A Portfolio of Academic, Therapeutic Practice & Research Work

Including: Developing an outcome measure derived from clients’ perceptions of therapy (TARECC)

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Submitted for the degree of PsychD in Psychotherapeutic and Counselling Psychology
University of Surrey
March 2003
This portfolio is dedicated to Max my husband, and Zoë my daughter. Thank you Max for your wise reflections and for helping me to cope with setbacks and failures. Thank you Zoë, your joy and enthusiasm for life can brighten any moment. I would also like to thank the other members of my family – the Brownrigg’s, Blake’s and Hughman’s for their support, encouragement and patience during the last five years. Also I would like to acknowledge my co-housing community, in particular John Atkins for sharing his firm grounding in statistical reasoning and Jonathon for driving me to an email connection when our village line was down. Also, thanks to everyone in the community who has listened, helped out with technical word processing problems, not moaned about my lack of input, and most importantly provided moments of convivial relaxation. Finally, I would like to thank my department head and line manager for their unflinching support and the secretaries for their empathy, kindness and friendship.
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Helen Brownrigg, 2003
A critical discussion of the concept of transference

In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components, which directly challenge the client’s faulty appraisals.

Integrating principles of humanistic, psychodynamic, and cognitive-behavioural theory and practice

Reflections on the use of self in research concerning clients’ perceptions of therapy

Clients' perceptions of change following integrative therapy: How have clients experienced the process of change when they consider the outcome of therapy to be a success?

Developing an outcome measure derived from client’s perceptions of therapy (TARECC)
Introduction to the Portfolio

Since my teenage years I have been driven to seek out explanations of life and human behaviour that might provide rich and meaningful ways of understanding or coming to terms with this experience of being a human being. Following various explorations into fairly obscure theories, I undertook some personal humanistic based therapy. The emphasis on experiential process and encounter helped me to integrate some new perspectives into a meaningful way of interacting with the world at large. Although controversial, following the recommendation of a friend, my husband and I explored various workshops and therapy models that became available in England during the 1980's having originated in America some years earlier. Though often described as 'pop psychology' these workshops were never-the-less attempts to popularise new paradigms that were emerging within psychology. For example, in one workshop there was a great emphasis on realising that people construct a version of reality through the personal stories they have constructed. Of course at a later date I was to realise that this was part of Narrative theory. Whilst I would not recommend these workshops, at the time they were an introduction to an eclectic mix of therapeutic approaches and (what I would now identify as) existential philosophy.

My initial enthusiasm for this personal work was followed a couple of years later by a depressing realisation. Little had actually changed in my life, what work could I do that would bring a deeper sense of meaning? At the time I had been working as a secretary for ten years since leaving school at sixteen. The work was not stretching me mentally. Things had to change! Looking through a newspaper I saw an advertisement for a psychology course run by the Open University. It sounded like a way to continue my exploration into human behaviour/potential and maybe it would help me to build a new career. That was the beginning of my engagement with further education and I loved it. I was being taught methods for critically evaluating and assessing other peoples' ideas and a whole new range of knowledge was made available to me. There were tutorials and summer schools, and it was stimulating and enjoyable. During this time I also came across Co-counselling developed by Harvey Jackins, an American who had been strongly committed to the trades' union movement. His method drew on humanistic and psychodynamic theory and
technique. It was my first introduction to individual counselling and I launched myself enthusiastically into this new area where I learnt the basic listening and reflecting skills identifiable as Rogerian technique as well as a technique for working with transference in the therapeutic relationship. The co-counselling approach was based on the simple notion that when we are distressed we need good attention in order to “discharge” our painful emotions and so re-evaluate, or ‘learn and move on’.

Regarding my studies in psychology, it can take many years to gain a degree through the OU, and so after three years I switched to a full-time degree course in social psychology at Sussex University. During this time I started a co-counselling group with a few other students that continued over the three years of the course. By now I knew that I found the counselling experience rewarding (as both client and therapist) and I was committed to pursuing a career as a fully trained and qualified therapist. I was therefore pleased that Sussex and Brighton universities had jointly set up a part-time MA course in counselling psychology. The course covered humanistic, psychodynamic and cognitive-behavioural approaches and I started this on completion of my BA. I had two ‘placements’ whilst on the course. One was as an assistant psychologist in the field of learning disability where I learnt how to use behavioural techniques integrated with humanistic aims and practices such as ‘gentle teaching’ (a method of ignoring negative and rewarding positive behaviour). I was also encouraged to develop an adult form of ‘play’ therapy, using toy models and psychodrama with a learning disabled client who had been sexually abused. Parts of this work were video taped (with the clients permission and not showing his identity) and were presented at a BPS conference. I also provided counselling for clients’ with a mild learning disability living independently in the community. My second position was as an honorary counsellor at a mental health centre where I received psychodynamic supervision. In this post I was encouraged to provide long-term therapy (two or three years in some cases). This taught me a lot about transference and counter transference and how to manage these dynamics. Also, I was grateful to be working within a Community Mental Health Team who provided additional support for those clients with severe and enduring mental health problems.

I had enjoyed working within the health service, but there were few positions available for counsellors at that time. Having completed my MA in psychological
counselling I was also disappointed to find that it did not qualify me for chartered status (the 'goal posts' for this were being decided at the time). I therefore started to apply for clinical psychology courses, but after being offered an interview I found out, happily, that I was pregnant. Given the intensity of the course I did not pursue the interview at that time, as I wanted to give sufficient attention to becoming a mother. Obviously, becoming a parent was a major life-change and enabled me to have a greater empathy with so many of my clients who would discuss various family related problems, or in the saddest cases had experienced the death of a child. When I returned to work it was in a new post as a research co-ordinator for the Trust for the study of Adolescence. In this position I was responsible for developing a qualitative research project investigating the relationship between young mothers (i.e. teenage mothers) and their mothers. This was my first experience of conducting in-depth qualitative interviews and analysing the resultant data. It became apparent to me that I was able to put people at their ease in the interview situation and that the skills required were very similar to Rogerian counselling techniques. Participants came from all different social classes and I realised that it was fairly easy for me to relate to different social-cultural backgrounds. I think that my personal background of growing up in a working class, multi-cultural area, going to a comprehensive school, and working in general offices for many years contributes to my ability to empathise with the experience of a broad range of clients. This attribute has undoubtedly contributed to the quality of interview data I was able to obtain for my first PsychD research project.

After a year of working as a researcher I was able to obtain a post as a counsellor in the adult mental health department of an NHS trust. This was a marvellous opportunity as I was able to work with a broad range of clients presenting a great variety of different problems, mostly referred from primary care. I received individual supervision from clinical psychologists within the department and further individual and group supervision from an ‘external’ clinical psychologist specialising in cognitive behavioural and psychodynamic approaches. After three years of working in the department the head at that time felt that I should complete my training by achieving chartered status. I was lucky enough to be granted one days study leave per week to attend the PsychD. I am still happily employed in this psychology department.
In retrospect the hiatus in my training as a therapist (brought about by the arrival of my daughter), was fortuitous because the PsychD in psychotherapeutic and counselling psychology became available. One of the attractive elements of this training was that the sole focus was adult mental health, which I felt would provide a worthwhile depth of learning and experience. Also the training course was focused solely on counselling and therapy, unlike the clinical training that had to stretch to include neurological and intelligence testing within the same time period. In addition, the course requirement for personal therapy demonstrated a recognition that personal experience of therapy helps to develop a respectful empathy for the client. This was in line with my own belief that academic achievement and professional status need to be balanced by humility and honesty about one's own human failings and need for personal development.

The work in this portfolio has been influenced by all of the experiences recounted here. The essays presented span both psychodynamic and cognitive behavioural theory and are indicative of how significantly these two approaches are integrated into my practice. The themes within the essays also represent the issues that are important to me personally. For example in my essay 'A Critical Discussion of the Concept of Transference' I am concerned about the potential of the therapist to consider themselves superior to the client by believing that they do not distort or project their own history into the current relationship. The essay addresses the temptation the 'expert' may have to discount the experience and critical comments of an individual who is not entering the relationship with the same professional status. As I did not grow up within a 'privileged' background, and am also a woman from a slightly older generation, I am keenly aware of power differentials in relationships.

The essay concerning the effective components of cognitive therapy was an opportunity to review the literature and consider the interaction between effective techniques and the importance of delivering these within a sound therapeutic alliance

The final clinical paper was a way of demonstrating how theory, research and personal challenges have been used to inform my practice. The paper also describes a personal framework for integration of theory, technique, research and experience that provides a platform for further enquiry and professional development.
Academic Dossier

This dossier contains a range of papers and reports submitted over the duration of the course. The papers come from the course module concerning “Advanced theory and Therapy”. The first paper addresses theoretical debates and neo-Freudian models of transference. The second paper concerns the important balance in cognitive behavioural therapy between attention to techniques and working with the therapeutic alliance.
A Critical Discussion of the Concept of Transference

In this essay I will consider the traditional conception of transference and clinical approaches derived from this theory. I will also consider three neo-Freudian perspectives and the ways in which they regard transference. Whilst considering the possibilities offered by these models it must be remembered that the theory of transference, or indeed the benefits that might be obtained by working with this concept in a therapeutic setting, can only be speculative. I feel, therefore, that it is also essential to consider the criticisms of Smith (1991) who, whilst remaining within the psychoanalytic field, is highly critical of the way that Freud and certain neo-Freudian's developed and used the concept of transference.

Beginning with the traditional approach, Freud concluded that during the process of analysis the patient would tend to transfer on to the analyst, feelings about significant others (often from early childhood), which related to underlying and unresolved conflict. It was seen to be the job of the analyst to assist the patient to work through the transference feelings to bring about insight and change. It was felt that transference is often positive at first with the patient admiring and becoming emotionally attached to the analyst, but that this tended to be followed by a negative phase where the patient is likely to become critical and aggressive. These two phases are supposed to represent a working through of the ambivalent feelings experienced by the patient towards their parents (Stevens, 1983). A standard Freudian definition of transference is outlined by Greenson (1967) who states that transference is the direction of wishes, fantasies, defences, feelings, drives and attitudes towards another person which do not pertain to that person and are inappropriate (cited in Smith 1991, p34).

There is, however, a fundamental problem with the practice of analysing transference that is pointed out by Smith (1991). Developing the work of Langs, Smith asks how the therapist can determine whether behaviour towards them is rational and appropriate or
not. To determine whether a response to the therapist is inappropriate the therapist would probably examine their own behaviour to see if they have warranted the transference. But, as Smith points out, according to Freud's theory the analyst must also consider that many of their emotional motivations may be unconscious. The typical response to this type of criticism is that the therapist must first undergo their own analysis so that they are aware of any propensities for invoking transference in relationships i.e. where they might be tempted into reproducing old conflicts or project their own fantasies onto another. Smith attacks this assumption as self-serving on the part of the analyst and over simplistic. Can the therapist really be so sure that they know themselves that well? Further, supposing the client comments on the appropriateness of the analysts behaviour, would the analyst be able to hear the criticism and make adjustments. One could also speculate that during analysis a particular therapist might unwittingly collude with a trainee-analyst in keeping certain motivations or desires hidden (due to their own unresolved issues, etc.). Smith suspects that the emphasis on the analysis of transference during therapy places too great a temptation in the way of the analyst to defend himself or herself from criticism or correction by the client. The therapist can easily interpret such 'interventions' from the client as inappropriate projections. Smith argues that if introspection really led to completely accurate self-knowledge there would not be the disputes and often acrimonious theoretical debates within the psychoanalytic profession.

Drawing on numerous publications by Langs (spanning 1959 to 1988, cited in Smith 1991) Smith (1991) proposes a radical departure from the concept of transference. He suggests that what has been labeled as transference could also be construed as "Derivatives of accurate unconscious perceptions" (p.52). Smith argues that clients' derivatives (i.e. stories and reflections) pertain to their unconscious and accurate appraisal of the therapists' skills and motivations. Smith demonstrates that on the one hand Freud largely claimed that mental processes were unconscious but on the other hand he tended to link information input or perception to consciousness. Further inconsistencies are said to arise in Freud's theories because he did not extended other assertions, regarding perception, to their logical conclusions. For example, Smith notes that Freud advises the therapist to listen with his or her own unconscious system to the derivative messages from
the unconscious of the patient during free association (Freud, 1912b, cited Smith 1991). Smith quotes two passages where Freud asserts that all people have an unconscious "instrument" or "apparatus with which to interpret the 'utterances' or 'reactions' of the others unconscious and the distortions through which their emotions may be expressed. (Freud 1913a; 320; Freud 1913b: 159: cited Smith, 1991, p. 60).

Smith (1991) argues that these conceptions of unconscious perception are inconsistent with Freud's more commonly adhered to proposition of the unconscious as hedonistic, being dominated by the pleasure principle and the release of tensions and energies. From this perspective, the unconscious has to be governed by the ego and its reality principle for the person to survive in the real world. The unconscious presented in this explanation is clearly incapable of perceptions that are not distorted by its own needs and fantasies. Smith defines this as an 'autistic' conception of the unconscious mind" (p. 63), which contradicts the concept of the unconscious as "undoing" the distortions of others. Smith points out that neo-Kleinien theorists such as Heimann (1950: 82, cited by Smith 1991) have adopted the idea of unconscious perception, but from a one sided perspective that never challenges the therapist. Heimann proposes that countertransference is largely to do with the therapists' experience of what has been projected into them by the patient (Casement refers to this as the 'projective identification or diagnostic response', see below). Smith argues that rather than taking up Freud's idea that all persons have the 'instrument' for unconscious perception Heimann's approach builds in a potential for abusing the client. If a therapist experiences any negative feelings or uncomfortability in the session, they can see these as responses invoked by the patient. In other words the therapist does not have to take responsibility for countertransference but is supposed to interpret it to the patient as feelings that the patient cannot bear to experience.

Smith proposes that perception takes place at both conscious and unconscious levels. He cites some of the findings of research into the effects of subliminally perceived stimuli
which point to the existence of unconscious perception. As Smith notes, however, this whole area of research remains controversial in the field of experimental psychology. (Of course one could add that there is still some debate about the whole notion of the unconscious within experimental psychology due to the difficulty of excluding other explanations for behaviour).

Thus we can see that Smith does away with the concept of transference altogether, rejecting it mainly on the grounds that the therapist cannot know their own countertransference contribution and is likely to want to pretend that they are not making one. But there seems to be a contradiction, if the therapist is so likely to “abuse” the patient through unconscious motivation, could not this be said to be a contamination of their interventions towards the client with their own (counter) transference. Conversely, then is not the client likely to do the same to the therapist. Just because analysts may use the concept of transference defensively, does not mean the concept has to be dismissed altogether. Smith would, however, argue that the notion of transference is a ‘cop-out’ on the part of the therapist. To avoid this, he proposes that the therapist gauges the development of the therapeutic relationship by only focusing on derivative communications made by the patient. Thus the therapist is to look for messages that are metaphorically encoded within these derivative communications i.e. any disrespectful behaviour or inaccurate interventions on the part of the therapist will be commented on derivatively by the patient. The traditional concept of transference as an infantile response to the analyst is not deemed appropriate. Smith admits that the patient may have particular sensitivities due to past negative experiences, but Smith takes the position that it is the job of the therapist to acknowledge their own manipulations or abuses rather than make interpretations to the patient that their fears of the therapist as infantile.

It would seem, however, that the problems of transference and countertransference are not truly solved by Smith. Smith’s therapist still has to unravel subjective messages locked up in derivatives. The therapist has no real way of knowing whether it is unconscious
perception or not that they are dealing with and they may still respond defensively. I have no doubt that therapist interventions can trigger reflections or stories that are unconsciously pertinent to the intervention and are rich in metaphorical meaning. If however, every negatively toned story that the client relates is an encoded message about the therapist (or the therapeutic context) the responsibility assumed by the therapist becomes awe-inspiring. The value of Smith's approach, however, is that it severely cautions the therapist against assuming any superiority of personal development over the patient. Smith even highlights the potential of the 'patient' to heal the therapist through their corrective responses to interventions. This is indeed an egalitarian view of therapy and a long way from the notion of the therapist as an expert who is aware of any personal distortions (via their own analysis) and can therefore simply point out where the patient is going wrong.

Casement (1985) certainly feels that the therapist can be guided by the patient (although they are still conceptualized using the medical term 'patient'), his first book being entitled "On learning from the patient". Unlike Smith, Casement does not, however, consider it necessary to do away with the concept of transference. Casement sees the model of transference as not only a therapeutic tool, but also as a way of understanding how learning, in particular learning about relationships occurs. He proposes that the unconscious picks out elements that are familiar in an unfamiliar experience in order to try and anticipate either safety or danger. For example, if a person's mannerisms remind us of our friendly uncle, we are likely to feel well disposed towards them. The friendly uncle may belong to what Casement terms a "set" i.e. all men with rosy cheeks tend to be friendly. In therapy the patient is faced with an unknown therapist and one can therefore assume that they will be trying to deduce from their knowledge of people, what kind of person they are dealing with now. Casement concludes that in order to lessen this anxiety of not knowing, the phenomenon of transference occurs (p. 5). To use this model in therapy one assumes that some learning may contain distressing situations that have been repressed and are causing defensive reactions in present relationships. The assumption is that once a "set" is located the trigger for transference can be identified (p. 6). Casement
is quite clear, however, that transference “the sense of similarity, between past and present, can be initiated by either patient or therapist” and that “the trigger for transference can also be unwittingly created by the therapist behaving in a way that echoes some aspect of the patient’s past”.

Casement does not think that transference is a phenomenon that occurs only in the therapeutic relationship. Particular ‘sets’ of circumstances may be sufficient to evoke similar emotions through the process of abstraction e.g. if someone is crying and someone is shouting this may trigger feelings of distress about being shouted at and then crying when one was a child. The therapist can sometimes assist a patient to understand an emotional response in the present by abstracting out the emotional and relationship components so that the patient can identify the pattern or ‘set’ that is affecting them. For example, recently I was working therapeutically with a client who could not understand why he felt so undermined by a man whom in many ways he felt was less accomplished than himself. However, the man had expressed a racist attitude. Racism belonged to a ‘set’ of emotions that had involved enormous harm to this client’s family when he was growing up. By looking at the overlap with past and present it helped the client to see why he felt so undermined even though he rationally considered the other person to be “pathetic”. It appeared that the client was extremely anxious because he was in some ways perceiving the present as though it were the past without realising that he was doing so.

Casement however does maintain, along traditional Freudian lines that during the therapists’ own analysis they learn to observe their own transference onto the therapist. He sees this as the foundation for building an “internal supervisor” (pp. 29-56). Thus, whilst, perhaps remaining somewhat over-optimistic about the reliability of self-observation, Casement does consider that the therapist-patient relationship is an interactive one, where patients either unconsciously or consciously assess interventions and subtle cues given off by the therapists. Casement (1985) cites the work of Langs...
(1978) as assisting him to develop “an awareness of the patient’s perception of the therapist’s reality, and some responses to that reality” (p71). Casement (1985) emphasises the importance of accurate empathy with the client, which he terms “trial identification” (pp. 34-35) so that the therapist can try to imagine the patients’ reality and how they may perceive interventions from the therapist. Casement also stresses the importance of the therapist being able to ‘listen’ for unconscious communications. Casement does this in a way that would, however, be unacceptable to Smith because he largely recommends the method of “projective identification” (p77). As with the approach of Heimann referred to above, this once again encourages the therapist to view his or her own feelings and responses as evoked by the patient rather than arising from countertransference.

It is important to note that the development of the transference relationship is actively encouraged by analysts and is achieved in several ways. The patient lying on a couch enhances the vulnerability and trust required of the patient in relation to the analyst who usually sits behind their head, out of view. The frequent appointments (up to 5 or 6 per week) strengthen the role of the therapist in the patient’s perception of how they cope with everyday life. Finally, the way in which analysts endeavour to reveal as little about themselves as possible means that patients experience the relationship as one-sided. They reveal sensitive information exposing their vulnerabilities whereas the analyst does not. Smith does not reject these traditional methods of working. He is interested in the unconscious perception of the client and therefore wishes the patient to free associate without distractions from the therapist. Analysts such as Casement work with the assumption that these steps are necessary so that the patient will project wishes or anxieties onto them. In this way old conflicts will emerge that can then be worked through within the therapy. Ironically, it does seem that by rejecting the concept of transference altogether Smith denies the unequal power structure that is specifically induced by Freudian methods of working. Casement whilst endeavouring to create an interactional relationship would also adopt the Freudian style of the couch and probably more than one appointment per week. The question that seems to remain is whether it is
really possible to incorporate a paternal model that evokes an infantile transference relationship, with an egalitarian conception of the therapist patient relationship.

Schwaber's (1990) thinking about interpretation and transference has certain parallels with Smith, but does not reject the concept of transference altogether. In line with Smith, she too believes it is important for the therapist to focus on the here and now relationship with the patient. In particular her focus for assessing the appropriateness or usefulness of an intervention is to watch for non-verbal cues that indicate negative affect. When these occur Schwaber asks the client to reflect on what has happened and what the therapist may have said or done which triggered this feeling. “And then I could begin to locate how the present resembled the past, how I had replicated the old internalized object” (p. 231).

Schwaber is very particular about how this interpretation and linking of past to present is made. She illustrates with several case studies, how the therapist can distress the patient if the therapist assumes that they know the meaning of a particular transference or defence mechanism. In all likelihood the patient will often experience such a dogmatic approach as further damage or abuse. However, when the therapist notices signs of negative effect they can begin to elicit the connections being made by the client, and together with the client explore what meaning this may have. Once a trigger to feelings has been noted by the therapist and identified by the patient the process of unraveling the meaning (i.e. when I did/said this, you felt/did that) can become the process of interpretation.

Like Smith, Schwaber argues that traditional beliefs about transference let the therapist 'off the hook'. The therapist must acknowledge that negative affect from the patient, which arises following an intervention means the analyst is not correctly understanding or perceiving the patients reality. Schwaber argues that in this case the analyst has not correctly empathised. The problem of countertransference is overcome in this approach by the therapist striving to perceive the meaning and reality of another person’s experience. This is opposed to any assumption that the therapist could have sufficient self-knowledge to avoid imposing a personal agenda, and operates on the basis that when meaning is unravelled by therapist and client together, both are open to learn from each
other. Thus, Schwaber puts forward a neo-Freudian approach to transference that, whilst still susceptible to the criticisms of Smith, also demonstrates how the therapist might use transference therapeutically. Schwaber considers it sufficient that the therapist is careful to not lose sight of the clients' reality and bears in mind the therapists ability to act in a way that is reminiscent of previous neglect or abuse.

A rather different approach to transference is found in Self Psychology, which was conceived by Kohut and started to gain popularity in America during the 1960's as a neo-Freudian development. Baker (1991) proposes that Self Psychology can also be an effective approach in short-term psychotherapy that tends not to rely on regression to a transference neurosis. Kohut's theory was that when we are children we have to learn how to regulate our sense of self. In order to do this we need certain experiences that develop a sense of our Self as adequate. Thus, we need "mirroring" which is conceptualised as acknowledgment and praise from adults. We also have "idealising" self-object needs whereby someone else is regarded as ideal and we have a sense of merging into them. This can be seen in parent child cuddles and the capacity of the parent to soothe and calm the child and finally, "Twinship" is thought to be essential in order to develop the sense of sameness with another. This can be seen in peer friendships and our need to feel like others and have a sense of connectedness (p. 292). These elements give rise to a sense of selfhood.

The theory proposes that these early experiences provided by the 'good enough' parent will form the foundations of positive experience to draw on in later life. The child is at first totally dependent on others to provide them with these experiences, but gradually as the individual develops they are thought to be able to internalise and perform these functions for themselves to a much larger extent. This happens through what Kohut termed "optimal frustration". This is when insufficient empathy (or disillusionment) occurs and the young person has to learn to calm themselves and rebuild their self-esteem. The emotionally deprived child will not develop a sufficiently robust level of
self-esteem and will tend to be over dependent on others to maintain their sense of coherence. "His dependence may terrify him, leading him to flee from relationships. But his inability to care for himself draws him back in a way that some would consider greedy" (Baker, 1991 p.292). Baker notes that such intrapsychic conflict will lead to interpersonal conflicts. The traditional Freudian approach would be to interpret the self-object elements which Kohut outlines as they arose in the transference relationship with the therapist. But Baker (1991) proposes that an effective self-object transference is created by accurate empathy or "understanding" of the client.

From this perspective the transference relationship "holds" the client whilst they re-organise and change and this experience demonstrates that "past and future need not he endless repetitions of the past" (p 301). In other words the therapist corrects what has remained as a deficit of empathic responses from childhood. Baker argues that it would not help, for example, to try to clarify how the client is so needy or point out the compulsive nature of their flights to independence. The interpretation of transference is not sufficient because the person does not have the necessary intra-psychic ability to care for themselves. This is why self psychologists focus on deficit rather than conflict. The role of the therapist is therefore to provide the necessary developmental relationship in order for the person to establish a stronger self-cohesion. There is a sense that rather than pointing out to the client where their 'weakness' are (which might simply intensify their disintegration), it is necessary for the therapist to describe the nature of the need and show the client that they understand it. Baker acknowledges that it is difficult to ascertain the right level of optimal frustration. He recommends that the therapist may need to give certain praise and encouragements, however, the client is not just given reassurances but there is an "optimal level of frustration" as the therapist mostly holds back but offers some encouragement whilst remaining non-critical and nonjudgmental.

In conclusion, it seems that the neo-Freudians discussed here (and many others who are not) are seeking to find a more egalitarian and respectful way of working with clients than
is likely to emerge with the traditional model of transference. The traditional model is
aive in assuming that a personal analysis frees the therapist from countertransference.
Smith is proposing a model which jettisons transference altogether, but he seems to do
this by bypassing the problem of individual learning regarding relationships (as described
by Casement) and therefore might loose out on the potential for reflection by therapist
and client on how history manifests between them in a way which mirrors situations in
the clients other relationships. Casement aims to develop an interactional and empathic
relationship but still uses the concept of projective identification which Smith would
consider a dangerous route in that countertransference can easily he denied. Schwaber
also highlights the potential for therapists to abuse clients by imposing their own agenda
or understanding and recommends striving for empathy and a process of joint discovery.
Self psychology focuses on the developmental deficits represented in transference and
recommends that these are worked through with an empathic therapist who creates
"optimal frustration". Baker proposes that interpretation of transference is useless and
could only really be perceived as an attack or criticism by the therapist as the client
simply cannot change until their developmental needs are met. It seems that all of the
theorists discussed present certain perspectives regarding possible routes to discovery and
relief from emotional suffering, as well as drawing attention to potential pitfalls within
the therapeutic alliance.
References


In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components which directly challenge the client's faulty appraisals.

