

Psychotherapists' experiences of client reported feedback in therapy:
How do therapists engage with feedback?

David Michael O'Halloran

Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)
The University of Leeds
Academic Unit of Psychiatry and Behavioural Sciences
School of Medicine

May 2013

The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

© 2013 THE UNIVERSITY OF LEEDS AND DAVID MICHAEL O'HALLORAN

THE RIGHT OF DAVID MICHAEL O'HALLORAN TO BE IDENTIFIED AS AUTHOR OF THIS WORK HAS BEEN ASSERTED BY HIM IN ACCORDANCE WITH THE COPYRIGHT, DESIGNS AND PATENTS ACT 1988

ACKNOWLEDGEMENTS

I would like to thank my supervisor, Dr. Gary Latchford for all his help support and guidance throughout this research. I have enjoyed our work together and learned a lot from him. I would also like to thank the staff on the programme for their guidance and support. In particular, Dr. Carol Martin deserve special mention for providing a Qualitative Support Group and helping me in understanding Grounded Theory.

Of great importance and my rock throughout my academic life is Katy, my wife. She has been a tower of strength and so understanding of the demands and needs of a Doctorate student and his thesis. This is not the first thesis Katy has guided me through, and I am sure she will hope it is my last. Katy has been particularly helpful to me in getting my comma's and grammar correct. I am also grateful to Abby (5 weeks old) for helping her Dad to keep focused on his research.

I have also had a mountain of support from my classmates and colleagues from my clinical placements. Having people around me going through a similar task reminds me of Yalom's (2005) argument for 'universality' being a core component of change in group psychotherapy. It certainly lessened the burden knowing that others experienced similar challenges and overcome them, and it helps me know I will too.

I could not have completed this research without the support of the staff and participants from the two therapy services. I owe them a particular debt of gratitude. In particular, the service leads and principle investigators, Jeremy Halstead, Richard Kerry, Mark Stein, and Chuck Rasleigh helped this research run smoothly, and have been a great help.

"You can know the name of a bird in all the languages of the world, but when you're finished, you'll know absolutely nothing whatever about the bird... So let's look at the bird and see what it's doing -- that's what counts."

Richard P. Feynman

ABSTRACT

In the last 10 years there has been extensive research focused on patient reported outcome measures and feedback in Psychotherapy. Overwhelmingly, these studies have reported that using feedback is associated with increased gains in therapy. However, little is known about the processes that underlie these gains. The present study used a Grounded Theory approach to explore therapist's reflections and experiences of using feedback in their practice. Ten psychological therapists from two psychological therapy services were interviewed; five therapists from each service. One services was an Adult Psychological Therapy Service, the other service was a Student Counselling Service. All interview transcripts were analysed using Grounded Theory techniques, and secondary analysis comparing and contrasting the two treatment services. This analysis produced a theory of *therapist engagement with and disengagement from feedback*. This theory provides the context and experiences under which therapists are likely to engage or disengage from feedback. Furthermore, this study found that therapists across the services responded to feedback information in four ways: (1) they shared it directly with clients, (2) reflected on information outside of the session, (3) reject the specific information, or (4) rejected the feedback system as a tool of therapy. These findings are interpreted in light of the existing literature on feedback in psychotherapy, and theoretical underpinnings such as the theory of planned behaviour, self-efficacy and cognitive dissonance. This thesis also makes suggestions for further research on therapist engagement factors, their responses to feedback and therapeutic gain.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
ABSTRACT	4
TABLE OF CONTENTS	5
LIST OF TABLES	7
LIST OF FIGURES	8
ABBREVIATIONS	9
INTRODUCTION.....	10
Overview of area	12
Introduction to feedback	13
Psychological theories of feedback in clinical settings	15
How do therapists use feedback?	17
Conclusion:	27
The Present Study:	27
METHOD.....	29
Research design.....	29
Methodological considerations	29
Settings	32
Participants	34
Measures	34
Semi-structured interviews.....	34
Procedure.....	35
Ethics and R&D approval	35
Recruitment	36
Interviews:.....	37
Data analysis	37
Software	38
Transcribing	39
Coding	39
Quality control	43
Supervision.....	43
Other techniques.....	43
The researchers perspective	44
RESULTS	46
Overview of chapter	46
Overview of data - Sample.....	46
Pen portraits	46
Student Counselling Service (SCS) analysis.....	53
Service description	53
Theoretical formulation.....	53
Core category: Reflections on feedback	56
Core category: Reflections on therapy	76
APTs Analysis.....	79
Service description	79
Theoretical formulation.....	79
Core category: Reflection on feedback	82
Core category: Reflections on therapy	107
Theory of Therapist Engagement with Feedback	109
Compare and contrast.....	109

Overview of Theory	112
Theory of engagement.....	115
Contextual level of feedback.....	115
Experiential level of feedback.....	115
Engagement response to feedback	116
Theory of disengagement.....	118
Contextual level of feedback.....	118
Experiential level of feedback.....	119
Disengagement response to feedback	119
Summary	120
Conclusion.....	121
DISCUSSION	122
Overview	122
Research Aim	122
Summary of Main Findings	122
The theory of therapist engagement.....	123
The context of engagement and disengagement	123
The experience of feedback information.....	128
The therapist’s response – engagement & disengagement	134
How do therapists use feedback?	140
Strengths and limitations.....	142
Limitations	142
Strengths.....	144
Clinical Implications:	145
Implications for future research:	146
Conclusions:	147
REFERENCES.....	150
APPENDICES.....	158
Appendix A: University of Leeds Ethics Approval Letter.....	158
Appendix B: South West Yorkshire Foundation Trust R&D Approval	159
Appendix C: Participant Information Sheet and Consent Form	162
Appendix D: Interview Schedule	167
Appendix E: Page of Transcript and Analysis Notes.....	170

LIST OF TABLES

Table 1: Student Counselling Service participant demographics	47
Table 2: Adult Psychological Therapy Service participant demographics	47

LIST OF FIGURES

Figure 1: Map of feedback research (Adapted from Greenhalgh et al., 2005)	19
Figure 2: Procedural flow through the study.....	35
Figure 3: Overview of Student Counselling Service core categories	54
Figure 4: Model of therapist responses and actions - Information.....	56
Figure 5: Model of therapist responses and actions - Utilising.....	58
Figure 6: Model of attitudes to feedback	62
Figure 7: Model of feedback in the session	65
Figure 8: Model of accuracy of feedback	68
Figure 9: Model of process reflections.....	70
Figure 10: Model of client response to feedback	72
Figure 11: Model of theory and practice of feedback.....	74
Figure 12: Conceptual categories for 'Reflections on Therapy'	77
Figure 13: Overview of Adult Psychological Therapy Service core categories	81
Figure 14: Model of therapist response to feedback - Actions	83
Figure 15: Model of therapist response to feedback - Information.....	88
Figure 16: Model of therapist views of feedback.....	91
Figure 17: Model of therapist engagement with feedback.....	95
Figure 18: Model of accuracy of feedback	97
Figure 19: Model of therapist difficulties with feedback - Service and system.....	99
Figure 20: Model of therapist difficulties with feedback - Obstacles.....	102
Figure 21: Model of client interaction with feedback.....	104
Figure 22: Conceptual categories for 'Reflections on Therapy'	107
Figure 23: Overview of theoretical model of therapist's response to feedback.....	113
Figure 24: Theory of therapist engagement	114
Figure 25: Theory of therapist disengagement.....	117

ABBREVIATIONS

ALERT: Algorithms for Effective Reporting and Treatment

APTS: Adult Psychological Therapy Service

ASIST: Administration Scoring Interpretation Storage Technology

CBT: Cognitive Behavioural Therapy

CI: Chief Investigator

CORE-OM: Clinical Outcomes Routine Evaluation – Outcome Measure

FI: Feedback Intervention

FIT: Feedback Intervention Therapy

GP: General Practitioner

GT: Grounded Theory

OQ-45: Outcome Questionnaire 45

ORS: Outcome Rating Scale

PCOMS: Partners for Change Outcome Management System

PROMs: Patient Reported Outcome Measures

QDA: Qualitative Data Analysis

RCT: Randomised Control Trial

SCS: Student Counselling Service

SRS: Session Rating Scale

INTRODUCTION

Our knowledge of psychological therapy is constantly advancing. In the last fifty years, there has been extensive research and evaluation of psychotherapies, and it has been established beyond doubt that psychological therapies are effective (Wampold et al., 1997). However, the factors that contribute to the reported effectiveness are still in dispute (Hubble, Duncan, & Miller, 1999; Norcross, 2002; Wampold, 2001). More recently, the use of feedback in psychotherapy has emerged as one of the most promising areas of research on ways to improve effectiveness (Duncan & Miller, 2000; Lambert et al., 2001; Lambert et al., 2002), yet surprisingly little is known about possible mechanisms of action.

A large amount of effort has been focused on the effect of monitoring outcomes from therapy through client feedback measures (Duncan & Miller, 2000; Lambert et al., 2001; Lambert et al., 2002; Wampold, 2001). The work of Lambert and colleagues (Lambert et al., 2001; Whipple et al., 2003) has clearly demonstrated that monitoring clients on a session-by-session basis and sharing their progress or lack of progress with the therapist reduces dropout and improves their outcome from therapy. However, little is agreed about how this has this effect. Lambert and colleagues (Asay, Lambert, Gregersen & Goates, 2002; Harmon et al., 2005; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert & Shimokawa, 2011) conducted a series of studies supporting the use of Patient Reported Outcome Measures (PROMs). By comparing the differences between the methodologies in these studies, it is possible to provide some hypothesis of the active ingredients within PROMs:

- Therapists receive previously unknown information,
- Therapists change their approach,
- The process of asking clients to share their experience has intrinsic value and fastens their commitment to change,
- PROMs stimulate dialog between client and therapist.

The present study aimed to address a gap in our knowledge about PROMs and increase the understanding of how therapists experience client reported feedback. As little is known about the process of utilising feedback in therapy, a grounded theory approach was used to explore psychotherapist reflections on their experience of using feedback within a psychotherapy service. This research will

improve our understanding of what therapists report occurs when client reported feedback is provided as part of the therapy environment. While it was not possible to objectively observe what therapists *actually* do or experience, their reflections will provide a foundation for further exploration and validation. This study is concerned with constructing a model of therapist experiences within a feedback system.

Overview of area

Lambert (2009) argues that between five to ten per cent of adults and fourteen to twenty-five per cent of children deteriorate in psychotherapy. This is a large figure when considered in the context of the efficacy and effectiveness rates of psychotherapy commonly reported. Seligman (1995) describes a client-reported study of psychotherapy effectiveness that psychotherapy had helped 'a great deal' in 54% of cases, and helped at least 'somewhat' in 90% of therapy cases. Smith, Glass and Miller (1980) reported that 80% of treated clients fared better than untreated clients. These studies used different methodologies to evaluate the effectiveness/efficacy of psychotherapy, but are two of the most widely cited studies of effectiveness, yet each has a number of methodological flaws. By looking at Seligman (1995) and Smith et al. (1980) in terms of treatment failure each study estimate that between 20% and 46% of clients will not be helped by psychotherapy. It is therefore important to identify as early as possible clients who are likely not to benefit from therapy or who are likely to deteriorate as a result of psychological interventions. In recent years a number of researchers have developed measures for monitoring client change and therapeutic outcome. One of the most promising is the client feedback system developed by Michael Lambert (Lambert et al., 2001; Lambert et al., 2002; Whipple et al., 2003). The Outcome Questionnaire 45 (OQ-45) is a self-report measure completed by clients before each therapy session and provides the therapist with information on the clients' progress. This system is concerned with identifying clients who are not progressing and are likely to deteriorate and/or drop out of therapy.

At least two other feedback systems have been developed. Michael Barkham and colleagues (Cahill et al., 2008) developed the Clinical Outcome of Routine Evaluation (CORE) system and Scott Miller and Barry Duncan (Miller et al., 2005) developed the Partners for Change Outcome Management System (PCOMS). The CORE system is a set of measures developed in the UK, and looks at client's reported distress and functioning. Individual client scores can be compared to the average population and clinical norms and used to identify whether they experience clinical levels of distress or are functioning in a clinical range. Finally, the PCOMS consists of two questionnaires; the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). The client completes these before (ORS) and after (SRS) each session. They monitor the client's reported distress (ORS) and the client's view of

the therapeutic relationship (SRS). Again these measures can be used to identify clients who are functioning well and progressing in therapy and those who are experiencing distress and not progressing in therapy. These systems are at the forefront of the patient reported outcomes movement within psychotherapy, which will be explored in this study.

Introduction to feedback

A search of the psychological literature on feedback will produce two distinct strands; (i) the behaviourism and learning literature on the Law of Effect (Thorndike, 1911) and to a smaller degree (ii) the use of feedback as a clinical intervention. Feedback as a clinical intervention can be further separated into interventions such as Motivational Interviewing or the use of feedback from clients on their progress in therapy. The present study was interested in the latter; what the therapist experiences when they receive feedback from clients on their progress in therapy. However, there appears to be much overlap between this and the use of feedback as a clinical intervention tool (i.e. Motivational Interviewing).

Despite these distinct meanings of feedback in psychology, the majority of attention has been given to the effect of feedback on learning and motor tasks (i.e. The Law of Effect). It is only in the last 10 or 15 years that the second and third aspects of feedback have received any attention.

The use of feedback in medical settings has received significant attention. Sapyta et al. (2005) reported on a meta-analysis of 30 RCT studies that evaluated client health status feedback to clinicians and reported that 58% of clients in the feedback condition had better health outcomes than those in a non-feedback condition. It is unclear from the study what 'health outcomes' referred to, but we can infer from the studies' methodology that clients who provided feedback reported better health statuses on conclusion of treatment. Sapyta et al. (2005) conclude that this should be interpreted with caution because the methods of feedback delivery varied between studies, and it cannot be established which means of feedback was most effective. One further criticism is that the meta-analysis reported (Sapyta, 2004; cited in Sapyta et al., 2005) has not been published as yet.

The importance of feedback on outcome in medical settings has long been known (Velikova, Wright, Smith, Stark, Perren, Brown & Selby, 2001). Furthermore, there is a considerable amount of attention given to feedback systems

in medical settings. Typically, feedback has been studied through doctor-patient communication. It can be argued that much of medicine is guided by feedback information. A scan of the medical literature for literature on doctor-patient communication and feedback systems is likely to bring three distinct interpretations of feedback. Each will be highlighted briefly for the purpose of drawing comparisons to the literature on the use of feedback systems in psychotherapy. A further purpose of drawing attention to medical studies on doctor-patient communication is to highlight the depth of research in this area in comparison to the field of psychotherapy research.

The first interpretation of feedback systems in a medical setting is perhaps one of the most commonly seen by the general public. Doctor-patient communication occurs in almost every interaction with a medical professional. It is important to note that ‘doctor-patient communication’ as reported in the following studies refers to a one off consultation or sharing of a diagnosis. This differs from the definition of ‘communication’ used in the psychotherapy studies reported shortly. A GP’s use of blood tests can be seen in terms of a feedback system, and an analogy can be made between this procedure and a feedback system such as Administration Scoring Interpretation Storage Technology (ASIST, CVI, 2012) or OQ-45 (PROMs). A patient reports to their GP they are feeling ill. The GP requests a blood test, and the patient provides a sample (provides feedback information). The GP then receives the blood results (a feedback report), and the GP then makes a decision about how to use this information in their next communication with their patient (Sharing feedback).

Woolley, Kane, Hughes and Wright (1978) report that doctor-patient communication was one of four factors that influence patient satisfaction. Ong, De Haes, Hoos, and Lammes (1995) review the literature on doctor-patient communication and report that the relationship between communication, feedback, and outcomes is a complex one, but that when clients/patients rate communication as high, their satisfaction, outcomes, and compliance/adherence are all increased and improved. Recently, Lockett, Butow, and King (2010) reviewed 6 RCT’s on PROMs in cancer care, and found that five of these studies found some impact on patient outcome. However, Lockett et al. (2010) state that this impact was limited by poor methodology, intermittent use of PROM data by doctors/therapist, and variances across studies. Lockett et al. (2010) do note that when analysed by studies

there was a consistent finding that communication resulting from PROMs improved patient outcomes.

A second interpretation of feedback systems in medical settings can be seen in the use of psychological feedback (Quality of Life) as a measure of outcome. This is also closely analogous to the use of feedback systems (PROMs). There is increased recognition of the impact of psychosocial wellbeing on physical health outcomes (Velikova et al., 2001). Velikova, Brown, Smith and Selby (2002) have demonstrated that regularly eliciting and providing this information to doctors resulted in more conversations and enquiries about daily activities, emotional problems and work related issues. Patients also reported high satisfaction with consultations. Velikova, Booth, Smith, Brown, Lynch, Brown, and Selby (2004) reported that feedback of Quality of Life scores to clinicians resulted in a clinically significant improvement of patient wellbeing.

A final and topical use of feedback systems is the use of outcome data in service provision. There is currently much debate on outcome markers for children's heart surgery in Leeds General Infirmary. It is clear that the modern NHS takes outcome data very seriously and that psychological therapy services are also under similar pressures to show that they are effective and viable in the financial climate.

In comparison to medical settings, there is a paucity of research exploring the use of feedback in clinical psychology settings. As stated above there is recognition that collecting client reported measures and feedback is effective in reducing drop out and improving overall outcome. This is also true in studies of psychotherapy (Harmon et al., 2005; Harmon et al., 2007). However, this relationship between the therapist's receipt of feedback and their use of the feedback in subsequent interactions with the client has largely been unexplored.

Psychological theories of feedback in clinical settings

While there is little empirical evidence to date, there have been a number of theories of how therapists may make use of feedback. For example, Sapyta et al. (2005) describe the *contextual feedback intervention theory* (Riemer, Rosof-Williams & Bickman., 2005). This theory states that clinicians benefit from feedback when (i) they are committed to the goal of improving their performance, (ii) they are aware of a discrepancy between this goal and reality, (iii) the feedback source is credible, (iv) the feedback is frequent, immediate, systematic,

straightforward and unambiguous and (v) feedback provides clinicians with concrete suggestions of how to improve.

Being committed to a goal is related to the amount of interest the person (therapist) has in accomplishing this goal. In the case of psychotherapy, one might expect that a therapist's goal is to facilitate or aid change; alternatively a therapist's goal may be to achieve a positive therapeutic alliance with the client. Sapyta et al. (2005) cite self-regulation theory as a source of why a therapist may be influenced by a client's feedback on therapy. In this case, self-regulation theory proposes that a discrepancy between a person's ideal goal (good alliance, positive outcome, successful therapist) and the actual goal state (poor alliance, negative client feedback, unsuccessful therapist) will motivate the therapist to make changes in their approach. Therefore, when a therapist is presented with feedback, they will check how this fits with their desired goal, and if they find a discrepancy, they may change their approach or if they do not value the feedback or the received information, may ignore the feedback. In summary, Sapyta et al. (2005) hypothesised that the therapist's goals for themselves and their client will influence how they interpret the feedback.

It is clear that a therapist has to be aware of a discrepancy between their goal and the reality in order to make use of feedback from clients. Sapyta et al. (2005) suggested that the fact that the client provides feedback to the therapist should be enough to bring the therapists attention to the discrepancy. This would suggest that negative feedback would have more significance to the therapist.

The next three factors stated by Riemer et al. (2005) relate to the feedback itself. The source, the content and the format of the feedback all influence the impact feedback will have on the therapist and in turn the therapeutic relationship.

According to Riemer et al. (2005), the source of the feedback must be deemed as credible to be taken on board by the therapist. In many cases the source will be the client. There are some questions about the reliability and validity of self-reported data. Biases such as social desirability, expectancy effects, or over reporting negative symptoms may all affect the credibility of client reports. Despite these limitations, it can be largely assumed that clients are credible sources of feedback.

The content can also affect the effect feedback has on a therapeutic situation. If the information was previously unknown to the therapist, Riemer et al. (2005)

proposes that therapists will take more account of this information than if it was information already known to them. Furthermore, feedback is utilised more when it contains concrete information that therapists can implement or use to improve their intervention (Sapyta et al., 2005). Finally, if the feedback relates directly to therapist behaviours, it is easier to use than if it relates to outcome of the client.

As stated already, negative feedback is valued more than positive feedback. Sapyta et al. (2005) report the timing of feedback is crucial to its incorporation into the therapy process. When feedback is delivered to the therapist shortly after collection (at the end of a session for example), the feedback is more closely associated with the content and process of that therapy session. This will increase the likelihood that the feedback is taken on board.

A final theory that may influence how therapists take account of feedback from clients is ‘cognitive dissonance’ (Festinger, 1956). Returning to the discrepancy between the ideal goal of the therapist and the reality reported through client feedback, this discrepancy would create dissonance within the therapist and in turn produces psychological discomfort. This dissonance and discomfort will create motivation for the therapist to reduce the discrepancy and change their approach or behaviours.

How do therapists use feedback?

Returning to the definition of feedback, it is important to draw a distinction between (i) therapists giving feedback to clients (i.e. Eating disorders treatment), and (ii) therapists receiving feedback from clients (i.e. PROMs). In the first instance, therapists may use weight changes or blood work to indicate a client’s progress or deterioration, and may deliver an intervention based upon these. The latter is the focus of this study and involves a subtly different process or action.

Currently, little is known about how therapists interpret feedback from client PROMs. Hannan et al. (2005) has shown that client outcome was unaffected when the therapist shared feedback with the client, and they hypothesise that the process of seeking feedback from clients might be the factor that reduces dropout and improves outcomes. However, this has not been studied widely, and this finding has not been replicated. It is therefore necessary to explore the therapist’s contribution to feedback.

Furthermore, Lambert et al. (2003) report that when clients are ‘on track’ for a positive outcome, less therapy is required than for those clients who are ‘not on

track'. This suggests that the use of feedback may be related to the dose-response of therapy.

One way of conceptualising the relationship between collecting PROMs and psychotherapy is to adapt the conceptual model proposed by Greenhalgh, Long and Flynn (2005). Greenhalgh et al. (2005) took the literature on PROMs in relation to health related quality of life in medical services and constructed a framework of interactions. Figure 1 shows this diagram as applied to psychotherapy and the monitoring of PROMs and feedback. Where research has identified a relationship, this will be indicated. Each of the boxes identified in Figure 1 will be explained and expanded upon in the subsequent section.

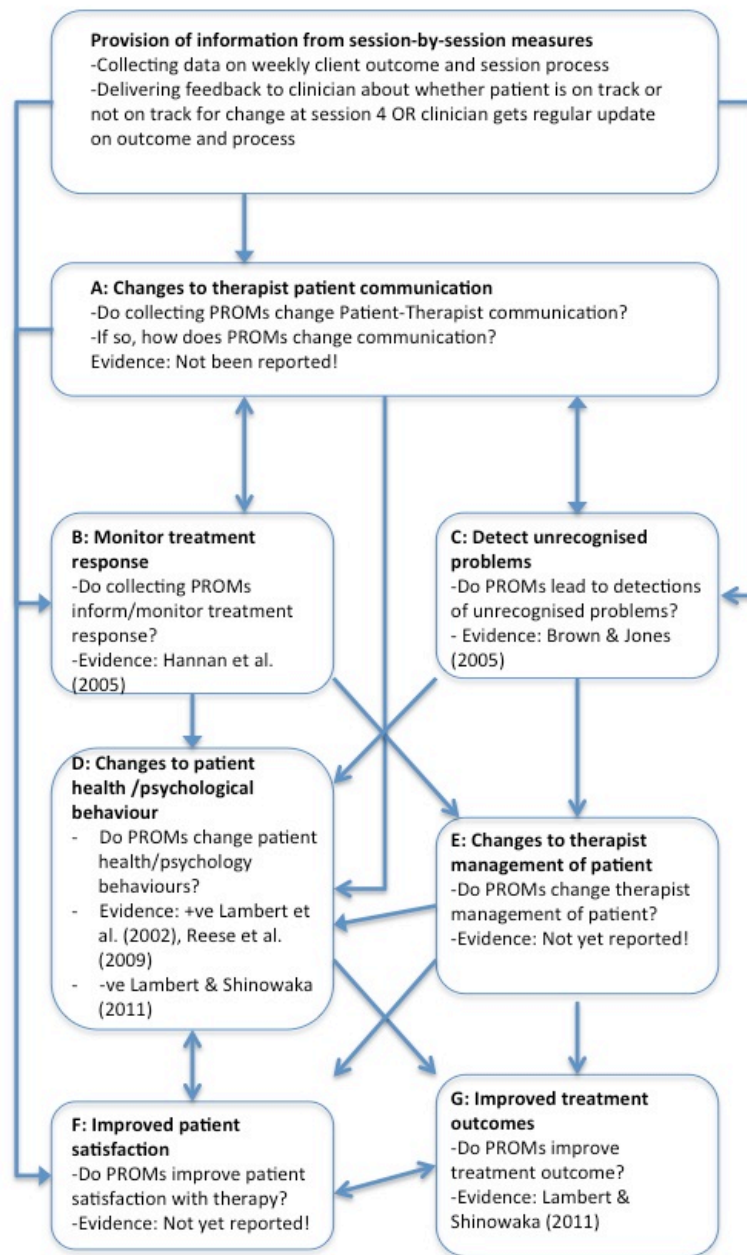


Figure 1: Map of feedback research (Adapted from Greenhalgh et al., 2005)

A. Feedback leads to new client-therapist communication?

Does the utilisation of patient reported outcome measures improve client-therapist communication? The suggested hypothesis is that the feedback report given to therapists facilitates a dialogue between the therapist and the client in the subsequent session. The therapist actively uses the contents of the feedback report to discuss the therapy to date, and to build the therapeutic relationship. However, there is currently a paucity of research exploring therapist-client communication in sessions subsequent to client feedback. There is some support in medical studies of the positive effect of health related PROMs on doctor-patient communication. Detmar, Muller, Schornagel, Wever and Aaronson (2002) report that the majority of doctors and patients reported improved communication following client completion of PROMs. It should be noted again, that these studies relate communication to how the doctor provided feedback (diagnosis).

One study of psychotherapy (Lambert et al., 2002) does mention new or altered therapist-client communication. However, no clarification or description of how communication changed was provided, only those therapists used feedback in their communication during subsequent sessions.

B. Feedback enables monitoring of treatment response?

One of the stated aims of collecting Patient Reported Outcome Measures is to measure treatment outcome and by extension a client's treatment response. There is some evidence that collecting PROMs enables monitoring of treatment response (Hannan et al., 2005), and furthermore that therapists are poor at judging client change without PROMs (Hannan et al., 2005; Lambert & Shimokawa, 2011).

Lambert and Shimokawa (2011) concluded that monitoring outcome through client feedback improves overall outcome, reduces treatment failures, and ultimately improves service efficiency. It is for these reasons that further exploration of client feedback and continued monitoring of therapeutic change and outcome is important.

Hannan et al. (2005) highlighted that therapists are often poor at predicting or estimating their client's treatment response, and show that through patient reported outcome measures such as the OQ-45, therapists become more accurate in predicting deterioration. It can be claimed that there is a positive relationship between the collection of PROMs and improved treatment response monitoring. However, as stated previously in relation to the hypothesised relationships/outcomes

from PROMs, little is known about the contribution of a therapist's interpretation of the feedback report to this improved monitoring.

C. Feedback produces new understanding?

Does client feedback produce a new understanding for the therapist? One hypothesis or proposed outcome of PROMs is the facilitation of a new perspective or understanding for the therapist about the client and/or the client-therapist relationship. This new understanding could be in the discovery of previously unknown information. For example, Brown and Jones (2005) identify that substance use and suicidal ideation when flagged by a feedback system (ALERT) had not been previously identified by the treating clinician.

Hannan et al. (2005) also reported a positive relationship between the development of new understanding and the use of PROMs feedback. It should be concluded that more exploration of the relationship is needed before a clear direction for the relationship is identified. It may be hypothesised that PROMs increase a therapist's understanding of previously unknown difficulties, or that within subsequent sessions a dialogue is developed in which new understanding is achieved.

D. Feedback produces changes to client behaviour

Feedback can be defined in two ways; (i) feedback provided to therapists and shared with clients and (ii) the impact of the feedback system on clients' behaviours.

The first interpretation has been explored within the therapy literature. Lambert et al. (2003) found that when clinicians are made aware of deteriorating scores they are able to keep clients engaged in treatment longer and reduce dropout. However, how this is achieved is unclear. Lambert and Shimokawa (2011) reported that when therapists shared the feedback report with the client, they were 3 times more likely to improve. However, Lambert and Shimokawa (2011) urge caution in interpreting this as a robust effect. They highlight previous studies have been inconclusive on the additive effect of sharing feedback with clients. While more research is needed, on the balance it is likely that there is a relationship between therapists providing feedback from PROMs and changes to clients' behaviours. Finally, Claiborn and Goodyear (2005) highlighted that feedback from a therapist

who is respected and trusted is more likely to be taken on board and applied, thus influencing and producing changes in health/psychological behaviour.

The second interpretation of this relationship is the system of PROMs. It is possible those clients will feel more engaged in the service, or that the questionnaires and systems prompt clients to think about their level of distress and their functioning. There has been little empirical research exploring this interpretation.

E. Feedback produces changes to therapist management of clients

Does the use of feedback from clients influence the therapist's management or approach to the client? Lambert et al. (2002) carried out an extensive study with over 1000 clients split into two conditions (*Feedback* or *No Feedback*). Therapists in the '*feedback*' group received a report on whether their client was 'on track' or 'not on track'. Therapists in the '*no feedback*' group received no report of whether the client was 'on track' or 'not on track'. Lambert et al. (2002) reported that when therapists received feedback on clients who were 'not on track' for change, as indicated by the OQ-45, they altered their approach and shared or utilised the OQ-45 and OQ-45 feedback in their subsequent sessions. Furthermore, there was a significant difference in treatment outcome between those identified as 'not on track' for change whose therapists received feedback, and those identified as 'not on track' for change whose therapists did not receive feedback. Lambert et al. (2002) concluded that this shows the effectiveness of feedback.

One weakness is that the authors do not describe in what way therapists altered their approach or how they shared the feedback. Thus it can be difficult to state whether feedback has such an influence, and in what way it influences a therapists' approach.

Halderlie (2009) reported that little is known about therapist responses to feedback. Halderlie (2009) conducted a qualitative exploration of therapist responses to feedback and reports that therapists rated negative feedback as more valuable than positive feedback. Furthermore, therapists' ability to accurately estimate change increased over time, as they grew more experienced.

F. Do PROMs improve patient satisfaction with therapy?

It could be suggested that PROMs improve client/patient satisfaction with psychotherapy. However, there has been limited research exploring this relationship directly. What can be shown is that clients report having a more positive experience and subsequently more positive outcomes when feedback systems are used (Velikova et al., 2004).

G. Do PROMs improve treatment outcome?

From the above studies, it is clear that patient reported outcome measures do influence treatment outcome. However, there is still much we do not know about the contribution feedback systems have on treatment outcome. Nonetheless, Lambert and Shimokawa (2011) reported on the effectiveness of feedback systems and provide supporting evidence that there is a strong relationship between feedback and outcome.

Furthermore, looking at feedback as an intervention, Claiborn, and colleagues (Claiborn & Goodyear, 2005; Claiborn, Goodyear, & Horner, 2001, 2002) reported that there are a limited number of studies that measure feedback as an intervention. They reported that of the eleven studies reviewed, eight had positive outcomes and three mixed. Although not directly linked to the use of feedback as way of communicating outcome, it nonetheless highlights how feedback to clients can influence their outcome and their behaviour.

Other relationships

The literature presented so far has focused on one of the areas within psychotherapy research that has received much attention in recent years. However, within this field there is another area that has been a strong focus for psychotherapy researchers; the exploration of the process of therapy, and identification of successful ingredients. I shall now provide a brief overview to highlight the probable overlap of the two areas and show how some of the principles and successful ingredients of therapy may act as mediators and moderators of feedback and outcome. Since psychotherapy research has shown that therapy works (Smith et al., 1980), the focus has been on how and why it works. Recent research has explored the process of psychotherapy. There is still much disagreement on the relative contribution of effective ingredients.

Hubble, Duncan, Miller and Wampold (2010) argue for four common factors of therapy; (i) the client and extra-therapeutic effects, (ii) the model or technique, (iii) the therapeutic relationship or alliance, and (iv) therapist factors.

Each of these factors will be discussed in relation to the feedback literature, and the hypothesised influence on each other and on outcome. Particular attention will be given to therapeutic relationship and alliance and therapist factors.

It is clear that the client and their environment outside of therapy can have an influence on therapeutic outcome. How the client approaches their therapy and their expectations for therapy will influence whether they engage initially and ultimately make the changes necessary to have a successful outcome. Yalom (2005), speaking about effective factors of group psychotherapy, identifies the importance of a client's hope and expectations for change. Yalom (2005) states when clients have a positive expectation for their outcome, they are likely to have a positive outcome. This can be seen as a placebo effect. Although it has not been studied, it can be argued that a client's hope and expectation that giving feedback to a therapist will improve their outcome will act as a mediator of the quality of the feedback given, and perhaps influence therapeutic outcome. The purpose of hypothesising this link is to try and draw together two important and rapidly developing areas of psychotherapy literature (feedback and process). Likewise someone's experience outside of therapy is likely to influence how he or she reports feedback to his or her therapist. This in turn may impact on outcome.

The model or technique employed by the therapist is also likely to impact on the recognition and utilisation of feedback. Again this is speculation, but it could be said that certain therapeutic approaches may be more suited to collecting and using feedback in sessions. Cognitive behavioural therapy often uses client material completed outside or even inside of sessions to shape the content of therapy. It could be said that asking clients for feedback on their progress and the relationship in therapy is an extension to the traditional 'homework' in CBT. However, certain psychodynamic approaches may feel that the true therapeutic relationship could not be captured by a set of questions or measures collected during sessions. Again these are tentative hypothesis on other relationships or factors that may influence feedback systems and in turn therapeutic outcome.

Alliance

Horvath, Del Re, Fluckiger and Symonds (2011) argue that the therapeutic alliance is (i) one of the most studied aspects of psychotherapy, (ii) widely believed by researchers and clinicians to contribute to most of what clients find beneficial about therapy and (iii) a major factor in outcome. For this reason, it is important to identify any possible role therapeutic alliance may have in feedback systems.

At its most basic, the therapeutic alliance is made up of three components. According to Bordin (1979), a strong therapeutic alliance occurs when (i) there is agreement on goals between client and therapist, (ii) there is collaboration on the task of therapy and (iii) there is a bond between therapist and client. Put simply, it is proposed that positive outcomes from therapy occur when the therapist and client agree on what they work on, they work on it together, and they have a relationship that is strong enough to carry out this piece of work. Horvath et al. (2011) carried out a meta-analysis of 190 alliance-outcome relationships of over 14,000 treatments and report an effect size of 0.28. This is slightly larger than previous studies of alliance-outcome relationships (Horvath & Bedi, 2002; $r = 0.21$, $k=100$). This finding shows that a strong alliance accounts for a modest proportion of the variance in positive therapeutic outcome. Crits-Christoph et al. (2011) looked at the fluctuations of alliance scores in the early stages of therapy. They report that the correlation between alliance and outcome is higher when the average alliance score is taken. For example, when alliance measures are taken weekly, the average of session 3 to session 9 accounted for 14.7% of the outcome variance. Session 3 scores alone accounted for 4.7%. Thus continual measures can show the relationship between alliance and outcome.

Putting this in the context of feedback systems as described by Lambert and colleagues, it is apparent that clients providing feedback to therapists and therapists sharing or utilising this feedback is contingent on the three components of therapeutic alliance. Intuitively, there appears to be a relationship between alliance, feedback and outcome; however, it must be stated that there is still no conclusive evidence that there is any directionality to this relationship.

A full discussion of therapeutic alliance is beyond the scope of this thesis; however, a rudimentary knowledge of the role of therapeutic alliance in therapeutic outcome may provide some further insight into the impact of feedback systems in therapy.

Furthermore, it should be stated that therapeutic alliance is a subset of the therapeutic relationship. Other aspects of the therapeutic relationship may also influence feedback systems. For example, Norcross (2011) identifies warmth, genuineness, and positive regard as key components to a therapeutic relationship; however, these can also be seen as therapist qualities.

Therapist effects

Finally, in a similar vein to the role a client plays in their therapy and subsequent outcome, the therapist is also thought to contribute some of the variance in therapeutic outcome. Therapist effects on therapy can be seen in the impact of their level of experience, their allegiance to models of therapy, or their interpersonal style. It could also be hypothesised that the particular client-therapist match can have an impact on the outcome. Beutler et al. (2004) provide an extensive overview of the research into the contribution that therapist variables make to outcome. For example, Beutler et al. (2004) identify three areas of therapist interpersonal style that have been explored; reciprocal interactive styles, patterns of verbal expression, and verbal and nonverbal behaviours. Beutler et al. (2004) proposed that good outcomes can be distinguished from poor outcomes by the pattern of high therapist positivity/friendliness, low levels of therapist hostility, and low levels of reciprocal client self-criticism.

