLAS (Method of Levels Adherence Scale) and the CTS-R (Cognitive Therapy Scale-Revised)**

<table>
<thead>
<tr>
<th></th>
<th>H</th>
<th>TA</th>
<th>R</th>
<th>GT</th>
<th>TF</th>
<th>E</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Approach (SRS)</td>
<td>0.68</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship (SRS)</td>
<td>0.67</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals and Topics (SRS)</td>
<td>0.51</td>
<td>0.63</td>
<td>0.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking Freely</td>
<td>0.50</td>
<td>0.50</td>
<td>0.43</td>
<td>0.42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotion</td>
<td>0.59</td>
<td>0.70</td>
<td>0.62</td>
<td>0.49</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>0.62</td>
<td>0.62</td>
<td>0.53</td>
<td>0.48</td>
<td>0.49</td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td>Perspectives</td>
<td>0.40</td>
<td>0.40</td>
<td>0.42</td>
<td>0.59</td>
<td>0.58</td>
<td>0.46</td>
<td>0.35</td>
</tr>
</tbody>
</table>

Helpfulness (H), Therapist Approach (TA), Relationship (R), Goals & Topics (GT), Talking Freely (TF), Emotion (E), Control (C) and Insight (S).
<table>
<thead>
<tr>
<th>Rater</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td>T1</td>
<td>T2</td>
</tr>
<tr>
<td>MOLAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item no.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>CTS-R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item no.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>23</td>
</tr>
</tbody>
</table>

Scores for the MOLAS were out of a total score of 36. Scores for the CTSR were out of a total score of 60 (excluding items 1: Agenda Setting and item 12: Homework)

**Appendix 17**

Line graphs showing client ratings for Helpfulness and Control at 2 minute intervals across each session.
Line graphs for each of the 18 clients included in the study are presented below. These were categorised by into 3 categories for the purposes of referring to them in the current study. These were represented by subset A: Low Variability (a range in scores of 0-50), B: Moderate Variability (a range in scores of 50-100) and C: High Variability (100-150). The differences between the highest and lowest scores for the control and helpfulness variable were calculated for each graph and added together to reflect produce a composite variability score. A conscious effort has been made by the researcher not to add in any further interpretation.

**Subset C**

**Client 2**

![Graph for Client 2](image1)

**Client 4**

![Graph for Client 4](image2)

**Client 6**

![Graph for Client 6](image3)
Subset B: Moderate Variability

Client 3
Client 17

 Subset A: Low Variability

Client 5

Client 7
Appendix 18
Invitation to BABCP Conference

Dear Alexandra Cocklin

Re: BABCP Open Paper submission
‘Client Perceptions of Helpfulness: A Study of the Therapeutic Relationship’
Presenter: Alexandra Cocklin, University of Manchester

Thank-you very much for your submission to the BABCP 2014 Conference. It has been considered by the Scientific Committee and we are delighted to inform you that your submission has been accepted for the 2014 conference. It has provisionally been allocated to the ‘Perceptions of Therapy Process’ session.

The timetable will be finalised at the beginning of May, you will then be informed which day your session is taking place on. Please keep 23-25 July available to present until you hear from us.

The session, ‘Perception of Therapy Process’ is a ‘mini-symposium’ and will take place in the first half of a two hour slot. The second half of this symposium will be on a different topic, therefore there are only 3 people speaking in your symposium.

Please could you let me know by return email if you would like to take up this invitation? We would be grateful if you could please confirm that the above talk title is correct and the named presenter is the person who will be attending to give the symposium talk.

The abstract you submitted will be included in the Book of abstracts at the Conference.

With regard to Conference registration, the BABCP rules are clear, in that all presenters must register to present at the Conference. Please visit www.babcpconference.com to register at your earliest convenience. The Earlybird rate is available until 31st May 2014, so we recommend you register now!

Thank you once again for your submission and contribution to this year’s Conference, which, we are sure will be an excellent and successful event. Please refer to the BABCP website www.babcpconference.com for up to date conference information.

Yours sincerely,

Sarah Halligan and Nick Hawkes
Stream Leaders for Open Papers and Posters, BABCP 2014