

**Therapist responsiveness in psychotherapy: an exploration of the construct and its importance for clinical practice**

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**Declaration**

I declare that this work has not been submitted for any other degree at the University of Sheffield or any other institution. This thesis is my own original work and all other sources have been referenced accordingly.

**Word Count**

Literature Review

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**Abstract**

As a field of research, therapist responsiveness is in its early stages and its importance for clinical practice has been underestimated. Key literature reviews have focused on research methodology and there has been little consideration given to responsiveness and clinical practice.

A systematic literature review was conducted with the aim of defining therapist responsiveness as a construct and ascertaining its importance for clinical practice. The review comprised 23 studies and found that the concept of therapist responsiveness had been defined in a variety of ways and across different time frames. Quantitative research estimates that responsiveness accounts for between 10- 23% of variance in the therapeutic environment and is key to building alliances, promoting therapeutic engagement, helping organise therapeutic skills, maximising therapeutic outcomes and is particularly important for resistant clients.

In order to investigate the role of responsiveness in promoting therapeutic engagement and maximising outcomes, a research study used a recently developed therapist responsiveness scale (TRS) to consider the hypothesis that therapist responsiveness in the first therapeutic encounter would increase level of engagement in therapy and lead to a decrease in symptomology. Independent raters were trained in the use of the TRS and coded audio-recordings of therapy sessions (n= 40) taken from a non-inferiority trial of cognitive behavioural therapy (CBT) and counselling for depression (CfD). Results indicated that there was no link between level of responsiveness and decrease in symptomology or unilateral termination. However, the more responsive a therapist was the more likely a patient was to engage in therapy over a longer period of time (more than 10 sessions) and that the level of impairment patients experienced in their everyday life reduced. The findings suggest that the degree of therapist responsiveness during the first therapy session is significant and has an impact upon later outcomes.

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**Part One: Literature Review**

A systematic review of therapist responsiveness in psychotherapy: its definition as a construct and importance for clinical practice

**Abstract**

**Aim**

To review the contemporary literature relating to therapist responsiveness; to define it as a construct and to consider its significance for clinical outcomes.

**Method**

Systematic literature review of 10 databases: PsycINFO, Scopus, Web of Science, Medline via Ovid, the Cochrane review library, Google Scholar; Latin American and Caribbean research via VHL Regional Portal; grey literature via Open Grey and Doctoral level theses via EThOS and ProQuest. The key search term was “therapist responsiveness”. Studies meeting the inclusion criteria were evaluated using established quality appraisal criteria. A qualitative review of the included studies was then conducted.

**Results**

Twenty-three papers were identified; 9 quantitative studies, 2 qualitative studies, 4 case studies including both qualitative and quantitative elements, 5 literature reviews and 3 positional or opinion papers. Research to date has approached the concept of therapist responsiveness in a number of different ways and across a number of different time frames. This diversity may be a consequence of the responsiveness problem outlined by Kramer and Stiles (2015). Despite the difference in approaches, responsiveness has been shown to be important for clinical practice; it aids in building alliance, promotes engagement in therapy, helps organise therapeutic skills, has a positive impact on clinical outcomes and is particularly important for resistant clients.

**Conclusion**

In conclusion, this review suggests that as a field of research, therapist responsiveness is in its early stages. Quantitative research to date suggests that it is a significant factor within the therapeutic environment accounting for between 10- 23% of the variance. Further research replicating existing findings and literature reviews focusing on finding a unifying definition or diversifying the area of research are indicated.

**Practitioner points**

* Be aware/ reflect upon therapist tendency to react differently to different patient characteristics
* Monitor closeness and quality of therapeutic relationship
* Deliver manualised therapy in a responsive manner to build alliance
* Timing of responsiveness appears particularly important during the initial stages of therapy
* Be aware of tendency to be less responsive to resistant clients
* Responsiveness at service level with regard to treatment selection and delivery is indicated
* Supervision should be a responsive process which mirrors the therapeutic environment

**Limitations:**

* Research in this area is in its early stages- ability to consolidate and compare studies is limited
* Relatively small sample sizes
* Research limited to depression and anxiety

**Introduction**

The equivalence paradox is the observation that the outcomes of differing psychotherapies appear comparable despite differences in treatment techniques (Hardy, Shapiro, Stiles, & Barkham,1998). In a conceptual literature review, Stiles, Honos-Webb and Surko (1998) suggest that therapist responsiveness may provide a solution to this paradox. They argue that treatments tend towards equivalence because of responsiveness within each therapeutic framework where therapeutic models are adapted to individual clients. To some extent the concept of therapist responsiveness appears to be relatively straightforward; a therapist responds to their patients appropriately to maximise outcomes. On closer examination however, it becomes apparent that the concept has been approached in different ways, across different timeframes using different definitions by both researchers and clinicians alike. As a result of this diversity it is possible that the importance of responsiveness for clinical practice has not been recognised.

Stiles (2009) discusses how the importance of therapist responsiveness has been underestimated by both randomised controlled trials and studies focused on process-outcome correlations. As far as randomised controlled trials (RCTs) are concerned Stiles (2009) describes how the linear, experimental logic of RCTs is confounded by therapist responsiveness. It can be seen how client information feeds back to the therapist who then adapts their delivery of treatment, i.e. the dependent variable alters the independent variable. This feedback violates independence assumptions, maximises outcomes and means that no participant in an RCT receives the same treatment. Stiles (2009) argues that this means that results from RCTs are not interpretable. This is an important consideration when much of clinical practice relies upon evidenced based therapies.

In terms of process- outcome correlation research i.e. the degree to which a process variable relates to outcome, it is argued (Stiles & Shapiro, 1994; Stiles, 2009) that different client requirements mean that different levels of a particular process component are necessary for each individual to achieve optimum outcomes. In a later literature review, Kramer and Stiles (2015) give the example of a psychodynamic therapy in which a client with low insight requires interpretations to be revised and rephrased more frequently than clients with a greater degree of insight. Despite this responsivity the former may have worse outcomes which is suggestive of a negative correlation between frequency of interpretation and symptom change i.e. clients given more interpretations have poorer outcomes. This does not make sense when interpretations are seen as an effective ingredient of that therapy’s success.

The difficulties associated with researching the significance of therapist responsiveness in therapeutic situations has been referred to as the responsiveness problem (Kramer & Stiles, 2015). In a systematic literature review Kramer and Stiles (2015) examined the way researchers had engaged with the responsiveness problem and identified six categories of research: empirical research focusing on patient personality features, quantitative research rating responsive behaviours, qualitative descriptions detailing how client and therapist respond to each other during interactions, evaluative measures using related concepts such as therapeutic alliance, clinical strategies explicitly designed to be responsive at the level of treatment choice and the consideration of responsiveness in domains such as clinical supervision. It was found that the closest unifying definition of therapist responsiveness within the research field was “the observation that clinicians try to do the right thing at the right time, considering the client, the context and their therapeutic approach” (Kramer & Stiles, 2015, p. 279).

Whilst Kramer and Stiles (2015) literature review was helpful in bringing together diverse research approaches and considering how researchers had engaged with the responsiveness problem, there was little consideration given to responsiveness and its importance for clinical practice or the way in which responsiveness operates within the therapeutic environment. The current review therefore aimed to move away from a focus on research methodology, to define therapist responsiveness as a clinical construct and be the first to ascertain its importance for clinical practice.

**Method**

**Identification of studies**

Due to the narrow field of research available in this area an extensive literature search was conducted between the 10th to 21st November 2017. Ten databases were searched: PsycINFO, Scopus, Web of Science, Medline via Ovid, the Cochrane review library, Google Scholar; Latin American and Caribbean research via VHL Regional Portal; grey literature via Open Grey and Doctoral level theses via EThOS and ProQuest. The key search term was “therapist responsiveness”. Using truncation to expand search results returned a large number of irrelevant articles and therefore proximity operators which allowed the specification of how close the two search words appear next to each other in the title and abstract were used. As proximity operators work slightly differently in each database, search terms differed as a result. For PsycINFO the search term was: (therapist OR context OR optimal) adj3 responsiveness. For Scopus the search term was (therapist OR context OR optimal) W/3 responsiveness and the subject area was limited to psychology. For Web of Science, 3 search terms were used; therapist NEAR/3 responsiveness, context NEAR/3 responsiveness and optimal NEAR/3 responsiveness and the research domain was limited to Social Sciences. The remaining databases all used the same search term of “therapist responsiveness”; the Medline search was limited to psychotherapy as subject area. Due to the explorative nature of this systematic review both qualitative and quantitative analysis were included and no date restrictions were put on the search. As the Google scholar search returned a large number of irrelevant articles ordered in terms of relevance, only the first 25 were included.

To increase the chance of accessing all relevant research, an ancestry search was carried out i.e. the reference lists of all included articles were reviewed to check for research which had not been captured in the electronic database search.

Preferred reporting items for systematic reviews and meta-analyses (PRISMA) procedures (Moher, Liberati, Tetzlaff, & Altman, 2009) were utilized to describe the flow of information; the search strategy is outlined in Fig 1.

**Identification**

**Screening**

**Eligibility**

**Included**

733 records identified through database searching

PsycINFO: 198

Scopus: 94

Web of Science: 202

Medline: 10

Cochrane Library: 31

Open Grey: 0

VHL: 16

EThOS: 11

ProQuest: 146

Google Scholar: 25

6 additional records identified via ancestry search

483 records after duplicates removed

64 records after relevance screening

419 records excluded

23 full-text articles after eligibility

23 studies included in final synthesis

41 full-text articles excluded according to inc/ excl criteria

Not individual therapy: 2

Not qualified/ doctoral level training clinicians: 1

Main focus not on therapist responsiveness: 11

Not in English language: 1

Not in peer reviewed journal/ grey lit or theses: 25

Focus on out of session behaviour: 1

*Figure 1.*  PRISMA diagram outlining search strategy

**Study selection criteria**

Studies were included if they met the following inclusion criteria: a) published in a peer-reviewed journal or included in a database for grey literature or doctoral level theses; b) written in English; c) focused on individual therapy; d) doctoral level therapists in training or qualified therapists delivered the treatment and; e) primary focus on therapist responsiveness.

In addition to the reverse of inclusion criteria the exclusion criteria were a) focus of responsiveness of intervention rather than therapist and b) focus on between session behaviour.

**Quality assessment**

The papers included in the review adopted different research methodologies. Because of this, 4 quality assessment tools were used to critique the articles. An adapted version of the Downs and Black checklist (Downs & Black, 1998; Appendix A) was used to review quantitative cohort studies. This 27- item checklist was chosen as it is designed to evaluate the quality of both randomised and non-randomised studies. The tool assesses studies for quality, external and internal validity and statistical power. Each of the 27 items is assigned a score (yes = 1, no = 0 and unable to determine = 0.; except item 5 where yes =2, partial = 1, no =0). The checklist has high internal consistency (KR-20= 0.89), good test-retest (r= 0.88) and inter-rater reliability (r= 0.75) with lower scores for external validity (KR-20= 0.54). The final score is the sum of the items; a higher score indicates a higher quality study. The adapted version of the checklist used in this study removed two items (Q14, 15) related to blinding due to the difficulties involved in blinding participants, therapists and researchers to process issues in psychotherapy. Item 27 relating to statistical power was also removed from the checklist, as much of the research in this area is in its early stages and there is not sufficient knowledge to calculate required sample sizes. Finally, item 8 relating to adverse events was also removed as none of the included studies referred to adverse events related to psychotherapy. Because of these exclusions the adapted scale had a total score of 25.

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research (CASP, 2013b; Appendix B) was used to review two studies. CASP does not recommend a total score for this scale but suggests that it be used as a guide to any significant limitations.

The CASP checklist for systematic literature reviews (CASP, 2013a; Appendix C) was used to assess the five review studies, as although the reviews tended to be non-systematic or conceptual this checklist best matched the work carried out. Again, no score was determined but the tool was used as a guide to limitations.

Four of the studies retrieved were case studies and for these studies the SCRIBE 2016 checklist (Tate et al., 2016; Appendix D) was used as a quality assessment tool. The SCRIBE 2016 checklist is a set of 26 items that were developed following 2 online surveys and a 2-day meeting of experts in the field. It is primarily a guide for authors who wish to publish single case research however the authors also suggest that it provides a practical checklist against which reports can be critically evaluated. Again, it does not produce an overall score but allows limitations to be identified.

Three of the papers (Bacal & Herzog, 2003, Rachman, 1998, Stiles, 2009) were essentially positional papers and therefore did not demonstrate methodological rigour. They were included in the review to set the scene and add depth to more robust studies where appropriate. Given the limited evidence base available the quality checking process was not conducted to exclude articles but rather to assess any significant limitations that needed to be discussed.

Four of the quantitative cohort studies (44%) were selected at random and quality assessed by a second reviewer to check for inter-rater reliability. The reviewer was a third year Doctorate of Clinical Psychology student who had experience of the Downs and Black (1998) checklist. An intra-class correlation using two-way mixed absolute, average measures ICC (McGraw & Wong, 1996) was carried out. The level of inter-rater reliability was determined to be excellent (ICC= 0.87; Cicchetti, 1994). Given the high rate of agreement, where discrepancies existed the first reviewer’s scores were accepted.

**Results**

The electronic database and ancestry search returned 483 articles. Following removal of duplicates, relevance screening and the application of inclusion and exclusion criteria this was reduced to 23 (see Figure 1).

**Details of Included Studies**

The final breakdown of the 23 papers was; 9 quantitative studies, 2 qualitative studies, 4 case studies including both qualitative and quantitative elements, 5 literature reviews and 3 positional papers. One of the qualitative studies was a doctorate level thesis and contained 2 separate research projects. These were treated as 2 separate studies; study 2 and study 3 (Linna, 2004).

Sample sizes were relatively small for all studies. The research ranged from single (n=1) case studies (Bugatti & Boswell, 2016; Linna, 2004: study 3; van der Linde & Edwards, 2013) to a cohort study with 114 participants (Hardy et al., 1998). Studies primarily focused on adults, with only two studies focusing on young people. Most of the studies were concerned with patients experiencing depression. Ten of the sixteen studies that included patient groups, focused on depression, two were concerned with comorbid depression, anxiety and substance misuse, one focused on anxiety and three on post-traumatic stress disorder (PTSD). In terms of the therapeutic models used clinically these fell into 3 categories: cognitive behavioural therapy (CBT; n=11), relationally focused psychotherapy (n= 8) and trans-theoretical models (n= 1). Four studies included two of these psychological models within the design.

The ratings given using the Downs and Black (1998) quality assessment tool suggest that the 9 quantitative studies ranged in quality from 14 to 19 out of 25 (Table 1); detailed ratings are provided in Appendix E. A common issue for most studies was that it was not clear if participants were representative of the general population due to lack of detail. Most studies were also penalised for not building randomisation into the study design.

Results from the CASP Qualitative tool (CASP, 2013b; Appendix F) suggest that there were issues related to lack of information regarding ethical considerations. This may be a consequence of a lack of requirement at the time of the research to follow formal procedures.

In general, the case studies checked against the SCRIBE 2016 checklist (Tate et al., 2016; Appendix G) consistently met the criteria. The exceptions to this were issues to do with randomisation and blinding.

Finally, with the exception of one review (Kramer & Stiles, 2015) the literature reviews were not carried out in a systematic manner and do not provide sufficient detail to allow replication. Given the limited research available however and their usefulness in highlighting key issues they have been included. Table 2 gives a summary of all papers included in the review.

**Table 1**

|  |  |
| --- | --- |
| Study | Total |
| Caspar et al. (2005) | 18 |
| Chu & Kendall (2009) | 17 |
| Connolly Gibbons et al. (2003) | 14 |
| Elkin et al. (2014) | 19 |
| Hardy et al. (1998) | 17 |
| Owen & Hilsenroth (2014) | 17 |
| Richards et al. (2013) | 18 |
| Russell et al. (2008) | 14 |
| Stiles & Chapiro (1994) | 14 |

