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The Components of

Person-Centred Experiential Therapy and

Their Impact on the Effectiveness of Counsellors

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A thesis submitted in partial fulfilment of the requirements for the

degree of Doctor of Philosophy

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List of Contents

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I have been lucky in many ways. A lot has happened in the five years that I have been working on this thesis. When the Covid pandemic disrupted the work of many PhD students, I could continue work on data that had already been gathered. My family has grown and changed. We have gained a Ukrainian family, a son-in-law and two grandchildren, and sadly we have lost my Dad.

What a journey.

Abstract

Person-centred experiential therapy (PCET) is a brief therapy for adults experiencing depression and delivered in NHS Talking Therapies services. A recent randomised controlled trial (PRaCTICED) found PCET to be non-inferior to cognitive behavioural therapy at 6 months. The aim of this thesis is to use PRaCTICED data to determine the role of the person-centred, experiential, and proscribed components of PCET in effective practice.

Following introduction and background chapters, the thesis comprises (1) a systematic literature review and meta-analyses seeking evidence for the efficacy of the experiential components of PCET; two qualitative studies investigating (2) how stakeholders conceptualised the PCET model, and (3) how PRaCTICED therapists used the experiential components in practice; three quantitative studies investigating (4) how competence was related to next-session and (5) end-of-therapy outcomes; and (6) the interrater reliability of the Person-Centred and Experiential Psychotherapy Scale (PCEPS-10, the measure used to assess therapists' competence in PCET).

The systematic review and meta-analyses showed the experiential components to be effective as standalone and added interventions. Qualitative analysis of interviews showed that trainers and stakeholders see PCET as coherent and effective, although some differences were found regarding conceptualisation of the model and assessment practices. Qualitative analysis of PCET sessions showed that, generally, therapists successfully integrated the experiential components into practice.

Quantitative analysis showed that baseline severity and competence were related, but that competence and next-session change were not. Early change was related to end-of-

therapy change but the latter was not related to competence. Interrater reliability of the PCEPS-10 was found to be fair when used for RCTs but poor in wider practice.

In conclusion, while no relationship between competence and outcome was found, therapists successfully operationalised experiential components into practice with initial severity of the client's condition and early phase change being the best predictors of outcome.

Publication

A thematic analysis of the interviews presented in Chapter 3 of this thesis has previously been published in *Counselling and psychotherapy research.*

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The paper is available in Appendix B.

Table of Contents

Chapter 3

How Person-Centred Experiential Therapy (PCET) Trainers and Other Stakeholders Perceive the PCET Model and Training   60

Chapter 6
The Effect of PCE Therapist Competence on Next-session Client Outcomes

List of Tables

List of Figures

Chapter 1

The History and Conceptualisation of

Person-Centred Experiential Therapy

This thesis presents an investigation of person-centred experiential therapy (PCET), a model of therapy in the humanistic tradition. PCET is a relatively new model of therapy, developed as an intervention for depression in primary care within high-volume English NHS Talking Therapies for Anxiety and Depression services. This brief therapy model was designed to be teachable in the form of a five-day top-up training to a workforce of trained and qualified counsellors. In order to meet National Institute of Health and Care Excellence criteria to be recognised as an evidence-based intervention, the model integrates components of person-centred therapy and emotion focused therapy which have been shown by research to be effective. The efficacy of the new PCET model has been demonstrated in the PRaCTICED randomised controlled trial. The current thesis drills into the findings of the PRaCTICED trial, using data from the trial to conduct more detailed investigations of the effective components of the model. The aim of the thesis is to accumulate evidence which will build a clearer understanding of the characteristics and implementation of the effective components of PCET.

Terminology

The term person-centred experiential therapy (PCET) will be used throughout the thesis. The model was originally named counselling for depression (CfD), since counselling was approved by the National Institute for Health and Care Excellence (NICE, 2009; 2022) for the treatment of depression. The term person-centred experiential therapy (PCET) is used here, which captures the theoretical basis of the model in the person-centred and

experiential approaches, and avoids diagnostic categories. In the person-centred tradition, the therapist responds to the experience of the individual client, rather than a diagnosis. In the context of training, the model is termed person-centred experiential counselling for depression (PCE-CfD). Although someone who delivers PCET is often known as a 'counsellor', the term 'therapist' will be used here to reflect PCET as a model of therapy.

When PCET was first commissioned, NHS primary care mental health services in England were known as Improving Access to Psychological Therapies (IAPT). This name has now changed to NHS Talking Therapies for Anxiety and Depression, abbreviated to NHS Talking Therapies. In the following thesis the terms CfD and IAPT will be used where they reflect the usage and literature at the time under discussion. Elsewhere the up-to-date terms of PCET and NHS Talking Therapies will be used.

The History of PCET

Person-centred and experiential therapies are long-established and effective models of therapy rooted in the humanistic tradition. They have been shaped by the work of Carl Rogers, Eugene Gendlin, Les Greenberg and Robert Elliott, among many other influential names (Cooper et al., 2010; Sanders, 2012). PCET as delivered in primary care in the English National Health Service (NHS) is a specific model within this tradition.

In the first CfD textbook, the authors stated that their aims in developing the model were twofold: to strengthen the position of humanistic counsellors within health services, and to offer a well-defined and coherent model of therapy that would be conducive to efficacy research (Sanders & Hill, 2014). These two aims are intertwined, since any intervention offered in the NHS must be supported by evidence of effectiveness which meets the standards set by NICE.

The English IAPT programme was rolled out from 2008 and implemented

recommendations set out in the NICE guidance for the treatment of anxiety and depression.

Based on the NICE-approved evidence, the majority of therapy offered in IAPT was cognitive

behavioural therapy (Clark, 2018; IAPT, 2011; NHS England, 2016). In order to offer choice

for clients, and for clients who do not respond to CBT, IAPT commissioned training

programmes for four further 'IAPT approved high intensity therapies additional to CBT'

(IAPT, 2011; National Collaborating Centre for Mental Health, 2018). These were: brief

dynamic interpersonal therapy for depression; interpersonal psychotherapy for depression;

couple therapy for depression; and CfD, which would provide a therapy model in the

humanistic tradition. Curricula were developed for each of these therapies based on

research evidence of effectiveness, and designed to be delivered as five-day top-up trainings

for counsellors who were already qualified and employed in IAPT services.

The Development of the PCET Model

In the context outlined above, the British Association for Counselling and

Psychotherapy (BACP) was commissioned to develop CfD (Sanders & Hill, 2014). The new

model was based on evidence from five randomised controlled trials (RCTs) of humanistic

therapy included in the NICE Depression Guidelines (Hill, 2010; Sanders & Hill, 2014). Two of

these RCTs were trials of nondirective counselling, one comparing counselling with

antidepressant medication (Bedi et al., 2000), and the other with usual GP care and CBT

(Ward et al., 2000). Three were trials of emotion focused therapy (EFT), two comparing it

with client-centred therapy (an alternative term for person-centred therapy. Goldman et al.,

2006; Greenberg & Watson, 1998), and one comparing it with CBT (Watson et al., 2003). In

their review, the NICE Guideline Development Group considered that all these trials

suffered from methodological problems, making the evidence limited and applicable only to people experiencing mild to moderate depression (NICE, 2009).

Experiential Interventions Distinguishing EFT from Person-Centred Therapy

The treatment descriptions in two of the RCTs outlined above highlight the additional experiential interventions which distinguish EFT from person-centred therapy. Greenberg and Watson (1998) randomly allocated depressed adults (*N* = 34) to one of two groups. One group received client-centred therapy alone, while the second group received client-centred therapy plus the addition of three process-directive interventions. This therapy was referred to as process-experiential. The three interventions were: (a) two-chair dialogues for a self-evaluative conflict, (b) empty-chair dialogue for resolving unfinished business with a significant other, and (c) systematic unfolding for problematic and puzzling reactions. These interventions were offered in response to markers in the client's narrative which indicated cognitive-affective processes contributing to depression. Therapists (*N* = 11) offered both forms of therapy, and were thus used as their own controls to account for therapist effects. Sixteen to twenty sessions of therapy were offered in both arms of the trial. At end of therapy and six-month follow-up depression for both groups had improved equally. However, the process-experiential group improved more quickly, and showed greater improvement on measures of self-esteem and interpersonal problems.

A further RCT conducted by Goldman et al. (2006) replicated the 1998 Greenberg and Watson study with 38 clients with depression. For this trial, process-experiential therapy was referred to by its new name of emotion-focused therapy, and the same process-directive interventions were offered as in the previous trial. Again, therapists acted as their own controls and clients were offered 16-20 sessions. The results of this trial again showed that both therapeutic models were effective, though this time the EFT group

showed greater improvement in depression. In contrast to the previous study, no differences were found between the group that received client-centred therapy and the group that received EFT on measures of self-esteem or interpersonal problems.

While both these trials emphasised the relational conditions of empathy, positive regard, and congruence in their descriptions of client-centred therapy, neither of them referred to the person-centred principle of nondirectiveness. The authors described client-centred therapy as "one of [the] components [of process-experiential therapy]" (Greenberg & Watson, 1998, p.210). Since process-experiential therapy is described as 'process-directive', it would not make sense for one of its components to be nondirective. Also of note is that in both studies the description of the process-experiential/EFT treatments referred to 'depressogenic cognitive-affective processes' of clients. Again this highlights a difference between this therapeutic model and the person-centred approach, which does not place an emphasis on the client's cognitive process, nor identify any specific problematic emotional processes.

Conceptualisation of the PCET Model

Drawing on the evidence from the five RCTs described above, the PCET model was conceived as an integration of person-centred therapy and EFT. Both therapies are rooted in the humanistic tradition, a broad umbrella encompassing a range of psychotherapeutic models which have evolved in distinct ways from classical person-centred therapy (Sanders, 2012). These models share a belief in the centrality of every person's unique experience and striving for self-actualisation. All humanistic models emphasise the therapeutic function of the relationship conditions, and especially the therapist's empathy, positive regard, and congruence. Following Rogers (1951) these are known as the 'core conditions'. The shared philosophy of the two modalities, and the endorsement of NICE for nondirective counselling

and EFT, meant that they could be integrated in a coherent and evidence-based way (Sanders & Hill, 2014).

PCET therefore integrates the core person-centred relational conditions with an understanding of psychological distress and mechanisms of change derived from the emotion theory of EFT (Elliott et al., 2004; Murphy, 2019). In contrast to the nondirectiveness central to classical person-centred therapy, EFT incorporates 'tasks', where therapists actively propose process-directive interventions in response to specific 'task markers' within a client's narrative (Greenberg & Paivio, 2003). The effectiveness of this approach was examined in the RCTs described above (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). A challenge in the PCET model is therefore to retain the person-centred spirit of nondirectiveness, while at the same time actively attending to the client's emotional process and incorporating the components with proven effectiveness. One way of conceptualising the various possible solutions to this challenge is as a spectrum of process-guiding, with strict nondirectiveness at one end, changing to process-direction as delivered in EFT at the other end. This is illustrated by Figure 1.1 below.

Figure 1.1

The process-guiding spectrum
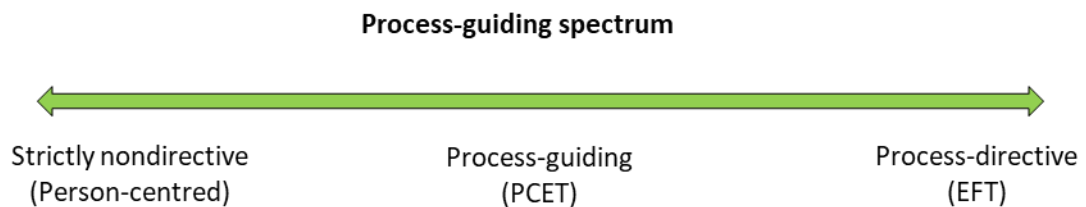
For some people who adhere to the classical person-centred approach, the development of an evidence-based humanistic model of therapy for delivery in the NHS was

controversial. Some in the person-centred community believe strongly in the philosophy of following the unique direction of each individual client without the imposition of any external expectations, meaning that therapy is strictly nondirective and no aspect of it is standardised (Jackson et al., 2019; Proctor & Hayes, 2017). However, some standardisation of a therapy model for delivery in the NHS is inevitable. NHS Talking Therapies follow a medical model, characterised by diagnosis-driven treatment and routinely administered outcome measures and targets. Also, for a therapeutic model to be tested in research trials, it needs be defined and delivered in a standardised way (Miller & Binder, 2002). Therapists working in NHS Talking Therapies are expected to adhere to NICE guidelines, which means consistently offering therapeutic components that have evidence of effectiveness from research trials.

One element in the standardisation of a therapeutic model is the creation of a manual. In developing the new CfD therapy model, therefore, it was necessary to produce a manual for use in research and in training.

Manualisation of PCET

Manuals provide a definition of a therapy model, as well as descriptions of interventions used by therapists to operationalise the theory-based therapeutic mechanisms (Miller & Binder, 2002; Waltz et al., 1993). As outlined above, there are challenges in creating a manual for a person-centred model of therapy. Many of those who adhere to the classical person-centred tradition fear that manualisation would lead to a 'cookie cutter' approach, where therapy is reduced to a series of standard techniques and the uniqueness of the client and the therapist are lost (Bohart et al., 1998; Strupp & Anderson, 1997). Also, as highlighted by Perepletchikova et al., (2007), there are difficulties in producing a "specific operational definition of an intervention" in process-oriented or

'non-skill-building therapies' such as PCET, where "flexible, spontaneous responding in the moment is valued" (p.835). Perepletchikova and colleagues suggested that adherence in process-oriented therapies should be measured according to "the general principles and philosophy of an approach, rather than to specific techniques" (Perepletchikova, 2009, p.380).

Accordingly, the texts providing a definition of PCET are descriptive rather than prescriptive (Pearce et al., 2013). The counselling for depression competence framework (Hill, 2010) was developed by the Centre for Outcomes Research and Evaluation (CORE, University College, London). CORE hosted a programme to create competence frameworks for most psychotherapy modalities, drawing on the best available evidence of efficacy. The CfD competence framework was based on the humanistic competence framework (Roth, Hill, & Pilling, 2009), but provided a more tightly defined model that could be used in a consistent way by counsellors in NHS Talking Therapies. A curriculum for the training of CfD therapists was also written, built on the foundation of the competence framework (Hill, 2011). Taken together, these texts constitute a flexible and descriptive manual for the PCET model. In keeping with the person-centred tradition, these resources allow trainers and practitioners the freedom to respond to the uniqueness of each client, allowing variations in the interpretation of the model by different practitioners, trainers, and training centres, including how or whether to incorporate process-guiding interventions.

A CfD textbook was also written, which described the position of the new therapy model within the humanistic and person-centred tradition, as well as within IAPT (Sanders & Hill, 2014). Like the CfD training curriculum, it focused mainly on person-centred practice, and briefly outlined some process-guiding concepts, calling them 'auxiliary techniques'. The second edition of the PCET textbook is described in its title as 'A manual for training and

practice' (Murphy, 2019). In the second edition, the experiential elements are considered central to the model, and the term 'auxiliary techniques' has been dropped. Like all the other training materials, both editions of the textbook refrain from being prescriptive.

Introduction to the Thesis

This chapter has provided the historical context for the development of PCET. The chapter has described the conceptualisation of PCET as an integration of elements from emotion focused therapy theory and practice into a nondirective person-centred therapeutic relationship. The aim of this thesis is to examine the key components of the PCET model and determine their role in the delivery of effective practice, using data collected from a single NHS Talking Therapies service for the PRaCTICED randomised non-inferiority trial. The design and details underpinning this study, together with an overview of the thesis chapters, are set out in the next chapter.

Chapter 2

Person-Centred Experiential Therapy and the PRaCTICED Trial

Chapter 2 focuses on PCET in practice. This includes the delivery of PCET training and assessment, particularly the Person-Centred & Experiential Psychotherapy Scale (PCEPS-10; Elliott & Westwell, 2012), used as the measure of PCE therapist competence. This chapter also presents details of the PCET arm of the PRaCTICED trial, providing important context for four of the studies which follow.

PCET Training for Counsellors Working in NHS Talking Therapies

The premise of PCET training was to build a workforce of therapists who would deliver a consistent, evidence-based, and effective form of therapy to clients in primary care across England (Pearce et al., 2012). Training provides the link between the evidence of PCET as an effective model, and the effective delivery of PCET by practitioners with clients (Pearce et al., 2012). Importantly, the new model had to be familiar enough to therapists who were already qualified and working within IAPT for the training to be delivered as a five-day top-up course. According to a 2010 BACP survey, 70% of counsellors had received training in person-centred therapy (Sanders & Hill, 2014). EFT, on the other hand, as a model developed and practised mostly in Canada and the U.S.A., was unfamiliar to most English practitioners, including those who delivered the new training. From a foundation in person-centred principles, EFT researchers have elaborated a detailed theory of emotions, and therapeutic interventions to work with them (Greenberg & Watson, 2006). It was unrealistic to incorporate more than the basic principles of EFT into a five-day curriculum, and therefore only aspects which would build on the existing knowledge of trainees were included (Hill, 2011).

PCET training is offered as a five-day top-up course to therapists who already have a counselling qualification, preferably including a grounding in person-centred therapy. The majority of trainees are employed in NHS Talking Therapies services, and training is funded by Health Education England, the NHS training body. Training takes place in one of four university-based centres in England, delivered by trainers who are experienced in teaching person-centred and experiential therapy. The PCET training delivered in each of the four centres has achieved BACP accreditation, indicating that it conforms to the BACP definition of the PCET model (BACP, 2023).

Assessment of Competence for PCET Trainees

The assessment of competence is important for the training and qualifying of therapists in a particular model of therapy, and must be consistent to ensure fairness and the continuing effectiveness of practice (Barber et al., 2007; Kühne et al., 2020; Pearce et al., 2012; Power et al., 2022). PCET training, assessment, and qualification are high stakes endeavours for therapists and trainers, since to ensure continued employment in NHS Talking Therapies, therapists (who are already qualified and experienced in counselling) must gain a qualification in at least one of four evidence-based modalities, which include PCET (NCCMH, 2021).

Following the five-day training course, trainees must complete 80 hours of PCET practice with clients in their routine clinics. The work is discussed in supervision with a qualified PCET supervisor, and the supervisor must endorse the 80 hours of practice. Therapy sessions are audio-recorded, and the recordings encrypted before submission for assessment by the team at the training centre. Trainees may select for assessment the recordings and the twenty-minute segment from each recording which they consider the most adherent. Trainees may submit up to six recordings, from which four segments must

achieve the nationally defined competence threshold. Recordings can also be played and discussed with the supervisor before submission. In routine assessment practice, audio-recording segments are rated by only one assessor, though segments may be double-marked by a colleague in borderline cases.

While the experience of PCET trainees has previously been researched (Drewitt et al., 2018; Nye et al., 2019; Pearce et al., 2013), it is equally important to capture the experiences and perceptions of trainers and other stakeholders in the PCET project. This will be the focus of a qualitative analysis of interviews with trainers and stakeholders in this thesis.