From the therapist effects and the therapeutic alliance and relationship literature there is a clear overlap and inter-relationship between therapist characteristics and the alliance, and together these facilitate or contribute to positive outcomes.

Again, in terms of feedback, having a therapist that is in tune with the client and possesses the skills to facilitate a therapeutic alliance and relationship is likely to influence and be influenced by client feedback. It could be hypothesised that these therapists would be receptive to feedback and likely to implement or attempt to improve clients who are not on track or who report not benefiting from therapy.

As with the therapeutic alliance research, there seems to be a paucity of studies bringing feedback and therapist effects together.

Summary

The complexity and depth of research into the process of therapy would be prohibitively large to do it justice in this short space. I have attempted to draw the reader's attention to other aspects of psychotherapy research that may have an influence in the present study or in future studies into the use of patient reported outcome measures (PROMs). The aim of highlighting alliance and therapist effects in particular is to introduce the influence that the therapists within this research may draw upon or bring into the interview.

A further aim is to highlight the difficulty in separating out the individual processes, variables and ingredients that may be present at any one time during a therapy session.

Conclusion:

In the preceding sections I have summarised the emerging literature on the effectiveness of providing feedback in psychotherapy, and attempted to explore the possible processes underlying it. While these factors have been introduced separately, this is in reality an artificial distinction. There may be multiple factors at play when a client is completing feedback, when the therapist receives feedback and also what the therapist decides to do with the feedback. Through the present study, I hope to illuminate some of these factors and build a tentative model of therapist reflection on their experiences of using feedback. This is an exploratory study using grounded theory and it was hoped that the concepts and hypothesis presented in this review would act as a guide to the subsequent discussion with psychotherapists, without closing off any avenues not highlighted in the above text.

The Present Study:

The present study will explore therapeutic feedback systems from the therapists' perspective, which has not so far been studied. The principal research objective is to explore psychological therapists' reflections on the process of receiving client feedback, and their reports of what actions they take in response. It is felt that exploring therapist narratives of how they experience positive and negative feedback from clients will help to construct a tentative model that informs therapist responses to poorly performing patients.

For the purpose of this study, the central phenomenon to be explored will be labelled as *therapist feedback reflections*. This will be defined as ‘therapists’ reflections on their actions, experiences and decisions when presented with a client’s feedback’. The scope of this exploration will cover the moments from when therapists receive feedback up until the therapist takes actions or makes decisions based on feedback. In some instances, the scope of the exploration will cover the subsequent therapy sessions and outcome from therapy, and therapists’ general reflections on the usefulness of feedback.

This research is an exploratory study, and thus no fixed set of hypothesis will be tested. The main research question addressed in this study will be:

- What do psychotherapists reflect about their experience of client reported feedback in therapy?

METHOD

This chapter describes the method used in this research as well as highlighting the rationale for choosing a qualitative research design. Two adult psychological therapy services were sampled in this research and each will be described in turn as part of a single method and procedure.

Research design

A qualitative research design utilising semi-structured, face-to-face interviews was employed for the purpose of this study. The semi-structured interviews were conducted with ten psychological therapists for the purposes of eliciting therapists' experiences, understandings and perspectives of the use of client feedback measures in therapy. Participants were drawn from two psychological therapy services that elicit client feedback in the course of therapy; five participants were drawn from each service. The data generated from these interviews were transcribed and then analysed using strategies taken from Grounded Theory Methodology (Corbin & Strauss, 2008). Using Grounded Theory allowed systematic coding of the data and enabled the emergence of core categories, which were then structured and presented as two service specific models of therapist engagement with feedback. Additional analysis strategies were used to compare and contrast the two service models of feedback. Finally, an overarching conceptual and theoretical framework was developed which provided an explanatory theory of therapist engagement with feedback.

Methodological considerations

This study utilised strategies from Ground Theory Methodology as the overarching approach to data collection and analysis. Additional theoretically driven analysis was used to provide a rich theoretical explanation of the data.

The most suitable research design that meets the aims and objectives of the proposed study is a qualitative design. The aim of "qualitative research is to understand and represent the experiences of people as they encounter, engage, and live through situations" (Elliott, Fischer, & Rennie, 1999). The rationale for selecting a qualitative design is based on the following:

Existing literature and research tell us that monitoring process and outcome in psychotherapy can increase positive outcomes and reduce drop out (Lambert & Shinokawa, 2011). However, we do not know what it is about these systems that produce these results. By utilising a qualitative methods design, we can explore the

depth and breadth of therapists' reflections and perceptions about feedback within the target services. In order to increase our knowledge and understanding, it is necessary to approach this topic with an open frame of reference. Using a quantitative approach could potentially limit the scope of the exploration through the use of pre-existing and standardised measures of therapist decision-making.

There are many qualitative research methodologies each with merits and weaknesses. Grounded Theory was used as a foundation of the analysis due to aim of theory building. However, it was also felt that limiting the analysis to a prescribed model of Grounded Theory (Corbin & Strauss, 2008) would inhibit the richness of sampling two services that employ feedback systems. Therefore, higher level analysis departed from prescribed methods of Grounded Theory Analysis.

The rationale for selecting Grounded Theory as the foundation for analysis over other qualitative methodologies such as Interpretative Phenomenology Analysis or Thematic Analysis was that Grounded Theory (GT) provided a form of analysis that will remain close to and be led by the data. GT as a method allows the Chief Investigator to generate a model of therapists' experiences of feedback that is close to each participants' responses yet also general enough to be representative of the collective experience of the participants. Other qualitative methods may do this also, but GT provides the analytic frame that is most comfortable to the Chief Investigator.

Grounded Theory also explicitly acknowledges the Chief Investigators perspective and interpretation through the use of 'Memos'. These provide a clear pathway through the analysis and provide a quality check. Other strategies to aid the Chief Investigator include 'constant comparisons' across and between data, and 'checking for negative cases' within the codes.

The justification for departing from a structured and prescribed form of Grounded Theory emerged during the theory building stage of analysis. It was felt that to remain close to Grounded Theory would limit the explanatory power of the emerging model of engagement. The researcher felt that the data from the two distinct services provided an opportunity to go beyond a description of the services, and would permit an explanatory theory of engagement through comparing the two service models. This is not Grounded Theory in the strictest sense, but the chief investigator views this departure as an evolution of grounded theory rather than a

dilution of the method. Additional consideration and consultation was sought from qualitative researchers available to the chief investigator.

Another methodological consideration is the argument for and against keeping the services separate and analysing the data from each service sequentially. From the outset of this study consideration was given to whether the two services could be combined in one grounded theory analysis. While this had merits, it was felt that there were considerable benefits for treating each service as a separate entity and to compare and contrast the service models to create an explanatory theory of feedback. Arguments in favour of keeping the services separate were based on the differences between the service profiles; client populations, feedback system, service rationale for collecting feedback, and therapeutic approach. The decision to separate the services presented a number of challenges to the analysis procedure and the emerging theory of feedback engagement. The first challenge was how to manage overlap and non-independence of codes and categories in each service generated through open, axial and selective coding. It is likely that once the first service model of feedback engagement was generated that the CI would have a tendency towards seeking out similar codes in the data from the second service. This presents a challenge for the claim that each service was kept separate until the final stages of the analysis (Phase 2; Compare and Contrast). It is not possible to eliminate overlap completely, however, the CI employed 2 practical solutions to minimise overlap during analysis. First, there was a 'cooling off' period of 3 months between analysis of the first service and commencement of collection and analysis in the second service. Second, while collection and analysis was underway in the second service, the CI did not consult the SCS model of feedback engagement. Only when both models were complete did the CI compare and contrast them. It is impossible to eliminate overlap and it is likely that that CI was influenced by codes and categories from the first service model. I do not feel that some overlap affects the overarching theory developed in this research. I believe that it is an example of a researcher being led by the data and staying true to the principle of Grounded Theory.

A second challenge to the analysis was whether separating the services would provide a rich enough data pool to develop service specific models, before merging though a compare and contrast of both services. I considered this initially, but feel it was not an issue as the proposed theory seemed to have a resonance with

the literature, and seemed to capture the experiences of often reported anecdotally by therapists.

Settings

Service A: Student Counselling Service

The Student Counselling Service is located in a 3rd/4th level institution of between 15,000 – 20,000 students. It is a busy counselling service offering counselling to over 6% of the student body annually. There are nine trained counselling psychologists and psychotherapists currently employed. The service is well established and provides short-term (8 session) therapy for students at this university. Therapists described their approach as solution focused, but used different models and training backgrounds in their work. There is a strong tradition of using feedback in therapy within this service. The service has used the Outcome Rating Scale (Miller et al., 2003) and Session Rating Scale (Duncan et al., 2003) for at least five years. They considered and trialled the CORE-OM initially, but found it too unwieldy. This service uses a computer-based feedback system; ASIST for Agencies Version 4.09 (CVI, 2012). Clients are asked to complete the ORS on the therapist's computer prior to commencing the session, and the SRS at the end of session. Clients complete these measures throughout their therapy; usually 8 sessions; therefore the service and therapist has access to eight sets of feedback (ORS and SRS) for each client. Therapists are sitting in the room but not beside the client when these forms are completed. This allows the therapist to have an active role in collecting and monitoring feedback and the clients response to feedback.

Service B: Adult Psychological Therapy Service

This service provides psychological therapy to adults in the North East of England. The service is made up of nine qualified clinical psychologists and psychotherapists. Each therapist operates in a model they are most comfortable working in. Therapeutic approaches include Cognitive Behavioural Therapy, Short Term Experiential Dynamic Psychotherapy, Cognitive Analytical Therapy, Interpersonal Psychotherapy, and Psychodynamic Psychotherapy. There is no requirement for therapists to operate in a prescribed way.

The typical referral to this service is for individuals who have severe and enduring emotional and psychological difficulties. Therapy is time limited insofar as clients/patients are usually seen for a period of up to 2 years of weekly or biweekly

sessions. Typical presentations include eating disorders, anxiety, depression, and OCD, among other difficulties.

There is a strong history of collecting outcome measures from clients, but less for collecting process measures. It also appears that therapists were not required to share feedback scores or to integrate them into their practice. However, some therapists did. The service is currently undertaking a feasibility study on the collection of feedback measures and their use in measuring early change and as a signal system to provide feedback to therapists to improve outcomes for 'not on track' cases.

The feedback system in use in this service is made up of three questionnaire sheets; a pre-session measure, a post-session measure, and a post-session 4 measure.

The pre-session measure was made up of the CORE-10 (Barkham et al., 2013), and the sPaCE (Halstead, Leach, & Rust, 2007). The post-session measure was called the HASQ. This contained four sections looking at (i) the helpfulness of the session (Elliott, in press), (ii) the therapeutic alliance, (iii) the stage of therapy (assimilation model; Styles et al., 1991), and (iv) current experience of therapy. The post-session 4 measure was called the ASC. This contained forty questions about (i) the clients attitude about the therapist, (ii) support outside of therapy, (iii) current feelings about being in therapy, (iv) and experiences in the last week.

Clients complete a pre-session measure before each session in the waiting room and place it in a locked box, the therapists gives them the post-session form to complete in the waiting room after the session. This happens for every session that the client attends. After the fourth session, an additional measure is given to the client at the end of the session.

Dedicated researchers then compile a post-session 4 feedback report for therapists indicating if the patient is on track i.e., reduction of 5 points on session-by-session measures (CORE-10, sPaCE). This report also indicates to the therapist what problems may be getting in the way of the client making more progress and signposting the therapist to a manual for intervention ideas. Therapists were encouraged to share this feedback if they wished. Some therapists reported doing so, but others didn't.

This feedback system was set up as a research task as part of a feasibility study, therefore, the completed feedback was managed by a research team rather

than the therapists themselves. Therefore, therapists had a more indirect relationship with the feedback information.

Participants

Participants were psychological therapists recruited from two psychological therapy services. Therapists were eligible for participation if they had a recognised qualification in psychological therapy (MA, DClinPsychSci), they had used the feedback system in their place of employment (therapy service), and had an active caseload of clients/patients. Participants were excluded from the study if they were currently training for a therapy qualification, if they were not using the feedback system or were not currently seeing clients/patients.

Measures

One interview schedule was used (See Appendix D) for both services. This was based upon suggestions made by Charmaz (2006) and consisted of 11 open-ended questions. Each question had associated prompts designed to elicit rich accounts of the participant's experience. The interview schedule was designed to elicit the participants experience of client feedback in their therapy, and moved from general experiences to specific clients experiences.

The interview schedule was piloted on a trainee clinical psychology colleague who worked in the Adult Psychological Therapy Service and had experienced the feedback system. This pilot resulted in a rephrasing and clarification of a number of questions.

Semi-structured interviews

The chief investigator attempted to establish rapport prior to turning on the digital Dictaphone and commencing the interview. This rapport was maintained throughout the interview through the flexible use of the interview schedule (See Appendix D). Participants were informed that the aim was to have a conversation about their experience and reflections on eliciting and using client feedback in their therapy with clients. They had prior access to the interview schedule, which primed them for the topics we would discuss. While all 11 questions were covered, the order changed depending on the direction the interview took. At times participants were directed to use specific examples from their caseload, but reminded that they were not to discuss identifiable material in detail. They were also reminded that

identifying details would be removed when the interview was transcribed. The majority of interviews lasted 1 hour and all were conducted in private.

Procedure

There were nine stages within this procedure. Using a qualitative methodology allowed the procedure to be an iterative one, where interviews shifted and changed as the information and themes began to emerge from the transcripts. The procedure for recruitment, interview and analysis was identical for the two treatment services. However, recruitment, data collection and analysis were completed with the Student Counselling Service before recruitment, data collection and analysis commenced with the Adult Psychological Therapy Service. I shall describe the procedure sequentially. Please see figure 2 for a diagrammatic representation of the procedure that occurred in both services.

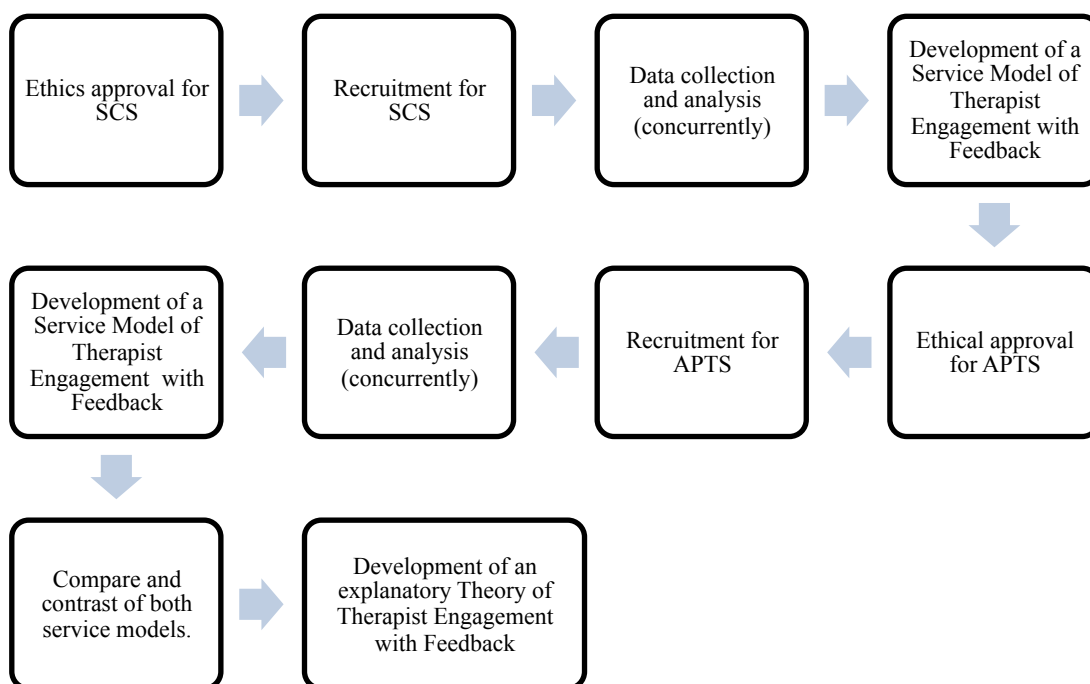


Figure 2: Procedural flow through the study

Ethics and R&D approval

Research ethics was sought and received prior to beginning data collection from the University of Leeds Faculty of Medicine and Health Ethics Committee

(See Appendix A). The South West Yorkshire Partnership Foundation NHS Trust Research and Development (R&D) department gave permission to carry out this research with therapists in their trust (See Appendix B).

The Student Counselling Service is not part of the Health Service Executive (Ireland's health service) and independent of the University student health service, thus the internal procedure of the service was adhered to. The lead clinician gave approval for this research and accepted the ethics approval of the University of Leeds.

Recruitment

After ethical approval was granted from the required bodies, the clinical lead for each service was contacted and it was arranged to circulate the participant information sheet and consent form to eligible therapists. In service A (Student Counselling Service; SCS), the clinical lead led recruitment and arranged interview dates. In service B (Adult Psychological Therapy Service; APTS), the service lead was unavailable at the time of recruitment, and a secondary contact arranged an information session for staff, where the Chief Investigator presented the proposed research to the staff team. A list of therapists and their level of engagement with the feedback system was also made available for Service B (APTS) and those who had recently received feedback reports on their clients/patients were targeted, however all therapists who were eligible for inclusion were invited to participate.

In both services, participation was voluntary and all potential participants were given 7 days to consider their options. In Service A (SCS), participants informed the service lead of their desire to participate. In Service B (APTS), the CI contacted potential participants by email. Recruitment occurred sequentially; Service A (SCS) was approached first and all interviews conducted, before Service B (APTS) was approached.

In both services, once written (email) agreement was received, the CI arranged an interview. At this interview, participants were again presented with the participant information sheet and consent form (See Appendix C) and encouraged to read the information sheet and give their informed written consent. All interviews occurred on site at each service.

Interviews:

The timetabling of interviews was mutually agreed between Chief Investigator and participant. Two interviews were conducted during each visit to the service. After two interviews were conducted, an independent person transcribed the recordings. Therefore, the first transcript of the interview pair was not able to inform the interview with the subsequent participant. However, the Chief Investigator wrote memos and reviewed the audio between these interviews, and memos were used to guide and follow up topics with participants in the subsequent interview. Therefore this study did not employ 'theoretical sampling' in the strictest sense. At all times during this data collection period, interviews, transcription, analysis and coding occurred simultaneously.

The Chief Investigator used the topic guide and previous interview themes to guide the participant's reflections on their experience of the feedback system in their service. After each interview and regularly through the data collection and analysis period, 'memos' were used to collect the thoughts and initial analysis ideas from participant interviews and any links or emerging themes or categories were explored. These memos formed a large part of the analysis plan (described below) and the content of the interviews.

Data analysis

Data analysis occurred in two phases. Corbin and Strauss's (2008) model of Grounded Theory guided the initial stages of developing the service models of *therapist engagement with feedback*. During this stage of analysis, data collection and coding occurred in parallel. Creswell (2012) describes this as a 'zig-zag' process. Interviews were conducted, transcribed and then analysed before the next interview was conducted. This enabled the Chief Investigator to check out hypotheses and clarify the phenomenon of feedback as a therapeutic tool. The coding process began with the transcription of an interview; each transcript was then subjected to a structured process of open and axial coding. Selective coding occurred when all interviews within the service were conducted and transcribed. It was at this point that the conceptual framework of feedback in the service was developed. Data from each service were kept separate and analysed independently, and the above procedure was followed for each interview. The methods of coding will be outlined in the following sections. Data analysis was supported by

techniques commonly used as part of GT and suggested by Corbin and Strauss (2008). Techniques included constant comparison, memo writing, diagramming and visual maps, and searching for negative case examples.

The second phase of data analysis commenced once both service models of feedback were complete. This phase departed from prescribed methods of Grounded Theory. Remaining close to Corbin & Strauss's (2008) methods would have presented a challenge to the research question, and would have limited the explanatory power of the emerging theory of feedback. It was felt that departing from these methods would be in the spirit of Grounded Theory in that the researcher remained close to the data and let the data guide the analysis procedure. Thus the aim of this phase was to develop a higher order explanatory theory of *therapist engagement with feedback*. This decision also allowed the Chief Investigator flexibility to follow the emerging trends from both service models.

This decision is further justified by emerging trends in the data from both services about the ideas of 'buying in' and the processes therapists might go through in committing to using feedback in sessions. As stated this was a key aim of the research and it felt necessary to depart from Grounded Theory in order to address this aim. It became clear that each service had unique characteristics and nuances that would be lost when using prescribed methods of Grounded Theory. It was felt that departing from these methods would make best use of the rich data produced through sampling two distinct treatment services with different feedback systems and service contexts. This approach enabled the Chief Investigator to move beyond a descriptive model of feedback engagement. A more detailed description of the decisions made and processes followed will be presented below.

Software

Qualitative Data Analysis (QDA) software was used to aid the coding process. Nvivo 9 was chosen due to the availability within the University of Leeds. Nvivo was used to aid the organisation and structuring of codes and categories. All interviews were imported into Nvivo, and open coding and axial coding took place with the aid of the programme. Higher levels of coding (theoretical) and structuring the data took place using pen and paper method and post-it notes. The Chief Investigator recognises that QDA software is not a substitute for analysis, and that the Chief Investigator still needs to identify codes and conduct the analysis using the methods described below.

Transcribing

All interviews were recorded using a digital Dictaphone and were transcribed by a trained third party. Interview recordings and interview transcripts were password protected, and stored electronically on a secure password protected university server. When a completed transcript was first received, the Chief Investigator listened back to the recorded interview and corrected any errors and inaccuracies in the transcript. Any remaining identifiable information or features were also removed at this point. A further benefit of this was to enable familiarity with the participant's story and to enhance immersion in the data (Henwood & Pidgeon, 2006).

Coding

Corbin and Strauss (2008) define coding as “deriving and developing concepts from data” (p.65). They propose that this is achieved by following a structured series of stages; moving from lower order codes through higher order categories to a theoretical framework of the topic of interest. Each step in this process will now be discussed.

Phase 1: Service specific model development

Open coding

The first stage began by analysing each transcript line-by-line seeking out ‘meaning units’ and assigning codes to each. A meaning unit was defined as a portion of text that conveys a singular meaning; it can be a word, a phrase, a full sentence, or even a paragraph.

Open coding was an iterative process, with each code being compared to other coded units of meaning. Over a number of iterations codes began to group together and rough categories began to form. This was achieved through the concept of constant comparison. As each interview transcript was analysed, open codes underwent several transformations; their definitions were refined, the labels revised, and similar codes collapsed

Axial coding

The next stage in the process was axial coding. This is a method for grouping open codes into categories and focusing on the core concepts of the codes. Corbin and Strauss (2008) define this stage as “crosscutting or relating concepts to each other” (p.195). Fassinger (2005) states ‘axial coding puts the fractured data back together’. In the present study, constant comparison was used for this process.

It was also during the axial coding stage that categories reached saturation. This was achieved when data (interview transcripts) did not produce any new ‘meaning units’. The process of constant comparison described below provided a further test of saturation.

The aim of axial coding is to explore and identify the inter-relationships between the categories and begin to formulate a theory that fits the experiences described by the participants. Therefore the main focus of this stage involved creating a hierarchy of categories and linking similar categories and sub-categories. Again, diagramming and modelling the relationships aided this. See Appendix E for an example of axial coding.

Selective/Theoretical coding

The final stage of coding is theoretical coding. This is also referred to as selective coding (Fassinger, 2005). During this stage, the substantive service model of therapist use of feedback was developed. At this stage, and all stages of the analysis process, both treatment services were kept separate. Each service provided a model of feedback use. These theories stand on their own. However, as described above further theory development occurred once both service models were complete. This was achieved through the exploration of similarities and differences between the services.

The main focus of theoretical coding is the selection of the ‘core’ categories and generating the core ‘story’ (Fasinger, 2005, p161). This story was expanded and explored using theoretical memos and the use of Corbin and Strauss’s (2008) conditional/consequential matrix. This technique involved looking at the conditions and consequences of the use of feedback by the therapists in each service, by answering the questions of ‘who, what, where, why’ of the story. This was done independently for each service. The result was a descriptive service specific model of therapist engagement in feedback.

Phase 2: Theoretical model development

One strength of this study was the presence of two distinct services with differing feedback systems. In order to move of these two models of feedback engagement, it was necessary to step away from a prescriptive Grounded Theory methodology. Each descriptive service model of feedback was compared and contrasted to each other to produce a explanatory and theoretical model of therapist engagement with feedback. This process sought similarities and differences between participant's experiences of their service and sought to elaborate on the process of engagement with feedback. In order to approach this phase of analysis in a structured way, the following procedures were followed. Where necessary, the justification for each procedure will be provided.

Step 1

In order to compare and contrast the two service models, conceptual categories were placed side by side. Conceptual categories were judged comparable if they appeared to represent a similar aspect of therapy or feedback. For example, in the SCS model, participants identified *attitude to feedback*, this is deemed similar and comparable to the conceptual category of *views of feedback*. Within each conceptual category, similar lower order categories were then compared. This process was followed until a list of similarities and differences between the conceptual categories were produced.

Step 2

This list provided areas for further exploration. The Chief Investigator returned to the original transcripts and sought to address the essence of similarities and differences between the services. The CI was guided by a number of questions and thoughts about the data such as:

- What factors were present in this service, that was absent in the other service?
- Are these categories alike and what are can be extrapolated from them considering all instances of these categories? (i.e. what is universal about these categories)
- Is there redundancy and overlap when these categories are compared?
- Is the experiences identified by participants in Service A similar or different to that identified in Service B?

- What is the psychological underpinning linking these categories?
- Can this category be said to influence or contribute to a participant's engagement with feedback in this service?
- Why is this highlighted in one service but not the other?
- What does the presence/absence of this category tell me about therapist engagement with feedback?
- Is there a universal process that therapists go through when engaging with feedback?
- Why do some therapists but not others identify this as a factor of engagement?

The responses to these questions were considered and used to generate an explanatory theory of feedback engagement.

Step 3

Through a repeating process of questioning the data and reflecting on the similarities and differences between models and service contexts, a theory of feedback engagement evolved. This theory is presented in the next chapter.

Other aspects of analysis

Constant comparison was used throughout the coding process to help classify and refine codes and categories. Corbin and Strauss (2008) describe this as “essential to all analysis because it allows the Chief Investigator to differentiate one category/theme from another and to identify properties and dimensions specific to that category/theme” (p.73). Fassinger (2005) identified 4 types of comparison (i) comparing and relating subcategories to categories, (ii) comparing categories to new data, (iii) expanding the density and complexity of the categories, and (iv) exploring variations in the data and reconceptualising the categories and their relationships.

The Chief Investigator made extensive use of memos to collect and document reflections, experiences and hypotheses. Memos were used alongside open, axial and selective coding and constant comparison to structure and develop the analysis creating a theoretical framework.

Looking for the negative case was used to identify meaning units, codes and themes that did not fit a pattern of the data. Negative cases are useful in refining categories and to clarify conceptual differences in the data. Finally, the use of

diagram's helped in organising and identifying the core categories and subcategories.

Quality control

A number of quality control techniques were considered for this study, each will be outlined and the justifications for and against using such techniques will be provided.

Supervision

A key aspect of quality control during this study was the use of supervision. Regular meetings with an academic supervisor were arranged throughout the research period. Initial meetings focused on question formation and research design. Once data collection and analysis were underway, supervision meetings focused on the analysis and helped in the construction of higher order categories and axial coding. During these meetings, the chief investigator brought examples of codes, categories and interview transcripts. This process allowed the Chief Investigator to clarify and at times justify his thinking and to ensure methodological and analytical robustness. Furthermore, all meetings were documented and minutes compiled to produce an audit trail, which again contributed to quality control.

A second form of supervision received throughout the research process was through the attendance of a peer supervision group facilitated by an experienced qualitative researcher from the course academic staff allowed for further discussions about the analysis procedure and coding choices.

Other techniques

There is a considerable literature base on the use of quality control procedures and credibility checks aimed at reducing subjectivity and increasing generalizability of qualitative studies (i.e. Elliott et al., 1999; Lincoln & Guba, 1985). Within this literature, there are also arguments for the maintenance of the Chief Investigators subjectivity and recognising the distinction between quantitative methods and qualitative methods, and that it is not appropriate to apply empirical and positivist measures to a subjective qualitative study.

Nonetheless, other techniques of quality control were considered; inter-rater reliability and respondent validation. The CI felt that grounded theory acknowledges the subjectivity of the researcher and that an independent rater would bring their

own biases and subjectivity to the data, therefore, there would be limited utility in utilising inter-rater reliability. Respondent validation was considered as an additional quality check, however this was decided against due to time constraints.

Versions of these procedures were utilised however. Through supervision with the academic supervisor, codes and transcripts were scrutinised and suggestions and clarifications were followed up upon. Secondly, participants were asked to validate their pen portraits and the service leads were asked to validate the service portraits. All portraits contained the Chief Investigators sense of the interview and the participant's main points and narratives.

The researchers perspective

Within qualitative research it is acknowledged that research cannot be conducted in a vacuum and that the researcher will bring their own perspectives and biases to the research (Altheide & Johnson, 2011; Elliott et al., 1999; Willig, 2008). Elliott et al. (1999) state that the researcher's perspective is an important component of qualitative research and recommends 'owning ones perspective'. Willig (2008) identifies that the researcher can influence the research process in two ways, "as a person (personal reflexivity) and as a theorist/thinker (epistemological reflexivity)" (p.18). Elliott et al. (1999) identify this as one strategy for increasing the credibility of the research. Therefore it is important to acknowledge and own my perspective and reflexivity. Disclosing my theoretical, methodological and personal orientation towards the research topic helps the reader interpret the data, and to consider my understanding of the topic, as well as possible alternative interpretation and potential biases due to my perspective. I recognise that there may be a number of factors that have influenced this research, primarily my life experience and experience of clinical psychology training.

Prior to commencing clinical psychology training, I completed a PhD using a qualitative research design to explore client and therapists significant events in their therapy. From this piece of research I will have some underlying beliefs and experiences that will shape how I view the present study. In this previous piece of research, I used Thematic Analysis (Braun & Clarke, 2006). I am thus familiar with the concepts and procedures within this design. However, for the present study I used aspects of Grounded Theory. I am inexperienced in this methodology, and my experience of thematic analysis may dilute the GT principles. However, there is

some overlap between the methods and I see my previous qualitative analysis experience as a strength in approaching this present study. I have sought advice and read through the broad literature on Grounded Theory methods, and I feel that I am clear in how to conduct the present analysis using GT principles.

A second perspective is introduced by my position as a trainee clinical psychologist. Being a trainee clinical psychologist provides me with a specific view of psychotherapy, and the benefits and advantages of psychotherapy when intervening in people's distress. Furthermore, I undertook a clinical placement in one of the therapy services used in this research as part of my clinical training. Here I was exposed to their service, the therapists and the feedback system. I took part in their feasibility study and contributed my client feedback data. This provides me with a dual lens. I am both an external researcher and an internal therapist. I have reflected on how this may contribute to my biases and how I might interpret the therapists' transcripts and experiences.

When I analyse respondent's transcripts there may be a danger that I apply some of my perspective onto their words. I may project some of my personal and professional views of this particular feedback system, my likes, my dislikes and frustrations. Furthermore, as a trainee therapist, I may be reluctant to ask difficult questions of former therapy colleagues, I may also let personal views of therapists cloud my interpretation of their experience. Furthermore, I may wish to see the role of therapist as a positive influence on client's distress and presenting problems. Ultimately, I acknowledge that my perspective on psychotherapy and as a trainee and user of feedback will frame my interpretation of data, my analysis, my recommendations and my conclusions. I also acknowledge that it may not be possible to fully account for my biases and perspectives that occur within the deeper levels of consciousness (Cutcliffe, 2003).

Grounded theory allows the researchers bias to enter into the analysis, and recognises that the research question will be guided by the researchers explicit and implicit assumptions. Finally, I submit the above section as my perspective and encourage the reader to allow this to guide their interpretation of the credibility of this research.

RESULTS

Overview of chapter

This chapter will comprise three parts. I will first present an overview of the sample, and describe the two services and ten participants interviewed. I shall then present the analysis of each therapy service separately. Analysis will be presented in terms of highest order to lowest order categories (core categories, conceptual categories, subcategories). The aim of this research was to explore therapist reflections of their engagement with feedback information; therefore most attention will be given to this aspect of the results. Participants also reflected on their engagement with clients in therapy. A brief summary of core categories of therapist reflections on therapy will be provided to situate the main results and findings. The chapter will conclude with an overall theory of therapist engagement with feedback. This theory will combine both services and highlight similarities and differences between services and participants. Furthermore, this theory will be grounded in the data and inform the reader of the process of therapist engagement with feedback.

Overview of data - Sample

Ten participants (5 from each service) took part in this study. All were qualified psychotherapists or psychologists and worked in psychological therapy services providing therapy to adults. One service was a third-level university student counselling service, while the second was an adult psychological therapy service. Demographic information on each participant is provided below. Pseudonyms have been used in order to maintain confidentiality.

Pen portraits

The purpose of a pen portrait of each participant is to introduce the reader to the participants by providing some more detailed background information. These portraits will also include some of the author's own impressions which were formed throughout and immediately after the semi-structured interview and written down in memos.

Table 1: Student Counselling Service participant demographics

Participant	Age	Gender	Years Qualified	Current Post (years)	Therapists Qualification	Therapeutic Allegiance
Alan	35-44	Male	9	5	M.Sc. Counselling Psychology	Integrative: Person Centred / Cognitive
Beth	55-64	Female	30+	5	M.Sc. Cognitive Behavioural Therapy	CBT
Carol	55-64	Female	23	10+	MA Psychotherapy	1. Systemic 2. Constructivist
Denise	25-34	Female	3	1	MA Counselling Psychology	Solution Focused
Edith	35-44	Female	15	6	MSc Marriage, Family, Child Counselling	Psychodynamic

Table 2: Adult Psychological Therapy Service participant demographics

Participant	Age	Gender	Years Qualified	Current Post (years)	Therapists Qualifications	Therapeutic Allegiance
Frank	35-44	Male	4	1	MRCPPsych CCT in Psychotherapy	Psychodynamic
Geraldine	25-34	Female	1	1	DCLin Psych	CAT/eclectic
Hillary	25-34	Female	1	1	DCLin Psych	Psychodynamic
Ingrid	25-34	Female	1	1	DCLin Psych	Integrative
James	45-54	Male	5	4	DCLin Psych Core-IEDP Core-ISDP	Experiential Psychodynamic

Student Counselling Service (SCS):

Alan

Alan is a qualified counselling psychologist. He described himself as person centred and solution focused. He has worked in this service for 5 years, and been qualified for 9 years. He introduced the current system of feedback into the service and has been the main driver behind pushing therapists to adopt the system. He offers training to his colleagues. Alan described how he has lost some enthusiasm

for the system, as he is unsure of the utility of it with some clients. He makes a distinction between the outcome rating scale (ORS) and the session rating scale (SRS); he actively uses the ORS but does not use the SRS as much as previously. This was explained as a lack of perceived accuracy and a mismatch between the sense from the client in the room about the relationship and what is put on the form.

My sense of this interviewee was that he values the use of feedback and sees it as a therapeutic tool. He is realistic about its limitations and approached the interview in an honest manner. This was my first interview for this study, so there may have been a sense of apprehension and I stuck to the topic guide quite closely.

From this participant I got a strong sense of the need for everyone involved to 'buy in' to the feedback system. Furthermore, I perceived a strong sense of how eliciting feedback can be a gentle way of getting information, which can be used to start therapeutic conversations.

Beth

Beth is a qualified CBT therapist. Beth described herself as using a CBT but client centred approach to her work in the service. She has worked in this service 5 years, and as a therapist before this for more than 25 years.

During our conversation, Beth described how she valued the process measures over the outcome measure, but felt both are useful. She felt less comfortable using just the ORS in the absence of the SRS rating that was trialled at one point in the service. I felt we spent much of our time talking broadly and generally about experiences and reflections on feedback and this was at the expense of discussing specific client interactions. We did explore the graphs of three clients and this was useful in seeing the trajectory of change, but I did not get a sense of how feedback was used specifically with these clients. There were strong themes of 'buying in' and 'being more directive' in sessions during our interview. Overall, this interview confirmed some of the concepts identified by Alan but also introduced concepts about tracking change from week to week.

Carol:

Carol described her therapeutic approach as being eclectic, using systemic and constructivist ideas. Carol has a social work background and holds a Masters in Constructivist Psychotherapy. She has worked in the service for more than 10 years and been qualified for 23 years. This was not her first experience of feedback

systems. Carol was with the service when they first explored the use of feedback and participated in the trial use of the CORE system. Carol expressed her satisfaction with ASIST being a computer based (paperless) system and her opinion that the CORE-OM was difficult to integrate into sessions and required a lot of admin and scoring between sessions.