***Overall scores for Downs and Black (1998) Checklist***

**Table 2**

***Summary of therapist responsiveness study characteristics***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Author Name | Definition of responsiveness | Design | Number of participants | Client group/ presentation | Psychological approach | Key findings | Method of data collection |
| Bacal & Herzog (2003) | Within session, moment to moment responses | Positional paper | N/A | N/A | Psychodynamic | Therapeutic engagement to be continually monitored | N/A |
| Bugatti & Boswell (2016) | Context responsiveness | Case study/ Qualitative | 1 | Depression/ anxiety/ substance misuse/ Adults | Integrated/ Unified Protocol (Barlow et al., 2011) | Clinical errors related to low expectations/ self-striving & lack of outcome monitoring | Patient report / session notes/ observation of video recordings |
| Caspar et al. (2005) | Complementarity focusing on custom tailoring the relationship to an individual level | Cohort study/ Quantitative | 22 | Inpatients/ depression/ Adults | Interpersonal psychotherapy (IPT) | Correlations between complementarity and outcome measures/ increased complementarity for friendlier patients | Plan analyses of video recordings/symptom measures: SCL-90, BDI. |
| Chu & Kendall (2009) | Flexibility within manual based CBT | Cohort study / Quantitative | 63 | Anxiety/ young people | Manual based Cognitive Behavioural Therapy (CBT) | Flexibility positively related to child engagement later in therapy | Parent and child interviews/ coding of child involvement and therapist flexibility |
| Connolly Gibbons et al. (2003) | Variation in therapist interventions related to specific patient characteristics | Cohort study/ Quantitative | 72 | Adults/ major depression | IPT and CBT | 10-23% of variance in responses accounted for by patient characteristics | Transcripts and coding using response modes |
| **Table 2 (Continued)** | | | | | | | |
| Author Name | Definition of responsiveness | Design | Number of participants | Client group/ presentation | Psychological approach | Key findings | Method of data collection |
| Constantino et al. (2013) | Context responsiveness | Literature review | N/A | N/A | Trans-theoretical | Evidence supporting context responsive model | Literature review |
| Edwards (2010) | Focusing on a particular phase of therapy in response to client need | Case series/ Qualitative | 6 | Adults primarily with 1x 15 yr. old, PTSD | CBT | A model is derived to offer responsive treatment planning | Narrative case studies |
| Edwards (2013) | Flexibility across the process using a phase based model | Literature review | N/A | Adults/ PTSD and trauma disorders | CBT/ psychodynamic | Provides evidence base for treatment planning | Literature review |
| Elkin et al. (2014) | Within session therapist behaviour | Cohort study/ Quantitative | 72 | Adults/ major depressive disorder | CBT/ Interpersonal Psychotherapy | Responsiveness positively predicted engagement/ outcome | Therapist responsiveness scale (TRS); BLRI, no. of sessions attended |
| Hardy et al. (1998) | Therapists responding to client’s interpersonal styles | Cohort study/ Quantitative | 114 | Adults/ depression | Interpersonal psychotherapy/ CBT | Therapists appropriately adapted their approach in response to clients’ interpersonal styles | IIP/ therapist intentions measure/ self- report/ session impact/ alliance measures |
| Hatcher (2015) | Therapist’s ability to adjust responses within session | Non-systematic literature review | N/A | N/A | N/A | Related to executive functioning/ a metacompetency/ a component of effective supervision | Literature review |
| **Table 2 (Continued)** | | | | | | | |
| Author Name | Definition of responsiveness | Design | Number of participants | Client group/ presentation | Psychological approach | Key findings | Method of data collection |
| Kramer & Stiles (2015) | Behaviour that is affected by emerging context | Conceptual literature review | N/A | N/A | N/A | Six categories of research used to address the responsiveness problem | Conceptual literature review |
| Linna (2004): study 2 | Adaptation to interpersonal styles | Cohort study/ Qualitative | 10 | Adults/ depression | CBT | Within session processes differ according to attachment style which links to outcome | Grounded theory based on therapy transcripts |
| Linna (2004): study 3 | Therapist activity during helpful therapeutic event | Case study/ Qualitative | 1 | Adults/ depression | CBT | Importance of balance between challenging and holding client | Comprehensive process analysis using therapy transcripts |
| Owen & Hilsenroth (2014) | Variability within adherence to therapeutic model | Cohort study/ Quantitative | 70 | Adults/ mood disorders | Psychodynamic psychotherapy | 10-11% of variability in outcomes was related to variability in adherence to psychodynamic model | Coding of video recordings using psychotherapy technique scale |
| Rachman (1998) | Relaxation in psychoanalytic technique | Positional paper | N/A | N/A | N/A | Optimal flexibility allows the therapy situation to be based on the analysand’s needs, capacity and demands. | N/A |
| **Table 2 (Continued)** | | | | | | | |
| Author Name | Definition of responsiveness | Design | Number of participants | Client group/ presentation | Psychological approach | Key findings | Method of data collection |
| Richards et al., (2013) | Presence or absence of therapist | Randomised parallel group trial/ Quantitative | 101 | Adults/ Depression | CBT | Bond stronger for group with responsive online therapist | BDI-II, CORE OM, WAI-SR |
| Russell et al. (2008) | Variability in manually guided CBT | Cohort study/ Quantitative | 54 | Adolescents/ depressive disorder | CBT | Responsivity increases alliance formation in first session, timing of responsiveness important | Psychometric alliance measures, coding of video recordings |
| Shapiro et al. (1999) | Responding to client demands within a specific goal and treatment theory | Cohort study/ Qualitative | 10 | Adults/ depression | Interpersonal psychotherapy (PI) | Therapists responded differently to clients depending on attachment styles | Coding of therapy transcripts |
| Silberschatz & Curtis (1993) | Therapist interventions in response to problems and treatment goals | Case series/ Quantitative | 2 | Adults/ dysthymic disorder | Brief psychodynamic therapy | When a therapist responds appropriately to “tests” within the relationship; the patient improves | Therapy transcripts, case formulations, patient rating scale, therapist rating scale |
| Stiles & Shapiro (1994) | Moment to moment feedback | Cohort study/ Quantitative | 39 | Adults depression and anxiety | CBT/ psychodynamic interpersonal therapy | Highlights difficulties with process-outcome research; outcome not correlated with essential process components | Rating of verbal process components, rates of change on BDI, SCL-90 |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Table 2 (Continued)** | | | | | | | |
| Author Name | Definition of responsiveness | Design | Number of participants | Client group/ presentation | Psychological approach | Key findings | Method of data collection |
| Stiles et al. (1998) | Behaviour that is affected by emerging context across the process | Non-systematic literature review | N/A | N/A | N/A | Lack of linear relations between responsiveness and outcome. Research strategies to overcome this include evaluative measures, systems approaches, qualitative and narrative approaches | Literature review |
| Stiles (2009) | Behaviour that is affected by emerging context across the process | Positional paper | N/A | N/A | N/A | Responsiveness is a problem for outcome research including RCTs. | Literature review |
| Van der Linde & Edwards (2013) | Formulation on an ongoing basis between and within sessions to determine the appropriate focus of therapeutic work | Systematic case study/ Quantitative and Qualitative | 1 | Adult/ PTSD | CBT | Responsiveness is required to meet the needs of clients with complex presentations. | Systematic case study |

**What is therapist responsiveness?**

Despite the concept of responsiveness being recognised in the therapeutic environment since 1928 (Rachman, 1998), as a field of research it is in its early stages. There is a lack of consensus regarding research approach and a lack of clear definition regarding what constitutes therapist responsiveness.

A number of terms have been used to refer to the same construct. These terms include the relaxation principle (Rachman, 1998), optimal responsiveness (Bacal & Herzog, 2003), therapist flexibility (Chu & Kendall, 2009) and complementarity (Caspar, Grossman, Unmüssig & Schramm, 2005). In terms of timeframe there is a continuum of responsiveness ranging from the absence or presence of a therapist online across the treatment process (Richards, Timulak & Hevey, 2013) to within session responsiveness studied at 5-minute intervals (Elkin, Falconnier, Smith, Canada, Henderson, Brown and McKay, 2014). To explore these differences, the first part of this literature review will consider the ways in which responsiveness has been defined within the clinical environment to date.

**Responsiveness as a deviation from psychological model.** *Psychoanalysis*: Rachman (1998) argues that Sándor Ferenczi (1873-1933) first introduced the idea of therapist responsiveness in clinical practice with his use of the relaxation principle. The relaxation principle encouraged a relaxation in attitude and technique, rather than neutrality, as was promoted by traditional psychoanalysis. Rachman (1998) outlines a series of vignettes taken from clinical examples of his work with patient, OFB, in which he adopts the relaxation principle. Essentially, in an attempt to be responsive to OFB’s anger, Rachman (1998) avoids the usual course of action, i.e. interpretation of the origins of OFB’s anger, and offers an empathic response around basic anxiety that OFB may have regarding being controlled within session. This responsive behaviour allowed the therapeutic process to continue. Rachman (1998) describes responsiveness as a function of the analyst, which allows the psychoanalytic experience to be stretched in the direction of the analysand’s needs based on his or her capacity to process the emotional and interpersonal demands of the experience. Rachman (1998) did not attempt to offer a full case study of his work with OFB and much of the quality assessment guidelines against which other case studies in the review were assessed were not applicable. As a result of this, the case material should be considered anecdotal information which helps define the concept rather than evidence of the importance of responsiveness in clinical practice.

Bacal and Herzog (2003) also working in the psychoanalytic tradition, present an argument for a move away from traditional approaches by developing the idea of optimal responsiveness. The use of the term optimal, recognises that different patients require different responses and therapists are encouraged to pay attention to client feedback via their subsequent behaviour to maintain optimum levels. The authors argue that whilst on one level the process appears to be quite simple it requires detailed knowledge on the therapist’s part to recognise what is going on within the therapy dyad.

*Cognitive Behavioural Therapy* (CBT): Therapist responsiveness within the CBT tradition has been seen as an adaptation of treatment protocols in response to individual need. Chu and Kendall (2009) in their research with anxious young people (n= 64) define therapist responsiveness as therapist flexibility- i.e. the degree to which treatment is adapted within the boundaries of fidelity to treatment protocol. Raters used both quantitative (Coping Cat Adherence Checklist- Flexibility Scale CCPAC-F; Southam-Gerow, Jensen, Gelbwasser, Chu & Weisz, 2001) and qualitative measures (Therapist Flexibility Questionnaire, TFQ-R; Chu & Kendall, 1999b) to assess within session flexibility. They found that therapists demonstrated significantly more (p≤.001) content flexibility (M= 5.28, SD = 5.82) i.e. making CBT sessions more relevant to the child with personal examples, than structural flexibility (M= 0.97, SD= 1.45) in which the treatment protocol was modified.

In a series of case studies of adults and adolescents in South Africa experiencing PTSD; Edwards (2010, 2013) and van der Linde and Edwards (2013) focus on what Chu and Kendall (2009) define as structural flexibility. In this research therapist responsiveness is defined as the degree to which manualised CBT is delivered paying attention to the therapeutic alliance and collaborative engagement with the client. Edwards (2010, 2013) uses case study evidence (n=10) to develop a phase-based model of treatment which relies on ongoing case formulation and feedback to allow therapists to decide which phase of treatment to offer at a given time in the therapeutic process. Five levels or tasks of therapy are presented within the model and it is argued that one level or task needs to be completed within the wider CBT framework before moving onto the next. The levels are crisis intervention, establishing necessary conditions, promoting processing of trauma memory, consolidating resources and rebuilding a new life post trauma. Edwards (2013) argues that the responsive use of treatment, aided by the model, is preferable to empirically supported protocol driven treatments which are suggested by RCTs.

**Responsivity as the presence of a therapist**. A randomised parallel group study (n=101) compared the efficacy of self-administered online CBT and a therapist assisted email CBT treatment (Richards et al., 2013). Responsiveness was measured dichotomously as the presence or absence of an online therapist globally across the therapeutic process. Both groups experienced similar reductions in symptoms following the programme and the authors conclude that self-administered online CBT can be substituted for the more responsive therapist administered email programme. Closer examination of findings however shows that there were benefits to the therapist administered treatment in terms of working alliance scores as measured by the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and that these scores were more positively related to outcome, although not statistically significantly, within the responsive therapist group. It would appear that this research, as suggested by Stiles (2009), underestimates the importance of responsivity within therapy due to the difficulty in relating process variables directly to outcome.

**Responsiveness in the context of patient characteristics.** In the largest study in this review, Hardy, Stiles, Barkham and Startup (1998) considered therapist responsiveness at the level of moment to moment in session behaviour in response to client interpersonal styles (n=114) using a retrospective therapist self report measure (Therapist Session Intentions, TSI; Stiles, Startup, Hardy, Barkham, Rees, Shapiro, & Reynolds, 1996) alongside an observer rated measure (Sheffield Psychotherapy rating scale; Shapiro & Startup, 1992), coding of interpersonal styles (overinvolved v underinvolved v balanced); treatment (psychodynamic- interpersonal therapy (PI) v CBT) and duration (8 vs 16 sessions). ANOVA analysis revealed that clients with different interpersonal styles received different versions of the same treatments. Therapists tended to use more cognitive methods with underinvolved clients, particularly in CBT therapy and more relationship-orientated interventions with overinvolved clients, particularly in PI. Despite this, their therapeutic alliances and outcomes were similar suggesting that this is a result of appropriate responsiveness whereby therapists respond to their clients’ varying requirements including their interpersonal styles.

Research by Shapiro, Hardy, Aldridge, Davidson, Rowe and Reilly (1999) builds support for the idea that therapists respond to individual patient characteristics. Ten client identified helpful therapy events were analysed to identify client attachment styles, attachment issues and therapist responsiveness. Attachment styles were categorized as secure, dismissing or preoccupied following linguistic analysis of audio recordings. Qualitative analysis demonstrated that therapists responded to preoccupied attachment styles with reflection; in PI this is considered a more accepting, holding strategy; and to dismissing styles with interpretation; a more active, challenging intervention. It should be noted that the research did not consider negative therapy events or include participants who had not improved over the course of therapy. These omissions may mean that the degree to which therapists responded to client attachment styles was over estimated.

A quantitative study focusing on flexibility in manual-based psychotherapies (Connolly Gibbons, Crits-Christoph, Levinson, & Barber, 2003) adds to the evidence base of therapist responsiveness in the context of diverse patient characteristics. This work considered pre-treatment depressive symptomology, interpersonal difficulties, level of empathy and degree of narrative completeness and their impact on 8 different therapist response modes. Differences in patient characteristics accounted for between 10-23 % of variance in the use of such modes. Therapists used more restatements and clarifications for patients who rated the therapeutic empathy higher, more questions and clarifications with patients who rated higher on depression and more learning statements for patients who provided more complete personal narratives.

**Responsiveness as a behaviour across the therapy process.** In a series of literature reviews looking at the responsiveness problem; levels at which responsiveness operate are given (Stiles et al., 1998; Stiles, 2009; Kramer & Stiles, 2015). These levels include treatment assignment, treatment strategy in which delivery of a particular therapy is adapted, treatment tactics i.e. selection of topics and moment to moment within session responsiveness in which therapists modify their behaviour in response to ongoing feedback. In his literature review Hatcher (2015) supports the idea of responsiveness as a behaviour across the therapy process in order to achieve optimal benefit for clients. He considers empathy to be a core feature of this. Despite the centrality of empathy in the ability of a therapist to be responsive, Hatcher (2015) argues that they remain distinct constructs. The responsive therapist is said to judge, using feedback from the client, when and when not to offer an empathic response to maintain therapeutic distance and maximise outcomes.

**Responsiveness and neuropsychology.** Hatcher (2015) also discussed how the concept of appropriate responsiveness shares some features with the idea of executive functioning. Hatcher highlighted how, in a changing environment, executive abilities allow shifting of mind set quickly in an adaptive manner at the same time as inhibiting unwanted responses. The importance of planning and organizing in a goal orientated way, as is the case in appropriate responsiveness, is also highlighted. Whilst executive functioning is largely thought of as a cognitive model of processing Hatcher discussed how it can also incorporate affect in that it controls and uses emotional resources as appropriate. In this way therapist responsiveness, as an executive function, gives direction and order to competences required in psychotherapy.

**Responsiveness as a required therapist competence.** Edwards (2013) in his literature review argued that responsiveness is a metacompetency as outlined by Roth and Pilling (2008) in their CBT competency checklist. Edwards (2013) gives the example from the checklist of the “ability to detect and respond to implicit feedback which indicates that the client has concerns about important aspects of the therapy” and the ability to develop “a comprehensive formulation that considers all relevant aspects of the client’s presentation… in a manner which is flexible and appropriately adapted”.

Hatcher (2015) also refers to responsiveness as a metacompetence which is necessary for effective therapy and considers the degree to which responsiveness can be taught. It is suggested that for psychology trainees the nature of their formative experiences pre-training may limit their innate responsive ability and that the assessment of baseline appropriate responsiveness and interpersonal and facilitative skills would be beneficial at application to doctoral level training.

**Responsiveness in supervision.** Whist there is limited research into how to enhance appropriate responsiveness Hatcher (2015) drew upon existing research to discuss how supervision and the modelling of responsiveness may be the key to this. Bacal and Herzog (2003) also acknowledged the importance of supervision in maximising responsiveness and discussed how a supervisor who is optimally responsive is required to take an interest in the particular characteristics of the supervisee, monitor the reactions of supervisees, understand how the supervisor- supervisee interaction may reflect the reciprocal therapeutic relationship and recognise that direct advice about what the supervisee should do with a particular patient may not necessarily be helpful.

In summary, research to date is somewhat confusing in terms of what is considered therapist responsiveness within the therapeutic environment. It has been seen as a deviation from psychological model, a deviation from treatment protocol, a response to individual patient characteristics, a behaviour across the therapeutic process from treatment assignment to within session behaviour, a cognitive ability linked to executive functioning and a required therapeutic competence to be fostered in supervision. In addition to these differences, study timeframes have ranged from the presence of an online therapist across the therapy process to therapist behaviour measured at 5-minute intervals. As a result of this diversity it is not possible to specifically define the construct of responsiveness and the closest unifying definition remains that of Kramer and Stiles (2015) who stated that responsiveness is; “the observation that clinicians…try to do the right thing at the right time, considering the client, the context and their therapeutic approach” (Kramer & Stiles, 2015, p. 279).

**Why is therapist responsiveness important?**

Despite the lack of clarity around the definition of responsiveness, a number of research studies have been able to demonstrate its importance for clinical outcomes. Kramer and Stiles (2015) acknowledged that whilst responsiveness is a problem for researchers, it is a core operating principle for clinicians. The second half of the review will look at this research to determine the importance of responsiveness in clinical practice.

**Building alliance.** Russell, Shirk and Jungbluth (2008), in their work with adolescents experiencing depression, discussed how responsive therapist behaviours are particularly important when trying to build a therapeutic alliance. They observed that adolescents are rarely self-referred and tend to deny or minimize psychological problems. In addition to this, developmental issues relating to emerging autonomy also present barriers to therapeutic engagement. They considered therapist behaviours at 10-minute intervals across the first therapeutic encounter. Following factor analysis four underlying structures related to therapist alliance building behaviour were identified. One of these factors was therapist responsiveness. This factor related to high positive loadings for providing support, humour, cognitive restructuring, attending to subjective information, praise and high negative loading on failing to acknowledge emotion. In terms of degree of responsivity, the study found that this varied across the session. There was a growth trajectory observed for responsiveness in which responsiveness began 0.75 SD below its mean at the beginning of the session to 0.28 above by section 5, i.e. 50 minutes into the session. The betas associated with individual growth curves across session 1 correlated significantly with therapist ratings of the alliance at session 3 (r = 0.38). There were no significant relationships between the mean of therapist responsiveness collapsed across the session and alliance ratings, which suggests that different levels of responsiveness are required at different times to build alliance. The authors suggested that the most successful therapists in terms of building alliance increase their focus on responsivity after the first 10 minutes of the session but slow down the rate of increase over the remaining session time. They suggested that this pattern allows CBT therapists to personalise treatment by fitting manualised CBT to individual clients’ stories before moving to implement the more traditional CBT model. It is worthy of note however that whilst therapists reported an increase in alliance, adolescent ratings of alliance related to responsiveness are not reported.

**Promotes engagement in therapy.** Elkin et al. (2014), considered the degree to which therapist responsiveness promoted early patient engagement as well as therapeutic alliance (n=72). They devised a measure, the Therapist Responsiveness Scale (TRS) to measure responsiveness quantitatively. The TRS is composed of 3 parts. Part one measures 11 specific behaviours rated at 5-minute intervals; examples being making eye contact, part 2 consists of items that are rated globally; examples being compatible level of discourse, respect. Finally, a third section captures raters’ global impressions of the therapist and patient. Following principal axis factor analysis four factors were identified within the measure: attentiveness, early empathic responding, negative therapist behaviour and positive therapeutic atmosphere. The positive therapeutic atmosphere factor included a comprehensive measure of responsive aspects of the therapists’ behaviour e.g. caring/ compassion, respect and attunement. In order to test the hypothesis that therapist responsiveness would predict early engagement in therapy, separate regression analyses were carried out for each identified factor with a patient reported therapeutic relationship measure (Barrett- Lennard Relationship Inventory; BLRI; Barrett- Lennard, 1986), and whether or not patients had engaged for four or more sessions as dependent variables. A significant predictive effect was found for positive therapeutic atmosphere (p= .025) and a single item global responsiveness rating question from the scale (p = .034) on the BLRI; with higher scores on the responsiveness measures leading to higher ratings of the alliance. In addition to this, patients with higher positive therapeutic atmosphere (p=.011; OR= .628) or global responsiveness scores (p= .001; OR= .085) were less likely to terminate therapy early.

Chu and Kendall (2009) also found that therapist flexibility was significantly related to increases in child engagement in later therapy sessions (sessions 6-10) which in turn related to an improvement in post treatment outcomes. Interestingly however, therapist flexibility was not associated with earlier child engagement. Closer examination of these results suggest that further evidence is required as the correlation between therapist flexibility and later engagement is relatively small; r= .25 and is significant at the 5%, rather than 1% level.

Bugatti and Boswell (2016) present a case study in which lack of therapist responsiveness leads to unilateral termination of therapy by the client after 7 sessions. The case study points to the context-responsive psychotherapy integration framework for clinical decision making (Constantino, Boswell, Bernecker, & Castonguay, 2013). The context-responsive framework identifies five responsive markers that need to be recognised and reacted to clinically to provide responsive therapy that maximises outcomes. These five factors are low outcome expectations, change ambivalence, self-strivings, alliance ruptures and outcome monitoring.