In order to discuss this statement it is important to firstly consider the two opposed elements within it, namely, 'system of delivery' versus 'active components'. If we consider the system of delivery to be the how you do it, then we are examining qualitative aspects of therapy such as the therapists' personal style and attitudes towards clients. The effects of these aspects upon the client and upon the outcome of therapy are difficult to assess quantitatively as they are not easily observed or measured, and they may vary significantly between therapists. It could be argued that a focus on what you do, the so called active components, reflects an admirable aim to make therapy more formalised and effective. However, the risk is that a bias towards technique starts to depersonalise therapy and underplay the subtle exchanges that take place. To understand how the statement for discussion might have come about it necessary to consider the development of cognitive behaviour therapy (CBT), and its underlying assumptions about therapeutic change. This can be contrasted with the assumptions made by humanistic and psychodynamic theories of therapeutic change.

CBT emerged from behaviourism, which ignored unobservable mental processes, and as Spinelli (1994) notes, this laid the foundation for an emphasis on the more tangible structures and techniques of the approach. Accordingly, research methodology originally focused on quantifiable results (such as symptom reduction). Little attention was paid to more complex and difficult to quantify elements stimulating change such as the therapeutic relationship. The term 'system of delivery' is in itself reminiscent of something mechanical and highly structured. This is in contrast to the relationship-oriented process of change that humanistic therapists envisage. Historically, the most radical adherence to the importance of the therapy relationship was set forward in the humanistic theory developed by Carl Rogers. Rogers (1946, 1977) argued that congruence, positive regard and accurate empathy of the therapist towards to the client were sufficient to promote change and personal development. Rogers considered that given an encouraging and supportive environment the client would be able to change spontaneously and creatively. The
CBT approach was thus initially in exact opposition to this philosophy. For example, if we consider the active components of therapy to be what is done to promote change within cognitive-behavioural therapy then we are only giving importance to the techniques therapists employ. Originally, the CBT emphasis was entirely on the therapists active interventions, this took the form of directly challenging what were considered to be the client’s faulty appraisals of the phenomena they were experiencing. It was thought that merely by challenging incorrect thinking poor functioning and unhappiness could be corrected. Apart from a behavioural influence, the initial lack of attention to the therapeutic relationship was also probably due to the theories development by Beck as a brief, structured, outpatient treatment for uncomplicated unipolar depression (Beck 1976). However, the relationship with the client was not entirely disregarded, indeed Beck was clear that therapists should encourage clients to take charge of their therapy, so that they saw themselves as a colleague of the therapist, learning self help skills in a collaborative effort. The client would be encouraged to set the agenda for the session, identify contextual triggers to negative states of mind, tease out associated negative thoughts and with the therapist’s instruction, understand how these maintained unpleasant emotions. Clients would also be encouraged to engage in mutually agreed homework tasks to encourage a thoughtful and active engagement with the therapy. These aspects actually relate to the system of delivery i.e. the techniques are worked on together and problems are tackled in the spirit of a joint effort. This approach in CBT is seen as vital to the enabling of the client in adopting more helpful ways of construing their experience. Whilst the Rogerian facilitative aspects of warmth, empathy and positive regard were not seen as sufficient for good outcome, it was acknowledged that these skills were helpful, especially with more problematic patients (Bedrosian and Beck 1980). However, what was not initially given due consideration was that for some clients the forming of a therapeutic relationship may be the most profound and difficult aspect of therapy.

In particular there is evidence to suggest that with client’s who have severe relationship difficulties little will be achieved unless therapists give due consideration to the ongoing condition of the therapeutic alliance that is formed. This awareness of relationship factors grew as cognitive therapy began to be more widely applied. For example when used with borderline personality (Layden et al. 1993), or substance
abuse (Beck et al. 1993), it became clear that there were complications occurring. Clients were bringing a history of chronic interpersonal problems to therapy which meant that establishing a good working alliance was often not straightforward. Also these clients needed longer term therapy and the changing dynamics of a long therapeutic engagement started to become more apparent. As Newman (1998) notes, the therapeutic relationship was no longer seen as a prelude to treatment, but an integral part of the process. Thus the whole area of transference and counter transference, that which was traditionally psychoanalytic territory, started to be used in case formulation and interventions. Therapists were now aware that phenomena such as misunderstandings, misperceptions, overreactions on the part of client or therapist could be used to facilitate a learning experience.

Thus, cognitive therapists have started to recognise that whilst the active tools of the therapy are capable of evoking change there is a valuable source of information live and present within the therapy room that can give further leverage for change. By noticing how the client is responding to them the therapist can help the client to access the beliefs or unwritten rules they use in relationships and question those that are unhelpful. For example, I have found this useful if clients feel stupid and embarrassed when disclosing fears in therapy. One client, Liz, would say to me after talking about her fear of the number four “You must think I’m so stupid”. It was then productive to trace such feelings of stupidity to a more central belief about herself as being stupid because of experiencing fear. By encouraging Liz to challenge this belief she was then able to conclude that her fears were founded in certain earlier experiences. It became apparent that she felt stupid because of a belief that she must be perfect and not show signs of weakness.

Another aspect of the therapeutic relationship which may create change pertains to the educative process invoked through the experience of a positive relationship with the therapist. Newman (1998) argues that it is the personal qualities a good therapist displays such as consistency, humble self-confidence, clear communication, optimism, problem solving skills, and warmth, that help to encourage the client to give their best to the therapy. By interacting with the client in these ways the therapist also acts as a
role model of what is possible. This may be particularly important if clients have come from dysfunctional family backgrounds where these behaviours were not usual. Also, they may need the feeling of safety and respect that an empathic therapist can give in order to even begin to talk about their fears and concerns, and the establishment of this trust may take quite some time, thus lengthening the amount of therapy required.

The need for continued positive regard and interpretation of transference have been particularly important in my work with one client, who spends large amounts of time in depressive reflections on difficult past experiences. She makes negative comparisons of herself to other mothers, and of her children to other children. She has a powerful belief that she was damaged by her own parents and this will unavoidably damage her own children. In therapy it has been important to talk about the way she transferentialy anticipates that I will find her to be abnormal and unacceptable. Her ability to challenge negative automatic thoughts is severely limited, and it would be easy for me as the therapist to show demoralisation or disapproval at the apparent lack of effort or progress. However, by continuing to accept and empathise with her feelings, by showing optimism and a belief in her ability to improve, through working together to find ways of challenging her negative self-beliefs I hope to model the very attitudes which she needs to be able to apply to herself. Over the last 9 months she has had many low periods, but is starting to find that she can develop strategies and find different ways of evaluating herself that improve how she feels.

However, financial constraints within the NHS mean that long-term therapy is viewed as problematic due to the pressure of long waiting lists. It is usual to offer six to ten therapy sessions. However, for a few clients the prospect of this brief engagement provokes severe feelings of anxiety and dismay and issues of separation and loss may become apparent quite quickly. The importance of the relationship, or system of delivery aspects of therapy, are thus to the fore when trying to do short term therapy with clients who have issues around separation and loss. Once again, it is not sufficient in these instances to simply focus on the collaborative educational elements of CBT. Firstly, such clients probably genuinely sense their need for longer term
therapy and I am usually able to arrange this, although it is still time limited.

Secondly, the clients' feelings about ending therapy may have to become part of the therapeutic agenda and possibly the meaning of a strong attachment to the therapist explored.

Quite often, though, in cognitive therapy the relationship with the therapist is not actively explored. As cognitive therapists teach their clients about the cognitive theory of emotional disorders and clients start to apply the active components they usually start to feel a sense of greater competence and emotional improvement. It is important to appreciate how this in turn then strengthens the sense of partnership in the therapeutic relationship. However, even in brief therapy, the positive tone of this relationship can break down if therapists do not keep a check on how the client is thinking and feeling about the experience of therapy. For example, the active components of the cognitive therapy may seem overwhelming at first to some clients. When someone is feeling depressed they may find it hard to make the effort to try something new or to engender a feeling of hopefulness regarding it working. If they suffer from low self esteem, they may be fearful that they will not be able to make sense of it, or produce homework of which the therapist will approve. Part of the system of delivery concerns getting feedback from clients about their perceptions of the techniques and any misgivings they may have about trying them out. Clients may need to be reassured that you do not expect them to produce reams of insightful homework sheets, but that they can experiment and review their homework efforts with you. I will usually advise clients to attempt the homework, but not to worry if they can't get it all done at first. Some clients do seem to have an absolute aversion to homework, perhaps they either feel it is beneath them or conversely are too concerned about feelings of criticism. It may be that some people find a rational, problem solving approach, more immediately amenable than others. Of course I realised my mistake in this respect when a particular client (with very low academic achievement) didn't show up for the second session. By speaking to her on the telephone I realised that she had been completely overwhelmed by the homework task, and didn't feel she knew how to do it. Luckily I managed to convince her that homework charts did not suit everyone and we continued sessions and simply set verbal agreements for
homework. More generally, it seems that many clients do only small amounts of written homework, but nonetheless these can prove very fruitful in consolidating new ways of viewing self and others.

Ruptures in the therapeutic alliance can occur in a number of ways. Ironically one of these concerns the clients need to maintain control. Although the therapist is hopefully showing that they wish therapy to be collaborative the cognitive therapist is implicitly signalling that the client needs to change the way they think. A client may feel that although they are depressed, they at least have a realistic view of their life or life in general and perhaps the therapist is simply naive to be optimistic. Indeed, Spinelli (1994), has strongly criticised the way CBT assumes that the therapist is more objective and rational than the client. He sees this as particularly problematic precisely because it is easy for CT therapists to focus solely on the active components of the therapy and not therefore make sufficient efforts to enter into the world view of the client. He proposes that there are two dangers here. The first is that therapists may fall prey to their own delusions, i.e. not question their own assumptions or not fully appreciate the disempowering effects of social influences such as poverty or unemployment. In this case the client may see themselves in a struggle with the therapist about “who is right”, and the therapist may simply be supporting the status quo of society. The second danger is that clients may acquiesce and apparently give up their negative beliefs but actually do not feel any better i.e. they can see the rational argument, but as Spinelli sees it, the underlying dynamic conflict may not have been addressed because it was not fully explored and understood.

Newman, 1988, proposes that therapists address the power struggle rupture by telling the client that therapists also sometimes need to consult other mental health professionals in order to gain greater objectivity and that this is not a failing, but an acknowledgement that we can all become prone to bias, especially when under duress. Newman also feels it valuable to acknowledge with clients that of course therapists can fall prey to their own idiosyncratic views which may not all be helpful and that the best approach is to therefore see views and opinions as hypotheses to be tested. This seems very close to being both a system of delivery i.e. conveying a non-judgemental and respectful attitude and an active component i.e. a questioning experimental
outlook. This of course relates very much to Kelly’s concept of the person as a scientist, testing hypotheses and arriving at theories (Kelly, 1955). Spinelli’s argument is a powerful one, and makes one think of the Rogerian criteria of congruence. It is no good the therapist pretending that they are also joining in on a collaborative experiment, they must try genuinely to understand the world view of the client even if it seems irrational to them, otherwise the process is something of a sham. In this respect I have found it useful to try and consider what purpose or function a negative belief might serve, e.g. the belief that other people should never be trusted serves the function of protecting a person from experiencing further pain and disappointment with others. Thus the apparently irrational becomes rational.

Turning to the evidence of research, if the statement under discussion were true we might expect research to show CT to be superior in its results to therapies that do not emphasise techniques that actively challenge clients’ beliefs. However, studies have consistently shown there to be no discernible difference between therapies in their effectiveness. For example in a study of the treatment of depression Elkin, Parloff, Hadley & Autry, (1985) compared CBT and dynamic interpersonal psychotherapy. The sample size was 250 patients, which included a control condition where patients were given drug therapy only, or placebo. Researchers suggested that nonspecific factors seemed to account for the equal level of improvement across therapies. Frank (1971; Frank & Frank, 1991) have proposed that all forms of therapy include four common nonspecific factors. These factors relate to 1) the emotional and confiding relationship with a helper 2) a legitimised healing setting i.e. a hospital or clinic, 3) a rational explanation or myth is used to explain symptoms 4) client and therapist engage in a ritual or procedure that is believed by both to be a means to better health. These four factors are thought to combat “demoralisation”, (an umbrella term for the features of depression and low self-esteem). They do this by overcoming alienation; providing a relationship that offers inspiration and meets the expectation for help; providing new insights and learning experiences; assisting the client to tolerate the intense emotions they fear, and providing experience of increased sense of mastery. In broad agreement with these factors, Stiles (1986) emphasises the non-specific factors of therapist warmth and clients expectation of improvement implicit in seeking
help and devoting time and effort to therapy. An alternative explanation to that of non-specific factors is that the measures used so far in comparative research are not sophisticated enough to detect differences (Strupp, 1986). Outcome studies may have failed to measure the distinct types of change associated with different therapeutic techniques (Oei & Shuttlewood, 1996).

Of course some cognitive therapists might consider that the statement from which this essay arises encourages dichotomous thinking so that we might feel that it is either the system of delivery or the active components that are most important. Whilst there is so far little evidence of difference between schools of therapy that emphasise either relationship or technique factors, it can be argued that even the non-specific factors proposed by Frank et al. (1991) involve certain relationship skills or techniques which encourage reassessment and exploration by clients. I hope therefore, that the discussion in this essay might suggest that the ‘truth’ appears to lie somewhere in the middle.
References


Therapeutic Practice Dossier

This dossier contains a short description of my placement during the Psych D course. There follows an essay on how I integrate theory, research and practice.
Description of Placement

Second and Third Year Placement:
An NHS Adult Mental Health Outpatient Service

October 1998 – August 2002

Due to my prior MA qualification in psychological counselling I was exempt from part one of the BPS requirements for the PsychD. I was also already employed as a counsellor within two specialty areas and will remain so on completion of the PsychD. I have been a part-time student. Firstly, an adult mental health psychology outpatient service within an NHS trust. This ‘placement’ provided experience of working with primary care referrals either in on of the health centres or at the general hospital. My responsibilities included individual therapy for clients suffering from a range of difficulties. For example, anxiety problems including panic attacks, post-traumatic stress disorder, depressive disorders or problematic low mood, relationship difficulties (including some couples counselling), complicated grief reactions, eating disorders and obsessive compulsive disorder. The psychology department included clinical and counselling psychologist some of whom were attached to a community mental health team, and others like myself mostly focused on primary care.

Individual supervision (weekly) and group supervision (fortnightly) was provided during the first two years by a clinical psychologist who had retired from the position of department head at another NHS trust. During the third and fourth years I continued with the same group supervision arrangement. Individual supervision, for the third year, was provided weekly by a B grade clinical psychologist within the department specialising in eating disorders and post traumatic stress disorder. For the fourth year individual supervision was provided by a chartered counselling psychologist.

Supervisory input was integrative, but focused primarily on psychodynamic and cognitive behavioural approaches.
During the placement period I had the experience of presenting my research on clients' perceptions of therapy to the department. I also presented these results at an area training day. Also I would take part in fortnightly departmental meetings.

I was responsible for managing the waiting list of a particular health centre and for writing reports, letters and keeping clinical records that were audited once per year.
Integrating principles of humanistic, psychodynamic and cognitive-behavioural theory and practice

Introduction

In this paper I will reflect on my development as a trainee-counselling psychologist and demonstrate my effort to integrate different psychotherapeutic approaches into my everyday clinical practice. I will, therefore, begin by presenting several perspectives regarding integration that I have explored and found useful during training. Following this I will present two clinical examples that show how I engaged with the approaches taught in each training year whilst seeking integrative frameworks. As integration can also be said to take place ‘within’ the therapist and the therapeutic relationship (Hollanders, 2000) I will also include a consideration of how personal and professional challenges or experiences have shaped my work as a counselling psychologist. Finally, I will reflect on the experience of re-writing this paper and outline how I hope to continue my personal and professional development in the future.

The development of my approach to integration

As I moved through the course I was continuously faced with the fact that often theories do not agree and yet (with several exceptions) research has not conclusively proved any one theoretical approach to be superior in practice (Clarkson, 2000; Lambert & Bergin, 1994; Smith, Glass & Miller, 1980; Stiles, Shapiro & Elliot, 1986). Given these findings it seemed important to acknowledge the contributions of different approaches whilst considering how integration might take place within my own value base of humanistic principles.

Organicism

Initially I was drawn to an Organicist approach to integration (Messer, 1992). Organicism aims for theoretical integration and proposes that the different schools of therapy arise from fragments of experience that when compared with another school inevitably give rise to contradictions. The various parts have a tendency to be
resolved by assimilation into an organic and transcendent unifying theory that was always implicit within the fragments.

I was, however, uncomfortably aware during the training that theories contained somewhat irreconcilable differences regarding their model of the person and the purpose of the therapeutic endeavour. For example, Freudian psychoanalysts interpret transference as it arises in the therapeutic relationship in order to uncover unconscious conflicts. These are thought to arise from tensions between anti-social instinctual drives and social constraints (Freud, 1923). The aim here is to bring instinctual conflicts into conscious awareness and thereby lessen unconscious distortions. Conversely, humanistic theory proposes that humans benefit from an organic tendency towards the maintenance, and enhancement of the experiencing organism and this predisposition also has a socialising influence (Rogers, 1951). The therapist’s task is to provide the optimum psychological conditions for this tendency to manifest. Yet another focus is provided by the cognitive behavioural approach, which points to the effect of faulty cognitions as the root of problems and aims to change these cognitions through a rational and questioning dialogue coupled with behavioural exercises (Bedrosian & Beck, 1980).

With time I came to believe that a complete integration of all theories was either impossible or a long way in the future. Further, I came to think that, despite possible limitations, the rich diversity represented within these approaches suggests that a more appropriate stance to integration lies within the epistemological positions proposed by perspectivism and pluralism (Messer, 1992).

Pluralism and the postmodern critique
Postmodern authors (e.g. Messer & Safran, 1997) argue that theoretical knowledge cannot be absolute or neutral. In fact pluralism places a specific value on theoretical contradictions as spurs to new knowledge. This perspective is also in line with my socio-political ideals where I value diversity of opinion and culture. Even so, initially I had feelings of confusion when reflecting on my work with clients from different therapeutic perspectives. Now I enjoy this process and believe it offers greater opportunity to appreciate the personal and sometimes contradictory inclinations and
requirements a client might have. Of course one possible risk here is to justify an ad hoc eclecticism that is not based on any coherent underlying framework but arises from extreme relativism. As I will exemplify later in a case example, I have found a way to avoid this in Austen’s (2000) client led method of Integrated Eclecticism. Austen (ibid.) proposes that a focus for integration of approaches can be the client’s stage of problem conceptualisation. This may suggest the type of processing a client would find beneficial at different times in therapy which can then be related to particular insights and methods within humanistic, psychodynamic or CBT approaches.

Common factors
Indeed, whilst adopting the pluralist position I am still very interested in attempts to conduct research and develop theories that, whilst recognising difference, also look for common themes across schools. The problem here, again, is with oversimplification whereby the particular insights of theories may be lost. I think, however, that there has been useful speculation about what have been called “common factors” (e.g., Garfield & Bergin, 1994; Garfield, 1992; Beitman 1990; Frank, 1985; Goldfried, 1980). This work can provide a focus for developing knowledge about common stages or processes that may occur within the therapeutic relationship. Inspired and fascinated by this area, my own research examined the emergence of common factors in clients’ descriptions of their experiences of various therapeutic approaches (Brownrigg, 2002). The research examined both positive and negative elements reported, and four categories emerged from this data. Not surprisingly the perceived quality of the therapeutic relationship and therapist interventions constituted one category (i.e., acceptance and sensitivity to client). A further important grouping was labelled ‘re-evaluation processes’ (i.e., expression of thoughts and feelings, new awareness, focus and clarity). Another category was ‘experimentation and challenge assumptions’ (i.e., trying out new ways of thinking and behaving). The final category was described as ‘change factors’ (i.e., new acceptance of self and others and increased confidence). Of course these categories are described within a limited psychosocial frame of reference and I agree with Beitman (1992), that at this point in time, a scientist-practitioner should view attempts at common factor research as an explorative endeavour.
Three locations for integration:

In my struggle to strike a balance between ‘objective’ or positivist oversimplification and ‘subjective’ or relativist confusion I found it helpful to consider the question asked by Hollanders (2000) as to where integration takes place. He proposes three aspects to integration, the first being “external” or outside the practitioner, for example within theory and research. In this sense my interest in organicism and common factors represents my engagement with various fields of debate. The second area of integration is said to happen within the therapist, or “internally”, and refers to the practitioner’s individual reflexive process. In practice this involves reflecting on the choice of intervention, its application and outcome, both during and following a session as well as in supervision. Interestingly, at the beginning of my training a greater amount of my reflexive process happened after a therapy session or in supervision. As I have started to develop what Casement (1985) terms the Internal Supervisor, and also consider what Smith (1991) describes as “hidden communications”, I am starting to be more reflexive when with the client. I will give some examples of these aspects developing in my practice during the case examples.

Hollanders’ third location for integration is “within the relationship” and relates to the interaction between the client and therapist. The idea here is that the client will indicate what is needed by the way they are relating to the therapist and their interventions. As Hollanders notes, this facet of integration allows a client’s needs to shift and change the therapeutic approach (e.g., as in Austen’s model which I will illustrate in my second case example). The importance of this aspect of integration is the way it acts as a balance against any tendency towards rigidity in theorising or practicing with a client. Indeed, research reviews (e.g., Orlinsky, Grawe & Parks, 1994) have consistently suggested that the therapeutic relationship has more of a bearing upon outcome than the particular approach used. Maintaining a focus on a sensitive and responsive relationship towards the client has, therefore, been an important theme regarding my approach to integration.
How my practice as a counselling psychologist has evolved

I came to the course with an MA in “Psychological counselling” which exempted me from year one of the doctoral programme. At that time my practice was essentially humanistic but was also influenced by Egan’s (1990) eclectic model. My doctoral training then covered psychodynamic and Cognitive Behavioural Therapy (CBT) approaches and it has been interesting to see how these might be integrated with the humanistic values I hold dear. To illustrate this journey and how it has been interwoven with personal experiences and challenges, I will now present two case examples. (In order to protect confidentiality and the anonymity of clients, pseudonyms have been used and any identifying information is omitted.)

Year 2 – Navigating the tensions between humanistic and psychodynamic approaches: a case example and reflections on personal development during this year

At the start of my time at Surrey I was rather cautious about working with transference. My concern related to humanistic criticisms regarding the restrictions of Freud’s biologically determined model. Also, the argument that focusing on transference interpretations could force the therapist into a ‘paternal role’ and the client into a ‘child role’ creating a power imbalance that would be hard for the client to challenge. Rowan (1983) notes however, that transference or power issues can occur even when aiming to be egalitarian and therapists can use the concept of transference whilst maintaining a focus on the respectful stance of person centred approaches. The following case example demonstrates my first endeavours to integrate a psychodynamic approach with the humanistic aims I value, and also how I explored my own countertransference issues.

Case example: Mrs Jameson presented with difficulties concerning adjustment following the unexpected break-up of her marriage. She reported having loved her husband and his family and felt deeply shocked and abandoned when he left suddenly. She subsequently experienced a period of addiction to amphetamines and was
mortified that during this time social services had insisted that her two young children live with their father. At the initial assessment she reported feeling that other people often disliked her but, from her reports, it seemed to me that she became distant or hostile following the slightest hint of criticism. As a result, she tended to avoid social contact and was rather socially isolated. She also stressed that her family history consisted of turbulent and disappointing relationships stretching back to early childhood. She was particularly upset at the way her father had left the family when she was only three which appeared to have left a narcissistic wound as she felt he did not care about her. This emphasis in her presentation concerning difficulties with early relationships, coupled with an apparent lack of insight into how this might create an unconscious dynamic in her present social interactions, led me to hypothesise that a psychodynamic exploration of childhood relationships could offer her useful insights. As I was employed within a clinical context that offered short-term psychotherapy, my supervisor recommended the Self Psychology approach of Kohut as proposed by Baker (1991) for short-term therapy. Self Psychology also appealed to my person-centred stance because clinical phenomena are not understood in terms of drives and mechanisms, but in terms of constructed self-experience. Indeed, Kohut (1983) gives central importance to the therapeutic value of working towards a non-judgemental, accurate empathic understanding of the client. His emphasis is on understanding the client's experience of developmental deficit, which is different to the Freudian focus on interpreting intrapsychic conflict. This emphasis stems from Kohut's conviction (derived from his own clinical practice) that some clients may not have sufficiently strong selfobject structures to receive interpretations concerning conflict without loss of self-cohesion. For Mrs Jameson, this particular psychodynamic focus could help guard against an experience of interpretations as too threatening, resulting in her withdrawing from therapy. My initial therapeutic aim was thus to build a positive selfobject transference so that Mrs Jameson could internalise more cohesive and sustaining selfobjects.

With hindsight I can see how I used Kohut's psychodynamic theory as a site for external integration where I could also bring in humanistic principles and techniques. To facilitate the development of selfobject transference with Mrs Jameson I hence began with what Rogers (1965) terms "intuitive sensing", i.e., settling into a mind
state of attentive awareness where I tried to set aside any preconceptions. By summarising and reflecting back my empathic sense of her experience I continuously tested and adjusted my understanding of her situation. Spinelli (1994) describes this as ‘entering’ the clients’ world-view. I was also influenced by the concept of “resonance” first described by Watkins (1978: cited in Rowan, 1983), which proposes that her accounts evoked certain “resonances” with my personal, albeit limited experience of addiction (e.g., to nicotine in the past), which therefore helped my understanding and formed only a temporary identification.

As she was not seeing me in a centre for substance misuse Mrs Jameson insisted on knowing if I had specifically worked with amphetamine addiction. This faced me with an immediate focus on potential negative transference emerging at this initial stage of the relationship. I could have encouraged Mrs Jameson to reflect on the significance of her need to ask me this question, however, I was concerned that she already seemed highly distrustful and a firm therapeutic alliance had not been established. My worry was that she might interpret such an intervention as manipulative on my part. I also felt it important for my own sense of integrity to acknowledge that my expertise was limited and so I decided that it was better to make a self-disclosure to assist me in the Rogerian task of remaining congruent and genuine. My intervention was, hence, to honestly say that I had not had this particular experience, but felt that I would be able to build an understanding by drawing on her own experience. She said that she appreciated an honest answer and was willing to see how therapy would go. I took this attitude to indicate that the embryonic therapeutic relationship had been maintained.

Initially therapy progressed well. Mrs Jameson recounted a history of passivity and lack of warmth from her mother, coupled with reports of her father’s neglect and aggression. These early experiences were understood by me to indicate lack of empathic “mirroring” and the satisfaction of “idealising” selfobject needs required to internalise strong supportive selfobject aspects to her personality. I therefore, purposefully empathised with how she felt when her father left and her mother was

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1 Rogers believes the therapist should aim to understand the client without emotional identification however, I tend to agree with Watkins and Rowan that temporary identification may occur naturally and can be useful if viewed as a point of departure towards understanding.
not emotionally available. She was then able to understand how, when experiencing a further loss (i.e., the narcissistic insult of her husband leaving), she had become involved with a group of drug users in order to feel a sense of connectedness. Kohut describes this as “twinship”, but in this instance twinship was unfortunately attempted through mutual drug dependency. She also came to reflect that the stimulation of amphetamines had helped her to fight off feelings of depletion and depression.