The adherence scale used in the assessment of PCET competence is the Person-Centred and Experiential Psychotherapy Scale (PCEPS-10; Elliott & Westwell, 2012), discussed below.

The Person-Centred and Experiential Psychotherapy Scale – The PCEPS

The authors of the original Person-Centred and Experiential Psychotherapy Scale (PCEPS; Freire et al., 2014) aimed to design an instrument which would define the PCET model and provide a measure to assess treatment fidelity in research on person-centred and experiential therapy. The original scale consisted of 15 items comprising two subscales: a 10-item person-centred subscale, and a five-item experiential subscale (described below). The scale was subsequently condensed to a single 10-item scale. In PCET training the 10-item PCEPS is used not only for the assessment of trainees but also to help to elucidate the model alongside the competence framework (Hill, 2010) and curriculum (Hill, 2011). The PCEPS therefore contributes to the conceptualisation of the PCET model.

Development of the PCEPS

Following a review of instruments measuring competence in person-centred practice such as the Truax Scales for Therapist Accurate Empathy, Non-possessive Warmth, and Genuineness (Truax & Carkhuff, 1966), Freire and colleagues (Freire & Grafanaki, 2010; Freire et al., 2012; Freire et al., 2014) concluded that no existing measure effectively and reliably captured the person-centred therapist attitudes of empathy and nondirectiveness. The authors therefore developed a 15-item scale, the original PCEPS, to describe and operationalise the attitudes and behaviours of therapists which characterised the person-centred experiential model.

Although the PCEPS is used as the measure of adherence for PCET, the authors of the scale stated that since adherence is assumed, the PCEPS is principally a measure of competence (Freire et al., 2014). To explain this assumption, Elliott, one of the authors of the PCEPS, pointed out that to be adherent to PCET, components such as empathy must be offered with at least a minimum level of competence, or they must be judged to be absent: "bad empathy is not empathy" (personal communication, 2023). For this reason, this thesis refers to competence rather than adherence.

The PCEPS-10 (reproduced in Appendix A) comprises 10 items, each introduced with a descriptive summary. Each item has a rating scale of 1-6, with each point anchored in a narrative description. The developers of the PCEPS stated that anchors for scale points 1-3 were written to reflect practice not seen as competent (Freire et al. 2014). Scale points 4-6 reflect increasing levels of competence, with 6 indicating excellence (Elliott & Westwell, 2012). A rating of 1 could be seen as so lacking in competence as to be nonadherent (Robert Elliott, personal communication, 2023). A pass mark in PCET training is set as a rating of 40

or more for a recording segment (i.e., an average rating of 4 across 10 items) out of a maximum of 60.

Subscales of the PCEPS

The original PCEPS consisted of 15 items, incorporating a 10-item person-centred subscale, and a five-item experiential process subscale (Freire et al., 2012; 2014). Reliability analysis conducted as part of the programme to validate the 15-item measure showed that some of the items overlapped and were therefore redundant. An exploratory factor analysis found that rather than dividing into clusters corresponding to the two subscales, the items fell into a 12-item facilitative relationship factor, and a three-item nonfacilitative directiveness factor. Following this analysis two of the authors refined the instrument into the 10-item scale currently in use, retaining seven items from the person-centred subscale, and three items from the experiential process subscale (Westwell, 2018). Consequently, although the PCEPS-10 itself is no longer divided into subscales, it can be separated into clusters of items reflecting the original person-centred and experiential subscales.

The authors of the PCEPS recognised that refraining from nonfacilitative behaviours is also a defining characteristic of the person-centred approach. According to the most commonly used definition of therapy adherence (Waltz et al., 1993), behaviours that the therapist must refrain from in a therapy model are termed 'proscribed procedures'. Although the two PCEPS items which describe nonfacilitative or directive therapist behaviour were originally included in the person-centred subscale of the 15-item PCEPS, they can be seen as proscribed components, and consequently be separated into a third cluster in PCET. Throughout this thesis, therefore, the three clusters are referred to as (a) the person-centred cluster, (b) the proscribed cluster, and (c) the experiential cluster.

The clusters are described below, with the definition for each item drawn from the

PCEPS-10.

The Person-Centred Cluster

The person-centred cluster of the PCEPS-10 includes items which capture the nature

of a person-centred therapeutic relationship, where the therapist strives to understand the

client's experience and what it means from the client's own frame of reference, and which is

empathic, containing, and non-judgemental. In the 15-item scale Clarity of Language fell

into the nonfacilitative directiveness factor (Freire et al., 2014). However, in the PCEPS-10

Clarity of Language is framed as a positive quality of the therapist rather than being

proscribed, and therefore in this thesis it is retained in the person-centred cluster of

facilitative items. These facilitative items are:

- Item 1. Tracking/Client Frame of Reference

   **"How much do the therapist's responses convey an understanding of
   the client's experiences as the client themselves understands or
   perceives it? To what extent is the therapist following the client's
   track?**

   *Do the therapist's responses convey an understanding of the client's
   inner experience or point of view immediately expressed by the client?
   Or conversely, do therapist's responses add meaning based on the
   therapist's own frame of reference?*

   *Are the therapist's responses right on client's track? Conversely, are the
   therapist's responses a diversion from the client's own train of
   thoughts/feelings?"*

- Item 2. Psychological Holding

   **"How well does the therapist metaphorically hold the client when they
   are experiencing painful, scary, or overwhelming experiences, or when
   they are connecting with their vulnerabilities?**

   *High scores refer to therapist maintaining a solid, emotional and
   empathic connection even when the client is in pain or overwhelmed.*

Low scores refer to situations in which the therapist avoids responding or acknowledging painful, frightening or overwhelming experiences of the client."

- Item 4. Accepting Presence

  "How well does the therapist's attitude convey an unconditional acceptance of whatever the client brings?

  Does the therapist's responses convey a grounded, centred, and acceptant presence?"

- Item 8. Clarity of Language

  "How well does the therapist use language that communicates simply and clearly to the client?

  E.g., therapist's responses are not too wordy, rambling, unnecessarily long; therapist does not use language that is too academic or too abstract; therapist's responses do not get in the client's way."

- Item 9. Core Meaning

  "How well do the therapist's responses reflect the core, or essence, of what the client is communicating or experiencing in the moment?

  Responses are not just a reflection of surface content but show an understanding of the client's central/core experience or meaning that is being communicated either implicitly or explicitly in the moment; responses do not take away from the core meaning of client's communication."

The Proscribed Cluster

The items of the proscribed cluster capture therapist behaviours which contravene the person-centred principles that the client is the expert, both in their own experience, and in what they need from therapy. These behaviours are seen as directive and nonfacilitative. The PCEPS-10 item labelled Content Directiveness captures the requirement for the therapist to refrain from directing the content of the client's narrative. The item labelled Dominant or Overpowering Presence captures the requirement for the therapist to refrain from conveying an attitude of authority or being the expert. In the exploratory factor

analysis of the original 15-item scale, these items fell into the nonfacilitative directiveness factor.

These items are:

- Item 5. Content Directiveness

  "How much do the therapist's responses intend to direct the client's content?

  Do the therapists' responses introduce explicit new content? e.g., do the therapist's responses convey explanation, interpretation, guidance, teaching, advice, reassurance or confrontation?"

- Item 7. Dominant or Overpowering Presence

  "To what extent does the therapist project a sense of dominance or authority in the session with the client?

  Low scores refer to situations in which the therapist is taking charge of the process of the session; acts in a self-indulgent manner or takes over attention or focus for themselves; interrupting, talking over, silence or controlling the process; or acting in a definite, lecturing, or expert manner.

  High scores refer to situations in which the therapist offers the client choice or autonomy in the session, allows the client space to develop their own experience, waits for the client finish their thoughts, is patient with the client, or encourages client empowerment in the session."

The Experiential Cluster

The three items of the PCEPS-10 retained from the original experiential subscale describe the therapist's endeavour to help the client to symbolise and translate their experience from abstract into concrete and accessible terms, to focus on their emotional experiences, and to maintain a productive level of in-session emotion regulation, all to facilitate exploration and change. These three items are:

- Item 3. Experiential Specificity

  "How much does the therapist appropriately and skilfully work to help the client focus on, elaborate or differentiate specific, idiosyncratic or

personal experiences or memories, as opposed to abstractions or generalities?

E.g., By reflecting specific client experiences using crisp, precise, differentiated and appropriately empathic reflections; or asking for examples or to specify feelings, meanings, memories or other personal experiences."

- Item 6. Emotion Focus

    "How much does the therapist actively work to help the client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit?

    E.g., By helping clients focus their attention inwards; by focusing the client's attention on bodily sensations; by reflecting toward emotionally poignant content, by inquiring about client feelings, helping client intensify, heighten or deepen their emotions, by helping clients find ways of describing emotions; or by making empathic conjectures about feelings that have not yet been expressed. Lower scores reflect ignoring implicit or explicit emotions; staying with non-emotional content; focusing on or reflecting generalized emotional states ("feeling bad") or minimizing emotional states (e.g., reflecting "angry" as "annoyed")."

- Item 10. Emotion Regulation Sensitivity

    "How much does the therapist actively work to help the client adjust and maintain their level of emotional arousal for productive self-exploration?

    Client agency is central; this is not imposed by the therapist. There are three possible situations:

    If the client is overwhelmed by feelings and wants help in moderating them, does the therapist try to help the client to manage these emotions? E.g., By offering a calming and holding presence; by using containing imagery; or by helping the client self-soothe vs. allowing the client to continue to panic or feel overwhelmed or unsafe.

    If the client is out of touch with their feelings and wants help in accessing them, does the therapist try to help them appropriately increase emotional contact? E.g., by helping them review current concerns and focus on the most important or poignant; by helping them remember and explore memories of emotional experiences; by using vivid imagery or language to promote feelings vs. enhancing distance from emotions.

    If the client is at an optimal level of emotional arousal for exploration, does the therapist try to help them continue working at this level, rather

than deepening or flattening their emotions?)"

Each of these items can be identified as components in a range of therapy modalities, with research offering evidence for their effectiveness both as standalone interventions, and as components of broader therapeutic approaches. These three components constitute the experiential element of PCET, introduced to enhance the evidence for the effectiveness of the new model, but new and unfamiliar to most person-centred therapists (as discussed above). The three components are therefore a major focus of this thesis. The question of whether the evidence supports the inclusion of interventions which operationalise these components in PCET is addressed in Chapter 4 of this thesis with a systematic literature review covering each of the three components. There is also a need for research to investigate how these interventions are operationalised in PCET practice. This question is addressed in Chapter 5 of this thesis, comprising a qualitative analysis of PCET session transcripts.

Reliability of the PCEPS-10

Whether for use in research or assessment, the validity and reliability of rating scales such as the PCEPS-10 should be evaluated (Perepletchikova et al., 2007; Waltz et al. 1993; Webb et al., 2010). The developers of the PCEPS calculated the inter-item reliability of the scale as part of the programme to test its validity (Westwell & Elliott, 2018). Results returned an average Cronbach's alpha of .97, equivalent to ICC >.75, indicating excellent inter-item reliability. This supported the internal validity of the PCEPS-10 by confirming that all 10 items were measuring the same construct. This means that although conceptually the person-centred, proscribed, and experiential clusters can be distinguished, differences may be too small to identify at a significant level in a statistical analysis.

Another aspect of the programme to evaluate the validity of the PCEPS was the testing of interrater reliability. The interrater reliability of the original 15-item PCEPS was analysed by the authors and found to be good, with an average Cronbach's alpha of .78 (Freire et al., 2014). Analysis of the PCEPS-10 initially found poor interrater reliability, which was improved following interventions including supervision of raters (Westwell & Elliott, 2018).

This raises the question of the interrater reliability of the PCEPS-10 as it is used by the teams in the national training centres for the assessment of trainees. A study of variations between ratings awarded by raters may highlight differences in their interpretation of the PCEPS items, i.e., the components of PCET, and to what extent raters share an understanding of the model. An analysis of the interrater reliability of the PCEPS-10 in the context of an RCT is also needed. These questions are addressed in Chapter 8 of this thesis. The PCEPS was originally conceived as an instrument for use in research trials (Freire et al., 2014), and its first use for this purpose was to assess treatment fidelity in the PCET arm of the PRaCTICED trial, a major randomised controlled trial that will now be introduced.

The PRaCTICED Trial

Researchers from the University of Sheffield conducted an RCT titled "Person-centred experiential therapy versus CBT delivered in the English Improving Access to Psychological Therapies service for the treatment of moderate or severe depression: a pragmatic, randomised, non-inferiority trial", and known as the PRaCTICED trial (Barkham et al., 2021). The trial investigated the non-inferiority of PCET compared to CBT for the treatment of moderate or severe depression, using a randomised controlled trial (the 'gold standard' evidence; NICE, 2012). Participants were clients referred to IAPT by primary care providers. Clients assessed in the IAPT service as having a score over 12 on the Patient

Health Questionnaire-9 (PHQ-9; Kroenke et al., 2002) and consenting to participate in the trial were referred for further screening by researchers. This screening identified appropriate participants as people suffering from moderate to severe depression, using the Clinical Interview Schedule-Revised (Barkham et al., 2021). The trial was pragmatic, based on the routine delivery of PCET and CBT by therapists employed by Sheffield IAPT, working in their usual primary care settings. Non-inferiority was determined by a difference of less than 2 points on the PHQ-9, measuring depression symptomatology. Randomisation of participants resulted in 254 clients in the PCET arm of the trial and 256 in the CBT arm.

At the end of the trial the PRaCTICED dataset included data for 202 clients randomised to PCET. Of these, three clients had switched to CBT and 14 clients did not attend any PCET sessions. The full sample therefore includes pre- post-therapy PHQ-9 scores for 185 participants.

Results of the PRaCTICED Trial

Results showed that at six-months post-randomisation outcomes for PCET were non-inferior to CBT (PCET mean PHQ-9 = 12.74 [SD 6.54], CBT mean PHQ-9 = 13.25 [6.35], adjusted mean difference -0·35 [95% CI -1.53, 0.84]). At 12-months post-randomisation, results favoured CBT (PCET mean PHQ-9 = 12.57 [SD 7.48], CBT mean PHQ-9 = 10.95 [6.58], adjusted mean difference 1.73 [95% CI 026, 3·19]). This suggested that while CBT clients' depression continued to improve following the end of therapy, PCET clients maintained their gains, but did not continue to improve.

Use of PRaCTICED Trial Data for the Current Thesis

The baseline and outcome measures extracted from the PRaCTICED trial dataset for the current thesis are PHQ-9 score at the first PCET session and the last PCET session respectively. The outcomes under analysis, therefore, mirror the data gathered in routine

practice in NHS Talking Therapies services, making the findings generalisable beyond the PRaCTICED trial. At the same time, the randomisation of clients to either PCET or CBT in the trial means that the studies presented here avoid selection bias and the risk of unknown confounding factors (Kazdin, 2023).

Person-Centred Experiential Therapists Who Delivered Therapy for the PRaCTICED Trial

Sixteen qualified IAPT therapists delivered PCET for the PRaCTICED trial. Four had received their training and qualification in the pilot phase of CfD training provided by the BACP in 2011. Two other therapists had received their training prior to the trial from the University of Nottingham, one of the two training centres which provided the evaluation of PCET treatment fidelity for the PRaCTICED trial. The remaining 10 therapists received their training and qualification in the service setting as a requirement for participation in the trial. This training was delivered by the team from York St. John University, the other centre which evaluated PCET for the trial (Barkham et al., 2021).

All therapists were accredited by a recognised professional body. Fourteen therapists were female and two were male. Therapists received 1.5 hours of routine in-service individual supervision, and three hours of in-service group supervision from a qualified PCET supervisor per month. For the purposes of the trial, therapists brought recording segments from sessions 2, 6 and 12 for each trial client for discussion and assessment in group supervision. Group supervisors rated these segments using the Session and Adherence Competence Scale, devised for the PRaCTICED trial (Barkham et al., 2021; see Appendix A).

Assessment of Treatment Integrity

Perepletchikova et al. (2007) provide the following widely accepted definition of treatment integrity in psychotherapy research:

Treatment integrity (also known as treatment fidelity) refers to the extent to which the intervention was implemented as intended. Treatment integrity encompasses three aspects: (a) therapist treatment adherence, the degree to which the therapist utilizes prescribed procedures and avoids proscribed procedures; (b) therapist competence, the level of the therapist's skill and judgment; (c) and treatment differentiation, whether treatments differ from each other along critical dimensions. (Perepletchikova et al., 2007, p.829)

In their recent review, Power et al. (2022) refer to treatment fidelity as adherence, competence, and integrity (ACI). Wampold and Owen (2021) have pointed out that in the past, studies of the efficacy of specific models omitted the therapist, assuming that all therapists were equally adherent and competent, and therefore only the model itself was being tested. More recently it has become standard practice in conducting trials of therapy efficacy to control for one possible therapist effect i.e., therapists' adherence to the model being tested. Therapist adherence and competence in the therapy models specified in the trial protocol are assessed and reported to ensure that results can be attributed to the model itself, rather than variability due to therapist effects (Perepletchikova et al., 2007; Saxon et al., 2017; Waltz et al. 1993; Webb et al., 2010).

In the case of a trial comparing different therapy modalities such as the PRaCTICED trial (Barkham et al., 2021), intervention competence rather than global competence is assessed (Barber et al., 2007). The most common method of assessing therapy adherence and competence is through the employment of at least one expert judge. Reliability is enhanced when multiple judges independent of the research team are employed (Waltz et al., 1993). Session recordings are rated by judges, or raters, on the basis of pre-defined criteria, such as a rating scale or therapy manual.

Centres and Raters Who Assessed PCET Treatment Fidelity for the PRaCTICED Trial

For the evaluation of treatment fidelity in both the PCET and the CBT arms of the PRaCTICED trial, every therapy session was digitally audio-recorded with the client's consent and encrypted. For the PCET arm, therapist competence was assessed by four expert raters, that is, two trainers from each of two university-based training centres. For the purposes of the research reported in this thesis, the training centres are labelled as Centre A and Centre B, and the raters are referred to as R1, R2, R3 and R4. All raters were female and had delivered training in person-centred counselling at university level for at least 15 years. Three raters had delivered PCET training and competence assessment since the first roll-out of the programme in 2012 and one shortly afterwards.

For the purpose of the PRaCTICED trial, a PCET manual was written to define the model as delivered by the PCE therapists working for the trial, and to contribute to the checks on integrity necessary for a RCT (Appendix A). Therapy manuals provide a definition of how theoretical concepts are operationalised, supporting the internal validity of a trial, including guidance for therapists in the delivery of the model being tested. In keeping with the person-centred foundation of the model, the guidance in the PRaCTICED trial manual was descriptive rather than prescriptive, allowing flexibility on the part of the therapist, and encouraging responsiveness to the client. The expert raters had access to the manual to aid rating, but it is not known if the raters referred to it. All raters were also given a pre-publication copy of the first edition of the PCET textbook (Sanders & Hill, 2014) to support a shared understanding of the model.