Carol described how she has not used the SRS recently, and felt this was because the questions are naturally woven into therapy, so that she gets the process feedback directly from the client. This may be a case of feedback duplicating what therapists already do. My sense of this participant and our conversation was that she integrated feedback into her practice, and had done so for some time. ASIST was not used to its full potential, and this was due to slippage and possibly a sense of feeling unnatural to ask a client about process and then ask again to complete the SRS about the session. Carol had a positive experience with the ORS and saw it as a lead into the therapeutic conversation.

Denise

Denise was a counselling psychologist. This was her first post-qualification job and she has been with the service for 3 years. She also has a private practice. It was apparent that she operates psychodynamically in her private work but uses a solution-focused approach during her work within this service. She reported that this does not present too much conflict. She identified administrative difficulties with the feedback system initially and that this led to her disengaging from the system. However, she has stated she plans to reengage with both the SRS and the ORS when the next academic year commenced.

This change was attributed to a shift from seeing it as a research or audit tool to one which may contribute to the therapeutic conversation. This is a shift that has been identified by me in the interviews with other therapists in this service and by therapists in the other service.

My sense of this interviewee was that she was comfortable with the idea of being evaluated as she had recently completed counselling psychology training and that this feedback system was no different. However, I got the sense that the value of the system was not fully explained and it was only through reflecting on her practice during the quieter summer months that she made a conscious effort and decision to engage with the feedback system.

Edith

Edith is a psychologist and family therapist. She has worked in the service for more than 6 years and been qualified for 15. She described her way of working as psychodynamic but also considered other ways of working. Like her colleagues, she worked within a solution-focused service that offered 8 sessions, although she spoke of being able to request longer periods of therapy on a case-by-case basis.

I found this interview to be challenging as the interviewee stated she had not engaged in the feedback system, and was sceptical about its utility. The participant stated she did administer the SRS and ORS using the ASIST system, but did not use it in session. It was seen as an admin tool and not something that was part of this therapy. I found this challenging, as I had not prepared for this response, therefore we spent the time talking about the barriers to engaging with the system and how it could be improved. I understood that this system was not compatible with the way Edith worked. This person was open to other measures or ways of eliciting feedback but this system was seen as not being specific enough to confirm changes in clients or in the relationship. We spoke about a number of administration difficulties. Despite the difficulties in not being able to reflect on how feedback was used specifically with this therapist's clients, the discussion about the barriers was very useful in giving a balanced and honest experience of feedback in day-to-day practice.

Adult Psychological Therapy Service:

Frank

Frank is a medical psychotherapist. He described himself as a psychodynamic orientated therapist. Frank identified with the difficulty in measuring the many aspects of therapy and spoke of how he had attempted to develop measures in the past. He stated he has had difficulties accessing the feedback reports and was unsure of whether the reports told him anything useful about a client/patient that he did not already know. He did however report that he looked at risk items on the pre-session measure and that he was aware of his duty to monitor risk or harm to self. He said he did not use the feedback report in any way. In explaining his reasons, he felt that it did not fit with his view of therapy.

I was aware of his sense that this was a research task and that he was not made to feel part of it and would have invested more of his time and thoughts if he

was told more about the research and how it could be used in therapy. My sense of this therapist was that he valued eliciting client feedback but that this is something that is done as part of therapy and in the room, and that pen and paper questionnaires may not identify the right or most useful information.

Geraldine

Geraldine is a recently qualified clinical psychologist. She described herself as working within an integrative model. Geraldine identified her unease with the feedback system and with using feedback in therapy. She felt it was something that was difficult to utilise and that it was unfair to ask clients to complete sessional measures if they had no therapeutic value.

She stated that she did not use the feedback report or the pre-session measure in her therapy with her clients. She agreed that there were some administration issues with the feedback system in the service but also felt that she was not someone who believed the questionnaires told her anything more about a client that was not already apparent during therapy.

My sense of our conversation was that Geraldine's experience of the feedback system was not very positive. She felt she was not adequately trained in how or why it was being used. Geraldine saw feedback as a piece of research and separated it off from her therapy practice. If clients did not complete measures, she did not chase them. While she did not engage with the feedback system explicitly, I got the sense that she did seek out feedback from clients in her sessions and adjusted her practice based on client responses. She also utilised model specific measures that formed part of therapy with her clients.

Again the distinction between feedback as research and feedback as therapy was made quite strongly, and I found the interview confirmed many of the ideas that previous interviewees raised.

Hillary

Hillary is a qualified clinical psychologist. She described herself as being psychodynamic in her approach. There is a sense that this interviewee felt very attuned to the needs of her patients and was interested in improving her practice through the use of video recording of sessions and using the feedback system as it currently stands. She expressed a desire to continue to elicit feedback and to use the measures when the research period finishes.

Ingrid

Ingrid was a recently qualified clinical psychologist. She described herself as not working in a particular therapeutic model or having specific training to work in a particular way. She described herself as an integrative therapist who took from interpersonal therapy, dynamic therapy and CBT. She expressed her enthusiasm for using feedback with clients in their therapy, but felt it was difficult to do so in the current system and she found it difficult to engage with the research project as it was something that was pushed down the priorities while she became comfortable in a new service in her first qualified job.

I got the sense from her that she would like to use feedback with her clients and has begun to see it as a part of clinical practice rather than a research component separate from therapy. When feedback was seen as a research tool, she reported not engaging with it for the above reason and during our interview it was difficult to get specific examples or instances where she shared feedback directly with clients. She reported using it to inform and confirm her thoughts and feelings about clients and how sessions were going.

James

James is a qualified clinical psychologist. He described himself as working within a psychodynamic framework. James has worked at the service for less than 5 years, and was the longest serving interview participant. James has also been collecting feedback measures within this service prior to the commencement of the feasibility study. These factors may eliminate the sense of distance from collecting feedback that was expressed by other participants.

My sense of our conversation was that James was positive towards the feedback system, and valued some aspects more than others. There was a clear message that the trajectory of change is of significance and interest to him. I felt that James had a very active participation in the research. He spoke of how he would seek out measures and use graphs to chart the patient's progress; and that this was something that could be shared in therapy.

This was my last interview and I was aware of trying to cover all topics and to try to wrap up any loose categories or themes. This may have affected my engagement with the interview topics. I also felt that we did not look at specific clients, but talked about the general use of feedback in James's work. Again, this may change the impact of this interview.

Student Counselling Service (SCS) analysis

This section will begin by outlining the theoretical formulation of the SCS group data, which consists of two core categories. Codes were identified from this service initially, and may have influenced the coding for the second set of data (APTS group). Core categories will be further described by explaining the associated subcategories. Quotes will be taken directly from the interviews to further illustrate the subcategories.

Service description

My sense of the service is that it works with clients on a specific issue, often academic but also anxiety and social or relationship difficulties. When clients are more complex, they may be referred to other services. All clients are attending university and therefore referrals come from a particular section of society. Furthermore, as this is a university service, clients could be considered high achievers and have high levels of academic ability. This may not be typical of a general population or a service that caters for adults with complex and severe difficulties (like the other service in this study).

The overall sense I got from the therapists is that they were receptive to using feedback in session, and will often give some active attention at the start and end of each session. However, there was also a sense from the therapists that they relied on their own skills and sense of sessions primarily and used the feedback scores as a backup or support for their intuition. Feedback was seen as a service demand and this introduced the belief that it was less of a therapeutic tool. Nonetheless, therapists were supportive of the system.

Theoretical formulation

The detailed process of coding produced 1202 open codes and 74 axial codes. These were then revised to produce 2 core categories and 11 conceptual categories. The theoretical formulation comprises a number of interacting processes described in Figure 2.

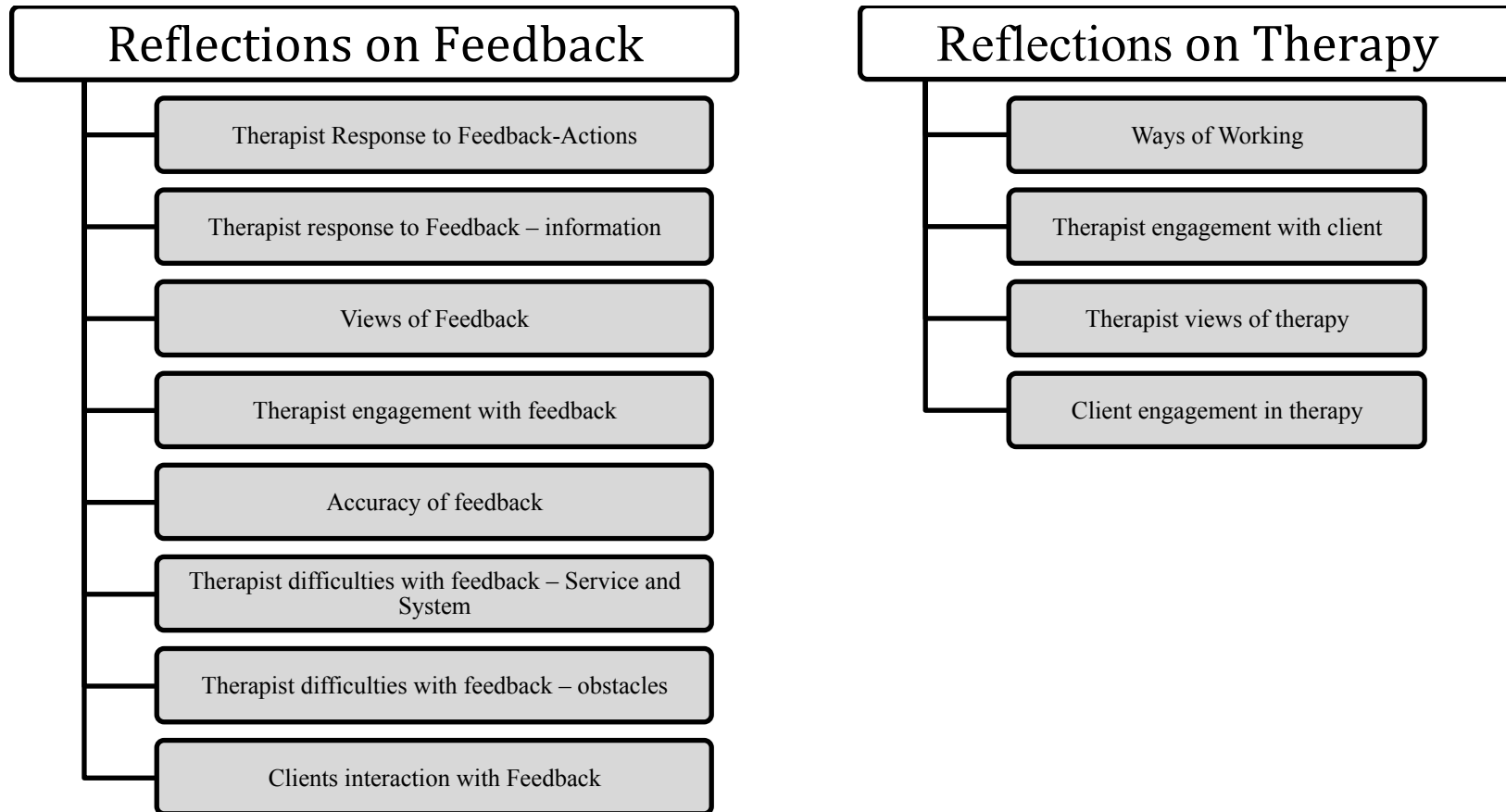


Figure 12: Overview of APTS core categories

Description of core categories

Two core categories were identified from participant interviews. It was clear throughout the analysis that when asked about their reflections of using feedback, therapists described both their engagement with the feedback system in their service and their engagement with therapy. As the analysis progressed from open coding through to axial coding and then to theoretical coding, this distinction became clearer. These were labelled 'Reflections on Feedback' and 'Reflections on Therapy'. Each will now be described briefly.

Reflections on feedback:

The core category 'reflections on feedback' was the larger of the two core categories. Within this category, there were 8 conceptual categories.

The overarching theme within 'reflections on feedback' is the different levels of engagement therapists described. There was a strong sense of the role played by therapist attitudes, service environment, and client factors in the extent therapists engaged with the system. These concepts and likely routes towards engagement became conceptual categories on which the proposed theory of therapist engagement with feedback is based.

Therapists spoke about their responses and actions, the information they gained and how that information was used in therapy. There was also a clear evaluation of the value and accuracy of the feedback therapists received.

Reflections on therapy

This was the smaller of the two core categories. This core category contains 3 conceptual categories. As with the above category, therapists reported how they had a number of tasks within therapy and that how they engage a client in therapy is facilitated by their approach and style of therapy. Therapists also reflected on client factors to engagement with therapy. Exploring therapist's engagement with therapy was not the goal of this research, however throughout the analysis it was difficult to separate therapeutic engagement and feedback engagement. It was often that one linked to the other.

Core category: Reflections on feedback

Category 1 – Therapist responses and actions – Information

This conceptual category captures participants’ experiences of gathering and utilising information collected from feedback measures. Three subcategories were identified (See figure 3).

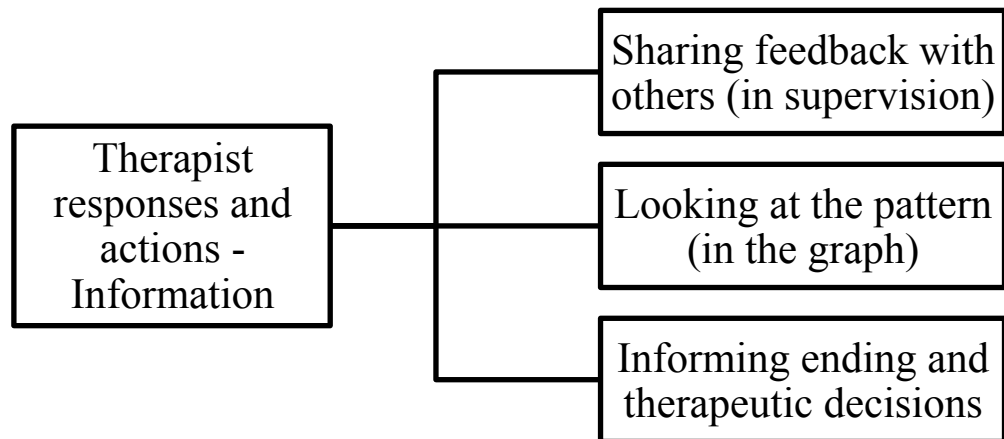


Figure 4: Model of therapist responses and actions - Information

All participants commented on sharing feedback in supervision. One spoke of feelings about their performance, and of how a low score may not reflect a session: *“we’ll have team meetings and you’ll be like oh that person’s ORS score is quite low but yet they actually had a really good session”* (Denise)

Another commented on the use of feedback scores in team meetings; they felt that it is not possible to make sense of them out of context, and they are not taken seriously. However, two spoke of how looking at the feedback scores can prompt therapists to bring clients to supervision; they had done this but also noted that scores are actually not discussed very often.

Two participants reported using the graph from the scores, and some indicated that the graph showing a change in their client’s trajectory over a number of sessions was particularly useful. One spoke of how it was useful to see large drops or increased from a previous week, and to be able to prompt a discussion with

a client about what this peak or drop was about. It appeared that looking at the pattern informed therapeutic discussions and possibly the direction of therapy:

it gives me information right off the bat. ... I mean to see it in a graph sometimes and to see how variable something can be you know I might say to her when she had her very low day I said ... that's extremely low this week (Edith).

Three participants reflected on how feedback scores can inform the ending of therapy and other therapeutic decisions. Participants identified how feedback scores are an aid to therapeutic decisions but that the therapist needs to account for other signs that further intervention is not needed:

I would use it in the content of the session as a guide as to whether this person needs further intervention or ... should I offer this person another session or should I just say to ring us if you need another session ... so if they're above the clinical cut off score, there are questions I ask myself (Beth).

Category 2 – Therapist responses and actions – Utilising

This conceptual category captures participants' experiences of interacting with feedback scores and how they were used in the course of therapy. Eleven subcategories were identified (See figure 4).

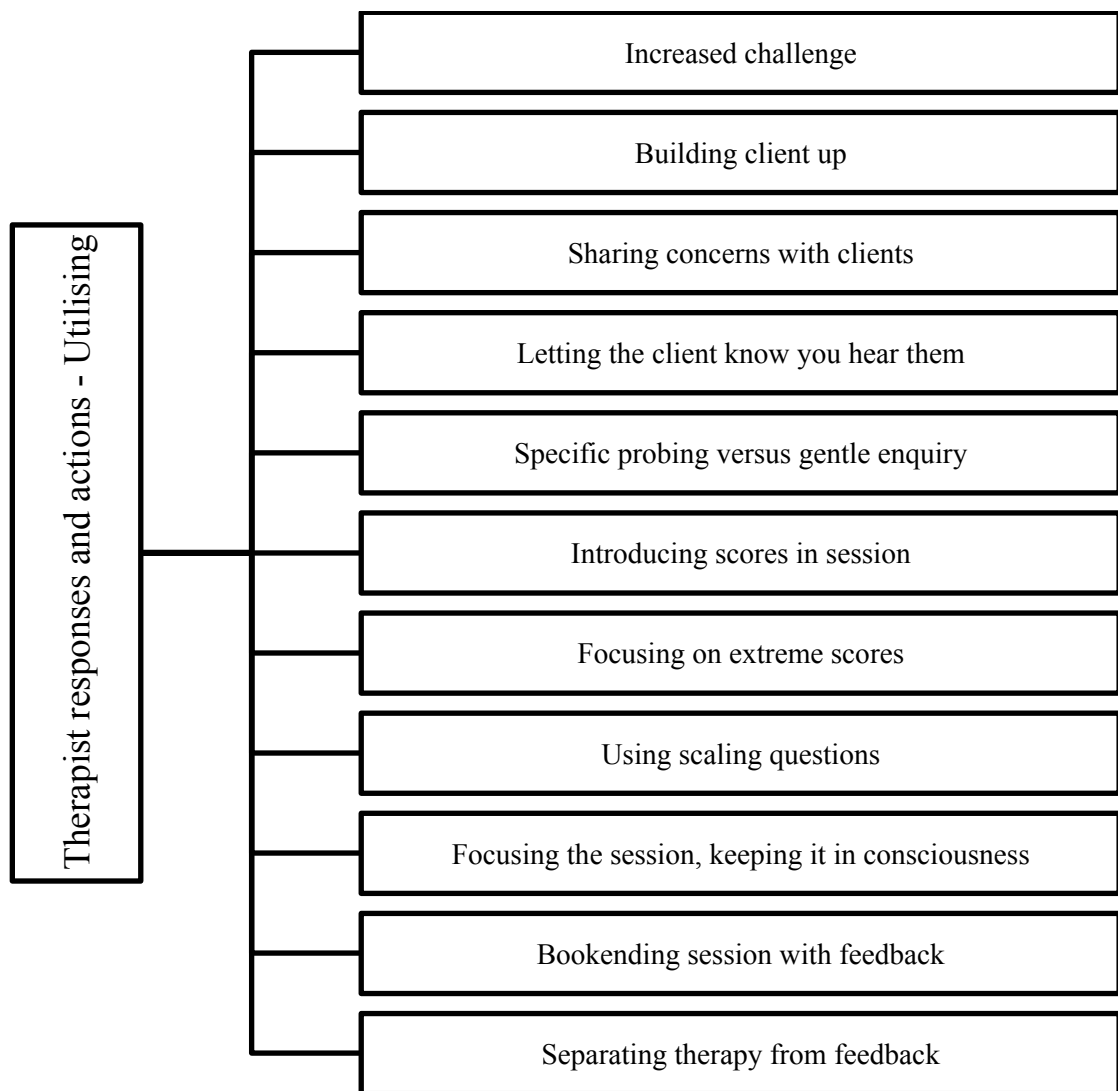


Figure 5: Model of therapist responses and actions - Utilising

Participants reflected on directly using feedback scores in sessions. Three reported utilising feedback scores to challenge clients to think more about aspects of their life or therapy. One described increased challenging as a reality check for clients and that this was helpful. For some therapists, an increased challenge was asking a client to look at what is so low about their scores; if there is something they could change in their life or in how they come to therapy. One described how they would like to have challenged clients more about the meaning of the feedback score, and that this would have been helpful for the client:

I think if I was to do things differently, it would be to take the session rating scale and the really break it down ... Maybe focus on the scores that he was giving and to challenge him a bit more (Alan).

Three reported they used feedback scores and improvements from week to week to improve a client's confidence. They described how this gave new hope to clients, emphasised change and built resilience: *"I'd say ... you gave me a much better account of how you were and I notice you improved in this and that and so there was that dance of empathising, trying to understand but also empowering"* (Beth).

Participants reflected on sharing scores with clients. All identified using feedback scores and the progress or lack of progress to share concerns or to be honest with clients about their situation. One reflected how having the score could make it easier to be honest and used it as supporting evidence of a client's distress. Another described how they could use the score to highlight the conflict between what they report on the feedback form and how they present in session: *"I did say to her like I was a bit concerned ... sounds like you're saying everything's ok but you know there seems to be a lot of struggle here"* (Beth).

All commented on how they were able to reflect back to clients that they had listened to them and heard them. Participants reflected that client feedback scores and the pattern of responses could indicate specific needs or difficulties for clients. All agreed that feedback scores made it easier to explicitly identify a client's distress: *"there have been so many occasions when I have said 'I notice that score is, it is not really low but it is lower than the other ones, can you comment on that'."* (Alan).

Although all stated that while feedback scores help recognise client difficulties, these are often what clients come to therapy for and would be discussed in the course of therapy anyway.

Participants reflected on how they used feedback scores in therapy. Four commented that feedback scores enable both direct probing and/or a gentle nudge to query a client's presentation. Participants use both approaches at different times and also with different clients. Some identified the 'gentle' or un-intrusive nudge feedback provides was a way of building a rapport with clients who are more defensive or find it difficult to be open. Participants reported the benefits of being more directive or probing, as it can help clients confront areas of distress:

So I might say look at this particular bit it's not so good ... can you tell me a little bit about what I could do differently or whatever ... So we'd go towards the lower score rather than the total score (Beth).

Three reflected on how they will pay more attention to extreme scores. One reported that as time passed they became lazier and would only comment on scores that were extreme:

Probably, I look less at the detail now than I did at the beginning and I am not proud of that ... sometimes I will just look at the general one and see if there is anything that I notice, hover over the thing on the screen and if anything really jumps out fine (Alan).

Four commented on how feedback scores became part of the conversation in therapy. However, participants reported not discussing scores with everyone. As with the other sub-categories, participants reported introducing scores when there was an improvement and praising the client, or when there was deterioration and enquiring what meaning the client puts on this score:

there was sort of an opportunity to say well actually this score is really low and this tells me that ... perhaps there are things going on for you, ... in terms of your wellbeing and maybe you're not coping so well as you'd like to and I wonder can we look at that over a few sessions and you know (Beth).

Two reported how feedback scores could be used similarly to scaling questions. That therapists could ask clients what would have to happen for you to increase your score by 2 or 3, or what would have to happen for you to not to return to a lower score. This is a technique commonly seen in Motivational Interviewing. Although this approach was not mentioned, it was clear that this was one of the strategies.

Two described how they use feedback to focus the session, and keep a client in their consciousness. Both spoke about how feedback scores can focus a client onto an area of distress and also to help the therapists think about the client and the distress they might experience outside of the session: *"it keeps that in your consciousness to use that feedback to pay attention to those things"* (Denise).

Finally, participants reflected on keeping feedback and therapy separate. Four commented on bookending sessions with feedback, and indicated that they started and ended sessions with feedback. This approach matched the feedback

system in place. One spoke of how they did not let feedback intrude on the session and kept it to the start and end of a session, but continued to practice therapy uninterrupted during sessions. Other therapists spoke of how feedback was allowed to enter the therapy session, and that the start and end of session were used to check out the client's wellbeing. For these participants, bookending sessions with feedback was an active attempt to elicit feedback about the clients world and the session:

So I began to use it but not, not like taking over the whole session but at the end of the session or at the beginning of the session I might just allude to you know an improvement or a dip in it and try and just tease out what that might be (Beth).

Four reported keeping feedback and therapy separate. One explained how feedback was not a priority for them and that sessions were quite full and often ran over. Another described how initially their therapy was quite separate from feedback, but that they have now integrated it closer: *"they do that and we'd sit down over here and do the therapy and the two things weren't very linked."* (Carol).

Category 3 – Attitudes to feedback

This conceptual category captures participants' attitudes towards the feedback system. Participants shared their initial views and then how these views changed as they became more comfortable with the process of eliciting feedback. Eight subcategories were identified (See figure 5).

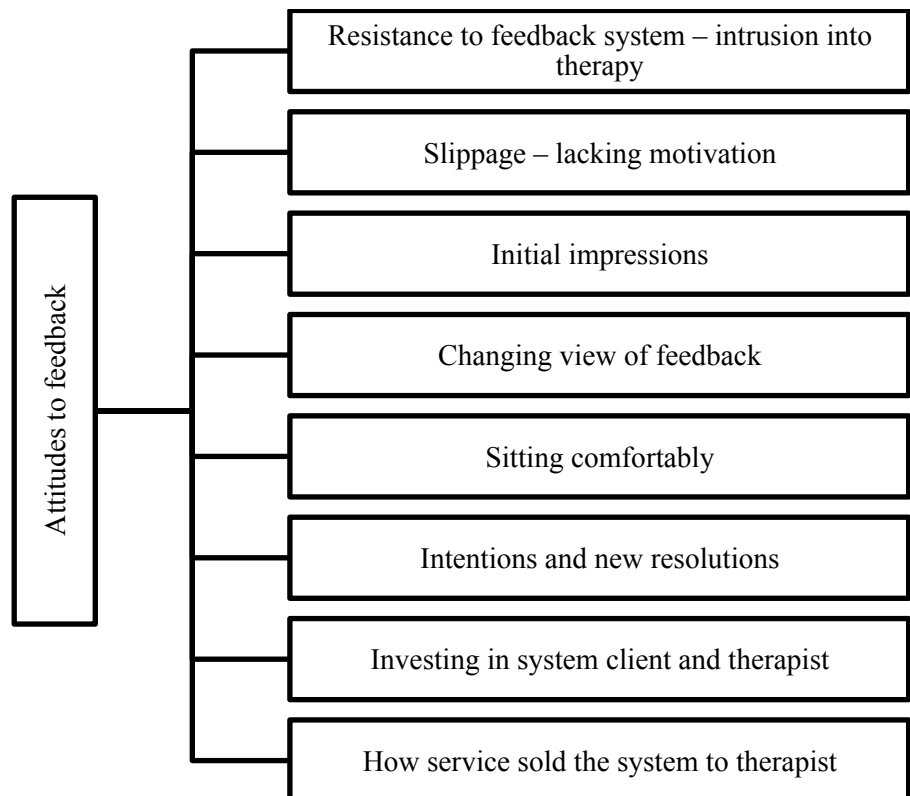


Figure 6: Model of attitudes to feedback

Participants reflected on their negative attitudes towards feedback. Three reported that they had concerns that feedback could intrude into the therapy. This occurred in two ways. First, clients might take too long rating themselves. Second, the discussion of the meaning placed on the feedback might intrude into the session. One highlighted that they: *“dropped using SRS because I just find my time so limited ... it’s just too much to do all in one session.”* (Denise).

All reflected on how their attitude towards eliciting feedback or using the feedback system waxes and wanes. When a client is not engaging well in therapy or is resistant to completing feedback, their motivation can drop and participants reported not administering the measures: *“I think everybody is, has fall offs but we just get out of that habit ... of forgetting”* (Carol).

One reported that their motivation to use the session rating scale has dropped as the scores don’t say much about the relationship, and clients can respond dishonestly, which makes the scores meaningless.

Participants reflected on their initial attitudes and how these changed over time. Four commented on their initial impressions of feedback. Two identified that

they were enthusiastic about it, while two others were apprehensive. Two described how they were aware of having a negative or cautious impression initially, and only after engaging with the system did they warm to it. One was quite resistant towards the system and was sceptical of the benefit or accuracy:

So I volunteered to take part ... because I was so resistant to it. My initial response was 'oh god like here's another intrusion to our therapy', our, you know you get 50 minutes with somebody. ... here's yet another thing that I have to introduce into that hour, it's going to take up time (Edith).

All described how their attitude towards feedback changed as they used it with their clients and were able to see some of the positives: *"I think the fact that we're still doing it would show that we're reasonably positive towards it."* (Carol).

One reported feeling less enthusiastic about the feedback, and acknowledged they approach it differently, and feel that it should be used selectively with clients who might be open to using feedback.

Three shared how they often needed a period of time before they were comfortable with the feedback system and that during this time they may find feedback difficult to implement:

[I] do think there is a piece of becoming familiar with the score, feeling at ease with how you administer it so that it doesn't become like an add on or a cumbersome thing so that it's fluid, so that it's part of what you do ... that it becomes embedded in your therapy session and that it's a, it's like a valuable part of your therapy session so it's got a space of it's own (Beth).

Four reported they had new intentions and resolutions for using feedback in the new academic year (September). Depending on how they used feedback already, participants either engaged more with the process measure (SRS) or made more of the meaning of the scores on the outcome measure (ORS) with clients. One reflected: *"I might erm consider ... being a bit more attentive to this here in the sense of ... that it just being a bit more specific about what exactly was helpful about the session"* (Beth).

Finally, participants reflected on the process of investment. All described how they became invested in the feedback system and what factors lead them to 'buy in' to using feedback in their therapy. In addition, some described the factors that helped clients invest in the system. One factor identified was being able to see

the impact of introducing the scores into the session and the conversations that emerged on the goals of therapy. Participants also reported the support that they received from colleagues as being a factor in their investment. It seemed that placing a therapeutic value on feedback would improve both client and therapist investment: *“I think if you have an investment personally in your own therapeutic process, it is going to make it so much more useful for you as a therapist.” (Denise).*

One participant commented that when the client reminds their therapist to use the measures it is obvious that they are invested. Furthermore, clients who notice their change or symptom improvement tracked by the feedback graph are more likely to ‘buy in’ to the system.

All reflected on how the service sold the system to them. All said that on one level feedback was viewed as an admin duty and that outcome scores from therapy were used in auditing the services’ efficiency and prospective funding. However, they also identified how the feedback system was sold as something that could help their clients and also help their therapy practice. More experienced therapists also spoke of how they received training when feedback was first introduced with the service:

And what I really found valuable about the training initially was ... how [NAME]’s language around the dips and hollows in it ... ‘What would you say to your client, if you have a bad SRS score?’, ‘how would you bring that up?’ he delivered some role play on that and I found that really helpful. (Beth).

Category 4 – Feedback in the session

This conceptual category captures participants’ general therapeutic responses to feedback. This differs from the actions that therapists might employ with a specific piece of feedback. Participants identified how feedback was seen as supporting the effectiveness of therapy, or providing a topic for conversation. Ten subcategories were identified (See figure 6).

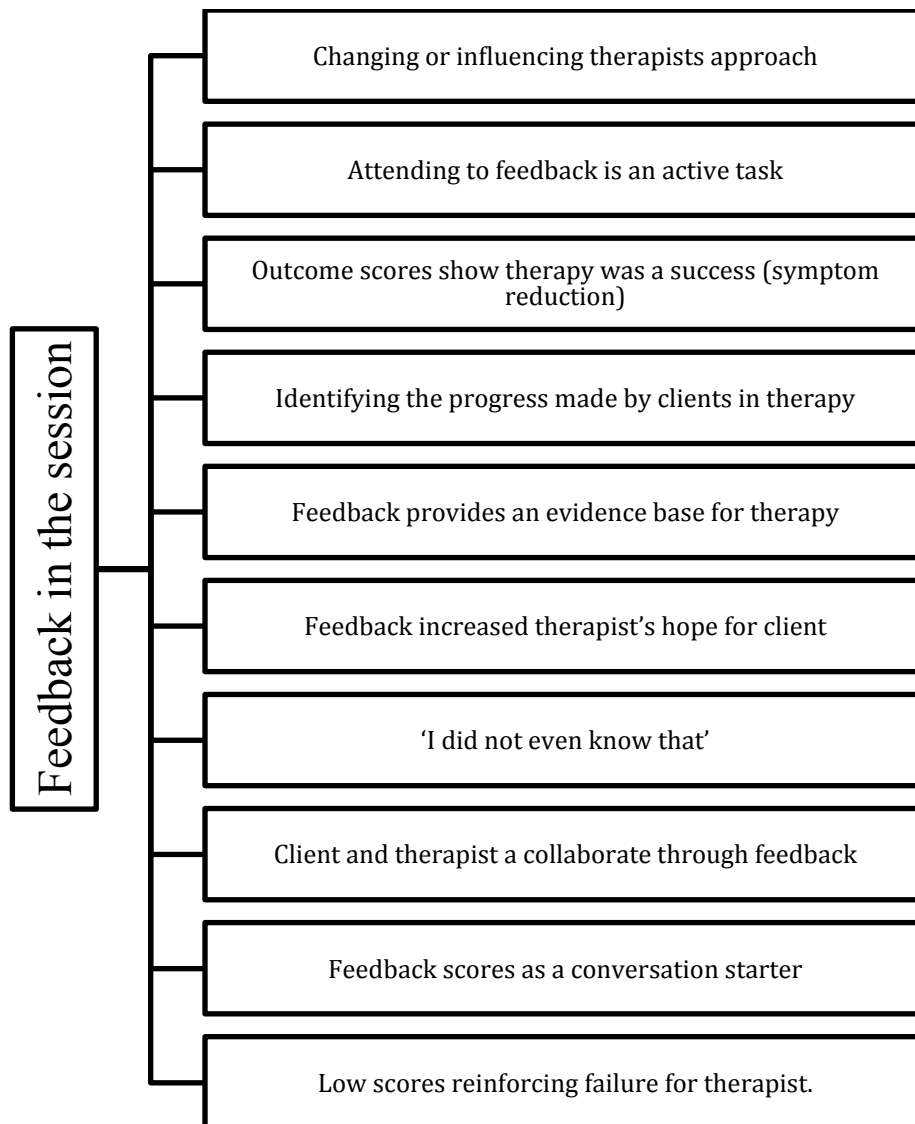


Figure 7: Model of feedback in the session

Participants reflected on the approach to feedback and therapy. All commented on whether feedback influenced their therapeutic approach. Three acknowledged that feedback required them to work slightly differently, but that their therapeutic model was not affected. Two felt that their way of working was unchanged, as they believed they asked ‘those questions’ already and that the feedback questionnaires formalised the process:

I think it enhanced my sort of sense of the value of it ... and I think then [that] increased my attentiveness to the detail of it and probably increases in general ... my sense of how you can actually use this feedback system in a therapeutic way so, not all the time but some of the time (Denise).

Three reported that they sometimes would have different conversations with clients now they had feedback information. Two stated these conversations occurred in therapy anyway, but with feedback they occurred earlier or more explicitly.

It might be difficult for a therapist to acknowledge or notice a change in approach or to say whether the conversation they had with a client about something would have not happened anyway if feedback were not used. When a change in approach was identified, participants identified what had changed. Specific areas of change were either at the beginning, where therapists would discuss the meaning of feedback scores, and at the end, where therapists asked about the client's experience of the session.

Four reported that eliciting or using feedback in therapy was something that required the therapist to actively engage with it. Participants spoke about how they would explicitly draw client attention to the scores, and that because the system was computerised it required the therapist to 'put it on the agenda':

there is a sense of you have explicit examples ... so I think it helps to open up and keep that therapeutic alliance going as such erm maybe in a much quicker way and that really enhances you know when you try to do brief therapy (Denise).

Participants reflected on the measurement of outcome. Two reported specifically that outcome scores could show the client, the therapist and the service that therapy was a success. All commented that feedback scores and improvements over time as shown on the feedback graphs provided an evidence base for the work they did:

"[I would] be really trying to get a sense of where they're at and is this useful and how are they viewing it ... and not assuming that just because I've think we've had a brilliant session that that has actual been their experience (laughs) you know." (Carol).

Two identified that improvements in feedback scores often raise their hope for a positive client outcome. One reported how small changes in scores were seen as a life vest for the therapy, and something that was emphasised for the client. When a participant's hope was increased this was passed on to the client: *"I got more and more motivated with him because of his investment and also I was then getting great ratings, and it became easier to do that" (Alan).*

Four reported how the feedback graphs can help recognise progress of clients. However, it was also clear that participants felt that this was only one aspect of progress, and that client self-report was also a sign of progress: *“He really started to appreciate that as well. It was almost like he was benchmarking himself” (Alan).*

Participants reflected on the therapeutic relationship. All reported on how feedback scores can be used to start therapeutic conversations about feedback itself but also its attributed meaning and how the score relates to therapy, or to the clients life. Participants stated that often conversations about feedback opened up other conversations into areas of significant distress for clients. Participants spoke about how it seemed easier to introduce a score and have a discussion than to ask directly about someone’s interpersonal difficulties or how they felt therapy was going or whether there was a good working alliance:

I think there’s a lot of times where people were more likely to put something on a computer that feels more well not anonymous but that they don’t have to make the effort to explicitly say something that they may be feeling, that find it hard maybe to say to a therapist (Denise).