It was around this time in my training that, through supervision and personal psychodynamic therapy I realised how some of my lingering concerns about working with transference interpretations were linked with my own fears of rejection, oppression and fear of upsetting the client by being too confrontational.

The personal challenge for me here was to become more aware of my own internal unconscious dynamics and see how these could affect my practice. In particular, I remember a very influential seminar with Smith concerning Communicative Psychoanalysis (Smith, 1991). Moving on from Langian theory and in line with the argument first expressed by Szasz (1961), Smith argued that the concept of transference could provide a ‘cop-out’ for the therapist. What has often been labeled as a transference response could have actually been “derivatives of accurate unconscious perceptions” (Smith ibid., p52). This means that clients may often usefully comment on the accuracy of interpretations and the personality of the therapist, but do so indirectly through narrative or metaphor. This idea affected me very deeply and when I met with Mrs Jameson and other clients my mind felt stretched to usefully interpret their communications. Their accounts seemed more potentially symbolic and my listening felt more alive. For example, when Mrs. Jameson selected a narrative about neighbours avoiding her, it occurred to me that she could be communicating an awareness of my fear about working with hostility.

Working with audiotapes of sessions during supervision helped me to reflect on the potential significance of client narratives. I was, however, extremely uncomfortable when sometimes hearing myself miss symbolic feedback and so, meanwhile, in my personal therapy I continued to work on fears of confrontation and criticism. I started to understand how these reflected some deficits in my own mirroring needs. I became
more aware of how this could manifest as a feeling of wavering self-esteem sometimes followed by defensive anger regarding criticism. Addressing these issues in the transference relationship of my own therapy led me to feel less anxious and more open to feedback both from my supervisor and clients. Also, when writing an essay at the time I became aware that, with my supervisor’s guidance, I was developing what Casement conceptualises as the “internal supervisor”. For example, by attempting to abstract themes as they were related in the client’s narrative I could plan how to interpret abstracted themes in the following session (Casement, 1985).

This process of internal reflection seems to me what Hollanders refers to as internal integration and it assisted me to become more aware of Mrs Jameson’s selfobject deficits as they manifested in the transference relationship. I was now aware that my own fears had manifested as countertransference and made me overly anxious about working directly with her selfobject needs. I started to abstract themes and be less affected by her aggressive style. As our understanding of her experiences deepened we came to reflect that her aggressive way of relating to others came from her fear of rejection and had often created a ‘self fulfilling prophesy’. Kohut (1972) describes this as thwarted mirroring needs precipitating feelings of narcissistic rage. We started to link her aggressive behaviour to the feelings of rejection from her mother and father as a child and, in turn, to her craving to be liked by others in the present. Accordingly, I suggested that she seemed to be angry with me when I did not offer reassurance. Although I felt rather anxious when making this interpretation it appeared to provide what Kohut terms “optimal frustration”. Mrs Jameson seemed able to use the basis of the positive selfobject relationship to help her maintain a sufficient level of self-esteem whilst evaluating her angry feeling. Following this work, she reported a change in her way of relating to others. She felt she was being less critical and started to initiate contact without waiting for others to approach her. In her relationship with me she expressed pleasure at this change and was now warmer and less hostile or suspicious. She also resisted the temptation of a flattering but, she felt, potentially damaging ‘overture’ from her estranged husband. Kohut’s theory suggests that she may have achieved greater self-cohesion, demonstrated by a decrease in her need to gratify a desire for mirroring whatever the cost.
In summary, for me the second year brought about a useful integration of humanistic values and a psychodynamic approach to the role of empathic understanding. Personal therapy and supervision helped me to develop my “internal supervisor” and an increased awareness of hidden communications.

*Year 3 – Developing CBT skills and using a model of integrated eclecticism: a case example and reflections on personal development*

During the third year of the course I was presented with a training focus on cognitive behaviour therapy (CBT). At first I was apprehensive about how this model approached the therapeutic relationship because my limited knowledge had led me to believe CBT gave it very little attention. I found however that Beck, the forefather of CBT, had always encouraged the fostering of an egalitarian working relationship with clients, to some extent paralleling a humanistic value regarding the relationship (e.g., Beck, 1976). I also discovered that as CBT became more widely used with client groups such as those with personality disorder, clinicians had begun to draw on psychodynamic concepts to understand dynamics that hindered the smooth progress of therapy (e.g., Waddington, 2000; Newman, 1998; Scott, Stradling & Dryden, 1995; Layden, Newman, Freeman & Morse, 1993; Bedrosian & Beck, 1980).

Following my pluralistic stance, whilst developing my CBT skills I searched for a model that would assist working integratively with other approaches if this seemed appropriate. Austen’s client centred model of “integrated eclecticism” appealed to my humanistic values and seemed to provide a coherent rationale within which I could bring in humanistic, psychodynamic and CBT ways of working (Austen, 2000). Austen recommends that the psychodynamic approach is particularly effective for working with painful warded off, dissociated material, whilst already available but vague awareness can be brought to greater clarity by humanistic experiential methods. Once a clear conceptualisation of the problem is achieved, maintaining the client’s frame of reference, the problem can be addressed with CBT techniques. Whilst this model offers an external form of integration, one might argue that Austen has developed it to work within the relationship to the client and it could thus be taken as an example of Hollanders ‘integration within the relationship’.
Case example: When I first saw Mrs Blake she was 28 years old and suffering from depressed mood. She reported two previous episodes when she had been diagnosed with clinical depression and treated with antidepressants, once at 16 years of age and again at 26. Mrs Blake’s presenting problems involved a sense of being distant and detached from people around her. She found she was generally lethargic and low in mood, particularly at weekends when the days were less structured. She wanted to avoid social occasions and only went out if persuaded to do so by her husband. When she felt particularly low she recounted that she “self-harmed” by picking at any spots or by pulling out hairs from her scalp.

She readily formed a warm and positive working alliance and responded well to the egalitarian and collaborative style of CBT. She quickly adopted the CBT technique of using an “ABC model” for analysing mood changes (Scott, Stradling & Dryden, 1995). She appreciated how her interpretation of an event (B), was the major influence stimulating an emotional response (C), rather than the event itself (A). She also started to keep a thought and feeling diary in order to identify the Negative Automatic Thoughts (NATs) that perpetuated her low mood (Beck, 1987, 1991). Frequent NATs were “I’m not a nice person” and “they don’t like me”. When examining these thoughts, however, she still had only a vague awareness of the accompanying feelings and the predominant affect seemed to be “numbness”. McGinn and Young (1996), propose that “numbness” of affect may indicate early experiences of disconnection, rejection and abuse from childhood carers. Their method of work involves tracing the early development of maladaptive schemas, i.e., the clients’ views of themselves, their personal world, and strategies for interacting with the world.

To assist us in this process and bearing Austen’s model in mind, I first drew on the humanistic techniques of reflecting and summarising (Rowan, 1983) to encourage her to experience thoughts and feelings more vividly. This seemed to enable a shift from “numbness” to powerful expression of “self hate” and “emptiness”, feelings that had begun in childhood. Whilst she told me that this process was emotionally challenging, she also valued a sense of unburdening and “coming to terms with” painful memories.
We could then return to the CBT approach and formulate the underlying schemas that had developed in childhood. It appeared for example, that when as a child Mrs Blake had been punished for minor misdemeanours with beatings and being ignored, she developed an ‘explanatory’ organising schema that she referred to as “I am a bad person”.

Following this work Mrs Blake reported an improvement in her mood that lasted about a month. She then, however, suddenly became moderately depressed again. In a session with me she was distressed, childlike, could not understand her sudden low mood, her renewed “numbness”, intrusive thoughts and new suicidal ideation. My first instinct was to encourage her to explore the thoughts and feelings connected with wanting to self-harm, but I somehow came to offer some undue reassurance, probably due to unconscious anxiety about powerful emotions and fears about loss of cohesion. At this stage it was, again, useful to draw on Austen’s model and use the psychodynamic perspective to appreciate that there might be further, painful feelings Mrs Blake was warding off and not assimilating. I also had a sense in the session of trying to protect the client with reassurance and I made efforts to correct this by, once more, encouraging her to explore her feelings in depth. My self-correction seemed sufficient, as she felt safe enough to disclose (for the first time) her distress about ‘unacceptable’ intrusive violent images, e.g., imagining herself or others badly mutilated in a car accident. We then reflected on how her feelings about these thoughts related to the way she had experienced disapproval from her father and mother and felt upset as a child. This led on to an exploration of why, although she had a strong desire to have warm close relationships, she could become withdrawn from people. It began to appear that her desire for closeness and affection might be in conflict with her feeling that as a “bad person” she did not deserve it (except out of sympathy). In this case a Freudian interpretation of intrapsychic conflict, made within the context of a positive transference, brought Mrs Blake a new insight.

Having reached a greater clarity and assimilation of experience it was again useful to return to a CBT approach. I helped Mrs Blake to realise that she was evaluating her thoughts in terms of what she believed she “should” or “should not” be thinking. Thus, she began to conclude that this way of evaluating led her to set unrealistically
high standards of human conduct (Scott, Stradling & Dryden, 1995). Once she
became aware of doing this she was able to start changing her way of thinking about
intrusive thoughts and they no longer caused her such distress. Also, following the
constructivist emphasis on uncovering the function of inappropriate behaviour, she
concluded that her self-harming served the function of evoking loving attention from
her partner. Mrs Blake then thought up the alternative strategy of asking for a hug,
which she practiced in-between sessions to good effect.

In summary, my integrative efforts with Mrs. Blake using Austen’s client led
“integrated eclecticism” did appear to be of benefit. Although this model may benefit
from further theoretical development and research regarding effectiveness, it did
provide a coherent rationale for using different approaches. By completion of therapy
Mrs. Blake was no longer depressed and she had become more accepting of herself,
for instance, feeling confident for the first time that she would make a ‘good enough’
parent.

Further Personal Challenges:

A personal event of relevance to my work and training occurred towards the end of
my third year when I was diagnosed with breast cancer. My studies had to go on hold
whilst I went through surgery, chemotherapy and radiotherapy treatment. During this
time I engaged in a great deal of self-reflection and became interested in mindfulness
meditation. When practicing the state of mindfulness thoughts are seen as ‘events’ in
the field of awareness and one’s aim is to observe attendant emotions with
equanimity. I found that often this practice could bring about a sense of peacefulness
and transcendence of negative emotions. I would also try to observe a NAT arising
and reflect as to what underlying schema it might arise from.

Although I am now in remission and healthy, I think that having a life threatening
disease has contributed to my therapeutic work as I sense an increased acceptance and
appreciation of the fear and despair that clients frequently bring. At the same time, I
am less prone to anxiety about others’ distress and, therefore, less likely to feel a need
to reassure clients. It seems that by facing my own fears of death and disintegration
there is less unconscious blocking of clients’ warded off feelings. I am now convinced
that openly exploring even the greatest difficulties and suffering can lead us to gain a richer and deeper appreciation of life.

Conclusion

The exercise of writing this paper has led me to deepen and broaden my understanding of different approaches to integration and what it means to work integratively as a counselling psychologist. Although this will be an unfolding process, having completed this paper feels like pausing on the brow of a hill to view where I have been, as well as turning around to sense where I might be going. What lies ahead is partly unexplored territory. Aiming to work integratively at this time in the history of counselling psychology could be thought of as proceeding with all sorts of maps that represent different and sometimes contradictory diagrams of the terrain. Whilst difficult and sometimes frustrating, this ongoing challenge is what draws me to the endeavour of integrative counselling psychology. There is always something new to explore. For example, I have recently been reading about an attempt at integration between two areas I have come to value: mindfulness practices and cognitive therapy for depression (Segal, Williams & Teasdale, 2002). The positive research results of Segal et al. (ibid.) show this to be a promising integration and I may choose to run a therapeutic group according to their recommendations. I am also intending to learn more about psychodynamic approaches to group work. I am interested in how individuals’ contributions to the group may, in part, be manifestations of unconscious group dynamics and how one can maintain a therapeutic relationship with individual clients within a group context. I am also intent on continuing to pursue the personal development work of confronting my fears and engaging in reflexive practices such as meditation, personal therapy and supervision. I also look forward to pursuing my interest in outcome research and have recently put myself forward as an agent for promoting and disseminating research within the NHS trust where I am employed. In brief, I continue to find my work as a counselling psychologist both challenging and very rewarding.
References


Research Dossier

This dossier contains a section concerning "reflections on the use of self in research" and two research reports, one from the second year and one from the third year of the PsychD course. The first report is a qualitative analysis of clients' perceptions of change following integrative therapy within a primary care setting. This examined how clients, who considered their therapy outcome to be successful, had experienced the process of change during therapy. The second report was a continuation of the enquiry into the perspective of the client. The first part involved a meta-analysis of thirteen qualitative papers concerning clients' perceptions of therapy. This analysis was then used to develop a quantitative questionnaire, firmly rooted in clients' accounts, that could measure therapeutic outcomes and satisfaction with therapy. The questionnaire was piloted with sixty participants alongside a widely used outcome measure (CORE) and the results are discussed.
Reflections on the use of self in research concerning client’s perceptions of therapy

I originally became interested in researching clients’ perceptions of therapy for my second year research project. This enquiry arose from a personal desire to generate a ‘feed-back loop’, to therapists from clients. I had come across papers that were critical of existing empirical measures of outcome and they echoed my own misgivings. Therefore, I wanted the data from my research to reflect therapy outcome in a way that was comprehensive and meaningful to practitioners. Also, at that stage in the course I was keen to gain experience in qualitative research, as this was a new area for me. In line with these aims, I was particularly drawn to the underlying epistemology connected with qualitative methods such as Interpretative Phenomenological Analysis, (IPA, Smith 1996, 1997, 1999). IPA arises from the phenomenological perspective and therefore connects to the existential approach that I find inspirational. It also has links with Critical Realism, which proposes that whilst reality constitutes an external causal order, reality is also perceived through language or discourse (Secord, 1983). In turn, Critical Realism has parallels with the theory of Symbolic Interactionism, which considers the meanings ascribed to events to be arrived at through social interactions (Ballie & Corrie, 1996). These theories seemed to combine a consideration of the objective and subjective in a way that resonated with my personal worldview.

Regarding my third year research project, I was not keen to undertake quantitative research at first. My attitude is exemplified by a quotation from Bergin and Strupp (1972) “The dilemma is that in order to treat complex problems effectively we seem to have to simplify in order to gain precision and power in our techniques; but when we simplify we seem not to do justice to the complexity of the phenomena in question” (p.216). As a result of this conflict I was often concerned by the necessity of using what seemed to be overly simplistic measures of a total therapy. After all, I had dedicated so much of my time to studying the subtle complexities of human behaviour and developing a therapeutic relationship with each unique client. The measures used to evaluate my work had limited meaning for me, and I suspected this was often the case for my clients. Alternatively, I could see the necessity of justifying my
effectiveness as a counselling psychologist particularly within the setting of an NHS trust with limited resources. Also, there was the disturbing possibility that my personal commitment to being a therapist might have blinded me to possible weaknesses within the whole concept of therapy as well as my own failures to help particular clients. As I pondered these problems, when considering what direction to take for my third year project, it seemed that it would be useful to compare my qualitative results with those of other researchers so that an outcome measure could be generated that was firmly grounded in the reports of clients. I speculated that clients might gain more from using a measure if they knew that it had been developed with much reference to the opinions and experiences of clients that had come before them. This is why I introduced each set of questions, on the TARECC measure that was developed, with a short paragraph explaining how some clients ‘had commented that this happened in therapy’ or ‘that it was useful when the therapist did...’. Obviously there is a danger here in that clients may evaluate their therapy in terms of other people’s experiences, but I tried to word the questions so that this effect would be minimised.

I was interested to see whether some of the complexity of clients’ qualitative accounts could be captured and used in a quantitative measure. As I started to consider this, I reconciled myself to the position that on the one hand there is a need for qualitative complex enquiry and on the other hand there is a requirement for objective evaluation. I became aware that I had previously perceived this natural tension as a battle between the ‘human potential’ anti-reductionists (that I leaned towards) and the empiricists. Thinking about how I could negotiate a path between these two ideologies was part of the endeavour of using the first qualitative study to inform the second quantitative one. For example the effort to capture essential elements within the richly textured qualitative data and categorise these into key processes associated with therapy.

Another factor influencing the evolving direction of my research was a personal dilemma concerning the conflicting conceptualisations of the person presented by different theoretical schools of therapy. Despite these conflicts there were obvious overlaps in aspects of theory and practice that might provide a framework for personal integration. I must admit a bias towards existential and humanistic theory and practice.
(although these two schools are not always compatible). Therefore the personal contact with participants in the first study appealed to me. However, this element of personal contact brought certain limitations. For example, the difficulty of contacting clients who had not experienced a successful therapy. Apart from a possible reluctance to take part, it would have been difficult to research their 'failure' or dissatisfaction as the relevant therapists were my colleagues. However, with my second research project one advantage of using questionnaires was client and therapist anonymity. Questionnaires were posted to anyone who had completed or dropped out of therapy and therefore, analysing the returned questionnaires gave me more of a mixed feeling about the experiences of clients. Clearly, a few received little or no benefit and although they represented a minority I could see that this needed further research.

All of these factors spurred me on and helped me to feel a personal commitment to the research. I think that as a result of the third year research project I am more optimistic about qualitative and quantitative studies complementing each other regarding the full range of processes therapy can engender, and any individuals' engagement with these processes.
References


Clients' perceptions of change following integrative therapy:
How have clients experienced the process of change when they consider the outcome of therapy to be a success?
Clients' perceptions of change following integrative therapy:
How have clients experienced the process of change when they consider the outcome of therapy to be successful?

Abstract

This study explores experiences of therapy for 9 clients by analysing retrospective, post-therapy accounts. A 'Counselling Interview' technique (Coyle & Wright, 1996) was utilised to gather in-depth data concerning participants' perceptions of change processes when they considered that therapy had been successful. The aim of this study is to draw out factors that contribute to successful outcome so that measures of outcome are comprehensive. Interpretative Phenomenological Analysis (Smith 1999, 1997, 1996) was used to analyse the data and the superordinate theme emerging to describe change processes was 're-evaluation'. Re-evaluation consisted of five sub-themes outlining valued change processes. These were: 'Review/reassessment: telling of the life story, including past and present relationships'; 'self-enhancement: through a positive therapeutic alliance'; 'metaphor and analogy: tools for exploration'; re-education': therapy is viewed as an educational process'; 'turning-points: catalysts for change'; and 'expression of withheld thoughts and feelings: symbolization and communication'. Quotes from participants' are used to illustrate these themes and how they interlink. Their accounts also help to shed light on the effects of therapeutic interventions and techniques. Implications for therapeutic practice and recommendations for measurement of outcome are discussed.
Clients' perceptions of change following integrative therapy:
How have clients experienced the process of change when they consider the outcome of therapy to be a success?

Introduction

There has in recent years been increasing pressure on psychologists to provide empirical evidence as to the efficacy of psychological therapies both from health insurance companies in America, (Strupp, 1996) and health service managers in England. The aim of this study is to elucidate further the factors that clients report as contributing to a successful therapeutic outcome. A substantial review of studies of clients’ experience in psychotherapy was conducted by Elliott and James (1989). They found that when clients’ own evaluation of specific outcomes is compared with researchers structured self-report measures it is apparent that there is an excessive focus on symptom relief on the part of the researchers. This shows a disregard of other changes that are also perceived by clients to be important.

If studies are to avoid becoming unrepresentative of clients’ experience, it must be borne in mind that the research paradigm of the natural sciences is only partially suitable for a study of psychotherapy and cannot really provide comprehensive information. Quantitative research is based in positivist philosophy that assumes that there is an external world that can be observed and understood in a purely objective fashion through a process of selective segmentation and reduction. The request for quantitative figures regarding outcome tends to assume that theories of therapy have defined the key elements and outcomes that can be expected. This is still far from being the case. Clearly, further exploratory work is necessary and it must be argued that the need to understand the intrapersonal and interpersonal factors, which operate in therapy, requires an approach that is enquiring and interpretative, rather than focused on testing the researchers pre-formed hypotheses.
This fits well with Critical Realist epistemology, where reality whilst constituting an external causal order is also seen to be perceived through language or discourse (Secord, 1983). Critical realism has parallels with the theory of symbolic interactionism, which considers the meanings ascribed to events to be arrived at through social interactions (Ballie & Corrie, 1996). A particular development within the qualitative research paradigm that aims to incorporate these philosophical traditions is that of Interpretative Phenomenological Analysis (IPA), (Smith, 1996, 1997, 1999). IPA is particularly useful to psychologists who want to interpret the experience of their clients whilst avoiding a ‘top down’ theory driven approach.

**Psychotherapy change Process Research**

Whilst having set the stage for a phenomenological approach it is important to consider the merits and as well as the limitations of some recent change process research. It can be noted that research into change process has tended to use one of two approaches to analysis: The use of observational coding systems which relates to quantitative methods, or the use of verbal reports which can either be quantified or explored for meaning in a qualitative fashion (Rennie & Toukmanian, 1992).

*Studies of therapy events:* There is a branch of research that concerns itself with the study of brief episodes (or events) taking place in therapy of a few minutes length. The aim of this type of research is to establish the significant occurrences in therapy (Rennie & Toukmanain, 1992). For example, Clarke (1996) explored change processes occurring within a “Creation of Meaning Event”. She proposes a model of change in therapy that is based on the importance of the client developing new meanings by challenging old (and unhelpful) beliefs. Following a therapy session, clients and therapists were asked to rate the session, by structured questionnaire, to ascertain whether a Meaning Event had occurred. The researchers suggested that a Meaning Event had occurred for clients if belief had been challenged, or if there had been emotional confusion about a belief, or if the client felt that they had learned something new or experienced something ‘shifting’.
The study was small, five clients only, but the results are interesting. Examples of such
meaning events were indeed found and were seen to be accompanied by condensing
(paraphrasing) or symbolising beliefs through words or metaphors. Change was
associated with challenge to a belief, a consideration as to the origin of the belief, and an
evaluation of the belief by clients.

Booth, Cushway and Newnes (1997) studied helpful and unhelpful events or ‘impacts’ as
perceived by clients receiving counselling in primary care. These were gathered after
each session by use of questionnaire and subjected to content analysis. They found that
‘Problem Solution’, ‘Personal Insight’ and ‘Awareness’ impacts related to ways of
instigating change in “behaviour, thoughts, views and feelings” (p.183). They concluded
that the marked frequency with which these events were reported portrays the importance
clients apportion to evolving ways of bringing about change or new ways of coping in
therapy. However impacts recorded from individual sessions were not found to have a
simple correlational relationship with overall outcome.

Elliott and Shapiro (1992) looked in minute detail at where the perspectives of the client,
the therapist, and research observers vary when analysing an event. Data were gathered
(using tape assisted recall) of an event that had been decided as significant by a single
client. The event presented was chosen because it was rated as significantly helpful by
client and therapist and represented the most common impact of the therapy, namely
‘Insight’. Elliott and Shapiro conclude that examining discrepancies between client and
therapist perceptions can help therapists to critically examine their implicit assumptions
during therapy sessions. They found that these can be overly driven by theory, and not
provide a good match to the interpretations made by clients or research observers.

Whilst these studies give us insights into the effects of therapy and point to important
aspects of change, it also has to be noted that the important occurrences in therapy are
being assumed to be within discrete compartments of experience. What we cannot elicit
from this type of research is how such events might go on to effect a client over a course
of therapy, or how clients may reflect upon events between sessions and integrate any
insights gained into their ongoing life experiences. Also, when researchers define a
particular type of event to be observed they may be missing other equally important
elements of the change process.

session questionnaires to elicit perceptions of helpful or hindering processes as assessed
by client and therapist. These were then subject to content analysis. They found that the
most frequent helpful process mentioned was ‘Self-exploration’ and its facilitation,
followed quite closely by ‘Insight into oneself and situations’ and then ‘Relationship with
the therapist’. Following this was a group of responses categorised as ‘Momentary relief’
which related to a client’s sense of ‘Progress and confirmation’ by the therapist. Clients
rated ‘relationship attitudes’ as helpful more frequently than therapists and this factor
tended to identify high quality sessions.

Another approach taken by Connolly and Strupp (1996) was to ask clients who had
completed therapy to describe in writing the most important changes they had received
from psychotherapy. Cluster analysis was then used to analyse the data. Two overarching
categories were ‘Improved Symptom’ and ‘Improved Self-Concept’. Of the second,
‘Improved Self Confidence’ was most frequently reported and ‘Self definition’ was also
an important category. Connolly and Strupp make the point that improved self concept is
rarely assessed in outcome studies. It would also be useful to know in what ways clients
perceived they had achieved greater self-confidence and self-definition, so that therapists
could know more about ways to promote these valued outcomes.

Ballie and Corrie (1996) looked for evidence of ‘Narrative’, the importance to clients of
negotiating a causal ‘Practical Order’ and ‘Shifts in Consciousness in Accounts of
Therapy’. They carried out a content analysis on 20 global retrospective post therapy
accounts (recorded by Dinnage, 1988) where clients had been asked to write about the
impact of therapy on their lives. They did find evidence of these three domains and also
considered that three themes had emerged from the data. The first was to do with ‘Experiences triggering the journey for self exploration’, the second was ‘The experience of therapy and the relationship with the therapist’, and the third was to do with ‘Outcomes of therapy and life after therapy’. This paper provides a fascinating theoretical overview of different domains of experience and how they can be seen in accounts of therapy. However, although there are some quotes given from the original data, there are not quite enough to get a real sense of the voice of the participants. Also researchers did not try to put their own hypothesis and theory base to one side to give as open an enquiry as possible, but actually set out to test their hypothesis, i.e. to see if they could find in the data what they expected to find. This is of course a top down approach and is the way to test theory. However, this adheres to the notion that research must be driven by theory rather than theory arising from the bottom up and being forced to accommodate fully the phenomena being analysed. As Rennie (1992) has argued, within the “narrative” approach to explanation it is not assumed that there is a reality waiting to be discovered but that human experience is best appreciated in terms of a co-construction of “reasons rather than causes” (p. 241).

Strupp, Martin, Wallach, and Wogan (1964) asked patients (and their therapists) who had been in long-term therapy to complete post-therapy questionnaires. These were then analysed by cluster analysis. They found that ‘Warmth’ and in particular ‘Respect’ were considered important aspects by clients. The most important changes experienced were categorised: ‘Insight into feelings and motives’; ‘Increase in self-esteem’; ‘Better interpersonal relations’; ‘Improvement in symptoms’, and ‘More active in working out solutions’. They did ask what aspects of therapists’ activities accounted for change experienced and found that patients were most affected by ‘Learning from therapists’ personality’. This study gives us important clues as to the experience of persons in long-term therapy, although it would be helpful to know more about the process of ‘Learning from the therapists’ personality’ and how clients viewed this.

A potential benefit of written self-reports is that clients can construct considered answers
in their own time. However an advantage of structured self-report questionnaires is the speed with which data be coded and subjected to quantitative statistics. Whilst self-report studies give us important information about changes experienced and certain factors relating to change, the disadvantage is an absence of interactive enquiry.