Raters used the PCEPS-10 to rate 15-minute segments from the middle of each of 65 session recordings, representing 65 clients and 14 therapists. (Two therapists joined the trial

in the late stage, and did not have segments rated.) Raters were blind to outcome to allow

an unbiased assessment of competence.

The instructions for rating were for raters to rate each 15-minute segment as they

normally would in assessing training segments (i.e., awarding a rating between 1 and 6 for

competence in each of the 10 PCEPS-10 items, resulting in a rating between 10 and 60

overall). In order to avoid bias for any single recording, raters were instructed to listen to

each 15-minute segment only once. Raters were also asked to note timings and examples of

practice under each PCEPS item heading on which their ratings were based.

Table 2.1 gives sample numbers and definitions for the terms used in this thesis in

reference to the competence rating of recording segments.

Table 2.1

Terms, definitions and sample numbers for the rating of recording segments in the PRaCTICED trial

Term	Definition	N
Rater	PCET expert who rated therapist competence for the PRaCTICED trial	4
Centre	University-based PCET training centre	2
Segment	15-minute segment between 20 and 35 minutes from audio-recording of a PCET session	65
Calibration segment	15-minute segment as above, rated by all four raters	5
Non-calibration segment	15-minute segment as above, rated by two raters	60
Therapist	Therapist employed by IAPT who delivered PCET for the PRaCTICED trial, and had at least one segment rated	14

Sampling of Recording Segments

A protocol was written for the sampling of recording segments (Barkham et al.,

2021), and is briefly described here. Sampling was conducted in two waves, so that

therapists who qualified in PCET or who joined the IAPT service later were represented in

the second wave of sampling. The first wave of sampling comprised 49 recordings, and the second wave 16, giving a total of 65.

Number of recordings per therapist. A protocol was designed to ensure that for each therapist the number of recordings segments sampled for rating reflected the number of clients seen by that therapist. One case was selected from the caseload of therapists who saw between two and five trial clients, rising to six cases for therapists who saw more than 30 trial clients. This was achieved by grouping all the clients seen by each therapist into blocks of five, and recordings for assessment randomly selected from each group in sequence, using a random number generator. For example, a therapist who saw fewer than five clients would have one block from which to sample one client. A therapist who saw 13 clients would have one recording randomly sampled from each of two groups of five clients and one group of three clients, totalling three recordings. The number of segments rated for each therapist ranged between 0 and 15, median = 8, mode = 1. Details are given in Table 2.1A, Appendix A.

Number of recordings per therapy duration. The range of therapy duration (i.e., number of sessions attended by a client) was accounted for by grouping duration into four bands, and ensuring that the number of recordings selected for each duration reflected its frequency in the trial. For example, since 36% of the PCET patients in the PRaCTICED trial attended between six and 10 sessions, 36% of the recordings selected for assessment were from session 6 to session 10. The sampling protocol ensured that no client had more than one recording selected. Details are available in Appendix A, Table 2.2A. As a client-led modality, PCET does not prescribe a set number of sessions, and episodes of therapy can range from two to 20 sessions according to the wishes and needs of the client.

Recordings were renamed to remain anonymous for allocation to the four raters. In the first wave of sampling, five segments were submitted for assessment to all four raters for calibration purposes, with the remaining non-calibration segments allocated to pairs of raters. The five calibration segments were interspersed with 22 non-calibration segments for each rater. This gave a total of 27 segments for each of the four raters. In the second wave of sampling, eight segments were allocated to each rater, meaning that in total each rater had five calibration and 30 non-calibration segments to assess. The order of segments in both waves of sampling was randomised, and divided between two raters (labelled R1 and R2 for this thesis). Half of each of these sets of segments were also allocated to the remaining two raters (R3 and R4) in reverse order. In this way raters were paired within and between centres. The allocation design is shown in the map in Figure 2.2.

Figure 2.1

Map of allocation of PCET recording segments for assessment of treatment integrity
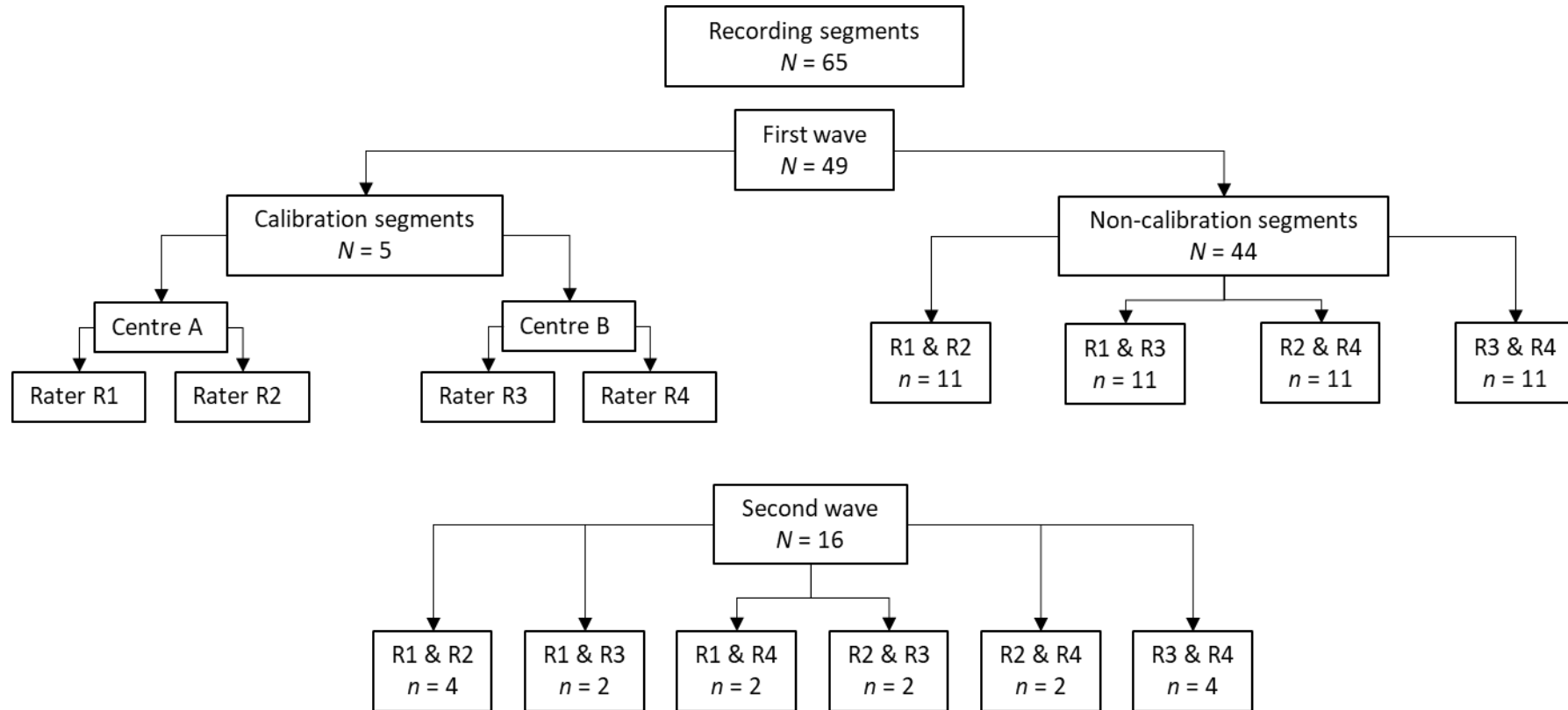
One 15-minute non-calibration segment allocated to R3 and R4 was inaudible and not rated, leaving 59 non-calibration segments. Ratings were unavailable from R3 for one further segment which was rated by R1, making a total of 117 non-calibration ratings. Two of the 16 therapists who delivered PCET for the trial had no recording segments rated, leaving data for 14 therapists. The number of segments and the number of ratings for centres, individual raters and pairs of raters is shown in Table 2.2.

Table 2.2

Numbers of segments and ratings from the PCET arm of the PRaCTICED trial

	N	Calibration segments (N)	Calibration ratings (N)	Non-calibration segments (N)	Non-calibration ratings (N)
Totals for centres	2	5	10		
Totals for individual raters	4	5	20	59	117*
R1 & R2				15	30
R1 & R3				12	24
R1 & R4				2	4
R2 & R3				2	4
R2 & R4				13	26
R3 & R4				14	28
Totals for pairs of raters	6	5	30	58	116*

* One segment was rated by only one rater, resulting in different totals

Therapy which is delivered competently and adherently (i.e., in accordance with the definition of the model) demonstrates the operationalisation of the theoretical mechanisms of the model. Analysis of the relationship between adherence and outcome provides evidence for the effectiveness of a model (Perepletchikova et al., 2007). Research into this relationship is needed to supplement the existing evidence for the PCET model. The

PRaCTICED trial dataset, which includes competence ratings for 64 recording segments of

PCET practice and a measure of depression at every therapy session, offers an opportunity

to investigate the relationship between PCE therapist competence and outcome

(i.e., change in the client's depression).

The Effectiveness of PCET

As described above, the PCET model was developed by integrating therapeutic

components whose efficacy had been tested in five RCTs (Sanders & Hill, 2014). Since its

inception, further evidence for the effectiveness of PCET has been provided by the

PRaCTICED trial, and by data collected routinely in NHS Talking Therapies services (practice-

based evidence, Pybis et al. 2017).

Practice-Based Evidence for the Effectiveness of PCET

Every NHS Talking Therapies client is requested to complete a minimum data set at

every therapy session, creating local and national datasets of outcome measures (NHS

Talking Therapies manual, 2023). The minimum data set includes the PHQ-9, which

measures the client's symptoms of depression in the previous two weeks. NHS Talking

Therapies defines recovery as moving from 'caseness' (scoring 10 or more on the PHQ-9 and

eight or more on the GAD-7; Spitzer et al., 2006), to below caseness. Reliable improvement

is defined as a reduction of six or more PHQ-9 points and four or more GAD-7 points

(Jacobson & Truax, 1991).

Counsellors in NHS Talking Therapies currently make up 9% of the workforce, and

21% of the high intensity workforce, though not all are PCET accredited. According to NHS

Talking Therapies data, accredited PCET practitioners delivered 5% of high intensity therapy

appointments (NHS Benchmarking Network, 2022) in the year 2021-22. In that year, 49,676

courses of PCET (labelled CfD) were delivered, with 47.7% of clients moving to recovery, and

55.5% achieving reliable improvement. These were the highest rates of therapy-based recovery and improvement in that year (NHS Digital, 2022).

NICE Guidance 2022

The most recent NICE guidance on the treatment of depression includes an acknowledgement of the PRaCTICED trial (without specifically naming it), stating that:

> "large-scale and pragmatic trials … were excluded from the network meta-analysis (because they involved patient populations that did not meet specific search criteria). However, the results of these studies were largely consistent with the evidence reviewed and supported the recommendations" (Section 1.6, NICE, 2022).

The guidance includes counselling as a first line intervention for more severe depression, recognising that it is cost effective, but with the caveat that there are several other therapies with more evidence of effectiveness. It states that counselling is not cost effective for less severe depression, but should be available to meet client choice.

<div align="center">

Reflexivity

</div>

Throughout the process of producing this thesis I needed to maintain awareness of my own thoughts and feelings around the subject. I have been enthusiastically immersed in the PCET model for 12 years, from completing the initial training in 2011. As a PCE therapist and supervisor, I am an "insider researcher" (Jamieson et al., 2023). More details about the context of this research and my position within that are given in Chapter 9. A personal statement detailing my involvement in PCET and the PRaCTICED trial is available in Appendix A. When discussing the views of trainers and stakeholders about the controversies around the model (Chapter 3), I needed to bracket my own opinions. When analysing the evidence for the experiential components of PCET (Chapter 4) I needed to keep an open mind about the effectiveness of these components. This was also the case for Chapter 5, looking at the experiential interventions offered by PCE therapists in the PRaCTICED trial, and Chapters 6

and 7, which looked at the effectiveness of the clusters of components for clients in the trial. For these chapters, as well as for Chapter 8, which investigated the agreement between raters using the PCEPS-10 to assess therapist competence, I needed to bracket my feelings about my own competence as one of the trial therapists.

Overview of the Thesis

This chapter has highlighted a number of issues around the PCET model. These include:

a) the effectiveness of the experiential components (experiential specificity, emotion regulation sensitivity, and emotion focus), which are defined in the PCEPS, and distinguish PCET from classical person-centred therapy;

b) the operationalisation of the experiential components by therapists;

c) the relationship between the competence of therapists in delivering the evidence-based components of the PCET model, and client outcomes;

d) the contribution of PCET training towards therapists delivering the evidence-based components of the model, including consistency between trainers and training centres.

The chapters of this thesis, comprising a systematic literature review and five studies, are designed to address these key issues. Each chapter is described below. Figure 2.3 presents a map of the thesis, showing how the five studies and systematic literature review relate to each other.

Figure 2.2

Map showing how studies and systematic literature review relate to each other
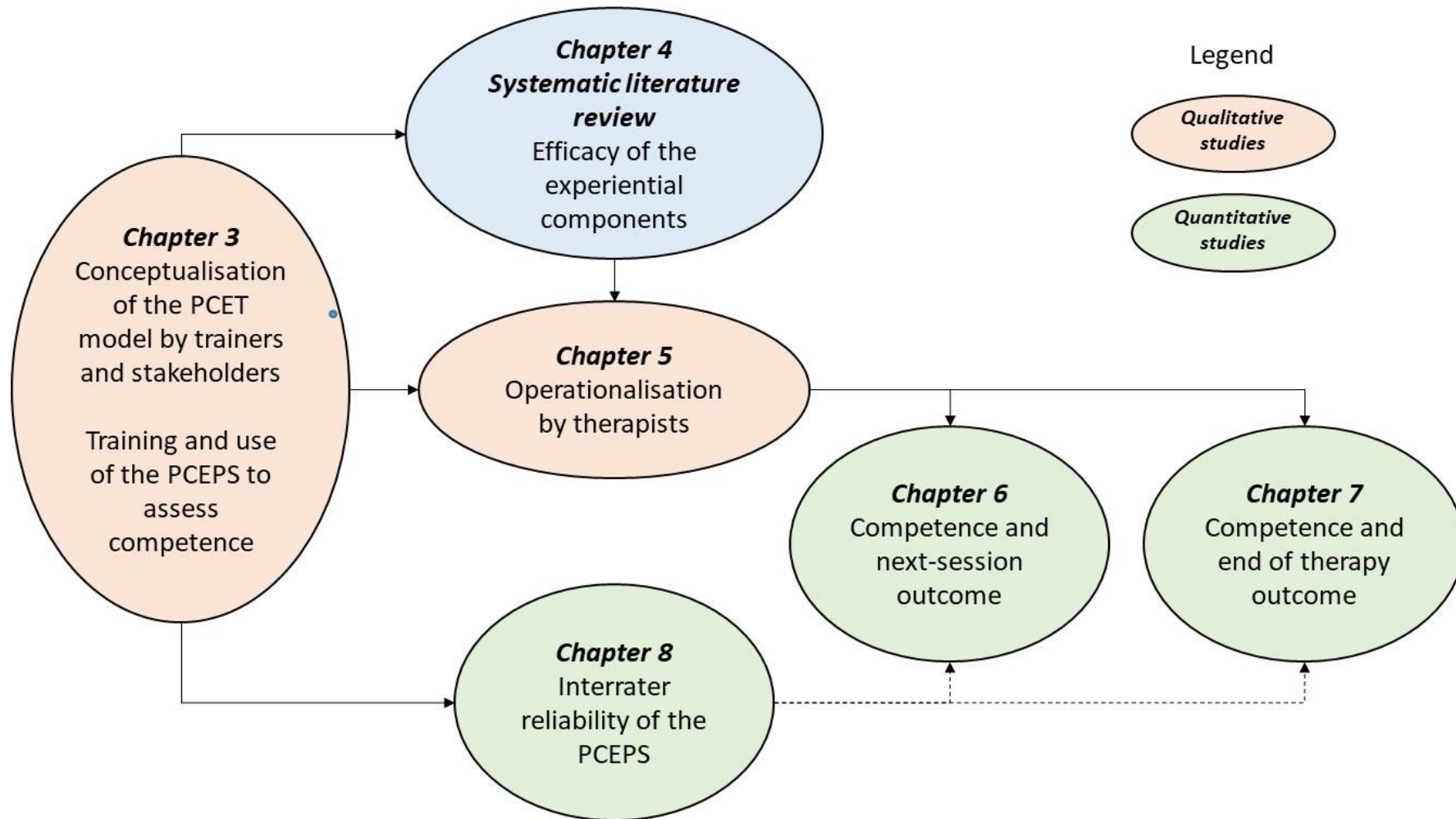
The following sections summarise the topics introduced above and the questions

arising from them. The sections offer a brief overview of how these questions are addressed

in the studies which comprise this thesis, and how the studies relate to each other.

Chapter 3: How Person-Centred Experiential Therapy (PCET) Trainers and Other

Stakeholders Perceive the PCET Model and Training

Chapter 3 addresses the following questions: How is the PCET model conceptualised

by the people who developed it, and the people who deliver the training? How are the new

experiential components of the model understood by these members of the PCET

community? How do they navigate controversies around the model? Chapter 3 comprises a

qualitative thematic analysis of interviews conducted with trainers and other stakeholders

in the PCET programme, focusing on participants' conceptualisation of the PCET model,

delivery of training and assessment. This chapter provides context and background for the

subsequent research.

Chapter 4: Systematic Literature Review. The Influence of Experiential Specificity, Emotion

Regulation Sensitivity, and Emotion Focus on the Effectiveness of Psychotherapy with

Adults Experiencing Depression. A Systematic Review of the Evidence

The systematic literature review presented in Chapter 4 also provides context for the

subsequent research, by investigating the efficacy of the three experiential components of

the PCET model as defined in the PCEPS-10: (a) experiential specificity, (b) emotion focus,

and (c) emotion regulation sensitivity. The review is presented in two stages. Stage 1

comprises a process of reciprocal translation which illustrates the transtheoretical

application of the three components. Stage 2 comprises three meta-analyses, which

synthesise the results of RCTs testing each of the three components. Evidence is presented

for the efficacy of the three components as standalone interventions, and also for emotion regulation and emotion focus as additional components in additive studies.

Chapter 5: How Do Person-Centred Experiential Therapists Use Experiential Specificity, Emotion Regulation Sensitivity, and Emotion Focus in Practice?

In the context of the findings of the systematic literature review for the efficacy of experiential specificity, emotion regulation, and emotion focus, Chapter 5 addresses the question of how these experiential components of PCET are operationalised by therapists in practice. Chapter 5 comprises a qualitative thematic analysis of PCET as delivered by therapists in the PRaCTICED trial. One full session recording was transcribed for each of 10 therapists, and the transcriptions analysed using the three experiential components as *a priori* themes. Under these headings, sub-themes were identified, with the level of greatest detail being individual therapist interventions. Exemplars were created to offer a typical example of each experiential intervention identified in the analysis.