Four commented on how feedback often told them information that they had not known, though one felt that feedback rarely told them anything new, that often the feedback mirrored their experience. When participants reported they had learned something new, they also spoke about how this helped the therapy and the client:

I don’t know whether this is something I wouldn’t have known but I think I was very struck by the fact that her score had gone down ... your initial reaction’s like oh gosh I thought that was a great session (Denise)

All participants reported how feedback was a collaborative tool, and even when feedback was not to be used, this decision was taken collaboratively: *“I think what this feedback system tries to do, is it tries to share power, responsibility ... In some ways I stopped using it in the same way that I might.” (Alan).*

One participant felt that feedback highlighted the different goals the client and therapist had and how that prevented collaboration.

Finally participants reflected on negative feedback scores. Three identified how low scores on the ORS and the SRS can reinforce failure and can have a demotivating effect for therapists and clients. One reported that bringing low scores

to team meetings can also have a demotivating effect and reinforce a therapists vulnerability that they are not ‘fixing their client’: *“I took my eyes off the feedback thing because all it was, it was another confirmation that I was not fixing him.”* (Alan).

Category 5 - Accuracy of feedback

This conceptual category captures participants’ perception of the accuracy of feedback they receive. Four subcategories contributed to this category (See figure 7).

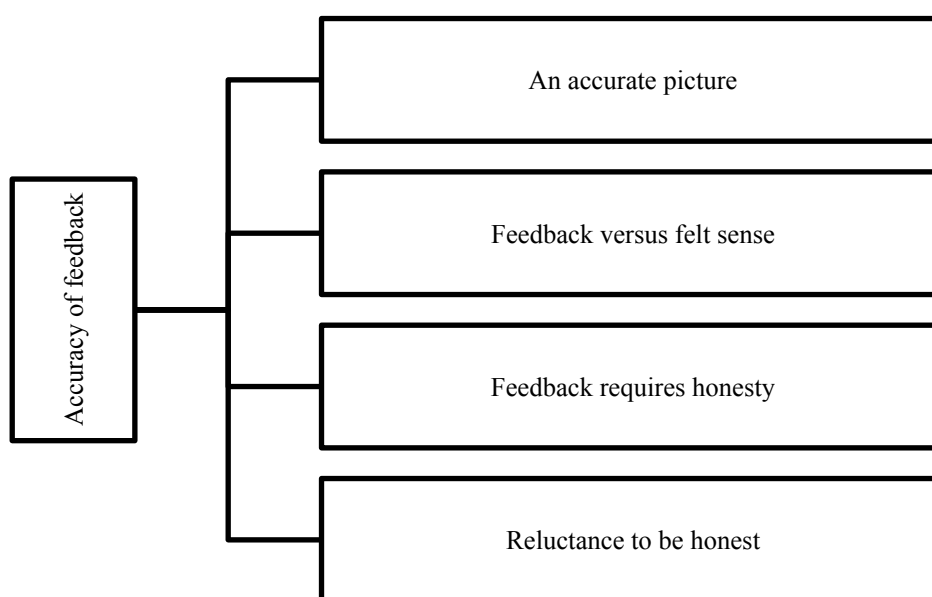


Figure 8: Model of accuracy of feedback

All participants reported how they evaluated feedback, and made a judgement about whether they found it accurate. One spoke of how the feedback system elicits general concepts of distress and the therapeutic relationship and this might reduce accuracy and specificity. All reported how feedback could be accurate, but also experienced it to be inaccurate at other times. Two reported that some clients could minimise their distress and one way of judging accuracy was to establish if scores were higher (or lower) than how clients presented: *“I asked her about it because she was one of those who ... she would come in and almost with her eyes closed clicking so I never knew if it was accurate”* (Carol).

All commented on how they often measured the accuracy of feedback according to how it matched their felt sense. They spoke of using the mismatch

between their sense of a client and the feedback score to create a dialogue about the meaning of the feedback. Participants reflected most about times when it did not match their sense, and that it was through this experience that they got to know the client better.

Participants spoke of how feedback often supported their sense of how therapy was for the client: *“she was very clear it was her score it was her number that she chose you know it meant that I wasn’t imagining something or I wasn’t you know hypothesising something” (Beth).*

All participants reported how important it was for clients to respond honestly to questionnaires. Furthermore, without this honesty, the feedback system falls down. Participants felt clients are not honest for a number of reasons, and that when a client is dishonest it means that therapists might get the wrong message about therapy: *“it means I’m picking up things then very differently from what you might be saying here and then what you’re saying actually in session” (Denise).*

However, participants also noticed that a client not being honest could be useful feedback, as it might lead into a conversation about what it is difficult to talk about. Participants valued this aspect.

Three participants commented on how clients may be reluctant to be honest for a number of reasons. All three reported examples of when clients under-reported their level of distress as well as examples of client over-reporting distress:

they go over to that terminal, I am still sitting and they go ‘ah sure, your grand, of course you are doing a great job, thanks very much’. They almost don’t want. Maybe there is a tendency to not want to look ungrateful or not want to anger me (Alan).

Reasons provided by participants included, client not wanting to let the therapist down so they said they felt better, or not wanting to seem ungrateful so they rated the alliance high.

Category 6 – Process reflections

This conceptual category captures participants’ reflections on the process of feedback. Participants reported how they felt feedback could impact on them emotionally, and how they are able to separate out feedback from therapy. Six subcategories were identified (See figure 8).

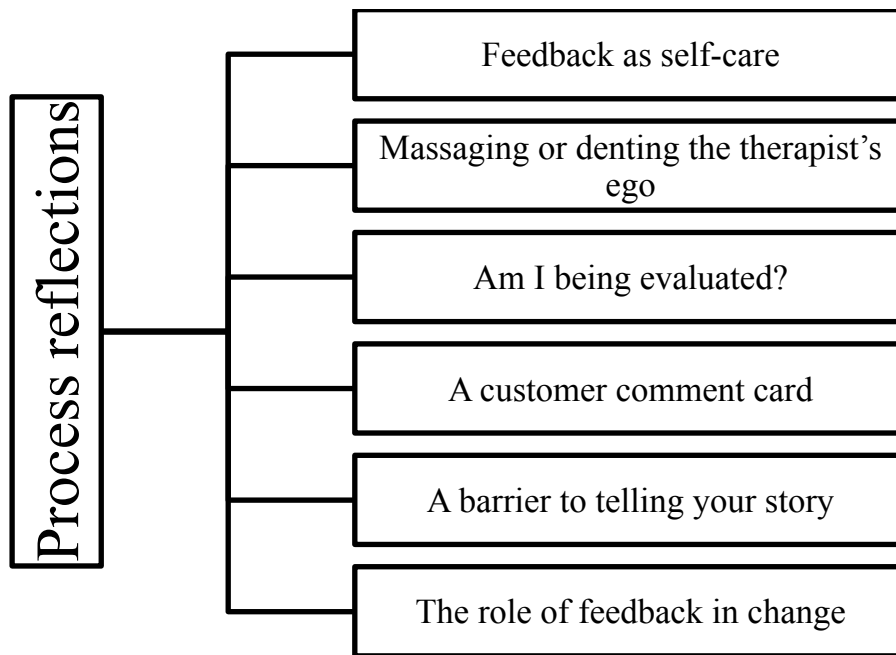


Figure 9: Model of process reflections

Participants reflected on the impact of feedback on their practice. One spoke of how session feedback together with a therapist’s sense of themselves can indicate self-care issues. Specifically, they said if a client rated the session low, it might draw their attention to whether they were a bit tired or a bit distracted. This raised an interesting perspective on the therapeutic relationship but also a therapist’s duty to monitor their reactions and how they are managing with their work and life:

sometimes at the really busy times here, when your energy might be a bit low and you might be fatigued and you might not be attending to your client in the way you would like ... that [it] is an interesting time to look at the SRS (Beth).

While this is clearly a small subcategory, and not verified by other participants, I feel it has a strong resonance with the ethos of feedback and therapy.

Three reflected that feedback about a client’s experience of a session could affect a therapist’s ego. Feedback critical of the session can demotivate them, whereas feedback praising them can massage and overinflate the therapeutic relationship. Participants noted this when it occurred during therapy and they were able to evaluate the meaning of it: *“why did I not find it useful to her to continue [administering measures]? I suppose if I’m honest for me this was depressing, (laughs) it must be!” (Carol).*

As with the other subcategories described above, participants described a complex process of noticing the clients' verbal and non-verbal communication, the therapists (own) felt sense of the client and therapy, and also what is reported in the feedback forms, and making a therapeutic decision.

Two reflected on how the feedback system felt like an evaluation of their abilities or their qualities as a therapist. Both participants referred to their experience at university where evaluation was used to assess knowledge and skills. However, they recognised that this is evaluation in a different sense, but that maybe clients don't recognise this aspect:

When I started it, you know I was still very much in the student frame of mind, ... you feel like you've just completed your course and you're sort of ready to go and then it's another sort of ... now I'm going to be evaluated constantly by this (Denise).

Participants did not speak of being evaluated by the service explicitly, but there was a sense that this may have been the case, as seen in other categories.

Participants reflected on the process of feedback with clients. Four reflected that the process of eliciting feedback is like a customer comment card, and that this can have an impact on how it is viewed and utilised by client and therapist. Two spoke about how it is important to get the customers comments and views on the service that is provided:

It was like giving him permission for him to say 'this is hard'. A lot of clients do this, they say 'well it is not you, you are really good, it is me'. 'I'm just building up to this', or 'I feel I need to trust you a little more before I can say this' (Alan).

All reflected on how eliciting feedback can be seen as a barrier to the clients telling their story. Participants spoke about clients who felt discussion of feedback could intrude on the session, and that clients are reluctant to put themselves in a 'box' or rate themselves on paper: "*Sitting someone down at a computer I find jarring ... I find it a bit intrusive*" (Edith).

Participants experienced this as a usual reaction from clients who were quite defended or resistant to looking at their distress in detail. One felt there needed to be a 'buy in' to feedback, otherwise clients see it as a barrier to their therapy.

Finally, three participants commented on how they viewed feedback as having a role in client change. Participants agreed that feedback can have a role in change, but that it was often unclear what percentage of change could be attributed to feedback: *“I would say yeah absolutely that it would have, whether it was the ORS or it was a realisation herself that that was something that she was finding particularly difficult” (Denise).*

Category 7 – Client response to feedback

This conceptual category captures participants’ reflections on their client’s response to feedback. Seven subcategories were identified (See figure 9).

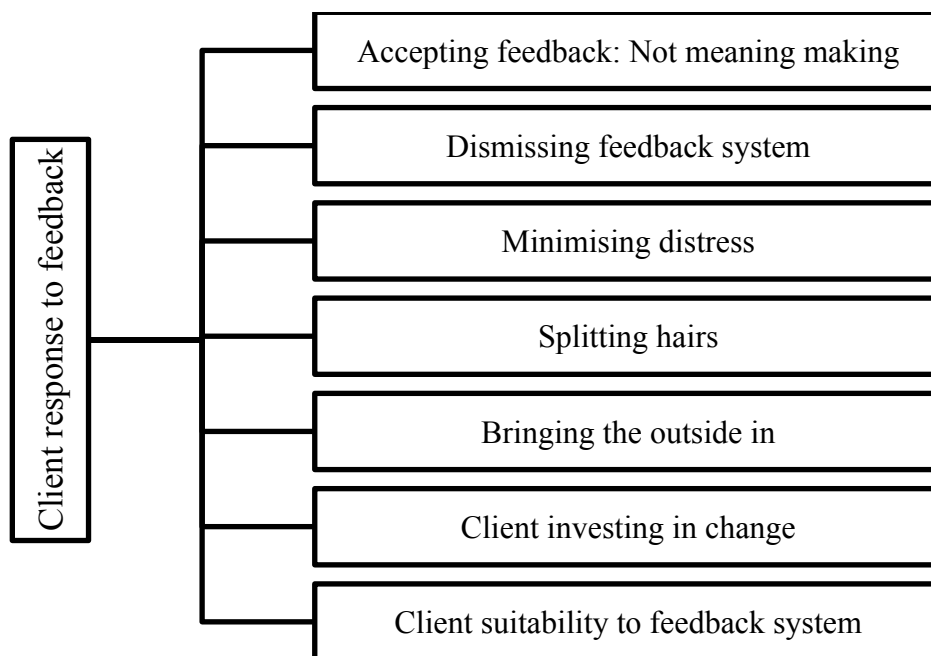


Figure 10: Model of client response to feedback

Participants reflected on positive and negative responses to feedback. Two reported that some clients don’t engage with the feedback system; clients complete the questionnaires, but do not engage in discussions about what the scores mean. Participants described how some clients comply with therapist requests and accept the system: *“Erm as a base line people just accept it as that I think ... they don’t really think is that a very low score or is that a you know?” (Carol).*

Three experienced that some clients dismiss the system outright; clients will be explicit and dismiss the system when therapists attempt to discuss the meaning of feedbacks scores: *“Cos I know there’s some people that just don’t place any value on it and think it is a load of rubbish” (Edith).*

Four reported how clients often minimise their distress when completing the feedback questionnaires. Participants also reported that client may orally minimise their distress and report that everything is fine and that they had a fine week between sessions. Participants speculated that this was due to clients not valuing the system or being afraid to confront their true level of distress by seeing it on a computer screen: *“that was reflected, her scores were fairly, fairly good you know ... But for what the content of what she was talking about, the emotions weren’t there”* (Denise).

Three reported how clients found it hard to place themselves along a line of distress in the feedback questionnaires. Two spoke about how much time clients spent completing the measure and that this intruded into the therapy time: *“he would really sit there and think about it and I would sit there and think ‘ok, almost anticipating, here it is again’. He is taking longer than most.”* (Alan).

Participants reflected on positive client experiences too. All reflected on how clients who invest in therapy and invest in the feedback system bring examples of their life and their distress in response to being asked about their feedback responses. Participants also spoke of how accurate they felt client responses to therapy were when they invested in the feedback system: *“it may have been actually a more accurate reflection of, well I’m sure it was to do with what happened in the room but erm it connected a bit more to the struggles outside”* (Beth).

Three described how the feedback system was a way to confirm that a client was invested in change. All three reported how clients were able to show how changes made were linked to increases in feedback scores:

Probably, I think that the most important thing to state is his investment. I am drawing attention to it, but he is actually buying into it. That is ...’ I am thinking about how I am doing every time I sit down. And I, that is a real accurate reflection of where I am at’ (Alan).

Finally, three participants reflected that some client’s personalities did not match the feedback system. One felt their client was very computer minded, and found it easier to put his experiences and distress into the feedback questionnaire on the computer than speak about it in session. This client accordingly suited the system: *“I think some clients really enjoy it as a way of engaging, as a way of*

looking at what they do in their lives and with us. But I think some of them just really don't." (Alan).

Category 8 – Theory and practice of feedback

This conceptual category captures participants' reflections on the theory and practice of feedback. Eight subcategories were identified (See figure 10).

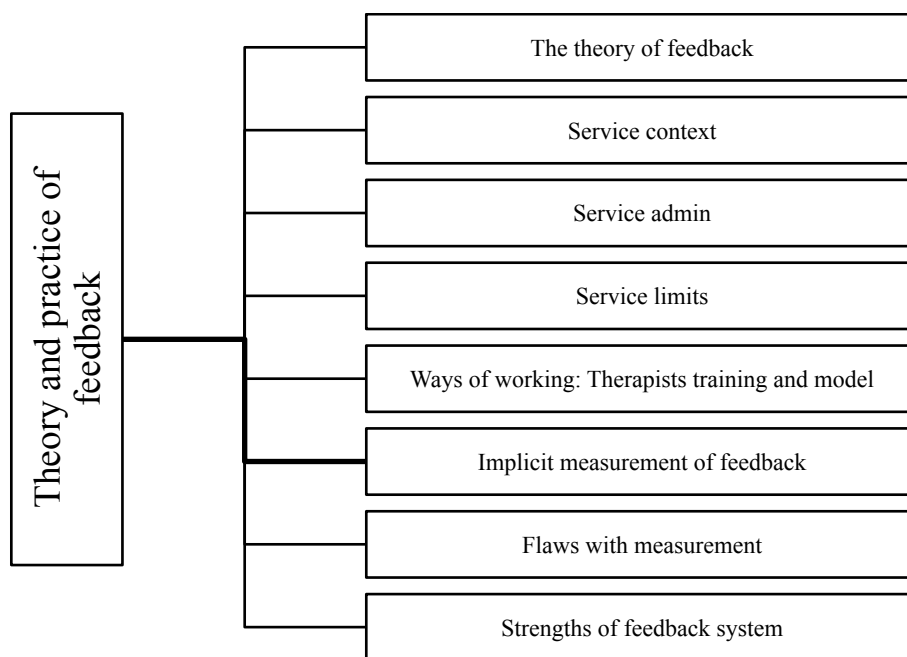


Figure 11: Model of theory and practice of feedback

Participants reflected on the service and the feedback system. Two spoke about how the feedback system matches well with the ethos of the service's solution focused approach. Participants also commented on how they might not use the feedback in the way it was intended and that their engagement with feedback might not be in the spirit of the theory: *"I've also done some brief solution focus therapy training as well ... so that model obviously is where the Assist outcome measure comes out from I think."* (Carol).

All identified the context within which the feedback system exists; that the service operates an 8-session solution focused service. Participants identified how their own training and modalities are incorporated into this context. Participants spoke about how the service context frames the use of feedback: *"how I work as a therapist has been influenced by how I have to work here it is a brief service"* (Denise).

Three commented on aspects of the feedback system that is admin heavy, and commented upon some of the difficulties of administration and interpretation of feedback. Two reported that the feedback system is often thought about as an admin tool, which is something they are told, is important to show externally that they are an effective service, and that the therapists lack certain amount of ownership:

The reason we're doing it is suppose overall is to be able to measure outcome. Also you know in terms of what we can report to the college ... in terms of funding and all of that justify our existence [laughs] (Carol).

Four reported that within the service there are a number of limitations that can impact on the ability to make the most of the feedback system. All stated that when the service is busy, it is more difficult to give time to client feedback responses, and that at their busiest; it is difficult to request clients to complete the forms. Another limitation is that the service offers a crisis service. One participant reported fearing they would seem insensitive to ask a client to report their distress on a questionnaire, and then get them to talk about that process:

where I have fallen down, ... is that I find when there's crisis work ... I find it really hard to start talking to somebody, a new person start talking them through the whole program (Carol).

Participants reflected on how they fit into the feedback system. Two reported that their way of working does not match the feedback system, and that in private practice or in previous jobs they would not use this system. They identified how their way of working does value the client's feedback but they seek it in a less formal way.

Three reported that they use implicit feedback from their clients to direct the course of therapy. Two reported that they have always built some element of eliciting the client's experience either through questions or through the client's nonverbal responses. Participants felt that the feedback system makes this more explicit and perhaps there is a degree of overlap:

Philosophically I kind of agree with the concept of feedback, like ... I will talk to my clients very much about it being a collaboration, that I have ideas and you let me know if ... if it's not working for you. So I kind of very much would encourage them ... to give me feedback as we're going along (Edith).

Participants reflected on the strengths and weakness of the feedback system. Two reflected that the system currently used has some flaws. Both agreed that there might be a ceiling effect in place when clients are asked to rate the session and when rating distress. One felt that some clients could reach a ceiling within each measure and this is not realistic. The other spoke about how it is not in the nature of some clients to rate things high or low. So it creates a tendency to rate in the middle: “*there’s very few people give you really high score I mean it’s just not in the nature of ... the Irish or the British to give people ten out of ten or nine out of ten so you know*” (Carol).

Three identified the strengths of the feedback system. Two spoke about how the computer programme simplifies the system, provides a graph of progress and makes interpretation easy.

Core category: Reflections on therapy

The present study explored therapist engagement with client reported feedback. Participants reflected on their experiences of feedback in the context of their therapy workload. Therefore, a brief summary of this core category will be presented to situate the major core category (*Reflections on Feedback*) described above.

Three conceptual categories were created through the analysis of interviews with five participants from this service (See figure 11).

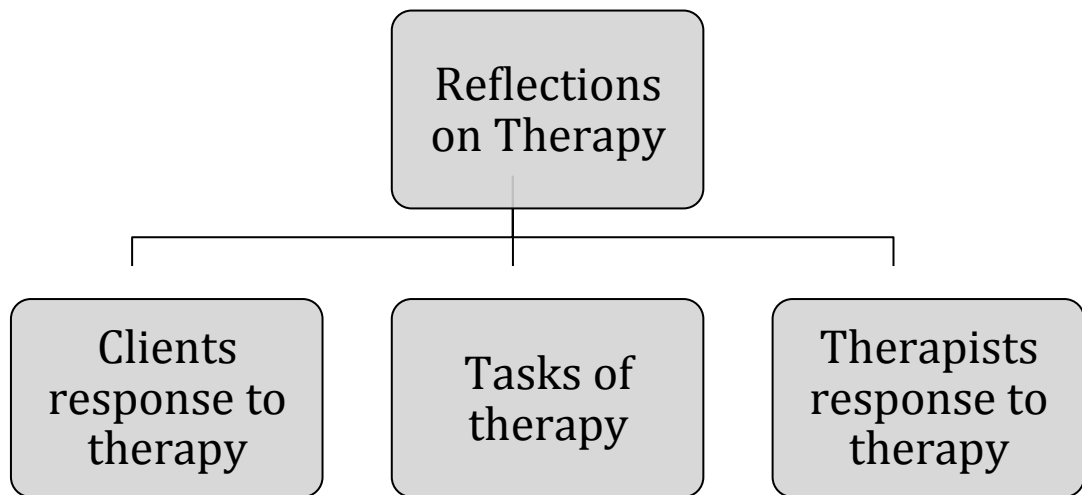


Figure 12: Conceptual categories for 'Reflections on Therapy'

Participants reflected on experiences of their *client's response to therapy*. Nine subcategories were identified. The main themes reported are as follows. Participants reflected on how clients engaged in therapy. Three commented on measuring a client's engagement by their openness in sessions. Three reported that clients who had engaged well in therapy shared their positive experiences outside with the therapist in session. Four described positive and negative responses to therapists from clients. Negative responses included dismissing the therapists' actions. Three reported experiencing clients' closing up when therapists enquired about their distress. Participants reflected on their client's negative experiences in therapy. Four described how their clients became stuck in therapy. One reported their client dropping out early.

Participants also spoke about client changes and progress. Two found it difficult to establish what contributed to a client's positive progress in therapy. Two reflected they felt clients got something from therapy but were unable to discern it.

Participants reflected on their *tasks of therapy*. Six subcategories were identified. Tasks of therapy can be summarised under two areas; content tasks and process tasks. Content tasks identified were meeting a client's goals, and providing advice. Two reported checking whether their client's goals have been met in the session. Two reflected that sometimes clients require very practical things in

therapy. Process tasks identified included relationship building, respecting a client's experience and watching over their client. All reflected that they engage in relationship building when they first meet a client and continually attend to it. Two experienced a therapeutic mismatch and experiencing difficulties in building rapport with some clients. Four reflected that they consider their clients experience of sessions, and are respectful of client's experience of distress.

Participants reflected on their *own response to therapy*. Three subcategories were identified. The main themes identified are summarised as follows. All participants spoke of difficulties they experienced in therapy, and how they often relied on their hunch or gut feeling about a client can guide the session. One spoke of feeling challenged and scared by their client who demanded to be 'fixed' yet took no responsibility for their own change.

APTs Analysis

The analysis of the APT data produced 2 core categories. Each will be described through the expansion of associated subcategories with quotes to support and illustrate the category.

Service description

Previously, I worked as a trainee clinical psychologist in this service on a 5-month placement. While there I got a sense of their research project and therefore had some hunches or ideas about the feedback system going into the interviews with participants. Another contextual factor was that the service lead that was spearheading the feedback system research had been on leave for some time, it is possible that their absence may have led to a reduced focus on this research in the service, and in analysing participant responses this has been considered.

My sense of the participants was that they saw the feedback system as a piece of research; they were not involved in the planning or in the implementation of the system. They spoke of how it was enforced on them and they may have had some difficulties accessing their data. There was a feeling that it was not seen as being a therapeutic tool, and was rarely explicitly discussed in the session or shared with clients. Despite the apparent hurdles, a number of participants spoke of their wish to make the feedback or some aspect of the system a part of their therapy. There was a specific message from newly or recently qualified therapists, who felt that feedback was useful and worthwhile but was something that could easily be put to one side, as there were more pressures on them to adapt and become comfortable with their work. Furthermore, at the time of the interviews, the service research project had stopped recruiting new participants, and was in the process of writing up its results and conclusions. Again this may provide a context for what is discussed in my research interviews with therapists.

Theoretical formulation

The detailed process of coding provided 712 open codes and 105 axial codes. These were then revised to produce 2 core categories and 12 conceptual categories. The theoretical formulation comprises a number of interacting processes described in Figure 12.

Description of core categories

Two core categories were identified from participant interviews. As with the Student Counselling Service, participants provided their reflections about their engagement with feedback and with therapy. Similarly, as the analysis progressed from open coding through to axial coding and then to theoretical coding, this distinction became clearer. Two core categories were identified; 'Reflections on Feedback' and 'Reflections on Therapy'. Each will now be described briefly.

Reflections on Feedback:

The core category 'reflections of feedback' was the larger of the two core categories. Within this category there were 8 conceptual categories.

The overarching theme with 'reflections on feedback' was quite similar to those identified by the SCS participants. Participants in the Adult Psychological Therapy Service identified the role played by therapist attitudes, service environment, and client factors contributing to their engagement with feedback. Participants also reflected on how feedback provides information about clients and the trajectory of therapy and how this information might be used to help clients. Participants appeared to engage with feedback individually, and the service left it up to them whether they use feedback with clients in session or not.

Reflections on Therapy:

This was the smaller of the two core categories, made up of 4 conceptual categories. Participants reflected on their way of working and how they engage clients in therapy. Participants described the deep distress that client bring and how they work with clients to reduce this distress.

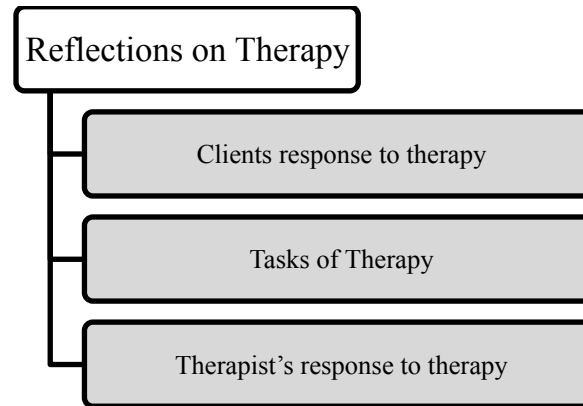
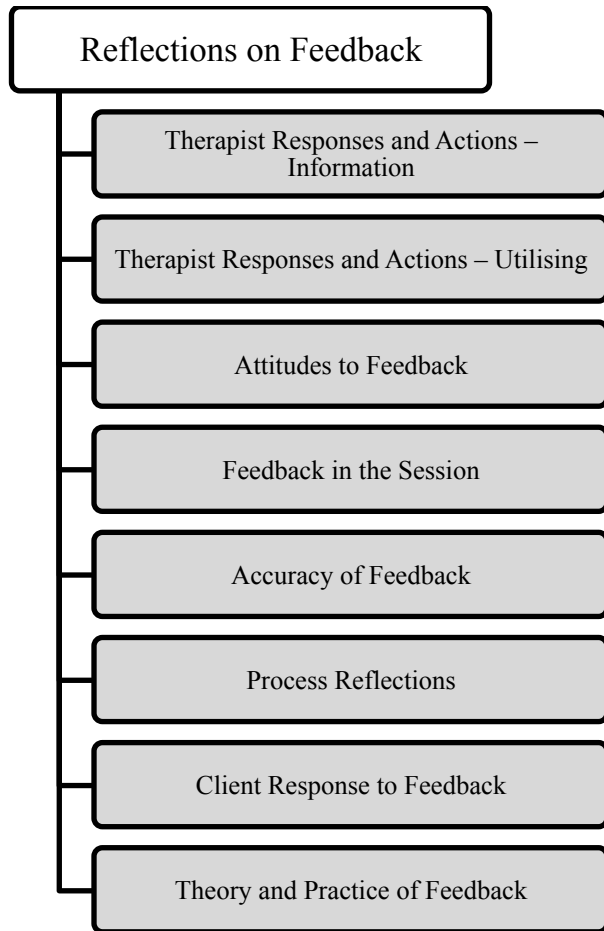


Figure 2: Overview of SCS core categories

Core category: Reflection on feedback

Category 1 - Therapist response to feedback-Actions

This conceptual category captures therapist's responses and actions to feedback. 18 subcategories were identified (See figure 13).

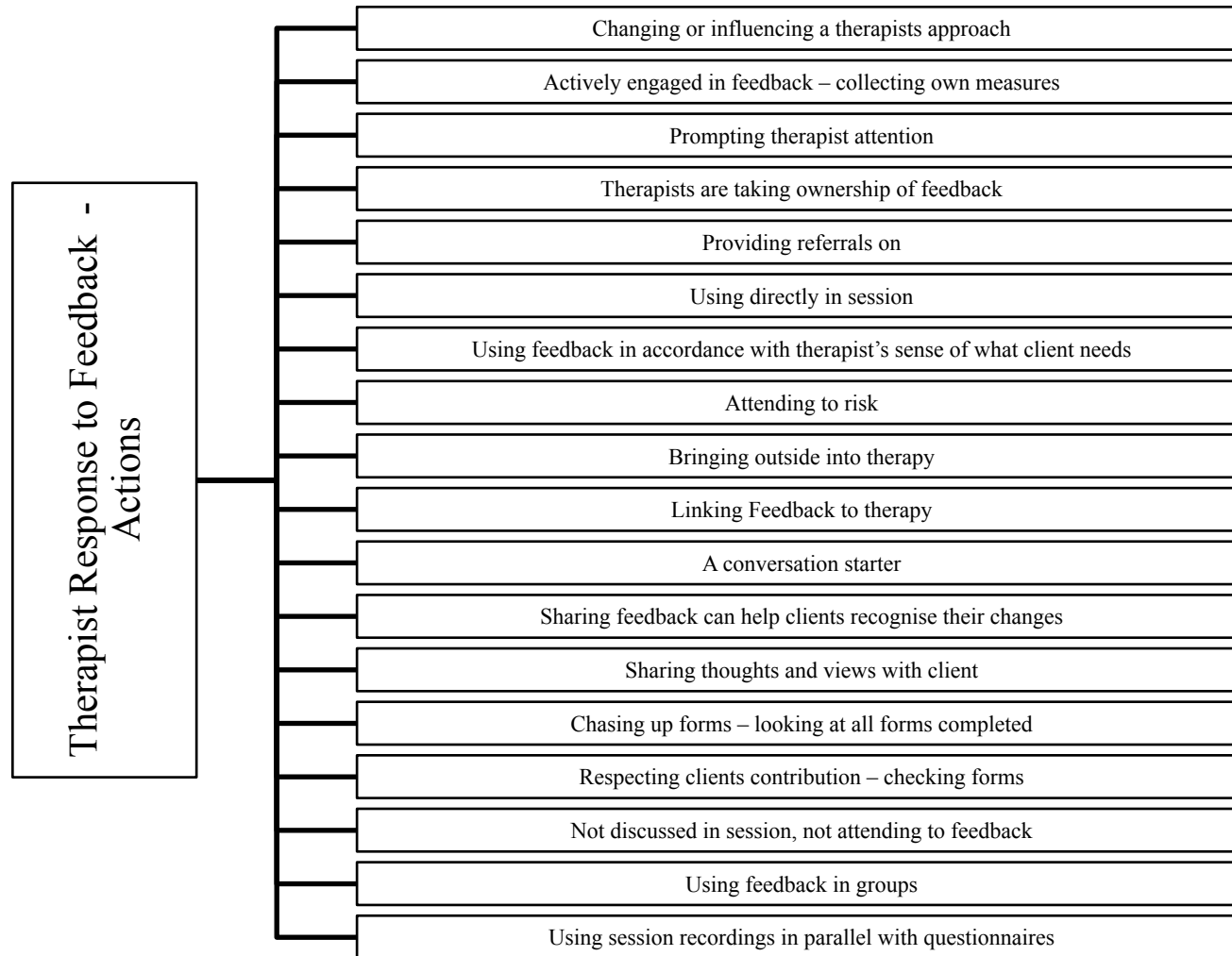


Figure 13: Model of therapist response to feedback - Actions

Participants reflected on how feedback impacted on their approach to therapy. Four reflected on the degree to which the feedback system changed their approach to clients or therapy. One recognised that the feedback system changed the way they worked. The remaining three participants felt that feedback did not change their approach to therapy, as they did not engage with it beyond checking for risk. One participant reflected: *“Erm not really to be honest, probably not, I mean as you say maybe looking at the risk items and but other than that not, not massively”* (Geraldine).

Three commented that they collect or plan to collect their own measures and that they are actively engaged in feedback. All three spoke about their intention to continue to elicit feedback from their clients. One reported collecting measures before the start of the feasibility study, while the remaining two stated they would make use of the existing measures and continue to keep their own database of clients. One reflected that they would use feedback to audit their work:

Probably as prescribed in that I'd give them all at the same points but I might use them as a general, I might almost do a bit of an audit of myself or my own effectiveness as well using them individually with the clients (Ingrid).

All reflected on how feedback prompted their attention in a session in some way. Three reported how feedback directed their attention towards specific areas of a client's distress or therapy. One participant reflected on how feedback prompted them to look at the therapeutic alliance: *“The alliance questions, I find them helpful in two ways. One if the patient indicates a problem where I also perceive a problem then it invites an explanation of that”* (James).

Another reflected how feedback prompted them to revisit the client's goals. One commented on how they have taken ownership of the feedback measures and looks forward to introducing them as a tool for therapy rather than a research task. They spoke about how over the course of using feedback they began to invest in the measures and make more use of them: *“I will be using them and I will be tracking them in session and it might be occasions where we think about things together”* (Ingrid).

Participants also reflected on specific actions they undertook following feedback. Two identified how feedback prompted them to look at other agencies of support or referrals to different services.

if a patient is reporting lots of problems in their daily life and a lack of support then it would indicate to the therapist that they might want to bring in some other agency to help the patient in for example, tenancy support (James).

Three spoke of how they used feedback in a way that meets the client's needs or benefits the client's therapy. All three suggested that they used their experience and judgement about what might be most useful for clients. One reflected that they look at their practice and use feedback to adjust their approach:

if there's a break in alliance and there's a drop in scores I'll be looking at what am I doing to create a misalliance or what's happening, ... so then I might change my intervention erm rather than talk about it on a conscious level (Hilary).

Four talked about using the pre-session form directly in session. Three felt it was more accessible to them. This was partly due to it being presented directly to the therapist at the start of sessions. One reflected:

it is much more easy to be using the direct feedback you get before the session, because you see it it is given to you it is in your hand, than something that is sort of produced elsewhere afterwards and I couldn't actually access (Frank).

Not all participants used feedback directly. One reflected that the system was not sold to them as something to be shared with clients: *"It's not really being sold that that's something that we're supposed to be doing to be honest"* (Geraldine).

All reported how they use feedback to attend and monitor a client's risk of self-harm. Four reflected on how the pre-session measure is useful for scanning a client's self-reported risk level. One reflected: *"I used it to cover my back a bit in terms of risk because he was someone who I couldn't get a clear sense of risk."* (Ingrid).

Another reflected on the accuracy of the risk ratings. This participant felt that one client they worked with was incredibly risky, but this did not come across on the forms. They reported:

I've had a client where erm their objective risk rating on the feedback form looked very low and to me this client's one of the riskiest people I've worked with so that didn't reflect my, my erm, my understanding of their risk level (Hilary).

Three reported how they use the feedback forms to reflect on a client's patterns outside of therapy. One reflected on how bringing a clients experience outside improved the therapeutic alliance:

[This] is a pattern that she does in her life erm and so we hit that head on and since we talked about that very openly and she was able to express her feelings towards me, erm the alliance measures have gone, gone up to the highest they can be I think or somewhere there (Hilary).

Three commented on how they link feedback to therapy. Two spoke of how in retrospect they could link feedback to therapy, with one stating they would make the link more in the future: Another reported making links at the time between feedback and therapy, but did not share this link with the client:

[I] picked up on something that she had maybe said and then sort of went, went with it, so I added it to my sort of evidence, but I didn't speak about it erm isolate it as a ... as a particular thing (Hilary).

Four reported how feedback was important as a conversation starter and topic generator in sessions. All four noted times when returned feedback forms have been a topic generator and 'grist for the mill'. One reflected: "*Sometimes I'll bring it forward and discuss with a patient what they meant or I explore something with them. So yes, it can become a discussion point in the therapy*" (James).