This paper aims to improve our understanding of clients’ perceptions of personal change when they consider therapy to have been successful. It is concerned with the question of how change processes evolve or are instigated in therapy and the ways in which clients define a successful therapy. Through the use of qualitative in-depth interviews, the study will avoid a top-down approach in order capture the full range of information clients can provide. This should contribute to the field of research concerning change and its facilitation in therapy.

Method

Participants: Recruitment was undertaken via an information letter given to clients by their therapist at the completion of therapy, or by post (Appendix 1). Participants had all been referred to the psychology department of an NHS Trust for outpatient counseling. They had received between 6 and 20 therapy sessions and had completed therapy between one week to two months prior to interview. There were 4 men and 5 women, all white Europeans. The names of participants have been altered and any identifying information has been omitted to preserve confidentiality. Participants gave permission for quotations to be used. All clients spontaneously described the main problem that brought them to therapy these were classified by the researcher as: depression (x 2), depression and alcohol abuse (x 2), problematic anger (x 2), communication difficulties (x 1), interpersonal difficulties (x 1), and Post Traumatic Stress Disorder (x 1).

Therapists and therapy: Participants came from the client pools of three clinical psychologists and one counselling psychologist who were all female. The least experienced had two years post qualifying experience. Therapists had training in cognitive-behavioural, psychodynamic, and humanistic/experiential therapy. They
considered that they worked in an integrative fashion. Three therapists saw three clients each and one therapist saw one.

Development of the interview schedule and interview technique: An interview schedule was designed by referring to existing change process literature. The counselling interview technique developed by (Coyle & Wright, 1996) was used. This allows the interviewer to encourage a client in the exploration of their ideas so that a full expression of experiences is given. Also, the interviewer can be sensitive to the developing themes of the participant, which might be quite different to the original area of enquiry.

Procedure: Ethical approval was obtained from the relevant NHS Trust ethics committee (Appendix 2). All participants signed a consent form (Appendix 3). Participants were interviewed in a therapy room at the hospital’s psychology department. The interview began informally with the question “What was your experience of therapy like?” Often this was all that was needed in order to explore issues of change. Further prompts used for clarification included: did anything happen in therapy to help change occur; were past relationships looked at and what effect did this have; were there any emotionally intense experiences during therapy or significant moments between sessions; how did participants feel about the relationship with the therapist and what changes in themselves had they noticed. Questions regarding the therapeutic alliance were only asked about if no mention of the relationship was given. Two pilot interviews were undertaken in order to make adjustments to the interview schedule (Appendix 4). As only minor adjustments were made (i.e. exclusion of unnecessary prompts) these interviews were included in the sample. Interviews lasted between forty-five minutes and one hour and were recorded on audiotape and transcribed verbatim (Sample: Appendix 5).

Analytic strategy: The questionnaires were analysed using Interpretative Phenomenological Analysis (IPA). This qualitative mode of enquiry (developed by Smith (1996; Smith, Jarman, & Osborn, 1999; Smith, Flowers, & Osborn, 1997) is concerned with an individual’s subjective account of events. It uses a series of idiographic accounts
to gradually look for patterns across cases (Elliot & Shapiro, 1992). An important element of the IPA approach is that the researcher tries to suspend their own theory base rather than operating from any pre-formed hypotheses. This is to prevent the phenomena of interest being defined solely according to the researcher's world-view. However, IPA also recognizes the dynamic interaction between researcher and participant, as Smith (1996) points out “Access is both dependant on, and complicated by, the researcher’s own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity.” (p.264). It must be acknowledged that this may have lead to omissions or distortions during the interviews and analysis presented here. My own researcher bias is obviously influenced by personal life experiences, and also by my training in humanistic, experiential, cognitive behavioural and psychodynamic theory. To some extent personal bias may have been balanced by reference to the diverse range of existing relevant literature, but narrative theory also reminds me that subjective bias is inherent in all enquiry as psychological approaches are particular narratives belonging to communities of persons, negotiated to give meaning to experiences which shape our lives (The Dulwich Centre, 2002). What follows is the procedure used to interpret the information given by participants.

Initially each individuals' transcript was read several times and aspects that seemed significant were noted, sometimes as attempts at summarizing or noticing connections to previous sections of the interview, sometimes in the form of preliminary interpretations. During a further reading, possible emergent themes that seemed to capture the essential quality of meaning being expressed were noted as possible theme titles. Themes that related to each other were then grouped together and considered to be super-ordinate concepts. These super-ordinate categories were then compared with the original transcript to check that there was a good fit with participants' own words. Illustrative quotes were noted and used in conjunction with category themes to form a table of themes. This process was repeated for each transcript and then a consolidated list of master themes was constructed by comparing all the resultant themes and re-referring to the original texts for confirmation. Finally there was an analysis looking for any patterns
of linkage between themes, once again by referring to participants' observations of 'what contributed to what'.

The frequency of themes was not quantified as with a small number of participants quantification in the analysis can play down the significance of themes. Also, there are no existing criteria with which to assess what level of frequency is required of a theme in order to establish whether it merits citation. In order to give some idea of salience without obscuring the range and complexity of phenomena reported, adjectival phrases such as 'few' or 'many' are used (Krueger, 1994). Empty brackets in quotations indicate the omission of repetitions or hesitant forms of speech, whilst any words enclosed in quotations show the use of participants' descriptors rather than the researchers interpretation. Italics are used to denote the emphasis participants used in a sentence. Reference to categories is denoted by italic script.

Analysis

Whilst different aspects of therapy process were reported in somewhat different sequences, it was possible to ascertain from participants' accounts that certain experiences and interventions led to change process and that the change processes had certain qualities which could be grouped together despite the obvious interactions and overlaps between them. Through analysing and interpreting the factors that participants reported regarding change processes in therapy one super-ordinate category emerged termed 're-evaluation' which consisted of the following five sub-themes: 'review/reassessment: telling of the life story, including past and present relationships; 'self-enhancement: through a positive therapeutic alliance'; 'metaphor and analogy'; 're-education: therapy is viewed as an educational process'; 'turning-points: catalysts for change' and 'expression of withheld or repressed thoughts and feelings: symbolisation and communication'.
Review / reassessment: telling the life story

On the whole, clients were encouraged to begin therapy by talking about their childhood and current relationships. The way that this was perceived by clients varied somewhat. For several participants talking about their history was at times an emotionally testing experience. A couple of participants did not wish to engage too fully in such an exploration because of this, and because they or the therapist wished to pursue other avenues. Hence it does not feature as a central component in all the accounts of therapy. Those who did review their life story found it a process for arriving at greater insight, objectivity and control of their current problems. Therapists are seen as facilitators of this process and one has a sense that through confiding and trusting the therapist with highly personal information the building of a good therapeutic alliance is encouraged.

For example, Jackie recounted how she had been covertly physically abused by her stepfather for most of her childhood. Telling her life story involved trusting and confiding in the therapist whilst she explored painful memories and fears. This led her to taking practical action that became a ‘turning point’, a feature of change discussed more fully later. She described it as:

Going over and over all the things that had happened, the things that I’d never been able to talk to anyone about.

It appears that telling the life story involves participants in a process of reassessing how and why they had come to think, feel and act the way they did. This was a recurring theme for many participants. The process is described in such a way as to suggest participants established a meaningful continuity between the social context of their family history and the effects of this on present day relationships. This appeared to counteract the opposite narrative of being an isolated agent who is entirely self-determined. For
example, when Dave came to counselling he was going on alcohol binges during which
he might feel suicidal and this would leave him confused.

I would feel (..) I'm not hurting anyone except myself and that doesn't matter
'cause I don't care about myself anyway (..), I didn't understand really why I felt
that way, I thought that was just me, what I failed to realise was that who you are
very much depends on how you were brought up and what experiences you've had
in the past.

The process of *reviewing* behaviour, thoughts and feelings through exploration and
clarification with the therapist also tended to lead to a greater sense of choice and control.

On the one hand it allowed me to not necessarily take all the blame on myself...but
at the same time take responsibility for the right bits and to realise that I . . . did
have some control over, about how I felt about these things. (Dave)

Similarly when talking about her history of problematic anger with family members,
Jackie recounted:

I used to (..) go Wraggh! and really shout and let it all out and get really mad and
then end up crying and then I'd feel so much better afterwards (..) but of course, I
knew that was wrong, you can't be like that with people

In the last two quotes we can see that social family history has been balanced with
individual responsibility. This sense of taking responsibility has been described by
humanistic psychotherapist John Rowan (1983) as adopting the position of a being a
person rather than behaving like a thing; becoming an “origin rather than a pawn” (p. 91).

Andrew summarised the process of looking for links between childhood and present
difficulties as making meaning out of the manic depressive incidents he had experienced:
It gave me an explanation, a partial explanation of things that had happened to me.
He felt this led to him changing the "defensive" way he related to his boss, by
understanding that his current boss had:

    taken the role of my father

This sense of explanation was also found in Paul’s account, he had always wondered why
he did not seem to be able to fit into the formal relationship structures that society offered
such as marriage. What he started to appreciate was that:

    Nobody ever taught me how to behave in society and it caused a lot of problems

Martina came from a socio cultural background where counselling was the preferred route
for dealing with any problems and had no "stigma" attached. She tended to use the
personal history aspect of therapy to see where old patterns of relating were creeping into
her current relationships:

    I could use the therapy to see where things were coming back again that I had
    worked on before

There were two negative comments about the life story process. Julie was regretful that
she had not had more opportunity to analyse her childhood which she felt was curtailed
by the time limited nature of therapy, thus presumably preventing a more radical review
and reassessment process:

    I still feel that the things that happened in the past still define me in my mind sort
    of thing, I still wonder why did they happen like that, what was wrong with me
    that these sort of things happened.
This aspect of being “defined” by the past is of course embedded in psychodynamic theory, and implicit in the psychodynamic way of working. As one might expect, participants did not allude to Freudian theory regarding developmental process, but focused on the dynamics of relationships and the repetition of patterned styles of relating that had caused them distress. Whilst the review/reassessment process is largely bound up with analysing the life story and present day relationships participants also describe how this leads to the formation of new concepts about the psychology of self and others. Many participants reported that they were now more likely to consider the motivations of others (rather than feeling attacked or defensive). They started to define and express their wants and needs. This in turn was precipitant of changes in perception about self-image and sometimes evoked a significant perceptual shift (see turning points below).

Overall, there is a strong indication that therapists are not passive during the life story (or narrative) review but are working actively with clients to interpret and create meaning. Several participants indicated that they valued this sense of working together to unravel the influence of past on present although it may sometimes have been emotionally painful or difficult to arrive at significant meanings. One can also see how this intimate mutual activity creates a bonding effect that can precipitate an openness to new perceptions and change of beliefs about self and others.

*Self-enhancement:* through a positive therapeutic alliance

There is a wealth of literature which points to the substantial correlation between a good therapeutic alliance and a positive therapy outcome (for a review see Horvath & Greenberg, 1994). This would fit with Rogers’ (1977) thinking that the relationship is the basis of therapy. In this study several participants spontaneously referred to the relationship with the therapist. For many participants, however, it was not referred to as a major instigator of change, but had more a sense of being the ‘bedrock’ upon which all else could take place. It can be noted that four out of the ten participants did not mention the nature or quality of the relationship with the therapist until prompted by the researcher
near the end of the interview. In these cases the quality of the alliance was then reported as very good.

For three clients, however, the alliance was a particularly salient feature of therapy. Deborah recounted a perfect example of how change processes could not proceed until a good alliance had been established (Goldfried & Wolfe, 1996). As this was also a turning point in therapy this is presented under that heading below. Julie who considered the quality of the therapist client relationship had been one of the most significant factors recounted that a previous therapy was rather unhelpful and “dehumanising”. In this earlier therapy the therapist, although “kind”, appeared to have adopted a more passive and non-interventionist approach that led to her feeling awkward and inferior. This was in contrast to her recent experience:

she made me feel that I was genuinely a person that she was responding to in a purely human way (...) I think that the only way you can actually get self esteem is if somebody esteems you so to speak

Julie felt that due to therapy and the study of religious doctrine her attitude towards herself and others had changed and she did not get angry in the problematic way she had before.

if you condemn other people all the time, you’re bound to have those feelings about yourself.

Sandier & Sandier (1994), hypothesise that the acceptance and tolerance of the analyst are important because in the here-and-now of therapy the client can identity with and adopt such an attitude towards themselves.

Jane who was suffering from PTSD was perhaps also in particular need of empathic acceptance and validation of her feelings. Her experience at the time of her road traffic
accident was that an unhelpful person was trying to minimise the situation, making her extremely angry whilst her husband was himself understandably shocked and upset. It was therefore also very important for her that the therapist was:

sensitive to my feelings (...) she said it in a lovely caring fashion (...) her kindness (...)she understood (...) she was just there for me

John felt that it was important that the therapist was:

somebody that trusted what you said, what you said about yourself, and how you feel, was how you felt about yourself

For most of the participants in this study the element of a positive alliance, as well as being the supportive tone within the therapeutic relationship, also led to quite active intervention processes of positive reinforcement from the therapist that promoted self-enhancement.

Therapists are generally discouraged during training from “rescuing” clients i.e. from stepping in and validating clients rather than letting them arrive at a stronger position for themselves, and this is bound to be appropriate in many instances. It is interesting to note, however the value that participants placed upon the encouragement and validation given by the therapist. This appeared to promote self-enhancement. Interventions could be in the form of a validation of feeling i.e. your anger must have been justified, which led to less self blame; or positive feedback that therapy is going well; or an encouragement to trust one’s own judgement.

Jackie described how important interventions that enhanced her self-esteem were:

I always used to think I was doing it wrong (...) but _____ (therapist) really helped
me... nothing you do is wrong', you know, 'everybody is different'

Later, the therapist by responding with conviction enhanced, her ability to trust her own judgement. This brought great "comfort" to Jackie. It is as if the therapist is strengthening Jackie's ego or sense of self, regarding her thoughts and feelings about the abuse she had experienced:

I needed someone to say 'that was wrong' (...) 'that's terrible what happened to you' (...) she was there and she was open about it

It can be assumed that this process of enhancement contributed to Jackie's later resolve to take practical action that would improve her situation.

The importance of supportive feedback was noted by Andrew:

well it made me feel good and it reinforced what I was doing (...) you could have someone who sits there (...) it could be off putting

Paul was impressed with the therapist's encouragement of him to celebrate his differences and to explore how alternative lifestyles could be a productive form of experimentation. These are some of the most obvious examples, but the sense of hearing a positive view of oneself from someone whom you feel you can trust is evident throughout the transcripts, and the effects of this both enhanced self and appeared to lead to an openness to change.

*Metaphor and analogy:*

Sometimes the *re-evaluation* process involved a strong visual element. For example, a few clients' recounted metaphors or visualisations they had worked with. They appeared to be a potent and emotionally charged way of processing feelings, and symbolising insight and intention. For example John developed his own visualisation:
I used a visualisation technique of all these painful events, I put them one by one into a sack (..) and I imagined myself sort of leaving it behind and walking away from it, and that for me was helpful.

Dave described a guided visualisation process he did with the therapist where he met himself as a child:

This was the most powerful (..) I really did choke up and I said I’d run to the child and say ‘It’s going to be all right (..) you don’t have to worry (..) and then I said, the same goes for the future now doesn’t it (..) because depression’s about fear as well.

Andrew recounted a therapist’s metaphor as a way of describing the way his emotions functioned:

She used the idea of the pot and the heat under it needed to be turned down, but also needed to vent the steam as well, and those sort of images I found very helpful and I could relate to.

A few clients found it helpful to describe depression or anger as a ‘pit’. They also used the analogy of learning to climb out of the pit as an ability that they had developed during therapy:

The first time you wake up in the bottom of this hole, and you don’t know why you’re there (..) and then you learn to climb out, and then you learn to stop yourself falling in, your on the edge and you stop yourself falling in, and then you learn that ‘Oh well if I go down that way there’s a hole there I could fall in so you go in a different direction (Andrew).
Jackie described how for her it was like:

through therapy she was helping me to see that if it was coming, I might not be able to stop myself falling in it, but at least start to recognise that its coming and when I'm in there, try and make it not so deep so that you can get back out again (...) I did find the longer I was going the smaller the pit got, and I did see it coming and I couldn't stop myself going in it, but I sort of warned myself and it made it a little bit easier

Re-education: elements of therapy are viewed as an educational process

It appears that within the basis of the alliance there emerged a willingness to work with and adopt the concepts that were being conveyed by the therapist. Several participants saw this as a process of instruction where they were “taught” models for understanding human experience, or particular concepts or offered a “point of view” that was useful. There was also “learning” through the use of the metaphors put forward by the therapist. The newly learnt concepts and metaphors that clients started to use for themselves contributed to the re-evaluation of self and relationships and the ability to self-analyse when necessary. This was connected with a sense of therapy being productive and led to greater self-confidence and self-control. A few participants mentioned that these concepts and models could then be used to help others, which again helped to increase self-esteem. Examples of statements alluding to this process are:

I found that a very powerful concept (...) and I started to use that almost straight away (Andrew)

Having it explained (...) knowing the reason why these things happen is half the battle (...) I had more confidence (Jane)
I was keen to understand her view (Paul)

_____ (therapist) would help me to try and see things from a different point of view, ‘your looking at it is making you feel bad, you must be looking at it wrong’ (Jackie)

I hear myself talking about things that I’ve been taught myself (Jackie)

You know it was able to give me structure as to how to get out of the situation, whereas before I was just bumbling about in the dark not really figuring out what I was doing (Dave)

Interestingly, one participant actually did not feel that he was gaining sufficient knowledge to suit his need for theoretical explanation and so engaged in his own psychology education programme at the library. Although his experience was not typical his comments are similar to those of others:

The model helps understanding, gives you a framework to think your specific problems through (..) feeling I was doing something to help myself was useful (John)

There were a few occasions when the process of learning about oneself was recounted as the therapist suggesting, or facilitating thoughts and feelings into awareness that were previously not readily available to the client’s conscious perception or had remained unconceptualised. Paul described this as a process of “enlightenment”. Jackie found that although she had dealt with her abuser there was still something bothering her:

(therapist), was the person who suggested it to me, so she must have seen it and I couldn’t and suddenly it all came pouring out.
Dave comments that he would have denied certain feelings before therapy because they had been “repressed” or he “chose to ignore them”. He felt that it was useful for the therapist to help him become more aware of his cognitions by saying:

    well what did you think about that when that happened ‘cause no one had actually...
    that isn’t a typical conversation

Paul felt that he was in the process of deciphering a message that the therapist was giving him by recommending that he read a certain book. He felt that the way this had happened and the process it was encouraging in him was “really quite remarkable”. Sometimes re-evaluation and shifts in perception were particularly intense or dramatic and represented a turning point in the change process.

*Turning points:* catalysts for change

Four of the participants experienced an event during therapy that could be seen as a potent catalyst for change. These were in the form of therapist (or in one case client) interventions that lead to insights, followed by changes in ways of relating to others.

For Jackie the process began with the therapist’s suggestion of writing down her feelings in ‘letters’ to her abuser which she brought to therapy. She finally wrote to the abuser and told him he was no longer welcome to visit her house. She recounts:

    That’s when there was a real breakthrough

The change-effect was for her to attain a feeling of power in her relationship with the person who had abused her, the shift is clearly expressed:

    He had that power over me still, he could just come to my house (...) suddenly that was gone, it was back, it was over to me and that was such a big change, that was
the main thing

For Paul the catalyst came when the therapist made the intervention that appears to have directly contradicted his distressed pattern of compliance in relationships. He recounts of the therapist:

She tried to make me say what I wanted

Paul had felt unable to assert himself in his relationship and felt he was deferring his life to someone else. When he started to behave differently, change was dramatic:

The strange thing about it was that once I started to assert my wants, my relationship (...) fell apart because, probably because, one of the things she really liked about me was that I was so compliant

For Deborah her effort to establish a working alliance that was right for her was a turning point. Her story confirms studies that demonstrate how ruptures in the alliance can result in productive work if sensitively handled by the therapist (Foreman & Marmar 1985, Safran, Crocker, McMain, & Munay 1990). As Smith (1991) proposes, this does not mean that the problem is all in the mind of the client, but that the therapist may behave in a way that is reminiscent of earlier behaviour that caused the client distress. In Deborah’s case, she found it difficult when the therapist asked her to describe how she had felt in certain situations. She experienced her mind becoming ‘blank’ and was upset by the therapist trying to elicit this information. She made the observation that:

We had a few problems with communication, which has never been my strong point, that’s the problem anyway

In between sessions she had felt first upset, then angry and decided to tell the therapist
that this approach was not working for her. She recounts the effect of this:

The therapist became aware that it's no good keep asking me questions about something

Having raised this it seemed to her:

I felt more of a sense of control (..) I want to work on this, you know

Even a first step can feel like a turning point and as with the observations above often this involves the expression of a need, as John remarked:

Simply asking for help seemed like a big step forwards

When clients ask for help and are able to form a good alliance, it appears that one of the important routes to change is to find expression of needs and emotions.

Expression of withheld or repressed thoughts and feelings: symbolisation and communication

It is evident in several of the examples above that the expression of withheld thoughts and feelings can be achieved through symbolic representation as an important aid to re-evaluation. In some cases expression was mainly to the therapist but seemed to impact on ways of relating in general. For two participants it led to a direct communication to others with whom they had significant relationships. In several cases there was a sense that feelings had been suppressed or even repressed either due to protecting others or out of
fear of reprisals, or fear of being socially unacceptable to others. Thus John said:

> It helps to discuss emotions with somebody you know is um used to that (...) cause invariably it feels sort of wrong probably particularly for a male to fall apart in front of somebody else

Sometimes there was a realisation that a feeling exerted more influence than they realised:

> It was one of the feelings that I was suppressing for so long (...) a lot of it was to do with bottling up feelings, and that was a behaviour I think I’d learnt from my father (...) I used to admire him for that

Interestingly, within a different context Jane had felt compelled to withhold her feelings at the time of her accident:

> I had to keep a really tight control (...) ’cause you tend to bottle things up inside you because you don’t want your husband to be upset

As with some of the examples given in turning points above, we can hypothesise that part of the function of expression is to promote a sense of congruence within the person where thoughts and feelings are not hidden from themselves or others and the person is able to assert their true opinions (Rogers 1951). John gives an example of this:

> Now I say to him what I think, whereas in the past maybe I’ve been, I don’t know, maybe said one thing to him and meant something else. Well now I’m more truthful and say “No I don’t agree with you”.
Discussion

It must be borne in mind that this is a small sample study that could not claim to provide findings that would be generalisable without further research. Different themes might emerge with another group of participants, or with therapists or a researcher from different theoretical orientations. Also the ‘post-therapy interview’ elicits a clients’ story or narrative concerning their therapy that may be influenced by factors such as ‘the interviewers questions, responses and personality’, ‘wanting to appear to have done well’, ‘not wanting to be disloyal to the therapist’ and ‘cultural expectations of desired therapeutic outcomes’. Also, as proposed by IPA one must assume that there is an interaction between clients’ stories of therapy and the ways these are interpreted by researchers.

It is important to relate a sense of participants’ comments when asked about their experience of the research interview. Most felt that it served a very useful function of clarifying and consolidating what they had achieved in therapy. In line with narrative theory a function of the questioning regarding important experiences and changes was to evoke a deepening of any re-authoring work that had taken place during therapy. Indeed the categories used to present clients experiences were considered to belong to a superordinate category that suggests re-authoring, termed re-evaluation.

Turning to applications for practice, this study is relevant to the continuing development of counselling psychology because it provides an opportunity to present clients’ accounts with something of the detail that is usually only possible in individual case studies. Unlike individual case studies, however, the IPA method allows the researcher to make comparisons across cases and draw inferences from these. This qualitative approach provides an alternative to empirical studies of outcome where the locus of concern has primarily been generated by the researcher. For example, where there is a distorting emphasis on the value of symptom reduction Connolly and Strupp (1996).
Clients' accounts provide useful feedback to therapists about the changes they valued and how these were achieved. It would appear, as with the studies mentioned above, that this group of participants found a successful therapeutic alliance important as the 'bedrock' upon which change processes and *self-enhancement* could proceed. For example, within a positive working alliance clients emphasised the importance the therapists' active participation. They spoke about the helpfulness of positive feedback from the therapist both through the validation of their feelings and with regard to their strengths and progress in therapy. These particular interventions appeared to increase self-esteem and lead to *self-enhancement*. However, one participant demonstrated, that active intervention can be construed negatively unless the alliance has been established. This suggests that outcome measures must incorporate the therapeutic alliance in order to check the quality of this relationship. If the quality is poor then the therapist may need further training or supervision in certain areas. Alternatively the client may work better with a different personality or therapist style, or may need to work specifically on the establishment of a therapeutic relationship, or indeed may be unable to benefit from therapy. These aspects must be considered when outcome is poor.

Personal change was also brought about through a *review/reassessment* involving telling the life story. This processes seemed to promote an appraisal of why one had come to think, feel and act in a certain way leading to greater insight, objectivity and control. As clients' recounted different approaches to undertaking this review it suggests that particular techniques are not of great importance and therapists should be flexible according to client preferences.

It is also evident that participants were describing not just the relational aspects of therapy but also the "points of view" models and techniques therapists brought to bear when examining problems. The way several participants referred to aspects of therapy as a re-*education* fits with a study by Henry, Schacht & Strupp (1986), of high change therapeutic relationships where therapists were seen to engage in more helping, teaching
and protecting behaviours than with low change cases. Some participants in this study recounted how metaphor and analogy had played a significant part in their personal change process. Therapists who do not show clients how to use theoretical models or provide exploratory techniques such as analogy may be denying their clients helpful tools.

Of further interest is the importance clients attached to an expression of withheld or repressed thoughts and feelings. Although theory differs regarding the reasons or mechanisms for withholding expression the result of this study suggest that outcome measures need to ascertain whether clients and therapists feel that this process has effectively taken place.

In conclusion, further research regarding the development of outcome measures, which incorporate these factors, is indicated. This would provide an empirical measure that delivers a more comprehensive measure of therapy that may also help therapists increase their effectiveness. Such a measure could also be used at various points during therapy to indicate if client or therapist are not maximizing potential change processes.
References


## Appendix

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Appendix I

Dear Sir or Madam

Patients Perceptions of change relating to their experience of integrative therapy: How have patients experienced the process of change when they consider the outcome of therapy to be beneficial?

This study is interested in your thoughts and feelings about beneficial changes or outcomes that you relate to therapy. It is important to the psychology department and psychologists in general to know more about the things that you feel were important and helpful in therapy and about your experience of therapy as a whole. The research is part of a doctoral programme and is supervised by the University of Surrey.