Chapter 6: The Effect of PCE Therapist Competence on Next-Session Client Outcomes

The sample of PCET sessions analysed in Chapter 5 was selected by finding the session awarded the highest competence rating for the experiential components for each therapist. Chapter 6 investigates how the therapist's competence in the different components of PCET impacts on a client's depression at the next PCET session. The study presents a quantitative analysis of the relationship between therapist competence as assessed by the expert raters, and proximal outcome, i.e., change in the client's depression at the next PCET session. The study examines the effect of therapist competence overall, and for each of the three clusters of components.

Chapter 7: The Effect of PCE Therapist Competence on Client Outcomes at End of Therapy

The purpose of PCET, like all therapies, is to help clients to achieve the changes that they desire. In the context of NHS Talking Therapies the most relevant change is improvement in clients' depression at the end of therapy. Chapter 7 examines how the therapist's competence in the different components of PCET impact on the client's depression at the end of a course of PCET. The quantitative analysis in Chapter 7 is parallel to the analysis in Chapter 6, investigating the relationship between therapist competence and the ultimate outcome, i.e., change in the client's depression at the end of therapy. This relationship is examined for overall PCEPS-10 ratings, for each of the three clusters of components, and for the individual PCEPS items, in order to identify the PCET components which appear to have most influence in the process of therapy. Chapter 7 also makes the connection between the studies in Chapters 6 and 7 by analysing the effect of a change in the client's depression from one session to the next on the ultimate outcome of therapy.

Chapter 8: The Interrater Reliability of the PCEPS-10

Since the analyses in Chapters 6 and 7 are based on the average competence ratings of the expert raters in the PRaCTICED trial, using the PCEPS-10 to assess the competence of the trial therapists, it is important to review the interrater reliability of these ratings. Chapter 8 comprises analyses of the interrater reliability of the PCEPS-10 in the context of (a) an RCT, and (b) routine assessment of PCET trainees. The chapter addresses the issues of the raters' shared understanding of the PCET components as reflected in the level of interrater agreement, and what this might mean for the consistency of training in the model. These issues are especially significant given PCET's position as an evidence-based therapy model offered nationally in high-volume NHS Talking Therapies services.

Chapter 9: Discussion and Conclusions

The final chapter presents a synthesis of the key findings of the systematic literature review and five studies. Possibilities for enhancing the effectiveness of PCET raised by the research presented in the previous chapters are discussed, with recommendations for future research.

Chapter 3

How Person-Centred Experiential Therapy (PCET) Trainers and Other Stakeholders Perceive the PCET Model and Training

Introduction

This chapter, comprising the first study of this thesis, is intended to provide background and context for the thesis that follows. The study presents a qualitative thematic analysis of interviews with stakeholders involved in creating the PCET model, and the trainers who currently deliver PCET training. The purpose in conducting the interviews was to survey the experiences and opinions of the people who originally conceptualised the PCET model, and the people who continue to influence its evolution through their training programmes.

As outlined in the introduction to this thesis, there are aspects of the PCET model and its position in the NHS which are controversial, especially for people from the classical person-centred approach. Research was needed to determine whether the way in which stakeholders navigated these tensions influenced their understanding of the PCET model. One question was whether varying ways of conceptualising the balance between the nondirective person-centred elements of the model and the active experiential components led to participants positioning themselves at different places on the process-guiding spectrum.

Research was also needed to determine whether differences between the trainers in this regard influenced their delivery of the training. Another question arising from the controversies around the PCET project was how participants' values affected their use of

manuals during training, and of the PCEPS-10 in assessment. Inconsistencies between trainers and training centres on these issues may affect the form of PCET offered to clients across the country, potentially leading to variations in outcome beyond those explained by client, therapist, and service effects.

A further research question was whether differences in the participants' experiences of the practicalities of delivering the curriculum and assessment affected the consistency of PCET training around the regional centres. At the time of this study, the PCET implementation project had eight trainers in four regional university-based centres in England. All eight trainers participated in this study.

Previous Research

An evaluation of the first phase of PCET training was published in 2013 in the *Healthcare Counselling and Psychotherapy Journal*, aimed at practitioners (Pearce et al., 2013). It presented a study conducted by the people who developed the model and the training curriculum, and those who delivered the first three courses. The study consisted of a questionnaire emailed to the 60 trainees who attended the three courses, followed by telephone interviews with six trainees, two from each course. Thirty questionnaires were returned. The authors found that trainees felt the competence framework (Hill, 2010; Roth et al., 2009) and the adherence scale (PCEPS-10, Ellliott & Westwell, 2012) were helpful, being 'descriptive rather than prescriptive'. They hoped that completing the training would enhance their status and job security within IAPT. Sixty per cent of respondents said that the training had changed their practice, but not necessarily to adhere more to the PCET model. The authors noted that anxiety around submitting recordings for assessment was understandable, especially since a number of trainees struggled to meet adherence. Participants felt that the input on EFT was insufficient, and that supervisors were not

familiar enough with PCET. They also found that IAPT services often did not permit them to offer the full 20 sessions. Participants suggested that there was a need for research about the clients who would benefit most from PCET, and to provide evidence of the model's effectiveness.

A second paper investigating the experience of PCET trainees was published in 2018 (Drewitt et al., 2018). This paper used mixed methods, with a quantitative study analysing the results of an online survey, and a qualitative thematic analysis of semi-structured telephone interviews. The survey was emailed to all the 53 members of the BACP CfD practice research network, eliciting 18 responses for analysis. From these, six were selected to be interviewed, representing three practitioners who felt the CfD model fitted well with their philosophy, and three who felt restricted by it. The results echoed those of Pearce et al. (2013), that, in general, participants were positive about the model and the five-day training, but felt there was a lack of support and understanding from IAPT services during the period of assessed practice. As in the Pearce et al. study, participants said that their initial hope, that the training would enhance the status of counselling in their IAPT services, was not fulfilled. The analysis appeared to suggest that participants employed in non-IAPT services experienced greater respect and support, for example being permitted to offer the full recommended number of sessions to clients. Among the caveats to the conclusions noted by the authors they observed that, being members of the practice research network, the participants had already demonstrated interest in the PCET model.

Nye et al. (2019) were able to address this limitation, by investigating the experiences of therapists from one IAPT service who were required to undertake PCET training in-house, as opposed to choosing to do so. The authors interviewed ten therapists, of whom five had qualified in PCET, two were still in the period of submitting recordings for

assessment, two had withdrawn from the training, and one had failed to complete. Some themes identified were similar to those described by Pearce et al. (2013) and Drewitt et al. (2018), for example challenges with perceived directiveness in the model, mixed experiences of supervision, and counsellors feeling undervalued and vulnerable in their employing IAPT service in comparison with CBT. By asking participants about their previous theoretical orientation, and their status in terms of completion, the authors were able to investigate whether differences in orientation contributed to success in PCET training. They concluded that theoretical orientation and choice played less of a role in completion than intrapersonal characteristics such as flexibility and resilience.

The Current Study

This study complements previous research by capturing the stakeholders' and trainers' perspectives on the factors that facilitate trainees' competence in the model. It was also important to determine aspects of conformity and difference between training centres in their conceptualisation of the PCET model, delivery of training, and assessment practices. The research questions for this study therefore were:

1. How do trainers and stakeholders conceptualise the PCET model, and specifically the balance between nondirective person-centred therapist skills and experiential components intended to guide the client's emotional process?

2. How are therapy manuals, specifically the Person-Centred and Experiential Psychotherapy Scale (PCEPS-10) and competence framework, used in assessing trainees?

3. What are trainers' and stakeholders' perceptions of the difficulties faced by trainees as they progress through training and assessment?

Methods

Ethics

Ethical approval for this study was granted by the University of Sheffield ethics review panel on 29/4/2019, Application Reference Number 026096 (Appendix B).

Participants and Roles: Stakeholders and Trainers

This study includes the total population of trainers delivering PCET training nationally at the time, based in four universities, covering the whole of England. Two other participants were stakeholders employed by BACP in 2010/11, when IAPT called for training to be developed in various non-CBT modalities. One had been a member of the Expert Reference Group that developed the Humanistic Competence Framework for Skills for Health (Roth et al., 2009), and subsequently designed the Competence Framework for Counselling for Depression (Hill, 2010), as well as being co-author of the first edition of the PCET textbook (Sanders & Hill, 2014). Another is still involved in the accreditation of PCET courses. Along with these participants, two of the trainers interviewed were members of the team who developed the curriculum for the five-day training, and a programme for assessment and qualification (Hill, 2011; Pearce et al., 2012), and later trained the trainers. One participant had been a trainer in the past, and was still closely involved in the PCET project, including writing the second edition of the textbook (Murphy, 2019).

All the participants were themselves trained therapists, and the majority delivered person-centred training in university settings either currently, or in the past. Two had purely person-centred backgrounds, three from a broader humanistic background, two had training which included gestalt, one had an integrative training, one multiple trainings including person-centred, psychoanalytic and CBT. Another participant had previously been a clinical psychologist.

For the current study participants are identified by numbers from P1 to P8.

Methodology

In order to encompass both the objective realities of the context, and the subjective and constructed nature of participants' views, qualitative research has been chosen for this study, grounded in a pragmatic methodology (Feilzer, 2009; Morgan, 2007). For this purpose, the framework analysis method described by Ritchie and Spencer (2002) was employed. Framework analysis was developed as a method within applied policy research, to capture and map the experiences of people affected by the issue under investigation, seeking associations and explanations for experiences, attitudes and behaviour, and so contributing to the formulation of new theories and strategies which could benefit the same people in the future. An advantage for this study is that the systematic charting of themes across cases allows transparency, with each participant's contribution being visible within each theme, and within the context of their contribution as a whole. This transparency supports the descriptive and interpretive validity of the analysis, which is particularly important where a study may have implications for public policy (Elliot et al., 1999; Kiernan & Hill, 2018).

Framework analysis involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 1994). As described by Gale et al (2013, p.4), there is 'ongoing interplay' between data collection and analysis, and insights gained from one interview inevitably informed aspects of subsequent interviews. For this study, familiarisation began with conducting and transcribing each interview. Transcripts were imported to QSR International's NVivo 12 to aid analysis.

The identification of a thematic framework began with the *a priori* themes outlined in the interview schedule (Appendix B). Themes were also identified inductively, beginning at the familiarisation stage, and continuing with a 'constant comparative' process of reading each transcript and noting where participants' ideas seemed to group together, revealing similarities and differences (Gale et al., 2013). Potential themes were clarified and defined by combing through all the transcripts multiple times. This resulted in an 'index' of themes, with subject headings and sub-categories (Ritchie & Spencer, 1994). The index was then applied systematically to each transcript through the QSR International's NVivo 12 coding facility.

The charting stage was achieved by creating framework matrices, enabling comparisons to be made between participants' contributions for each of the identified themes, and facilitating a process of defining concepts as described by the participants, mapping the range of participants' views, and developing new ideas based on these insights.

Interviews

A schedule was used to guide interviews, based on the following topics:

1. Context

    1.1   Participant's original orientation

    1.2   Workload

    1.3   IAPT

2. Model

    2.1   Integration of person-centred therapy and EFT

3. Training

    3.1   Adaptation of the curriculum

    3.2   Use of PCEPS

3.3 Barriers to learning

Follow-up probes were suggested to aid in the further exploration of themes (Appendix B). A pilot interview was conducted initially with a PCET colleague of the researcher, and handwritten notes taken by the researcher to aid further development of the interview schedule.

Written consent was obtained from all participants to conduct, record and transcribe interviews. Interviews ranged between 50 minutes and 1 hour and 38 minutes long. Trainers were interviewed face to face at their place of work, between May and July 2019, by the researcher. Participants were interviewed individually, apart from those from one training centre, who were interviewed together. Two other stakeholders were also interviewed by the researcher, one by telephone in October 2018, and one by video conference in March 2020. Interview recordings were transcribed by the researcher and pseudonymised, and an encrypted version of their own transcribed interview was emailed to each participant, giving them the opportunity to amend or redact any part. Transcripts were then uploaded to QSR International's NVivo 12 for analysis.

Trustworthiness

For this study, the trustworthiness of the interview transcripts was established by sending each transcript back to the interviewee via encrypted email, giving participants the opportunity to amend or redact any part of the transcript, and thus providing a form of member checking for the validity of the transcripts (Brinkmann & Kvale, 2015). A further validation stage was included, called Synthesised Member Checking (Birt et al., 2016), where the themes that had been developed were submitted to participants to confirm that they had resonance, and to invite additional comments.

Any problem of generalisability is avoided in this paper, since the whole target population of trainers is represented. Additionally, the study conforms to the CASP Checklist for Qualitative Research (2018a), and the recommendations of Elliott et al. (1999) for the publishability of qualitative research.

Reflexivity

Reflexivity can be considered as one of the ways of establishing the trustworthiness of qualitative research. As a practitioner-researcher, with personal involvement as a PCET counsellor and supervisor, it was important for me to maintain a reflexive stance through the interview and analysis process. In order to maintain an awareness of and preserve the distinction between the views of participants and my own, it was necessary to 'bracket' my views (Kvale, 2015). For this purpose, before embarking on interviews, I wrote my own responses to the interview topics, and kept these responses available alongside the responses of the participants (Bolam et al., 2003). I also kept a journal of reflections and observations during the period of conducting the interviews.

Results

Analysis of the interview transcripts resulted in four over-arching themes. These themes corresponded broadly to the *a priori* themes of (a) participants' understanding of PCET theory; (b) PCET practice; (c) delivery of the training and assessment; and (d) perceived difficulties, both for trainees throughout the training process, and also for the participants themselves and the wider counselling community. Within each over-arching theme, sub-themes emerged through the process of coding the interview transcripts. Every theme was identified from the interviews of at least four participants. The themes and sub-themes are listed below.

Table 3.1

Themes and sub-themes

Theme	Theoretical coherence	The model in practice	Training	Difficulties
Sub-themes	The PCET model: 'contemporary' or 'no different'	Client-led	Courses	Values
	Coherent, effective and evidence-based	Moment-by-moment collaboration	Assessment	Original training
	Manualised but flexible	Use of self		Drift
	New language	Process-guiding spectrum		
		Experiential components		

Theme: Theoretical Coherence

It was clear from the interviews that all the participants regarded the PCET model as theoretically coherent, which they felt was crucial to its validity and effectiveness. They believed that an important aspect of the value of the training was the ability to offer trainees a grounding in and a language for the theory of PCET. There were differences, however, in whether participants viewed the model as new in itself, or a new articulation of an existing model (i.e., person-centred therapy). Analyses of the sub-themes are given below.

Sub-Theme: The PCET Model: 'Contemporary' or 'No Different'

Participants' views varied on whether PCET is a new model of therapy, a contemporary development of the person-centred approach, or no different from the person-centred approach. Some participants held the view that PCET is no different from

person-centred therapy. For one participant, their understanding of PCET as "attentiveness to the emotion, listening to the emotion, engaging with the feelings" (P5) was identical to person-centred therapy. Another participant cited Carl Rogers, seen as the founder of the person-centred tradition, saying that no intervention could be ruled out from person-centred therapy, as long as it came from the client rather than the therapist, and enhanced the therapist's empathy with the client's experience (P7).

On the other hand, one stakeholder, who was involved at the inception of the model, reflected that EFT and person-centred therapy are both humanistic modalities, and EFT shares fundamental principles with the person-centred approach. They felt that PCET, however, as an integration of the two modalities based on empirical evidence, was "completely new in the counselling and psychotherapy field" (P1). Another participant also emphasised that they saw PCET as a humanistic model, rather than more narrowly person-centred, and stressed this in the training (P4). There was a view that PCET was not a clumsy combination of person-centred with EFT "bolted on", but was an evolution of person-centred therapy (P4, P6).

None of the participants referred to PCET in relation to working with cognitive-affective problems. One participant stated that in PCET the client should be "encouraged and supported to have an emotional exploration rather than a cognitive" (P5). In reference to the assessment of recordings of trainees' practice, another participant said "if it's too directive, or cognitive, that's where people fall down" (P4).

Sub-Theme: Coherent, Effective and Evidence-Based

Several participants commented that the model was effective in their own and trainees' work with individual clients, and that trainees felt very encouraged when clients

seemed to engage with the PCET process, and make progress towards their goals as a result (P5, P8).

Two participants alluded to the ability to explain the rationale for a model to a client as one of the common factors of effectiveness (P6, P9). They believed that having a sound understanding and awareness of the purpose of the therapy as a whole, as well as individual interventions, gave therapists themselves and their clients more confidence in the work.

Participants appreciated that the model was derived from empirical evidence of effectiveness, and that this evidence could be helpful for trainees communicating with non-counselling colleagues in their IAPT services. At least one training centre therefore provided references that trainees could share in their workplace (P9).

The expectation was also expressed that PCET could contribute to further evidence of effectiveness in the future. There was recognition that the generic title of 'counselling' could include very diverse or eclectic practice, making it difficult to identify the elements contributing to its effectiveness (P8). As one participant put it, research is difficult unless "we know that people are doing what we think they're doing" (P6), and having a clearly defined and consistently delivered model of therapy such as PCET could potentially provide the necessary transparency.

At the same time, it was recognised that there is a lack of research, with the PCET model being developed on the basis of evidence from only five randomised controlled trials, three for EFT, and two for person-centred therapy (Sanders & Hill, 2014) (P1). One participant also pointed out that not all of the evidence-based components from EFT were incorporated into the PCET model, saying "that was a bit of a fudge, really, wasn't it?" (P7).

Sub-Theme: Manualised but Flexible

The participants recognised that for many person-centred therapists, the idea of a model of therapy being manualised was anathema (P2). This was the case for at least one of the trainers themselves, who said that when the model was described as manualised, it was "being vilified" (P5).

Others accepted that the materials were descriptive, rather than being prescriptive (P3, P4), and that having "pre-written articulated competencies" was an advantage (P6).

The participants were clear that manualisation was not the same as standardisation, and that flexibility is a defining feature of the model, retaining the person-centred respect for the uniqueness of each client. Practice could appear very different, according to the personality of the practitioner and the needs of the client, and yet still be adherent to the competence framework and the PCEPS (P4, P6).

Sub-Theme: New Language

For some participants, the model enabled them clearly to articulate humanistic principles in a way that they felt they and their trainees had been unable to do before (P3). For some participants, this was seen as a failure of some person-centred therapy training courses (P2, P9). One participant described the PCET model as supplying "a language and grammar to existing person-centred practice, I think, certainly contemporary practice." (P9)

Many of the participants remarked on the reciprocal relationship between having a sound understanding of the model, and having the language to describe it. They also observed that the course gave the trainees confidence to describe the theory and practice of the model to colleagues of different modalities.