Three reflected on how feedback scores and graphs can help clients notice change or motivate clients to maintain their progress. One spoke about how sharing a client's symptom chart can be a motivator:

If they're not making progress, I'll share the graphs with them and say to them how should we understand this, what do we do about it? ... And if they're making progress but ignoring their progress, I'll show them the graphs and if they're making progress and happy with the progress, then I'll also show them the graphs and say look, this is brilliant (James).

Three reflected how they share thoughts and views about feedback with clients. Two reported sharing when they noticed a change and discussing their impressions of the forms. One described: "*If there's an improvement, I might comment on it. If there's a deterioration I'll comment on it.*" (James).

Participants commented on respecting the client's commitment to feedback. Three reflected on how they chase up forms to monitor their clients from week to week. Two spoke of how they review forms each week. One reflected: "*I really value that measure at the end so I always get it*" (Hilary).

The remaining participant stated they did not chase forms as they were unsure where they would go to find them, emphasising the difficulties in monitoring clients: *“No, that’s partly because I’ve never bothered to find out where I’d go and get it from” (Ingrid).*

Three felt they had to check feedback forms as clients have agreed to complete them; out of respect for the client. One stated: *“I always sort of do take a moment to check through that just to respect that they’ve done it” (Hilary).*

Another reflected on their dilemma of not making use of forms yet still asking a client to complete them. They reported: *“it’s rude if I don’t look at it, [but] then I don’t really know why I’m looking at it because we’re not discussing it.” (Ingrid).*

All spoke of how they either don't attend to feedback or do not discuss it with some clients. Two reflected on how with some clients they have not attended to feedback forms and have not looked at some post-session 4 reports. One spoke of times when they did and did not attend to feedback: *“I’ve never discussed them directly with the client ... I think I just wasn’t in the habit of discussing things with people in that way.” (Ingrid).*

Participants also reflected on using feedback in different contexts. One reflected on how feedback is used in a skills group that they co-facilitate. They identified how pre-session symptom measures can be useful for subtly monitoring risk and progress with the group, without drawing attention to specific clients. Qualitative open feedback was also useful in guiding the content of future sessions:

it just felt like in the group because I had them in front of me, I used them and I used them and I think that’s where I ... not made best use of them in my individual work is because I haven’t had them handed back to me (Ingrid).

Two who use session recordings as part of their therapy commented on how feedback questionnaires might be useful in tandem with session recordings. One spoke of how feedback questionnaires can cue therapists to sections of sessions that can then be reviewed for the benefit of adjusting approach or developing therapist’s skills:

because [session] is an hour and a half so much bigger job to try and pick out alliance from the [tape] but if you’ve noticed someone who’s gone from a 35 to a 28 and you can use your knowledge in your head and think well actually in the

middle of that session there was this, ... I would prefer erm to have an objective measure always I think so (Hilary).

Category 2 - Therapist response to feedback – Information

This conceptual category captures participants’ response to feedback. Specifically, what information they take from the system and what they find helpful or useful. This category also taps into what therapist find unhelpful about the information provided through the system. Eleven subcategories were identified (See figure 14).

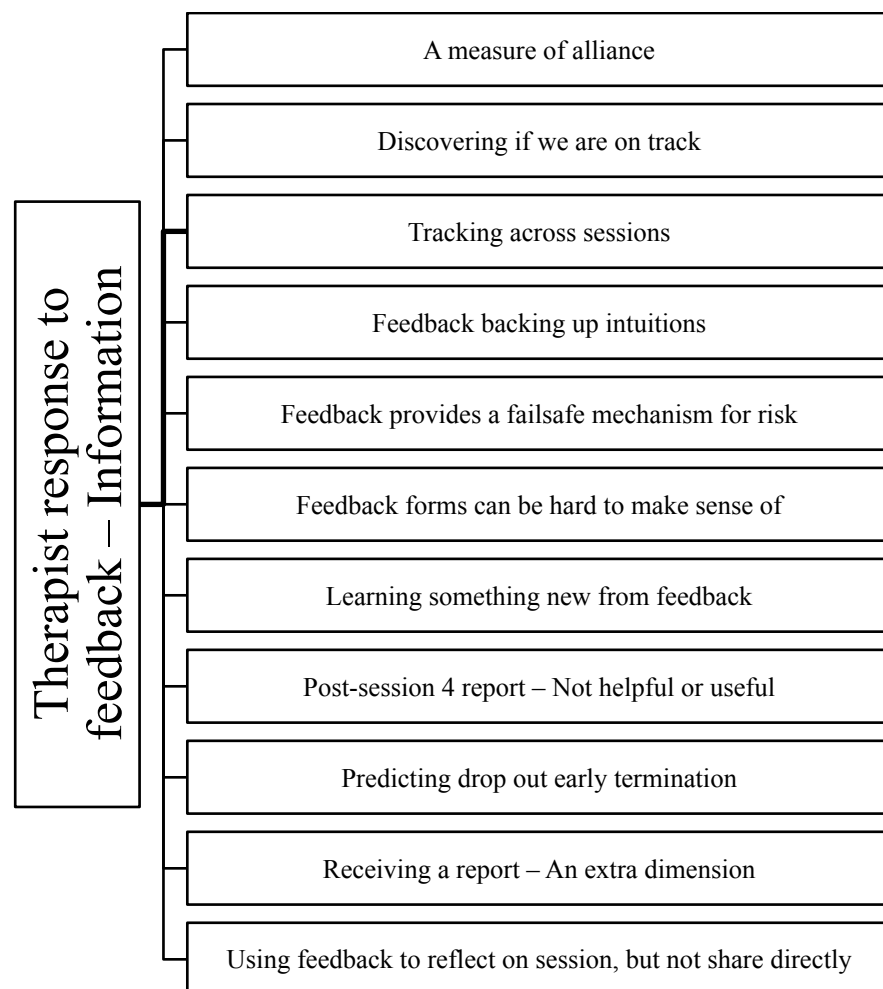


Figure 15: Model of therapist response to feedback - Information

Participants reflected on the therapeutic information received through feedback. All identified that they valued the measurement of alliance and other process issues within the therapeutic relationship. Two explicitly identified that they would place more value on measurement of alliance than of symptoms in regard to

therapeutic progress. One reflected: *“the alliance one is very important and I think I probably use that more clinically than the symptom one ... Erm in terms of whether we’re on track”* (Hilary).

Two spoke about their desire to check on the progress of therapy and that finding out if someone is on track can be useful for both therapist and client. One reflected: *“I find that really helpful to know whether I’m on track and whether we’re on track more to the point”* (Hilary).

All reflected on whether feedback received backed up their felt sense or intuitions about their clients. Four reported that feedback supported their experiences of the client: *“it was a part of the clinical picture so it wasn’t just going by them, that just sort of added to my [experience]”* (Hilary).

Some reported that this was not always the case, and participants described that they experienced *“incongruence”* (James) or: *“there’s certain people that I’ve got, further down the line in terms of number of sessions and thought there were probably quite good indicators at the start that we weren’t really going to get anywhere”* (James).

Two participants reported their difficulties in making sense of the pre-session form, that there is a lot of information provided and that it is difficult to make sense of it at the time of receiving it in a session. One reflected: *“I don’t think you can make that much sense of the form when you’re presented with you know however many questions there are”* (Geraldine).

Another reported that they have often been left *“confused and not knowing how best to use that information”* (Hilary).

Participants reflected on whether feedback provided useful information for therapists. Four commented on whether they learned something new from feedback. One felt that feedback has provided new information or brought attention to something they were not aware of. However, three felt that they had not learned anything new from feedback. One described *“often from my experience of getting a report is erm yeah that’s you know this is what I already know from talking with the person it’s very rare that I’m kind of surprised by it”* (Ingrid).

One participant who did report learning something new stated: “so it feels like that’s a massive piece of information that’s really helpful to me, and sometimes shocks me ‘cos I think we’re on track and they don’t and that’s helpful” (Hilary).

Two reported that they were unsure of the utility of the post-session 4 feedback report. They described how the information is not new, and does not feel relevant to the work with the client. One reflected: *“I’m not sure that the session 4 questionnaire and the feedback that results from that is really relevant to that.” (James).*

In contrast, two reflected that the post-session 4 report indicated a client was not on track that the client often disengaged or dropped out of therapy. They recognized that in retrospect this might suggest some predictive value in the feedback report. One stated: *“it is interesting to see someone giving you slightly less good feedback who then subsequently tends to decide to not carry on with the therapy fairly early on, which has happened to me” (Frank).*

One reported that receiving the post-session 4 feedback report provides an extra dimension and when they don’t have the report it feels like something is missing: *“I think it definitely adds. I think any of the cons, the pros outweigh the cons for it” (Hilary).*

Participants reflected on using feedback to reflect on a session but not sharing. Two stated they share the graph produced with clients, while another two use this information to reflect on sessions themselves. One reported sharing the symptom profile graph with a client:

we shared this graph last week ‘cos one of the presentations is hopelessness that things are not changing and so I was able to show to her an objective, you know that it was objective of me, it was, because I could say ‘listen you’re doing great and she wouldn’t hear that’ (Hilary).

Four reflected that they are conscious of what clients report in feedback but that they might not always share this with them. All reported that this information is useful to reflect on how the session went, to think about therapy and to aid clinician judgement. One indicated: *“And so I might be more keyed into that myself but I don’t share that erm consciously” (Hilary).*

Category 3 - Views of feedback

This conceptual category captures how therapists view the feedback system and what factors contributed or influence that view. Eighteen subcategories were identified (See figure 15).

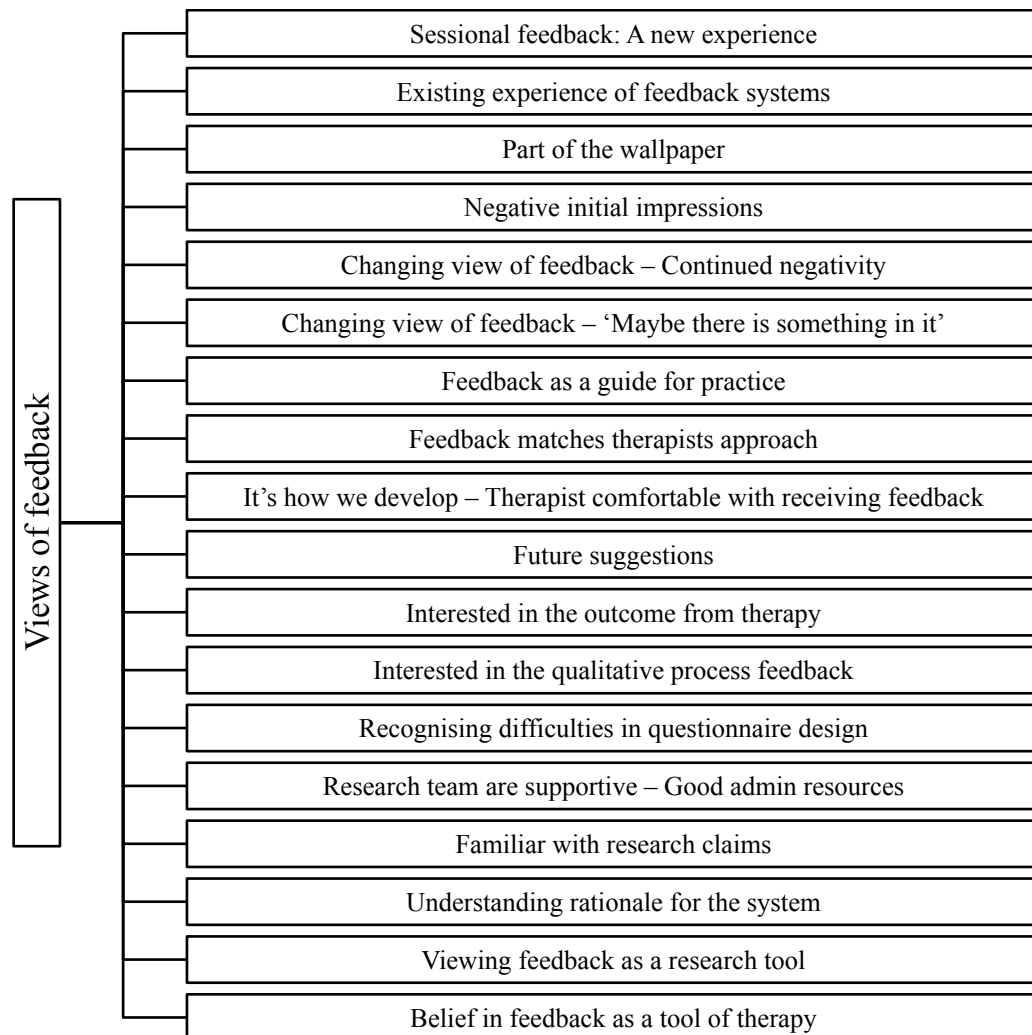


Figure 16: Model of therapist views of feedback

Participants reflected on their experience of feedback. Three highlighted that sessional feedback was a new experience for them. All spoke of their awareness of sessional feedback systems, but two had never used them previously. They had used outcome measures before, but these were for service audits or to measure pre-post changes in therapy. One who had used sessional feedback reflected on the imagined difficulty to integrate sessional feedback into practice if it was completely new: “*I think if I come to this service and I wasn’t used to session by session feedback or I*

wasn't used to that it would have been very different to integrate that into me as a person, into my practice" (Hilary).

Three identified that they had previous experience of using feedback in their therapy. One had experience from working within the service; the remaining two had experience when training: *"I've done it with particular clients as part of the [clinical] training we have to do well use sessional measures don't we or use more idiosyncratic measures which can feel more relevant" (Hilary).*

Two commented on how they viewed feedback as part of the wallpaper of the service. One reported: *"Yeah she would find it very weird if we didn't do the forms now I think she's so used to doing them" (Hilary).*

Participants reflected on their initial impression of feedback and how that changed. Two expressed negative initial impressions of the feedback system, one not understanding it at the time.

One reflected on their continued negative view. They were initially apprehensive about the feedback system, and after using it continued to experience it negatively: *"Erm I think I've probably stayed about the same ... I'm really negative about this" (Geraldine).*

Two expressed their view that they have begun to re-evaluate the value of the feedback system. Both reflected that they initially were not keen on the system, but had recently begun to look at it again: *"It is only a future thing I think, which is actually beginning to think 'maybe there is something in it' which I hadn't kind of appreciated and I guess I have come in relatively late to all of this" (Frank).*

Participants also reflected on their view of feedback in relation to their therapy. Two commented that they viewed feedback as a guide or aid with clients. Both experienced the feedback they receive as a tool to guide their therapy. One therapist referred to their practice as follows: *"for me I use it to guide my practice and to to change practice if need be." (Hilary).*

Four commented on whether feedback matched their approach. Two stated they felt it matched and fitted their approach 'complimenting' what they were already doing, while the remaining two participants reported that it did not match their style. One reflected that they believed the feedback system matched their approach.

Three reflected on how receiving feedback has a developmental and training component. One reflected:

I am humble enough that it may give a measure and that I might need to attend to if there are patterns seem to emerge, and everyone has blind spots. And you don't know you have a blind spot til someone points it out ... It may well pick up some things that I am less aware of. (Frank).

Participants reflected on their interests and suggestions for feedback. Four suggested amendments to the feedback system that might improve its usefulness, or its adaption by therapists and clients. One suggested that a second feedback report later in the client's therapy might help the therapist to monitor the client's progress. Another suggested that the feedback system is burdensome with a heavy emphasis on paper, and that using a computer system would make it less intrusive to clients and more immediate for therapists. One reflected on how further training might be helpful:

I'd probably encourage them [research and therapy staff] to think more about how to take the feedback form at the end of the fourth session further and are there any indications when you've been using it, presenting it to the client might be helpful if you're going through with them (Ingrid).

Two reported that they were curious of their client's outcome from therapy. One wondered about the outcomes of people who are 'on track' at session 4: *"It would be interesting to know ... the patients who are on track at session 4 ... what's their post therapy data look like? Patients who are not on track at session 4, what's their outcome look like?" (James).*

Three reflected on the open text box at the bottom of the post-session feedback form. All expressed their view that this is a valuable piece of feedback. One reflected that they wished they made more use of them, but they are difficult to track down at the time and often the information comes too late. Others reported seeking these responses out and explicitly requesting clients complete this part of forms. One stated: *"The most helpful bit, is the qualitative comments, where the patients are saying about their experience. And ... I try to not to let patients leave the room without filling that part in." (James).*

Participants also reflected on the research aspects of feedback. Two on their knowledge of the research claims associated with feedback systems in therapy. Both differed on their knowledge. Only one spoke of their awareness of research supporting feedback, but they were not invested in the system: *“And I know that there’s research to show that that is the case but then I kind of” (Geraldine).*

One described their previous experience with designing a questionnaire. They reflected on difficulties designing questionnaires that meet the needs of all the therapists and clients:

I am vaguely aware of questionnaire design, because I did try to design some as a trainee, and went to the research department and was, had my eyes opened at just how careful you have to be and how you cant try and ask two questions in one (Frank).

Three commented on the research team and the admin resources available to therapists during the feasibility study. All reflected on the support they receive from the service manager and the admin and research staff in the service. One commented: *“I think we’ve got a lot of resource here so you know they get, generally they get given out erm and a collection and the entering seems to be pretty smooth” (Hilary).*

Three reported understanding the rationale for providing a feedback report after 4 sessions. However, each felt that it was not helpful. One stated:

“the way I work is much longer term than four sessions, and I am aware that perhaps 4 sessions is a good time to get an idea of how things might or be likely to progress in the longer term” (Frank).

Two described how they viewed the feedback system as a research tool. Both were introduced to the feedback system as a research tool and not as something to help or aid therapy. One reflected:

“I think part of the reason I haven’t used them that explicitly with clients because I’ve set it up as this is research project that the department was doing, do you mind filling them in? Rather than, this is something that I like to use. And we’ll think about these in sessions” (Ingrid).

There was acknowledgement that this was due to how the service positioned the questionnaires and how it was introduced to therapists as a feasibility project.

Finally, Three reflected on their belief that feedback is a tool of therapy and can be used to help a client achieve their goals. One reflected that feedback was about improving therapy: *“I have less anxiety about giving people measures because I think it’s important, I always set it up in a way that this is about me being able to help you to the best of my ability” (Hilary).*

Category 4 - Therapist engagement with feedback

This conceptual category captures how therapists engage with feedback and what are the factors that enhance or inhibit a therapist’s engagement. Nine subcategories were identified (See figure 16).

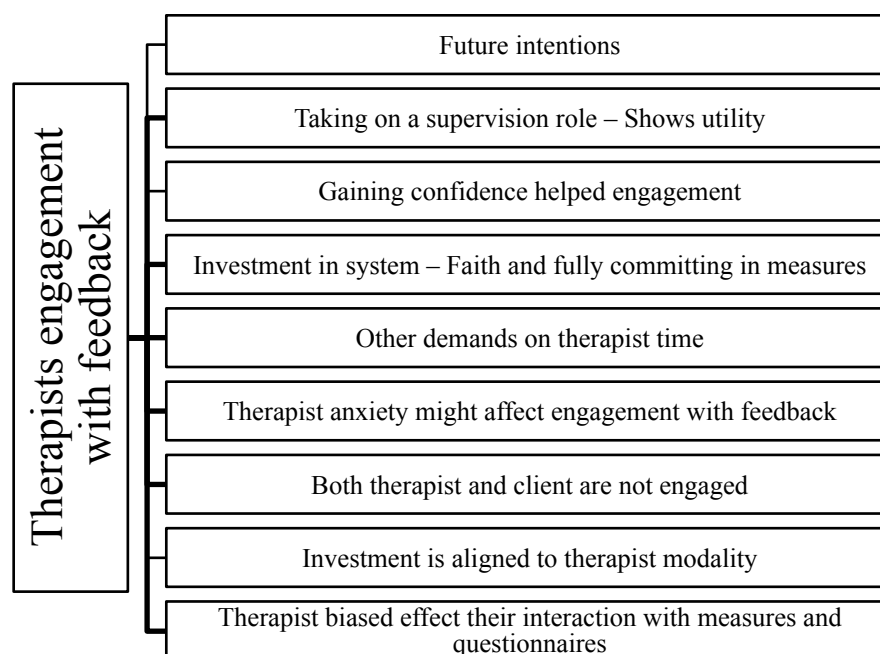


Figure 17: Model of therapist engagement with feedback

Participants reflected on positive factors of engagement. Two commented on how they planned to use aspects of the feedback system in the future once the feasibility study had been completed. Both planned to continue to engage with feedback and use it as part of their therapeutic practice. One reported: *“I would definitely retain the post session measure. So beyond the feasibility study my intention will be to keep going with the SPACE as a pre session measure, to keep going with the HASQ as a post session measure.” (James).*

One identified how taking on a trainee clinical psychologist, had brought a new level of engagement in feedback: *“I’ve ... part supervising a trainee here and*

so I know there's been a big emphasis now on measures so that's got me thinking about it again. And the value of using measures" (Ingrid).

One identified that as they settled into their role as a qualified clinical psychologist they became more confident in their work: *"definitely. And I think now I've become more confident in what I'm doing, I've got more headspace, to think oh well actually I could make use of these measures" (Ingrid).*

Three reflected on their faith in the feedback measures. The remaining two participants identified that they had faith in the measures and were fully committed to integrating feedback into their practice. Another identified that they did not have faith in the measures and felt they could not commit or invest in the feedback system: *"I think if I am going to bring something in [to the therapy session] it needs to be something perhaps I have some faith in, that I've had some investment in" (Frank).*

Participants reflected on negative factors of engagement. One commented that there are other tasks that therapists must attend to and that initially they neglected the feedback system: *"And obviously being newly qualified and things, I kind of felt like I had a lot to think about, so it felt like a bit of an extra thing that 'oh god, I've got to remember that questionnaire!" (Ingrid).*

Two reported that they were not actively engaged in the feedback system. One spoke of how they wondered why they had not been more engaged, and suggested that there was a relational component, as both the therapist and client were not questioning or discussing the feedback:

why is it that I haven't brought it up and they haven't brought it up, what is that about, you know that we are getting them to do something and not feeding back to them, and that might be another aspect which is doubtless a little bit me but I think it probably be some of the patients as well (Frank).

Three recognised that seeking feedback from a client about therapy can be exposing and anxiety provoking. One felt it was exposing and difficult to ask clients to complete forms. Two stated they did not feel exposed by the feedback system. However, felt that it could feel exposing and as if you were, being judged if results and scores were shared. One stated: *"Whereas for other people, there might be anxiety or ... disquiet, to feelings about being evaluated or judged. Or within their own therapeutic approaches, a resistance" (James).*

Participants commented on the therapeutic modality. Three spoke about how their modality of therapy influenced their investment in the feedback system. One spoke about how their way of working limited their investment, and they found it hard to integrate the questionnaires into their therapy.

In contrast, two spoke about their modality of therapy encouraging exploration and eliciting feedback from clients. Both found it easier to integrate the feedback system. One participant believes:

the model itself that we're using is all about exposing ourselves to the idea that people don't always have great therapy sessions and don't always get better no matter how hard you try and it's in some way exposing yourself to almost get over yourself in order to use the data in a way that's going to be helpful (Hilary).

Finally, One acknowledged their personal biases against feedback systems and recognised that this inhibited their engagement with feedback measures. They stated: *"I think I've got probably got some biases about that which mean that I erm which probably affects the way I use measures"* (Geraldine).

Category 5 - Accuracy of feedback

This conceptual category captures how the participants interpret the accuracy of the feedback forms that they receive. Six subcategories were identified (See figure 17).

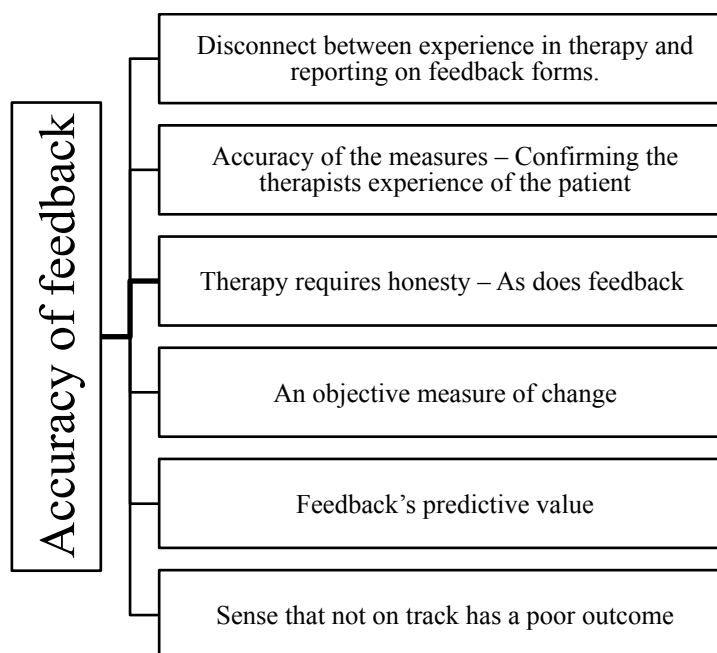


Figure 18: Model of accuracy of feedback

Participants reflected on the accuracy of feedback. Three described their sense that feedback may not be accurate; clients may report one way on their feedback forms but could present differently in the therapy session: *“The one client where I had thought it would have been more helpful to use it is, there was quite a discrepancy between how he’d present and what he’d say and what he’d put on his form” (Ingrid).*

Four commented on how accurate they perceived the feedback measures. It appears that participants largely felt the measures were accurate, however, they did comment on times when they were not seen as accurate *“it’s been a mixed bag really” (Hilary)*. One reflected that *“I never got a report that was completely different to what I’d felt.” (Ingrid).*

Two reflected on how both therapy and feedback requires the client’s honesty. Both felt that mostly clients are honest in therapy and on their feedback forms. One reported: *“My sense is overall that patients are honest and that they can say if there’s a problem and they do say if there’s a problem.” (James).*

Participants reflected on the predictive power of feedback. Three commented on viewing feedback as an objective measure of change. Participants differed to some degree. One reported how they felt one of the measures (CORE-10) *“isn’t so sensitive to the session by session change” (James)*. The remaining two participants reflected that they experienced the feedback measures as objective measures of change: *“it was an objective measure of her own change and she could see that whilst there have been some bumps on the way the definite path was downward like a decrease” (Hilary).*

Two commented on feedback’s predictive value. Both felt that they were unsure of whether feedback had a predictive value and they questioned the statistics behind the link between feedback and outcome: *“that the questionnaires are more likely associated with the outcomes at the end, than would be expected due to chance is not the same thing as every time someone does well on the questionnaire they are going to do well in the therapy.” (Frank).*

Finally, One participant wondered about the link between a client being ‘not on track’ and having a poor outcome. This participant questioned whether there is

anything that a therapist can do to change someone’s trajectory of therapy. Their experience has been that those who do not do well at the post-session 4 feedback report, tend to not do well overall. This participant reflected that: *“And my sense also is that it doesn’t matter what I do for those patients, the outcome of their psychological therapy won’t change”* (James).

Category 6 - Therapist difficulties with feedback – Service and system

This conceptual category captures the difficulties identified with the feedback system and the way the service implemented it. These difficulties inhibited therapist engagement and their ability to make use of the feedback in therapy. Eight subcategories were identified (See figure 18).

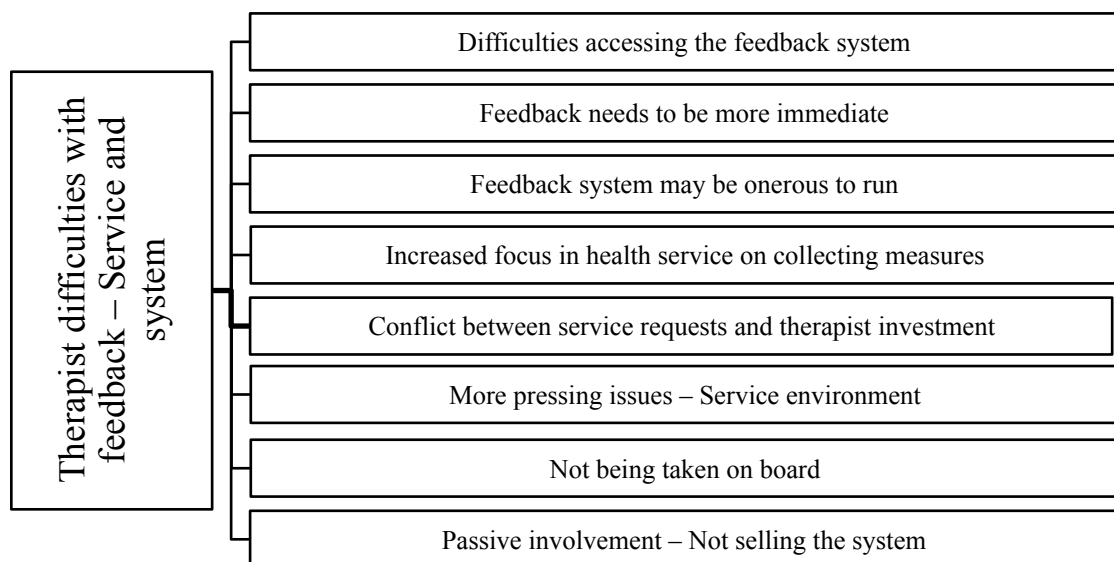


Figure 19: Model of therapist difficulties with feedback - Service and system

Participants reflected on system related difficulties. Four reflected on difficulties accessing the scores and completed questionnaires. Three described how feedback was analysed and stored separately from therapy files, and if they were interested in a clients scores, they would have to chase research staff and seek out completed measures. One stated that they have to be very active and chase up forms if they want to monitor their client’s responses:

sometimes I won’t get that feedback, if I actually want to get the post-session feedback I have to after every session go and find the form from either the box and go through all the forms in the box to find their initials or code or I have to go and

find it in the cabinet where it's already been stored and stuff or whoever's already entering it to the system and stuff (Geraldine).

Two identified how there is often a delay between a client completing a feedback form and the therapist receiving this feedback. Specifically, the post session-4 feedback report where therapists may miss this information or it may arrive too late for the therapist to use. One reported: *"Because I'm just not getting the forms, the forms aren't coming back to me so I'm not doing anything about them."* (Ingrid).

Three commented on their difficulties with running a feedback system on top of their therapy caseload. Two reported how the work environment (offices, buildings) makes it difficult to administer, collect and manage the completed feedback forms: *"that makes it, yeah logistically impossible in some places that I work in and 'cos there aren't a lot of places for me to give the forms beforehand or drop them the forms off afterwards so, em so"* (Geraldine).

Another reflected that the system is perhaps not as onerous as they first thought and felt they could make better use in the future:

And actually, at first it seemed like a huge, onerous task, but in reality clients then just do it themselves and I've had people say, oh you forgot to give me a green form. And so I've given them one. ... it's almost like clients take responsibility themselves for getting one and filling it in ... it's not hugely onerous at all (Ingrid).

Participants reflected on the culture of the health service generally and therapy service specifically and the difficulties these presented. Two recognised the shift within the health service, and that there is a pressure to show therapy is effective. One stated: *"I am aware of working in a system where it is not in isolation and things don't get valued if you don't demonstrate that they have a value"* (Frank).

Two felt there are more pressing things to tackle as a service. One reported how for them the electronic records system takes priority and feedback gets pushed down:

I think for me that's like, I'll just check I've done all the [Records System] and all the things that people are going to see and check on and all the GP letters and then ... this kind of came way down the list (Ingrid).

One felt uncomfortable engaging with the feedback system, as they did not personally see it as beneficial. They managed this by engaging with the measures and keeping them separate from their therapy tasks: *“It feels difficult because in some ways we’re asking someone to do something but I’m not paying that much attention to it so that feels a bit erm uncomfortable in some ways”* (Geraldine).

Finally, participants reflected on their personal difficulties with the feedback system. Three reported how they felt that they were not taken on board with the research, and that they did not have an investment in collecting feedback. In particular, two reflected on how the system was not explained to them, and they did not feel confident to use the feedback provided in therapy. One reported that their engagement is *“because I am told to look at them, perhaps more than because I have an interest in it.”* (Frank).

Two reported how they go along with the feedback system, and only engage with it because they feel its part of their role: *“for example when I guess I don’t sell the research to my clients, I’m very clear with them that it’s their choice and that they don’t have to do it if they don’t want to do it”* (Geraldine).

Category 7 - Therapist difficulties with feedback – Obstacles

This conceptual category captures what therapists report are the difficulties and obstacles with using feedback into therapy sessions. Eleven subcategories were identified (See figure 19).

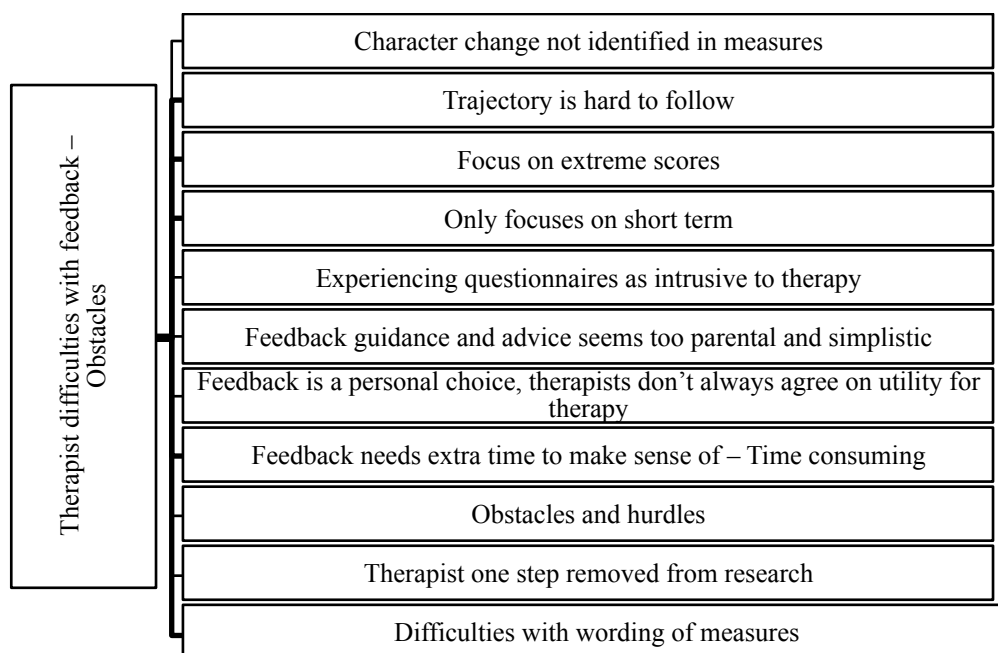


Figure 20: Model of therapist difficulties with feedback - Obstacles

Participants reflected on their difficulties with measuring change. Three reflected on how character change is not picked up by the feedback report, yet noted personality or character change in clients and when clients reported changes in their life: *“that’s made me think about well I’m seeing a lot of maybe personality change in the way they’re relating to themselves and relating to others but that’s not necessarily reflected in symptoms at that stage” (Hilary).*

Three spoke about difficulties in following the trajectory of clients across sessions. Monitoring across sessions is hard due to difficulty accessing forms at the time, and delays in producing symptom charts. One reflected that it is not possible to keep session scores in their head week to week: *“Obviously I can’t remember from the top of my head what they answered the week before so I can’t make that kind of direct comparison” (Geraldine).*

Four spoke about the emphasis on extreme scores in the feedback report. Participants reported that subtle changes may not be picked up, and that extreme scores are likely to be recognised through the therapeutic relationship. One reflected: *“it surprised me actually, because unless someone puts a zero on something, it doesn’t get flagged up. So I don’t see the questions” (Frank).*

Two perceived that the post-session 4 feedback report focuses on short term gains, while therapy focuses on slower change and longer term outcomes: *“if they*

had those same colours 6-months in, that might have caused me more consternation or whatever... But it might just be because I am just not used to the short-term way of trying to solve peoples difficulties” (Frank).

Participants also reflected on utility of feedback in a therapeutic setting. Two viewed feedback questionnaires as intrusive to therapy. Both spoke about how they don't make clients complete forms if they have forgotten to do so. One reflected that feedback forms take away from therapy: *“you want to be talking about that stuff in the room not them doing it in the waiting room and posting it into this secret box type thing” (Geraldine).*

Two reflected they felt the feedback manual and its content seemed simplistic and parental. One spoke about how clients in the service often have complex difficulties and interpersonal relationships are difficult for them, therefore seeking social support is hard: *“Yes, because a lot of people just struggle in forming and maintaining healthy relationships so to say ... it's not that they, it's not that the opportunities aren't out there, they just can't access them” (Ingrid).*

Two commented on how they recognise that feedback is a very personal choice and therapists may not find it helpful to them: *“For me, for me, [feedback is useful] it might not be everyone else's experience” (Hilary).*

Three reflected on their time constraints and that to engage with feedback fully involved additional time. Two reported how there are time pressures and other things that often are prioritised and feedback often gets forgotten about: *“Yeah I am all over the place, em yeah and it is when I am there, I am very squeezed for time. It is just get in see your patients, rush off unless they cancel or something” (Frank).*

Participants reflected on difficulties with the context and process of feedback. Four commented on general obstacles and hurdles to the feedback system. One reflected on the complex nature of client's distress, and the likelihood they won't complete forms in a waiting room. Another reflected that there are a lot of steps therapists need to go through to get access to the client's feedback:

but without that you know like at [PLACE] just giving out questionnaires is trying to get the receptionist to remember to give it them is a bit of a nightmare as well and when it's not integrated into a system it's much harder (Hilary).