The aim of the research is to produce a paper for publication in a professional journal that will help to inform therapists of the kind of experiences that clients have during therapy and what their perceptions of the therapists’ role are. If you would like to take part I will contact you to arrange to meet and discuss your experience of therapy for about 30 to 45 minutes. This will be an informal discussion and I really want to emphasise that I am interested in your particular account of therapy and the way it helped you and affected you. As a counsellor myself it will be of great interest and value to receive in-depth accounts from the clients’ perspective. I hope that you will also find this a useful experience as it will give you an opportunity to go over what has changed and how you felt this was achieved.

I would just like to reassure you that there will be no requirement for you to discuss any painful memories or experiences during the meeting, although you are of course free to do so. As part of our discussion, I would like to ask whether you looked at your past relationships in therapy and if so, whether it was useful, but the amount of detail is up to you. Similarly if you should wish to end the meeting at any time this would be absolutely fine.

If you do not wish to take part, please feel free to say so and know that this will in no way alter the attitude of your therapist or the psychology service towards you. It will in no way affect our response to you in the future if you were referred to us, and your G.P. will not be informed.

If you would like to participate in the research your counsellor will give me your telephone number so that we can arrange a convenient time to meet and I can answer any questions you may have.

Yours faithfully

Helen Brownrigg
Counselling Psychologist in training
Helen Brownrigg
Psychology Department
Horsham Hospital
Hurst Road
HORSHAM
RH12 2DR

Dear Ms Brownrigg

Patients' Perceptions of Change Relating to their Experience of Integrative Psychotherapy: How have patients experienced the process of change when they consider the outcome of therapy to be successful?

Thank you for submitting the modifications requested by the Ethics Committee in the letter dated 18 January. I am happy therefore to give your our approval on the understanding that you follow the amended protocol and use the Patient Information Letter and Consent Form submitted with your letter of 29 March 1999.

It is a requirement of the Committee that we are sent reports on the outcome of the various studies we approve and I would be grateful if you could ensure that you send us a brief summary, on a single sheet of A4 if possible, at least on annual basis or at the end of the study if this is sooner.

Yours sincerely,

Dr J R Quiney BSc MB BS FRCPath
Chairman - Chichester Research Ethics Committee

Reviewed by Dr J Quiney, Chairman
Appendix III

RESEARCH CONSENT FORM

TITLE: CLIENTS' PERCEPTIONS OF CHANGE RELATING TO THEIR EXPERIENCE OF INTEGRATIVE THERAPY: How have patients experienced the process of change when they consider the outcome of therapy to be beneficial?

I have agreed to take part in the above research project and I have been informed as to the aims and purposes of the research as stated in the Information Letter. I have had the opportunity to ask any questions and to obtain answers that satisfy me. I understand that I am entering this project of my own free will and am free to withdraw from this study at any time without necessarily giving any reasons.

I have agreed to the research interview being audio taped and understand that the audio tapes will be wiped clean once the research paper has been assessed. I agree to quotes being used in the research paper as long as there are no details that would reveal my identity or be recognisable identifiers of me or other persons known to me.

Name (in capital letters)...........................................................................................................

Signed ......................................................................................................................................

Date .......................................................................................................................................
Appendix IV

Semi-structured interview schedule

Introductory question: “What was your experience of therapy like?”

These additional prompts were used if needed in order to explore clients experience further:

- Have you noticed any changes in yourself?
- Did anything happen in therapy to help change occur?
- Did the therapist do anything to promote changes?
- Were past relationships looked at and if so, what effect did this have?
- Were there any emotionally intense experiences during therapy or significant moments between sessions?
- How did you feel about the relationship with the therapist?
- If no reference to the therapeutic relationship is given ask: how did you find the relationship with your therapist?
Appendix V

Research Interview No. 1 Male Therapy length 3 months

I. So, um first of all, you've felt that you've had some benefits from therapy.

P. Ah yes, very much so. I was referred to the department by Dr ____ my GP, following a second episode of, uh to my mind, severe clinical depression

I. Right

P. and that was I suppose around about a year ago, going through that second bought and it was in October'ish that I first saw ____ (therapist) and I had been keen on having cognitive therapy, I think as a result of an article my wife read

I. Hmm, hmm

P. and having spoken to my sister who's a doctor, and she said yes, it works and is widely recognised and so on, and I asked Dr Fisher the same question

I. Hmm

P. he said yes he believed in it so certainly on that basis a reference was made

I. Right

P. and I saw ____ (therapist) and she said that before going into cognitive-behavioural therapy, she thought it important to explore other issues and aspects and so on

I. Yes

P. ah obviously I don't know the technical or professional side of what happened

I. Right
but from my perspective ah it was.. I suppose one of the things that struck me about it first of all.. it was the fact of whole human beings being made up of a number of elements, I think it was this four circle thing she drew in a diagram

and the thoughts, feelings, stroke, emotions, behaviour and physical sides of your being and how they all relate and interrelate and how certain behaviour can cause good or bad feelings and certain feelings can cause, and so on and so on

and I found that a very powerful concept, and I could relate to that both in terms of ways in which I’d previously sought to manage my moods and feelings.

and, ah, perhaps more importantly for future strategies

and I started to use that almost straight away

by this time, incidentally, I’d come out of the depression

Was that, before you started to see her

Yes, there was quite a long delay

Yes

I’d been a bit concerned about that, but I was still keen to do it, but obviously I had to take my place
I. Hmm

P. and so I wasn’t depressed when I saw ___(therapist), and I think she said to me and certainly my sister did when I was speaking to her

I. Hmm

P. that the process, the therapy, of whatever kind I suppose, can kind of make you feel a bit unsteady, and I certainly went through that and at one stage, because ___(therapist) got me to keep a mood graph

I. Hmm, hmm

P. and ah, at one stage I thought I was really plummeting.. and at that stage I er stopped and thought about the four circles that she’d drawn

I. Right

P. and I worked out for myself what I thought was happening to me

I. Right

P. and I put in place a plan, which that day involved making sure that I went swimming that day at lunch time

I. hmm, hmm

P. and there were one or two other things and when I spoke to ___(therapist) about that the following week, she was very impressed and thought I’d sort of cottoned on very quickly

I. Hmm

P. and er, and so that was the first thing that struck me about it
I. Yes, Yes

P. and I found beneficial

I. Yes, I mean, umm yes, it sounds like your saying this was a really useful model, something you could get hold of

P. Mmm

I. er as a tool for yourself, that you know, when you felt yourself starting to go down, umm this was something that helped you...ah.. how do you think it.. you said you arranged some activities, but I’m interested was there anything else that helped you to think or feel or connect to about yourself

P. Yes well, the bit I’ve missed out, well there’s a lot I’ve left out..

I. Sure

P. but when I said earlier on that, because I think those four circles, when I came back to seeing ___(therapist) in January, she was saying well that’s cognitive behavioural therapy

I. Right

P. But the bit that she was doing with me right at the start was like taking me back to my childhood, and so on..

I. Right

P. and that was what I found upsetting

I. Right

P. and there was one Monday in particular and I was talking about my parents and how er they used to, and they still do, have, er how can I say violent, they
never used to beat each other up, but they were very violent in a non physical way, I mean violent language, certainly from my mother

I. Yes

P. and these er terrible, terrible rows in front of us as children and just describing it to her because I was in that frame of mind thinking about when I was small and I found that very upsetting, I didn’t cry, but that was the closest I came to, during it, to crying,

I Yes, Yes

P. and that made me feel very unsettled and for part of the week after that, that’s when I felt my mood sliding

I Right, right

P. and then I, one morning I just felt I needed to do something, and I worked out for myself, I can’t remember quite how I did it, relating it to the four circles it was what I’d been going through that impacted upon my feelings and that I needed to do other things to bring them up and the thing that, well I know that, from quite a few years experience, it works for me is and I’ve since sort of heard and read that there’s scientific evidence to back it up is the exercise thing, and so I went swimming, I swim quite regularly, but I hadn’t been for about a week or something and I went swimming and that helped and by the end of the day, I was starting to feel very positive again

I. Right, right

P I think the other thing to say is, its of, its to do with my childhood

I. Hmm, hmm

95
in a way, I think, a number of things, an enormous amount I’ve learnt out of it

Hmm, hmm

um she said that she thought that the fact that I came in and so definitely wanted cognitive behavioural therapy was unusual, ah that I was so clear about what I wanted, and after we’d spoken, I think that day, or it may have been the following week, she said that that was an indication of the way I’d managed my feelings

Hmm, hmm

for most of my life, by trying to control them too much

I see

and she used the idea of the pot and the heat under it needed to be turned down, but also needed to vent the steam as well, and those sort of images I found very helpful and I could relate to

Yes

and another thing about my parents, how because, I don’t know whether you know, or whether I told you, but er when I was first depressed, the first of the two episodes

Yes

The first of the two episodes, I was referred to the _______ consultant psychiatrist

Right
P and he concluded that I had suffered from manic depression

I. Right

P. er and I denied that, for a while, until I was into the second depression, and I've been on Lithium for a year

I. Yes

P. Um I've still got some doubts about whether I'm so severe, but

I. Sure

P. what the heck

I. a label (joint laughter)

P. but one of the things that came out of the sessions with ___(therapist)

I. Yes

P. was that uh, those two extremes of emotion, feeling behaviour

I. Yes

P. are mirrored by the, uh, my parents behaviour

I. Ahh, yes

P. as individuals and their behaviour towards me as a child

I. Hmm
because my mother in those rows, she was the one, who was absolutely out of her mind with anger, and rage and my father would sit there and stick his fingers in his ears

and so he totally, has always controlled his feelings

you know bottled them up and so on, and so there were these two extremes

in that respect

and also in the way that they behaved towards me, my mother, she still does it, always, would always tell me how wonderful I was and build me up and so on and so on

Whereas my father on the occasions I can remember him expressing an opinion, it would normally be, I'm sure there was some justification, but I don't think it was totally justified

would be telling me how crappy I was

how he was ashamed of me, those two extremes
I two real contrasts

P Yes .. and the grandiosity which comes with mania

I hmm, hmm

P is related to some of the things my mother was saying to me

I Right,right

P and the feelings of low self esteem, and so on

I Yes

P this depression is things my father said to me

I Yes

P and its helpful to understand that

I Yes

P and also, through talking to ___(therpaist), that where most people are and a sensible place to be is, obviously neither extreme but its somewhere in the middle

I Yes

P which means that you sort of go up and down a bit and you have good days and bad days

I mm

P whereas for most of my life, I've been trying to be always up there,
Ahhh

you know, not exactly manic, but really buzzing

Yes, yes

and er, she said that she felt that one of the problems, one of the things I needed to do was tolerate minor depressions and not to catastrophise um, and I think that there had been a certain amount of that, and I think that nearly happened after Christmas

mm

'cause I finished seeing her before Christmas, and just after Christmas, I started to feel down

ummm

and I thought my God, I'm going, you know

Right

and so I phoned her up and arranged to come and see her and by the time I'd seen her I'd got things in perspective again, I'd done some of the techniques I'd learnt for myself and I was fine

Yes

but I'd started to catastrophise

Yes, but you'd also perhaps seen yourself doing it

Yes that's right

and that helped you to pull yourself out of it
People at work, um I've been in my present job for three years and I mean in some ways I'm convinced that the two episodes I had of depression, and one of mania, or two actually of mania at the time are very largely attributable to not so much my job, but the relationship I had with my boss.

and in fact (therapist), identified that he was probably taking the role of my father.

and people at work, colleagues, that I'm like a changed person.

because the other thing I learnt through the process of counselling was that the aspect of my personality that had been identified through the appraisal process at work and I agreed were issues to work on.

personal development, are all part and parcel, 'cause you know we're whole people aren't we.
are all part and parcel of the bigger problem or issue

and things like a tendency to over-react and er lack of focus, I mean various things like that

which er I’ve managed to not completely address, but make a lot of progress in

addressing as a result of this therapy

Yes, since you’ve identified the underlying things

Yes that’s right, and I can see it as a complete picture now whereas I used to think, well that’s work and that’s this and that’s that

Sure, sure

but I can see; and er the anger thing, ‘cause I, I suffered well it was part of the, well it was one of the feelings that I was suppressing for so long

Hmm, hmm

and er I, I manage that a whole of a lot better now

right, right, so you became more aware of that you were suppressing anger
Yes, yes and er assuming the worst in terms of like, primarily, my boss, in what his motives were for asking certain questions, and then I'd get defensive and attack and so on.

Yes

and again, one of the uh images, that uh, (therapist) used was uh, you know, the first time you wake up in the bottom of this hole, and you don't know why you're there.

Mmm

and you know I think she was using it in relation to depression and anger and all sorts.

Mmm

and then you learn how to climb out.

Hmm, hmm

and then you learn how to stop yourself falling in, you're on the edge and you stop yourself falling in.

Yes

then you learn that oh well if I go down that way there's a hole there I could fall in so you go in a different direction.
I Oh right, yes, yes

P and again that’s really useful

I Yes, Yes

P and another one she used and it was again, actually this was the most powerful, the most moving episode, even more so than the one about my parents, I mean I can’t quite remember how we got into this; it was about childhood insecurity and the fear of the unknown, and she said picture a field with a path going across it diagonally

I Mmm

P and think of yourself as a child at a time when you were hurting and then you put yourself in the middle of the field, no hang on that’s not right, put yourself as you are now in the middle of the field and as you were as a child when you were hurting

I Hmm, mm

P and think of it at one end of the path

I hmm, mm

P and I did, I really did choked up and I said I’d run to the child and say, “It’s going to be alright”

I Hmm
"You know, you don’t have to worry", ahh, god, actually I’m getting quite emotional thinking about that now

Hmm

and er and then I said, the same goes for the future now doesn’t it and she said, that’s why I put you in the middle of the field, because depression’s about fear as well isn’t it (said to interviewer)

Oh yes, yes

Yes, yes

So that was very powerful

Very, very yes

And that’s something that’s still, you carry with you now as a really powerful image

hmm, hmm, that’s right

That almost allows you to not feel so frightened or ..

That’s right

get depressed because you actually are able to perhaps give yourself something that you didn’t get when you were a child

Hmm, hmm
Yes, right, and you've mentioned a lot about images and how powerful those were for you.

Yes definitely.

do you still use those images?

Yes, yes, ah one of the things I remember saying to (therapist),

Yes.

that er, obviously while I was going through it I was, well it seemed like thinking about nothing else.

Yes.

and I felt ah a bit obsessed with this and she said well it will settle down, you know, it will become just part of the background.

Yes.

and it has done, like I don't er constantly think of it.

No.

But there'll be probably, I don't know, if I wake up in the morning and I think Oh god, I've got a busy day, I just say, well it's going to be alright, er you've just got to plan it out, nothing's ever as bad as you think it's going to be.

Hmm, hmm.
I suppose there may be some things (laughter), but most things that’s true of, isn’t it

Yes

the great majority of things, that it’s not going to be as bad as you fear

Right

and I use, er during the period I was seeing her in the early part of that where I started to feel unsettled

Hmm

I started listening to classical music in the car

Hmm, hmm

and I still do and I find that er very helpful er and er when I told her about that, she asked me what sort of music did I like previously, and its all sort of dergey stuff, you know, Bob Dylan, and Leonard Cohen

Yep

and all sorts of, not exclusively, and Irish folk music

Right

and that stuff it’s all pretty depressing

and you found yourself choosing more uplifting more peaceful
I Yes peaceful and er yes well I think I'm a lot calmer than I was

I Hmm, hmm, ok......let me see

P that was one question was it

I that was great, we don’t have to follow any format

P No

I I'm just seeing (looking at schedule) if there's any, yes, I mean you've spoken to me quite a bit, I suppose, about what (therapist), umm kind of led you to, images that were helpful and umm, I suppose I'm thinking also, um how did you think or feel about the relationship with (therapist), how did that strike you at the time

P I was very impressed, er I....I think its a great skill, when somebody can, which is obviously is a lot of what people in your profession do, er are able to get people talking and move things along and so on

I Hmm, hmm

P and er, I always felt relaxed with (therapist), and totally able to confide in her

I Yes

P and I found on the occasion I phoned her up, 'cause she said when we stopped, that I should, if I had a problem

I Hmm, hmm
if I was worried that I could get in touch with her again, and that was very, and she even said you don't have to worry about going back to your GP

Right

and I found that very comforting, because I was getting nervous about stopping

about ending, yes

and, er then when I did phone, she was immediately very positive and supportive about coming to

Hmmm

and she was very understanding, when I said well I think I'm a bit of a fraud 'cause I feel fine now

Hmm

so no, I thought that was pretty good

So it was umm, the way that you felt so relaxed and you could confide in her and she was also supportive

Yes, yes

and um, umm especially at the end when you were feeling a bit nervous about ending
mmm, and she gave me feedback as we went through it, it wasn't just as if I talked and that was it

Right

I mean she gave me lots of really useful feedback, umm, apart from anything else a lot of people with my sort of (inaudibel)...because she said that I was good to work with, she said it was good how I would go away and take away concepts that she talked to me about

Hmmm

and think them through and that was good and that in its.. well it made me feel good.. and it reinforced

yes

that what I was doing in applying within myself the ideas and so on, it sort of reinforced that and so it made them stick

Yes, and perhaps made it feel like a bit of a partnership

Yes definitely,

you know that she was actually enjoying this too, and this seemed to be going well, and as you say that was all reinforcing in itself, yes, and er what do you think it was about the way she was, I know it might be difficult to say, but that helped you to feel that you could really relax or trust or confide in her, know that you could
I don't know sometimes you feel you can relate to some people and not others. I think the fact that she was a woman helped.

Yes

P actually, I don't think I would have related as well to a man

Right

er and she just has a nice manner and because I mean you could have someone who, I suppose it's like body language or something, someone who sits there and ok they don't say anything and so get you to speak, but could be off putting even so.

Yes

there's an intangible element I think to the way people can relate, and I think some people get on

Yes, sure. Ok we've probably covered an awful lot here already... is there anything you would have liked her to do differently or anything that was unhelpful, was there any misunderstanding or anything like that

No, not at all

Mmm

It wasn't, it didn't feel like it was terribly structured, but then I was pleased that it wasn't

Mmmm
I think one of the things, I mean it would have been too much like work, if it had been fairly structured, or like school or something

Hmm

Um, and I prefer sometimes, and I do like structure in my life, but sometimes, I think its nice for things to flow and evolve, you know

Yes, sure

and that was helpful, so I wouldn’t have wanted that to be different

No, no, that would have been unhelpful, if you’d come in and there was a sort of programme you had to work through

Yes, that’s right, that’s my boss

Yes, sure, ok. And you’ve told me that you did look at your past relationships in therapy and that was difficult for a while... um

hmm, hmm, it helped me to understand my parents a bit more as well

Yes

She, one of the things she said is that as you grow up you can learn to forgive your parents, you come to understand them, not always or with everyone, but some people I suppose totally go off their parents..

Yes
but I, because I don’t blame them at all, I’m one of six and it was difficult the circumstances in which we were brought up

Hmm, hm

um, my father was a product of his generation; I said that to my mother the other day and she said “No he wasn’t he was just a mean bastard”

Right

but a bit of both I think, so I don’t blame them, I still love them, I haven’t, I wouldn’t tell them anything, they wouldn’t understand and my mother would just use it as ammunition against my father in one of her rows

Right, but maybe you’re saying you felt you’ve got a bit of a different perspective on it looking back

Yes, yes

Mmm, and also maybe that’s a bit intangible, but it’s something to do with the experience of the way you looked back

Yes, yes. I think also I’m more aware of other people’s behaviour, um, or at least more aware that there’s more to it than meets the eye

Ah, ha

Um, I think more about the psychology, you know, in inverted commas

Yes, yes
of relationships, at work, and at home a bit more as well

and my wife says I'm a much better person to be with, it's not, it's very largely about the therapy, I think that, in fact funnily enough it came at the right time, if it had been any sooner, I think it would have been too close to the depression

but the whole experience of the two depressions and everything culminating in the therapy

has been an amazing learning experience for me

and I think I'm much better, and I get feedback to that effect as well

Sure, which is all helping to consolidate how your feeling, yes and um, when you say that you are more aware of, or you're more aware of what might be happening with other people, does that sort of help you to see some of their vulnerabilities or some of their dodgy motivations, so that you sort of take it all onto yourself

Yes, yes
I Yes, hmm, ok, great, umm..Yes, I mean what do you think it was about looking at your childhood relationships in therapy that helped you to change in the present, if you can sort of put a finger on that

P I think, er, a lot of it was to do with the bottling up of feelings, and that was behaviour, I think I'd learn't from my father

I uh, huh,

P um, I mean I used to admire him for that

I ah, I see

P and think, you know, stoic and so on, right um, I think understanding how the extreme difference between behaviour, between my parents, both as individuals and towards me, helped me, gave me an explanation, a partial explanation, of things that had happened to me

I Yes,

P the thing about childhood fear of the unknown, still ticking away within me, the thing with the field and that, that was enourmously liberating I thought, and I thought ok with a few minor exceptions, being struck down, and ok mystery illness or something, we are very much in control of our own destiny, more than we sometimes think

I Yes

P and certainly I can do something about depression or about mood turning into depression, and so on
I  Yes, right, whereas as a child one wouldn't be able to

P  Yes, that's right

I  Hmm, hmm, you'd just have to wait for your parents to do something different, sort of thing, yes, yes.

P  Hmm, mmm

I  Yes, that's really interesting what you're saying there, very, hmm.. ok...I think we've covered a lot there.... Have you made any practical changes in your life, the way it's set up

P  I said I listen to classical music

I  Yes that's right
Developing an outcome measure derived from clients' perceptions of therapy

(TARECC)
Developing an outcome measure derived from clients' perceptions of therapy

(TARECC)

Abstract

Qualitative research concerning clients' experiences of therapy suggests that important psychotherapeutic benefits are not routinely measured as outcomes. A review and meta-analysis were undertaken of thirteen qualitative papers concerning clients' experiences of therapy in order to categorise the phenomena that were being reported. The four main categories emerging from the meta-analysis were 'the therapeutic alliance'; 're-evaluation processes'; 'experiment and challenge assumptions' and 'change factors' (TARECC). Whilst endeavouring to retain the original language and sentiments captured within the meta-analysis a quantitative questionnaire with 52 items was developed, the intent being to promote a measure of outcome firmly based on clients' reports of what was most useful or important. This was piloted with sixty participants who had completed therapy. Forty-five participants also completed the Clinical Outcomes in Routine Evaluation measure (CORE: Audin, Barkham, Connell, Mellor-Clark, Evans, McGrath & Margison) before and after therapy. A preliminary Principal Components factor analysis was used to reduce the number of items and attempt to improve the reliability of TARECC. The participants' scores on TARECC were compared with their scores on CORE (which showed significant therapeutic improvement). There was one area of correlation between the measures regarding the category of 'problems' (CORE) and the category of 'experiment and challenge' (TARECC) that may indicate TARECC could detect behaviours and interventions that lead to improvement in presented problems. Apart from this it appeared that the two instruments measure different phenomena with TARECC providing more of a focus on the quality of the therapeutic relationship and satisfaction with therapy. The importance of evaluating the phenomena measured by TARECC is discussed and further development of this outcome measure is indicated.
Developing an outcome measure derived from client’s perceptions of therapy
(TARECC)

Introduction

Several authors have emphasized the need for further qualitative research exploring therapeutic outcomes as experienced by clients (Baillie & Corrie, 1996; Connolly & Strupp, 1996; Cummings, Hallberg & Slemon, 1994; Elliot & James, 1989, Elliot & Shapiro, 1992; Feifel & Eells, 1963; Lietaer, 1992; Lindgren & Stenfelt, 1998; Paulson, Truscott & Stuart, 1999; Sigrell, Cornell, Gyllenskold, Lindgren, and Stenfelt, 1988). Part of the reason for this demand is a concern that some of the quantitative outcome measures used to assess therapy may, due to a ‘top down’ approach, have prematurely defined potential areas of therapeutic gain. A particular criticism has also been expressed about quantitative outcome studies that, partly due to financial pressures, only use measures of symptom reduction (Strupp 1996; Elliot & James, 1989). In fact, as Strupp et al. (1964) and Paulson et al. (1999), point out clients may only pay minor attention to symptom reduction when left to make their own evaluation. Thus, whilst evaluation of symptoms provides a useful indicator of certain outcomes, it does not provide mental health services with comprehensive feedback about satisfaction with the service as well as the impact of therapy on clients’ quality of life overall. Further, certain therapeutic processes valued by clients and the contribution of these to psychological change may remain unreported. Greater knowledge of these processes could be gathered alongside information about symptom reduction and would thereby help to inform mental health services as well as illuminate links between theory and practice (Garfield 1990; Greenberg 1986).

As a result of the above concerns, there is now a substantial body of qualitative research that has endeavoured to authentically represent the client’s experience of therapy (Strupp, Wallach & Wogan, 1964; Elliot & Shapiro, 1992; Rennie, 1992; Lietaer, 1992; Cummings, Hallberg & Slemon, 1994; Cummings, Hallberg & Slemon, 1994; Connolly & Strupp, 1996; Booth, Cushway & Newnes, 1997; Paulson Truscott & Stuart, 1999; Jinks, 1999). Researchers in this field are attempting to provide more information about the phenomena that clients report and how these relate to desired
change and psychological health. It would appear that the time has now come when this body of knowledge can be used to inform an outcome measure that, whilst still retaining the language and sentiments of clients, could also be used for quantitative research.

The first step undertaken was a review of the qualitative literature, briefly assessing the studies available according to the range of information gathered, the direction of inquiry taken by the researcher and the methods of data collection and analysis used. Indeed, it is important to remember that, whilst most researchers aim to be objective or minimize the effects of personal bias, they may still influence the participants’ focus by means, for instance, of the questions asked (e.g. about change, or helpfulness of therapist). Even non-directive interviews may be influenced by the prompts of the interviewer. The majority of studies considered here are of brief therapy and cover a range of therapeutic approaches (See Table 1 for details). They are, therefore, fairly representative of the range and types of therapy practised within the health service today and form the data for the analysis of clients’ perceptions presented here.