Theme: The Model in Practice

A synthesis of the themes emerging within the over-arching theme of the model in practice provides a depiction of PCET as understood by the participants. There were some variations of opinion, particularly around the concept of process-guiding, but consensus that the model is client-led. Several of the trainers emphasised the moment-by-moment collaboration between client and therapist, and the importance of the therapist's use of self. Analyses of the sub-themes are given below.

Sub-Theme: Client-Led

There are different aspects to the description of PCET as 'client-led'. The first derives from the person-centred principle that the client is the expert on their own experience, that the client knows what is hurting them, and what needs to be explored. One participant referred to the person-centred conception of the person, from which flowed the belief in "trusting the client's direction. Not believing that it's worthwhile following my direction, or maintaining my direction" (P6). Similarly, participants emphasised that this model was not based on the expertise or insight of the therapist (P3, P5).

Another aspect of the theme of being client-led is how the principle is applied in practice. The term used in the PCEPS is 'tracking', or, in person-centred language, how closely the therapist remains within the client's frame of reference. Tracking was seen as one expression of the person-centred principle of empathy (P5).

Sub-Theme: Moment-by-Moment Collaboration

Related to the principle of the model being client-led, and the importance of tracking, is the view of the therapy being moment by moment work within each session, rather than conforming to a protocol or an agenda. While client and therapist might agree on a focus for the work as a whole, or for each session, the focus can change according to

what arises for the client. One participant described it as the therapist constantly asking themselves "what [is the client] experiencing at this exact moment all the time?" (P6).

Every intervention offered by the therapist is tentative, proceeding with the consent of the client (P5, P9). One participant described this as a series of "mini-contracts" (P10).

Sub-Theme: Use of Self

As with the principle of therapy being client-led, therapist congruence, or self-awareness and genuineness within the therapeutic relationship, is a tenet of the person-centred approach. Some of the participants saw the therapist's use of self as vital to the therapeutic relationship, and the therapist's awareness of their own emotional process as an important element of their empathic understanding of the client. Lack of self-awareness was seen as a potential block to fully engaging with the client's emotional experience. (P5, P8). One participant regretted the absence of an explicit measure of therapist congruence from the PCEPS (P10).

Sub-Theme: Process-Guiding Spectrum

The idea of a process-guiding spectrum is a way of capturing the range of possible therapist directiveness, from a classical nondirective person-centred therapist, to an EFT therapist introducing appropriate 'tasks' when particular markers are identified in the client's emotional process. The participants appeared to identify with a variety of possible positions on such a spectrum, for example "We do describe it as directive, but directing the process" (P4), "I think we try to use 'guiding', 'process-guiding' (P9) and "process identification … if you're working closely enough … it's part of the client's direction" (P6).

Although the participants expressed their views in different language, there seemed to be consensus that, in order to be adherent, the therapist needed to be neither too passive nor too directive. Being passive might mean tracking only the content of the client's

narrative, and neglecting the emotional process (P8, P9). Being too directive might mean

using an intervention too "enthusiastically" (P4), even when the client is not engaging with

it, or pursuing the therapist's direction when it seems that the client's direction is different.

One participant saw this as some therapists needing to "do something", possibly to reach a

target set by the service, rather than the person-centred principle of simply being with the

client (P8). One participant used the metaphor not of a spectrum, but of a dance: "a dance

between being directive and nondirective. And if all you do is follow the client, you can be

ineffective, but if all you do is lead them you disempower them." (P4)

Some of the participants suggested that the degree of process-guiding should

depend on the client's existing depth of experience. One trainer referred to the

Experiencing Scale (EXP, Klein et al., 1986), saying that where clients already had a sufficient

depth of experience, process-guiding would not be necessary (P10).

Sub-Theme: Experiential Components

The participants talked about emotion focus as the central endeavour of PCET,

rather than any specific intervention. For example, one participant characterised the model

as "work[ing] closely with emotional responsiveness. … attentiveness to the emotion,

listening to the emotion, engaging with the feelings. … encouraging the client to go deeper

into their process, and that it's being done with consent" (P5). The idea of consent was also

raised by another participant, reflecting the emphasis of most of the participants on

nondirectiveness.

Emotion regulation sensitivity was also referred to in ways that suggested

nondirectiveness. One participant, for example, described emotion regulation sensitivity as:

"The flatness or the overwhelmedness. That you're, you're alert to that, and able to stay

with that. … I think, potentially, that regulation element is the congruence" (P5).

Experiential specificity was mentioned by participants in terms of differentiating emotion (P4, P10). One participant stated

> the [PCEPS-10 item] that I think is the least clear perhaps is the third item, Experiential Specificity. … I mean, obviously "abstractions and generalities" (inaudible) something specific to bring them down into their feelings, rather than talking about it, in the moment, rather than out there. But that's not what it says, really. It's this "idiosyncratic" bit, really which is a specific EFT piece, that is one of those auxiliary bits, I think. … that's less often, probably either taught, or certainly present in somebody's work than any of the others. (P9)

Although some participants alluded to interventions aimed at clients' unhelpful emotional processes, such as working with a client's conflict split, these were not seen as distinct 'techniques'. In fact, the description of interventions as 'auxiliary techniques', as proposed in the first edition of the textbook (Sanders & Hill, 2014) was seen as unhelpful. One participant cited person-centred theorists, including Carl Rogers, who said that nothing could be ruled out from person-centred therapy, and that therefore referring to 'auxiliary techniques' creates an "unnecessary split" between PCET and person-centred therapy (P7). Some participants commented that a five-day course is too short to introduce training in new and unfamiliar interventions (P2, P5).

Theme: Training

Similarities and differences emerged from the interviews within the themes of delivering the five-day training courses, and the process of assessing recordings leading to qualification.

Sub-Theme: Courses

Some practical differences between the courses were identified. At one training centre, trainees were referred to as 'delegates', while at others they were called 'students' or 'trainees'. Trainers delivered the curriculum according to their own understanding of the

model, so, for example, one trainer said that, in order to be consistent with the person-centred approach, the course was 'facilitated' rather than delivering taught modules (P5). In contrast, a trainer from another centre said that they did follow the curriculum as it had been set (P10). It was acknowledged that some elements of the original curriculum had become "redundant" (P2), giving trainers some space within the five-day course that each centre could use differently.

For one centre, workload was a significant problem, because the university expected the trainers to fit PCET training into their existing timetable, and did not provide any extra staff support. This limited the time that they could devote to providing extra support to trainees (P3). Another centre, on the other hand, had been able to create a training team, including supervisors and assessors. A trainer from this centre expressed some concern that there might be "a boundary issue about training somebody, and then either supervising them, and then assessing the things that come in at the end", which could be avoided by having an expanded team (P9).

Several participants commented that five days seemed insufficient to give trainees a thorough grounding in the model (P5, P10), even without the introduction of specific new skills. The necessity to design a model for which the training could be delivered as a five-day 'top up' meant that new elements such as those derived from EFT which would have been unfamiliar to most person-centred therapists had to be omitted (P7).

One of the centres had sufficient resources to incorporate two extra days of training some weeks after the initial five days, to provide "some theoretical shoring up" (P10). This centre had also introduced a system of providing audio-feedback on trainees' recordings, to be more "experience-near".

All the training centres had introduced deadlines for completion, ranging from one year (P5, P10) to two years (P8, P9), with the option of applying for an extension, although this change was too recent to gauge any effects. All the centres experienced trainees dropping out, but the rate varied from 4/5% (P10) to 40% (P5).

Sub-Theme: Assessment

One participant described the assessment of trainees' recordings as "a very subjective process, that is supposed to be objective." (P4)

The centres were BACP-accredited, and all the training centres double-marked recordings, but the participants acknowledged that the criteria for rating recordings might vary among centres. This was seen most clearly around the question of whether it would be possible for a trainee to get full marks (i.e., a score of 6 on all of the ten PCEPS items). Some trainers happily awarded full marks, while others felt that awarding full marks on any course was questionable. Trainers from one centre expressed the view that achieving full marks in PCET was actually impossible, because using some of the process-guiding elements would require "pulling something in from outside [the client's] frame of reference", and therefore sacrificing the close tracking (P3).

Some difference also emerged between centres in the method of selecting 20 minutes from a recording for assessment. Originally, trainees were asked to identify a particular 20-minute segment to represent their work, but the trainers at one centre observed that there was then a risk that trainees would not be adherent in the rest of the session. For this reason, at this centre, the trainers assessed two 10-minute segments at random from each recording.

Several trainers acknowledged the difficulty of assessing certain PCEPS items, without having any way to know how the client experienced the therapy. Interestingly, one

trainer cited item 9, Core Meaning, as an example where the therapist's accuracy couldn't be heard on a recording, but only judged by asking the client (P3), while another trainer believed item 9 could be heard on a recording, as the client's "surprise of 'my self-process'" (P10). This trainer, on the other hand, perceived that gauging the accuracy of item 10, Emotion Regulation Sensitivity, was "much more subjective" (P10).

The participants did not feel that such variations among the centres presented a problem, but instead reflected the flexibility of the model. One participant demurred from the idea of moderation between the training centres being necessary, saying that "there's risks in trying to define something too rigidly" (P7).

It was recognised that trainees may struggle with having their work assessed, sometimes because there is some resentment at having to undergo further training when they are already qualified, or because, despite being qualified in person-centred therapy, there is a lack of confidence in their work, or difficulties with practising the model. This could cause tensions for the trainers; for example, one trainer found that in supervision, trainees would strenuously avoid listening to a recording to get feedback (P5). Another trainer stated that "we become the bad guys" (P3).

Theme: Difficulties

Various difficulties around the model and the training were identified by the participants, stemming from the organisational contexts that they and the trainees had to operate within, as well as from aspects of trainees' previous training, and personal and community values. These issues, as well as some specific difficulties, could present barriers to trainees completing the qualification, or contribute to drop-out from the training.

Sub-Theme: Values

The person-centred approach has its own well-defined ontology, values and

principles, and, as noted above, for many person-centred therapists these clash with the

medical model of IAPT and the NHS. One of the participants recognised that this caused

resistance from some members of the person-centred community from the beginning of the

PCET project (P1).

The trainers from one centre particularly struggled with the compromises needed to

work in a person-centred way in a health service:

> I'm not even sure that I, you know, I think about person-centred
> therapy as a form of health practice. You know, I think it's unhelpfully
> located within a health discourse. Because in our systems, health and
> mental health really are aligned much more with mental illness,
> pathology, dysfunction, diagnosis. And that us as an approach, we're
> based in a different paradigm, which is about growth, and human
> development and human potential. (P7)

For another trainer from this centre, the idea of PCET as offering a non-medical

alternative within the NHS was especially important, and their involvement in the project

was an expression of their personal values (P5). Similarly, other participants celebrated PCET

as a recognition of the person-centred approach within the Health Service (P2, P9).

Specific compromises required for working in IAPT identified by the participants

included outcome measures which do not reflect the goals of counselling (P6, P8), and the

title 'Counselling for Depression'. 'Depression' is a diagnostic label, and in IAPT a particular

therapeutic modality is prescribed on the basis of a diagnosis, whereas the person-centred

approach values the uniqueness of each client, and their individual experience, and

therefore rejects the idea of generalisable diagnoses (P7).

One participant welcomed the new name for the model for this reason, that the

term PCE-CfD has less association with the concept of diagnosis, and because it reflected a

validation of the modality (P8). This echoed the view of another participant, who felt frustrated by the reputation of the person-centred approach as "anti-scientific", and hoped that PCET would receive more recognition as a specific modality, therefore offering more opportunities for research (P6).

Sub-Theme: Original Training

Participants commented that person-centred therapy can be seen in the therapy world as "a little bit flaky" (P2), and "not very effective" (P3). For the participants, this meant that many trainees were disadvantaged by having no "clear, theoretical underpinning" (P2). Integrative trainings, especially where modules included approaches from different ontological traditions, were therefore considered problematic by some trainers. One explained that theories, such as behavioural, based on the concept of conditioning, psychodynamic, based on the Freudian theory of human drives, and person-centred, based on the actualising tendency, are "different philosophical premises that are incompatible" (P7).

In contrast, other participants observed that trainees who had received a thorough grounding in one modality, such as psychodynamic, even though not person-centred, often engaged better with the training, and were able to translate concepts from PCET into concepts that they recognised from their original training (P4, P6).

Participants were critical of some training courses, particularly those which were "idiosyncratic", or of low quality (P1, P6). As one participant put it: "I think it was viewed in the early days as a simple thing of people returning to practice. ... It ain't that simple." (P3)

Sub-Theme: Drift

Compounding the problem of inadequate original training, as the participants saw it, was therapists' tendency to drift from adherence to their original modality (P2, P3, P8). It

seemed that therapists would accumulate non-humanistic interventions or 'tools' through continuing professional development (CPD; P6), and possibly had lost, or had never had, trust in the person-centred approach on its own (P4). It was also seen as "a natural movement towards eclecticism that some people have" (P1), or as "the IAPT effect" (P3). At the same time, both in the interviews and with trainees, the trainers were careful to acknowledge that, regardless of whether they were adherent to the person-centred model or not, most trainees were doing their best for their clients, and achieving good outcomes (P7, P8).

Discussion

The findings of this study provide valuable context for the research described later in this thesis. In many ways the findings reinforce those of previous studies (e.g., Pearce et al., 2013; Nye et al., 2019; Proctor & Hayes, 2017), for example about trainees' theoretical background prior to embarking on PCET training. This study also supplements previous studies, which focused on the experiences of PCET trainees, by seeking the perspective of the trainers and originators of the model. The analysis conducted for this study revealed differences between the learning environments and working practices of the four training centres, which could affect the experience and potentially the outcome of training for trainees. It also identified commonalities and differences in the respondents' values, including attitudes to counselling in the NHS and the manualisation of therapy. Of most interest for this thesis were differences in the respondents' conceptualisation of the PCET model, and in particular its active, process-guiding components.

Conceptualisation of the PCET Model

Participants' Views on PCET Theory

The participants expressed a range of ways of conceptualising PCET, as no different from classical person-centred therapy, as an evolution of person-centred therapy within the humanistic tradition, or as something "completely new" thanks to its basis in empirical evidence. These views corresponded to participants' views of the classical person-centred therapist as more or less active, and whether PCET involved introducing new and specific interventions to the person-centred relationship. All the participants regarded the model as coherent, and particularly welcomed a new clarity in the language available to describe the model offered by emotion theory. They recognised the reciprocal relationship between understanding the model and having the language to articulate it, which improved both their own confidence and that of trainees, and may ultimately contribute to improved outcomes for clients (Chatoor & Kurpnick, 2001).

Common themes in the participants' conceptualisation of PCET were principles that are fundamental to the person-centred tradition, especially empathy. Participants also stressed that the model is client-led and collaborative, with the client and not the therapist being the expert in the client's experience, that the therapist strives to remain within the client's frame of reference, at the same time maintaining self-awareness or congruence. The question of expertise may suggest another tension for the PCET model, since the possibility of incorporating specific interventions, as with EFT, relies on the therapist having the expertise to introduce an appropriate intervention at the appropriate time for the client.

Two themes which appear consistently in this analysis, that a competent person-centred experiential therapist is (a) nondirective and is (b) not the expert, are captured in two of the PCEPS-10 items, namely Item 5, Content Directiveness, and Item 7, Dominant or

Overpowering Presence (Freire et al., 2014). Being directive or dominant are behaviours that are viewed as not person-centred, and are therefore proscribed in PCET (Waltz et al., 1993). The participants' description of the model suggests that, for them, coherence is defined as much by the proscribed behaviours as by specific prescribed interventions.

In contrast to the papers which provided the evidence-base for PCET, in which process-experiential therapy was described as offering interventions to address 'cognitive-affective problems' (Greenberg & Watson, 1998), the participants in the current study stressed that PCET is about the client's emotions, and not their cognitions.

Participants' Views on the PCET Model in Practice

There appeared to be agreement that, while the model may be very flexible, and the therapist's freedom to be responsive to the client in each moment was seen as fundamental to the model (Norcross, 2002), most therapists' practice would look and sound similar. Essentially, practice was seen as being based on the Rogerian core conditions, attending closely to the client's emotional process, and tentatively offering interventions to help the client identify and express unclear feelings.

The coherence of the model, and the fact that the training is based on a competence framework (Hill, 2010), with specific criteria for assessing adherence/competence (PCEPS, Elliott & Westwell, 2012), were seen as offering the expectation that training, and consequently therapists' practice, would be consistent. Some respondents also expressed a hope that this consistency would offer new opportunities for research. While the participants valued the new possibility of consistency, they also valued the flexibility of PCET, and expressed relief that manualisation did not lead to standardised practice.

Process-Guiding Spectrum

It is difficult to interpret from the participants' responses whether they would position themselves at different points on a process-guiding spectrum, or whether the apparent differences captured in the analysis actually arise from differences in their conception of therapist activeness. This may relate to the debate within the person-centred community around the difference between 'being' and 'doing', where, for some classical person-centred adherents, 'being' is itself active, and 'doing' (i.e., offering specific interventions) violates the principle of nondirectiveness (Elliott & Freire, 2007). Similarly, participants may have differed in their attitudes to the debate within the person-centred community around whether nondirectiveness is 'principled', and is therefore not open to challenge, or whether it is 'instrumental', i.e., whether it is valued in person-centred therapy for being effective in facilitating change for the client (Grant, 1990). Given the context of PCET as a model founded on empirical evidence of effectiveness to be delivered within the medical model of NHS Talking Therapies, it seems clear that nondirectiveness in PCET must be instrumental, meaning that participants would position themselves on a process-guiding spectrum according to the amount of process-guiding they believed to be most effective.

Experiential Components

When the current analysis of the participants' conceptualisation of the PCET model is compared with the studies which provide its evidence base, it seems to closely match the description of client-centred therapy offered by Greenberg and Watson (1998), rather than process-experiential therapy, which included the addition of specific process-guiding interventions. For example, participants' interpretation of emotion regulation sensitivity was framed as a nondirective 'staying with' the client's expressed emotions, rather than "actively work[ing] to help the client adjust and maintain their level of emotional arousal for

productive self-exploration" (PCEPS Item 10; Elliott & Westwell, 2012). The participants encouraged trainees to be active in facilitating clients' experiential specificity in terms of exploring emotions, but not in terms of the therapist encouraging concrete and episodic memories (Elliott, 2014).

Counselling in the NHS

In the context of this study, counselling in the NHS refers specifically to PCET delivered in NHS Talking Therapies services. Many of the respondents' observations echoed those from previous research about trainees' challenges in their employing services, including expectations about qualifying in multiple therapeutic modalities, lack of support from managers to complete the training, lack of understanding of person-centred values, and lack of equality in pay and conditions with other modalities (Pearce et al., 2013; Proctor & Hayes, 2017).