Three commented on being slightly removed from the feedback system. Two reported how the research team manages feedback forms makes it difficult to use directly in sessions. The pre-session forms are the only forms given directly to therapists. One reflected that they were unsure if their clients were completing the post-sessions forms: *“I don’t know whether she did do those [Green forms] because I never ... never got those back. So she couldn’t have taken them home and not bothered putting them in the box” (Ingrid).*

One commented on their difficulty with how the measures were worded. This participant felt questions about social support made suggestions towards religion, and that this may not be appropriate for all clients or therapists: *“You know very subtle changing in wording can be quite significant in terms of are you asking the person a question because you are after a particular kind of answer or does it says something about the questioner” (Frank).*

Category 8- Clients interaction with feedback

This conceptual category captures how clients interact with the feedback system and what to therapists recognise of notice about this interaction. Seven subcategories were identified (See figure 20).

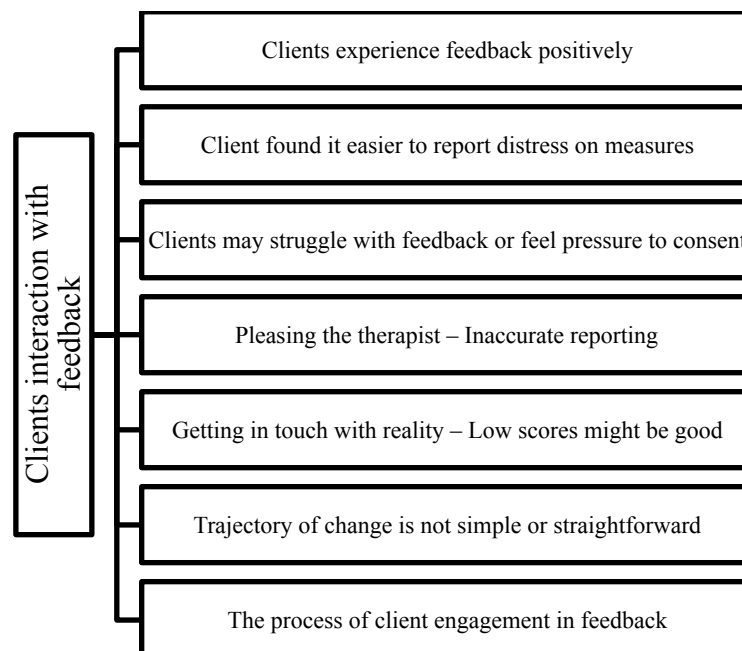


Figure 21: Model of client interaction with feedback

Participants reflected on positive client experiences of feedback. One reflected on their belief that clients experience feedback positively and respond well to it. They spoke about how clients appear genuinely interested in the therapist's view of the forms, that clients complete forms and seem to take an interest in their meaning: *"they all seem to be genuinely interested in when I'm looking at the form what I'm thinking"* (Hilary).

One spoke about their experience of a client who reported high levels of distress on their feedback forms, and minimised their distress when in session: *"he really struggled to accept vulnerability and accept that he wasn't feeling ok ... Minimise how difficult he'd found the week"* (Ingrid).

Participants also reflected on the negative aspects of the feedback system. Four reflected on the struggle that clients might face with the system. Difficulties included, pressure to consent and comply with the therapist, a large volume of measures over an extended period of time, and not being sure of how to rate themselves: *"I'd have to be getting people to do a form before every session and a form after every session and another form before session did feel like it does feel like a lot really from that perspective"* (Geraldine).

Four participants commented on clients trying to please and inaccurate reporting. Three reflected that it was usually when clients were asked to comment on 'therapist variables' and give feedback on the session. One described how it is not lying but it might be responding in a way they think the therapist wants:

I don't think that anyone was deliberately lying, ... they may be answering questions because they think I want them answered in a particular way. Or they may be answering them because they are trying to give me a kind of ... message (Frank).

Participants reflected on the client's interpretation of feedback scores. All reflected how a 'not on track' feedback score early in therapy may be good, as it shows the client is getting in touch with reality and becoming aware of their distress. Two commented on how reporting high symptoms and low therapeutic alliance may be useful as it highlights the true level of distress and that the client is being honest. One spoke about how low alliance scores might be expected as the client is not sure about therapy and may never have experienced a therapeutic relationship before: *"sometimes people should have symptoms, but they would hope that they had cut*

themselves off from things, or some symptoms are healthy, they are expressions of things, and some are unhelpful” (Frank).

Two participants reflected on the trajectory of change experienced by clients. Both spoke about how clients could report high on feedback one week and low the next week; the trajectory was up and down, and difficult to predict: *“so that she could see there’d been some change ... but then the next session it’s all gone a bit back up so” (Hilary).*

Finally, three participants commented on how clients may either leave sections blank or not complete the forms as requested. Equally, participants spoke about how clients took on board feedback and were able to reflect on the meaning of their scores. One reported: *“it’s certainly capturing some of her symptoms but it’s the way she’s using it I think is a reflection of her intra and inter personal style” (Hilary).*

Core category: Reflections on therapy

The present study addressed therapist engagement with client reported feedback. Participants reflected on their experiences of feedback in the context of their therapy workload. A brief summary of this core category will be presented to situate the major core category (*reflections on feedback*) described above.

Four conceptual categories were created through the analysis of interviews with five participants from this service (See figure 21).

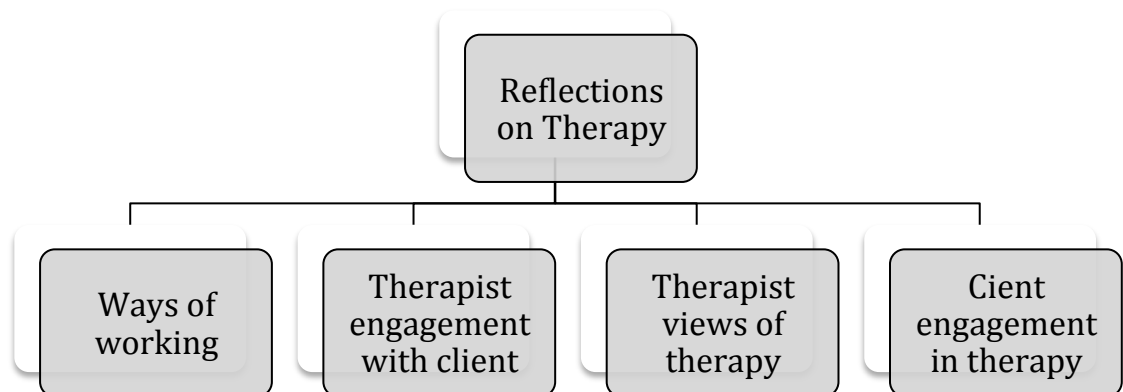


Figure 22: Conceptual categories for 'Reflections on Therapy'

Participants reflected on their *way of working* and the models they operate within. Four subcategories were identified. Three reflected on how they used the intuition, experience and knowledge to guide their decisions and planning for sessions. Two spoke of splitting therapy into smaller more distinct tasks. All reflected on their styles of therapy and their way of working. A therapist’s way of working will impact on how they engage with the feedback system, as it will inform their views and facilitate the integration of feedback into a session.

Participants reported on *how they engage with clients* during sessions. Six subcategories were identified. The main themes reflected by participants were as follows. Three reported experiencing difference between a client’s goals for therapy and their own goals for the client. One reported on repairing therapeutic ruptures directly in session when they happen. Four spoke of engaging with the client’s distress in session and how this can be difficult for clients to stay with. Three reflected that client’s distress is often deep rooted and hard to shift. One reflected

how the focus of therapy might be to shift expectations from symptom eradication to acceptance and improved functioning. Three participants reported finding hope for clients and seeking positive change for clients in other areas such as quality of life.

Participants expressed *their views of therapy*. Three subcategories were identified. The main themes reported by participants were as follows. Two reflected on the importance of openness and honest dialogues between client and therapist. Two reflected on the importance they place on ‘how’ clients report in sessions above ‘what’ a client reports in session. Finally, one reported feeling that model specific measurement was more collaborative and therapeutically useful. The implication for the feedback system is the importance of accuracy and honesty of client reporting and the therapist’s focus on seeking out the meaning behind a client’s report.

Finally, participants reflected on their *client’s engagement in therapy*. Five subcategories were identified. Four reflected on how this also applied to the feedback system, and that clients who are not engaged in therapy are unlikely to be engaged with feedback. Four felt clients often have a negative initial perception of therapy and that it requires a strong will to perceive and attend to therapy if you are hugely distressed. Again, this was related to a client’s ability to engage with the feedback system.

Four reported that clients typically present with high levels of distress and that therapy can be quite difficult for them. It was felt this high level of distress makes therapy difficult and often limits the ability to engage with the feedback system. Two reflected on how it is the client who must engage with the process of therapy to make changes and therapists cannot force engagement.

Theory of Therapist Engagement with Feedback

Interviewing 10 therapists from 2 psychological therapy services produced twenty-three categories describing therapist response to feedback and therapy. There was some overlap between the services, but also some differences. This theory is an attempt to bring together these similarities and differences and hypothesise the relationships and factors that contributed to therapists becoming involved in feedback and utilising feedback in therapy.

Interview participants experienced feedback both positively and negatively and it seemed that their experience of feedback was very individualistic and varied across services and between therapists within services. The explanatory theory that emerged is the result of integrating the unique and common characteristics of the services and their therapists with the grounded theory service models of therapist engagement presented in the previous section. This section will outline the comparison procedure and present a theory of engagement and a theory of disengagement.

Compare and contrast

This study sampled two diverse services each with unique characteristics. It is important to highlight these characteristics in order to situate the explanatory theory of therapist engagement with feedback information. In order to retain the uniqueness of each service, analysis of participant interviews were kept separate until the point of integrating the core categories into the explanatory theories described below. The similarities and differences within (between therapists) and between each service will be explained. Within differences (between therapists) will be explored in terms of therapeutic style, attitude toward the concept of feedback, and use of feedback. Between service differences are also explored. Placing these similarities and differences alongside the core and conceptual categories described in the previous section, adds context to following explanatory theories.

Between participant differences

Similarities and differences between participants in each service were explored by returning to the original transcripts and codes and using memo's to build up a coherent comparison between participants from both service. Comparisons were only made between participants within the service. Therefore each service will be commented upon separately. There are a number of unique

differences between participants, which add useful context to the theory of engagement, and disengagement. For example, within both services, there were participants who rejected the feedback system and also the feedback information when presented to them. This seemed in spite of support and advice in how to use feedback therapeutically.

Looking first at the SCS service, most participants presented a unique insight into how their personal therapeutic model could be adapted to fit with the feedback system. However, at least one participant spoke of how their training did not focus on measurement and outcome, and that this made it difficult to take the system fully on board. This makes a useful contribution to the role of someone's personal beliefs and experiences guiding the engagement with feedback. Other experiences that add to the context of feedback in a therapy setting is that some participants spoke of withdrawing from the system some times due to limited space to reflect, but maintaining their underlying belief in the utility of the system. They reported wishing to engage more, and of finding ways to overcome their difficulties with utilizing feedback. In terms of engagement factors, all participants spoke of having immediate feedback presented in an understandable way as being helpful, and that when their computer system was not working, that the lack of immediacy reduced their engagement.

Looking next at the APTS service, therapists also differed in how they engaged with feedback. The personal beliefs and previous experiences of feedback seemed to guide participants in how and if they used feedback therapeutically. In this service, participants were encouraged to engage with feedback as part of a feasibility study, but were also encouraged to use it therapeutically. Most therapists commented on the therapist support manual and felt it was not helpful and did not provide adequate guidance in how to use feedback in therapy, they felt the advice was simple and not relevant to their clients.

Therapists that did engage with feedback therapeutically found a way to incorporate it with their belief system and to choose what measures they used and what measures they did not. This was possible due to the larger range of sessional measures completed by clients.

Therapists that reported struggling with the system expressed frustration at the delay between a client completing the feedback measure and the therapist receiving the information. This seem to present a disconnection between the

information received by the therapist and their sense and memory of the session/time it referred to. Therapists also reported disengaging when feedback information was not accurate, not useful to therapy, and not intuitive.

Between service differences

Service level differences can be seen in how the services were set up, the feedback system utilized and the therapist responses. There were also service similarities in these areas. These similarities and differences are important in situating the engagement and disengagement theories.

The unique characteristics present in the Student Counseling Service was that the feedback system was championed by a clinician, this seemed to aid other therapists with feeling confident in using the system and of asking for help and advice. Another unique characteristic that seemed to increase engagement was that feedback scores were immediate and therapists could make use of feedback in the same session that it was received. Feedback information was kept on the therapist's computer and this seemed to produce a sense of ownership and investment in the feedback system.

There were a number of unique characteristics present in the Adult Psychological Therapy Service that seemed to contribute to therapist engagement or disengagement from feedback. The feedback system was a recent addition, and therapists were using the system for less than 18 months. Although therapists were familiar with the concepts of feedback, there may be a lack of familiarity with its use. Coupled with this was that the system was part of a feasibility study to explore the use of early feedback as a predictor of outcome; therapists were encouraged but not required to use this information therapeutically. Therapists reported that there was support from the research team but there lacked clinical support. Another factor seemed to be that the feedback information was kept separate from the therapy information in the client notes. These characteristics seemed to introduce a split between feedback in therapy and feedback in research, with a strong emphasis on feedback research. Furthermore, therapists felt that there was a lack of ownership of the feedback.

There were also a number of commonalities across the services. Across both services, therapists engaged and disengaged with feedback depending on specific situational variables and based on information available to them at the time. This

suggests a fluctuating response to feedback information and to the system. Together with a fluctuating response, therapists in both services had autonomy to respond to feedback in their own way. This produced two opposing outcomes, when therapists felt confident to use feedback and believed feedback was helpful to their client, the role of autonomy improved engagement with feedback information. In contrast, when therapists seemed to have a negative view or experience of feedback, having autonomy was likely to result in disengagement. In both services, when there seemed to be more space and time for therapists to reflect on their practice and on feedback outside of session, therapists were likely to engage and respond to feedback. A final common characteristic across services was the role of feeling supported and having confidence to use feedback resulted in therapists engaging with feedback information, when this was lacking, therapists often disengaged.

These similarities and differences provide the underlying context upon which therapists decided to engage or disengage from feedback. Feedback appeared to be seen at two levels; (i) the feedback information provided to therapists, and (ii) the feedback system as a helpful or unhelpful tool for therapy. This is important to distinguish because therapists who held positive views of the feedback system seemed to continue to engage with feedback information even after unhelpful or negative experiences of receiving inaccurate feedback information. In contrast, those who had a negative view of feedback seemed to disengage more from the system after unhelpful or inaccurate information, and less likely to engage positively in the system in future.

The last stage of analysis built on the core and conceptual categories highlighted in the previous section, and the contextual factors extracted from comparing and contrasting the services. The result of this analysis was the development of two theories of therapist interactions with feedback information and feedback system.

Overview of Theory

The theory of engagement with feedback is best understood as two sides of a coin. One side shows the path towards engaging with feedback, while the other side describes the path towards disengagement. Essentially, they have the same underlying structure. There are two levels of influence contributing to the therapist's response to (i) specific instances of feedback and (ii) the general feedback system.

A brief diagrammatic representation of both theories is presented in figure 23 below. The next section populates each theory with the factors that promote engagement (1st theory), or promote disengagement (2nd theory).

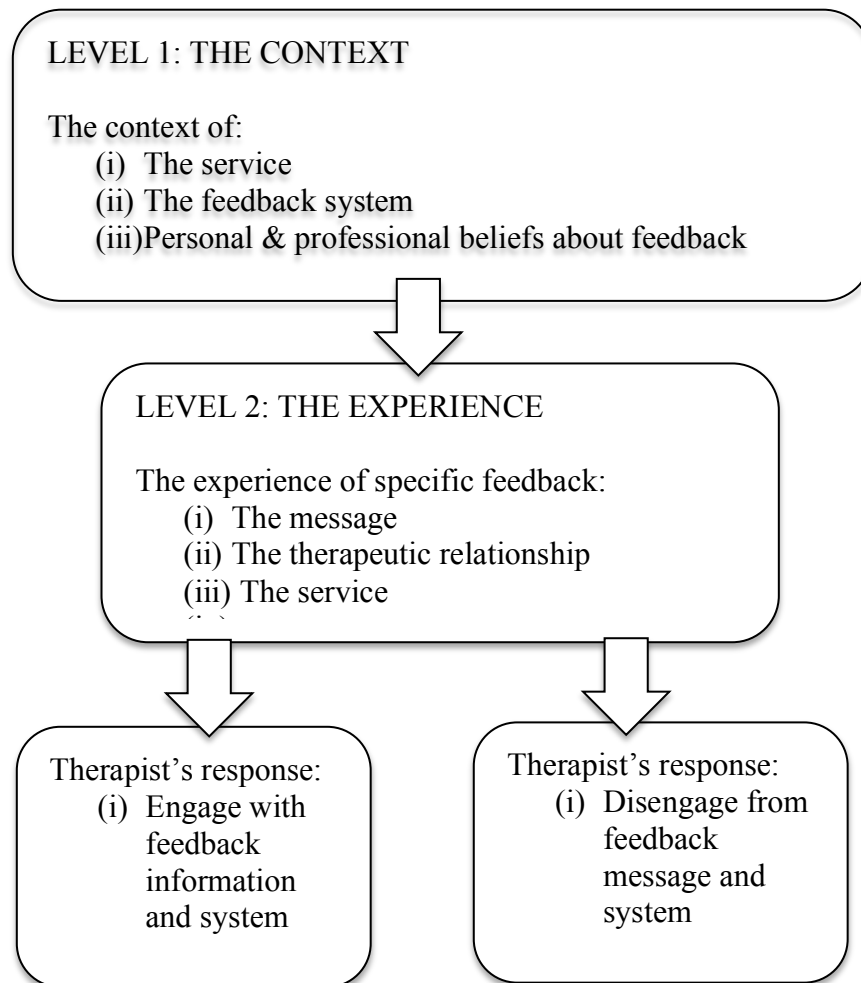


Figure 23: Overview of theoretical model of therapist's response to feedback

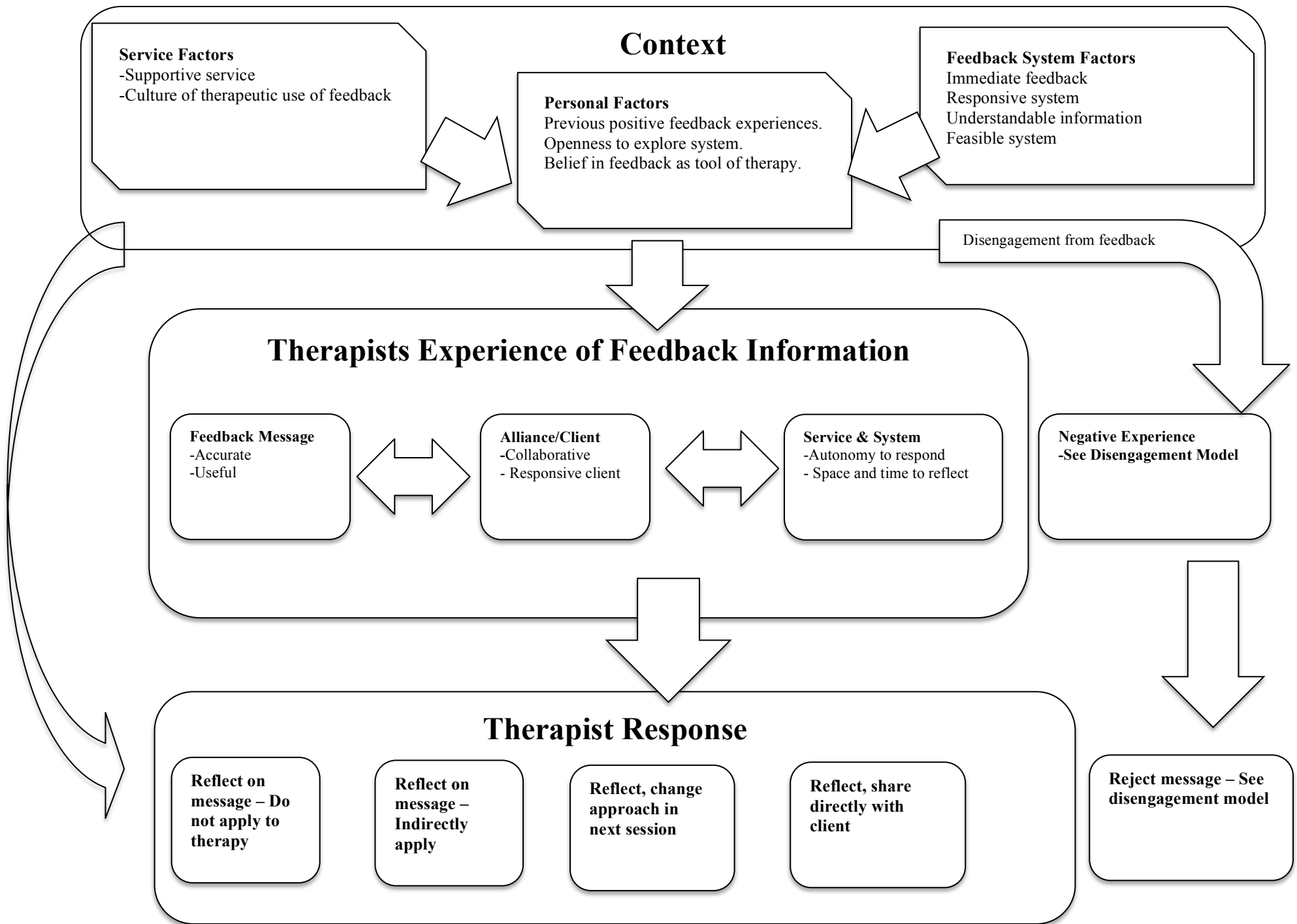


Figure 24: Theory of therapist engagement

Theory of engagement

The first theory will be explained here (See figure 24). The therapist theory of engagement with feedback proposes that therapists consider a number of factors and pieces of information when deciding on their response to specific instances of feedback information and that these decisions also influence the therapists wider views of the feedback system operating in their therapy service.

Contextual level of feedback

According to this theory, there are two levels of influence on a therapist's response to feedback. The first level is the *context* in which the therapist operates and is made up of three contributing factors; the service, the feedback system, and the personal attitudes and past experiences of feedback. At this level the therapist receives static information about the service around them such as the ethos of the service, the service approach to the feedback system, the level of autonomy they experience in their practice, and their allegiance to the service. The therapist also receives information about the feedback system such as whether the system is being used for audit, research or therapy purposes, whether the system is complex and unwieldy or if it straightforward and easily understandable.

The therapist then applies this information to their own personal beliefs and integrates it into their overall attitude towards the feedback system. At this stage the therapist is not faced with specific instances of feedback information (a client feedback report or feedback score). It is at the *context* level that the therapist makes a decision about whether they will approach client feedback positively and to some degree consciously or unconsciously decides whether to use it therapeutically. The most important contextual factor is the therapist's attitude and belief about feedback.

Experiential level of feedback

The next level that influences a therapist's response to feedback is their experience of the feedback information (i.e. client feedback report, client feedback scores). There seem to be three factors that contribute to a positive experience of feedback information. The presence of these three factors are likely to result in a therapist positively engaging with the specific feedback information and more generally in the therapist engaging with the feedback system. Therapists seem to place a higher value on feedback information that is (i) accurate, (ii) relevant, (iii) applicable in session, and (iv) matches their sense and intuition. Therapists also engage with feedback information if they feel there is a positive and collaborative

relationship between them and the client. Having a client who is responsive to the feedback system and also values it will likely result in the therapist have a positive experience of feedback, and will make use of it in therapy. Finally, as service and therapist demands and the work place environment are in a constant state of flux, therapists reported needed a reflective space with low competing demands in order to engage with feedback information.

Engagement response to feedback

The initial aim of this study was to explore how therapists use feedback information in therapy, however, therapists were often vague or unclear about their specific responses to feedback information, therefore therapists' responses were grouped according to the level of engagement with the feedback message. There seem to be four ways therapists who are engaged in feedback as a tool of therapy make use of feedback in their day to day practice; (i) reflecting on feedback message but not applying it directly in session, or indirectly out of session, (ii) reflecting on feedback message outside of session and applying it indirectly, (iii) reflecting on feedback message and applying it directly in session, and (iv) reflecting on feedback, sharing scores and using feedback discussion to shape session.

A difficulty with this theory is that even if the context and experience of feedback is positive, some therapists will still disengage from the message and from the system. It seems that therapists can shift between the engagement theory and the disengagement theory depending on the current environmental, relational, and message cues.

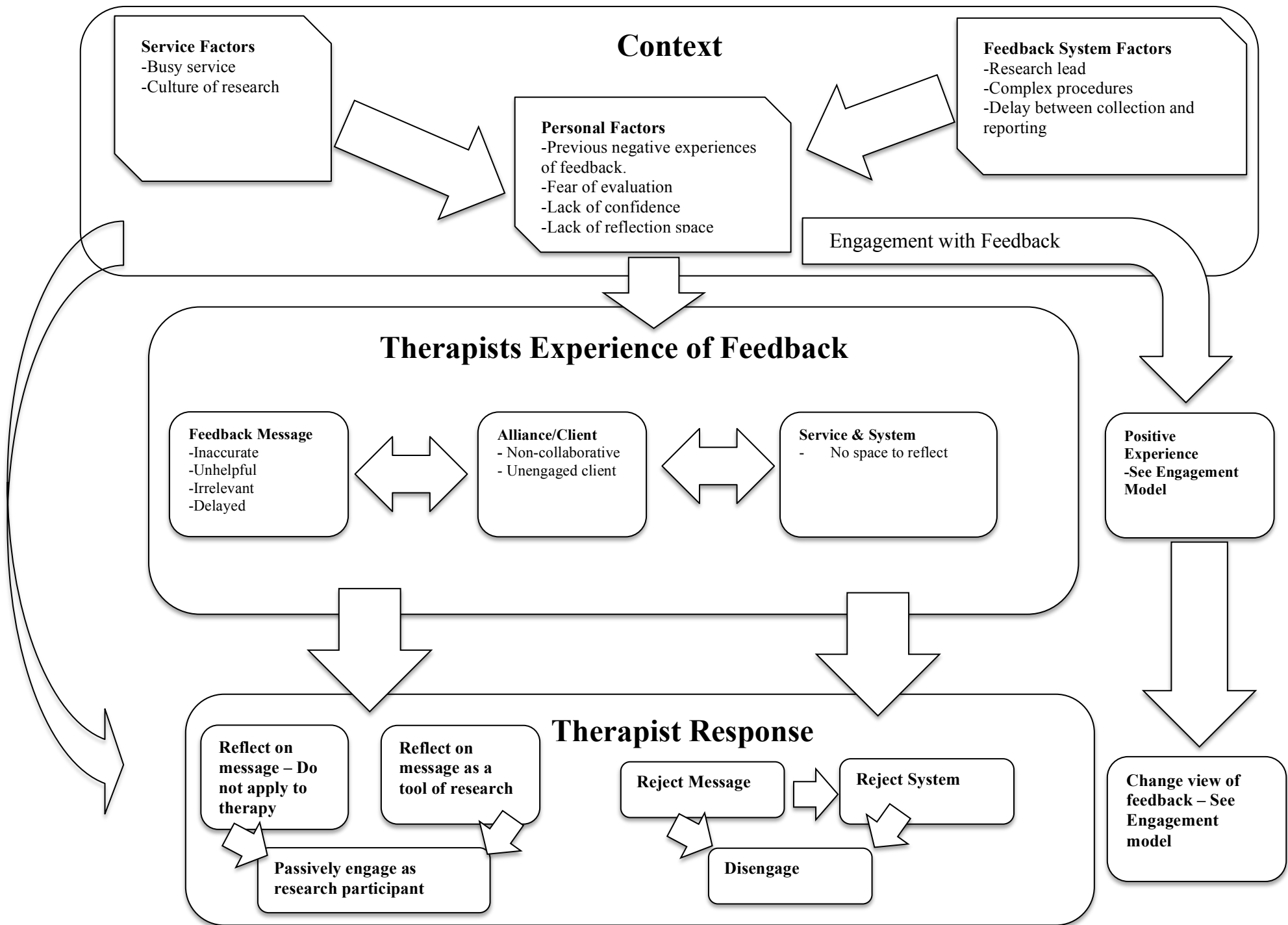


Figure 25: Theory of therapist disengagement

Theory of disengagement

The second theory to emerge from the data is a theory of therapist disengagement (see figure 25). In many ways this is a parallel theory, and operates in tandem to the above engagement theory. The purpose of highlighting two theories of therapist responses to feedback rather than a unified theory of engagement and disengagement is that to do so would reduce the subtle differences between the factors that promote engagement and those that reduce engagement.

As with the theory of engagement, the therapist theory of disengagement proposes that therapists consider a number of factors and pieces of information deciding on their response to a specific instance of feedback information (i.e. client feedback report). Furthermore, the theory proposes that these decisions influence the therapist wider views of the feedback system operating in their therapy service.

Contextual level of feedback

The theory of disengagement proposes that there are two levels of influence on a therapist's disengagement from feedback. The *context* in which the therapist is working and the feedback system is operating contributes to a therapist's decision to disengage from a specific instance of feedback information and from the feedback system. As in the theory of engagement, therapists seem to be influenced by the service context and the feedback system in use. Factors that promoted disengagement included the service not adequately supporting therapists in using feedback therapeutically, a busy or overworked service. This was primarily the experience of therapists in the APTS service; however, therapists in the SCS service also reported this. It is important to recognize that the rationale for the feedback system in the APTS service was to evaluate the feasibility of using a feedback system to measure early change as a predictor of therapeutic outcome. Therapists were encouraged to collect data for a research project and to use the information if they wished. As such the service ethos was on audit and research rather than therapeutic feedback. Another contributor to the context in which a therapist experiences feedback information is the system itself. A disengaging factor of the feedback system was it being overly complex, being research led rather than clinician led, being out of sync with the therapy (delay between collection and use), and non-intuitive. Again, there was a strong sense that the therapist's personal beliefs about therapy and feedback contributed more to the context in which a therapist responded to feedback information. Both the system and service context

informed and guided the therapist, but it was their instinct that decided whether the therapist would engage or disengage.

Experiential level of feedback

The next level of the process was the specific experience of the feedback message. In contrast to the engagement theory, therapists seemed to reject feedback and disengage from it when they felt the message was (i) inaccurate, (ii) unhelpful, or (iii) contradicted their sense of the situation. Also in contrast to the experience of engaging feedback information was that therapists reported the therapeutic relationship not being as collaborative, or that the client did not value or engage with the feedback measures when requested to do so. Sometimes this produced inaccurate feedback, and on other occasions no feedback was provided. It is also of interest when therapists commented on their sense of the therapeutic alliance. One reason for not engaging with feedback information was that the alliance scores might not match with the therapist's sense of the alliance. Some therapists experienced low alliance scores early in therapy as a sign that the client can be honest with their therapist. However, believed that the feedback system interpreted low alliance scores as indicating a negative therapeutic relationship and that the client would drop out. This relates to the therapists sense that their clinical judgment may be superior and that they are not fully trusting of the feedback interpretations provided in the therapist support manual or reports.

Another contributor to the therapist's negative experience of feedback information is the current state of the service. When therapy services are busy and therapists feel stretched, they are unable to dedicate time to reflect on feedback information, and are more likely to put feedback reports to one side and rely on their clinical judgment and continue therapy as usual.

Taken together these three factors can contribute to a negative experience of feedback information and it seems the presence of these factors result in therapists disengaging from feedback.

Disengagement response to feedback

Moving on to the way in which therapists may disengage from feedback. Therapist responses were categorized into either (i) passively engaging on a research level but disengaging from the feedback as a therapy tool, or (ii) disengaging from the feedback message and also the system as tools of research and therapy. Looking

at both responses closer, some therapists who perhaps showed allegiance to their therapy service and believed in the research aims of the service would disengage from the feedback system as a therapy tool, but continue to recruit their clients and collect data for the research study.

It seems that other therapists would disengage from the feedback message when they felt it was inaccurate and subsequently were less likely to engage the next time feedback was presented to them, and therefore disengaged from the feedback system.

One difference from the engagement theory, is that some therapists disengaged from the feedback system by bypassing the experiential stage; moving from the context to the disengagement response. This is perhaps due to them holding a negative attitude towards the benefits of feedback and having previously negative and unhelpful experiences of feedback in therapy.

As in the engagement theory, therapists seemed to approach the feedback system on a case by case basis, therefore engaged with feedback with some client under certain circumstances, and disengaging with other clients in different circumstances. This suggests that therapists were able to maintain a curious stance and allow feedback to guide their therapeutic approach, but were also able to reject it when they felt it was not beneficial.

Summary

The two parallel theories of therapist engagement/disengagement with feedback were developed through revisiting the core and conceptual categories extracted from both services. These categories were then interpreted in light of the similarities and differences between each service. It can be seen that there were three stages to a therapists interaction (positive and negative) with feedback; the context, the experience and the response. It is clear that the context the therapist operates in influences how they will subsequently experience feedback information, and furthermore influences their response. Therapists either engaged or disengaged with there feedback system. The proposed theory highlights the varying degrees of engagement and integration of feedback into a therapists practice as well as highlighting the ways in which therapists may reject and disengage from feedback.

Conclusion

This chapter has presented the analysis of this study and presented a theory of therapist feedback engagement. The next chapter will discuss the implications of this theory and present the strengths and limitations of the findings. Specific focus will be given to evaluating the engagement theory and disengagement theory. These will be interpreted in light of the current research and received knowledge of feedback systems, and therapist decision-making.

DISCUSSION

Overview

This chapter will begin by revisiting the research aims, summarising the main findings and then placing this within the context of existing literature. The main findings will be discussed in relation to their contribution to the knowledge of therapist use of feedback measures in therapy. Specific attention will be given to how the current findings inform our understanding of therapist responses to feedback information. The main findings will also be interpreted in terms of the strengths, weaknesses of the study and future direction in this field of research.

Research Aim

The primary aim of the current study was to explore therapeutic feedback systems from the therapists' perspective. The principal research objective was to explore psychological therapists' reflections on the process of receiving client feedback, and their reports of what actions they take in response.

The main research question addressed was:

- What do psychotherapists reflect about their experience of client reported feedback in therapy?

The aims were achieved through interviewing 10 therapists from two therapy services. These interviews were analysed using grounded theory. A theory of therapist engagement with feedback was developed.

Summary of Main Findings

Participants reflected on their views of feedback, the service and feedback system context, their therapeutic style, and their client's reactions to therapy and feedback. Each of these contributed to the therapist's actions and response to feedback information. Therapist reflections touched on two broad areas. First, therapists reflected on the information that feedback provided. Some spoke about how this information added to therapy, gave deeper understanding, and introduced relevant symptom or process information earlier in therapy. This information also provided therapists with material for use in therapy, with the client, or to reflect on the session. Second, therapists' reflected on how this information was used (or not

used) with clients in therapy. Therapists varied in their engagement with feedback information. Some described that they shared the feedback scores and information directly with clients. Others reported that they did not share these scores or information directly with clients, but would reflect on session content and their practice outside of the session and adapt their approach in future sessions. Another group reported not using or sharing feedback at all. These therapists reported not engaging with feedback as a therapeutic tool, and cooperated only at the level of evaluating or auditing the service. Furthermore, most therapists reported using their intuition and experience in deciding their response; therapists appeared to consider their response based on a number of factors.

The main outcome from this study was the development of a theory of therapist engagement with feedback information, and a corresponding theory of therapist disengagement from feedback information. These theories emerged through comparing the characteristics of two treatment services, and incorporating the core and conceptual categories that explain therapist responses to feedback. The following section will explore the relevance and utility of each theory.

The theory of therapist engagement

The context of engagement and disengagement

The first level that contributes to a therapist's response to feedback is the context where they encounter feedback and how their personal attributes and experiences influence their initial approach. There were three factors that appeared to highlight the context of feedback for therapists.

The context of the feedback system

The context a therapist is working appears to influence their response to that situation. In the present study, one factor influencing therapist's views of feedback was the feedback system itself. Therapists from both services experienced their respective systems in both positive and negative ways. Some of the difficulties described by therapists appeared to lead to them disengaging from specific feedback information as well as the feedback system itself. In contrast, some of the positive qualities of their feedback system led them to engage with specific feedback and with the system itself. There seems to be indirect support in the existing literature for the factors of engagement and disengagement described by participants (i.e.