The second step was to undertake a meta-analysis of the thirteen papers reviewed the results of which are displayed in tables two and three below. Categories are presented in terms of a positive or negative therapeutic experience.
Table 1: Details of studies reviewed

<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors &amp; Date</th>
<th>No. of Participants</th>
<th>Type of Therapy practiced. Integratively (integ.), Eclectic (ecle.)</th>
<th>No. of sessions or Duration of Therapy</th>
<th>Method &amp; Measure(s)</th>
<th>Question(s) Asked Regarding:-</th>
<th>Method of Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Paulson et al. 1999</td>
<td>36</td>
<td>Eclec.: CB, Humanist, Family Systems</td>
<td>Mean of 11</td>
<td>Interview</td>
<td>What was helpful</td>
<td>Thematic clustering</td>
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<tr>
<td>2</td>
<td>Jinks, 1999</td>
<td>4</td>
<td>Integ.: Person Centred &amp; CB</td>
<td>1 year</td>
<td>Interview</td>
<td>Experience of counsellng</td>
<td>Grounded Theory</td>
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<td>3</td>
<td>Rennie, 1992</td>
<td>14</td>
<td>Various Humanistic or CB</td>
<td>Six weeks ↔ 2 years</td>
<td>Interview</td>
<td>Anything of interest or significance</td>
<td>Grounded Theory</td>
</tr>
<tr>
<td>4</td>
<td>Brownrigg, Unpublished</td>
<td>9</td>
<td>Integ.: Psychodynamic, CB, Humanistic</td>
<td>6 ↔ 20</td>
<td>Interview</td>
<td>What happened that facilitated change</td>
<td>IPA</td>
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<td>5</td>
<td>Booth et al. 1997</td>
<td>51</td>
<td>Psychodynamic or Humanistic/Eclectic</td>
<td>Mean of 6</td>
<td>Questionnaire (HAT)</td>
<td>Helpful/unhelpful /important events</td>
<td>TICAS</td>
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<td>6</td>
<td>Lietz, 1992</td>
<td>41</td>
<td>Client centred</td>
<td>Mean of 10</td>
<td>Questionnaire</td>
<td>Feelings, content, helpful/unhelpful</td>
<td>Content Analysis</td>
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<td>7</td>
<td>Llewelyn et al., 1988</td>
<td>40</td>
<td>*CB &amp; Psychodynamic, cross over design, 8 sessions of each</td>
<td>Questionnaire (HAT)</td>
<td>Helpul/unhelpful/importent events</td>
<td>TICAS</td>
<td></td>
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<tr>
<td>8</td>
<td>Elliot &amp; Shapiro, 1988</td>
<td>2</td>
<td>*CB &amp; Psychodynamic, cross over design, 8 sessions of each</td>
<td>Questionnaire/Rating scale (HAT &amp; HRS)</td>
<td>Helpul/unhelpful/importent events</td>
<td>Comprehensive Process analysis</td>
<td></td>
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<tr>
<td>9</td>
<td>Cummings et al., 1994</td>
<td>10</td>
<td>Eclec.: CB, Person-Centred, Experiential</td>
<td>8 ↔ 11</td>
<td>Questionnaire (IEQ)</td>
<td>Helpul/unhelpful/importence/changes</td>
<td>Content Analysis</td>
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<td>10</td>
<td>Feigel &amp; Ells, 1963</td>
<td>63</td>
<td>Psychoanalytic psychotherapy</td>
<td>Not less than 10</td>
<td>Questionnaire</td>
<td>Helpul/unhelpful/changes</td>
<td>Content Analysis</td>
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<tr>
<td>11</td>
<td>Connolly &amp; Strupp, 1996</td>
<td>67</td>
<td>Dynamic therapy</td>
<td>Up to 25</td>
<td>Written accounts</td>
<td>Describe the most important changes</td>
<td>Cluster Analysis</td>
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<td>12</td>
<td>Strupp et al. 1964</td>
<td>44</td>
<td>Psychoanalysis or Psychotherapy</td>
<td>Mean of 166</td>
<td>Questionnaire</td>
<td>Therapist activities related to change /attitudes to therapist/changes</td>
<td>Frequencies &amp; Content Analysis</td>
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<td>13</td>
<td>Wallerstein, 1989</td>
<td>42</td>
<td>Psychoanalysis or Psychotherapy</td>
<td>Open Ended</td>
<td>Questionnaires/clinical interview/case study</td>
<td>Diagnostic &amp; prognostic factors, motivation, psychic functioning</td>
<td>Case study summaries, factor analysis, MSA</td>
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Table 2: Meta-Analysis Categories that relate to a positive experience of therapy

<table>
<thead>
<tr>
<th>Study No</th>
<th>Therapeutic Alliance</th>
<th>Processes Involved In Re-evaluation That Lead To Change</th>
<th>Counsellor Intervention</th>
<th>Admin. Context Factors</th>
<th>Areas of Change Expressed as Positive Therapy Outcomes</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Review/ reassessment of Self &amp; past or present</td>
<td>Expression of thoughts &amp; feelings</td>
<td>Gaining Insight</td>
<td>Increased self- awareness</td>
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Table 3: Meta-Analysis Categories that relate to a negative experience of therapy

<table>
<thead>
<tr>
<th>Study No.</th>
<th>Problems with the Therapeutic Alliance</th>
<th>Problems regarding the Processes of Re-evaluation</th>
<th>Problematic Counsellor Intervention</th>
<th>Problematic Admin. Context Factors</th>
<th>Areas of Negative Change Attributed To Therapy or Lack of Improvement</th>
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<tbody>
<tr>
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<tr>
<td>13</td>
<td>Negative aspects are not commented on or discussed in this paper</td>
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</table>

Note: The table entries indicate the presence or absence of problems and are marked with symbols such as *, **, and *** to denote varying levels of significance.
A more detailed discussion of the review is presented below. The studies are grouped as either: ‘research concerning helpful or hindering processes in therapy’, or ‘research pertaining to change’. Each of these categories is divided into studies made either ‘post session’ or ‘post therapy’.

Research concerning helpful or hindering processes in therapy

*Studies collecting data post session:* Llewelyn, Elliot, Shapiro, Hardy and Firth-Cozens (1988) used the Therapeutic Impact Content Analysis System (TICAS) to study helpful and unhelpful events. They found that ‘reassurance’, ‘problem solution’ and ‘awareness’ were reported most frequently. ‘Unwanted thoughts’ were the most frequent hindering process. In a similar study Booth, Cushway and Newness (1997) found that ‘reassurance’, ‘problem solution’, ‘insight’, and ‘involvement’ impacts were reported most frequently by clients and that certain counsellors seemed to promote ‘awareness’ and ‘problem solution’ impacts more frequently. However impacts recorded from individual sessions were not found to have a simple correlational relationship with overall outcome. Lietaer (1988) conducted an unstructured content analysis, i.e. not using a pre-formatted coding structure, finding similar categories to those of Llewelyn (1988) and Booth et al. (1997) although being expressed somewhat differently. The most frequent helpful process was ‘self-exploration and its facilitation’. This first category was followed quite closely by ‘Insight into oneself and situations’ and then ‘relationship with the therapist’. Following this, was a group of responses categorised as ‘momentary relief’, which related to clients’ sense of ‘progress’ and ‘confirmation’ by the therapist. Interestingly when comparing the clients’ perceptions with those of the professionals, clients rated ‘relationship attitudes’ (i.e. the perceived quality of the therapeutic relationship) as helpful more frequently than therapists (who also completed questionnaires) and, most importantly, this tended to discriminate high quality sessions. The variation between studies as to the most important processes reported may be due to different methods of
categorization by researchers. Hence it would be valuable to work towards a consensus about the categorization and labeling of the phenomenon occurring for clients during therapy.

**Studies collecting data post therapy:** Paulson, Truscott and Stuart (1999) interviewed clients at completion of therapy or soon after, asking them to report anything they considered to be helpful. Particular attention was paid to participants’ language and sentiments and nine thematic clusters were identified: ‘counselor facilitative interpersonal style’; ‘counselor interventions’; ‘generating client resources’; ‘new perspectives’; ‘client self-disclosure’; ‘emotional relief’; ‘gaining knowledge’; ‘accessibility’ and ‘client resolutions’. From this highly qualitative analysis, we can see that, whilst there are overlaps with the areas in the TICAS measure, there are also differences in emphasis, i.e. the counsellor’s personal style and particular interventions are attended to as is the knowledge gained in therapy. Also practical considerations concerning accessibility, and resolutions reached are noted. One strength of retrospective accounts of a total therapy is that it allows clients time to ‘digest’ therapy and reflect on their experience and overall outcome. However, a weakness is that they may forget or mis-remember some aspects of the therapy process.

**Research pertaining to change**

**Post session studies of change:** Rennie (1992) analysed post session interviews with clients using grounded analysis. He identified four main categories of meaning which could be said to have a bearing on change: ‘The client’s relationship with personal meaning’; ‘the client’s perception of the relationship with the therapist’; ‘the client’s experience of therapist’s operations, and ‘the client’s experience of outcomes’. Rennie was particularly concerned to report the sense of agency and awareness or reflexivity that clients convey concerning their therapy.
Cummings, Hallberg and Slemon (1994), were particularly interested in identifying templates of change processes. They used the Important Events Questionnaire (Cummings, Hallberg, Martin and Slemon, 1992), which includes open ended questions to ask about importance, helpful/unhelpfulness, thoughts and feelings, and between session experiences. They also asked about experience of change and identified patterns of: ‘consistent change’, ‘interrupted change’ and ‘minimal change’. Cummings et al. concluded that the change process for the majority of clients seemed to result from a complex interaction between ‘feelings of safety within the therapeutic relationship’; ‘changing self-perceptions (insights)’; ‘tolerating and resolving painful feelings’; ‘connecting thoughts and feelings’, and ‘experimenting with new behaviours as a way of increasing insights and confidence’. The importance of connecting thoughts and feelings is a different emphasis emerging from this study, as is trying out new behaviours. It is likely that the researchers’ awareness of Cognitive Behavioural theory have led them to highlight these narrative themes in the data.

Studies collecting data post therapy: In an outcome study conducted by Connolly and Strupp (1996), clients were asked to “describe the most important changes you have experienced” (in writing). Cluster Analysis revealed four areas: ‘improved symptoms’; ‘improved self-understanding’; ‘improved self-confidence’, and ‘greater self-definition’. Two super clusters (or overarching themes) were also defined as: ‘improved symptoms’ and ‘changes in self concept’. Connolly and Strupp note that their results are consistent with those of other studies (Horowitz 1979; Horowitz & Vitkus 1985; Strupp, Fox & Lessler 1969), which suggested that important outcomes are found in the areas of symptoms, cognitions about the self, and interpersonal problems.

Strupp, Wallach and Wogan (1964) asked patients (and their therapists), who had been
in long-term (average of 2 years duration) supportive psychotherapy or analytical therapy, to complete global post therapy questionnaires. They asked what aspects of therapists' activities accounted for change experienced. These were then analysed by cluster analysis. They found that 'warmth' and in particular 'respect' was considered important aspects by clients. They also asked for a description of the most important changes experienced. These were categorised as: 'greater awareness of feelings and impulses'; 'increase in self esteem'; 'better interpersonal relations'; 'improvement in neurotic symptoms'; 'more active in working out solutions', and 'no change, changes due to factors other than psychotherapy'.

In a study utilising in-depth qualitative interviews, clients who considered therapy had been successful were asked how they felt change had taken place in therapy and what had they perceived the therapist to be doing to promote this during therapy (Brownrigg1999, unpublished dissertation). Five main themes emerged from the analysis. These were: 'self-enhancement: through a positive therapeutic alliance'; 're-education: therapy is viewed as an educational process'; 'turning points: catalysts for change', and 'expression of withheld or repressed thoughts and feelings'. Two superordinate themes were considered to be 'reassessment' and 'the therapeutic relationship'.

Jinks (1999) recorded interviews with four clients who had been in counselling for at least a year in total. Participants were asked to “reflect on their experience of being counselled” and to explore any changes to themselves or their outlook and consider what those changes could be attributed to. They were also asked whether any significant or specific events could be remembered as contributing to change. Jinks concluded that all clients felt more in control of their lives and key aspects of this were ‘increased self-awareness'; ‘confidence'; ‘insight'; ‘ability to make decisions and act to influence events'; and ‘assertiveness’. As in the study by Brownrigg above, Jinks noted that clients often affiliated the change process with aspects of the
The therapeutic relationship (particularly trust and certain skills). As we know, the therapeutic alliance is central to therapy and consistently shows a significant effect whereas different treatment approaches have not been strong predictors of outcome (Horvath & Luborsky, 1993; Horvath & Symonds, 1991).

Aims of this study: By performing a meta-analysis of the research data reviewed here, this study aims to develop a broad-spectrum self-completion measure of outcome that is representative of clients' qualitative reports about their experience of therapy. This may help to give a more complete picture of valued outcomes than is presently provided by many existing measures. A measure based on the phenomena clients value most in therapy could inform individual therapists or be part of research concerned with improving the therapeutic experience.

Method

Development of the therapy outcome measure: Therapeutic Alliance Re-evaluation, Experiment and Challenge, and Change Measure (TARECC)

Item Development: The method of questionnaire development described by Rust and Golombok (1999) was used. The items for the questionnaire were developed on the basis of a meta-analysis of the thirteen papers identified for this review (Table 1). The key themes or categories of previous studies were grouped together into categories on the basis of similarity of meaning. Categorisation was agreed with two therapists and mental health services about perceptions of the quality of therapy being delivered and levels of client satisfaction. The measure will also provide clients with a semi-structured way of evaluating their therapy as well as knowing that their feedback about therapy could inform individual therapists or be part of research concerned with improving the therapeutic experience.
independent raters. Where raters disagreed, there was discussion until a consensus was reached. Although there is conceptual overlap between certain items in separate categories, the item only appears in the category to which it seems most pertinent. Where possible, the language and sentiments of clients were captured by incorporating their phrases directly into the questionnaire to enhance content validity. As aspects of categories are interconnected and definitions are constrained by the knowledge and perspectives of the researcher (and independent raters), they cannot have absolute definitions and boundaries. It was deemed more important to aim for a full representation of the phenomena represented in the review even if the categories might have some conceptual overlap (Appendix 1 shows the data organised into categories).

Each category was then represented by drawing on the information contained within it to form a questionnaire format consisting of 52 items. Rating-scale items are most commonly used when eliciting personal information. This study used a five-point rating scale as this allows for a response to be expressed as a meaningful evaluation in relation to the other diverse options. The questionnaire was given as a first pilot to four participants who were asked to comment on its clarity. Following this the questionnaire was piloted with one more participant than items (53 participants) as recommended by Rust and Golombok (1999).

**Concurrent Validity:** In an effort to check concurrent validity (Rust and Golombok, 1999) the *Clinical Outcomes in Routine Evaluation* (CORE, Audin, Barkham, Connell, Mellor-Clark, Evans, McGrath & Margison) was used. Whilst the use of further measures might have increased validity this was felt to be too burdensome for participants. The CORE is designed to be a pan-theoretical measure of the ‘core’ components of clients’ distress. It measures: ‘Problems/symptoms’; ‘Subjective well-being’; ‘Life functioning’; and ‘Risk/Harm’. Clients are asked to think about how they have been over the last week and respond to 34 statements by using a five-point
scale ranging from “Not at all” (0) to “Most or all the time” (4). The measure gives cut-off scores for men and women from non-clinical and clinical populations. Clients are already routinely asked to complete the CORE when they first attend and at the last counselling session as part of the Trust’s monitoring and evaluation audit.

**Participants:** The sixty participants ranged in age from 18 to 69 years old (mean = 39 years old). In terms of occupation, 42 were employed (70%), 7 were unemployed (12%), 10 identified themselves as ‘housewives (17%) and 1 as a ‘carer’. The sample composition in terms of ethnicity was 91% white/Caucasian/European, 9% Asian, and 1% African-Caribbean. Nineteen (32%) of the participants were male and forty-one (68%) were female. The unequal sex balance is a reflection of the greater number of women who were seen for therapy. Participants had all been referred to the psychology department of an NHS Trust for outpatient counselling, and had completed therapy not more than 2 years prior to receiving the questionnaire. Participants had received not fewer than two and not more than twenty counselling sessions. (More than twenty sessions would not be the norm in most NHS or primary care settings). The mean number of sessions was 8. This range should capture data from those who benefit from a short or longer-term intervention, plus data from those who end therapy early due to unhelpful factors or who complete therapy but experience little helpful change. The CORE scores taken at the beginning of therapy defined 25(56%) of the forty-five participants who completed CORE as recording problems that would be considered to be at a clinical level of severity whilst 20(44%) did not have a clinical score (the clinical % would be somewhat higher if risk factors were excluded).

Participants were seen by either of four counselling psychologists or two clinical psychologists. The therapists have all had training in cognitive-behavioural, psychodynamic and humanistic/experiential therapy. They consider themselves to
work in an integrative fashion. The least experienced has one year post qualifying experience and the others have, in rank order, 2 years, 2 years, 3 years, 6 years, 6 years and 13 years.

Procedure: Each participant was given (at the penultimate session) or (if already completed therapy) had posted to them the TARECC questionnaire (including demographic questions to give information on the representativeness of the sample (see Appendix 2), an Information Letter (see Appendix 3), a Consent Form (see Appendix 4); and an addressed envelope (SAE for postal) to ensure anonymity and facilitate return. Ethical approval was granted by the relevant NHS Trust ethics committee and the University of Surrey’s Advisory Committee on Ethics.

Analysis

In order to make a preliminary test of the validity of the four sub sets that comprised the questionnaire, a factor analysis was computed using SPSS (Statistical Package for the Social Sciences) version 10. This was a cautious exploration due to the small sample size. Ideally a sample of between 150-200 would be required for a questionnaire comprising of 52 items. However, Rust and Golombok (1989) argue that factor analysis when used with caution can be a considerable aid to questionnaire construction giving useful information about the underlying structures of scores and the feasibility and number of sub-sets. The method of rotation employed by factor analysis can help to cancel out any effect caused by acquiescence (i.e. answering all questions positively). Rust and Golombok conclude that it is better to be informed by a factor analysis, even with a small sample. The main problem to bear in mind is over interpretation of the data. Factor analysis is a tool aiding interpretation, but cannot give definitive explanations. A factor analysis would have to be conducted with a larger sample.
before any of the results discussed here could be claimed to be representative of processes and outcomes in a productive or unhelpful therapeutic experience.

The factor analysis was conducted using Principal Components analysis with Direct Oblimin rotation, as it was anticipated that the resulting components would be correlated. The original questionnaire derived from the meta analysis comprised of 4 categories and, following a number of principal components analyses, it appeared that the best solution that offered a coherent structure and accounted for a high proportion of the variance also had four categories. Items with a structural coefficient over .4 were selected as correlating sufficiently with a component. For the items that factored under each category (or sub-set), a composite score was calculated using the mean scores for each category. The composite scores were used for all further analysis. The categories of the principal component solution were then tested for reliability using Cronbach’s $\alpha$.

**Concurrent Validity:** The CORE sub-set scores taken at the beginning and end of therapy were subjected to t-tests (paired samples) in order to see whether participants had significantly improved during therapy. The sub-set scores of participants who had significantly improved according to CORE were then tested for correlation with the sub-sets of TARECC to ascertain whether the CORE provided concurrent validity for TARECC as a measure of successful therapy. Also participants’ scores that fell within the lower third of scores on TARECC were classified into a low score sub-set and tested for correlation with the positive outcome scores on CORE.
Results

An initial appraisal of the scores of participants on the TARECC scale is presented below in the form of a descriptive analysis (Figure 1).

![Histogram of TARECC scores](image)

The possible range of scores on TARECC is between 52 and 260. By looking at the histogram above we can see that four people (7%) had low scores of more than 2 standard deviations below the mean and two people (3%) had high scores of almost 1.5 standard deviations above the mean. The majority of the participants (90%) gave scores of not more than 1.5 standard deviations above or below the mean. However it is worth noting that approximately 13 people had scores of between 155 and 180 which is somewhat lower than would be expected with an entirely normal distribution.
Principal Components Analysis of TARECC

In order to test validity of the four meta-analysis categories, a principal components analysis was carried out on the TARECC initially with five factors and then four to see whether four factors would provide a better fit. A scree plot (table 5) was made in order to assess the number of components that were likely to be within the data. Table 5 below shows that the data is largely composed of one factor (category A relating to re-evaluation). As the questionnaire was conceptually constructed from the meta-analysis as containing four main categories, it was decided to compute the principal components analysis with this number of categories in order to maintain conceptual coherence (whilst bearing in mind that the items in the questionnaire were likely to be highly related).

Table 5: Scree Plot
Three items were excluded as they did not group into a meaningful component on the first factor analysis or were almost equally weighted on two factors. The factor analysis was then computed again (direct oblimin due to predicted correlation with meta analysis with Kaiser Normalization; delta 0; rotated solution; rotation converged in 35 iterations). This resulted in four components being extracted (see Table 6 below). Seven items were factored on two components; one was placed with the component with which it was more strongly related and six were excluded. Five items did not group meaningfully and were therefore excluded.
The following table is an illustration of the Principal Components Analysis

**Table 6: The Principal Components Pattern Matrix for TARECC**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Components</th>
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<tbody>
<tr>
<td></td>
<td>Re-evaluation Process</td>
</tr>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>A28</td>
<td>.767</td>
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<tr>
<td>A51</td>
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<td>A24</td>
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</table>

Items in bold were excluded as they factored onto more than one component or did not group meaningfully.

The component correlation matrix (Table 7) shows the correlation between categories.

**Table 7: Component Correlation Matrix**

<table>
<thead>
<tr>
<th>Component</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tr>
<td>A</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>.167</td>
<td>1.000</td>
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</tr>
<tr>
<td>C</td>
<td>-.442</td>
<td>-.157</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>-.308</td>
<td>-.246</td>
<td>.367</td>
<td>1.000</td>
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</table>

The component correlation matrix shows that despite the overall dominance of the ‘re-evaluation’ component there are suggestions of some distinctions between the four components. For example the therapeutic relationship category (B), does not correlate so highly with the re-evaluation category (A), nor the ‘experiment and challenging beliefs’ category (C), nor the ‘change’ category (D). Whereas there is a higher correlation between re-evaluation (A); ‘experiment and challenging beliefs category (C), and ‘change’ category (D).

**Internal Validity**

Whilst the ‘therapeutic relationship’ category retained 4 out of 8 items from the meta-analysis category, it also appeared to incorporate the category of ‘therapist interventions’. It also gained one item from ‘re-evaluation’ concerning “avoiding..” (or not avoiding) “..talking about certain problems” which could easily be seen as more relevant to the quality of the therapeutic relationship. Re-evaluation was also a category that retained 11 original items, but also incorporated 2 items from the original ‘Change factors’ category. A new categorization of the items appeared to be
related to the clients’ experience of experimenting with new ideas and behaviours, and
being willing to have ideas and beliefs confronted with alternative perspectives by the
therapist (category named: ‘experimentation & challenge beliefs). This drew items
from the meta analysis categories of ‘re-evaluation’, ‘therapist interventions’,
‘therapeutic relationship’ and ‘change factors’.

Thirteen items correlated with component (a) which was construed as largely
representational of ‘re-evaluation processes’. Those items marked * are expressed as
outcomes rather than processes although if the wording of the questions had referred
to “experience during therapy” they might have linked with other items more
meaningfully in terms of process. They were excluded from the final questionnaire in
order to shorten this category and maintain the meaning of the category more
cohesively.

Re-evaluation processes:

A28 Therapy helped me become more aware of what I was thinking
A51* Therapy has made me feel worse than before
A29 Therapy did not help me become more aware of what I was feeling
A36 I was interested in working out the therapists view of things
A21 I am doubtful about whether talking over problems with a therapist is helpful
A26 Expressing my thoughts and feelings to the therapist did not really get me
anymore
A34 I understand myself better because of therapy
A17 Therapy enabled me to get clearer about my problems and this was helpful
A50* I have not experienced any positive change that I attribute to therapy
A16 Therapy helped me to focus and reassess myself/situations/relationships
A19 I can now consider the things that bothered me in a different more helpful way
A37 I have learnt new ways of solving problems and coping through therapy
A23 I found it difficult to arrive at any explanations about my problems or to find
answers to the questions I had
Eight items factored with component (b) which was defined as representing factors specifically referring to the therapeutic relationship.

*Therapeutic Relationship & Therapist Interventions:*

A13 My therapist hurt my feelings  
A12 My therapist was too pushy or challenging  
A6 My therapist sometimes seemed to be bored or irritated or angry with me  
A14 I felt badly treated by my therapist  
A4 My therapist was patronising or superior in manner  
A3 My therapist was not judgemental  
A20 I avoided talking about certain problems even though they might have been important  
A11 My therapist was too passive (i.e. not saying enough or not challenging you enough; or you felt unassisted too often)

Eleven items were retained that factored with component (c) which was defined as representing factors relating to client experimentation with new thoughts and behaviours and being willing to challenge attitudes and beliefs.

*Experimentation and challenging beliefs:*

A40 I experimented with acting differently towards others or behaving differently in-between therapy sessions  
A41 Going through therapy has helped me to decide when to put my own needs first, before the needs of others  
A39 Therapy helped motivate me to help myself  
A1 My therapist was supportive and understanding  
A32 I have seen new things about myself  
A9 The therapist reassured me that my feelings were important and understandable  
A10 It was helpful when my therapist challenged me (i.e. suggested I might question what I was saying or believing)  
A48 Therapy helped me to get things into perspective, or become more realistic  
A18 My therapy was like a journey of self-exploration
New knowledge or information given to me by the therapist was not very useful.

It was useful to think about the effects of childhood, family or early significant relationships and how these have influenced me today.

Six items factored with component (d) which was construed as representing factors relating to change.

**Change factors:**

- A44 I am now less critical and more accepting of others
- A47 Therapy has made me feel more confident
- A52 The number of therapy sessions I was given was sufficient
- A49 I am still just as hard on myself since therapy
- A33 I have not seen any new possibilities in my life
- A45 I am still bothered by the problems that brought me to therapy

(These 38 items are shown in the refined TARECC, appendix 6)

**Internal Validity**

The frequencies of the 4 refined TARECC sub-set scales are shown below in tables 8 to 11.