At the same time, PCET was seen as the means to keep a foothold in the NHS for the person-centred approach, offering clients the choice of a non-medical therapy, free at the point of delivery. The fact that the model is the result of a process of translating research into practice, and thus evidence-based, was seen as giving it more credibility than person-centred therapy enjoyed, especially in NHS Talking Therapies, where adherence to the NICE guidance is emphasised (NICE, 2009). As previously mentioned, the respondents also welcomed the clarity of the language offered by the PCET model, which helped therapists to articulate the principles of the model to colleagues and clients, again adding to its credibility.

Learning Environments and Working Practices

It appeared that differences in the resources available to trainers in the four training centres meant that some trainees received more input and support than others. For some,

extra training days beyond the five-day 'top-up' were offered. Presumably in those centres with an expanded team of supervisors and assessors, trainees would receive marking and feedback for assessment recordings more quickly than in less well-resourced centres.

One clear difference was identified in assessment, where it was reported that trainers from at least one centre were prepared to award a full 60 marks on the PCEPS-10, where others would not. Indications about respondents' conceptualisation of the model, and what constitutes competence, have been discussed above, though what these might mean for the assessment of trainees' practice cannot be specified from the current analysis. However, this is an important question, and warrants further research, as proposed for this thesis.

Strengths and Limitations

The strength of this study is that at the time the interviews were conducted, the respondents represented the whole population of PCET trainers in England. Interviews with other stakeholders, including two people who developed the model on the basis of evidence for effectiveness, and who campaigned for its roll-out in NHS Talking Therapies, provided further insight and context for the current research.

It is possible that in the time since the interviews were conducted, personnel at the four training centres have changed, so that there may now be perceptions and practices that are not represented here. The views and experiences of the study participants may also have evolved since the interviews were conducted, for example if they have since undertaken EFT training.

Conclusions

The analysis presented in this study suggests that overall, the stakeholders and trainers represented here shared a conceptualisation of the PCET model as being firmly rooted in a therapeutic relationship based on the Rogerian core conditions, with the therapist actively facilitating the client's exploration of their emotional experiences.

At the same time, the analysis also suggests various inconsistencies. The original trials on which PCET is based (e.g., Greenberg & Watson, 1998) described the therapy as having a cognitive-affective focus, where cognitions and emotions have reciprocal influence. Some of the trainers interviewed for this study, however, appeared to emphasise only the clients' emotional experience, seeing a focus on cognition as nonadherent.

The person-centred principles of nondirectiveness, and the therapist not being the expert, frame many of the participants' descriptions of PCET components. As a consequence, some of these components (such as experiential specificity and emotion regulation sensitivity) may be interpreted differently in PECT training from how they are conceptualised in the source material, and framed in the PCEPS. Specific interventions, such as working with a client's conflict split, were not discouraged, but it was felt that either they would risk interrupting the client's own direction, or there was not time in the five days to introduce such interventions adequately.

If PCET training is to fulfil the original hope of creating a link between theory and effective practice, the training must adhere to a conceptualisation of the model that incorporates its effective components. Otherwise, as one of the participants in the current study observed, it would be "a bit of a fudge".

The interviews represented here, and the thematic analysis of the interviews, set the scene for the following research. The systematic literature review presented in the next

chapter examines the evidence for the effectiveness of the three experiential components

of PCET as characterised in the PCEPS: experiential specificity, emotion regulation sensitivity

and emotion focus.

Chapter 4

Experiential Specificity, Emotion Regulation Sensitivity, and Emotion Focus:

Systematic Review and Meta-Analyses

Introduction

Evidence for the effectiveness of PCET has been provided by an analysis of practice-based data published by IAPT (NHS Digital, 2022; Pybis et al., 2017). The efficacy of the model has also been investigated in the PRaCTICED trial (Barkham et al., 2021). This RCT found that PCET is comparable to cognitive behavioural therapy (CBT) at 6-month post-randomisation in reducing depression. At 12-month post-randomisation, where symptoms continued to improve for CBT clients, PCET clients maintained but did not improve their gains. This raises the question as to which therapy components contribute to long-term change for clients, and whether a focus on specific components of PCET could improve the long-term effectiveness of the model.

Intervention components are the means by which the theoretical mechanisms of change of any therapy are translated into practice (Levin et al., 2012). In primary process research, therapy components can be investigated using dismantling studies, where the effect of an intervention with one component excluded is compared to the full intervention, or by additive studies, where a full intervention is compared to the intervention plus an extra component (Ahn & Wampold, 2001; Bell & Goodlad, 2013).

Component studies have not yet been undertaken for PCET, though elements of person-centred therapy and emotion focused therapy (EFT) have been intensively studied (Norcross & Lambert, 2019; Watson, 2018). As an integration of these two models, PCET theory relies on two change mechanisms: the therapeutic relationship, and emotional

processing. In person-centred therapy, the Rogerian core conditions of empathy, congruence, and positive regard are seen as sufficient in themselves to facilitate a client's self-determination, and effect psychological change (Rogers, 1957). There is evidence for the effectiveness of empathy and positive regard, and promising evidence for the effectiveness of congruence (Elliott et al., 2018; Norcross & Lambert, 2019). In EFT, client emotional processing, guided by the therapist, is seen as the principal mechanism of change, based on a foundation of the person-centred relationship conditions (Elliott & Greenberg, 2007). Additive studies have been conducted showing the effectiveness of process-guiding interventions such as chair work and imaginal exposure (e.g., Goldman et al., 2006; Paivio et al., 2010).

These studies, however, may not possess the methodological rigour required to demonstrate beyond doubt that these components are efficacious. Chambless and Hollon (1998) offered definitions for three levels of efficacy:

1. *Possibly efficacious*. A treatment or component is possibly efficacious if it is supported by only one study, or studies conducted by only one research team.

2. *Efficacious*. A treatment is efficacious if it is supported by at least two studies from independent research teams.

3. *Efficacious and specific*. A treatment is efficacious and specific if it is supported by studies showing that it is superior to other conditions which control for nonspecific processes, e.g., another bona fide treatment, where specific symptom measures have been used, and where a sample size of 25-30 in each condition provides adequate statistical power.

Statistical power is also relevant for literature reviews, where the evidence for the effectiveness of particular components is examined by collating evidence from primary studies, including trials, dismantling, and additive studies. The two commonly used effect size statistics are Cohen's *d* and Hedges' *g.* Hedges' *g* is preferred for small sample sizes. Cuijpers (2016) calculated that for trials comparing treatments for adult depression a sample of 548 would be needed to provide sufficient statistical power to provide an effect size of *d* = 0.24, the accepted threshold for a clinically relevant effect. For a meta-analysis to detect a significant effect of *d* = 0.24 at a power of 0.8, Cuijpers calculated that approximately 18 trials including on average 58 patients per study would be necessary.

Ahn and Wampold (2001) conducted a meta-analysis of 27 component studies, which found no added benefit from specific treatment components. The authors cast doubt on the usefulness of component research, concluding that the effective ingredients of all treatments are common factors such as client characteristics and therapeutic alliance. Bell et al. (2013), in a meta-analysis of 66 studies, found a small but significant effect for added components, with effects further increased at follow-up. The majority of the studies included in the Ahn and Wampold and Bell reviews, however, were compromised by the lack of statistical power. Cuijpers et al. (2019) reviewed 16 studies, representing 22 comparisons of 15 components. The authors found only one study, of emotion regulation skills to enhance CBT, which had sufficient statistical power to conclude that the component was effective in treating depression (*N* = 432, *g* = 0.25; Berking et al., 2013).

These disappointing findings are in the context of estimates of the contribution of treatment model and techniques to the effectiveness of therapy which are also small, ranging from 1% (Wampold, 2013) to 15% (Hubble et al., 1999). Nevertheless, there are other important reasons for conducting research into treatment components. Specific

interventions operationalising treatment components are the means by which the therapist translates theory into practice, so studying interventions can throw light on the theoretical mechanisms by which a model works (Joyce et al., 2006; Levin, 2012). Specific interventions can facilitate and enhance effective common factors, for example helping to establish the rationale and credibility of a treatment for both therapist and client, and so improving the therapeutic alliance and increasing expectation (Wampold, 2015a). Specific interventions can also be derived from neuroscience (Emmelkamp et al., 2014; Maxwell et al., 2016), or their usefulness can be confirmed by neuroscience (Lane et al., 2015).

Definitions and Roles of the Experiential Components of PCET

Definitions of the three experiential, process-facilitation components of PCET are specified in the Person-Centred Experiential Psychotherapy Scale, with descriptions of how levels of skill may vary (PCEPS-10, Elliott & Westwell, 2012, Appendix A). The components may be operationalised by the therapist through particular interventions derived from EFT (Haake, 2018; Murphy, 2019). The order in which the components appear in the PCEPS-10 is:

- Item 3, experiential specificity
- Item 6, emotion focus
- Item 10, emotion regulation sensitivity.

The PCEPS-10 definition of each of the three components is given in Chapter 2. A description of each component is given below. The definitions and descriptions given below and used for this review are derived from PCET, person-centred, and EFT literature, as well as from the PCEPS.

Experiential Specificity

The term experiential specificity is defined in item 3 of the PCEPS. The term has not

been found in any other PCET text, for example, the Competence Framework (Hill, 2011),

the two editions of the textbook (Sanders & Hill, 2013; Murphy, 2019), nor in the major EFT

texts (Elliott et al. 2004; Greenberg, 2015; Greenberg & Paivio, 2003). The definition of

experiential specificity adopted for this literature review is therefore based on the

explanation of the term written by Robert Elliott in a blog (Elliott, 2014). Elliott states that

helping the client to be specific about their experience serves several purposes: (a) it

counteracts the over-general autobiographical memory tendency of people with

depression; (b) it facilitates the identification of emotions within vividly recalled

experiences; (c) it allows the client to step back or become 'disembedded' from an

experience, creating a working distance by describing it from an observer standpoint; and

(d) it facilitates the differentiation and symbolisation of emotions.

Theory from person-centred, experiential, and cognitive behavioural traditions also

suggests that therapist facilitation of experiential specificity helps the client:

- by reducing avoidance of painful feelings (Williams et al., 2007)

- by providing greater exposure to aversive memories, which aids extinction learning

  (Maxwell et al., 2016)

- by providing opportunities to identify and challenge unhelpful beliefs (Williams et al.,

  2007)

- by encouraging a nuanced symbolisation of experience, helping to explore the

  meaning of a felt sense (Greenberg & Paivio, 1997)

- by enhancing the therapist's empathy with a more accurate internal representation

  of the client's experience (Dimaggio et al., 2003)

Emotion Focus

The PCET competence of emotion focus is described in Item 6 of the PCEPS. PCET relies on the therapeutic relationship and emotional processing as its two mechanisms of change. In the person-centred tradition, Rogers (1957) hypothesised that the therapeutic relationship in itself provides the conditions for emotional processing, so that when a client feels "fully received" in the therapeutic relationship, "[A] feeling flows to its full result" (Rogers, 1961. See also Murphy, 2019; Sanders & Hill, 2014). In PCET the therapist is seen as providing active interventions to facilitate the client's emotional processing, within a therapeutic relationship which provides the conditions proposed by Rogers. Emotional processing is understood as a cognitive-affective process involving finding meaning in emotional experience (Greenberg & Safran, 1989; Watson & Greenberg, 1996). The term 'experiential' refers to the theory that emotions must be experienced by the client live in the session, (i.e., aroused and experienced physically) and expressed or symbolised in words or images.

Theory from person-centred, experiential, psychodynamic and cognitive behavioural traditions also suggests that therapist facilitation of emotion focus helps the client:

- by communicating unmet needs, and creating motivation to have needs met (Elliott et al., 2004; Greenberg, 2015)

- by encouraging change from psychological rigidity to flexibility (Klein et al., 1986; Rogers, 1961)

- by allowing habituation to feelings and disconfirmation of unhelpful beliefs (Foa & Kozak, 1986)

- by contributing to a corrective emotional experience (Bridges, 2006)

Emotion Regulation Sensitivity

The PCET competence of emotion regulation sensitivity is described in Item 10 of the PCEPS. The primary function of the therapist's emotion regulation sensitivity is to help the client in the therapy session to access feelings which are painful without becoming overwhelmed, losing psychological contact with the therapist and being unable to explore and process the emotions (Greenberg & Paivio, 2003; Murphy, 2019; Sanders & Hill, 2014). In the PCEPS, Elliott and Westwell (2012) refer to this skill as creating and maintaining 'a productive, optimal level of emotional arousal'. Greenberg (2015) refers to this as 'working distance', and Bacon et al. (2018) as the 'window of tolerance'. In PCET, emotion regulation sensitivity has three goals, two explicit and one implicit: (a) explicitly to help the client to access previously avoided painful feelings; (b) explicitly to help the client to explore feelings without becoming overwhelmed; and (c) implicitly to enhance the client's general emotion regulation sensitivity skills, including confidence in their own distress tolerance (Greenberg, 2015; Greenberg & Paivio, 2003; Murphy, 2019; Sanders & Hill, 2014).

Theory from person-centred, experiential, psychodynamic and cognitive behavioural traditions also suggests that therapist facilitation of emotion regulation helps the client:

● by reducing distressing symptoms caused when emotions are experienced too intensely (Linehan, 1987)

● by reducing avoidance of painful feelings, which is associated with rumination and depression (Aldao et al., 2010)

● by allowing feelings to be experienced, which aids extinction learning (Foa & Kozak, 1986)

● by enhancing the experience of safety within the therapeutic relationship (Esplen & Garfinkel, 1998)

Since literature and research in the field of emotion regulation focus mainly on interventions to enhance clients' distress tolerance, rather than the therapist's sensitivity to clients' emotion regulation, the term 'sensitivity' is only used in the following work where appropriate.

The Relationships Among the Experiential Components of PCET

PCET theory, based on the emotion theory of EFT, says that it is the transformation of maladaptive emotions that is therapeutic, and interventions which facilitate the emotion focus component are central. Experiential specificity and emotion regulation sensitivity are skills intended to enhance the client's focus on their emotions, for example by increasing the poignancy of a memory and by helping to create a productive working distance from feelings.

Figure 4.1 offers an illustration of the relationships among experiential specificity, emotion regulation sensitivity, and emotion focus, based on the theory as described above. It highlights emotion focus as the central component of the therapy model, and the need to increase awareness of emotions, address the avoidance of painful emotions, arouse and re-experience emotions in the therapy session, to make them accessible for processing and resolution. The diagram shows examples of interventions to operationalise these emotional processes in PCET, with arrows indicating how interventions can target more than one process. Figure 4.1 also shows how the two other experiential components, experiential specificity and emotion regulation, support emotion focus, with examples of interventions to operationalise these components. Literature from different psychotherapeutic modalities reinforces the interrelatedness of these components in theory and practice (Auszra et al., 2013; Boritz et al., 2011; Fisher et al., 2019; Stevens, 2019).

Since, according to this conceptualisation of the experiential components of PCET, the central focus is on the client's emotion, facilitated by experiential specificity and emotion regulation, this study uses the order: (a) experiential specificity; (b) emotion regulation; (c) emotion focus.

Figure 4.1

Relationships among emotion focus, experiential specificity, and emotion regulation, showing goals and interventions
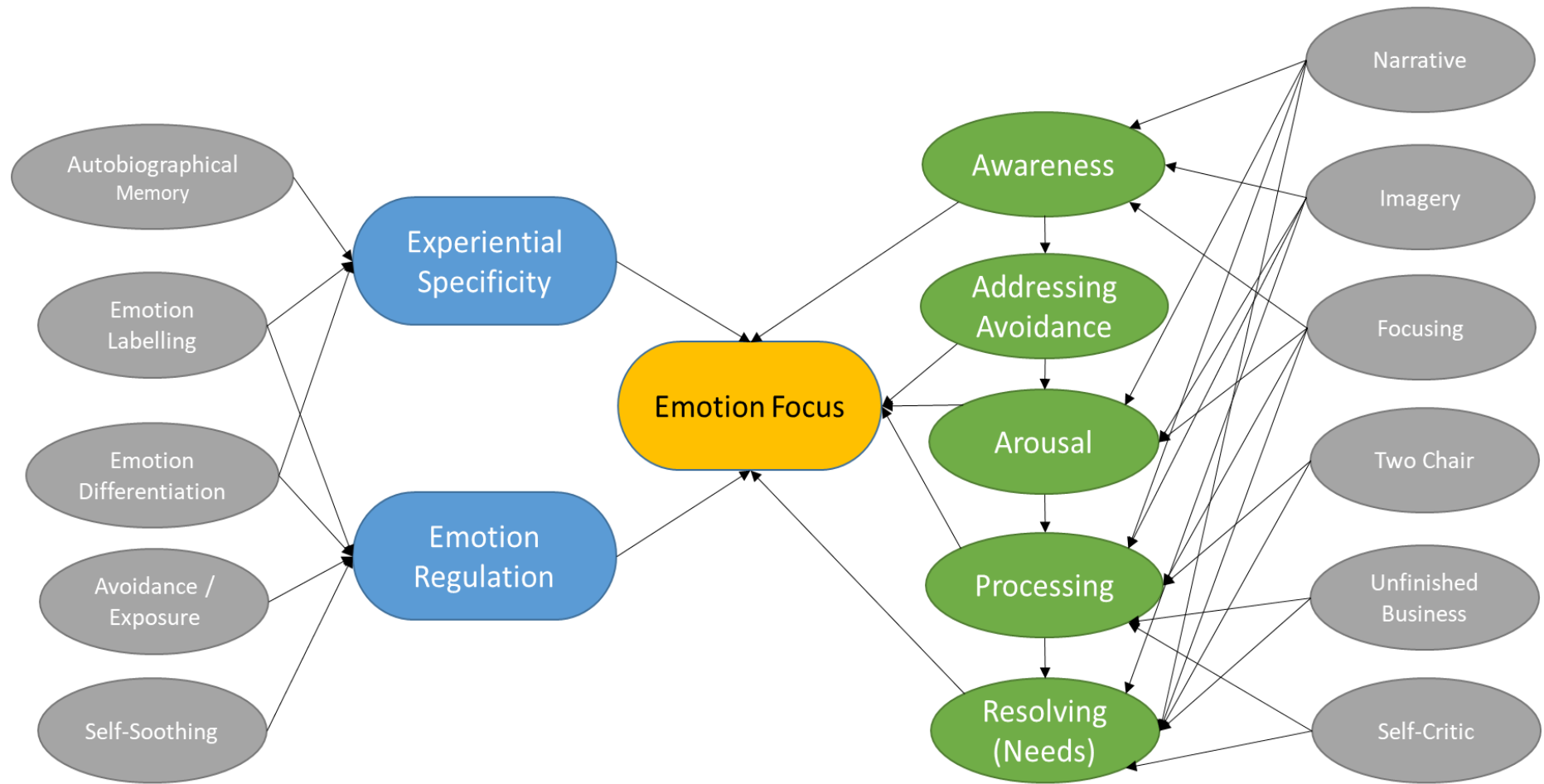
Terms Describing Concepts Related to Experiential Specificity, Emotion Regulation, and Emotion Focus

While the terms experiential specificity, emotion regulation sensitivity, and emotion focus are particular to PCET, the concepts that they describe are widespread in practice and research in the psychological therapies, and can be identified as components of many modalities. Other related terms are listed below.