Three of these context specific treatment markers are used to explain why the client terminated therapy (Bugatti & Boswell, 2016). The first is low outcome expectations. The client had previously had therapy which had not been perceived as successful. When this issue came up within session, the authors argue the therapist advanced too quickly to action-oriented, goal focused strategies rather than responding appropriately to this lack of expectation. The second marker was self striving, i.e. the client’s desire for evaluation and interactions that promoted a favourable sense of self within the context of a desire to have negative internal states recognised and validated. Rather than explore this complexity the therapist is reported to have engaged in a number of actions that could be labelled unresponsive i.e. viewing difficulties as cognitive distortions and moving to action oriented strategies. The final clinical error which was thought to have occurred was the lack of effective outcome monitoring. In the case study it appears that the client did not understand the function of such monitoring and there was no conversation when a discrepancy arose between the client’s verbal report that there was no improvement and the self report ratings which pointed to an improvement.

**It has an impact on outcome.** Caspar et al. (2005) established a link between responsiveness and improved outcomes in their research looking at the degree to which therapists’ responses were complementary to patients’ plans. They carried out research with inpatients who were experiencing severe depression. Therapists were rated by objective coders for complementarity on a 7-point Likert scale; where a score of 0 meant that the therapist ignored and acted against patients’ plans and 7 meant that the therapist acted in a way which was completely complementary to patient plans. Medium size, statistically significant correlations; ranging from r= 0.386 to 0.513, were found between complementarity scores and self-report symptom measures, related to depression (BDI; Beck, Ward, Mendelson, Mock & Erbaugh,1961) and a symptom checklist (SCL-90; Derogatis, Lipman, & Covi, 1973) suggesting that responsiveness is an important factor related to treatment outcome.

Silberschatz and Curtis (1993) were also able to show improvements in outcome related to therapist responsiveness. They present two case studies in which therapists who are appropriately responsive to “testing” of pathogenic beliefs in the therapy room are able to make immediate improvements for their patients. It is suggested that when therapists are able to identify and respond to pathogenic beliefs in a way that disconfirms them this lessens their impact and leads to immediate therapeutic gains. Significant correlations were found between therapist responsiveness, using objectively rated Likert scales, and an objectively rated patients’ experiencing Likert scale measuring such constructs as insight, productivity and lack of resistance. Correlations ranged from r= 0.62 (p ≤ 0.5) to 0.67 (p = ≤ 0.1). Replication of such event-based strategies across the therapeutic process would add further weight to this small scale study.

Owen and Hilsenroth (2014) looked at responsiveness from the perspective of variability in adherence to a psychodynamic treatment model across 70 individual therapy dyads at sessions 3, 9 and the final session as objectively rated using a psychotherapy technique scale. They found that the more variability there was in treatment approach, the more positive the outcomes for patients. These outcomes related to a global severity rating on the Brief Symptom Inventory (BSI; Derogatis, 1993) and a patient estimate of improvement. Variability in adherence explained 10-11 % of the variability in outcomes. Interestingly, as was found elsewhere (Russell et al., 2008), if mean variability across the process was used as a measure this was not found to correlate with outcomes; perhaps suggesting different levels of responsiveness are required at different stages of the treatment process- although the authors did not comment on this.

Van der Linde and Edwards (2013) presented a case study based on clinical work in South Africa treating a woman with PTSD which demonstrated the importance of responsivity for outcomes. The study provides a narrative across 27 therapy sessions and tracks progress using self- report scales including the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, & Steer, 1993) and the posttraumatic diagnostic scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). Psychometric outcome measures show symptom reduction across the course of therapy and the qualitative narrative data relates this to flexibility and responsiveness in treatment planning and delivery.

In a doctoral level thesis Linna (2004; study 3) used comprehensive process analysis (CPA) to explore a single therapeutic event in order to demonstrate the importance of therapist responsiveness in achieving desired outcomes. The significant event was taken during a CBT for depression session when the therapist was pushing for change by examining underlying assumptions and rules. Four observers followed the CPA process and the therapist was observed to be balancing between holding the client and challenging him in order to achieve therapeutic change. This allowed the client to remain on task and to reach a new level of insight.

**Particularly important for resistant clients.** Elkin et al. (2014) demonstrated that responsiveness had a particular significance for those patients who were rated as resistant. There was a significant interaction between level of resistance, alliance and responsiveness as measured by the positive therapeutic atmosphere factor of the TRS (p= .006) suggesting that the more responsive therapists are with resistant clients the better the therapeutic alliance. There was no interaction for those patients not rated as resistant.

Despite the importance of responsivity for patients who are considered resistant other research in this area has found that therapists are less likely to behave responsively with such clients. Caspar et al. (2005) found differential effects for responsiveness related to level of patient resistance and discovered that therapists were more responsive to clients that had less difficulty with inter-personal relationships as measured by the Inventory of Interpersonal Problems (IIP; Horowitz, Strauss, & Kordy, 1993). Complementarity and interpersonal effectiveness were moderately positively correlated in more friendly patients; r= 0.487; whereas a negative correlation was found between degree of complementarity and less friendly participants (r= -0.424). Whilst this study received one of the highest ratings in the Downs and Black (1998) assessment there are a few limitations which were not captured by the assessment tool; the main limitation is that the complementary rating system used did not allow for discrimination between poorly thought out confrontational therapist behaviour and necessary challenges which helped patients to achieve their goals. Further to this inter-rater agreement only reached 43.3% for the total complementarity rating scale which leads to questions regarding reliability.

Chu and Kendall, 2009 also found that therapists demonstrated more responsiveness to clients considered easier to treat or amenable to therapy. Whilst findings did not reach the level of statistical significance, the relationship between early child involvement and therapist flexibility was in the opposite direction to that hypothesised, i.e. therapists responded to engaged young people with more creativity and responsiveness than their less engaged counterparts. For engaged young people the correlation between responsiveness and engagement was r= 0.37 whilst for less engaged young people r= 0.13. The authors argued that active and engaged clients inspired greater creativity and involvement with the opposite being the case for young people who presented with flat affect and depressed mood. Given the lack of statistical significance however and relatively small correlations further research in this area is required.

In summary the review found a number of reasons why responsiveness should be considered a key component within the therapeutic environment. Responsiveness aids in building alliance, promotes engagement in therapy, helps organise therapeutic skills, has a positive impact on clinical outcomes and is particularly important for resistant clients.

**Discussion**

The aims of this review were to define therapist responsiveness as a clinical construct and to ascertain its importance for clinical practice. The concept of therapist responsiveness has been defined in a variety of ways and across different time frames. It is difficult to find a common factor between studies and to establish or define it as a single construct. Perhaps the most unifying definition found to date is that of Kramer and Stiles (2015) in which therapist responsiveness is described as “the extent to which the therapist did the right thing at the right time” (p. 279). Although there are difficulties in defining responsiveness, research suggests that this should not be taken as a sign that it is not significant or important. Connolly Gibbons et al. (2003) and Owen and Hilsenroth (2014) estimated that therapist responsiveness accounted for between 10- 23% of the variance in therapeutic environment. The findings of this review indicated that appropriate responsiveness is key to building alliances, promoting therapeutic engagement, helping organise therapeutic skills, maximising therapeutic outcomes and is particularly important for resistant clients.

The quality of the studies included in the review varied and there were particular issues with sample size and insufficient detail to allow for generalisation of findings. The literature reviews, with one exception (Kramer & Stiles, 2015) did not provide sufficient detail regarding methodology to allow for replication. In addition, research to date has focused on adults experiencing depression and anxiety disorders.

Scores on the Downs and Black (1998) checklist were perhaps unrepresentative of the quality of research. Most studies, with the exception of one (Richards et al., 2013) were penalised for a lack of blinding and randomisation. It can be seen how using a randomised controlled design is prohibitively difficult in process research as well as it being unethical to manipulate process variables, such as responsivity, experimentally in this way. The development of a quality assessment instrument for process research would help with these issues and be more representative of the quality of research in this area.

**Implications for clinical practice**

In terms of implications for clinical practice several recommendations emerge. As therapists have been shown to react differently to different patient characteristics and attachment styles (Connolly Gibbons et al., 2003; Hardy et al., 1998; Shapiro et al., 1999) it is important that therapists are aware of this and reflect upon this during supervision. Linna (2004, study 2) discussed the importance of monitoring the closeness and quality of the therapeutic relationship, level of hope and the push and pull of insecure client styles as well as being aware of clients’ zone of proximal development.

A number of researchers demonstrated the need to deliver manualised CBT therapy in a flexible, responsive manner (Chu & Kendall, 2009; Connolly Gibbons, 2003; Edwards, 2010, 2013; Russell et al., 2008). In line with this, the timing of responsivity in CBT therapy is significant (Russell et al., 2008) particularly in the first session as a precursor to therapeutic alliance. It is suggested that CBT therapists increase their responsivity during the first 10 minutes of the first therapy session before slowing down the rate of increase over the remainder of the session. This is to allow for personal information to be gathered before structuring the session around CBT principles.

The review suggests that therapists tend to be more responsive to less resistant clients (Caspar, 2005; Chu & Kendall, 2009). It is possible that these clients require less responsivity than those clients who are more difficult to treat. It is important therefore that therapists recognise and react responsively to resistance within the therapy room to maximise outcomes. Suggestions for this responsive responding include not blaming the patient for this resistance but seeing it as a useful phenomenon to be used to therapeutic benefit or using specific strategies, e.g. motivational interviewing techniques as an adjunct to therapeutic models (Elkin et al., 2014).

Finally, responsiveness has been observed to operate at all levels of the therapeutic process from treatments that are offered to moment to moment interactions in the therapy room (Kramer & Stiles, 2015). This suggests that it is important that the significance of responsiveness is recognised at a service level and within supervision to facilitate responsive therapy (Bacal & Herzog, 2003; Hatcher, 2015).

**Strengths and limitations**

To date the focus of work related to therapist responsiveness has been on research methodologies with particular consideration given to the responsiveness problem (Kramer & Stiles, 2015) and the difficulties inherent in RCTs and process-outcome research. This review is the first to explore the definition of therapist responsiveness and its implications for clinical practice. Given the novelty of this approach, an extensive literature review was carried out which incorporated a wide range of databases, grey literature and thesis material. A systematic approach reduced bias and optimised the information available.

Despite the attempts to limit bias, it is possible that in trying to establish the relevance of therapist responsiveness for clinical practice, there remains a bias towards studies that have demonstrated a significant link between responsiveness and outcomes; the file drawer effect or publication bias. In addition to this, given the wide range of terms used to describe therapist responsiveness it is possible that an important way of describing the phenomenon has been missed in the review. The review is also limited by the fact that the research is in its early stages and is very diverse in its approach. This puts limits on the amount of comparison and consolidation which can be carried out and the relatively small sample sizes raise questions regarding reliability. Finally, the search was limited to English language papers only.

**Future research directions**

Given the apparent significance of therapist responsiveness for clinical practice and the diversity of research methodologies and definitions found within the literature it is important that the knowledge currently available is consolidated. Further literature reviews focusing on finding a unifying definition or construct to allow the area of research to progress are indicated. If a unifying definition cannot be found it may be necessary to separate the field into different categories or levels to simplify and strengthen the evidence base. In addition to this, given the relatively small sample sizes in the research to date further replication of studies to increase the evidence base is indicated. As most studies to date have focused on depression and anxiety in adults, future research should broaden the age range and the mental health difficulties considered.

**Conclusion**

In conclusion, this review suggests that despite the concept of responsiveness being recognised since 1928 (Rachman, 1998) research is in its early stages. There is a lack of consensus regarding research approach and a lack of clear definition regarding what constitutes therapist responsiveness. In terms of timeframe there is a continuum of responsiveness ranging from the absence or presence of a therapist online globally across the treatment process (Richards et al., 2013) to within session responsiveness studied at 5-minute intervals (Elkin et al., 2014). Differences were also found with regard to what is meant by responsiveness across psychological models and between different phases of treatment. The reason for this diversity in approach is perhaps explained by the responsiveness problem (Kramer & Stiles, 2015) which recognises the difficulties in demonstrating the significance of responsiveness within process- outcome research. Despite this responsiveness problem a number of research studies have been able to demonstrate the importance of responsiveness within the therapeutic environment. Quantitative research to date estimates that responsivity accounts for between 10- 23% of the variance in therapeutic environment (Connolly Gibbons et al., 2003; Owen & Hilsenroth, 2014) and it is reported to aid in building alliance, promote engagement in therapy, help organise therapeutic skills, have a positive impact on clinical outcomes and appears particularly important for resistant clients.

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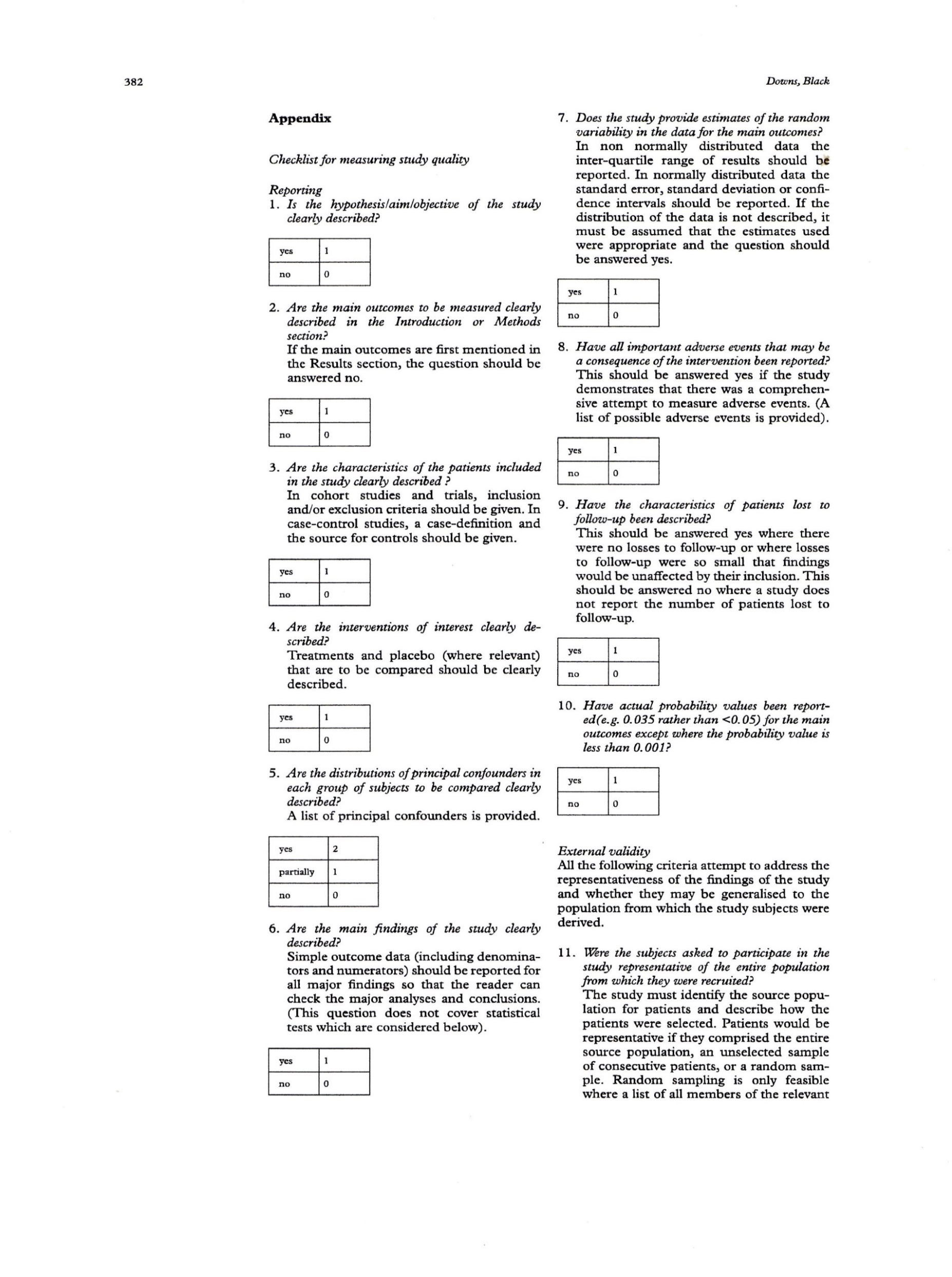
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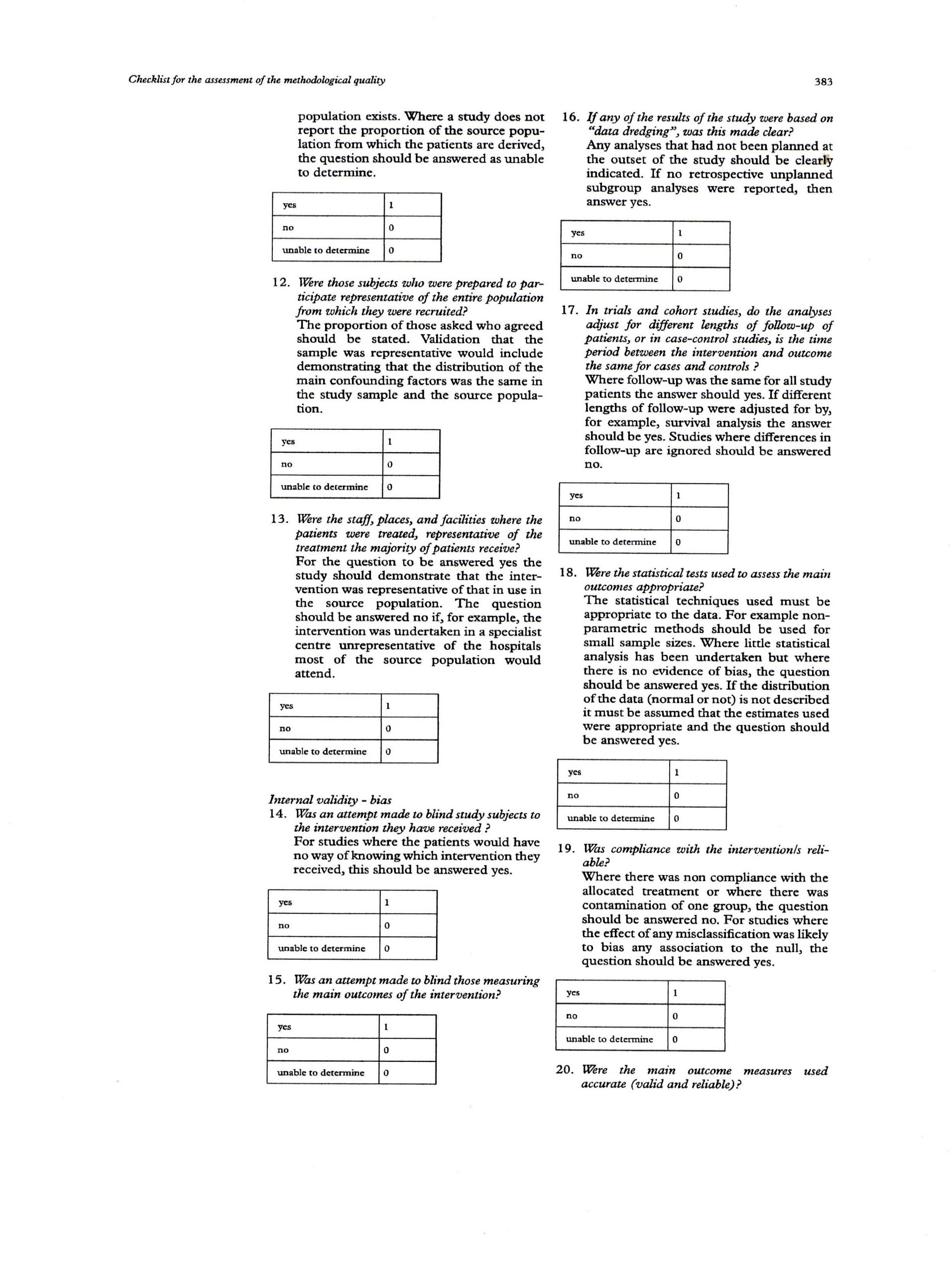
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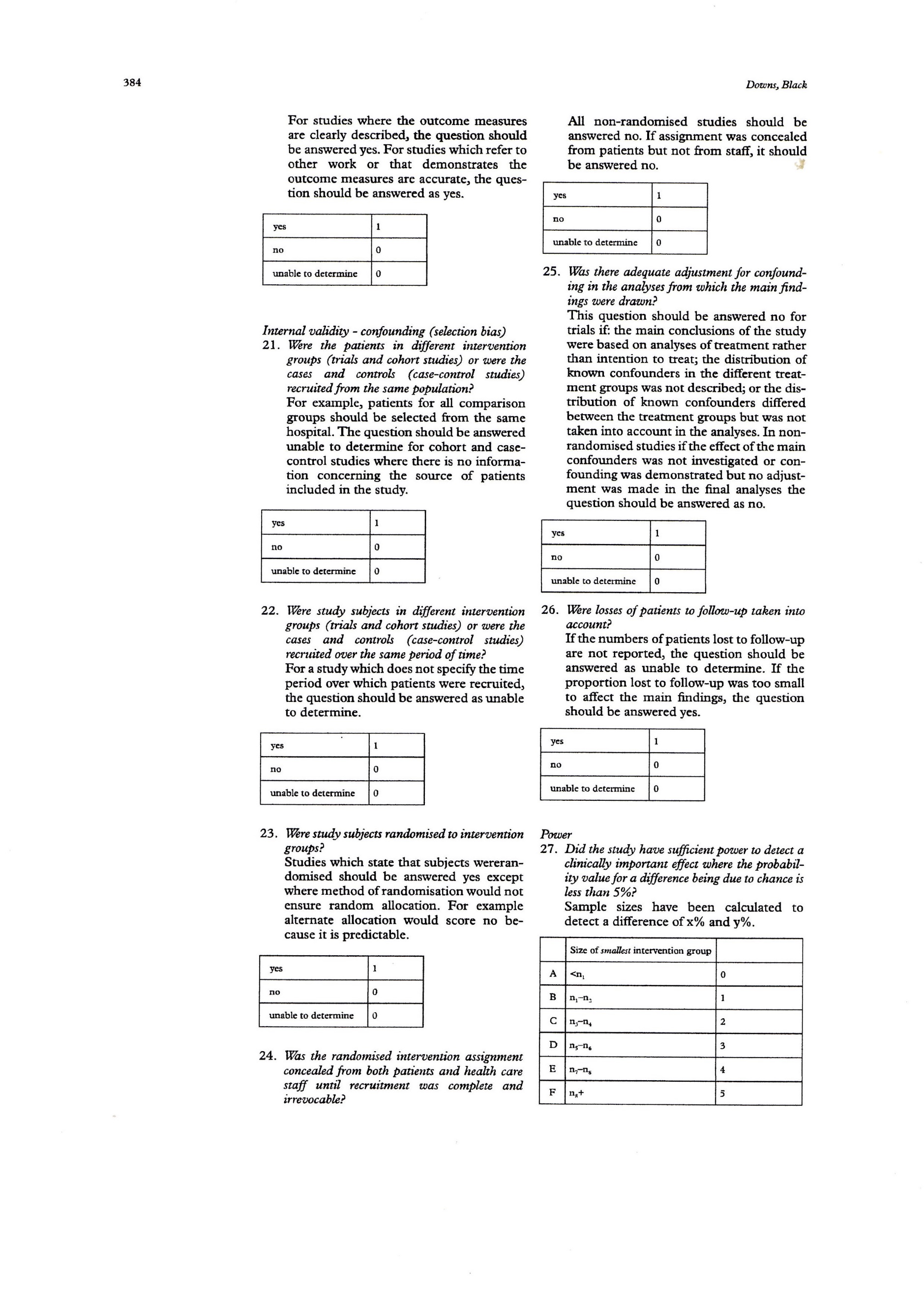
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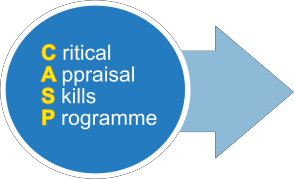
**Appendix A: Quality Assessment Tool (Downs & Black, 1998)**