**Table 8: Scale A comprising 11 items possible score range of 11-55:**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale A</td>
<td>60</td>
<td>12.00</td>
<td>53.00</td>
<td>41.066</td>
<td>8.1404</td>
</tr>
<tr>
<td>Valid N</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9: Scale B comprising eight items possible score range of 8-40:

<table>
<thead>
<tr>
<th>Scale B</th>
<th>N</th>
<th>Minimu</th>
<th>Maximu</th>
<th>Mea</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60</td>
<td>21.00</td>
<td>40.00</td>
<td>33.466</td>
<td>4.5266</td>
</tr>
<tr>
<td>Valid N</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10: Scale C comprising 11 items possible score range of 11-55

<table>
<thead>
<tr>
<th>Scale C</th>
<th>N</th>
<th>Minimu</th>
<th>Maximu</th>
<th>Mea</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56</td>
<td>16.00</td>
<td>53.00</td>
<td>41.339</td>
<td>7.1637</td>
</tr>
<tr>
<td>Valid N</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11: Scale D comprising six items, possible score range of 6-30

<table>
<thead>
<tr>
<th>Scale D</th>
<th>N</th>
<th>Minimu</th>
<th>Maximu</th>
<th>Mea</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60</td>
<td>8.00</td>
<td>28.00</td>
<td>18.883</td>
<td>4.3767</td>
</tr>
<tr>
<td>Valid N</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the descriptive tables above it was considered that the scales produced a fairly good range of scores for each sub-set with acceptable means and standard deviations. The internal validity was then statistically assessed by comparing a measure of scale reliability (Alpha), for both the sub-set scales of the original meta-analysis and the components analysis sub-sets (where these were conceptually related). A comparison was then made to see if the scale had improved overall via components analysis (see Table 12 below).
Table 12: Reliability Analysis of Original (meta analysis) and Component analysis Subsets

<table>
<thead>
<tr>
<th>Sub Scales of Meta-Analysis &amp; TARECC</th>
<th>Crohnbach's Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meta Analysis: Re-evaluation</td>
<td>.9</td>
</tr>
<tr>
<td>Component Analysis: Re-evaluation</td>
<td>.8</td>
</tr>
<tr>
<td>Meta Analysis: Therapeutic Relationship</td>
<td>.9</td>
</tr>
<tr>
<td>Component Analysis: Therapeutic Relationship</td>
<td>.9</td>
</tr>
<tr>
<td>Meta Analysis: Therapist Interventions</td>
<td>.8</td>
</tr>
<tr>
<td>Component Analysis: Experimentation &amp; Challenge Assumptions</td>
<td>.74</td>
</tr>
<tr>
<td>Meta Analysis: Change Factors</td>
<td>.9</td>
</tr>
<tr>
<td>Component Analysis: Change Factors</td>
<td>.8</td>
</tr>
</tbody>
</table>

Results show that Alpha levels are good (between .7 and .9 for all components analysis sub-sets), demonstrating good internal validity of each sub-set scale. A correlation matrix of the sub sets gave an Alpha of .84 (see table 13 below). The components analysis has not increased the subset levels of Alpha.
**Table 13: Correlation Matrix of TARECC subsets**

<table>
<thead>
<tr>
<th></th>
<th>Scale A</th>
<th>Scale B</th>
<th>Scale C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale A</td>
<td>.4885</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale B</td>
<td>.8049</td>
<td>.5119</td>
<td></td>
</tr>
<tr>
<td>Scale C</td>
<td>.6701</td>
<td>.5395</td>
<td>.6200</td>
</tr>
</tbody>
</table>

N of Cases = 56.0  
Reliability Coefficients 4 items  
Alpha = .8434

**Concurrent Validity**

To check that clients were, on the whole, finding therapy beneficial, the scores of the CORE taken at the beginning and end of therapy were compared and this demonstrated that the majority of participants had a significant improvement as measured by CORE. (see Table 14 below. n.b. males and females were grouped together due to the small number of males).
Table 14: Paired Samples t-test For Subsets of CORE: Functioning, Well-being, Problems, and Risk, Before Therapy and After Therapy

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>T</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functioning</td>
<td>.87</td>
<td>45</td>
<td>.74</td>
<td>-5.71</td>
<td>.000</td>
</tr>
<tr>
<td>Post therapy</td>
<td>1.42</td>
<td>45</td>
<td>.75</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                  | Mean   | N   | Std. Deviation | T       | Sig. (2-tailed) |
| Well being       | 1.03   | 45  | .93            | -6.71   | .000            |
| Post therapy     | 2.0    | 45  | 1.06           |         |                 |

|                  | Mean   | N   | Std. Deviation | T       | Sig. (2-tailed) |
| Problems         | 1.13   | 45  | .84            | -6.90   | .000            |
| Post therapy     | 1.95   | 45  | .95            |         |                 |

|                  | Mean   | N   | Std. Deviation | T       | Sig. (2-tailed) |
| Risk             | .15    | 45  | .30            | -2.50   | .017            |
| Post therapy     | .32    | 45  | .53            |         |                 |

Scale is 0-4 with 0 representing no difficulty and 4 extreme difficulties

Based on participants CORE scores, they were categorized into those who had achieved significant change and those who had not. The significant change CORE subsets were then tested for correlation with the 4 refined subsets of the TARECC using Spearman's rho (See Table 15).
Table 15: Correlation between the refined sub-sets of TARECC and the sub-sets of CORE where clients showed significant change

<table>
<thead>
<tr>
<th>Spearman's Rho</th>
<th>Refined Re-evaluation</th>
<th>Refined Therapeutic Relationship</th>
<th>Refined Experiment &amp; Challenge</th>
<th>Refined Change Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems Core</td>
<td>.21</td>
<td>.11</td>
<td>.34*</td>
<td>.15</td>
</tr>
<tr>
<td>Risk Core</td>
<td>.05</td>
<td>-.21</td>
<td>.21</td>
<td>-.02</td>
</tr>
<tr>
<td>Well being Core</td>
<td>.11</td>
<td>-.21</td>
<td>.29</td>
<td>.01</td>
</tr>
<tr>
<td>Functioning Core</td>
<td>.20</td>
<td>-.20</td>
<td>.24</td>
<td>.12</td>
</tr>
</tbody>
</table>

(2-tailed).
* correlation is significant at the 0.5 level

The results suggest that there may be a correlation between those who have changed according to CORE regarding their level of ‘problems’ and the TARECC component of ‘experiment and challenge’. There was no further significant correlation between those who have changed according to CORE and the other aspects of the therapeutic experience measured by TARECC. However, all of the ‘significant change’ CORE subsets were significantly correlated with each other (.01 or .05), and all of the TARECC subsets were significantly correlated with each other according to Spearman's rho.

A further test of internal validity was made by testing for correlation between the original meta-analysis categories and the refined components analysis categories (see Table 16 below).
Table 16: Correlation between the meta-analysis subsets and the refined component analysis subsets

<table>
<thead>
<tr>
<th>Spearman's rho</th>
<th>Refined Component Re-evaluation</th>
<th>Refined Component Therapeutic Relationship</th>
<th>Refined Component Experiment &amp; Challenge</th>
<th>Refined Component Change Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meta-analysis Change</td>
<td>.819**</td>
<td>.482**</td>
<td>.760**</td>
<td>.872**</td>
</tr>
<tr>
<td>Meta-analysis Re-evaluation</td>
<td>.964**</td>
<td>.530**</td>
<td>.860**</td>
<td>.658**</td>
</tr>
<tr>
<td>Meta-analysis Therapist Relationship</td>
<td>.616**</td>
<td>.891**</td>
<td>.544**</td>
<td>.545**</td>
</tr>
<tr>
<td>Meta-analysis Therapist Intervention</td>
<td>.694**</td>
<td>.699*</td>
<td>.751**</td>
<td>.520**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the .01 level (2-tailed).
* Correlation is significant at the .05 level (2-tailed).

Results suggest a strong correlation between the original meta-analysis TARECC and the principal components TARECC.

Finally, a test for correlation was made, between those whose scores registered in the lower third of the TARECC scale (who had therefore not had a highly positive experience), and those who had shown significant change on their CORE scores (Table 17).
Table 17: Showing correlation of those scoring on the lower third of TARECC and significant change on CORE subsets

<table>
<thead>
<tr>
<th></th>
<th>Spearman's rho</th>
<th>Refined Re-evaluation</th>
<th>Refined Therapeutic Relationship</th>
<th>Refined Experiment &amp; Challenge</th>
<th>Refined Change Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems Core</td>
<td>.486</td>
<td>.000</td>
<td>.621*</td>
<td>.539</td>
<td></td>
</tr>
<tr>
<td>Risk Core</td>
<td>.103</td>
<td>-.337</td>
<td>.375</td>
<td>.023</td>
<td></td>
</tr>
<tr>
<td>Well being Core</td>
<td>.183</td>
<td>-.202</td>
<td>.458</td>
<td>.433</td>
<td></td>
</tr>
<tr>
<td>Functioning Core</td>
<td>.232</td>
<td>-.011</td>
<td>.803**</td>
<td>.438</td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the .01 level (2-tailed).
* Correlation is significant at the .05 level (2-tailed).

Results suggest that participants may have a low score on TARECC but still show improvements in the areas of ‘problems’ and ‘functioning’ as measured by CORE.

** Discussion **

The purpose of the research described in the present paper was to make an initial psychometric analysis of a self-report measure derived from a meta-analysis of clients’ reports of their therapy. The self-report measure aimed to capture the therapeutic processes and change outcomes that clients value as important components and outcomes of therapy. A meta-analysis of thirteen qualitative studies was used as the basis for the development of the outcome questionnaire that would measure whether valued therapeutic processes had been activated in an individual’s therapy as well as valued change outcomes. The meta-analysis defined five main categories that had both positive and negative aspects (see Appendix 1 for details). The therapeutic
relationship was one category, incorporating elements such as ‘warmth’, ‘trust’, ‘understanding’, and ‘acceptance’. The type of active interventions made by the counsellor was another related but distinct category where clients described, for example, the therapist giving ‘objective feedback’ or applying ‘skills and techniques’. A further category concerned processes defined as ‘re-evaluation’ that, in turn, could be seen as leading to change in perception or behaviour. Re-evaluation covered a wide range of phenomena classed as ‘review of self’; ‘expression of thoughts and feelings’; ‘increasing self-awareness’; ‘gaining insight’; ‘re-education or the generation of client resources’; and ‘motivation’. ‘Areas of positive change’ (or negative change, or lack of improvement) was a further category that incorporated such phenomena as ‘improved symptom’; ‘improved control and effectiveness’; ‘improved self esteem’ and ‘improved relationships’. Finally, there was limited reporting of an area termed ‘administration/context’ which pertained to phenomena such as ‘accessibility’ of therapy.

An initial pool of 52 items was developed into a questionnaire from the meta-analysis that would represent the four main categories and where possible, retain the original language and sentiments reported. The TARECC questionnaire (therapeutic alliance; re-evaluation; experiment and challenge, and change) was then piloted with sixty participants who had completed therapy. Forty-five of the participants also completed the CORE, a pan theoretical outcome measure, at the beginning and ending of therapy in an attempt to provide concurrent validation.

Principal Component Factor Analysis was used to provisionally to assess the classification and reliability of the four subsets arrived at through the meta-analysis. Whilst one principle factor emerged, four categories were computed in order to maintain a conceptual coherence with the meta-analysis. On this basis four categories did compute when certain items were excluded due to an inability to group into a meaningful factor or because they were not specific to one factor. Thirty-eight items
were retained overall, but the composition of the categories was somewhat different to those of the meta-analysis (see appendixV1 for the final form of the questionnaire and scoring key). There was some consistency in the categories defined by the two methods but, a weakness is the degree of interchangeability between categorization of items as defined by the meta-analysis and components analysis. Whilst this interchangeability may be due to small sample size, it is common in many questionnaires where the underlying phenomena represented within the questionnaire are highly related (Rust and Golombok, 1989). The different aspects of the therapeutic experience may be difficult to categorize due to this interrelatedness and inherent complexity. Thus when the original subsets from the meta analysis were tested for correlation with those defined by the Principal Components analysis (to check for internal validity), the results showed good internal consistency (Alpha's varying between .8 and .9 with 'experiment and challenge' showing .74). On this basis, all the refined subsets were found to be internally consistent and reliable according to the recommended minimum correlation coefficient of .7 for person-based questionnaires. However the definition of subsets is not clear-cut and could be varied by factors such as a larger sample or the introduction of new items not yet tested.

Whilst it was hoped that some concurrent validity would be provided by conjointly using a fairly well validated outcome measure (CORE), it transpired that there was only one significant relationship between the sub categories of outcome measured by CORE and those measured by TARECC. The relationship that achieved significance (.05 level) was between 'problems' as measured by CORE and 'experiment and challenge' as measured by TARECC. If this result were born out by a larger sample it would suggest that TARECC is able to detect some of the behaviours that can lead to a significant improvement in presented problems. Whilst it is unfortunate that there were no other correlations to increase the concurrent validity of TARECC the absence of correlation may confirm the concerns of researchers who have argued that broad-spectrum measures of outcome (such as CORE) are only providing a partial picture of
the full range of outcomes.

Whilst CORE showed significant improvements for the majority, TARECC suggests that the therapeutic experience was not highly positive for about one third of the sample. This may be due to the limitations of a small sample size or it may be that the outcomes and therapeutic phenomena measured by TARECC are not related to the types of changes measured by CORE. The CORE addresses problems, functioning, levels of well-being, and risk whereas the TARECC is more concerned with the quality of the therapeutic relationship, the types of phenomena valued as part of the therapeutic encounter and the types of change factors that clients report as valuable.

The suggestion of a significant correlation between lower scores on TARECC (lower third) and significant changes in 'problems' and 'functioning' on CORE suggests that some clients may improve on these CORE subsets even if the 'therapeutic relationship', 're-evaluation' and 'change factors' (measured on TARECC) were only adequate. The correlations here were with the TARECC subset of 'experimenting and challenge'. Whilst it can only really be speculation at this stage, this could refer to the items concerned with the therapist being supportive but challenging and items concerned with changing behaviour in relationships that are contained in this subset. However, the lack of correlation between the two measures when all participants' scores are taken into account may mean that some clients may show little improvement on CORE but report a highly valued therapeutic experience and outcome in terms of satisfaction with therapy and the therapist. Possibly they still experience problems but feel less distressed by them. It is possible that the TARECC, by focusing on the therapeutic experience, is more inclined towards measuring satisfaction with therapy and the therapist rather than improvements per se.

Undertaking the Principal Components analysis with a larger sample, at the same time using supplementary measures that may provide concurrent validity, could develop the TARECC measure further. Suggested uses of a fully validated TARECC would
be several. Firstly, its use could be experimented with at different points during the total therapy in order to give feedback to the therapist and client about the therapeutic relationship and re-evaluation processes activated. It could also be used as a post therapy measure of client satisfaction with their therapy that would include the therapeutic relationship and the re-evaluation processes they engaged in, as well as any changes brought about. Therapists could use TARECC to monitor feedback given about therapy and the therapeutic relationship (and therapist style) in order to assess whether there are areas where they are not performing as well as would be hoped (i.e. according to the average performance of other therapists). Further training could then focus on an area where performance might be improved. Alternatively, different client groups could be compared regarding the experiential feedback they give via TARECC. This would allow comparison of response to the 'therapeutic relationship and therapist interventions'; the 're-evaluation process'; the ability of clients to 'experiment and challenge assumptions'; and experience 'change factors'. For example, one could compare those referred from Community Mental Health Teams, often with a more severe presentation, to those referred from primary care. This may help us to understand more about the factors that promote a very positive therapy.

In conclusion, the analysis of clients' perceptions of therapy appears to be an area that could lead to outcome measures which place more emphasis on the quality of the therapeutic relationship as well as the re-evaluation processes that may be activated, or not, in an individual's therapy. Further research is needed in order to achieve a questionnaire that will have the desired levels of validity concerning these aspects that could then be used for monitoring client or therapist, and would be particularly useful for detecting any areas of process or relationship where the client or therapist is failing to make gains. Finally, although this is a preliminary study, it does clearly highlight the importance of monitoring and evaluating the elements of therapy that clients report as most meaningful and important. Whilst the CORE measure is providing a guide to changes made or benefits accrued during therapy, the meta-analysis of qualitative
literature concerning clients’ perceptions of therapy demonstrates that it does not provide a comprehensive report on the experiences and processes activated during the therapeutic experience and may therefore distort our evaluation of a client’s therapy.
References


Brownrigg, H. (2002). Clients' perceptions of change following integrative therapy: How have clients experienced the process of change when they consider the outcome of therapy to be successful? Unpublished Doctoral research report, University of Surrey.


## Appendix

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
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<td>Data organised into categories</td>
<td>158</td>
</tr>
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<td>II</td>
<td>Core measure</td>
<td>166</td>
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<td>Original 52 item TARECC measure</td>
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<td>VII</td>
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<td>VIII</td>
<td>Ethical approval</td>
<td>190</td>
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<tr>
<td>IX</td>
<td>Requirements for submission to the journal “Psychology and Psychotherapy: Theory, Research and Practice”</td>
<td>192</td>
</tr>
</tbody>
</table>
Appendix 1

META-ANALYSIS OF WHAT CLIENTS SAY IS IMPORTANT, HELPFUL/UNHELPFUL OR RELATED TO CHANGE IN THERAPY

Areas of convergence between results are summarised below into five superordinate categories for positive and negative aspects: 1) Therapeutic alliance; 2) Process of reassessment; 3) Counsellor interventions; 4) Areas of improvement/lack of improvement or no change, 5) Administration/contextual factors. Each superordinate category is made up of sub-categories collected from the meta analysis and each item is given a code which briefly denotes the nature of the study from which it was derived:
E = exploratory qualitative study; S = Qualitative data gathered as response to structured questionnaire and coded according to pre-existing fixed number of categories derived from previous qualitative study; T = theoretical summary or discussion of qualitative research or case study material

POSITIVE ASPECTS

THERAPEUTIC ALLIANCE

(E) "Warmth; Respect; Learning from therapists personality", (Strupp, Wallach, & Wogan, 1964).
(E) "Counselor Facilitative Interpersonal Style" (Paulson, Truscott, & Stuart, 1999)
(E) "Aspects of the counsellor-client relationship (notably trust)”, (Jinks, 1999)
(E) "Involved, empathic accepting therapist; good Contact”, (Lietær, 1992)
(E) "Personal contact with an authentic therapist, (Lietær, 1992)
(E) “The client's perception of the relationship with the therapist: a) Nonspecific relationship factors (e.g. trust, acceptance and therapist care), (b) appears in negative aspects below), (Rennie, 1992)
(E) “The therapeutic alliance”, (Brownrigg, unpublished)
(E) “Therapeutic relationship (therapist as a person): attitudes & characteristics of the therapist”, (Feifel, & Eells, 1963)
(E) “Discriminating use of therapist (controlling the influence of the therapist)” , (Rennie, 1992)
(E) “Client’s attentiveness to therapist (tearing away from self-focus to attend to therapist)” (Rennie, 1992)
(S) “Forming a therapeutic relationship quickly, but the relationship not being central to the client” (Cummings, Hallberg, & Slemon, 1994)
(S) “Reassurance”: (“Client feels supported, relieved, more hopeful or more confident”, (Booth, Cushway, & Newnes, 1997; Llewelyn 1988; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988)
(S) “Understanding”, (“Client feels understood”, Booth, Cushway, & Newnes, 1997)
(T) “The firm establishment of a positive dependent transference attachment", Wallerstein, 1989)

PROCESS OF RE-EVALUATION

Review of self and past or present scenarios

(E) “Reassessment: Telling the life story” (Brownrigg, unpublished))
(E) “The pursuit of personal meaning” (e.g. “client's narrative”, “telling a story/reviewing past events, with self awareness”; Rennie, 1992)
(E) “Self-exploration and its facilitation by therapist” (Lietær, 1992)
(E) “Opportunity to talk over problems”, (Feifel & Eells, 1963)
“Clarification”, (“Client is clearer about what needs to change or be worked on in therapy”, Elliott & Shapiro, 1988)

“Involvement” (“Client feels more involved in the tasks of therapy, or is made to think more”, Booth et al. 1997)

Expression of thoughts and feelings

“Experiencing feelings fully; self acceptance”, (Lietaer, 1992)

“Momentary relief; experiencing progress; confirmation by the therapist” (Lietaer, 1992)

“Emotional relief”, (Paulson et al., 1999)

“Client self disclosure”, (Paulson et al., 1999)

“Expression of withheld thoughts and feelings” (Brownrigg, unpublished)

“Metaphor and Visualisation” (used to express thoughts and feelings: Brownrigg, unpublished)

“Able to express self” & “Able to express emotions” (Connolly & Strupp, 1996)

“Tolerating & resolving painful feelings”, (Cummings et al., 1994)

“Catharsis, (expressing feeling, the importance of doing so)”, (Rennie, 1992)

“Client’s contact with feelings”, (questing/discovering/assimilating feelings”), (Rennie, 1992)

“Client’s Metaphor”, (Rennie, 1992)

“Confessions by client (self disclosing with embarrassment)”, (Rennie, 1992)

“Interpersonal openness” (e.g. “able to express emotions”; “able to communicate needs”), Connolly & Strupp

“Satisfaction of emotional needs”: Catharsis; outlet for tensions, help in expressing feelings”, (Feifel & Eells, 1963)

Gaining insight

“New perspectives”, (Paulson et al., 1999)

“Insight”, (Jinks, 1999)

“Improvement in self understanding”, (Connolly & Strupp, 1996)

“Insight into oneself and situations, interpretation by therapist” (Lietaer, 1992)

“Insight into new possibilities, intentions and plans”, (Lietaer, 1992)

“Insight”, (Rennie, 1992)

“Getting to the bottom of the problem”, (Rennie, 1992)

“Insight”, (Feifel & Eells, 1963)

“Insight”, (“Client sees something new about self, sees links; a sense of ‘newness experienced”, Llewelyn 1988; Elliott & Shapiro 1988; Booth 1997)

Increased self awareness

“Increased self awareness”, (Jinks, 1999)

“Client scrutinises own processes (client appraises or explains cognitive/affective/volitional process)”, (Rennie, 1992)
Digestion (coming to terms, overtime, with a new awareness)”, (Rennie, 1992)

"Improved self understanding" (Connolly & Strupp, 1996)

"More realistic evaluation of self”, (Feifel & Eells, 1963)

"Greater awareness of feelings and impulses” (“insight into one’s feelings and motives”, Strupp, Wallach & Wogan, 1964)

"Awareness”, (“Client gets more in touch with feelings which may have been previously warded off”, Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988).

"Increasing awareness through connecting thoughts and feelings” (Cummings et al., 1994)

Re-education/Generation of client resources

"Re-education: therapy is viewed as an educational experience” (Brownrigg, unpublished)

"New perspectives”, (Paulson et al., 1999)

"Gaining knowledge”, (Paulson et al, 1999)

"Generating client resources”, (e.g. “My counselor showed me ways to deal with things”; “My counselor showed me how to stand up for myself”, Paulson et al., 1999)

"Developing schemas of how change occurs in counseling” (Cummings et al., 1994)

"Problem solution”, (“discovering means to achieve change or new ways of coping”, Llewelyn et al., 1988, Elliot & Shapiro, 1988; Booth et al., 1997)

"Psychotherapy is an educational or re-educational process”, (Strupp, Wallach & Wogan, 1964);

"Reeducation and reality testing”, (Wallerstein, 1989).

Motivation

"Counselling motivated me to help myself” (Paulson et al. 1999)

“maintaining hope and being determined to change” (Cummings et al, 1994)

“Using the time between sessions to process insights further and to experiment with corrective experiences” (Cummings et al., 1994)

“Doing reality testing with significant people” (Cummings et al., 1994)

“Motivation” (“Patients describe themselves as having profited from therapy to the extent that they also report themselves as eager and willing to work on problems at the start of therapy” Strupp, Wallach & Wogan (1964):

COUNSELLOR INTERVENTIONS

Validation and/or Objective Feedback

"Counselor interventions”, (e.g. “My counselor gave me an objective opinion”. “My counselor reinforced my decisions; My counselor provided clarification”. Paulson et al. 1999)

"Self enhancement through a positive therapeutic alliance”, (“...the value that participants placed upon the guidance, encouragement and validation given by the therapist. This appeared to lead to self-enhancement”, Brownrigg,
The client’s experience of the therapist’s operations: a) Operations bearing on the client-in-identity; b) Operations bearing on the client-as-agent; c) Operations bearing on therapist in relation with client” (Rennie, 1992)

“Advice; reinforcement of feelings, plans, behaviours” (Lietaer, 1992)

“Confrontation and feedback”, (Lietaer, 1 -92)

“Therapeutic skill and technique”, (i.e. how skillful the therapist was observed to be, Feifel & Eells, 1963)

**AREAS OF POSITIVE CHANGE**

**Improved symptoms**

“Improvement in presenting neurotic symptoms”, (Strupp, Wallach & Wogan, 1964)

“Improved symptoms”, (Connolly & Strupp, 1996. Two subclusters: “greater self-control” and “improved psychological symptoms”)

“Symptom relief”, (Feifel & Eells, 1963)

**Improved sense of control and effectiveness**

“More control of their lives”, (Jinks, 1999).

“Greater self-control”, e.g. “Put life in perspective”, “better handle feelings”, “able to handle problems”, (Connolly & Strupp, 1996).

“Client resolutions” (i.e. “It helped me knowing that what I had chosen was within my grasp”; “knowing I can come back if I need to”; “I got closure”, “Planning my future”, Paulson et al., 1999)

“Ability to make decisions and act to influence events”, (Jinks, 1999)

“More active in working out solutions”, (Strupp, Wallach & Wogan, 1964)

“Greater awareness” (Strupp, Wallach & Wogan, 1964)

“More ability to handle problems”, (Feifel & Eells, 1963)

“Changes in behaviour”, (Feifel & Eells, 1963)

**Improved self esteem**

“Improved self-confidence”, (Connolly & Strupp, 1996)

“Improved confidence”, (Jinks, 1999)
"Increase in self esteem", (Strupp, Wallach & Wogan, 1964)

"Ego mastery", (Strupp, Wallach & Wogan, 1964)

"More self confidence", (Feifel & Eells, 1963)

"Changes in self concept", (Strupp, Wallach & Wogan, 1964) [cited here under "insight"]; "improvement in self confidence" [cited here under "improved self esteem"]; "Greater self definition" [cited here under "improved interpersonal relationships"]; Connolly & Strupp, 1996

"Change in attitude" (Feifel & Eells, 1963)

**Improved interpersonal relationships**

"Greater self definition" (Connolly & Strupp, 1996; contains two subcategories: "Greater independence" and "Better boundaries").