Experiential Specificity

- therapist concreteness (Truax & Carkhuff, 1964)

- systematic evocative unfolding (Rice, 1974)

- affect labelling (Bucci, 1982)

- symbolisation and finding a 'handle' for a bodily felt sense (Gendlin, 2003)

- over-general autobiographical memory as a cognitive bias (Williams et al., 2007)

- over-general construal of self-relevant information as a cognitive bias (Watkins et al., 2009)

Emotion Regulation

- mindfulness (Hayes & Feldman, 2004)

- decentering (Segal et al., 2019)

- acceptance (Naragon-Gainey et al., 2017)

- distress tolerance (Berking et al., 2008)

- self-soothing (Gilbert & Proctor, 2006)

- interpersonal regulation (Schore & Schore, 2008)

- self-interruption (Shahar, 2014)

- interoception (Price & Hooven, 2018)

Emotion Focus

- emotional restructuring (Greenberg & Paivio, 1995)

- emotional transformation (Pascual-Leone, 2018)

- focusing (Gendlin, 2003)

- experiencing (Klein et al., 1986)

- emotional processing (Foa & Kozak, 1986; Fosha & Thoma, 2020)

- corrective emotional experience (Bridges, 2006)

Previous Research Related to the Experiential Components

The theoretical constructs described above have been developed within the various

psychotherapeutic modalities into standalone psychotherapeutic interventions for

individuals and for groups, as well as interventions to be incorporated into traditional

therapy. Several reviews and meta-analyses have been conducted bringing together

evidence for each of these constructs. Some reviews focus on client characteristics

hypothesised to present a vulnerability to mental health problems, or which may be

associated with psychotherapy outcome. For example, reviews of research have been

published which look at the relationships between psychological problems and over-general

autobiographical memory (ABM) as a client characteristic (Kashdan et al., 2015; Williams et

al., 2007), or maladaptive emotion regulation strategies (Aldao, et al., 2010; Kraiss et al.,

2020; Webb et al., 2012). Löw et al. (2020) conducted a meta-analysis investigating self-

criticism, one aspect of clients' experience relevant to emotion focus in PCET, and its

association with psychotherapy outcomes. Peluso and Freund (2018) conducted two meta-

analyses, one for therapists and one for clients, to investigate the effect of expressing

emotion in therapy on client outcomes.

Literature reviews investigating the relationship between interventions specifically or implicitly incorporating the three components and psychotherapy outcome are briefly described here, as well as reviews collating evidence for the effectiveness of psychotherapy for depression. References for further background literature, including theoretical and process research for the three components, can be found in Appendix C.

Reviews of Experiential Specificity

Two reviews have been conducted to assess the evidence for cognitive bias modification (CBM) interventions which address over-general autobiographical memory (Ahmadi Forooshani et al., 2020; Hitchcock et al., 2017). Both concluded that on the whole such interventions are moderately effective. Ahmadi Forooshani and colleagues (2020) speculated that these interventions may be most effective as a component of a more comprehensive form of psychotherapy.

Reviews of Emotion Regulation

Narrative reviews by Gratz et al. (2015) and Sloan et al. (2017) both found that various forms of psychological therapies reduce emotion regulation difficulties at the same time as reducing other symptoms, with more robust evidence for interventions designed specifically to target emotion regulation difficulties. A recent meta-analysis by Moltrecht et al. (2020) of interventions for children and adolescents with psychological problems showed a medium treatment effect for reducing emotion dysregulation, with interventions specifically targeting emotion regulation being more effective. At the same time the authors found that interventions which were more effective in reducing emotion regulation difficulties were also more effective in reducing psychopathological symptoms, although heterogeneity of studies and small sample sizes prevented them from drawing any firm conclusion.

Reviews of Emotion Focus

Some reviews of research on emotional experiencing and processing have focused on client or therapist effects or the processes at work. For example, Pascual-Leone and Yeryomenko (2017) carried out a meta-analysis of research on the relationship between depth of client experiencing and outcome, finding that in-session emotional experiencing is a small to medium predictor of symptom improvement, and may be a common factor in effective therapy. Watson (2018) conducted a narrative review looking at the therapeutic relationship and emotional processing as mechanisms of change, and Pascual-Leone (2018) examined research on a sequential model of emotional transformation, linking moment by moment processes to therapy outcome.

Other reviews have examined the possible therapeutic effect of emotion focus. In a narrative review, Littrell (1998) examined research from psychotherapy and experimental literature on the re-experiencing of painful emotion, to investigate whether re-experiencing and expressing emotion in themselves have health benefits. She concluded that simply re-visiting painful emotion can worsen distress, whereas helpful interventions combine arousal of negative emotion with a new response to the experience. Similarly, Whelton's 2004 narrative review of research on emotion in psychotherapy concluded that emotional re-experiencing is effective when emotion is appropriately regulated, and when it is accompanied by re-structuring and meaning-making.

Diener and colleagues (2007) conducted a meta-analysis of research on therapist affect-focus in brief psychodynamic therapy, finding a statistically significant relationship between therapist facilitation of clients' emotional experiencing and expression and outcome. The authors suggested "that therapist facilitation of patient affective experience/expression increased patient success rate from 35% to 65%" (p.938). The

authors note the similarity between this effect size and evidence for the contribution of the therapeutic alliance.

Reviews of Psychotherapy for Depression

Cuijpers et al. (2008) conducted a meta-analysis of trials where models of psychotherapy for depression were compared. The authors found negligible differences between therapies at end of therapy and at follow-up. A network meta-analysis by Barth et al. (2016) confirmed these findings, with large effect sizes for all therapeutic modalities compared to waiting list controls, but negligible differences between them. A meta-analysis of humanistic-experiential psychotherapies by Elliott et al. (2021) found weighted mean pre-post treatment effect sizes of g = 0.94 (95% CI [.74, .97]) and 0.92 (95% CI [.52, 1.31]) at late follow-up, and a pre-post effect size of g = 0.96 (95% CI [.80, 1.12]) specifically for depression. A further meta-analysis found that humanistic-experiential psychotherapies were comparable to other active treatments at post-treatment (g = -.09, 95% CI [-.26, .08]), but less effective at follow-up (g = -.21, 95% CI [-.35, -.07]; Duffy et al., 2023).

The Current Review

The systematic literature review presented here was conducted in two stages. The first stage comprises a reciprocal translation between theoretical concepts and terminology from different psychotherapeutic modalities and research approaches (Popay et al., 2006; Ryan, 2013). This stage addresses the question:

1. Can experiential specificity, emotion regulation, and emotion focus be understood as transtheoretical and transdiagnostic concepts?

The second stage comprises a review of the effectiveness of the experiential components through a statistical analysis of quantitative trials. This review collates evidence for the effectiveness of the three experiential components of person-centred experiential

therapy, i.e., (a) experiential specificity, (b) emotion regulation sensitivity, and (c) emotion focus. The questions it addresses are:

2. Are experiential specificity, emotion regulation sensitivity, and emotion focus interventions effective in their own right for the treatment of depression?

3. Do experiential specificity, emotion regulation, and emotion focus interventions improve the effectiveness of psychotherapy for adults experiencing depression?

This review is not intended to compare interventions based on these components with other forms of therapy, but to establish whether the components contribute to effectiveness in reducing depression when introduced into therapy, and whether they are effective as standalone interventions. The outcomes of interest therefore are any pre- to post-intervention and follow-up changes in outcomes for depression.

Methods

The review protocol was registered with PROSPERO on 27 August 2020 with the title 'Does therapists' use of experiential specificity, emotion focus, and emotion regulation sensitivity improve the effectiveness of psychotherapy for adults with common mental health problems? A systematic review of the evidence' (https://www.crd.york.ac.uk/PROSPERO/).

Separate searches and analyses were conducted for each of the three components under investigation, that is, (a) experiential specificity, (b) emotion regulation sensitivity, and (c) emotion focus. The search strategy and inclusion/exclusion criteria were the same for each of the three parts. The search strategy identified both quantitative and qualitative studies for each of the components.

Search Strategy

The databases PsycInfo and MEDLINE via Ovid, and Scopus were searched between October 2020 and March 2021 to identify relevant papers using terms found in the title, abstract, subject headings and MESH terms. Additional papers were identified through a process of pearl-growing (i.e., finding relevant material through reference lists and citing papers). Limits were set to peer-reviewed research published in English since 1986. This date was chosen for two reasons:

1. This was the year *The Psychotherapeutic Process* was published, edited by Greenberg and Pinsof. The book brought together work by researchers on observation systems, methodology and programmes for the study of psychotherapy process. In one chapter, Klein et al. (1986) published their review of studies which employed the Experiencing Scale, the measure that they had developed to assess a client's depth of experiencing, the effect of therapy on experiencing, and the relationship between depth of experiencing and outcome (Klein et al., 1986).

2. In the same year Frijda published his book called *The Emotions* (1986), which helped to inform EFT emotion theory.

Search Terms and Study Selection

Table 4.1 shows the search terms used for each of the three components, combining terms derived from the PCEPS and person-centred and EFT texts and limiting results to outcomes or effectiveness of counselling or psychotherapy.

Titles and abstracts of the papers returned in the search of each database were reviewed, and the full text of relevant articles retrieved. The full text of every quantitative study was then assessed for inclusion according to the PICOS framework of population,

intervention, comparator, outcome and study type. Table 4.2 shows how inclusion and

exclusion criteria were implemented for this review.

Table 4.1

Search terms for experiential specificity, emotion regulation, and emotion focus

Experiential Specificity

#1 Psychotherap* OR Counsel*

#2 Efficacy OR Effectiv* OR outcome

#3 = #1 AND #2

#4 Experiential specificity

#5 Concrete*

#6 Emotion* ADJ3 differentiat*

#7 Problematic reaction point

#8 Systematic evocative unfolding

#9 = #4 OR #5 OR #6 OR #7 OR #8

#10 (Autobiographical OR episodic) AND (memory OR memories)

#11 specificity

#12 Re-experienc* OR reexperienc*

#13 Re-activat* OR reactivat*

#14 Reprocess*

#15 = #11 OR #12 OR #13 OR #14

#16 = #10 AND #15

#17 = #9 OR #16 (sum for experiential specificity)

#18 = #3 AND #17

Emotion Regulation

#1 Psychotherap* OR counsel*

#2 Efficacy OR effectiv* OR outcome

#3 #1 AND #2

#4 Emotion regulation

Emotion Regulation continued

#5 (emotion* OR affect) AND (overarousal OR over-arousal OR overcontrol OR over-control)

#6 Self sooth*

#7 Distress tolerance

#8 = #4 OR #5 OR #6 OR #7(sum for emotion regulation)

#9 = #3 AND #8

Emotion Focus

#1 Psychotherap* OR counsel*

#2 Efficacy OR effectiv* OR outcome

#3 = #1 AND #2

#4 Emotion focus

#5 (emotion* OR feeling* OR affect) AND (arous* OR experienc*)

#6 Process ADJ3 guiding

#7 (experienc* OR experiential OR emotion*) AND process*

#8 focusing oriented therapy

#9 Felt sense

#10 Bodily felt sense

#11 Conflict split

#12 (Inner OR self) AND critic

#13 (Self OR selves) ADJ3 configuration*

#14 (internal OR inner) AND (voice* OR self OR selves)

#15 Chair work

#16 Empty chair

#17 Unfinished business

#18 = #4 - #17 combined with OR (sum of emotion focus)

#19 = #3 AND #18

Table 4.2

Inclusion/exclusion criteria for quantitative studies

	Included	**Excluded**
Population	• Adults (18+) with common mental health problems, or other conditions where a measure of depression is reported • Outpatient	• Non-clinical • Psychosis • Personality disorder • Inpatient
Intervention	• Where component meets definition for experiential specificity/emotion regulation/emotion focus • Individual/group • Component as a standalone or supplementary intervention	• Where components aren't clear • Where components are treated together • Where outcomes can't be ascribed to component • Telephone/computer
Comparator	• No comparator but pre- and post-treatment measures • Waiting list • Treatment as usual • Other therapy • Same therapy without component	• No comparator or pre- post-treatment measures
Outcome	• Recognised, validated outcome measure of depression	• No recognised, validated outcome measure of depression
Study Type	• Quantitative including controlled and uncontrolled trials, where pre- and post-intervention measures are reported	• Analogue or laboratory-based studies

Population

Studies were included where the population was adult (18 years of age and over)

and experienced common mental health problems. Studies focusing on clients with

problems such as eating disorders or trauma were included if a measure for depression was present. Studies were excluded if they focused on non-clinical participants, clients with more specialised problems such as borderline personality disorder or psychosis, where the intervention was delivered in a specialised setting such as hospital or prison, or where results could not be generalised to primary care populations with common mental health problems.

Interventions

Studies were included where the intervention could be seen as falling within the definitions of experiential specificity, emotion regulation sensitivity or emotion focus provided by the PCEPS. This required a degree of interpretation, and a preliminary process of reciprocal translation was conducted to determine whether the intervention as described in a study was relevant for this review. Reciprocal translation has been defined as "seeking a common rubric for salient categories of meaning … [where] accounts are directly comparable" (Popay et al., 2006). Studies were included if they used the component as a standalone intervention or if they were additive studies using the components as a supplement to another therapeutic intervention; differences were investigated in a subgroup analysis. In order to capture as much relevant information as possible, both individual and group interventions were included.

Quantitative studies were excluded where it was unclear which component was being tested, for example where two or more components were conflated, or where outcomes could not be ascribed to one component. Studies offering interventions delivered remotely, by telephone or computer, and studies which offered a single session intervention were excluded.

Comparator

Trials of interventions were included with no comparator as long as pre- and post-intervention measures were reported. Trials were also included with any comparator such as waiting list, treatment as usual, or another psychotherapeutic intervention as an active comparator.

Outcomes

While the primary outcome for many studies was a measure of the phenomenon being studied, for example the Experiencing Scale (Klein et al., 1986) as a measure of depth of client experiencing, for this review the primary outcome of interest was a reduction in depression, since this is most relevant for the delivery of PCET in primary care. Quantitative studies were included where a recognised, validated measure of depression was used. These were usually client self-report measures, but could be therapist or researcher reports. Where more than one measure of depression was reported, the most widely recognised and frequently administered measure was used for analysis.

Where a study reported multiple outcome measures for depression, data was extracted for the Beck Depression Inventory (BDI-II; Beck et al., 1996) where possible. Otherwise data was extracted for the most widely recognised and validated measure, or for a self-report rather than clinician-administered measure. For measures where results for multiple subscales were reported, such as the Depression, Anxiety and Stress Scale (DASS, Lovibond & Lovibond, 1995), only results for the depression subscale were included.

Study Type

Studies of any design were included. For quantitative studies measures of depression pre- and post-interventions had to be reported. For qualitative studies research data such as material from case studies had to be reported.

Test for Publication Bias

Funnel plots showing standard mean difference against standard error were created for the included trials (RevMan 5). These were used to highlight any potential bias, where only studies reporting favourable results may be submitted or accepted for publication.

Assessment of Methodological Quality of Quantitative Studies

The CASP randomised controlled trial checklist was used to assess the methodological quality of quantitative studies (CASPb, 2018), since it could be adapted for both randomised and nonrandomised trials. Questions concerning blinding of researchers and participants were omitted, since psychotherapy participants cannot be blind to the intervention they receive. A question to account for possible researcher allegiance was added, since effect sizes have been found to be larger when the researcher favours the intervention being investigated (Elliott & Freire, 2010; Lambert, 2013). A scoring system was devised by the researcher to provide a numerical measure of study quality, where RCTs could achieve a maximum of 8, and non-RCTs a maximum of 4.

To achieve a score of 4/4 for non-randomised trials, a paper needed to include at least brief comments on reasons for participant drop-out and any potential confounding factors or limitations of the research. For randomised trials, in order to achieve a score of 8/8, the study also needed to include a bona fide therapy control, matched for rationale, format, and treatment length. Where questions such as the demographic similarity of intervention and control groups at baseline are not specifically reported, a No has been recorded. Although this review does not report comparative outcomes for control interventions, studies which included such controls are seen as providing the most robust evidence. For all studies, researcher allegiance was gauged from evidence available in the paper. For example, if the researchers were also authors of a therapy manual, or were

themselves trial therapists or supervisors, the assessment was that researcher allegiance had not been accounted for. Where therapy consisted of guided self-help (Watkins et al., 2009; Watkins et al., 2012) it was judged that researcher allegiance would not affect the delivery of the intervention, and allegiance would not be a factor.

Data Extraction

The following information was extracted from every full text article:

1. Nature of the intervention

2. Study methodology

3. Client problem

4. Intervention format, i.e., group or individual; comparator if applicable

5. Number of participants

6. Depression measure (where more than one measure was administered, the most widely recognised measure was extracted)

7. Drop-out rate if reported

8. Length of follow-up if reported.

Data Analyses

Analysis of data from the quantitative studies was conducted separately for each of the three components in two stages.

Stage 1: Reciprocal Translation

An initial process of reciprocal translation was undertaken between theoretical concepts and terminology from different psychotherapeutic modalities and research approaches (Popay et al., 2006; Ryan, 2013).

Stage 2: Analysis of Quantitative Studies

Data Extraction. Pre- and post-treatment depression scores were extracted from reports of trials.

Meta-Analysis. Standardised effect sizes were calculated using Hedges' *g* with 95% confidence intervals (Hedges, 1985), using an inverse variance random effects model. Hedges' *g* was chosen as an appropriate effect size statistic for heterogeneous study designs and outcome measures. A Hedges' *g* effect size of 0.20 is seen as small, 0.50 as medium, and 0.80 as large. For some studies, where effect size was calculated according to a different formula, effect sizes reported here may differ from those reported in the original study. Effect sizes were displayed using forest plots (RevMan 5) and aggregated.

Analysis of Qualitative Data

A narrative review of the identified qualitative research was conducted for each of the three components, focusing on the effectiveness of interventions which facilitate the client's focus on their emotions. Results are presented in Appendix C.