**Appendix B: Critical Appraisal Skills Programme (CASP) Qualitative Checklist**



**10 questions to help you make sense of qualitative research**

## How to use this appraisal tool

Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)

What are the results? (Section B)

Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review)

were based on JAMA 'Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

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**Screening Questions**

1. **Was there a clear statement of the aims of the research?**

**Yes** **Can’t tell** **No**

HINT: Consider

* + What was the goal of the research?
  + Why it was thought important?
  + Its relevance

# Is a qualitative methodology appropriate?

# Yes Can’t tell No

HINT: Consider

* + If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
  + Is qualitative research the right methodology for addressing the research goal?



**Is it worth continuing?**

Detailed questions

# Was the research design appropriate to address the aims of the research?

# Yes Can’t tell  No

HINT: Consider

* + If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

# Was the recruitment strategy appropriate to the aims of the research?

# Yes Can’t tell No

HINT: Consider

* + If the researcher has explained how the participants were selected
  + If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
  + If there are any discussions around recruitment (e.g. why some people chose not to take part)

# Was the data collected in a way that addressed the research issue?

# Yes Can’t tell No

HINT: Consider

* + If the setting for data collection was justified
  + If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
  + If the researcher has justified the methods chosen
  + If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
  + If methods were modified during the study. If so, has the researcher explained how and why?
  + If the form of data is clear (e.g. tape recordings, video material, notes etc)
  + If the researcher has discussed saturation of data

# Has the relationship between researcher and participants been adequately considered?

# Yes Can’t tell No

HINT: Consider

* + If the researcher critically examined their own role, potential bias and influence during

1. Formulation of the research questions
2. Data collection, including sample recruitment and choice of location
   * How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

# Have ethical issues been taken into consideration?

# Yes Can’t tell No

HINT: Consider

* + If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
  + If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
  + If approval has been sought from the ethics committee

# Was the data analysis sufficiently rigorous?

# Yes Can’t tell No

HINT: Consider

* + If there is an in-depth description of the analysis process
  + If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
  + Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
  + If sufficient data are presented to support the findings
  + To what extent contradictory data are taken into account
  + Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

# Is there a clear statement of findings?

# Yes Can’t tell No

HINT: Consider

* + If the findings are explicit
  + If there is adequate discussion of the evidence both for and against the researchers arguments
  + If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
  + If the findings are discussed in relation to the original research question

# How valuable is the research?

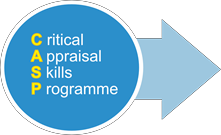
HINT: Consider

* + If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current

practice or policy?, or relevant research-based literature?

* + If they identify new areas where research is necessary
  + If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

**Appendix C: CASP checklist for systematic reviews**



**10 questions to help you make sense of a Systematic Review**

## How to use this appraisal tool

Three broad issues need to be considered when appraising a systematic review study: Are the results of the study valid? (Section A)

What are the results? (Section B)

Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

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**(A) Are the results of the review valid?**

Screening Questions

1. **Did the review address a clearly focused question?**

**Yes** **Can’t tell** **No**

HINT: An issue can be ‘focused’ In terms of

* + The population studied
  + The intervention given
  + The outcome considered

# Did the authors look for the right type of papers?

# Yes Can’t tell No

HINT: ‘The best sort of studies’ would

* + Address the review’s question
  + Have an appropriate study design (usually RCTs for papers evaluating interventions)



**Is It worth continuing?**

Detailed Questions

1. **Do you think all the important, relevant studies were included?**

**Yes** **Can’t tell**  **No**

HINT: Look for

* + Which bibliographic databases were used
  + Follow up from reference lists
  + Personal contact with experts
  + Search for unpublished as well as published studies
  + Search for non-English language studies

# Did the review’s authors do enough to assess the quality of the included studies?

# Yes Can’t tell No

HINT: The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies’ results. (“All that glisters is not gold” Merchant of Venice – Act II Scene 7

# If the results of the review have been combined, was it reasonable to do so?

# Yes Can’t tell No

HINT: Consider whether

* + The results were similar from study to study
  + The results of all the included studies are clearly displayed
  + The results of the different studies are similar
  + The reasons for any variations in results are discussed

**(B) What are the results?**

# What are the overall results of the review?

HINT: Consider

* + If you are clear about the review’s ‘bottom line’ results
  + What these are (numerically if appropriate)
  + How were the results expressed (NNT, odds ratio etc)

# How precise are the results?

HINT: Look at the confidence intervals, if given

**(C) Will the results help locally?**

# Can the results be applied to the local population?

# Yes Can’t tell No

HINT: Consider whether

* + The patients covered by the review could be sufficiently different to your population to cause concern
  + Your local setting is likely to differ much from that of the review

# Were all important outcomes considered?

# Yes Can’t tell No

HINT: Consider whether

* + Is there other information you would like to have seen?

# Are the benefits worth the harms and costs?

# Yes Can’t tell No

HINT: Consider

* + Even if this is not addressed by the review, what do you think?

**Appendix D – SCRIBE Checklist**

**Table 1**

The Single-Case Reporting guideline In Behavioral interventions (SCRIBE) 2016 checklist.

|  |  |  |
| --- | --- | --- |
| Item Number | Topic | Item description |
| Title and abstract | | |
| 1 | Title | Identify the research as a single-case experimental design in the title |
| 2 | Abstract | Summarize the research question, population, design, methods including intervention/s (independent variable/s) and target behavior/s and any other outcome/s (dependent variable/s), results, and conclusions |
| Introduction | | |
| 3 | Scientific background | Describe the scientific background to identify issue/s under analysis, current scientific knowledge, and gaps in that knowledge base |
| 4 | Aims | State the purpose/aims of the study, research question/s, and, if applicable, hypotheses |
| Methods | | |
|  | Design |  |
| 5 | Design | Identify the design (e.g., withdrawal/reversal, multiple-baseline, alternating-treatments, changing-criterion, some combination thereof, or adaptive design) and describe the phases and phase sequence (whether determined a priori or data-driven) and, if applicable, criteria for phase change |
| 6 | Procedural changes | Describe any procedural changes that occurred during the course of the investigation after the start of the study |
| 7 | Replication | Describe and planned replication |
| 8 | Randomization | State whether randomization was used, and if so, describe the randomization method and the elements of the study that were randomized |
| 9 | Blinding | State whether blinding/masking was used, and if so, describe who was blinded/masked |
|  | Participant/s or unit/s | |
| 10 | Selection criteria | State the inclusion and exclusion criteria, if applicable, and the method of recruitment |
| 11 | Participant characteristics | For each participant, describe the demographic characteristics and clinical (or other) features relevant to the research question, such that anonymity is ensured |
|  | Context |  |
| 12 | Setting Approvals | Describe characteristics of the setting and location where the study was conducted |
| 13 | Ethics | State whether ethics approval was obtained and indicate if and how informed consent and/or assent were obtained |
|  | Measures and materials | |
| 14 | Measures | Operationally define all target behaviors and outcome measures, describe reliability and validity, state how they were selected, and how and when they were measured |
| 15 | Equipment | Clearly describe any equipment and/or materials (e.g., technological aids, biofeedback, computer programs, intervention manuals or other material resources) used to measure target behavior/s and other outcome/s or deliver the interventions |
|  | Interventions |  |
| 16 | Intervention | Describe the intervention and control condition in each phase, including how and when they were actually administered, with as much detail as possible to facilitate attempts at replication |
| 17 | Procedural fidelity | Describe how procedural fidelity was evaluated in each phase |
|  | Analysis |  |
| 18 | Analyses | Describe and justify all methods used to analyze data |
| Results | | |
| 19 | Sequence completed | For each participant, report the sequence actually completed, including the number of trials for each session for each case. For participant/s who did not complete, state when they stopped and the reasons |
| 20 | Outcomes and estimation | For each participant, report results, including raw data, for each target behavior and other outcome/s |
| 21 | Adverse events | State whether or not any adverse events occurred for any participant and the phase in which they occurred |
| Discussion | | |
| 22 | Interpretation | Summarize findings and interpret the results in the context of current evidence |
| 23 | Limitations | Discuss limitations, addressing sources of potential bias and imprecision |
| 24 | Applicability | Discuss applicability and implications of the study findings |
| Documentation | | |
| 25 | Protocol | If available, state where a study protocol can be accessed |
| 26 | Funding | Identify source/s of funding and other support; describe the role of funders |

**Appendix E: Downs and Black (1998) Results**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | |  | | | | | | | | | |  | |  |
| Downs and Black criteria number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 9 | 10 | 11 | 12 | 13 | 16 | 17 | 18 | | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | Total |
| Caspar et al. (2005) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 18 |
| Chu & Kendall (2009) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 17 |
| Connolly Gibbons et al. (2003) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 14 |
| Elkin et al. (2014) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 19 |
| Hardy et al. (1998) | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 17 |
| Owen & Hilsenroth (2014) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 17 |
| Richards et al. (2013) | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 18 |
| Russell et al. (2008) | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 14 |
| Stiles & Shapiro (1994) | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 14 |
| Key: 0 = no; 1 = yes (except criteria 5 where 0 = no; 1 = partially; 2 = yes) | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Appendix F: CASP Qualitative Results**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **CASP criteria no.** | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |  |  |  |  |  |  |  |  |  |  |  |  | | Linna (2004): study 2 |  | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | | Linna (2004): study 3. |  | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | | Shapiro et al. (1999) |  | Y | Y | Y | Y | Y | Y | N | Y | Y | Y |   Key: Y = met criterion; NC = not clear; N = did not meet criterion. |  |  |  |  |  |  |  |  |  |

**Appendix G: CASP Systematic review results**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CASP criteria no.** | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Constantino et al. (2013) |  | Y | Y | NC | NC | Y | Y | Y | Y | Y | N/A |  |
| Edwards (2013) |  | Y | Y | NC | NC | Y | Y | Y | Y | Y | N/A |  |
| Hatcher (2015) |  | Y | Y | NC | NC | Y | Y | Y | Y | Y | N/A |  |
| Stiles et al. (1998) |  | Y | Y | NC | NC | Y | Y | Y | Y | Y | N/A |  |
| Kramer & Stiles (2015) |  | Y | Y | Y | NC | Y | Y | Y | Y | Y | N/A |  |

Key: Y = met criterion; NC = not clear; N = did not meet criterion, N/A= not applicable

**Appendix H: SCRIBE checklist results**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SCRIBE 2016 criteria. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| Bugatti & Boswell (2016) | Y | Y | Y | Y | Y | Y | N | N | N | N | Y | Y | N | Y | Y | Y | Y | N | Y | N | Y | Y | N | Y | N | N |
| Edwards (2010) | Y | N | Y | Y | N | Y | Y | N | N | N | Y | Y | N | N | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | N | N |
| Silberschatz & Curtis (1993) | N | Y | Y | Y | Y | N | N | N | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y |
| van der Linde & Edwards (2013) | Y | Y | Y | Y | Y | Y | Y | N | N | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | N | N |

Key Y= yes, meets criteria; N = no, does not meet criteria

**Part Two: Research Report**

Therapist responsiveness during the first therapeutic encounter and its impact on levels of engagement and subsequent outcomes

**Abstract**

**Aim**

To test the hypothesis that therapist responsiveness in the first therapeutic encounter increases level of engagement in therapy and leads to a decrease in symptomology.

**Method**

Audio-recordings of therapy sessions (n=40) taken from a comparative psychotherapy trial were coded for level of responsiveness by independent coders using two subscales of the Therapist Responsiveness Scale (TRS). The outcome measures used to assess engagement were unilateral termination, a patient’s decision to end treatment without the agreement of their therapist and a dichotomous measure of length of time in therapy i.e. attended for 10 sessions or less or attended for more than 10 sessions. Anxiety, depression and life adjustment were measured during an initial screening appointment and at the last therapy session attended using psychometric instruments.

**Results**

There was no difference in responsiveness levels between those that chose to unilaterally terminate treatment and those that did not, however, the more responsive a therapist was during the first session on a single item measure of responsiveness the more likely patients were to remain in therapy for longer than 10 sessions. In addition, the more responsive a therapist was during the first encounter, the greater the change in their life adjustment scores over therapy. Therapist responsiveness was not associated with changes in depression and anxiety.

**Conclusion**

A single item responsiveness measure taken from the TRS was found to be predictive of outcome. The more responsive a therapist was the more likely a patient was to engage in therapy over a longer period of time and the level of impairment patients experienced in their everyday life reduced. These findings suggest that the degree of therapist responsiveness during the first therapy session is significant and has an impact upon later outcomes.

**Practitioner points**

* Therapist behaviour during the first therapeutic encounter is important in promoting engagement and maximising outcomes.
* Responsive therapists are attentive to the patient; acknowledge and attempt to understand the patient’s concerns; are clearly interested in and respond to the patient’s communication, both in terms of content and feelings; and are caring, affirming and respectful towards the patient.

**Limitations**

* TRS is a relatively new instrument; further replication is required
* Future research to measure drop out as patient attended 4 sessions or less and to include a direct measure of therapeutic alliance

**Introduction**

The equivalence paradox is the observation that the outcomes of differing psychotherapies appear comparable despite differences in treatment techniques (Hardy, Shapiro, Stiles, & Barkham, 1998). In a conceptual literature review Stiles et al. (1998) suggest that therapist responsiveness may provide a solution to this paradox.

Sándor Ferenczi (1873-1933) first introduced the idea of therapist responsiveness in clinical practice with his use of the relaxation principle (Rachman, 1998). This principle encouraged a relaxation in attitude and technique, rather than encouraging neutrality as was promoted by traditional psychoanalysis. It was described as a function of the therapist which allowed the psychoanalytic experience to be stretched in the direction of the patient’s needs based on his or her capacity to process the emotional and interpersonal demands of the experience. Despite this early recognition; as a field of research, therapist responsiveness is still in its early stages and its importance for clinical practice has been underestimated (Stiles, 2009). There is a lack of consensus regarding research approach and a lack of clear definition regarding what constitutes therapist responsiveness. Indeed, it would appear that a number of terms have been used to refer to the same construct. These terms include the relaxation principle (Rachman, 1998), optimal responsiveness (Bacal & Herzog, 2003), therapist flexibility (Chu & Kendall, 2009) and complementarity (Caspar, Grossman, Unmüssig, & Schramm, 2005). In terms of timeframe there is a continuum of responsiveness ranging from the absence or presence of a therapist online globally across the treatment process (Richards, Timulak, & Hevey, 2013) to within session responsive behaviour studied at 5-minute intervals (Elkin, Falconnier, Smith, Canada, Henderson, Brown, & McKay, 2014). Taking these differences into account, the closest unifying definition of therapist responsiveness is “the observation that clinicians…try to do the right thing at the right time, considering the client, the context and their therapeutic approach” (Kramer & Stiles, 2015, p. 279).