"Interpersonal openness", (Connolly & Strupp, 1996; this is defined by the authors as a sub-category of "Improved self understanding"

"Better interpersonal relationships", (Strupp, Wallach & Wogan, 1964)

"Assertiveness", (Jinks, 1999)

**ADMINISTRATION/CONTEXTUAL FACTORS**

"Accessibility", (e.g. suitable time; no waiting at appointment; affordable; "the fact that it was constant; once a week", Paulson et al., 1999)

"Administrative factors" (Feifel & Eells, 1963. No details given)

**NEGATIVE ASPECTS**

**THERAPEUTIC ALLIANCE**

"Limits to trust" ("negative conjecture about what the counselor may have been thinking", Jinks, 1999)

"Feeling vulnerable and stigmatizing" (Jinks, 1999)

"Frustration with the counselor" (Jinks, 1999)

"Doubt about empathy" (Jinks, 1999)
"Lack of warmth, involvement, understanding" (Lietaer, 1992)

"Disapproval and undervaluing by therapist" (Lietaer, 1992)

"Client feels left to his fate at the end of the session" (Lietaer, 1992)

"Clients' perception of the relationship with the therapist", (Rennie, 1992)

"Therapists feelings of irritation, anger, boredom etc." (Feifel & Eels, 1963)

"Absence of emotional support" (Feifel & Eels, 1963)

"Misperception", (Helen Booth et al., 1997)

"Negative therapist reaction", (Helen Booth et al., 1997)

"Uncertainty about the therapist's feelings", (Strupp, Wallach & Wogan, 1964)

**PROCESS OF REASSESSMENT**

Review and reassessment of self and past or present

"Client does not cooperate: by talking superficially" (Lietaer, 1992)

"The session is too confrontational, too heavy" (Lietaer, 1992)

"Client is disappointed about the lack of progress" (Lietaer, 1992)

"The avoidance of meaning" (includes clients perceptions of their own "defensiveness", "resistance", "playing for effect", and "resistance to change", (Rennie, 1992)

"Resistance to change", (Rennie, 1992) [Resistance is taken to imply an unwillingness to reflect and re-evaluate]

"Repetition", ("Client feels bored, impatient or doubtful of value of therapy", Elliot et al., 1984; Llewelyn et al. 1988)

"Disappointment", (Helen Booth et al., 1997)

**Expression of thoughts and feelings**

"Certain feelings being too painful to talk about" (Jinks, 1999)

"Client does not cooperate: by waiting, silence" (Lietaer, 1992)

"Client does not dare talk about certain things" (Lietaer, 1992)

"Client's defensiveness (defensiveness against cognitive-affective operation", Rennie, 1992)

"Lying to therapist" (impact on client's internal processing), (Rennie, 1992)
(S) “Minimal connecting of thoughts and feelings”. (Cummings et al. 1994)

Gaining Insight

(E) “The session is too confusing” (Lietaer, 1992)

(E) “Failing to get to the bottom of the problem” (Rennie, 1992)

Self-awareness

(E) “Client’s defensiveness (defensiveness against self-awareness), (Rennie, 1992)

Re-education/Generation of client resources

(E) “Therapeutic skill and technique”, (Feifel & Eels, 1963)

(S) “A schema for change, but no action on it”, (Cummings et al. 1994)

Motivation & Hope

(E) “Negative preparatory set (recalcitrant mood regarding willingness to work in the therapy session”, Rennie, 1992)

(S) “Minimal use of time between sessions to process insights”, (Cummings et al. 1994)

(S) “Limited hope or determination to change”, (Cummings et al. 1994)

COUNSELLOR INTERVENTIONS

(E) “The therapist is too passive, confronts too little” (Lietaer, 1992)

(E) “Therapist is too active. Therapist constantly tries to go further into how client feels towards people whom client ignores” (Lietaer, 1992)

(E) “Therapist is too intrusive”, (Lietaer, 1992)

(E) “Therapist gives advice and suggestions that are painful and leave the client not understood” (Lietaer, 1992)

(E) “Therapist gives suggestions of interpretations which the client finds inadequate or inaccurate” (Lietaer, 1992)

(E) “Client’s [perception of their] resistance (resisting therapists’ response/strategy plan)”, (Rennie, 1992)

(S) “Confrontation”, (Helen Booth et al., 1997)

(S) “Misdirection”, (“Client feels confused or side tracked from important things; therapist interfered”, Elliot et al., 1988; Llewelyn, Elliott, Shapiro, Hardy & Cozens, 1988; Helen Booth et al., 1997)

(S) “Unwanted thoughts”, (“Client is made to think about uncomfortable or painful ideas or feelings in an unhelpful
way", Llewelyn et al., 1988)

AREAS OF NEGATIVE CHANGE, LACK OF IMPROVEMENT

(E) "No change, changes due to factors other than psychotherapy", (Strupp, Wallaoh & Wogan, 1964)

(S) "No change on clients' "Target Complaint Technique" ratings", Cummings et al. 1994)

ADMINISTRATION/CONTEXTUAL FACTORS

(E) "Frequent change of therapist" (Feifel & Eels, 1963)

(E) "More therapy time wanted" (Feifel & Eels, 1963)
## IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

*Please use a dark pen (not pencil) and tick clearly within the boxes.*

### Over the last week

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Only</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
<th>Never</th>
<th>Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I have felt terribly alone and isolated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 I have felt tense, anxious or nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>P</td>
<td></td>
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<tr>
<td>3 I have felt I have someone to turn to for support when needed</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>F</td>
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<td></td>
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<tr>
<td>4 I have felt O.K. about myself</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>W</td>
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<td>5 I have felt totally lacking in energy and enthusiasm</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6 I have been physically violent to others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>7 I have felt able to cope when things go wrong</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>F</td>
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<td>8 I have been troubled by aches, pains or other physical problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>9 I have thought of hurting myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>R</td>
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<tr>
<td>10 Talking to people has felt too much for me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>F</td>
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<tr>
<td>11 Tension and anxiety have prevented me doing important things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>12 I have been happy with the things I have done.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>F</td>
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<tr>
<td>13 I have been disturbed by unwanted thoughts and feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>P</td>
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<td>14 I have felt like crying</td>
<td>0</td>
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Please turn over
Appendix III

CLIENTS’ PERCEPTIONS OF THE THERAPEUTIC EXPERIENCE

QUESTIONNAIRE

INSTRUCTIONS

This questionnaire contains a series of statements that express what aspects of therapy people have found important and helpful, as well as what can be negative or unhelpful. Please read each statement and consider your own therapy, then circle how much you agree or disagree with the statement. For example:

My therapist gave me objective feedback

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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In order to help us know that we have a good variety of different people taking part we would be grateful if you could complete the following:

Sex: _____ Age: _____
Employed: _____ Unemployed: _____ Carer/mother/housewife: _____ Number of therapy sessions: _____

PLEASE START FROM HERE:

Some people feel the working relationship they developed with their therapist was important. The following 4 statements represent the relationship in either a positive or negative light. Please circle to show how much you agree or disagree with each statement.

1) My therapist was supportive and understanding

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<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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2) I soon began to feel I could trust my therapist

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<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
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3) My therapist was not judgmental

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<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
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<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
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4) My therapist was patronising or superior in manner

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<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
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<tr>
<td>Disagree</td>
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5) My therapist was cold and distant

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<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
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<tr>
<td>Disagree</td>
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6) My therapist sometimes seemed to be bored or irritated or angry with me

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<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
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<tr>
<td>Disagree</td>
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</table>

People have also told us what was helpful or unhelpful about the way the therapist assisted them to work on problems. Some of these observations are reflected in the following 8 statements. Please circle to show how much you agree or disagree with each statement.

7) My therapist gave me objective feedback

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
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<tbody>
<tr>
<td>Disagree</td>
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8) My therapist gave me encouragement

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<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
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<tr>
<td>Disagree</td>
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9) The therapist reassured me that my feelings were important and understandable

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<th>Strongly</th>
<th>Neither Agree nor</th>
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<tr>
<td>Disagree</td>
<td>Disagree</td>
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</table>
10) It was helpful when my therapist challenged me (i.e. suggested I might question what I was saying or believing)

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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11) My therapist was too passive (i.e. not saying enough or not challenging you enough; or you felt unassisted too often)

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<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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12) My therapist was too pushy or challenging

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<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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13) My therapist hurt my feelings

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<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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14) I felt badly treated by my therapist

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<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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If you talked about childhood, family or early significant relationships please answer question 15, if you did not explore these please go straight to question 16.

15) It was useful to think about the effects of childhood, family or early significant relationships and how these have influenced me today

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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</table>
Some people have told us that during therapy they are able to clarify their thoughts or change the way they have been approaching problems. The following four statements reflect some of the positive ways this can happen.

16) **Therapy helped me to focus and reassess myself / situations / relationships**

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tr>
<td>Disagree</td>
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<td>Disagree</td>
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</table>

17) **Therapy enabled me to get clearer about my problems and this was helpful**

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
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<td>Disagree</td>
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</table>

18) **My therapy was like a journey of self-exploration**

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tbody>
<tr>
<td>Disagree</td>
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<td>Disagree</td>
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</table>

19) **I can now consider the things that bothered me in a different more helpful way**

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
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<td>Disagree</td>
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</table>

Some people who have had therapy tell us that sometimes they might find it difficult to talk about certain things or they might feel unsure or uncomfortable during a session. The following statements reflect some of these difficulties

20) **I avoided talking about certain problems even though they might have been important**

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tr>
<td>Disagree</td>
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<td>Disagree</td>
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</table>
21) I am doubtful about whether talking over problems with a therapist is helpful

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
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<tr>
<td>Disagree</td>
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<td>Agree</td>
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22) There were times during therapy when it got too 'heavy' and I found the session too much

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td>Agree</td>
</tr>
</tbody>
</table>

23) I found it difficult to arrive at any explanations about my problems, or to find answers to the questions I had

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td>Agree</td>
</tr>
</tbody>
</table>

Some people have told us that expressing their feelings and honestly examining what they thought, and felt about difficulties, took place during therapy. Other people have not found this particularly helpful. The following statements reflect different aspects of this and how much it affected you in your everyday life.

24) I started to think that certain of my thoughts were making me feel worse than I needed to

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td>Agree</td>
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</tbody>
</table>

25) I found myself reflecting on my therapy in-between sessions and continuing to think about the understandings I'd arrived at.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
</tr>
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<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td>Agree</td>
</tr>
</tbody>
</table>

26) Expressing my thoughts and feelings to the therapist did not really get me anywhere

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
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<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td>Agree</td>
</tr>
</tbody>
</table>
27) Despite therapy I still find my feelings difficult to accept

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

28) Therapy helped me become more aware of what I was thinking

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

29) Therapy did not help me become more aware of what I was feeling

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

30) I am now more likely to confront painful feelings in everyday life

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

31) During therapy either myself or the therapist suggested metaphors, pictures or images to describe my experiences and feelings.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Some people feel that their therapy did not bring any new understandings. Others have told us that they feel therapy helped them develop a different outlook on life and themselves. The following statements reflect different aspects of this

32) I have seen new things about myself

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neithet Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
### 33) I have not seen any new possibilities in my life

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

### 34) I understand myself better because of therapy

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

### 35) New knowledge or information given to me by the therapist was not very useful

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

### 36) I was interested in working out the therapists' view of things

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

### 37) I have learnt new ways of solving problems and coping through therapy

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

### 38) I find myself and others just as difficult to understand as before

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
Some people might find therapy is unable to help them change things as much as they’d like. Other people might find that therapy helps them find some new energy and determination with which to tackle problems or experiment with behaving differently. The following statements reflect these views.

39) Therapy helped motivate me to help myself

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</table>

40) I experimented with acting differently towards others or behaving differently in-between therapy sessions.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</table>

Sometimes our problems are connected to difficulties we have in the way we relate to other people. The following statements reflect some of these difficulties and the ways therapy may or may not have helped to overcome them.

41) Going through therapy has helped me to decide when to put my own needs first, before the needs of others

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</thead>
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<td></td>
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</tbody>
</table>

42) I am no better at making sure other people hear and take note of my needs, wishes or views

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</table>

43) I am now more able to say “No I can’t” or “No I don’t want to” when it is necessary

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</tbody>
</table>
44) I am now less critical and more accepting of others

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

The following statements reflect either positive or negative results that people have said they got from therapy

45) I am still bothered by the problems which brought me to therapy

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

46) Therapy helped me to feel more in control than I used to

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

47) Therapy has helped me to feel more confident

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

48) Therapy helped me to get things into perspective, or become more realistic

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

49) I am still just as hard on myself since therapy

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

50) I have not experienced any positive change that I relate to therapy

| Strongly | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
51) Therapy has made me feel worse than before

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>Strongly Agree</td>
<td>Strongly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Agree</td>
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</tbody>
</table>

Finally, how do you feel about the number of therapy sessions you received

52) The number of therapy sessions I was given was sufficient

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
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</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>Strongly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

We would be very interested to know how you have found the experience of completing this questionnaire. If you would like to make any observations or comments please write them below. Thank you for your time.
Dear Sir or Madam

Clients' perceptions of the therapeutic experience

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 OBW.

Thank you for reading this.

What is the purpose of the study?

The study is interested in your reflections on your experience of therapy and what you have found helpful or unhelpful. We are also interested in the kinds of changes you may have experienced as a result of counselling.

The aim of the research is to inform therapists about the full range of experiences that can be helpful for the therapist to promote.

Why have I been chosen?

We are asking people like yourself who have seen a counsellor/therapist if they would like to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive.
What will happen to me if I take part?

If you would like to take part you will be asked to complete a questionnaire at the time of your last counselling appointment (as well as another copy of the original questionnaire you completed at the beginning of counselling). Completing the questionnaires should take approximately ten to twenty minutes.

What do I have to do?

You will only be asked to complete the questionnaire.

What is the procedure that is being tested?

The study is testing a new questionnaire that assesses how people respond to counselling and what they get out of it. It may give useful information to therapists about effective counselling approaches. The questionnaire has been developed on the basis of feedback from other people who have also seen a counsellor, but it needs to be tested to check that it is a valid measure. Analysing the responses gathered for this study will enable us to find out which are the most important questions to keep for a shortened version.

What are the possible disadvantages and risks of taking part?

It is possible that the task of completing the questionnaire might bring back unpleasant memories, thoughts or emotions. If this should happen please tell your counsellor or write your comments on the questionnaire and the researcher will contact you within a week (your counsellor will not see the questionnaire as you will place it in a sealed envelope on completion). If you would like to contact the researcher more quickly you can telephone 01403 227000 ext. 7272 and ask to speak to Helen Brownrigg. If you have become distressed you can be offered further support from your original counsellor or from another counsellor in the department.

What are the possible benefits of taking part?

You may well find the questionnaire provides a useful framework for reviewing your own therapy. It is an opportunity to reflect on your experience of counselling and consolidate any gains or changes you have arrived at. The information we get from this study may help us to improve our knowledge of what is most helpful or unhelpful in counselling and know more about the ways people change.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone’s negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during taking part in this study, the normal channel for this National Health Service Trust is to contact the Consumer Liaison Manager.
Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital/surgery will have your name and address removed so that you cannot be recognised from it. Your GP will be informed that you are taking part.

What will happen to the results of the research study?

The results of the research will be submitted to Surrey University as part of the researchers studies to become a doctor of psychotherapeutic counselling. Also they will be submitted to a professional psychotherapy/counselling journal towards the end of 2002. You will not be identified in any report/publication.

Who is organising the research?

The research is organised by the researcher under supervision from Surrey University. The researcher or counsellor will not be paid for recruiting you to the study.

Who has reviewed the study?

The research has been reviewed by the Sussex Weald & Downs Ethics Committee and teaching staff at the University of Surrey.

Contact for further information

If you would like further information about the study please contact Helen Brownrigg, Horsham Hospital, 1 Hurst Road, Horsham, W Sussex, RH12 2DR; Telephone: 01403 227000 ext. 7272.

Thank you for your time and attention.

Helen Brownrigg, MA Psychological Counselling  
Counselling Psychologist in training
CONSENT FORM

Title of Project: Clients' perceptions of the therapeutic experience

Name of Researcher: Helen Brownrigg

Please initial box

1. I confirm that I have read and understand the information sheet dated .................
   (version 01) 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 medical care or legal rights being affected.

3. I understand that sections of any of my medical notes may be looked at by responsible
   individuals from Surrey University or from regulatory authorities where it is relevant to my
   taking part in research. I give permission for these individuals to have access to my
   records.

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

Name of Patient ___________________________ Date ___________ Signature _______________________

Name of Person taking consent
   (if different from researcher) ___________________________ Date ___________ Signature _______________________

Researcher ___________________________ Date ___________ Signature _______________________

1 for patient; 1 for researcher, 1 to be kept with hospital notes
Appendix VI

CLIENTS' PERCEPTIONS OF THE THERAPEUTIC EXPERIENCE

QUESTIONNAIRE

INSTRUCTIONS

This questionnaire contains a series of statements that express what aspects of therapy people have found important and helpful, as well as what can be negative or unhelpful. Please read each statement and consider your own therapy, then circle how much you agree or disagree with the statement. For example:

My therapist gave me objective feedback

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

In order to help us know that we have a good variety of different people taking part we would be grateful if you could complete the following:

Sex: _____ Age: _____
Employed: _____ Unemployed: _____ Carer/mother/housewife: _____ Number of therapy sessions: _____

PLEASE START FROM HERE:

Some people feel the working relationship they developed with their therapist was important. The following 8 statements represent the relationship in either a positive or negative light. Please circle to show how much you agree or disagree with each statement.

1) My therapist was not judgemental

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

2) My therapist sometimes seemed to be bored or irritated or angry with me

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Agree</td>
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</tbody>
</table>
3) My therapist treated me as an equal

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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<tr>
<td>Strongly Agree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Disagree</td>
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</table>

4) My therapist was too pushy or challenging

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
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<tr>
<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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<tr>
<td>Strongly Agree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Disagree</td>
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</tbody>
</table>

5) I felt well treated by my therapist

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
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<tr>
<td>Strongly Agree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Disagree</td>
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</table>

6) My therapist hurt my feelings

<table>
<thead>
<tr>
<th>Strongly Agree</th>
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<th>Strongly Disagree</th>
</tr>
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<tr>
<td>Strongly Agree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Disagree</td>
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</table>

7) I felt able to talk to my therapist about all the things that bother me

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
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<tr>
<td>Strongly Agree</td>
<td>Neither Agree nor Disagree</td>
<td>Strongly Disagree</td>
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</table>

8) My therapist was too passive (i.e. not saying enough or not challenging you enough; or you felt unassisted too often)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tr>
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<tr>
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<td>Strongly Disagree</td>
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</tbody>
</table>

Some people have told us that during therapy they are able to clarify their thoughts and change the way they have been approaching problems. Some people have told us that expressing their feelings was helpful during therapy. Other people have not found this particularly helpful. The following 11 statements reflect these possibilities.

9) Therapy helped me become more aware of what I was thinking

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
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<tr>
<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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</tbody>
</table>

10) Therapy did not help me become more aware of what I was feeling

<table>
<thead>
<tr>
<th>Strongly Agree</th>
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</table>
11) I was interested in working out the therapists' view of things

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</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
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</table>

12) I am doubtful about whether talking over problems with a therapist is helpful

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td></td>
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</table>

13) Expressing my thoughts and feelings to the therapist did not really get me anywhere

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<tr>
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<tbody>
<tr>
<td>Agree</td>
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</table>

14) Therapy has not helped me to understand myself any better

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>Agree</td>
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</table>

15) Therapy enabled me to get clearer about my problems and this was helpful

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>Agree</td>
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</table>

16) Therapy helped me to focus and reassess myself / situations / relationships

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>Agree</td>
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17) I can now consider the things that bothered me in a different more helpful way

<table>
<thead>
<tr>
<th>Strongly Agree</th>
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<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>Agree</td>
<td></td>
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</table>
18) I have learnt new ways of solving problems and coping through therapy

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19) I found it difficult to arrive at any explanations about my problems, or to find answers to the questions I had

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some people might find therapy is unable to help them change things as much as they’d like. Other people might find that therapy helps them find some new energy and determination with which to tackle problems or experiment with new ideas or behaving differently. The following statements reflect these views.

20) I did not experiment with acting differently towards others or behaving differently in-between therapy sessions.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21) Going through therapy has helped me to decide when to put my own needs first, before the needs of others

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22) Therapy did not help motivate me to help myself

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23) The therapist reassured me that my feelings were important and understandable

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
24) My therapist was not supportive and understanding

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

25) It was helpful when my therapist challenged me (i.e. suggested I might question what I was saying or believing)

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

26) I have not seen any new things about myself

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

27) Therapy helped me to get things into perspective, or become more realistic

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

28) My therapy was like a journey of self-exploration

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

29) New knowledge or information given to me by the therapist was not very useful

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
If you talked about childhood, family or early significant relationships please answer question 30, if you did not explore these please go straight to question 35.

30) It was useful to think about the effects of childhood, family or early significant relationships and how these have influenced me today

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>

The following statements reflect either positive or negative results that people have said they got from therapy

31) I am now less critical and more accepting of others

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>

32) I am still just as hard on myself since therapy

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>

33) Therapy has helped me to feel more confident

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>

34) I have not seen any new possibilities in my life

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>

35) I am still bothered by the problems which brought me to therapy

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neither Agree nor</th>
<th>Agree</th>
<th>Strongly</th>
<th>Disagree</th>
</tr>
</thead>
</table>
36) The number of therapy sessions I was given was sufficient

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

We would be very interested to know how you have found the experience of completing this questionnaire. If you would like to make any observations or comments please write them below. Also please feel free to add any comments you would like to make about your therapy. Thank you for your time.
Appendix VII

CLIENTS’ PERCEPTIONS OF THE THERAPEUTIC EXPERIENCE

SCORING

The highest score possible overall is 180. The lowest score overall is 36. A high score indicates that clients have a generally positive view of the therapeutic experience, however individual scales should be examined to see if this is true for all aspects of the therapy. Please note that even if clients’ scores register in the lower third of possible scores (i.e. between 36 and 60) they may still have improved significantly on factors not measured by this questionnaire.

KEY TO SCALES

Scale A: Re-evaluation processes

Eleven items: Questions 9 to 19
Lowest possible score 11
Highest possible score 55

Scale B: Therapeutic relationship & therapist interventions

Eight items: Questions 1 to 8
Lowest possible score 8
Highest possible score 40

Scale C: Experimentation and challenging beliefs

Eleven items: Questions 20 to 30
Lowest possible score 11
Highest possible score 55

Scale D: Change factors

Six items: Questions 31 to 36
Lowest possible score 6
Highest possible score 30
Dear Ms Brownrigg

Re: 01/06/4a Clients' perception of the therapeutic experience
Protocol vers 2, Patient Information Vers 2, Consent Form vers 2, Questionnaire vers 2, all dated 10.07.01
Letter from University of Surrey supervisor, R Draghi-Lorenz.

Thank you for submitting the amended documents listed above and answering queries regarding participants. This meets the committee's concerns and the study has Chichester Research Ethics Committee approval.

All information sheets and consent forms in this study need to carry the Ethics Committee reference number and version number/date.

Permission is granted on the understanding that:

i) Any ethical problem arising in the course of the project will be reported to the Committee;
ii) Any change in the protocol or subsequent protocol amendments will be forwarded to the Committee using the enclosed form. The principal investigator should see and approve any such changes and this needs to be indicated in the forwarding letter to the Committee.
iii) All serious adverse events must be reported within 1 week to the Ethics Committee, at the same time indicating that the principal investigator has seen the report and whether or not they feel it poses any new ethical or safety issues.
iv) A brief report will be submitted one year after commencement, thereafter annually, and after completion of the study. Continuing approval is dependent upon this report.
v) Approval is given for research to start within 12 months of the date of application. If the start is delayed beyond this time, applicants are required to consult the Chairman of the Committee. If the study does not start within 3 months of date of this letter, please notify the Committee of the date of commencement for record purposes.

A list of members in attendance at the 11 June 2001 meeting is enclosed.

Yours sincerely,

Dr J R Quiney BSc MB BS FRCPath
Chairman - Chichester Research Ethics Committee
MEMBERS present on 11 June 2001

Dr JR Quiney (Chairman) Consultant Chemical Pathologist, St Richard’s Hospital

Dr C Murphy Consultant Cardiologist, St Richard’s Hospital

Dr TD Coates Consultant in Psychiatry of Old Age, Mental Health Services for the Elderly, Sussex Weald and Downs Trust

Mr R Lyon Chief Pharmacist, St Richard’s Hospital

Dr H Platts General Practitioner, Selsey, Chichester

Dr DL Hagen Consultant in Communicable Disease Control, West Sussex Health Authority

Dr D Candy Consultant Paediatrician, St Richard’s Hospital

Mrs P-Stigant Endoscopy Nurse, St Richard’s Hospital

Mr Colin Clark Director of Professional Standards, Sussex Weald and Downs NHS Trust

Mrs Beverley Meeson R & D Co-ordinator, Sussex Weald and Downs NHS Trust

Ms L Marshall Lay member
Psychology and Psychotherapy: Theory, Research and Practice
(formerly the British Journal of Medical Psychology)

Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice (formerly the British Journal of Medical Psychology) is an international journal with a focus on the psychological aspects of mental health, psychological problems and their psychotherapeutic treatments. Its aim has been to bring together the psychiatric and psychological disciplines and this is reflected in the composition of the Editorial Team. Nevertheless we welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The traditional orientation of the Journal has been towards psychodynamic and interpersonal approaches, which have defined its core identity, but we now additionally welcome submissions of original theoretical and research-based papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. The Journal thus aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attitudes, behaviour and relationships and psychological therapies (including both process and outcome research) where mental health is concerned. Submission of systematic reviews and other research reports which support evidence-based practice is also welcomed. Clinical or case studies will be considered only if they illustrate particularly unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications.

Counselling Psychology: A special section on counselling psychology has been created in the journal in recognition of the importance of this area within psychology and psychotherapy. This section aims to promote theoretical and research developments in the field of counselling psychology. Authors who wish to submit their papers for consideration in this section should state this in their covering letter.

1. Circulation

The circulation of the Journal is worldwide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

2. Length

Pressure on Journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

3. Refereeing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page (and the text should be free of such clues as identifiable self-citations ("In our earlier work..."))

4. Submission requirements

- Four copies of the manuscript should be sent to the Editor (Professor Phil Richardson, Journals Department, The British Psychological Society, St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR, UK). Submission of a paper implies that it has not been published elsewhere and that it is not being considered for publication in another journal. Papers should be accompanied by a signed letter indicating that all named authors have agreed to the submission. One author should be identified as the correspondent and that person's title, name and address supplied.
- Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.
Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

- Figures are usually produced direct from authors' originals and should be presented as good black or white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Paper clips leave damaging indentations and should be avoided. Any necessary instructions should be written on an accompanying photocopy. Captions should be listed on a separate sheet.

- All articles should be preceded by an Abstract of 200 words, giving a concise statement of the intention and results or conclusions of the article.

- Bibliographic references in the text should quote the author's name and the date of publication thus: Smith (1994). Multiple citations should be given alphabetically rather than chronologically: (Jones, 1998; King, 1996; Parker, 1997). If a work has two authors, cite both names in the text throughout: Page and White (1995). In the case of reference to three or more authors, use all names on the first mention and et al. thereafter except in the reference list.

- References cited in the text must appear in the list at the end of the article. The list should be typed in double spacing in the following format:


- Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see The British Psychological Society Style Guide at: http://www.bps.org.uk/publications/iAuthor.cfm).

- In normal circumstances, effect size should be incorporated.

- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

5. E-mail and Web submissions
Manuscripts may be submitted via e-mail and the BPS Website (http://www.bps.org.uk/publications/isubmissions.cfm). The main text of the manuscript, including any tables or figures, should be saved as a Word 6.0/95 compatible file. The file must be sent as a MIME-compatible attachment. E-mails should be addressed to journals@bps.org.uk with 'Manuscript submission' in the subject line. The main body of the e-mail should include the following: title of journal to which the paper is being submitted; name, address and e-mail of the corresponding author, and a statement that the paper is not currently under consideration elsewhere. Web and E-mail submissions will receive an e-mail acknowledgement of receipt.

6. Brief reports
These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

7. Ethical considerations
The code of conduct of The British Psychological Society requires psychologists 'Not to allow their professional responsibilities or standards of practice to be diminished by consideration of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors. The Society resolves to avoid all links with psychologists and psychological organizations and their formal representatives that do not affirm and adhere to the principles in the clause of its Code of Conduct. In cases of doubt, authors may be asked to sign a document confirming the adherence to these principles. Any study published in this journal must pay due respect to the well-being and dignity of research participants. The British Psychological Society's Ethical Guidelines on Conducting Research with Human Participants must be shown to have been scrupulously followed. These guidelines are available at http://www.bps.org.uk/about/rules5.cfm.

8. Supplementary data
Supplementary data too expensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Proofs
Proofs are sent to authors for correction of print but not for rewriting or the introduction of new material. Fifty complimentary copies of each paper are supplied to the senior author, but further copies may be ordered on a form accompanying the proofs.