Duncan et al., 2003; Reese et al., 2009). Therapists in the present study believed that feedback should be more immediate and that the delay between the session and receiving the information reduced its utility. Reese et al. (2009) reported in their study on providing continuous feedback to therapists, that immediate access to feedback information in session provides therapists with the best opportunity to use the information. These authors did not compare continuous to one off feedback (as occurred in the APTS service); however, the benefits of immediacy mirror the difficulties that therapists from the APTS service experienced with delayed feedback information. It should also be noted that therapists in the SCS service had access to immediate feedback on a continuous basis, and they spoke more positively about their system.

The benefits cited by Reese et al. (2009) also mirror difficulties experienced in accessing feedback information after sessions. Therapists from the APTS service were involved in a feasibility study at the time of the present research, and therefore researchers rather than clinicians themselves collected all feedback information. However, therapist reflections indicate that this presented an obstacle to their engagement.

Fitzpatrick (2012) highlighted a number of common questions therapists ask when they first engage with a feedback system, these questions mirror some of the therapist reflections in the current study. For example, therapists in the present study reflected on their difficulties with being monitored or evaluated.

The context of the service

Another influence on therapist's response is the context of their service. Therapists in the present study either worked in a Student Counselling Service or an Adult Psychological Therapy Service. Some aspects of these services promoted engagement with feedback, while other aspects of these facilitated disengagement. It seems that working in a busy service with little time for self-reflection and space to reflect on your case load limited the ability of therapists to engage fully with their feedback system, and often feedback information from clients was put to one side and not fully explored. Therapists who reported engaging in their feedback system also reported having the space and time to do so.

Other aspects of the service that influenced therapist's responses to feedback included the availability of clinical support and the emphasis on audit and research.

Therapists reported that they valued the availability of clinical support from other clinicians who were knowledgeable and skilled in PROMs. Therapists who reported not fully engaging with feedback reported the lack of clinical support, which seemed to be replaced with research and audit support.

Continuing with the emphasis on audit and research, some therapists recognised the pressure that services are under to provide evidence of their effectiveness. Participants described how this pressure was placed on individual therapists and that monitoring their clients through feedback was one strategy to ‘prove the value of the service’. There is a strong narrative supporting the importance of service and outcome audit. Ogles, Lambert and Fields (2002) highlight the recent drive towards greater responsibility and accountability to “demonstrate the utility of services and to obtain consumer input regarding the quality and outcomes of interventions provided” (pg.1). Participants in the present study emphasised their services’ desires to audit their interventions, some participants also stated they wished to audit themselves. The present study validates Ogles et al.’s (2002) claim that accountability is necessary for two reasons, first, for the confidence of the general public, services users and therapists, and second for the financial viability of the service.

The strong narrative on the pressures of auditing your practice, suggests that there is recognition that feedback systems, such as those implemented in both services sampled in this research, are a necessary evil at worst, and an evidence of effective and economical practice at best. Participants from this study took positions along this spectrum, with most recognising its potential benefits. In terms of engagement, those who held a positive view of feedback, and felt it was necessary to show effectiveness, appeared to engage with their respective system.

The context of the therapists views and beliefs

The final aspect of influence on the context in which a therapist experienced the feedback system in their respective service, is their own views and beliefs about feedback. These views and beliefs emerge through previous involvement in measuring outcome, or through previous training and skills development. Views and beliefs may also be shaped through early use of feedback systems. What was clear from the present study and is shown in the theory of engagement and disengagement is that the therapist’s personal views and beliefs strongly influenced their subsequent

responses. This is in line with the theories of behaviour and relationship between beliefs and future behaviour (Ajzen, 1991). This summary also draws on the concepts of self-efficacy (Bandura, 1994).

Participants reflected on their views or attitudes towards feedback, as well as their perception of the accuracy of feedback. The importance of therapist views of feedback is the suggested theoretical link between an individual's attitude towards behaviour and that subsequent behaviour (Ajzen, 1991). It is beyond the scope of the present study to provide a detailed analysis of attitude and behaviour prediction, however a brief summary will be used to highlight the link between a therapists attitude (positive or negative) towards feedback and their subsequent engagement with a feedback system. There is strong theoretical and empirical support for an individual's attitude towards a behaviour, the subjective norms of that behaviour, and their perceived control will influence their subsequent behaviour (Ajzen, 1991). The Theory of Planned Behaviour (Ajzen, 1991) highlights the importance of looking at attitudes towards behaviours when attempting to understand or predict behaviour. Ajzen (1991) places a strong emphasis on the perception of social norms, and behavioural control. It is not surprising that therapists described in detail their attitudes, views and beliefs about feedback. Another concept that can be argued to influence therapists' views of feedback is self-efficacy (Bandura, 1994). Therapist confidence and belief in their ability to use feedback is likely to be related to their level of self-efficacy (Bandura, 1994; Kruger & DiNisi, 1996; Reese et al., 2009a; Sapyta et al., 2005). Reese et al. (2009a) explored trainee therapist self-efficacy during training and through supervision. Their study reported a relationship between high trainee self-efficacy and positive client outcomes when feedback information was used. In contrast, trainee therapists in a 'no feedback' condition reported developing self-efficacy but had less positive client outcomes. This suggests a link between a therapist's confidence in their use of feedback and their subsequent behaviours and outcomes from therapy.

Many therapists spoke about the process of investing or 'buying into' the feedback system. Therapists spoke of how they believed in the system and they viewed it as a therapeutic tool. This seemed to be an important factor in whether therapists used feedback therapeutically, or whether they saw it in terms of research by the service. Support for this interpretation comes from Wampold's (2001) concept of therapist allegiance. According to Wampold (2001), therapists who have

an allegiance to a model of therapy, and adhere to the model are more likely to achieve positive client outcomes from therapy. It appears that therapists who invested in the process of feedback, collected, utilised and reflected on the feedback information were identifying an allegiance to the system. Although Wampold (2001) does not discuss allegiance in the context of feedback, it seems reasonable to assume that this concept can be applied to the participants in this study and their investment in feedback.

Therapists described how they viewed the feedback system and the information it provided as either a therapeutic tool or an evaluation of their service (a research tool). Therapists who viewed the feedback system as a therapeutic tool also spoke of how they used the feedback in a therapeutic way. In contrast, therapists who viewed the feedback system as a research tool did not bring feedback information into therapy. Some therapists spoke about how they shifted their initial attitude and more recently began to make more use of feedback information since seeing the therapeutic value. This narrative about the utility of feedback appeared to be strongly influenced by the service context. Therapists in both services had flexibility and autonomy about how they engaged with the feedback system. The APTS service more recently introduced the system and at the time was undertaking a feasibility study on the use of case tracking; this is likely to have influenced therapist's views from this service. The system in the SCS service was longer established and therapists were more comfortable and perhaps experienced with using feedback in therapy. It should also be said that therapists from both services held positive and negative views. Support for this narrative comes from Lyons, Howard, O'Mahony, and Lish (1997).

Lyons et al. (1997) suggested that a model of staff attitudes to computer technology could be applied to therapist responses to feedback systems. This original model described three types of responses to computer technology; eager adopters, hesitant 'prove its worthers', and 'resistors'. This model can be seen in the current study through how therapists initially viewed the feedback system, and whether this initial impression changed as time went on. The minority of therapists were initially invested in the feedback system; these can be seen as eager adopters. The majority of therapists in the SCS service and the minority of participants in the APTS service can be seen as 'hesitant prove its worthers'. These therapists were initially sceptical of the system, but over time began to get more invested and saw

the benefits of the system. The majority of APTS therapists were initially sceptical or hesitant to engage with the system. Over time, this hesitancy continued; these participants are termed resisters. The first two categories can be seen as those therapists who viewed feedback as a therapeutic tool, while the final category ‘resisters’ can be said to view feedback as a research tool.

Ajzen (1991) theory of planned behaviour is also relevant to participant’s reflections on feedback as a tool of therapy or a tool of research. First, the therapist’s perception of social norms; in the SCS service, there was a social norm of feedback as a tool of therapy, and the majority of participants experienced feedback as such. In contrast in the APTS service, there was a culture of research but feedback was a relatively new initiative; here three participants viewed feedback as a tool of research. Furthermore, the therapist’s perception of behavioural control or self-efficacy contributes to their view of feedback. Therapists in the both services had a large degree of control over whether to engage with feedback or not. This allowed both sets of participants to develop their own views of feedback. Bandura (1994) argues that a high level of perceived self-efficacy will enhance a person’s capability of accomplishing difficult tasks. According to Bandura (1994) people with high self-efficacy are likely to view “difficult tasks as challenges to be mastered, rather than as threats to be avoided” (p.71). In the present study, therapists differed in their view that feedback is a useful therapeutic tool. Although no measurements of self-efficacy were taken it is possible that therapists differed in their perceived self-efficacy towards feedback information and this could account for whether they viewed feedback as a therapeutic tool or a research tool external to therapy. Therapists with high self-efficacy may experience negative feedback (feedback which suggests clients are not improving or low therapist scores) as a challenge to be overcome and make use of this information in a therapeutic way. In contrast therapists with low self-efficacy may view these negative scores as a threat to their therapeutic skills and avoid viewing them as of therapeutic value. It is important to recognise that self-efficacy is a state specific to a task, and low self-efficacy for feedback does not indicate low therapeutic skills.

The experience of feedback information

The second level of the theory of therapist engagement and disengagement with feedback is their experience of the specific instances of feedback and how this

influences their response, and how it may contribute to a re-evaluation of their view and belief about the feedback system in place in their service. There were three factors that appeared to contribute to the therapist's experience of feedback. Each will be explained below and supported with the relevant literature.

The experience of the feedback message

Therapists from both services reflected on the information that they received from the respective feedback systems. Some felt that this information is new and was something they were unaware of, while others experienced this information as confirmatory and used it to support their existing knowledge of their client. However, another set of therapists felt that the information they received was not novel or new, and that it does not add to their formulation of their client. New feedback information included ratings of risk, levels of social support, difficulties outside of therapy, changes from the previous week, and therapeutic alliance.

There is some support for the role of feedback in creating new conversations in sessions. Detmar et al. (2002), looking at medical doctor-patient communication, reported improved conversation following use of PROMs. Lambert et al. (2002) did identify changes in client-therapist conversation following feedback however they don't elaborate in what way changes occurred. For therapists in the present study, conversations were created about the client's life outside of therapy, the changes they felt they had made, and how therapy is going.

The findings of the present study on the contribution of feedback information to a therapists understanding of their client's risk seem to match the findings reported by Brown and Jones (2005). The previous literature speculates on the nature of the link between new feedback information and its utility in therapy. Brown and Jones (2005) in their study found that therapists were often unaware of risk issues or suicidal ideation before clients self-reported. This confirms participant's reflections of their focus on identifying risk from feedback items and reports.

Another important narrative held by participants was their views on the accuracy of feedback. Therapists commented on whether they believed feedback information was accurate, whether clients were honest, what factors increased and decreased accuracy, and what factors were used to judge accuracy. Similarly, the belief in accurate feedback suggests that this information would be used in some

way by therapists. In a similar vein to the arguments above, support for this comes from the work of Wampold (2001) and Ajzen (1991).

Therapists reflected on their sense that some clients are reluctant to be honest in their reporting, specifically in relation to ratings of alliance or their therapist. This appears to be a common concern expressed by therapists. Sundet (2012) described issues with authority, where clients might minimise their distress or inflate their rating of the therapist in order to not offend their therapist or seem ungrateful for their sessions.

A therapist perception of accuracy seems to be an important factor in the process by which the therapist consciously or unconsciously decides whether to make use of feedback information (Kluger & DiNisi, 1996; Ilgen, Fisher & Taylor, 1979). Kluger and DiNisi (1996) discuss feedback accuracy in terms of Feedback Intervention (FI) Theory. These authors developed FI theory to explain feedback effects on performance. A basic tenet of their theory is that behaviour regulation occurs when comparisons are made between feedback information and the goal. Essentially, Kluger and DiNisi (1996) argued that when there is a discrepancy between the feedback and the desired goal, the individual (therapist) will actively attempt to reduce that gap. Of course, the therapist must interpret the information as accurate and providing information relevant to the therapy goal. The authors described the importance of the receiver's (therapist) perception of accuracy in whether the feedback information will have an influence on their performance. Although, participants did not explicitly link accuracy with their subsequent integration or rejection of feedback in the current study, a clear pattern emerged from participants who spoke positively of feedback accuracy and using feedback in session.

Another component of accuracy is the importance of clients' accurately reporting their experiences. Ilgen et al. (1979) highlight the individual's evaluation of feedback content. It should be noted that Ilgen et al. (1979) were not discussing feedback in the same sense that has been explored in the current study. Their interest was in feedback to individuals in organisations about their behaviour and performance. However, their concept can be applied to the present study. For example, if therapists perceive client responses as not honest, then the feedback message is not accurate and the link between feedback systems and outcome is broken. Therapists explicitly made this link, and spoke about the sense that at times

when clients were not honest, they put less weight on feedback. A related topic is that participants noted that the process of dishonest reporting in itself was useful feedback for therapists, and was used to start a conversation.

Therapists experience of the client and therapeutic relationship

Therapists spoke about how they had both positive and negative experiences with feedback information. Two contributing factors influencing whether a therapist's experience would be positive or negative was the client, and the therapeutic relationship.

Therapists reflected on their approach to clients and the role of therapeutic alliance and relationship. Therapists regardless of their views on feedback acknowledged that when there is a client-therapist mismatch or a poor alliance, it is difficult for clients to achieve change.

Therapists also highlighted the role of collaboration during therapy and specifically in their use of feedback. Again, collaboration is a well-researched component of the therapeutic relationship (Bordin, 1979; Bachelor, Laverdiere, Gamache, & Bordeleau, 2007; Tryon & Winograd, 2010). Tryon and Winograd (2010) report a medium effect between collaboration and therapeutic outcome. They defined collaboration as “the active process of working together to fulfil treatment goals” (Tryon & Winograd, 2010, p.157). Therapists in the present study highlighted how the feedback system was a collaboration between the client and the therapist, and when either side did not engage with it, the system did not work.

An interesting narrative that emerged from therapists in the APTS service was the interpretation of alliance as measured by feedback questionnaires. There was doubt among therapists about whether the scoring systems of the feedback system recognised that a low alliance in early therapy may predict drop-out, but that it also may represent a client who is being honest and open with their therapist and that the client is accurately experiencing the early stages of therapy (which is often difficult). For some therapists an early high alliance score was more concerning and indicative of drop out, as it suggests the client feels they cannot be honest with their therapist. This suggests that therapist interpretation and experience of the session is just as important for the prediction of change and client engagement as questionnaire measures of alliance.

Therapists also described their experience of clients' contributions to therapy and to the feedback system. Both services appeared to work with a different client

group. The SCS service worked with university students who typically presented with interpersonal, anxiety/stress, or mood difficulties. Any complex clients were referred on. In contrast, the APTS service catered from adult population who often had severe and complex or comorbid psychological needs. It is logical to assume that the services might identify distinct client factors. It follows, that the therapist's expectation of their client's progress might also differ. Therapists from both services reflected on the client's contribution to therapy, in respect to presenting factors, engagement with sessions, and responses to therapists and their approach. The psychotherapy literature highlights the influence client 'variables' have on the outcome of therapy (Clarkin & Levy, 2004; Garfield, 1994; Luborsky, Crits-Christoph, Mintz & Auerbach, 1988). Clarkin and Levy (2004) provide an overview of client factors that influence therapeutic outcome, including severity of difficulties, specific diagnosis, expectancies of therapy, readiness for change. It is easily argued that client factors will influence their outcome as well as their response to feedback systems.

Therapists from both services reflected that how their client responded to feedback influenced their approach. Therapists gave examples of clients who invested in the feedback system, and others that dismissed it. Other therapists reported that clients found it hard to place him or her on a scale of distress or to rate a therapy session. There are few studies that have explored the client's response to feedback directly. However, some support can be drawn from the literature on patient satisfaction (Hansen et al., 2010), and early termination (Piselli et al., 2011).

Hansen et al. (2010) suggest patient satisfaction with therapy is an important factor to measure. The authors created a measure PatSat (Hanson et al., 2010) that looks very similar to a measure of alliance, however on a broader scale. Hanson et al. (2010) also fail to acknowledge that a measure of satisfaction is not the same as a measure of success.

Therapists reflected on client dropout or early termination. This was relevant in the context of feedback predicting or failing to predict drop out. There is some overlap between the present study findings and the existing literature (Piselli et al., 2011). Piselli et al. (2011) explored therapist reflections on 'what went wrong with early termination of therapy. They reported seven themes, some of which were reported by therapists in the present study. Specifically, therapists in the present study commented on (1) the complex nature of client difficulties, (2) their clients

feeling overwhelmed, dissatisfied, defensive and missing sessions, (3) inconsistent or incomplete therapeutic gains and (4) negative attitudes towards treatment. In contrast to Piselli et al. (2011) therapists in the present study reported identifying the client's difficulties and the threat to therapy prior to drop out.

Therapists reflected on their fear that clients will reject or not buy into the feedback system. This in turn could affect the therapeutic relationship. Fitzpatrick (2012) shares that concern, and argued that this is a common concern when therapists are first introduced to feedback systems. However, Fitzpatrick (2012) also reports that when asked 60% of clients report finding feedback useful and helpful; only 6.6% of clients found the task disturbing. There is still much that remains unknown about client responses to feedback or the factors, which lead to clients investing in feedback as part of their therapy. Lambert and Shimokawa (2011) also comment on the need for clients to report accurately, and encourage therapists to be aware of times or situations when their client might not report accurately.

The theory of engagement suggests that the therapist's response is informed by the client's engagement with the process of feedback, and the client's ability to accurately respond to the measures presented to them. When clients are not engaged or responding accurately to feedback questionnaires, therapists are likely to disengage from the feedback information and not use the system with this client. Therapists responded that they felt some clients are better suited to the system. They proposed that perhaps it should be used as a tool selectively.

Therapist's experience of the service

Services are often in a state of flux, and therapists may experience occasions when their time is more limited and they are under more pressure. It is during these occasions, that therapists seemed to find it most difficult to engage with feedback. This follows on from the context with their service. If there is little time and space to reflect on feedback, therapists seemed to disengage from the feedback information and not make use of the system. When therapists were allowed time and space for reflection, they appeared more likely to engage in some way with feedback. This may be analogous to the concepts from cognitive psychology about processing load and attention. It is possible that therapists have a finite amount of space to attend to their daily tasks, and if client feedback is not valued or encouraged, it is likely to be neglected. However, even therapists who are positive about using feedback

therapeutically, spoke of times when the service environment and work load pushed feedback reflection out of the therapy.

The therapist's response – engagement & disengagement

The main focus of the present study was to explore therapist actions and responses to feedback information. Bringing the two services together, there seems to be three clear engagement responses, and two disengagement responses to feedback information. Therapists spoke of using these responses at different times with different clients. It appears that therapists rely heavily on their judgement and therapeutic knowledge in deciding their response to feedback. Other than general statements about sharing or not sharing feedback (Lambert et al., 2002; Harmon et al., 2005, 2007; Reese et al., 2009) and implementing clinical support tools (Harmon et al., 2005, 2007) the psychotherapy literature does not comment in great detail on what therapists do with feedback. One PhD study (Halderlie, 2009) explored therapist responses using a structured questionnaire. A closely related concept of expert reasoning may also inform the present study. Eells, Lombart, Salsman, Kendjelic, Schneiderman, and Lucas (2011) explored expert therapist reasoning in case formulation. Where applicable, those findings will be used to support or disagree with the findings from the present study. The following sections will focus on specific therapist responses to feedback.

Theory of engagement: Information gathering.

Therapists viewed gathering feedback information as an engagement response to feedback. Therapists in the both services reflected on using feedback information to inform endings and session provision. This is represented in the literature (Asay et al., 2002; Harmon et al., 2005; Lambert & Shimokawa, 2011; Lambert et al., 2002) as a benefit of feedback systems and an outcome of collecting client response to therapy. Asay et al. (2002) explored the dose-response relationship with feedback in a private practice. These authors conclude that feedback can be used to monitor client response and provide services according to need. Brown and Jones (2005) go one step further and suggest that intake levels of distress can be used to match effective therapists to those in most need of intensive interventions.

Therapists also reflected on the trajectory of change and one participant expressed their interest in monitoring trajectories for all their clients so that they can adjust their therapy to meet the client's need. Hardy, Stiles, Barkham, and Startup (1998) report on the benefits of therapists adjusting the approach to meet their clients needs, however, this was not a study on feedback information. Previous studies of feedback report the relationship between early change and final therapeutic outcome (Lutz et al., 2013), and early measures of alliance and final outcome (Anker et al., 2010).

Some therapists felt that feedback information and reports provided an extra-dimension in terms of information to guide and support therapy. This is similar to Brown and Jones (2005) when they report the additional information therapists received regarding risk.

Theory of engagement: Reflecting outside of session

Some therapists spoke about not sharing feedback information directly in session, but instead reflecting on the meaning of either symptom feedback or session feedback. Therapists reflected that in these circumstances session feedback information was used to think about adjusting approach in session and responding to a client's needs. Likewise, symptom feedback was used to reflect on whether the client needs support in other areas, such as practical support in housing, or social support. While therapists rejected the utility of clinical support tools, participants did seem to consider other areas of support for their clients. Reflecting on the client's needs and attempting to meet them either through therapy (Hardy et al., 1998) or through other areas of support (Harmon et al., 2005) has been highlighted in the psychotherapy literature.

Theory of engagement: Applying in session.

There appeared to be four ways therapists made use of feedback in their session. Therapists reflected on using feedback directly to adjust their approach, for example to challenge clients more, build clients up, and use scaling questions to set goals. Therapists used feedback information to aid their clinical judgements. The existing psychotherapeutic literature identifies this as therapist responsiveness (Hardy et al., 1998). Hardy et al. (1998) report that therapists will match the interpersonal style of their clients and adjust to meet what their client needs at the time.

Secondly, therapists reported using feedback to develop narrative and conversations in sessions. For example, one application of feedback information by participants across both services was in creating new conversations, or allowing conversations to occur earlier in session. Sundet (2012) highlights the six types of conversations that emerge from the use of the Session Rating Scale and the Outcome Rating Scale (feedback measures used in the student counselling service sampled in this study). Sundet (2012) argued that feedback information could be used to open conversation about change, progress and the feedback itself, and also about the client's experience of the therapy. Sundet (2012) specifically believed that the ORS could help create conversations about the clients work outside of the therapy room.

Therapists also spoke about drawing client's attention to their feedback scores and encouraging collaboration and meaning making. This can be seen in the work of Goldfried and Davilla (2005). These authors report that therapeutic change occurs at a level between the specific techniques employed and the general therapeutic theory underpinning the therapy. Goldfried and Davilla (2005) highlight 5 factors of therapeutic change; three of which can be seen through the use of feedback information and raising awareness of a client's distress through feedback. The authors suggest that therapists should (i) offer feedback that can help clients increase their awareness about what is contributing to their life problems; (ii) encourage corrective experiences (perhaps through discussing meaning of feedback); and (iii) emphasize continued reality testing (perhaps through the therapists responding to feedback information, i.e. increased challenging).

Thirdly, therapists reflected on introducing feedback scores, but focused on extreme or risk scores. Again therapists used feedback in tandem with clinical judgement, and depending of the context of the client and the scores, they might choose not to share feedback scores.

Fourthly, therapists reflected on the relationship between feedback and therapy, and how they managed to integrate feedback and therapy. They reported using three strategies; bookending, keeping it separate (not bring feedback into session), and threading feedback throughout therapy.

All these applications of using feedback directly in session seem to stem from the therapists modality of training and their expert knowledge and intuition. Beutler et al. (2004) highlight the contribution a therapist's interaction style has on therapeutic outcome, describing two specific styles; directive versus non-directive,

and insight orientated versus symptom orientated interactions. Insight orientated interventions emphasis client insight as a measure of change rather than symptom orientated change. Therapists spoke of fluctuating between directive probing of feedback and non-directive approaches. Insight orientated approaches appeared to be preferred by participants who described their therapeutic style as interpersonal, whereas participants who preferred directly challenging clients or monitoring symptoms could be said to use a symptom orientated intervention style. Again, it seems therapists described using both styles at some point with clients.

Theory of disengagement: Rejection of content

Therapists who disengaged from the feedback system or engaged to the level that was required by the service reported rejecting feedback information according to two related factors. First, therapists appeared to reject feedback information based on the content. They reported not believing feedback was useful to the client or therapy or helpful to the therapist. Therapists also felt that feedback offered nothing new, that the information collected was known to the therapist or would have emerged naturally in the course of a session. These rejections of feedback information have been reported in the existing literature. Claiborn and colleagues (Claiborn & Goodyear, 2005; Claiborn et al., 2001) highlight the feedback message as one of the three factors involved in accepting or rejection feedback information. More specifically they identify the message valence; whether feedback is positive or negative. Claiborn et al. (2001) speaking about feedback to clients suggest that clients might accept positive feedback earlier in session, as it helps build alliance and relationship, whereas they might be more willing to accept negative feedback later in the therapy. In the current context, participants were reflecting on their acceptance or rejection of feedback from clients. There is a subtle difference in the two types of feedback, however, it seems that for therapists in the current study, the opposite occurs. Therapists reported that they rejected positive feedback (high therapeutic alliance) early in the session and negative feedback (continued high symptom scores) later in sessions. One therapist reflected that they accept early negative feedback easier, as it seems more realistic rather than apparently artificially inflated therapeutic alliance or session scores. For therapists, rejection of content was likely to result from a lack of trust in the accuracy of the feedback message from clients.

Therapists also rejected the content of feedback when they felt it was not helpful or useful to the situation. It is clear that therapists employed an implicit or explicit process of decision-making. How therapists make that decision is less clear. Orlinsky, Ronnestad, and Willutzki (2004) use the term therapist expert understanding, and summarise the research on this. It seems that expert knowledge is closely linked to the therapist's modality and training, therefore, how a therapist will accept or reject feedback based on the perceived helpfulness or usefulness will depend on their therapeutic orientation. A therapist's expert understanding/intuition may also apply to participants who felt that feedback offered nothing new.

Theory of disengagement: Rejection of system/process

Some therapists rejected the feedback process and system. Generally, therapists cited a mismatch between their modality of therapy and the feedback system. These factors have been outlined above. The rationale for rejecting the feedback system and integrating feedback into your practice might again fail within Wampold's (2001) concept of allegiance and adherence. Therapists need to feel part of a culture of feedback and to feel it is of benefit to them professionally and to their clients. Therapists need to adjust their therapeutic allegiance in such a way that it incorporates feedback. Miller (in press) identifies the importance of developing a feedback culture as one of the steps in creating a Feedback Informed Therapy (FIT). However, it should also be acknowledged that some therapists and some therapeutic modalities might be less compatible with feedback systems.

The proposed theory of disengagement highlights a number of factors that influence a therapist's disengagement from feedback. Many of these receive support in the existing literature. For example, therapists from one service reflected on the obstacles to engaging with their feedback system. They reported that the system in place neglected aspects of change and therapy that they highly valued. For example, some therapists expressed frustration that the guidance provided in their 'feedback manual' was too simplistic and did not account for a client's individual needs. This is an interesting reflection, as there is a large emphasis on Clinical Support Tools (CST) and decision trees in the literature on feedback in therapy (Harmon et al., 2005, 2007; Shimokawa et al., 2010). A component of Lambert's feedback system is the provision of CSTs to therapists, and to offer guidance on how to improve a client's motivation, social support, and the therapeutic alliance. Harmon et al. (2007) reported a significant additive treatment effect when therapists utilised CST in

addition to feedback over when therapists received feedback only. One weakness with the Harmon studies (Harmon et al., 2005, 2007) is they utilised a student counselling service population. It is possible that clinical support tools are effective with a student population, but that an APTS population with more complex and comorbid difficulties might not benefit from such a manualistic way of improving client distress.

Secondly, therapist's emphasised that they often take account of more than the feedback scores when deciding how to engage a client in a subsequent session. The therapist's sense of a situation played an important role, and the value they place on a specific piece of feedback will determine their response. Some therapists who were less positive about the feedback system in their service spoke of the dangers of relying exclusively on feedback scores. This parallels Evans (2012), who warns of the risk of relying solely on feedback systems. He argues there is a danger that therapists can miss important therapeutic information not elicited from feedback measures. It can be argued that therapists' reflections on the weakness of feedback offer Evans' criticisms some empirical support. Evans (2012) also echoes the reports from participants that the phrasing of questions may ignore or miss some client difficulties. Sundet (2012) also expressed concern at feedback scores deflecting therapists away from the goals of therapy and to keeping scores low/high to show their effectiveness to external agencies.

Finally, therapists highlighted that some client reported changes aren't monitored by feedback (i.e. character changes or acceptance of their situation) and that the client or therapist may not value the changes that are monitored. Furthermore, they speculated that these changes might be harder to pick up through symptom checklists or process measures. Nonetheless, participants felt that these might be important changes to note and for some participants acceptance of their distress is their goal for therapy. The feedback movement prides itself on being able to predict treatment success and perhaps more importantly treatment failure. However, the existing literature doesn't highlight character or temperament changes as a measure of feedback. This is a unique contribution made by the theory of disengagement.

How do therapists use feedback?

Returning to the adapted map of feedback research (Greenhalgh et al., 2005) and the question of ‘what it is about feedback?’ that explains Lambert et al.’s (2003) finding of improved outcomes, shorter therapies and reduced dropout when feedback is used. Applying the model provided in Greenhalgh et al. (2005) to the present study, a number of claims can be supported, while others remain unsupported. Each will be addressed briefly and applied to the theory of therapist engagement and disengagement.

Does feedback lead to new client-therapist communication?

It is clear that some therapists felt that feedback led to new communication, and that during sessions, they had different conversations with clients. However, other therapists reported that their conversations and communications were unchanged. These therapists reported not letting feedback encroach on their therapy, and tried to separate it out from therapy.

It can be concluded that for therapists who engage with feedback in their service, their communication with clients is changed by feedback information, and it allows them a greater confidence in their decisions and directions taken in therapy.

Does feedback enable monitoring of treatment response?

Most therapists who engaged with feedback recognised that feedback reports enabled them to monitor their client’s responses. Some felt that it increased their confidence and backed up their intuition about a client’s treatment response. Therapists reported using feedback to inform endings and to monitor if someone is ready for discharge. Therapists also reported monitoring change over time and sharing gains and deterioration with clients. Therefore, it can be said with some certainty, that feedback does enable therapists, in these services to monitor treatment response. It should be noted however, that some therapists felt that feedback information and reports told them nothing about a clients progress, as these therapists valued other markers of change.

Does feedback produce new understanding for therapists?

It seems that for the majority of this sample of therapists, the feedback information received from clients produced some level of new understanding. Therapists reported how they were able to gain new understanding of a client’s

world outside, and that this was useful in terms of making therapeutic decisions. Some therapists felt that it told them nothing new and that their understanding of the client comes from what the client tells them in session, and from their sense of the client. These therapists were less likely to engage with feedback as a result.

While not all therapists agreed, it can be concluded that for some therapists who positively value feedback, that it does produce a new understanding for these therapists. This suggests the potential influence of a therapist's beliefs on their engagement with and response to feedback information.

Does feedback produce changes to client behaviour?

There seemed to be anecdotal reports of clients focusing more on their experiences and feelings during the week between sessions, and that clients were able to reflect more on their difficulties, but it still is unclear how feedback changed client behaviour. It cannot be concluded that based on the responses of therapists in this study, that feedback produced changes to client behaviour. This is not a surprise and therapists were not asked to reflect on this aspect of their feedback system. Perhaps, if clients were interviewed or therapists were asked specifically about client behaviours, that we would find a positive relationship between feedback and client behaviour change.

Does feedback produce changes to therapist management of clients?

A key aim of this research was to identify whether therapist management of clients changes when they use feedback. Therapists reported that they would use feedback to support their practice, but found it hard to identify times when it changed their management of clients. Therapists did report that feedback scores and reported were used to identify endings and when clients had improved sufficiently. It remains unclear if management changed and if it did, in what way.

Do PROMs improve patient satisfaction with therapy?

The present study did not explore patient satisfaction, and therapists did not identify whether patient satisfaction increased when it was used. However, there seemed to be some patients who engaged well with feedback and others who rejected the concept of feedback and their therapists reported that feedback was not helpful in their therapies.

Does PROMs improve treatment outcome?

The present study did not set out to explore whether therapist use of feedback improved treatment outcome. Therapists in the present study did not comment specifically on whether they felt it improved outcome for their clients. Furthermore, the proposed theory of engagement does not explain any supposed link between using feedback and improved outcome.

Summary:

The aim of this study was not to verify or apply Greenhalgh et al. (2005) model to psychotherapy feedback systems. Nevertheless, this model highlights the literature and hypothesis that are proposed in the PROM research. It can be tentatively concluded that the present study adds weight to some of these hypothesis and that further exploration is needed to definitive support for the Greenhalgh et al. (2005) model.

Strengths and limitations

Limitations

There were five main methodological limitations in the present study. Firstly, due to time pressures and service constraints it is possible that data saturation was not achieved in either service. Sample size and analysis procedure was a consideration from the outset of the present study. The sample size was chosen based on the feasibility of recruiting participants in the service and data analysis. The decision to analyse the services separately was made to reduce contamination of potentially two very different services with two very different feedback systems. The service models were compared and contrasted at the final stage of analysis in order to develop an explanatory theory of therapist experiences of feedback. There is debate in qualitative methods (Corbin & Strauss, 2008; Schmuttermaier & Schmitt, 2001; Yin, 1989) about if saturation is ever achievable realistically. I argue that saturation was not an issue in the present study. The majority of therapists available and eligible for recruitment into this study were recruited from each service, Furthermore, according to Corbin and Strauss's (2008) definition of saturation as 'when no new data are emerging', I feel that saturation was reached and the emerging categories and model are credible.

A second limitation is the possibility of participant or researcher biases that may affect the credibility of the resulting categories and model. Participant bias is a valid threat to credibility if sampling and recruitment has been biased. I do not believe this to be the case. I argue that recruiting the majority of available therapists makes the samples representative of the services. There was a spread of experiences across both services, and negative experiences appeared to be balanced with positive experiences, often this occurred within participant interviews. In conclusion, there is potential for participant bias, but it is negated by the expectancy for subjective experiences and the apparent balance of participants.

A third limitation is researcher bias. There is expectancy within GTM that the researcher will hold certain views towards the research topic, and will carry these subjective biases through the research process. This limitation is minimised by sharing of the researcher's perspective, and allowing the reader to evaluate the credibility of the findings.

Due to the decision to analysis data from one service before collecting and analysing data from the second service, there is potential for 'coding leakage' or transference of conceptual ideas from the first service onto the second. As the researcher developed a service model for the SCS before developing the service model for the APTS, it is possible that the second model was influenced by concepts from the first. This was recognised prior to and during the data collection and analysis phase for the APTS. The researcher attempted to minimise this through putting all material from the SCS to one side and not consulting or attending to it while collection and analysis took place with the APTS. The researcher also ensured that each model and its core categories and codes were kept separate by allowing a period of time to elapse between developing each model. The researcher recognises the risk that each model cannot be considered independent of the other due to the subjectivity of the researcher. However, pragmatically all steps were taken to minimise 'coding leakage'. Furthermore, it can be argued that nothing can be truly known, and most concepts and theories are socially constructed to some degree. Therefore, it is impossible to eliminate all bias.

A fourth limitation relates to quality checks conducted to ensure credibility. Elliott et al. (1999) outlined a number of credibility checks that can be used to increase the merit of qualitative research. Due to time limitations, it was not possible to implement a detailed array of credibility checks such as inter-rater reliability or

member checking. While these procedures may provide some external validation of the findings of the present study, they are arguably not necessary. Grounded theory methodology acknowledges the subjective nature of a researcher's perspective (as described above), and the methods employed in line with GTM go some way to countering the absence of robust quality checks. For example, GTM encourages the researcher to own one's perspective, to ground findings in examples, provide coherence, and for the research to resonate with the reader. I feel this research has accomplished this through pen portraits, memos, constant comparison, and providing the researchers perspective

A final limitation is the lack of outcome data for the clients discussed by participants. Some participants spoke about their sense of the client's final outcome, or whether the client reported improvement. Other participants reflected on active cases, and there was no outcome data available. The focus of the study was not to measure outcome as a consequence of providing feedback to therapists, however, this information would add some context and clarity to the reflections provided by participants. Again, this was an anticipated limitation. Without knowing the outcomes of clients, it is hard to claim that the actions and responses to feedback information highlighted in the present study represent effective responses. The question about what do therapists do with feedback to improve outcome remains unaddressed. What this study does explore is how therapists reportedly respond to feedback information. This provides a basis for further hypothesis testing to evaluate if there is a relationship between the strategies reported in the present study and improved or successful outcome from therapy.