Despite the lack of clarity around the definition of responsiveness a number of research studies have demonstrated its importance for clinical practice. Research in this area is in its early stages and further replication is required to establish reliability, however quantitative research to date estimates that responsivity accounts for between 10- 23% of the variance in therapeutic environment (Connolly Gibbons, Crits-Christoph, Levinson, & Barber, 2003; Owen & Hilsenroth, 2014) and it is reported to aid in building alliance (Russell, Shirk, & Jungbluth, 2008), promote engagement in therapy (Chu & Kendall, 2009), help organise therapeutic skills (van der Linde & Edwards, 2013), have a positive impact on clinical outcomes and appears particularly important for resistant clients (Caspar et al., 2005).

In an attempt to demonstrate the importance of responsivity in building alliance during early therapy sessions, Elkin et al. (2014) developed the Therapist Responsiveness Scale (TRS). In developing the scale, they narrowed the definition of responsiveness to “the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient’s current concerns; is clearly interested in and responding to the patient’s communication, both in terms of content and feelings; and is caring, affirming, and respectful towards the patient” (Elkin et al., 2014, p. 53).

The TRS is composed of 3 parts (Appendix A). Part I measures 11 specific behaviours rated at 5-minute intervals; examples being making eye contact, focuses on and demonstrates an interest in the patient; part II consists of items that are rated globally; examples being compatible level of discourse, respect. Finally, a third section captures the raters’ global impressions of the therapist and patient. Following principal axis factor analysis (PAF); four factors were identified within the measure: attentiveness, early empathic responding, negative therapist behaviour and positive therapeutic atmosphere. The first three factors; attentiveness, early empathic responding and negative therapist behaviour derived from the 5 minute ratings whilst positive therapeutic atmosphere was found to comprise four of the global measures; namely, compatible level of discourse, appropriate level of emotional quality/ intensity, caring/ compassionate and respectful (items 2,3,5,6 of Part II). Separate regression analyses were carried out for each identified factor with a patient reported therapeutic relationship measure (Barrett- Lennard Relationship Inventory; BLRI; Barrett- Lennard, 1986), and whether or not patients had engaged for four or more sessions as dependent variables. A significant predictive effect was found for positive therapeutic atmosphere (p= .025) and a single item global responsiveness rating question (Q10) from the scale (p = .034); with higher scores on the responsiveness measures leading to higher ratings of the alliance. In addition, patients with higher positive therapeutic atmosphere (p= .011; OR= .628) or global responsiveness scores (p= .001; OR= .085) were also less likely to terminate therapy early. The factor related to negative therapist behaviour factor was also significantly related to early termination (p= .010, OR= .001) with higher negativity scores seen in patients who terminated therapy early.

In terms of reliability and validity, positive therapeutic atmosphere had a Cronbach’s α of .737 and was shown to be significantly correlated with the “facilitative conditions” scale taken from the Collaborative Study Psychotherapy Rating Scale (CSPRS) (Hollon et al., 1988). No significant effect was found for the two factors i.e. attentiveness and early empathic responding, relating to specific behaviours measured at 5-minute intervals, leading Elkin et al. (2014) to suggest that it was the global therapeutic atmosphere that was important for patients rather than specific behaviours or responses.

Given the limited evidence to date and need for further replication of existing studies in order to demonstrate the importance of responsiveness for clinical outcomes, the current study aimed to further explore the work by Elkin et al. (2014) and consider within session therapist responsiveness and its implications for outcome and engagement using their definition and the TRS instrument. Given the internal consistency and predictive ability of the positive therapeutic atmosphere factor (PTA) (items 2,3,5,6 of part II) and the single item global responsiveness measure (GM) (item 1, part III) of the TRS, these constructs were used as measures of responsiveness. As the factors related to measuring behaviours at 5 minute intervals were not found to be predictive of outcome; and the nature of the data available i.e. audio rather than video recordings; the original TRS was adapted and part I of the scale was not included in the study (Appendix B).

Whilst Elkin et al. (2014) focused their study on the first two therapy sessions it can be seen how if a patient returns for a second treatment session then a degree of alliance may have already been established. Outcomes from this point may depend more on alliance than responsiveness. Indeed, research exists that suggests that the depth of the patient–therapist connection is largely established early in the first session (Sexton, Littauer, Sexton, & Tømmerås, 2005). Whilst the two concepts are inter-related: and responsiveness may be a precursor to alliance, in order to consider the concept of responsiveness independently, this study focused on the first therapeutic session. Furthermore, whilst Elkin et al. (2014) focused on the therapeutic alliance and level of engagement; this study will introduce outcome measures related to symptomology to explore the idea that responsive therapist behaviour optimises outcomes for patients in addition to increasing level of engagement.

In summary, the three hypotheses of the current study are:

* hypothesis 1, the more responsive a therapist is towards a patient during the first session the less likely it is that the patient will unilaterally terminate treatment;
* hypothesis 2, the more responsive a therapist is towards a patient during the first session, the more likely it is that the patient will remain in therapy for more than 10 sessions; and
* hypothesis 3, the more responsive a therapist is towards a patient during the first session, the lower the patient’s scores on standardised instruments measuring depression, anxiety and social adjustment will be at their final session.

Whilst therapist responsiveness was the main focus of the study, given the novelty of the TRS, some exploration of its psychometric characteristics was also carried out.

**Method**

**The PRaCTICED trial**

This study is based on audio-recordings of therapy sessions taken from the PRaCTICED trial (Saxon et al., 2017). The PRaCTICED trial is a pragmatic non-inferiority randomised controlled trial looking at the clinical and cost-effectiveness of counselling for depression (CfD) versus cognitive behavioural therapy (CBT) for patients in a primary care, Increasing Access to Psychological Therapies (IAPT) service within a Northern urban area meeting a diagnosis of moderate or severe depression. Exclusion criteria include the presence of prior diagnosis of personality disorder, bipolar disorder or schizophrenia. All therapy sessions within the PRaCTICED trial are routinely recorded with consent from patients. The trial is funded by the BACP Research Foundation, has NRES ethics approval (NRES 14/ YH/0001) and local NHS governance approval. The PRaCTICED trial protocol specifies that the use of selected recordings will be made for two main purposes: namely treatment fidelity and process analyses of common factors and therapy- specific mechanisms of change and patient engagement.

**Ethics and Data Protection**

The current study was sponsored by the University of Sheffield and has received approval from the Health and Research Authority (HRA): IRAS project ID 225886; and Sheffield Health and Social Care NHS Trust (SHSC) (Appendix C).

**Participants**

Forty participants were selected by a researcher on the project who was not involved in the rating process. The sample was balanced using the following criteria; treatment type (CfD vs CBT); followed by unilateral termination, i.e. a patient’s decision to stop therapy without agreement with their therapist and then the participants were matched as far as was possible for demographics, severity of symptoms and to give as wide a range of therapists as possible. The uneven number in each treatment group is a result of maintaining the best balance between treatment groups taking into account drop outs.

**Sample Characteristics**

Characteristics of the sample are shown in Table 1. The sample consisted of 40 adult participants aged between 19 and 66. Twenty-one participants received CfD and 19 received CBT. Using unilateral termination as an engagement measure: 21 people completed therapy and 19 dropped out. The majority of the sample were White British (n= 35) and employed (n= 21). Data on marital status was not collected as part of the trial.

To allow for comparison and to make each group as equitable as possible the variables of ethnicity and employment status were made dichotomous. For ethnicity; participants were considered to be either White British (n= 35) or Non-White British (5) and for employment; either in paid employment (n= 21) or not in paid employment (n= 19).

|  |  |  |
| --- | --- | --- |
| **Table 1** |  |  |
| ***Participant demographic and clinical variables*** | | |
|  |  | |
| Variable | *N* | *%* |
| Gender |  |  |
| Female | 22 | 55 |
| Male | 18 | 45 |
| Ethnicity |  |  |
| White British | 35 | 87.5 |
| White - other | 1 | 2.5 |
| Black/ British/ Caribbean | 1 | 2.5 |
| Mixed - White & Afro-Caribbean | 1 | 2.5 |
| Asian/ British/ Pakistani | 1 | 2.5 |
| Not disclosed | 1 | 2.5 |
| Employment |  |  |
| Employed | 21 | 52.5 |
| Sick leave | 5 | 12.5 |
| Unemployed | 3 | 7.5 |
| Student | 1 | 2.5 |
| Homemaker | 4 | 10 |
| Retired | 4 | 10 |
| Not disclosed | 2 | 5 |
| Unilateral termination status |  |  |
| Completer | 21 | 52.5 |
| Dropout | 19 | 47.5 |
| Treatment type |  |  |
| CfD | 21 | 52.5 |
| CBT | 19 | 47.5 |
|  | *M* | *SD* |
| Age | 40.15 | 13.46 |
| Intake severity score (PHQ-9) | 18.88 | 5.01 |
| Number of sessions completed | 10.20 | 5.75 |

**Therapist Characteristics**

In total the number of therapists included in the study was 26; 23 females and 3 males; with a range of 1 to 5 patients per therapist (mean= 1.54; SD = 0.95). Fourteen therapists provided CfD and 12 provided CBT.

**Treatments**

CfD is designed for use within IAPT services for patients experiencing depression. It aims to incorporate person-centred and emotion-focused approaches (Saxon et al., 2017). The curriculum was developed by the British Association for Counselling and Psychotherapy and follows the text by Sanders and Hill (2014). CfD training was provided to all counsellors prior to the commencement of the PRaCTICED trial. The training comprised a five-day taught component with 80 hours supervised practice.

CBT is delivered by high intensity CBT practitioners within high intensity IAPT services and is delivered in accordance with Cognitive behaviour therapy: Basics and beyond (Beck, 1995). CBT therapists were trained in Beckian CBT when they completed their IAPT training. In addition, regular top-up workshops were provided. Treatment fidelity was ensured according to the PRaCTICED trial protocol (Saxon et al., 2017) through rating randomly selected therapy tapes for competence according to a sampling strategy designed to ensure that a representative number of tapes from each therapist, at different stages of therapy were included. As the trial is still in progress the treatment fidelity results are not available.

**Sample size**

The TRS is a new measure and research regarding therapist responsiveness generally is in its infancy, with limited research available. As a result of this, decisions regarding sample size relied upon research considering the rule of thumb regarding regression analyses. Harrell (2001) suggests a minimum ratio of participants to variables of 10:1 whilst Austen and Steverberg (2015) suggest that a ratio as small as 2:1 may be sufficient. The largest number of predictor variables used in the study was 3 (Hypothesis 3) and therefore even taking the larger ratio of 10:1; the sample size of 40 is adequate.

**Selection and training of raters**

Nine candidates with an undergraduate psychology or social science degree responded to an internal University email regarding rater recruitment. Individual interviews were arranged with each candidate. Initial information regarding the study was provided during the interview. The interview focused on candidates demonstrating existing knowledge, skills and experience; understanding the importance of confidentiality and data protection; demonstrating an interest in, and understanding of, clinical research; and outlining their availability to participate fully in the training schedule and coding sessions. Candidates were also asked to watch a short video clip of a therapy session before reflecting upon it, in order to get a sense of their clinical awareness. Following the interview process six raters were selected for the study.

The selected raters were required to read information regarding ethical guidelines and confidentiality (Appendix D) and were supplied with background information regarding the TRS, including the rating scale and the manual associated with its use (Appendix E). The manual provides raters with general instructions, specific guidance related to each subscale and outlines how to rate sessions reliably. Following this acclimatisation, raters were asked to attend an initial half-day training session during which they signed a consent form (see Appendix F) agreed to ethical and confidentiality guidelines and gave a commitment to the study.

During the initial training session raters listened to a 20-minute segment of a psychotherapy session and rated this individually using the TRS before discussing their ratings with the rest of the group to clarify misunderstandings and improve reliability. Once most raters had completed 50% of their coding, specifically 5 sessions, with a minimum requirement of 2; a reliability check was carried out to minimise rater drift. The 2- hour session involved listening to a previously rated therapy session and discussing identified discrepancies between raters with reference to the TRS manual.

The raters rated 10 sessions each and 20 sessions were rated by the author. The author completed a proportion of rating prior to the selection and training of raters to ensure sufficient knowledge of the TRS and to identify any potential difficulties with the rating procedure. Although the raters were trained in the use of the TRS they were not made aware of the specific hypotheses of this study. All raters, including the author, were blind to outcome information and participant identity. In addition, the coders were blind as to whether they were listening to CBT or CfD treatment sessions, although they may have become aware of the different styles of therapy during the coding process.

**Responsiveness scale (TRS)**

The original TRS scale had three components. Part I focused on specific behaviour rated at 5 minute intervals. Part II consisted of items related to therapist and patient behaviour that were rated globally across the entire session and finally, Part III which tapped into the raters’ global impressions of the therapist and patient. Following regression analysis (Elkin et al., 2014) only positive therapeutic atmosphere (Part II, items 2,3,5,6) and a single item rating of global responsiveness (Part III, item 1) alongside negative therapist behaviour were shown to interact significantly with outcome and level of engagement. In the current study only Part II and Part III of the scale were rated.

Responsiveness was measured in two ways: the global measure from the TRS (Part III, item 1), abbreviated to GM, and the concept of positive therapeutic atmosphere (items 2,3,5,6 of part II), abbreviated to PTA. The TRS used in this study is comprised of 14 questions. The relationship between the TRS items not incorporated into the GM and PTA scales, such as level of patient resistance, degree of collaboration, the material presented by the patient and the study outcome measures were explored in order to make decisions with regard to control variables.

**Procedure**

Forty audio recordings were coded independently by two different raters. Raters were requested to avoid successive ratings of the same therapist and not to rate more than two therapy sessions in one sitting. Double ratings were used to calculate inter-rater reliability before averaging the scores across the two ratings to get an individual score for GM and PTA for each session. The recordings were stored on encrypted memory sticks and returned at the end of the rating schedule to the University of Sheffield.

**Outcome measurement**

***Symptomology.*** Symptom reduction was measured using three psychometric measures; the Personal Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) measuring severity of depression (Appendix G), the General Anxiety Scale (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) (Appendix H) and the Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear, & Griest et al., 2002) (Appendix I). The WSAS, unlike the other two measures, focuses less on observable symptoms related to depression and anxiety but focuses on the patient’s experience of these conditions and how they impact on daily functioning.

The PHQ-9 has been shown to have internal reliability (Cronbach’s α= 0.86-0.89) and construct validity (Kroenke et al., 2001). The GAD-7 has also been found to have internal reliability (Cronbach’s α= 0.92) and construct validity (Spitzer et al., 2006) and finally the WSAS has demonstrated internal reliability with a Cronbach’s α ranging from 0.7-0.94 (Mundt et al., 2002).

Scores on the PHQ-9, GAD-7 and the WSAS were taken during an initial screening session and at the last therapeutic session which the patient attended. The wait times between initial screening and first therapy appointment ranged from 4 to 283 days (mean = 73.06; sd = 52.29). Post treatment scores were labelled; PHQ-9 2, GAD-7 2 and WSAS 2.

***Engagement.*** Engagement, as an outcome measure, was measured in two different ways. For hypothesis 1 unilateral termination (DO1); i.e. a patient’s decision to stop therapy without the agreement of the therapist, was used as a dichotomous measure of engagement. Participants were rated 0 or 1 (0= patient terminated treatment; 1= patient completed treatment). For hypothesis 2 engagement was related to length of treatment taken up. The range of sessions patients had was 19, with 1 as the minimum and 20 as the maximum. The mean number was 10.20 (5.75) and therefore the group was split at the half way-point to further examine differences in responsiveness between those that engaged for a longer period and those that attended for fewer sessions. This dichotomy, i.e. those that attended for 10 or fewer sessions (n= 23) and those that attended for more than 10 (n= 17), was used in the analysis; this length of therapy measure was called LOT1. Participants were rated 0 or 1 (0= attended for 10 or less sessions or 1 = attended more than 10 sessions).

**Data Analysis**

***TRS.*** As the therapist responsiveness scale is a relatively new measure a Cronbach’s alpha test was run for the positive therapeutic atmosphere scale, PTA, in order to get some indication of internal consistency. In order to get some indication of the reliability of the single item GM scale a bivariate correlation was carried out looking at the relationship between GM and PTA.

Following this, analysis of the TRS focused upon exploring the relationship between demographic variables, pre-treatment severity, treatment type and the level of responsiveness measured using bivariate correlations for continuous variables and independent sample t-tests for categorical variables.

***TRS questions not incorporated into the global measure (GM) and positive therapeutic atmosphere (PTA).*** The following questions were rated but were not incorporated into the GM and PTA scales: therapist responds proportionately to expressed feelings (Q1), therapist is collaborative (Q7), presentation of material by patient (Q8), patient resistance (Q9), patients’ perception of responsiveness as measured by the rater (Q11), global impression of therapist (Q12), raters’ liking of therapist (Q13) and patient difficulty (Q14).

In order to make decisions with regard to which of these questions needed to be controlled for in subsequent analysis; bivariate correlations were carried out between the questions and the continuous outcome measures; PHQ 2, GAD-7 2 and WSAS 2 and multi-dimensional chi-square tests were carried out for the categorical outcome measures DO1 and LOT1 and the unincorporated questions.

***For hypothesis 1: The more responsive a therapist is towards a patient during the first session the less likely a patient will unilaterally terminate treatment (DO1).*** In order to make decisions with regard to potential control variables; independent sample t-tests were carried out for the continuous variables of age and pre-treatment severity with DO1 as the grouping variable. To test for any relationship between DO1 and the categorical variables of treatment type, gender, ethnicity and employment status a multi-dimensional chi-square test was performed. Following this two separate sets of independent sample t-tests were performed to identify significant group differences between mean responsiveness levels, as measured by GM and PTA, of those that unilaterally terminated treatment and those that did not.

***For hypothesis 2: The more responsive a therapist is towards a patient during the first session the more likely they are to remain in therapy for longer than 10 sessions.*** As in the first hypothesis potential control variables were considered: independent sample t-tests were carried out for the continuous variables with LOT1 as the grouping variable and multi- dimensional chi-square tests were performed for categorical variables. Following this; independent sample t-tests were performed to consider group differences in terms of responsiveness levels as measured by GM and PTA. In order to explore the predictive ability of GM on length of time in treatment (LOT1) a binary logistic regression was performed.

***For hypothesis 3: The more responsive a therapist is during the first encounter the lower patients’ severity as measured by PHQ-9, GAD-7 and WSAS at their final session.*** In order to explore any significant relationships between the symptom related outcome measures and the independent variables, GM and PTA; scatter plots were examined and bivariate correlational analyses were performed. Following this a linear regression analysis was performed to consider whether responsiveness (GM) could predict outcomes linked to impairment in work and social functioning as measured by the WSAS. To make decisions regarding which variables needed to be controlled for in the model, independent sample t- tests were carried out for the categorical variables of treatment type, gender, ethnicity and employment status considering any differences between groups regarding WSAS 2 scores. A bivariate correlational analysis was used to explore relationships between the continuous variable of age and WSAS 2 score.

**Results**

**Agreement between raters**

A weighted kappa statistic was used to test for inter-rater reliability. This statistic was chosen to increase the number of measurements which could be compared for each rating pair and therefore increase reliability. The weighted analysis allowed both GM and PTA to be considered within the same calculation.

**Table 2**

***Inter-rater reliability between coders using weighted kappa (Kw)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Coder pair | Number of sessions rated | Kw | p value | Confidence intervals |
| 2&3 | 6 | 0.58 | .001 | 0.423-0.729 |
| 1&5 | 6 | 0.84 | ≤.001 | 0.773-0.909 |
| 4&6 | 5 | 0.73 | .004 | 0.553-0.902 |
| 6&7 | 4 | 0.80 | .003 | 0.715-0.885 |
| 3&7 | 4 | 0.65 | .012 | 0.516-0.785 |
| 1&7 | 4 | 0.79 | .002 | 0.606-0.971 |
| 5&7 | 3 | 0.80 | .013 | 0.695-0.908 |
| 2&4 | 2 | 0.64 | .046 | -0.410-0.863 |
| 4&7 | 2 | 0.91 | .046 | 0.816-0.994 |
| 2&7 | 2 | 0.84 | .038 | 0.669-1.02 |
| 3&4 | 1 | 0.91 | .157 | 0.795-1.02 |
| 5&6 | 1 | 0.77 | .157 | 0.687- 0.851 |

All coding pairs, with the exception of pair 2 & 3, achieved a kappa statistic level of moderate or strong as defined by McHugh (2012) (see Table 2). For coding pair 2 & 3 the level of agreement was weaker and fell just below the moderate cut off point of 0.60. The non-significant p value for coders 3 & 4 and 5 & 6 is a consequence of the low number of sessions rated as a pair. These inter-rater reliabilities are consistent with those achieved by Elkin et al. (2014) which ranged from 0.67 to 0.74.

**Responsiveness scale**

The internal consistency of the scale PTA was found to be acceptable; α = .720 and this is consistent with that of Elkin et al. (2014); α = .897. A significant correlation between GM and PTA was found; r (38) = .400, p = .011, suggesting GM is also a reliable measure of responsiveness.

No significant correlations were found between GM and PTA and the continuous variables of age and pre-treatment severity; correlations ranged from 0.031 to 0.212; p values ranged from .189 to .847.

No significant differences were found between the categorical variables of treatment type, gender, ethnicity and employment status and levels of responsiveness as measured by GM and PTA; p values ranged from .411 to .982.

These results suggest that the TRS has internal consistency and that during the first session the level of responsiveness measured was not related to patients’ age, gender, ethnic origin, employment status or pre- treatment severity. There was also no difference in levels of responsiveness between the two treatments (CBT vs CfD); for GM; t (38) = 0.61, p = .657, and for PTA t (38) = -0.83, p = .793.

**TRS questions not incorporated into GM and PTA**

With the exception of Q1, none of the other TRS questions were found to be significantly correlated with post treatment scores on the WSAS, GAD-7 and PHQ-9; p values ranged from .89 to .977. Question 1, i.e. therapist responds to feelings in the context of how much feeling the patient expresses, was significantly related to all 3 symptom related outcome measures: PHQ- 9 2 (r= -0.335; p = .037); GAD-7 2 (r= -0.318; p= .049) and WSAS 2 (r= -0.446; p = .004).

However, despite the significant relationship between Q1 and outcome, a decision was taken not to control for Q1 in subsequent analysis as it was found to be significantly correlated with both GM (r= .755; p ≤ .001) and PTA (r= .371; p = .019) and was therefore, thought to be measuring similar constructs. All three factors related to responding to feelings within context.

Multi- dimensional chi-square tests were carried out to consider relationships between each of the questions and the categorical outcome variables DO1 and LOT1. None of the questions were significantly related to outcome; for DO1, p values ranged from .158 to .984 and for LOT1; p values ranged from .122 to .502.

It is worthy of note that unlike Elkin et al. (2014) no significant relationships were found between patient resistance (Q9) and any of the continuous (p values ranged from .247 to .331) or categorical outcome variables (p values ranged from .379 to .685). This is probably due to the lack of variation in resistant ratings. On a scale of 0-4; where 0 represents a patient that never exhibits resistant or hostile behaviour and 4 represents a patient who exhibits a great deal: the range was 1.5. Thirty-eight of the 40 participants received a rating of 1 or below.

**Descriptive Statistics**

Post treatment outcome data related to symptomology (PHQ-9, GAD-7, WSAS) was missing for one participant. As a result, pre and post symptom analysis was based on 20 CfD and 19 CBT cases. This missing data explains the difference in mean pre-treatment PHQ-9 scores given in tables 1 and 3.

When both treatments were considered together, paired sample t-tests showed that statistically significant reductions were seen on all measures. Further to this, when treatment groups were considered separately; for both CBT and CfD pre and post reductions were significant on all outcome measures (Table 3).

**Table 3**

***Pre and post scores for PHQ-9, GAD-7, WSAS overall and* for each treatment condition**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Measure | Pre-treatment M (SD) overall | Post-treatment M (SD) overall | *t(*38*)* | P | Pre-treatment M (SD) for CBT | Post-treatment M (SD) for CBT | *t(*18*)* | *p* | Pre-treatment M (SD) for CfD | Post-treatment M (SD) for CfD | *t(*19*)* | *p* |
| PHQ-9 | 18.77 (5.03) | 11.64 (6.89) | 5.90 | ≤.001 | 17.94 (5.47) | 10.11 (7.07) | 3.82 | .001 | 19.71 (4.53) | 13.10 (6.56) | 4.66 | ≤.001 |
| GAD-7 | 13.59 (4.68) | 8.54 (5.60) | 6.40 | ≤.001 | 12.26 (4.76) | 6.95 (5.43) | 4.59 | ≤.001 | 15.00 (4.30) | 5.43 (1.21) | 4.30 | ≤.001 |
| WSAS | 26.35 (7.61) | 16.13 (9.15) | 7.72 | ≤.001 | 24.89 (6.14) | 13.68 (8.30) | 7.27 | ≤.001 | 27.43 (8.62) | 9.52 (9.52) | 4.33 | ≤.001 |

**Hypothesis 1: The more responsive a therapist is towards a patient during the first session the less likely a patient will unilaterally terminate treatment.**

In order to make decisions regarding which variables to control for in subsequent analysis; independent sample t-tests were carried out for the continuous variables of age and pre-treatment severity with DO1 as the grouping variable. No significant differences were found, p values ranged from .101 to .431. To test for any relationship between DO1 and the categorical variables of treatment type, gender, ethnicity and employment status a multi-dimensional chi-square test was performed. No significant differences were found; p values ranged from .131 to .832. As a result of this no variables were controlled for in the subsequent analysis.

Responsiveness levels were slightly higher for those that completed therapy than those that did not (Table 4), however this difference did not reach statistical significance: For GM, t (38) = -0.825, p = .415 and for PTA, t (38) = -0.33, p = .741.

**Table 4**

***Means of responsiveness levels in those who did and did not complete therapy***

|  |  |  |
| --- | --- | --- |
| Responsiveness scale | M (SD) for patients who dropped out | M (SD) for patients who completed therapy |
| GM | 2.75 (0.83) | 2.95 (0.56) |
| PTA | 12.61 (1.81) | 12.80 (1.68) |

**Therefore, the first hypothesis was not met, i.e. level of responsiveness was not related to whether or not patients unilaterally terminated treatment.**

**Hypothesis 2: The more responsive a therapist is towards a patient during the first session the more likely they are to remain in therapy for longer than 10 sessions (LOT1).**

To make decisions with regard to control variables, independent sample t-tests were carried out for the continuous variables of age and pre-treatment severity with LOT1 as the grouping variable. No significant differences were found, p values ranged from .099 to .941. To test for any relationship between LOT1 and the categorical variables of treatment type, gender, ethnicity and employment status a multi-dimensional chi-square test was performed. No significant differences were found; p values ranged from .218 to .884. As a result, no control variables were included in the analysis.

With regard to responsiveness levels and length of treatment; independent t-tests found that there were no significant differences between PTA and those that completed less or more than 10 sessions, t (38) = 0.86, p = .398: however, there were significant differences regarding the GM scale, t (38) = -2.21, p = .033. The mean responsiveness level for those that completed 10 or less sessions was 2.65 (sd = 0.71) and for those that completed more than 10 sessions this figure was 3.12 (sd = 0.57).

To further explore the relationship between GM and LOT1 a binary logistic regression analysis was carried out. Results suggest that GM is a predictor of length of therapy; W² = 4.093, df = 1, p = .043. The amount of variance in whether people stay in therapy longer explained by responsiveness was 15.5%. The odds of people being in more than 10 sessions related to responsiveness was 3.176 Exp(b) and was correctly predicted 67.5% of the time. This suggests that for each unit increase in GM the probability of remaining in therapy for more than 10 sessions is higher by a factor of 3.176 (1.037- 9.726 at 95% Confidence Interval; CI).

**From the above findings there is some support for the second hypothesis, i.e. as measured by GM, the more responsive a therapist is towards a patient during the first session the more likely they are to remain in therapy for longer than 10 sessions. No significant results were found for PTA.**

**Hypothesis 3: The more responsive a therapist is during the first encounter the lower patients’ severity as measured by PHQ-9, GAD-7 and WSAS at their final session.**

Following scatter plot examination, bivariate correlations were carried out to examine any significant relationships that existed between the outcome measures (PHQ-9 2, GAD-7 2 and WSAS 2) and the continuous independent variables of GM and PTA. No significant associations were found for PTA with any of the outcome measures or GM and PHQ-9 2 and GAD-7 2. A weak, negative, statistically significant correlation was found for GM and WSAS 2: r= -0.288, n= 39, p=.038, one-tailed.

Linear regression analysis was performed to consider whether responsiveness (GM) could predict outcomes linked to impairment in work and social functioning as measured by the WSAS. To make decisions regarding which variables needed to be controlled for in the model, independent sample t- tests were carried out for the categorical variables of treatment type, gender, ethnicity and employment status considering any differences between groups regarding WSAS 2 scores. No significant differences were found for treatment type, ethnicity or sex with p values ranging from .083 to .980. Significant relationships were found between employment status and post treatment severity with those not in paid employment experiencing higher impairment in functioning, t (37) = -2.216, p = .033, as measured by the WSAS and so employment status was controlled for in the regression.

Bivariate correlations found no significant relationship between the continuous variable of age and post treatment severity as measured by the WSAS 2, p = .649. Significant correlations existed for pre and post WSAS scores (r = 0.526, p= .001). As a result of this; pre-treatment severity as measured by WSAS was controlled for in the model. In summary, pre-treatment severity and employment status were included in the model. The assumptions of sufficient sample size, normality, homoscedasticity, linear relationships and multi-collinearity were all met (Appendix J).

The regression model was significant, F(3,35) = 9.237; p= ≤ .001. Together the independent variables explained 44.2% of the variance in outcome (R² = 0.442). Both pre- treatment WSAS score (p = ≤.001) and responsiveness (GM) (p = .011) were significant predictors of outcome. Employment status was not found to be a significant predictor. Standardized Beta co-efficients suggest that the biggest predictor of outcome is pre-treatment WSAS score (standardized beta co-efficient = 0.502) followed by therapist responsiveness (-0.340). The negative standardized beta- coefficient value for responsiveness indicates the more responsive the therapist, the lower the score on the WSAS 2 scale indicating less impairment. For every unit of increase in responsiveness the WSAS score would be predicted to decrease by 0.34 (-7.90 to -1.087 at 95% C.I).

**Hypothesis 3 was therefore partly met; the more responsive a therapist is during the first encounter the lower patients’ severity as measured by the WSAS at their final session. No significant results were found for the PHQ-9 or GAD-7.**

**Discussion**

The aim of the current study was to test the hypothesis that therapist responsiveness in the first therapeutic encounter increased level of engagement in therapy and led to a decrease in symptomology. Findings suggested that the hypothesis was partially met. There was some support that the length of time patients spent in therapy was related to degree of therapist responsivity and that level of patient impairment was decreased in relation to degree of responsivity within the therapeutic relationship as measured by the WSAS. No significant effects for responsiveness were found with regard to unilateral termination, i.e. a patient’s decision to stop therapy without agreement with their therapist or levels of depression or anxiety, as measured by the PHQ-9 and GAD-7.

For hypothesis 1, responsivity did not have a significant impact on whether a patient chose to terminate treatment without the agreement of their therapist. Whilst t-tests revealed that there was a slightly higher responsiveness level for those that did not terminate when compared to those that did; this did not reach statistically significant levels. These findings contrast with those of Elkin et al. (2014) who found that early termination was the most predictable of the engagement variables. It is possible that these differences in results are related to the way in which early termination was measured. In the Elkin et al. (2014) study early termination was thought to have taken place if a patient attended for 4 or fewer sessions. In the current study patients attended for significantly more sessions than this but were still classed as terminating treatment if this was done without the agreement of their therapist. In the current study, for example, only 4 of the 19 patients classed as terminating treatment attended for 4 or less therapy sessions. The remaining 15 patients attended between 5 and 18 sessions before terminating. It can be seen how patients who attended for 18 weekly sessions may have had a very responsive therapist during initial therapy sessions but given the lengthy timeframe involved other factors may have become more significant in their decision to stop treatment. From this point of view, it would appear that the dropout measure used by Elkin et al. (2014) is a more appropriate measure to use when judging likelihood of treatment drop out and responsiveness in the early stages of therapy and it is recommended that future research use this potentially more sensitive measure.

The second hypothesis which focuses on length of time in treatment, rather than dropout, supports the hypothesis that the more responsive a therapist is towards a patient during the first session the more likely they are to remain in therapy for longer than 10 sessions. This adds weight to existing research around the importance of therapist behaviour during initial therapy sessions. It has been found, for example, that the depth of the client–therapist connection is largely established early in the first session and that this connection is more likely to decrease when therapists are less engaged, when therapist utterances are devoid of emotional content, and when they are providing general information or advice (Sexton, et al., 2005). Further to this, Elkin et al. (2014) discuss how the behaviour of the therapist in the initial encounters with the patient has an effect on whether or not the patient feels positive about and becomes involved in the therapeutic relationship and makes decisions with regard to staying in therapy. Chu and Kendall (2009) in their research with young people experiencing anxiety also found that therapist responsivity during initial therapy sessions related to later engagement in therapy.

With regard to the third hypothesis which considered the possibility that responsive therapist behaviour optimised outcomes for patients, there was some support for this. Whilst responsivity did not appear to have any effect on measures directly related to symptoms of depression and anxiety it would appear to have had a beneficial effect upon the way people were experiencing these conditions. The WSAS focuses on ability to work, home management, leisure activities and relationships. It is possible that responsive therapist behaviour promoted or enhanced the degree of therapeutic alliance which in turn led to patients feeling more positive about their wider social networks and relationships. Unlike Elkin et al. (2014) the current study did not include degree of alliance as an outcome measure. Improvements on the WSAS and their possible link to the therapeutic alliance suggest that future research in this area should include a measure of alliance, which may strengthen findings with regard to the significance of responsivity. In terms of the mechanism of change; research which focuses solely upon the relationship component of the WSAS rather than the global measure or considers each of the 5 components separately may shed further light on this; as would qualitative research focusing on how degree of responsivity impacts upon the experience of therapy and subsequent improvement in functioning.

With regard to the TRS and individual responsiveness measures; Elkin et al. (2014) found that both GM; the single item global responsiveness measure and PTA, the positive therapeutic atmosphere were significantly related to degree of alliance and of patients remaining in therapy for more than four sessions. The current study found predictive ability for the single item measure, GM, with regard to length of engagement and improvement in functioning; however, did not establish a relationship between PTA and any of the outcome measures. It is unclear why this was the case and further replication using the two measures would be beneficial, however it may relate to the outcome measures used. As mentioned previously, the current study did not consider responsiveness and therapeutic alliance and used unilateral termination rather than drop out following 4 or less sessions. Positive therapeutic atmosphere or PTA may have been predictive had different outcome measures been included in the study.

Whilst therapist responsiveness was the main focus of the study, given the novelty of the TRS, some exploration of its psychometric characteristics was also carried out. The positive therapeutic atmosphere (PTA) scale demonstrated internal consistency and there was a significant relationship between the two responsiveness measures; GM and PTA, which is suggestive of a degree of reliability. The fact that the TRS demonstrated a level of reliability and that GM in the current study was predictive of outcome suggests that it is possible to assess responsivity using observer ratings. This is a promising development given the difficulties with regard to demonstrating the significance of responsiveness for therapy outcomes i.e. the responsiveness problem (Kramer & Stiles, 2015) although further replication of measurement using the TRS is required.

**Limitations**

In terms of limitations of the study whilst the sample size of 40 was considered adequate for the analysis, increasing the number of participants would add statistical power and weight to the findings. Elkin et al. (2014), for example included 72 participants. In addition to this, the sample was largely of white British origin and the majority of therapists were female. Increasing diversity with regard to this would improve the ability to generalise findings to the wider population.

Whilst the single item measure, GM was able to predict outcomes within the study, confidence in the measure would be increased if a multi-item measure of this variable was available so that internal consistency and reliability could be calculated. It should also be acknowledged that the TRS is a relatively new measure and further exploration with regard to reliability and validity more generally is also indicated.

The current study was the first to focus on responsiveness, as measured by the TRS, during the initial therapy session. This was done to ensure that responsiveness was considered independently from alliance, however as a result of focusing on the first session it is possible that the degree of responsivity and therapist behaviours observed were limited. A significant amount of time is spent during the initial session framing therapy, explaining the process and contracting with the patient which reduces the amount of observable data or therapy time.

**Conclusion**

In summary the current findings suggest that it is possible to assess responsivity using observer ratings. This is significant given the responsiveness problem and the difficulties highlighted by Kramer and Stiles (2015) with regard to demonstrating the importance of responsivity in therapy. The responsiveness measure called positive therapeutic atmosphere factor or PTA; relating to therapist behaviours such as care, compassion, respect and attunement was not found to be predictive of outcome. This is in contrast to the original research on the TRS (Elkin et al., 2014) and it is suggested that this may be a result of the outcome measures used in the current study.

In contrast to this GM, a single item responsiveness measure related to the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient’s concerns, is clearly interested in and responding to the patient’s communication, both in terms of content and feelings; and is caring, affirming and respectful towards the patient; was found to be predictive of outcome. Using this measure, the more responsive a therapist was the more likely a patient was to engage in therapy over a longer period of time and the level of impairment patients experienced in their everyday life reduced. These findings suggest that the degree of therapist responsiveness during the first therapy session is significant and has an impact upon later outcomes.