Strengths

Three main strengths can be seen. First, this study focuses on two distinct services; a student counselling service and an adult psychological therapy service. Patient Reported Outcome of feedback research is typically conducted in student counselling services. Many of the most frequently cited studies of therapeutic feedback systems report their findings from SCS (e.g. Lambert et al., 2001; Harmon et al., 2007). Therefore, it is of value to explore therapist reflections on their experience of feedback systems in a student counselling service. The second service has a strong history of outcome research and work with a population that are less amenable to change, may provide more negative feedback reports or alert their therapists to more intractable distress, and are perhaps more likely to have less

positive outcomes. Therefore it is a strength that this study has sampled both services; one service as a representative of commonly sampled feedback services, and another service representing more intractable psychological problems but still a feedback ‘friendly service’.

A second strength comes from sampling the two services. Previous research has often focused on one therapeutic model; i.e. counselling psychologists (Lambert et al., 2001), clinical psychologists in private practice (Asay & Lambert, 2002), trainee therapists (Lambert et al., 2001), couples and family therapists (Reese et al., 2010). The present study sampled a mixture of counselling psychologists and psychotherapists in the Student Counselling Service, and a mixture of clinical psychologists and medical psychotherapists in the adult psychological therapy service. This represents a cross section of therapists in two distinct therapy services. The diversity of experience broadens the context of therapist engagement with feedback systems and adds weight and strength to the present studies findings. Furthermore, much of the previous research has been carried out under experimental conditions and settings. The present study aims to stay as close to naturalistic and real world conditions as possible. Again this is a strength of the study.

A third strength is the methodology used in the course of the study. Approaching the research question using grounded theory ensured that the analysis would remain close to the data. This was important, as the topic of therapist engagement with feedback is relatively unknown. It was important to capture therapist experiences in real life everyday settings, and using grounded theory approaches of constant comparison and seeking negative cases and memos helped keep depth and richness in the analysis. Keeping the service analysis separate and presenting the findings separately maintains the accuracy of each participants' and services' perspective. A related strength was the ability to adapt Grounded Theory techniques and build on its foundations to enhance the proposed theory of feedback engagement. The service specific models were revisited and deconstructed in order to unify the therapist experiences. Grounded Theory is a flexible and evolving methodology that made this possible.

Clinical Implications:

The purpose of this study was to explore what therapists do with feedback information. As there is little known about the mechanism of therapist engagement

with feedback, a qualitative design was employed. This produced a theory of therapists' engagement with feedback. This theory while preliminary and perhaps applicable only to the services sampled in this research has a number of implications for clinical psychologists and psychological therapy services.

There are clearly a number of steps or factors that occur before a therapist engages with feedback information. Similar to Miller's (in press) 3-step description of engagement with feedback, participants in the present study felt that the culture and context of the service and the specific feedback system are important to acknowledge. It is important for services to ensure therapists and clinicians are briefed about the administration as well as the utility of feedback information for client therapy. It is also clear that therapist's previous training or experiences will influence their engagement with feedback. It is important for services to be responsive to therapist concerns and needs when bringing feedback systems into a therapy service. Looking at the participants reported use of feedback information, it is clear that therapists use it in a number of ways. An important clinical implication of the present research is the range of responses available to therapists, and it is important that future therapists are made aware of these.

The most significant clinical implication is how therapists reported engaging with feedback information once it was provided to them. Therapists reported the rationale for sharing feedback with clients and under what circumstances this may occur. Perhaps more importantly, therapists provided an insight into the times when feedback was not taken on board and shared. These were times when they followed their intuition of what their client needed at that time. Allowing therapists to use their skills and knowledge to use feedback how and when they feel it aids therapy is an important service message, as it appears from participants that if they are not invested in the feedback system in general or the specific feedback message, feedback will not be used and therapists will grow resentful of the system.

Implications for future research:

The present study was a qualitative exploration of therapist's reflections of their engagement in feedback and how they used feedback in therapy. As such, there is much that remains unknown, the participants were recruited from two therapy services, and further research is required to test out the generalizability and representativeness of the therapists reported responses to feedback information and

the proposed theory of therapist engagement in feedback. More specifically, it would be important to explore further the precipitating mechanisms (the context and the experience) which aid or guide therapists in their decision to integrate feedback information or ignore feedback. This would involve exploring therapists' decision making which results from feedback information. Participants in the present study reported using their intuition or sense of what to do, but further exploration of what contributes to this intuition is necessary. In support of this claim, the APA presidential task force on evidence-based practice (2006) also called for further exploration of therapist intuition and its role in therapeutic outcome.

The present study sought to explore the relationship between negative feedback and therapist use of this information in aiding poorly performing clients to produce significant therapeutic change. Therapists discussed experiencing negative feedback but did not elaborate on the mechanisms involved in moving 'not on track' clients to 'on track' outcomes. Further research is needed to explore specific experiences of negative feedback and later positive outcomes.

This research topic would also benefit from further research into the trajectory of change for clients and if therapist feedback responses which reflect where a client is in their trajectory. One participant felt that this was one of their research interests. Prior to linking responses specific to trajectory, it would be necessary to identify if there are specific trajectories of change with client presentations, and if these changes can be generalised.

Ultimately, feedback systems as an aid to psychotherapy are a fast expanding area of research and clinical practice. There is much that is still unknown, and any research that explains the therapist's contribution and response to a clients change in feedback informed therapy would be of benefit to the profession.

Conclusions:

Over the last ten years there has been considerable research into the process and outcome of psychotherapy (Duncan et al., 2010; Norcross, 2011; Wampold, 2001). PROMs and feedback systems have consistently been shown to be associated with treatment gains (Lambert & Shimokawa, 2011; Reese et al., 2010; Shimokawa et al., 2010). However, little is known about the process or role that a therapists response to feedback specifically plays in therapeutic outcome (Halderlie, 2009; Lambert et al., 2002). This thesis was a qualitative study that aimed to explore the

process and role of feedback systems in therapy. Therapists from two distinct therapy services were asked about their experiences and reflections of using PROMs in their therapy.

This research developed a theory of therapist engagement with feedback. This theory highlighted both the factors that enhance therapist engagement with feedback and those that diminish engagement and influence therapists to disengage. There was a wide range of experiences reported by therapists. Many therapists spoke explicitly on how they used feedback with their clients and the findings can be summarised as follows:

- Therapists have a mixed response to feedback systems, some engage fully with the process, while others are sceptical of its utility.
- There are a number of factors which appear to contribute to therapists' attitude towards feedback, and that their responses to feedback is likely to follow their attitude towards it.
- There also appears to be a conscious or unconscious decision by therapists about their specific response to feedback information. Therapists are likely to use a number of strategies in deciding their response.
- Therapists reported 4 general responses to receiving feedback information:
 - Share feedback scores directly with client; perhaps use to create therapeutic conversations,
 - Reflect on information out of session and perhaps adjust their approach in light of feedback information,
 - Reject the information at the time,
 - Reject the system as a tool for therapy.

This research sought to explore and develop a deeper understanding of the role of feedback in therapeutic outcome, however there is still much that is not known about this process. Further research is needed to build on the findings of the present study. Two conclusions can be drawn that explain therapist's lack of clarity in their use of feedback. First, therapists may not be aware of what they do with feedback and how their response contributed to improved or reduced therapeutic outcome. Second, only certain clients benefit from PROMs, and the therapists in the present study did not reflect on these clients. It can also be argued that feedback may intrinsically benefit clients as it perhaps brings their therapist closer to their distress.

Finally, this study makes a valuable contribution to the field of therapist responses to feedback, and provides a theory of engagement and disengagement. This theory can be used to explore further how the context in which therapists encounter and experience feedback information influences their responses to 1) the feedback system, and 2) therapy.

REFERENCES

- Ajzen, I. (1991). The theory of planned behavior. *Organizational behaviour and human decision processes*, 50(2), 179-211.
- Altheide, D. L., & Johnson, J. M. (2011). Reflections on interpretive adequacy in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (pp. 581-610). Thousands Oaks, CA: SAGE.
- Anker, M. G., Owen, J., Duncan, B. L., & Sparks, J. A. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal of Consulting and Clinical Psychology*, 78(5), 635-645.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-Based Practice in Psychology. *American Psychologist*, 61(4), 271-285.
- Aronson, E. (1999). The power of self-persuasion. *American Psychologist*, 54(11), 875-884.
- Asay, T. P., Lambert, M. J., Gregersen, A. T., & Goates, M. K. (2002). Using patient-focused research in evaluating treatment outcome in private practice. *Journal of Clinical Psychology*, 58(10), 1213-1225.
- ASIST Outcome Management Software [Computer software] (CVI, 2012) Retrieved 24th April, 2013 from <http://www.clientvoiceinnovations.com>
- Bachelor, A., Laverdiere, O., Gamache, D., & Bordeleau, V. (2007). Clients' collaboration in therapy: Self-perceptions and relationships with client psychological functioning, interpersonal relations, and motivation. *Psychotherapy: Theory, Research, Practice, Training*, 44(2), 175-192.
- Bandura, A. (1994). Self-efficacy (t. April, Trans.). In V. S. Ramachandran (Ed.), *Encyclopedia of human behaviour* (pp. 71-81). New York, NY: Academic Press. Retrieved 25th April, 2013 from <http://www.uky.edu/~eushe2/Bandura/BanEncy.html>
- Beutler, L. E., Malik, M., Alimohamed, S., Harwood, M. T., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 227-307).
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

- Brown, G. S., & Jones, E. R. (2005). Implementation of a feedback system in a managed care environment: What are patients teaching us? *Journal of Clinical Psychology, 61*(2), 187-198.
- Cahill, J., Barkham, M., Hardy, G., Gilbody, S., Richards, D., Bower, P., Audin, K., & Connell, J. (2008). A review and critical appraisal of measures of therapist-patient interactions in mental health settings. *Health Technology Assessment, 12*(24).
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications Ltd.
- Claiborn, C. D., & Goodyear, R. K. (2005). Feedback in psychotherapy. *Journal of Clinical Psychology, 61*(2), 209-217.
- Claiborn, C. D., Goodyear, R. K., & Horner, P. A. (2001). Feedback. *Psychotherapy, 38*, 401-405.
- Claiborn, C. D., Goodyear, R. K., & Horner, P. A. (2002). Feedback. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 217-233). New York: Oxford University Press.
- Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 194-226). New York: Wiley.
- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd Ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Crits-Christoph, P., Gibbons, M. B. C., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance–outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology, 79*(3), 267-278.
- Cutcliffe, J. R. (2003). Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship. *Qualitative Health Research, 13*(1), 136-148.
- Detmar, S. B., Muller, M. J., Schornagel, J. H., Wever, L. D. V., & Aaronson, N. K. (2002). Health-related quality-of-life assessments and patient-physician communication. *Journal of the American Medical Association, 288*(23), 3027-3034.
- Duncan, B. L., & Miller, S. D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration, 10*(2), 169-187.

- Duncan, B. L., Miller, S. D., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*, 3-12.
- Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart & soul of change: Delivering what works in therapy*. American Psychological Association Washington, DC.
- Eells, T. D., Lombart, K. G., Salsman, N., Kendjelic, E. M., Schneiderman, C. T., & Lucas, C. P. (2011). Expert reasoning in psychotherapy case formulation. *Psychotherapy Research, 21*(4), 385-399.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215-229.
- Evans, C. (2012). Cautionary notes on power steering for psychotherapy. *Canadian Psychology, 53*(2), 131-139.
- Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counselling Psychology, 52*(2), 156-166.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Fitzpatrick, M. (2012). Blurring practice-research boundaries using process monitoring: A personal introduction to this issue of Canadian Psychology. *Canadian Psychology, 53*(2), 75-81.
- Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 421-430.
- Greenhalgh, J., Long, A. F., & Flynn, R. (2005). The use of patient reported outcome measures in routine clinical practice: lack of impact or lack of theory? *Social Science and Medicine, 60*(4), 833-844.
- Halderlie, M. (2009). *Patient-focused research: Examining the psychotherapist as a feedback receiver*. UNLV Thesis/Dissertations/Professional Papers/Capstones. Paper 65. University of Nevada Las Vegas, Las Vegas.
- Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*(2), 155-163.
- Hanson, L. S., Vincent, S., Harris, S., David, E., Surafudheen, S., & Kingdon, D. (2010). A patient satisfaction rating scale for psychiatric service users. *The Psychiatrist, 34*, 485-488.

- Hardy, G. E., Stiles, W. B., Barkham, M., & Startup, M. (1998). Therapist responsiveness to client interpersonal styles during time-limited treatments for depression. *Journal of Consulting and Clinical Psychology, 66*(2), 304. doi: 10.1037/0022-006X.66.2.304
- Harmon, C., Hawkins, E. J., Lambert, M. J., Slade, K., & Whipple, J. L. (2005). Improving outcomes for poorly responding clients: The use of clinical support tools and feedback to clients. *Journal of Clinical Psychology, 61*(2), 175-185.
- Harmon, C. S., Lambert, M. J., Smart, D. W., Hawkins, E. J., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*(4), 379-392.
- Hawkins, E. J., Lambert, M. J., Vermeersch, D. A., Slade, K., & Tuttle, K. C. (2004). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research, 14*(3), 308-327.
- Henwood, K., & Pidgeon, N. (2006). Grounded theory. In G. Breakwell, S. M. Hammond, C. Fife-Shaw, & J. A. Smith (Eds.), *Research methods in psychology* (3rd ed., pp. 342-365). Thousand Oaks, CA: Sage Publications, Inc.
- Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (1st ed.). New York: Oxford University Press.
- Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart & soul of change: What works in therapy*. Washington, DC: American Psychological Association.
- Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart & soul of change: Delivering what works in therapy* (2nd ed., pp. 23-46). Washington DC: American Psychological Association.
- Ilgen, D. R., Fisher, C. D., & Taylor, M. S. (1979). Consequences of individual feedback on behaviour in organisations. *Journal of Applied Psychology, 64*(4), 349-371.
- Kluger, A. N., & DeNisi, A. (1996). Effects of feedback intervention on performance: A historical review, a meta-analysis, and a preliminary feedback intervention theory. *Psychological Bulletin, 119*(2), 254-284.
- Lambert, M. J. (2009, November). *The OQ measures approach: Alerting clinicians to impending treatment failure*. Proceedings from Psychological Therapies in the NHS, London. Retrieved 25th April, 2013

- Lambert, M. J., & Barley, D. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (1st ed., pp. 17-32). New York: Oxford University Press.
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72-79.
- Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is It Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis. *Clinical Psychology: Science and Practice, 10*(3), 288-301.
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11*(1), 49-68.
- Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology and Psychotherapy, 9*, 91-103.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage Publications.
- Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York: Basic Books.
- Lucket, T., Butow, P. N., & King, M. T. (2010). Improving patient outcomes through the routine use of patient-reported data in cancer clinics: Future directions. *Psycho-Oncology, 18*, 1129-1138.
- Lutz, W., Ehrlich, T., Rubel, J., Hallwachs, N., Rottger, M.A., Jorasz, C., Mocanu, C., Vocks, S., Schulte, D., & Tschitsaz-Stucki, A. (2013). The ups and downs of psychotherapy: Sudden gains and sudden losses identified with session reports. *Psychotherapy Research, 23*(1), 14-24.
- Lyons, J. S., Howard, K. I., O'Mahony, M. T., & Lish, J. D. (1997). *The measurement & management of clinical outcomes in mental health*. New York: Wiley.
- Miller, S. D. (in press). Feedback informed treatment: Making services FIT consumers. Retrieved 25th April, 2013 from <http://scottdmiller.com/wp-content/uploads/FIT%20handouts.pdf>
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, 91-100.

- Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*(2), 199-208.
- Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York, USA: Oxford University Press.
- Norcross, J. C. (2011). *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.
- Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 3-24). New York: Oxford University Press.
- Ogles, B. M., Lambert, M. J., & Fields, S. A. (2002). *Essentials of outcome assessment*. New York: Wiley.
- Ong, L. M. L., De Haes, J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine, 40*(7), 903-918.
- Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behaviour change* (5th ed., pp. 307-390). New York: Wiley.
- Piselli, A., Halgin, R. P., & MacEwan, G. H. (2011). What went wrong? Therapists' reflections on their role in premature termination. *Psychotherapy Research, 21*(4), 400-415.
- Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431.
- Reese, R. J., Toland, M. D., Sloane, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy Theory, Research, Practice, Training, 47*(4), 616-630.
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology, 3*(3), 157-168.
- Riemer, M., Rosof-Williams, J., & Bickman, L. (2005). Theories related to changing clinician practice. *Child and Adolescent Psychiatric Clinics of North America, 14*(2), 241-254.

- Sapyta, J. (2004). The effect of the provision of information on client status toward clinician behaviour and outcome: A meta-analysis. Manuscript submitted for publication.
- Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology, 61*(2), 145-153.
- Schmuttermaier, J. R., & Schmitt, D. (2001). Smoke and mirrors: Modern illusions in the quantitative versus qualitative research debate. *Sociological Research Online, 6*(2). Retrieved 25th April, 2013 from <http://www.socresonline.org.uk/6/2/schmuttermaier.html>
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50*(12), 965-974.
- Shick-Tryon, G., & Winograd, G. (2011). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., pp. 153-167). New York: Oxford University Press.
- Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*(3), 298-311.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press.
- Sundet, R. (2012). Therapist perspective on the use of feedback on process and outcome: Patient-focused research in practice. *Canadian Psychology, 53*(2), 122-130.
- Thorndike, E. L. (1911). Laws and hypothesis for behaviour. *Animal Intelligence, 241-281*.
- Velikova, G., Booth, L., Smith, A. B., Brown, P. M., Lynch, P., Brown, J. M., & Selby, P. J. (2004). Measuring quality of life in routine oncology practice improves communication and patient well-being: A randomised controlled trial. *Journal of Clinical Oncology, 22*(4), 714-724.
- Velikova, G., Brown, J. M., Smith, A. M., & Selby, P. J. (2002). Computer-based quality of life questionnaires may contribute to doctor-patient interactions in oncology. *British Journal of Cancer, 86*, 51-59.
- Velikova, G., Wright, P., Smith, A. B., Stark, D., Perren, T., Brown, J., & Selby, P. (2001). Self-reported quality of life of individual cancer patients: concordance of results with disease course and medical records. *Journal of Clinical Oncology, 19*(7), 2064-2073.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. New Jersey, USA: Lawrence Erlbaum Associates, Inc.

- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Hyunnie, A. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes". *Psychological Bulletin*, *122*(3), 203-215.
- Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early indication of treatment failure and problem-solving strategies in routine practice. *Journal of Counselling Psychology*, *50*(1), 59-68.
- Woolley, F. R., Kane, R. L., Hughes, C. C., & Wright, D. D. (1978). The effects of doctor-patient communication on satisfaction and outcome of care. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, *12*, 123-138. doi: 10.1016/0271-7123(78)90039-1
- Yalom, I. D. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.
- Yin, R. K. (1989). *Case study research: Design and analysis* (Revised ed.). London: Sage Publications.

APPENDICES

Appendix A: University of Leeds Ethics Approval Letter

Faculty of Medicine and Health
Research Office

Room 10.110, Level 10
Worsley Building
Clarendon Way
Leeds LS2 9NL

T (General Enquiries) +44 (0) 113 343 4361
F +44 (0) 113 343 4373



UNIVERSITY OF LEEDS

Mr David O'Halloran
Leeds Institute of Health Sciences
University of Leeds
Charles Thackrah Building
101 Clarendon Road
LEEDS LS2 9LJ

22 June 2012

Dear David,

Re ref no: HSLTLM/11/038

Title: **An exploration of psychotherapists reflections about their experience of client reported feedback in therapy.**

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics and Leeds Institute of Molecular Medicine (LIHS/LIGHT/LIMM) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation as submitted at date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.



I wish you every success with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alastair Hay'.

Professor Alastair Hay/Mrs Laura Stroud/Dr David Jayne
Chairs, LIHS/LIGHT/LIMM Joint REC

Appendix B: South West Yorkshire Foundation Trust R&D Approval

 South West Yorkshire Partnership 
NHS Foundation Trust

14th August 2012

Dr David O'Halloran,
Leeds Institute of Health Sciences
University of Leeds
Charles Thackrah Building
101 Clarendon Road
Leeds
LS2 9LJ

Research Department
Ward 2
Castleford & Normanton District Hospital
Lumley Street
Castleford
WF10 5LT

Tel: 01977 605285
Fax: 01977 605298

Ref: APPROVAL Letter
Email address: helen.carter@swyt.nhs.uk
research@swyt.nhs.uk

Dear Dr O'Halloran,

Re: An exploration of psychotherapists reflections about their experiences of client reported feedback in therapy

REC Reference: N/A

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire NHS Foundation Trust.

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

Document	Version	Date
Protocol	V3	25/06/2012
Research Ethics Review	NHS REC approval not required as questionnaires are to staff employed by NHS	
Topic Guide (for Interviews)	V1.1	15/06/2012
Requested Demographic Information	V1.0	17/08/2012
Participant Information Sheet	V3.0	21/05/2012
Participant Consent Form	V3.0	26/05/2012

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit.

Chair: Ian Black Chief Executive: Steven Michael

1

- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care¹(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator²**.

They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

¹ Details from:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=WdeITy

² SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely



Professor Mike Lucock
Associate Director of Adult Psychological Therapies

On behalf of Dr Nisreen Booya (Medical Director)

Appendix C: Participant Information Sheet and Consent Form

**Leeds Institute of
Health Sciences**

FACULTY OF MEDICINE AND HEALTH



UNIVERSITY OF LEEDS

PARTICIPANT INFORMATION SHEET

Study Title: An exploration of psychotherapist reflections about their experience of client reported feedback in therapy?

You are being invited to take part in a research study. I, (David O'Halloran), am conducting this research as part of my Doctorate in Clinical Psychology. Before you decide whether you wish to take part, it is important for you to understand why the research is being conducted and what your participation would involve. Please take time to read the following information carefully. If there is anything that you would like more information on, please do not hesitate to contact me on the number/address supplied below.

Thank you for reading this.

What is the purpose of the study?

The aim of the research is to develop an understanding of psychotherapists' experiences of client feedback systems in their therapy service. This is currently a gap in our knowledge. Little is currently known about the therapist experience of feedback systems, and this study hopes to explore this issue. In contrast much is known about the effectiveness of feedback systems on outcome.

This study will interview therapists about their reflections on the process of using feedback systems and seek to explore their experiences of these systems. Each participant will be interviewed once for about 1 hour.

This research is being carried out as part fulfilment of a Doctorate in Clinical Psychology at the University of Leeds. The duration of this research will be 12 months. It is expected results will be submitted to the University in June 2013.

Why have I been chosen?

You have been approached to take part in this research because you are a therapist in a psychological therapy service that utilises a patient reported outcome (feedback) system. All qualified therapists in your service are being approached to take part in this research. However, I anticipate that 5 therapists will be interviewed from your service. Another service has also been approached, and it is also expected that 5 therapists from this service will be interviewed

Do I have to take part?

No. It is your decision as to whether you would like to participate. Participation is voluntary. If you choose to take part you can decide later to withdraw from the study prior to your interview without having to give a reason. You will not experience any negative outcomes from not taking part. Your employment or experience at work will not be affected.

Alternatively you may decide to take part, but ask that I do not use direct quotations from your interview when the results are written up.

Version 3.0 21/05/2012



What happens to me if I take part?

If you choose to take part in this study, you will be asked to sign a consent form. You will then be invited to take part in one interview with the Chief Investigator (David O'Halloran) within the next 4 months. This interview will last approximately 1 hour. You will be asked a number of questions relating to your experience of feedback and asked to reflect on clients who may have benefited or not benefited from feedback. You will also be asked to give some basic demographic information about your qualifications, therapeutic allegiance, age, gender and experience as a psychotherapist.

Prior to the interview, you will be given a brief topic guide that will be used in the interview. This is to give you an opportunity to think about what you wish to say. This will also give you an opportunity to think about client examples that represent your experience of feedback. You will be asked to discuss this in interview, but not to mention any identifying details of this client(s). Finally, the topic guide will serve as a prompt for whether you wish to discuss your issues and experiences. You may withdraw consent upon reading the topic guide.

This interview will occur in your place of work at a time convenient to you. You will not be required to take part in any further interviews or research as part of this study.

Your interview will be audio-recorded; this is so the interviewer can ensure the interview is as discursive as possible. If you do not wish to be audio-recorded, you should not consent to take part in this research.

I will not ask you to discuss client cases in detail or to identify clients. You will be asked to reflect on client examples in your responses, but please do not identify them. When the interview is transcribed, any identifying features or potential identifying features will be removed from the record. This is an attempt to protect the anonymity of clients in your service. During interview you will be encouraged to choose a pseudonym for any reflection about clients.

Expenses and payments:

You will receive no payment for participation in the study.

What are the disadvantages and risks of taking part?

There are no direct disadvantages to taking part in this study. You will however, be asked to donate an hour of your time to this research.

There is limited risk for you if you decide to take part. The interview seeks to gather your reflections on your therapy practice. It is possible that this may bring up distressing feelings or experiences, and thus you may require some time to debrief after interview or to seek further peer support. I do not intend to cause distress, and there are no questions in the interview that require you to be distressed.

What are the possible benefits of taking part?

There are no direct benefits for you personally in taking part in this study. However, there is a possibility that by reflecting on your therapy practice, you may gain some insight or a new perspective on a particular client or your work more generally.

Version 3.0 21/05/2012



There may be benefits for the service you work in, as the aim of this research is to bring a new understanding to the use of patient reported outcome systems. By taking part in this study, you will be adding to the knowledge base of this area of therapy.

There are also benefits for the Chief Investigator. This research is in part fulfilment of a Doctorate in Clinical Psychology; by taking part you will be part of a sample for the research that contributes to this degree.

Will my taking part in the study be kept confidential?

All information that is collected will be kept secure and confidential. Your interview will be audiotaped and transcribed, however they will be anonymized and kept securely and safely. No quotes identifying therapists or clients will be used when writing up the results.

Are there limits to confidentiality?

Yes, in the event of disclosures of harm or threats of harm to self or others, confidentiality will be limited. If you disclose any significant (and not currently known) harm to your self or harm to clients, I may report this or encourage you to report this to a relevant safeguarding body. Should this occur, I will discuss my concerns first with you and notify you if I was to break confidentiality. This is the same limit on confidentiality that you as a therapist would give to a client in your practice.

If you disclose significant harm or distress to yourself I will stop the interview and ask whether you wish to seek supervision or speak to your line manager. I will also provide contact details of support agencies. We may continue the interview if you wish to do so.

What will happen to the results of the research study?

The results of this study will be submitted as part of a thesis to the University of Leeds in fulfilment of a Doctorate in Clinical Psychology. It is also anticipated that results will be presented at national and international conferences and will be submitted for publication.

Furthermore, a copy of the results will be prepared for the therapy service and made available to all participants. Results will also be fed back to participants when the study has been completed (June 2013). This will be done through a short summary and brief talk given by the researcher

Participants are free to contact the researcher at any time to ask further questions or find out more information or any preliminary results.

What happens if I have a complaint about the research?

If you wish to make a complaint about the conduct of this research please contact Prof. Stephen Morley (s.j.morley@leeds.ac.uk) (Course Director for the Doctoral Programme in Clinical Psychology) on +44 (0)113 343 0815 or at the postal address below.

Alternatively, you can contact Debbie Williams (D.Williams@leeds.ac.uk) or Lydia Stead (L.stead@leeds.ac.uk) (Programme Coordinators) at +44 (0)113 343 0815 or at the postal address below.

Contact details:

Version 3.0 21/05/2012



If you have any further questions about the research you can contact:

Dr. David O'Halloran,
Leeds Institute of Health Sciences, Charles Thackrah Building, University of Leeds, 101
Clarendon Road, Leeds, LS2 9LJ
Tel: 07981 854249 Email: umdoh@leeds.ac.uk

**Most importantly; thank you for taking the time to read
through this information and making a decision about this
research.**



PARTICIPANT CONSENT FORM

Title of Project: An exploration of psychotherapist reflections about their experience of client reported feedback in therapy?

- I confirm that I have read and understand the information sheet. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw from the study at any point prior to the interview, without giving any reason. I understand that withdrawing from this study will not affect my working conditions. In addition, should I not wish to answer any particular question or questions, I am free to decline.
- I understand that the content of my interview will be anonymized and what I say will remain confidential. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
- I understand that there are limits to confidentiality in the event of disclosure of harm to self or clients.
- I understand that the results of this study may be published in a report, book or article and that I will not be identified nor recognised in any published material.
- I understand that the research interview will be recorded using a digital audio recorder. **(If you do not wish to be recorded, you should not consent)**
- I agree to take part in this study

_____	_____	_____
Participant (Print)	Date	Signature
_____	_____	_____
Researcher (Print)	Date	Signature

Appendix D: Interview Schedule

**Leeds Institute of
Health Sciences**

FACULTY OF MEDICINE AND HEALTH



UNIVERSITY OF LEEDS

Topic guide

Introduction

Thank you for agreeing to meet with me. Today, we shall talk for about 1 hour about your experience of the feedback system and how you may or may not use a client's feedback in your work with them. I am interested in your views and your experience, not what the service expects you to do when you receive feedback. I will be asking you about your experiences in general but would be particularly interested in specific clients that you feel reflect your experience in terms of feedback.

This is an interview about your experiences and meaning making of feedback, if there is anything you wish to discuss or highlight at any point, please do so. I am interested in your story. I will record our discussion, and will make notes occasionally; I have a topic guide but would like this to be a free flowing discussion as much as possible.

- Do you have any questions before we begin? I would like to begin by asking how would you briefly describe yourself as a therapist?

Main Body

- 1. This research is interested in therapists' reflections and experiences of feedback in therapy. When you first encountered feedback in therapy, what was your initial impression?
 - [Prompt?] Has this impression changed? If so, why?
 - [Prompt?] In what way has your therapeutic approach changed as a result of feedback?
- 2. Could you think of a client you have worked with recently who reflects your experiences of feedback? Starting from the beginning (perhaps, when you first seen the referral) could you tell me about your impression of this client?
 - [Prompt?] Reflection on referral?
 - [Prompt?] Reflection on initial session?
- 3. Could you tell me what was your reflection on your initial experience of the feedback from this client?
 - [Prompt?] First thoughts/feelings/emotions/impressions?
 - [Prompt?] Did you do anything with the feedback?
 - [Prompt?] Change in thoughts about client after reading feedback?
 - [Prompt?] Has this view changed?

Ver 2.0 16/06/2012

- 4. Could you tell me what did this client's feedback tell you?
 - [Prompt?] Was this feedback positive or negative?
- 5. Could you tell me a little about what was your experience of the subsequent therapy session(s)?
 - [Prompt?] Did you do anything different in this or subsequent sessions?
 - [Prompt?] Did you share the feedback?
 - [Prompt?] Is there anything you would have done differently?
- 6. What if any, was the client's reaction to the feedback?
 - [Prompt?] How if at all, did this client's reaction change as the session progressed?
- 7. What was your experience of this clients outcome from therapy?
 - [Prompt?] Gains due to therapy/Feedback?
 - [Prompt?] Deterioration due to therapy/Feedback?
- 8. Is there anything else about your experience of this client's feedback that you wish to tell me about? Is there anything we have not discussed?
 - [Prompt?] Reflecting on this experience is there anything that you would do differently in the future?
 - [Prompt?] How, if at all, has this client interaction changed your view of therapy/feedback/clients?
 - [Prompt?] As you look back on the feedback from this client, are there any other experiences that come to mind? Could you describe them?
- 9. You have already told me about a client who had a [positive/negative] feedback report. Could you tell me about another client who stands out for you? Perhaps someone who has had a [negative/positive] feedback report?
- [REPEAT ABOVE QUESTIONS 2-8]

End and summary of discussion

- 10. Is there anything that you would change about the feedback system in this service? Is there anything that you might not have thought about before that occurred to you during this interview?
 - [Prompt?] Tell me what has been your experience of getting feedback from clients?

- [Prompt?] After having these experiences with feedback, what advice would you give someone who has just started in a therapy service that uses feedback?

- 11. Is there anything that we have not discussed which you would like to mention?

Thank you for your time, if you have any questions or further comments, please don't hesitate to contact me.

Appendix E: Page of Transcript and Analysis Notes

I So you've said some things which I may come back to later and have a guess about how the model that you're working in and about how it might fit in with seeking feedback from clients erm but again to start quite generally erm what was your impression of the feedback system when you fir, when you started in this service first?

P Erm I enjoy feedback I think it's how we develop erm I'm quite open and I want to know as well as my own observations in session I like to have that as backed up by evidence so it's something that I started in my training is collecting my own measures

I Yeah

P So I find that really helpful to know whether I'm on track and whether we're on track more to the point. So I was really erm positive about the feedback system I'm very engaged, I set it up straight away, I don't have qualms about doing it with people. Erm I have less anxiety about giving people measures because I think it's important, I always set it up in a way that this is about me being able to help you to the best of my ability in the same way that I would set up video recording in my sessions. It's not about erm trying to abuse someone by recording them, I'm trying to actually, it's the best way I can help you

I Yeah

P And I find that people respond really well to that erm and for me I use it to guide my practice and to to change practice if need be. So I, yeah I was very positive about it and looking forward to getting involved in it really.

I And is that still the impression you hold? Are you still as enthusiastic about it?

P Erm I, yes, still enthusiastic about it erm I think there's been some difficulties within the feedback system that have sometimes have left me confused and not knowing how best to use that information and it's sometimes not always reflected my clinical impression and sometimes it's alerted me to something that I think I was a bit blind to so it's been a mixed bag really so I'm still very positive about it in fact I'm quite sad that erm than things are tailoring off 'cos I find that's introducing new issues because I really want to keep collecting data. Erm and so by not having the, the emphasis on the research now it's tailoring off a bit people aren't as up on giving out questionnaires it's

David O'Halloran 28/4/13 15:26

Comment [1]: Therapists comfortable about receiving feedback – its how we learn and develop

David O'Halloran 28/4/13 15:25

Comment [2]: Feedback backing up intuitions

David O'Halloran 28/4/13 15:25

Comment [3]: Actively engaged in feedback - collecting own measures

David O'Halloran 28/4/13 15:25

Comment [4]: Discovering if we are on track

David O'Halloran 28/4/13 15:24

Comment [5]: Actively engaged in feedback - collecting own measures

David O'Halloran 28/4/13 15:24

Comment [6]: Belief in feedback as a tool of therapy

David O'Halloran 28/4/13 15:23

Comment [7]: Clients experience feedback positively

David O'Halloran 28/4/13 15:23

Comment [8]: Feedback as a guide to practice

David O'Halloran 28/4/13 15:22

Comment [9]: Difficulties accessing the feedback systems

David O'Halloran 28/4/13 15:21

Comment [10]: Hard to make sense of - Feedback forms

David O'Halloran 28/4/13 15:21

Comment [11]: Accuracy of feedback – disconnect between experience in therapy and reporting on FB forms

David O'Halloran 28/4/13 15:20

Comment [12]: Therapists comfortable about receiving feedback – its how we learn and develop

David O'Halloran 28/4/13 15:19

Comment [13]: Accuracy of the measure – confirming therapists experience of the patient

David O'Halloran 28/4/13 15:18

Comment [14]: Belief in feedback as a tool of therapy

causing some other issues in collection continuing collecting my own [I: Yeah] Data

I OK erm have you, do you get a sense that your, how you work as a therapist has been changed by the introduction of feedback or has it like or is it something that has been part of your training so you've integrated it quite well?

P I think it erm has complemented what I was already doing. I think if I come to this service and I wasn't used to session by session feedback or I wasn't used to that it would have been very different to integrate that into me as a person, into my practice but because I was already there erm it felt like an easy enough transition erm and so yeah I think it's, it's just become an addition to what was my practice anyway

I Yeah

P Erm and so maybe a more, I mean I never have been given feedback I just been collecting it and seeing it myself session by session so that, that adds an extra dimension

I Yeah

P Where you're actually getting something physical that's in colours and is kind of is measuring your you know your clients improvement or not. Erm so that, that was different and that, that was, it took a bit of getting my head round.

I And that's the specific feedback report after session 4

P Yeah, yeah

I And, 'cos, it's a bit different, I guess we could talk about feedback system as one concept but, but here there seems to be a number of different strands to the feedback erm and it's elicited in different ways, there's a pre session measure which the client or patient brings in to you at the start of the session erm and then that's the CORE and SPACE

P Yeah

I And sometimes, and I guess that might be a bit more closer to your experience of when you were training of using feedback giving out a symptom measure

P Yeah and collecting session by session [I: yeah] As well

David O'Halloran 28/4/13 15:18

Comment [15]: Actively engaged in feedback – collecting own measures

David O'Halloran 28/4/13 15:16

Comment [16]: (1) Changing or influencing a therapists approach
(2) Existing experience of feedback system
(3) Feedback matches therapists approach

David O'Halloran 28/4/13 15:15

Comment [17]: A new experience – sessional feedback

David O'Halloran 28/4/13 15:14

Comment [18]: Existing experience if feedback system

David O'Halloran 28/4/13 15:13

Comment [19]: Receiving a report – an extra dimension

David O'Halloran 28/4/13 15:12

Comment [20]: Receiving a report – an extra dimension

David O'Halloran 28/4/13 15:11

Comment [21]: Using directly in session