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**Appendix A: Responsiveness Rating Scale (Elkin et al., 2014)**

**Part I- Therapist and Patient Behaviour**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Therapist** |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1. | Eye contact |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. | Minimum encouragers |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. | Focuses on/ demonstrates interest in patient |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. | Effort to understand |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. | On Topic |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. | Expressed feelings |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. | Inferences regarding unexpressed content or feelings |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. | Affirming, validating, normalizing |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. | Disrupts the flow of session |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. | Lectures |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. | Critical, judgmental, countering patient or minimizing or invalidating feelings |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. | Patient expresses feelings |  |  |  |  |  |  |  |  |  |  |  |  |

**(1= low; 12 = high)**

**Part II- End of Session Global Ratings of Therapist and Patient Behaviour**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Therapist | Global Ratings (End of Session) | 0 | 1 | 2 | 3 | 4 |
| 1 | Responds to feelings in the context of how much feeling the patient expresses |  |  |  |  |  |
| 2 | Compatible level of disclosure |  |  |  |  |  |
| 3 | Appropriate level of emotional quality/ intensity |  |  |  |  |  |
| 4 | Responds to pattern(s) of content and/ or feelings |  |  |  |  |  |
| 5 | Caring/ compassionate |  |  |  |  |  |
| 6 | Respectful |  |  |  |  |  |
| 7 | Collaborative |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Patient | Global Ratings (End of Session) | 0 | 1 | 2 | 3 | 4 |
| 8 | Patient presents material from which one can detect pattern of content and/or feelings |  |  |  |  |  |
| 9 | Exhibits resistant and/or hostile behaviour |  |  |  |  |  |

**(0= low; 4= high)**

**Part III- Rater’s general impressions of therapist and patient**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Overall rating of therapist responsiveness | 0 | 1 | 2 | 3 | 4 |
| 1 | Global rating of therapist responsiveness |  |  |  |  |  |
| 2 | Estimate of patient’s perception of therapist responsiveness |  |  |  |  |  |
| 3 | Global impression of therapist/ Would you refer a friend? |  |  |  |  |  |
| 4 | How much do you like this therapist? |  |  |  |  |  |
|  | **(0 = low; 4= high)** |  |  |  |  |  |
|  | Overall rating of Patient | 0 | 1 | 2 | 3 | 4 |
| 5 | How difficult do you think this patient is to treat effectively? |  |  |  |  |  |

**(0= not at all; 4= very difficult)**

**Appendix B: Adapted TRS**

**Scoring sheet for responsiveness rating scale**

**Please refer to training manual before and during completion**

**Rater initials: Date of rating:**

**Session ID:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Therapist | Global Ratings (End of Session) | 0 | 1 | 2 | 3 | 4 |
| 1 | Responds to feelings in the context of how much feeling the patient expresses |  |  |  |  |  |
| 2 | Compatible level of discourse |  |  |  |  |  |
| 3 | Appropriate level of emotional quality/ intensity |  |  |  |  |  |
| 4 | Responds to pattern(s) of content and/ or feelings |  |  |  |  |  |
| 5 | Caring/ compassionate |  |  |  |  |  |
| 6 | Respectful |  |  |  |  |  |
| 7 | Collaborative |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Patient | Global Ratings (End of Session) | 0 | 1 | 2 | 3 | 4 |
| 8 | Patient presents material from which one can detect pattern of content and/or feelings |  |  |  |  |  |
| 9 | Exhibits resistant and/or hostile behaviour |  |  |  |  |  |

**(0= low; 4= high)**

**Adapted TRS continued…**

**Part III- Rater’s general impressions of therapist and patient**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Overall rating of therapist responsiveness | 0 | 1 | 2 | 3 | 4 |
| 1 | Global rating of therapist responsiveness |  |  |  |  |  |
| 2 | Estimate of patient’s perception of therapist responsiveness |  |  |  |  |  |
| 3 | Global impression of therapist/ Would you refer a friend? |  |  |  |  |  |
| 4 | How much do you like this therapist? |  |  |  |  |  |
| **(0= low; 4= high)** | |  |  |  |  |  |
|  | Overall rating of Patient | 0 | 1 | 2 | 3 | 4 |
| 5 | How difficult do you think this patient is to treat effectively? |  |  |  |  |  |

**(0= not at all; 4= very difficult)**

**Appendix C Ethical approval**

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

|  |  |
| --- | --- |
| Mrs Katherine M Crosby Trainee Clinical Psychologist  Sheffield Health and Social Care NHS Foundation Trust Dept of Psychology, Cathedral Court,  Floor F, 1, Vicar Lane Sheffield  S1 1HD |  |

|  |  |
| --- | --- |
| **Study title:** | **Therapist responsiveness in psychotherapy: a quantitative**  **study.** |
| **IRAS project ID:** | **225886** |
| **Protocol number:** | **URMS 151603** |
| **Sponsor:** | **University of Sheffield** |

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

## Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

* *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
* *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
* *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) -* this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

**Ethical approval continued…**

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from [www.hra.nhs.uk/hra-approval.](http://www.hra.nhs.uk/hra-approval)

## Appendices

The HRA Approval letter contains the following appendices:

* A – List of documents reviewed during HRA assessment
* B – Summary of HRA assessment

## After HRA Approval

The attached document *“After HRA Approval – guidance for sponsors and investigators”* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

* Working with organisations hosting the research
* Registration of Research
* Notifying amendments
* Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

## Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

## User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

**Ethical approval continued…**

## HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **225886**. Please quote this on all correspondence

Yours sincerely,

Steph Blacklock, Senior Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

|  |  |
| --- | --- |
| *Copy to:* | *Mr Amrit Sinha*  *Dr Nick Bell, Sheffield Health and Social Care NHS Trust* |

**Ethical approval continued…**

## Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Confirmation of any other Regulatory Approvals (e.g. NIGB) and all correspondence [URMS scientific approval letter] | 1.0 | 13 February 2017 |
| IRAS Application Form [IRAS\_Form\_14032017] |  | 14 March 2017 |
| Research protocol or project proposal [Protocol 3.0 Therapist responsiveness in psychotherapy: a quantitative study] | 3.0 | 09 March 2017 |
| Summary CV for Chief Investigator (CI) [Katherine Crosby Research CV] | 1.0 | 09 March 2017 |
| Summary CV for supervisor (student research) [Research CV Gillian Hardy] | 1.0 | 08 March 2017 |

**Ethical approval continued…**

## Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations*, *capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.**

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Mr Amrit Sinha

Email: [a.sinha@sheffield.ac.uk](mailto:a.sinha@sheffield.ac.uk)

# Ethical approval continued…

# HRA assessment criteria

|  |  |  |  |
| --- | --- | --- | --- |
| **Section** | **HRA Assessment Criteria** | **Compliant with Standards** | **Comments** |
| 1.1 | IRAS application completed correctly | Yes | Applicant has clarified that filter question 4b should have been ticked as ‘previously collected, non-identifiable information’. |
|  |  |  |  |
| 2.1 | Participant information/consent documents and consent process | Not Applicable | Not Applicable |
|  |  |  |  |
| 3.1 | Protocol assessment | Yes | No comments |
|  |  |  |  |
| 4.1 | Allocation of responsibilities and rights are agreed and documented | Not Applicable | Not Applicable |
| 4.2 | Insurance/indemnity arrangements assessed | Yes | Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the  activities expected of them for this research study |
| 4.3 | Financial arrangements assessed | Yes | There is no external funding acquired for this study. |

# Ethical approval continued…

|  |  |  |  |
| --- | --- | --- | --- |
| **Section** | **HRA Assessment Criteria** | **Compliant with Standards** | **Comments** |
| 5.1 | Compliance with the Data Protection Act and data security issues assessed | Not Applicable | Limited to anonymised data only. |
| 5.2 | CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed | Not Applicable | No comments |
| 5.3 | Compliance with any applicable laws or regulations | Yes | No comments |
|  |  |  |  |
| 6.1 | NHS Research Ethics Committee favourable opinion received for applicable studies | Not Applicable | No comments |
| 6.2 | CTIMPS – Clinical Trials Authorisation (CTA) letter received | Not Applicable | No comments |
| 6.3 | Devices – MHRA notice of no objection received | Not Applicable | No comments |
| 6.4 | Other regulatory approvals and authorisations received | Not Applicable | No comments |

**Participating NHS Organisations in England**

|  |
| --- |
| *This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.* |
| Study documents will not be shared with participating NHS organisations in England because formal confirmation of capacity and capability is not required. No specific arrangements are expected to be put in place at each organisation to deliver the study.  If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approvalprogramme@nhs.net). The HRA will work with these organisations to achieve a consistent approach  to information provision. |

**Ethical approval continued…**

**Confirmation of Capacity and Capability**

|  |
| --- |
| *This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.* |
| The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research.**   * The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary. * Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than **09th May 2017):**   + You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate   + You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed.. * You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed. * The document “[Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected](http://www.hra.nhs.uk/about-the-hra/our-plans-and-projects/assessment-approval/#Resources)” provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expectations, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix. |

**Principal Investigator Suitability**

|  |
| --- |
| *This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and*  *experience that PIs should meet (where applicable).* |
| HRA would expect a central study coordinator.  GCP training is not a generic training expectation, in line with the [HRA statement on training](http://www.hra.nhs.uk/resources/before-you-apply/roles-and-responsibilties/researcher-suitability-and-training/) [expectations](http://www.hra.nhs.uk/resources/before-you-apply/roles-and-responsibilties/researcher-suitability-and-training/). |

**Ethical approval continued…**

**HR Good Practice Resource Pack Expectations**

|  |
| --- |
| *This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken* |
| It is unlikely that letters of access or honorary research contracts will be applicable, except where local staff employed by another Trust (or University) are involved (and then it is likely that arrangements are already in place). Where arrangements are not already in place, staff undertaking any of the research activities listed in A18 or A19 of the IRAS form, would be expected to obtain a |

Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

**Other Information to Aid Study Set-up**

|  |
| --- |
| *This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.* |
| * The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. |

**Ethical approval continued…**

Tel: 0114 2718804

Fax: 0114 2716736

E-mail: [rdu@shsc.nhs.uk](mailto:rdu@shsc.nhs.uk)

[www.shsc.nhs.uk](http://www.shsc.nhs.uk/)

# R&D Reference: 225886 *(*please quote this number on all correspondence)

21/04/2017

Dear Mrs Crosby

**Re: *Therapist responsiveness in psychotherapy: a quantitative study.***

# Sponsor: University of Sheffield Funder: n/a

**HRA Ref: 225886**

The Research Development Unit at Sheffield Health and Social Care NHS Foundation Trust are writing to acknowledge that we have been notified of this study and have no objections to the organisation’s participation.

We understand that the HRA has determined that participating NHS organisations in England do not need to formally confirm their capacity and capability to undertake their role in this research. We are issuing this letter on the information provided by HRA approval letter (dated 04/04/2017), with no review of study documents on the assurance provided by HRA Approval.

*No further authorisation is required from this Trust unless study amendments change the activities being undertaken or study management / oversight .*

Please note :

* you must ensure that all study personnel, not employed by Sheffield Health and Social Care NHS Foundation Trust hold either a letter of Honorary Contract with the Trust or a Letter of Access issued by the Trust, before they have access to any facilities, patients, staff, their data, tissue or organs
* You should to notify the Research Development Unit when your research is completed.

**Ethical approval continued…**

I would like to take this opportunity to wish you well with your project. If you have any questions or we can be of any further assistance to you, do not hesitate to contact the R&D Unit.

Yours sincerely

pp Signed on behalf of Nicholas Bell

Director Research Development Unit

c.c. Amrit Sinha

**Appendix D: Rating Confidentiality Form & Guidance Notes**

The recording you are rating has been collected as part of a research project. Recordings may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree:

1. Not to disclose any information you may hear on the recording to others,
2. If rating digital recordings – only to accept files provided on an encrypted memory stick
3. To keep the encrypted memory stick in a secure locked place when not in use,
4. When rating a recording ensure it cannot be heard by other people,
5. To adhere to the Guidelines for Raters (appended to this document) in relation to the use of computers and encrypted digital recorders, and
6. To show your rating scale only to the relevant individual who is involved in the research project.
7. If you find that anyone speaking on a recording is known to you, we would like you to stop work on that recording immediately and inform the person who has commissioned the work.

**Guidelines for raters**

**Introduction**

The course has created the guidelines below for anyone who is involved in rating data for staff or trainees in the Clinical Psychology Unit, University of Sheffield.

In addition to adhering to the following guidelines, **raters must sign a confidentiality and consent form** prior to beginning any work. If you are unsure about any of the information given below, or for a copy of the confidentiality and consent form, please contact the relevant trainee/member of staff.

When undertaking rating from a digital recording, you must:

* Password protect the computer files you are typing **before you type any**

**text** – this can be done easily in Microsoft Word (instructions below).

* Ensure that any personal information in the data you are rating is anonymized. Please contact trainee or member of staff if you have any queries about this.

**Rating Confidentiality Form & Guidance Notes continued…**

Delete any files from your computer (including from your ‘Trash’ folder) once you have submitted your completed rating forms.

Keep the encrypted memory stick in a secure locked place when not in use.

If rating from a digital recording, you must also adhere to the specific guidance on this (see additional information in this document).

**Instructions for a password protecting files on a PC**

For Word 2007:

1) Open a blank Word document

2) Go to Save As and choose the compatible mode

3) Click Tools, then select General Options

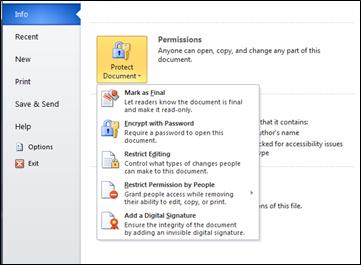
4) Enter a password to open the document. You will be asked to re-type this, then please ensure you click ok before closing the dialogue box.

For Word 2010 onwards:

APPLIES TO: Excel 2016, Word 2016, PowerPoint 2016, Excel 2013, Word 2013, PowerPoint 2013, Excel 2010, Word 2010, PowerPoint 2010, Excel Starter, Office 2010, Word Starter, Word Starter 2010

In an open document, click **File** > **Info** > **Protect Document**.

You see the following options.



**Mark as Final:**     Make the document read-only.

**Rating Confidentiality Form & Guidance Notes continued…**

When a document is marked as final, typing, editing commands, and proofing marks are disabled or turned off and the document becomes read-only. The **Mark as Final** command helps you communicate that you are sharing a completed version of a document. It also helps prevent reviewers or readers from making inadvertent changes to the document.

When you mark a document as final, Word asks you to save the file. The next time you open it, you will see a yellow **MARKED AS FINAL** message at the top of the document. If you click **Edit Anyway**, the document will no longer be marked as final.

**Encrypt with Password:**    Set a password for the document.

**Caution:** Keep your password in a safe place. If you lose or forget the password, it cannot be recovered

When you select **Encrypt with Password**, the **Encrypt Document** dialog box appears. In the **Password** box, type a password, and then type it again when prompted. **Important:** Microsoft cannot retrieve lost or forgotten passwords, so keep a list of your passwords and corresponding file names in a safe place.

**Restrict Editing:**    Control what types of changes can be made to the document.

When you select **Restrict Editing**, you see three options:

**Formatting restrictions**    This reduces formatting options, preserving a look and feel. Click **Settings** to select which style are allowed.

**Editing restrictions**    You control how the file can be edited or you can disable editing. Click **Exceptions** or **More users** to control those who can edit.

**Start enforcement**    Click **Yes, Start Enforcing Protection** to select password protection or user authentication. You can also click **Restrict permission** to add or remove editors who’ll have restricted permissions.

**Restrict Permission by People:**     Use a Windows Live ID to restrict permissions.

Use a Windows Live ID or a Microsoft Windows account to restrict permissions. You can apply permissions via a template that is used by your organization, or you can add permissions by clicking **Restrict Access.** To learn more about Information Rights Management see [Information Rights Management in Office](https://support.office.com/en-gb/article/Information-Rights-Management-in-Office-c7a70797-6b1e-493f-acf7-92a39b85e30c).

**Rating Confidentiality Form & Guidance Notes continued…**

**Add a Digital Signature:**     Add a visible or invisible digital signature.

Digital signatures authenticate digital information such as documents, email messages, and macros by using computer cryptography. Digital signatures are created by typing a signature or by using an image of a signature to establish authenticity, integrity, and non-repudiation. See the link at the end of this topic to learn more about digital signatures.

To learn about digital signatures, see [Digital signatures and certificates](https://support.office.com/en-gb/article/Digital-signatures-and-certificates-8186cd15-e7ac-4a16-8597-22bd163e8e96).

**Instructions for password protecting files on a Mac:**

1) Open a blank Word document

2) Go to Word on the menu bar and select Preferences

3) Click on Security and insert a password to open the document. You will be

asked to re-type this, then click ok.

**Additional Guidance for rating from digital recordings**

**Important:** Trainees and staff must provide you with recordings via an encrypted memory stick. Do not accept files via any other means.

**Installing DSS Player Pro software (you only need to do this once)**

In order to transfer audio files to your computer, you will need to have installed the DSS Pro software that comes to the machine. You will only need to do this once, not for each recording.

The procedure is as follows:

On a PC:

1. Insert CD
2. Go to My Computer – select the CD Drive, click on Launcher
3. Install DSS Player Pro programme (NOT the standard DSS Player) – follow the installation instructions as they appear (e.g. agreeing to terms and conditions)
4. You will be asked to provide the License ID number for Windows users- this can be found on the green card in the box.
5. The manual/help instructions for the DSS Player Pro will be automatically downloaded with the programme files.

**Rating Confidentiality Form & Guidance Notes continued…**

On a MAC:

1. Insert CD
2. Click on the CD icon – click ‘Setup’
3. Install DSS Player programme (Mac users cannot access the Pro version) – follow the installation instructions as they appear (e.g. agreeing to terms and conditions). Your machine will automatically ask you to restart.
4. Once you have restarted, go to the applications menu and select the DSS Player folder. Click on DSS player and you will be asked to provide the License ID number for Mac OS users, this can be found at the bottom of the green card in the box.
5. The manual/help instructions for the DSS Player Pro will be automatically downloaded with the programme files.

**To listen/download audio files from a memory stick (once DSS player is installed)**

1. Open DSS player programme
2. Plug in encrypted memory stick to USB port
3. Input password to unlock the memory stick
4. In DSS player, click on File/Import Dictation
5. Select the USB memory stick
6. Select the audio file, click ok to upload to DSS file.
7. Exit the memory stick by clicking on ‘lock and exit’ button – hand this back to the trainee, who will delete the audio file for you (please do not delete yourself)

**To open the audio files in order to transcribe**

1. Locate the folder within DSS pro player
2. Double click on the audio track within this, a pop up window will prompt you for the password. Enter the password given to you by the trainee

**Rating Confidentiality Form & Guidance Notes continued…**

**Reminder: ensure you have fully deleted your transcription and the original recordings from your computer once you have passed your transcription to the trainee/member of staff.**

The procedure for deleting files from DSS player is as follows:

* Locate the folder in DSS player where the track is saved within DSS player
* Select the individual files of the audio tracks you wish to delete
* Right click over them and select ‘delete’

**Appendix E: Therapist Responsiveness Study Rating Manual**

**Introduction**

You are participating in a study of therapist responsiveness to patients in psychotherapy. You will be listening to audio recordings from the PRaCTICED trial and will rate sessions in terms of the construct of responsiveness. In this study, responsiveness is defined as the degree to which the therapist is attentive to the patient, is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming and respectful towards the patient. This construct is particularly relevant to early treatment sessions, and you will be rating only the first session.

In order to help you think more carefully about the construct of responsiveness and to rate accurately and consistently, the research team has developed a very specific rating scale. The scale consists of 14 global items that will be rated at the end of each session. While each item has some bearing on the overall construct of responsiveness, it is important that you clearly understand the meaning of each item and rate each item as independently as possible from other items. Although the majority of the items focus on the therapist's behaviour, a few items are included which tap the patient's behaviour. Several items also address your overall reactions to the therapist and the patient in the recording you have just listened to.

This manual is intended to help clarify the meaning of the items to be rated. It is expected that you will need some time to become familiar with the rating scale and the manual and to learn to rate reliably. Therefore, you will be trained by the research team before you begin to rate recordings that will be used in the study itself.

**General Instructions for Raters**

* All raters must read and sign the study confidentiality agreement before listening to audio recordings.
* Raters should listen to a brief portion of each recording prior to rating. If there is any possibility that the rater knows the patient or the therapist, the rater should not rate the session and should move on to the next patient in the sequence. If this occurs, the research team should be informed as soon as possible.
* Rating sessions should last no more than four hours, which should be sufficient to listen to and rate two sessions. It is important for raters to take a break between recordings.
* Sessions should be listened to in the assigned order.
* Raters are permitted to stop and/or rewind the session as necessary during the rating process. Care should be taken, however, to stop and restart the timing device accurately when stopping or rewinding.
* Following initial training and mid-point reliability meetings raters should not discuss sessions among themselves except during the sessions.

**TRS manual continued…**

**How to Rate Reliably**

Try to rate each item independently, without regard to other items, i.e., be careful that your response to one item does not influence your response to another. For example, a therapist may rate highly on the Respectful item but rate much lower on Caring/Compassionate. Raters are encouraged to take detailed notes while listening to a recording and to refer to these notes while filling out the rating form. Raters are encouraged to refer to this manual frequently during rating, whenever they have a question about the definition or the anchors for an item. It is important to always use the definitions in the manual as a guide for ratings, not the rater's individual clinical or intuitive judgments. (Exceptions here are the global impression and liking of the therapist items and the judged difficulty of treating the patient.) Try to resist developing an overall impression of whether the therapist is “good” or “bad” or is doing “good” or “bad” therapy. In the last section of the scale, you will be asked to give your overall impression of the therapist for the purpose of controlling for this sort of bias. In a similar fashion, you will be asked, at the end of the scale, to indicate your impression of how difficult the patient is to treat effectively. Try not to let such overall impressions influence your ratings on individual items on the rest of the scale. Try, to the greatest extent possible, to use the entire range for an item (from 0 to 4) - i.e., try not to 'hug' the middle or either end of the scale. Rely as much as possible on the therapist’s actual behaviour. This study attempts to measure a number of concepts that are not always directly observable. Raters' responses should, however, be based as much as possible on the behaviours of the therapist and patient and NOT on the rater's' own inferences about the therapist's intentions, agenda, or unexpressed thought processes. Remember that the same therapist behaviour may be rated on more than one item, i.e., items are not mutually exclusive. For example, a therapist may respond to the patient's expressed feelings by making an inference. Such a statement would be rated in both the Responds to Expressed Feelings and Inference items. It may be clear to some raters which of the two psychotherapies is being used. However, try not to let the type of psychotherapy influence your ratings. Raters should attempt to rate the therapist's specific behaviours and refrain from making inferences about what these behaviours “mean' in the context of a particular therapeutic approach. The one exception to this rule is that CBT therapists often review the patient's BDI at the beginning of the session; they should not be penalized for doing this since it is considered part of the treatment.

**TRS manual continued…**

**PART-END OF SESSION GLOBAL RATINGS**

**Therapist**

1. Responds to Patient's Expressed Feelings (in Context)

Acknowledges patient's verbally expressed feelings. Asks about patient's verbally expressed feelings, and encourages exploration of them. These include feelings about the therapy itself, e.g., feelings related to the patient’s expectations, scepticism, etc. about the therapy, as well as about the patient's life outside of therapy. Rate this item without regard to how much emotion the patient has expressed non-verbally. If the therapist does not respond to feelings because the patient did not express any, the segment is still rated a 0. (The extent to which the patient expresses feelings will be taken into account in the final scoring of the scale.) This item includes following the patient's lead in regard to feelings regardless of the therapist's overall agenda. This item should NOT record the therapist's asking about the patient’s feelings when the patient has not already expressed them. That is covered under the “effort to understand” item.

Examples:

“Could you tell me more about that feeling of anger?”

“You were tired of being talked down to that way.”

“You just kept feeling inadequate whenever you had to perform.'

“How would rate the intensity of that feeling?”

Patient: I am afraid of how my husband will react when I tell him what I have done,

Therapist: “What do you think he might do?”

If the patient expresses a great deal of emotion during the session and the therapist responds to very little of it, the therapist might get a particularly low rating. If the patient expresses very few feelings in the session but the therapist focuses on these, he/she might get a particularly high rating.

O 1 2 3 4

Never         Sometimes     Almost Always

2. Compatible Level of Discourse

Use of language seems appropriate to the patient. The therapist neither “talks down” to the patient, using oversimplified language, nor “talks over the patient's head,” using psychological jargon or other overly sophisticated language that the patient may not understand. The therapist's use of the patient’s own words or phrases for concepts would contribute to a higher score. This should be rated in the context of the particular patient being seen.

O 1 2 3 4

Never        Sometimes    Always Compatible

**TRS manual continued…**

3. Appropriate Level of Emotional Quality and Intensity

Level of emotional intensity seems appropriate, not discordant with that of the patient. The therapist does not need to “mirror” the patient’s emotions at all times to receive a high score. At times it may be appropriate for the therapist to respond to a patient using a different level of emotion.

Examples:

The patient tells a humorous story and then laughs about it. The therapist laughs with her. This contributes to a high score. If the therapist had sat silently without smiling or laughing, it would contribute to a low score.

The patient becomes very sad to the point of crying as he describes ന a difficult time in his life. The therapist responds glibly, “Well, at least those days are over.” This would contribute to a low score.

The patient recounts tragic events in a casual, offhanded way,

making light of a terrible situation. The therapist responds in a serious tone of voice. This would contribute to a high score because the therapist is responding with a level of emotional intensity appropriate to the content expressed even though it does not match the patient's emotional presentation.

O 1 2 3 4

Never        Sometimes    Always Appropriate

4. Responds to Pattern(s) of Content and/or Feelings

Pause to think about the entire session before rating this item. Therapist picks up an underlying thread of patient's discourse over the course of the session, integrating material from separate things the patient has said. Ratings should be based on both the number of patterns identified and the extent or breadth of the integration. Do not rate therapist here for simply referring to a pattern that the patient has him/herself identified as one. Do not rate a simple listing of symptoms and/or problems that the patient has presented.

Examples:

Over the course of the session the patient states that he became paranoid, struggled to keep his job, experienced increased turmoil in his marriage, and began drinking heavily and using heroin about three years ago. The therapist points out that many of the struggles in his life seem to have begun around the time his drug and alcohol use became heavy.

Over the course of the session, the patient describes a number of life situations in which she often feels enraged--at work, with family members, with some of her friends, etc. The therapist highlights that similar feelings of rage occur in a number of situations and may represent an important pattern.

The patient recounts a number of situations in which she was very hopeful and then became deeply disappointed when the anticipated event did not work out as expected. The therapist points out that she has felt this kind of excitement

**TRS manual continued…**

followed by disappointment many times and that perhaps it was a pattern in her life. After the patient has described a number of symptoms and problems he is experiencing, the therapist points out that all of these problems are symptoms of depression.

0 1 2 3 4

No response      Some response to patterns    High level response to pattern(s).

5. Caring/Compassionate

Therapist appears to genuinely care about the patient and the patient’s well-being and responds to him or her with compassion. Ratings on this item may reflect both specific caring and compassionate statements as well as a general sense of “warmth' on the therapist's part throughout the session.

Examples of specific comments:

“Oh, my! That must have been very difficult for you to manage all by yourself.”

“It sounds as though it's really been a struggle for you to accomplish all the responsibilities you have at work while trying to take care of your kids and your father at the same time. You're working as hard as you can to do your best and right now it still doesn't feel like enough.”

"I am sorry that happened to you.” Example of general sense of caring/compassion:

The therapist conveys with nonverbal behaviour and/or general style of speech that he/she cares for the patient’s well-being.

0 1 2 3 4

Not caring or compassionate    Somewhat caring and compassionate    Very caring or compassionate.

6. Respectful

Therapist appears to recognize and respect the dignity and self-determination of the patient. Both content and tone of voice reflect respect. Therapist is not condescending or patronizing. Therapist uses respectful language even when he or she disagrees with the patient. To obtain a rating of 0, therapist must show some disrespect in actual Statements or manner.

0 1 2 3 4

Not respectful    Somewhat respectful  Very respectful.

**TRS manual continued…**

7. Collaboration

Therapist indicates to the patient that treatment includes Working together on Such things as setting goals for treatment and planning the agenda for sessions. Therapist invites input and welcomes feedback on treatment from the patient's point of

view. Examples:

“We will be working together to improve these symptoms.”

“How do you think this session has gone? Do you have any problems with it?”

Therapist indicates that the therapeutic process will involve teamwork of therapist and patient.

0 1 2 3 4

None    Some   A great deal

**Patient**

8. Patient Presents Material from Which One Could Detect an Underlying Pattern of Content and/or Feelings

*Pause to think about possible patterns over the course of the session before rating this item. Do not rate something patient has her/himself explicitly identified as a pattern. Examples:*

Over the course of the session, the patient describes a number of life situations in which someone has criticized him.

Over the course of the session, the patient describes a number of relationships in which she feels anxious and inadequate.

0 1 2 3 4

No material     Some     A great deal from which one could which one could detect one could a pattern

9. Patient Exhibits Resistant and/or Hostile Behaviour

May include overt expressions of hostility or more passive expressions of resistance or non-compliance. May also include apparent withholding of information such as giving only one-word answers, offering little without being pressed.

Examples:

“Listen, I’ve been to six therapists over the course of 20 years, and nothing has helped me at all.”

“Why are you asking me about my childhood when what I really want help with is what's going on now?'

“I can't see how it will help me to keep track of all my negative

thoughts. That'll just make me more negative.”

**TRS manual continued…**

0 1 2 3 4

Never   Sometimes   A great deal

**Rater’s general impressions of therapist and patient**

1. Global Rating of Therapist Responsiveness

Rate your overall impression of the therapist's responsiveness in this session. Responsiveness is defined as: the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming and respectful towards the patient.

0 1 2 3 4

Not at all   Somewhat   Very Responsive

2. Estimate of Patient's Perception of Therapist Responsiveness

To what extent do you think this patient finds the therapist responsive to him or her? This rating is distinguished from the previous one by being based on the rater's impression of the patient's experience of the therapist's responsiveness, rather than the rater's impression of the actual level of responsiveness.

0 1 2 3 4

Not at all    Somewhat     Very Responsive

3. Global Impression of Therapist

How comfortable would you, personally, feel about referring a relative or close friend to this therapist for treatment?

0 1 2 3 4

Not at all     Somewhat     Very Comfortable

4. Liking of Therapist

How much do you like this therapist? There is no correct answer to this question. A rater may base his or her response on any combination of factors rated above or on other personal reasons for liking or not liking the therapist.

0 1 2 3 4

Do not like at all    Like     Like very much

**TRS manual continued…**

5. Patient Difficulty.

How difficult do you think this patient would be to treat effectively? May include the rater's perception of the patient's hostility or resistance, commitment to treatment, hopefulness or scepticism about treatment, emotional openness, apparent motivation for treatment, as well the rater's perception of the seriousness of the patient's problems and difficulty in addressing them.

0 1 2 3 4

Not at all     Somewhat     Very Difficult

Appendix F:[](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiw-NXW9PnNAhWFJ8AKHZ4KDbAQjRwIBw&url=http://www.medsoc.net/&psig=AFQjCNGfuWFENbhPm1rgFBqGwyJrI0CqXA&ust=1468824706740000)

Rater Confidentiality and Consent Form

Therapist responsiveness in psychotherapy: a quantitative intervention study.

DClinPsy Trainee/Researcher: Katherine Crosby, [kcrosby1@sheffield.ac.uk](mailto:kcrosby1@sheffield.ac.uk)

Supervisor: Professor Gillian Hardy, [g.hardy@sheffield.ac.uk](mailto:g.hardy@sheffield.ac.uk)

1. I confirm that I have read and understood the information, including ethical considerations, outlined in the PRaCTICED trial protocol and the protocol related to this study and have had the opportunity to ask questions.
2. I have read the rating confidentiality form and guidance notes and I understand that:

* I will discuss the content of the recording only with the individual involved in the research project
* If rating digital recordings – I will only accept files provided on an encrypted memory stick
* I will keep the encrypted memory stick in a secure place when not in use
* When rating a recording I will ensure it cannot be heard by others
* I will treat the recording as confidential information
* I will adhere to the requirements detailed in the Guidelines for raters in relation to rating recordings and digital audio files
* If the person being interviewed on the recordings is known to me I will undertake no further transcription work on the recording

1. I agree to attend two pre-arranged, mutually convenient training/ reliability sessions. One before rating commences and one mid-way through ratings.

I agree to take part in the above study.

**Rater confidentiality and consent continued…**

Name of Rater:

Date:

Signature:

Name of Researcher:

Date:

Signature:

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please stop the transcription and raise this with the researcher as soon as possible.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Appendix G: PHQ-9  **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | | | | | |
| *(Use “✔” to indicate your answer)* | **Not at all** | **Several days** | | **More than half the days** | **Nearly every  day** |
| 1. Little interest or pleasure in doing things | 0 | 1 | | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | | 2 | 3 |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving .around a lot more than usual | 0 | 1 | | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | | 1 | 2 | 3 |

Scores represent: 0-5 = mild 6-10 = moderate 11-15 = moderately severe 16-20 = severe depression

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***(Use “✔” to indicate your answer)*** | **Not**  **at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7.Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

|  |
| --- |
| Appendix H: GAD-7  **Over the last 2 weeks, how often have you been bothered by any of the following problems?** |

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores represent: 0-5 mild, 6-10 moderate, 11-15 moderately severe, 15-21 severe anxiety

Appendix I: Work and Social Adjustment Scale (WSAS)

Rate each of the following questions on a 0 to 8 scale: 0 indicates no impairment at all and 8 indicates very severe impairment.

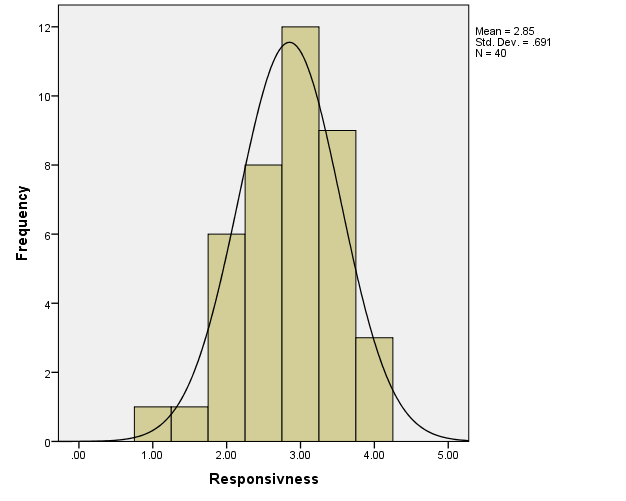
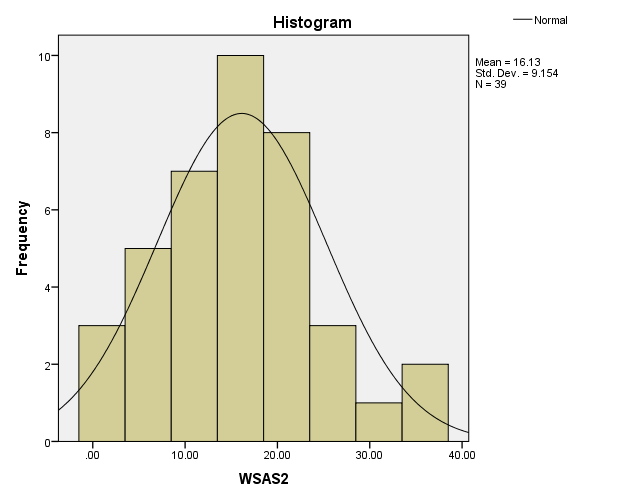
1. Because of my [disorder], my ability to work is impaired. 0 means not at all impaired and 8 means very severely impaired to the point I can't work.
2. Because of my [disorder], my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. 0 means not at all impaired and 8 means very severely impaired.
3. Because of my [disorder], my social leisure activities (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment) are impaired. 0 means not at all impaired and 8 means very severely impaired.
4. Because of my [disorder], my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. 0 means not at all impaired and 8 means very severely impaired.
5. Because of my [disorder], my ability to form and maintain close relationships with others, including those I live with, is impaired. 0 means not at all impaired and 8 means very severely impaired.

A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with subclinical populations.

**Appendix J: Assumption testing for linear regression, hypothesis 3:**

**Sample size:** three independent variables: pre WSAS score, responsiveness and employment status were added to model. As there were 40 participants this meant that there were 13.33 participants per variable.

**Normal distribution of variables:** Following examination of histogram plot the dependent variables: WSAS 2 and GM would appear to be close to the assumption of normal distribution.



**Variables should be linearly related to the dependent variable:**

Examination of scatterplots suggest that there are linear relationships between pre and post WSAS scores and GM and post WSAS scores. Bivariate correlations also suggest a linear relationship: for pre and post WSAS r=0.526, n=39, p=≤.001; for GM and WSAS scores r= -0.288, n= 39, p=.038.

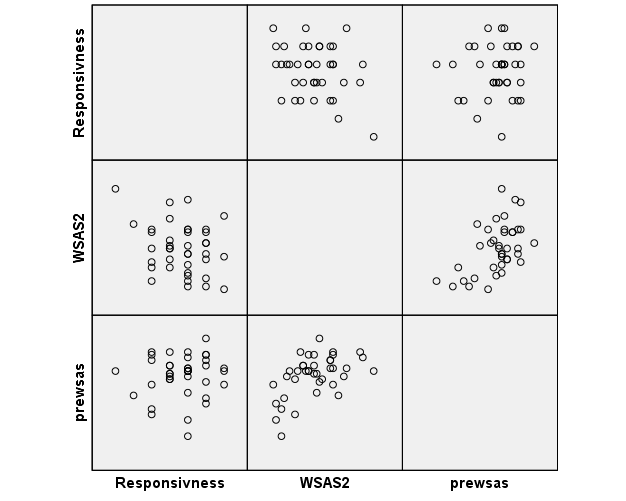
As employment status is a dichotomous categorical variable this assumption is not met.

**Assumption testing continued…**

No outliers were removed.

**Multicollinearity**

Examination of the scatterplot and bivariate correlations suggest that the independent variables of pre WSAS score and responsiveness (GM) are not highly correlated with each other r= .073, n=40, p= .655.



**Assumption testing continued…**

**Homoscedasticity**

Examination of scatter plots suggest that each variable has the same finite variance.