Figure 4.2

PRISMA Flowcharts for experiential specificity, emotion regulation, and emotion focus

Experiential Specificity

Papers identified
PsycInfo: 222
Medline: 114
Scopus: 129
Total: 465

→ Duplicates removed: 10

Total abstracts
screened: 455

→ Papers excluded
PsycInfo: 179
Medline: 95
Scopus: 92
Total: 366

Full text articles
assessed
PsycInfo: 8
Medline: 12
Scopus: 13
Total: 33

→ Papers excluded
Quality not clear: 5
Component not clear: 6
Outcome not clear: 2
Irrelevant: 9
Total: 22

Papers included
PsycInfo: 2
Medline: 1
Scopus: 6
Pearl-growing: 2
Total: 11

→ Quantitative: 9
Qualitative: 2

Emotion Regulation

Papers identified
PsycInfo: 80
Medline: 82
Scopus: 374
Total: 536

→ Duplicates removed: 14

Total abstracts
screened: 522

→ Papers excluded
PsycInfo: 62
Medline: 67
Scopus: 310
Total: 439

Full text articles
assessed
PsycInfo: 18
Medline: 1
Scopus: 64
Total: 83

→ Papers excluded
Component not clear: 10
Outcome not clear: 28
Irrelevant: 12
Total: 50

Papers included
PsycInfo: 4
Medline: 0
Scopus: 27
Pearl-growing: 2
Total: 33

→ Quantitative: 27
Qualitative: 6

Emotion Focus

Papers identified
PsycInfo: 787
Medline: 257
Scopus: 724
Total: 1768

→ Duplicates removed: 10

Total abstracts
screened: 464

→ Papers excluded
PsycInfo: 90
Medline: 228
Scopus: 473
Total: 791

Full text articles
assessed
PsycInfo: 94
Medline: 10
Scopus: 36
Total: 140

→ Papers excluded
Quality not clear: 9
Component not clear: 37
Outcome not clear: 24
Irrelevant: 49
Total: 119

Papers included
PsycInfo: 5
Medline: 2
Scopus: 11
Pearl-growing: 3
Total: 21

→ Quantitative: 11
Qualitative: 10

Results

Search Results

Figure 4.2 shows the results of the searches for each of the three components,

displayed as PRISMA flowcharts (Moher 2009). The following were found:

- For experiential specificity, nine controlled trials and two qualitative studies

- For emotion regulation, 27 controlled trials and six qualitative studies

- For emotion focus, 11 controlled trials and 10 qualitative studies

Stage 1: Reciprocal Translation

Table 4.3 shows terminology extracted from the included quantitative and

qualitative studies for each component, displayed according to the theoretical basis of the

research. Results of this process of reciprocal translation show the equivalence of the

concepts described in different psychotherapeutic modalities (Popay et al., 2006; Ryan,

2013). Full results for all of the studies identified for each component can be found in

Appendix C, Tables 4.1C to 4.3C.

Table 4.3

Results for reciprocal translation analysis

Theoretical basis	Terms
	Experiential specificity
EFT	Systematic evocative unfolding; concrete, vivid, imagistic, evocative language; vivid recreation of the situation; accurate symbolisation and labelling; concretely felt experiencing; memory specificity; emotional handle
Cognitive	Overgeneral recall; autobiographical memory specificity; specifics of event and context; concreteness; mental imagery; distinctive, sensory details; sequence of event unfolding; spatio-temporal, contextual and sensory-perceptual details

Emotion regulation

EFT (including theory of constructed emotion)	Attachment-based co-regulation of emotion; reducing suppression; compassion; meaning-making; window of tolerance; safe space imagery
CBT (including dialectical behaviour therapy, emotion regulation therapy and psychoeducation)	Emotion regulation skills; distress tolerance; mindfulness; identifying and labelling feelings; observing emotional experiences; identifying emotional triggers; bodily responses; interoceptive awareness; interoceptive exposure; emotion focused exposure; imaginal exposure; self-soothing; acceptance; expression of emotion; emotional intelligence; emotional repair; differentiation; relaxation; venting; reducing avoidance; self-compassion; non-judgement; normalising; breathing; decentering; curiosity; attentional flexibility; experiential flexibility; cognitive flexibility; cognitive reappraisal; grounding; optimal range of emotion regulation
Psychodynamic (including object relations, AEDT*)	Self-soothing; relaxation; warmth; therapist presence; dyadic regulation of affect; experiencing emotions; expressing emotions; reducing avoidance; modelling (*Accelerated experiential-dynamic therapy)

Emotion focus

EFT	Accessing emotion; reducing avoidance; exploration; restructuring; re-experiencing; cognitive-affective processing; unresolved feelings; process-guiding; emotion memory; gestalt interventions; experiential interventions; two-chair & empty-chair dialogues; self-criticism; unfinished business; systematic evocative unfolding; focusing; felt sense; primary adaptive emotions; emotional conflict; conflict split; corrective emotional experience; transformation of emotion; emotional arousal; insight; self-compassion; adaptive needs; internal dialogue; emotional interrupter; attunement; symbolising; meaning-making; core painful feelings; emotional flexibility; imaginal exposure; symbolisation
Person-centred	Emotion processing; metaphor; exploring previously denied aspects of self; unexpressed feelings; assimilation of emotional experience; stopped process; symbolisation; bodily felt sense; moment-by-moment process; experiential processes
CBT (including schema therapy)	Identifying and processing avoided emotions; emotional learning; deepening of affective experience; emotionally corrective experiences; emotion-focused techniques; activating memories and emotions; imaginal exposure; two-chair dialogue

	Emotion focus continued
Psychodynamic (including ISTDP*, STDP**, experiential-dynamic psychotherapy)	Emotional processing; Experiencing feelings; Expressing feelings; Mind-emotion-body connection; Unresolved feelings; Optimal level of emotional activation; Resolution of intrapsychic conflicts; Restructuring; Exposure to avoided emotion; Experiencing emotion; Gestalt techniques; Adaptive emotion; Physiological signs of emotion; Emotional arousal; Corrective emotional experience; Self-soothing; Guided imagery; Imaginal exposure; emotional flexibility; Insight; Exploration; Cognitive and emotional change

*Intensive short-term dynamic psychotherapy

** Short-term dynamic psychotherapy

Stage 2: Characteristics of Included Trials

Experiential Specificity

Table 4.4 shows the characteristics of the nine quantitative studies investigating experiential specificity. The trials identified were all for cognitive bias modification interventions, where participants received training intended to reverse cognitive biases such as over-general autobiographical memory and abstract thinking (Williams et al., 2007). One study focused on cancer patients in palliative care, two on post-traumatic stress disorder (PTSD), and six on depression or dysphoria. The nine studies all tested standalone interventions, and none had an additive or dismantling design. Table 4.4 shows that the interventions were memory specificity training (used four times), life review therapy (used three times), and concreteness training (used twice). These are described below.

Memory specificity training (MEST; Eigenhuis et al., 2017; Maxwell et al., 2016; Moradi et al., 2014; Werner-Seidler et al., 2018) is a group intervention consisting of psycho-education and practice at retrieving specific memories triggered by positive, neutral or negative cue words, and homework of continued practice. Participants also receive training

to notice any shift from specific to over-general retrieval or thinking. 'Dear Memories' (Kleijn et al., 2018) is an individual intervention combining life review therapy and MEST, developed to enhance ego-integrity and reduce despair in cancer patients in palliative care.

Life review therapy (Serrano et al., 2004; Serrano et al., 2012) is an individual intervention developed for older adults, consisting of practice in retrieving specific autobiographical memories. Each session focuses on a different life stage, with the therapist asking questions designed to trigger specific memories.

Concreteness training (Watkins et al., 2009; Watkins et al., 2012) is a guided self-help intervention, employing imagery of emotional scenarios, as well as autobiographical memories. It consists of a face to face psycho-education and training session with a helper, giving the rationale for how the intervention should reduce depression, and instructions for daily homework, encouraging concrete processing through focus on sensory experience and distinctive details.

Table 4.4

Study characteristics of the nine included quantitative trials of experiential specificity

Study	Intervention	Methodology	Problem	Format	Comparator	N	Measure	Drop out	Follow-up
Eigenhuis et al., 2017	Five sessions of memory specificity training	Pre- post-treatment	Depression	Group	N/A	32	BDI-II	7	3 months
Kleijn et al., 2018	Four sessions of life review therapy combined with memory specificity training 'dear memories'	RCT	Cancer patients in palliative care	Individual	Care as usual	107	HADS-D	30 (17 LRT-MST, 13 CAU)	1 month
Maxwell et al., 2016	Six sessions of memory specificity training	RCT	PTSD	Group	Cognitive processing therapy	16	BDI-II	0	3 months
Moradi et al., 2014	Four sessions of memory specificity training	RCT	PTSD	Group	No contact control	24	BDI-II	0	3 months
Serrano et al., 2004	Four sessions of life review therapy	RCT	Depression	Individual	Social services as usual	50	CES-D	7	N/A
Serrano et al., 2012	Four sessions of life review therapy	RCT	Depression	Individual	Supportive therapy	37	GDS	11 (5 LRT, 6 ST)	6 weeks & 6 months
Watkins et al., 2009	Seven daily 30-min practice of concreteness training	RCT	Dysphoria	Guided self-help	Bogus CNT/ Waiting list	60	BDI-II	10 (6 CNT)	N/A

Table 4.4 continued

Study characteristics of the nine included quantitative trials of experiential specificity

Study	Intervention	Methodology	Problem	Format	Comparator	*N*	Measure	Drop out	Follow-up
Watkins et al., 2012	Six weeks of daily practice of concreteness training, plus three phone support sessions	RCT	Depression	Guided self-help	TAU/TAU + relaxation training	121	BDI-II	23 (12 CNT, 11 RT	3 & 6 months (data not reported)
Werner-Seidler et al., 2018	Five sessions of memory specificity training	Cluster RCT	Depression	Group	Psycho-education and supportive counselling	62	BDI-II	4 (2 MEST, 2 PSC)	3 months (+ 6 months for MEST)

Abbreviations: BDI Beck depression inventory; CAU Care as usual; CES-D Center for epidemiologic studies depression scale; CNT Concreteness training; GDS Generic depression scale; LRT Life review therapy; LRT-MST Life review therapy with memory specificity training; MEST Memory specificity training; PSC Psycho-education and supportive counselling; PTSD Post traumatic stress disorder; ST Supportive therapy; TAU Treatment as usual

Emotion Regulation

Table 4.5 shows the characteristics of the 28 selected quantitative studies (from 27 research trials) for emotion regulation. Six studies focused on eating disorders, five on anxiety, five on general or complex emotional difficulties or stress, three studies on depression, three on PTSD, and two on comorbid depression and anxiety. Populations for the remaining three studies were people with breast cancer, irritable bowel syndrome, and refugees.

Table 4.5 shows that twenty-five studies were tests of standalone emotion regulation interventions, and three were additive studies. The most common interventions examined in these studies are described below.

The broadest range of studies for a single intervention was for the Unified protocol, used in six studies. Studies investigated both individual and group treatments for diverse problems, including perfectionism (Mahmoodi et al., 2020) and irritable bowel syndrome (Mohsenabadi et al., 2018) as well as emotional disorders, depression and anxiety (Bullis et al., 2015; Khakpoor et al., 2019; Kivity et al., 2020; Sauer-Zavala et al., 2020). The Unified protocol is a transdiagnostic treatment package in the CBT tradition, which aims to improve emotion regulation, based on the theory that emotion regulation is a mechanism at the root of most emotional difficulties (Barlow et al., 2010). Another transdiagnostic intervention was skills training of affect regulation – a culture-sensitive approach, developed for refugees (Koch et al., 2020).

Five studies represented dialectical behaviour therapy, in individual format to target anxiety (Afshari & Hasani, 2020) and in group format to target eating disorders (Cancian et al., 2019; Safer et al., 2010; Telch et al., 2000; Telch et al., 2001). Dialectical behaviour therapy began as a treatment for individuals with borderline personality disorder, and has

subsequently been adapted for use with other populations where it is hypothesised that problem behaviours such as eating disorders are maladaptive efforts to cope with emotions (Cancian et al., 2019).

Three studies investigated group-based mindfulness interventions. Carmody et al. (2009) analysed outcomes for large mindfulness programmes for people experiencing physical problems, stress and anxiety, and Boyle et al. (2017) offered mindfulness groups for women with breast cancer. Schanche et al. (2020) tested the effectiveness of mindfulness-based cognitive therapy for preventing relapse in depression. Two studies focused on compassion: a group programme for chronic depression based on mindfulness, compassion and loving kindness meditation was investigated by Graser et al. (2016), while Gilbert & Procter (2006) offered compassionate mind training to people with high shame and self-criticism.

Three studies focused on emotion regulation therapy, an individual treatment for generalised anxiety disorder (GAD) (Mennin et al., 2015, 2018; Renna et al., 2018). Two trials were identified which tested newly developed interventions for people with complex emotional difficulties seen as outpatients in secondary care. One was a group treatment called the emotional resources group (Bacon et al., 2018), and the other an individual intervention to improve distress tolerance (Wright et al., 2020).

Two further studies investigated the use of other group emotion regulation interventions for binge eating disorder, emotion regulation training (Clyne & Blampied, 2004) and acceptance-based behavioural therapy (Juarascio et al, 2017).

Three studies used an additive design, testing emotion regulation interventions prior to PTSD treatment. Cloitre and colleagues conducted two trials of skills training in affective and interpersonal regulation (STAIR, 2002, 2010) to improve tolerance for prolonged

exposure treatment for PTSD related to childhood sexual abuse. Similarly, Bryant et al.

(2013) offered emotion tolerance training prior to CBT exposure treatment for people who

were diagnosed with PTSD following road traffic accidents or non-sexual assault.

Table 4.5

Study characteristics of the 27 included quantitative trials of emotion regulation (28 studies in total)

Study	Intervention	Methodology	Problem	Format	Comparator	*N*	Measure	Drop out	Follow-up
Afshari & Hasani, 2020	Dialectical behaviour therapy	RCT	GAD	Individual	CBT	68	BDI-II DERS	5	3-month
Bacon et al., 2018	Emotional resources group	Uncontrolled study	Emotional difficulties	Group	N/A	47	WEMWS	11	N/A
Boyle et al., 2017	Mindful awareness practices	RCT	Breast cancer	Group	Waiting list	71	CESD	N/A	3-month
Bryant et al., 2013	Emotion tolerance training	RCT	PTSD	Individual	Supportive counselling	70	BDI-II	19	6-month
Bullis et al., 2015	Unified protocol	Open trial	Emotional disorders	Group	N/A	11	ODSIS	N/A	N/A
Cancian et al., 2019	Dialectical behaviour therapy	Open trial	Obesity	Group	Waiting list	31	DASS-21	11	N/A
Carmody et al., 2009	Mindfulness-based stress-reduction	Pre- post-treatment	Stress-related problems	Group	N/A	309	BSI	N/A	N/A
Cloitre et al., 2002	Skills training in affect and interpersonal regulation + prolonged exposure	RCT	PTSD related to childhood abuse	Individual	Waiting list	58	BDI	12	3 & 9-month BDI not reported

Table 4.5 continued

Study characteristics of the 27 included quantitative trials of emotion regulation (28 studies in total)

Study	Intervention	Methodology	Problem	Format	Comparator	N	Measure	Drop out	Follow-up
Cloitre et al., 2010	Skills training in affect and interpersonal regulation + prolonged exposure	RCT	PTSD related to childhood abuse	Individual	Support/Exposure or STAIR/Support	104	BDI	28	3 & 6-months
Clyne & Blampied, 2004	Training in emotion regulation	Multiple baseline study	Binge Eating Disorder	Group	N/A	11	DASS	2	3-month
Gilbert & Procter, 2006	Compassionate mind training	Uncontrolled trial	Complex difficulties	Group	N/A	9	HADS	3	N/A
Graser et al., 2016	Mindfulness based cognitive therapy with compassion focused therapy and loving kindness meditation	Pilot study	Chronic depression	Group	3-month waiting period for participants	11	BDI-II	1	3-month
Juarascio et al., 2017	Acceptance-based behavioral therapy	Open trial	Binge eating disorder	Group	N/A	19	BDI-II	2	3-month
Khakpoor et al., 2019	Unified protocol	RCT	Anxiety and depression	Individual	Not stated	26	BDI-II	3	2 month

Table 4.5 continued

Study characteristics of the 27 included quantitative trials of emotion regulation (28 studies in total)

Study	Intervention	Methodology	Problem	Format	Comparator	N	Measure	Drop out	Follow-up
Kivity et al., 2020	Unified protocol adapted for groups	Pre- post trial	Anxiety	Group	N/A	13	DASS-21-D DERS	3	1-month Data not reported
Koch et al., 2020	Culture-sensitive skills training of affect regulation	RCT	Refugees	Group	Waiting list	44	GHQ-28 DERS	8	3-month
Mahmoodi et al., 2020	Unified protocol	RCT	Depression and anxiety	Individual	CBT for perfectionism/ waiting list	75	BDI-II ERQ	9	6-month
Mennin et al., 2015	Emotion regulation therapy	Open trial	GAD with/without depression	Individual	N/A	21	BDI-II	1	3 & 9-month
Mennin et al., 2018	Emotion regulation therapy	RCT	GAD with/without depression	Individual	Modified attention control	53	BDI-II	5	3 & 9 month
Mohsenabadi et al., 2018	Unified protocol	RCT	Irritable bowel syndrome	Individual	Waiting list	64	DASS-42-D	7	N/A
Renna et al., 2018	Emotion regulation therapy	Open trial	GAD and depression	Individual	N/A	31	BDI-II	3	3 & 9 month

Table 4.5 continued

Study characteristics of the 27 included quantitative trials of emotion regulation (28 studies in total)

Study	Intervention	Methodology	Problem	Format	Comparator	N	Measure	Drop out	Follow-up
Safer et al., 2010	Dialectical behavior therapy for binge eating disorder	RCT	Binge eating disorder	Group	Active comparison group therapy	101	BDI	19	3, 6 & 12-month
Sauer-Zavala et al., 2020	Unified protocol	RCT	Depression	Individual	Single-disorder protocol or waiting list	44	ODSIS	N/A	12-month
Schanche et al., 2020	Mindfulness-based cognitive therapy	RCT	Recurrent depression	Group	Waiting list	68	BDI-II DERS	8	N/A
Telch et al., 2000	Dialectical behaviour therapy	Uncontrolled trial	Binge Eating Disorder	Group	N/A	11	BDI	None	N/A
Telch et al., 2001	Dialectical behaviour therapy	RCT	Binge Eating Disorder	Group	Waiting list	44	BDI	10	N/A
Wright et al., 2020	Distress tolerance brief psychological intervention	Uncontrolled study	Various	Individual	N/A	71	PHQ9 DERS	28	N/A

Abbreviations: CES-D Center for epidemiologic studies depression scale; DASS Depression anxiety stress scales; DERS Difficulties in emotion regulation scale; HADS Hospital anxiety and depression scale; BSI Brief symptom inventory; GAD Generalised anxiety disorder; ODSIS Overall depression severity and impairment scale; PHQ-9 Patient health questionnaire; STAIR Skills training in affect and interpersonal regulation; WEMWS Warwick Edinburgh mental wellbeing scale

Emotion Focus

Table 4.6 shows the characteristics of the 11 identified controlled trials for emotion focus. Five trials focused on depression, one on anxiety and depression, and one on mixed emotional problems. One study focused on generalised anxiety disorder (GAD), one on unresolved feelings to a significant other, one on self-criticism, and one on bulimia nervosa.

Seven of these are studies of EFT or process-experiential therapy: three for depression (Goldman, 2006; Greenberg & Watson, 1998; Watson, 2003), and others for anxiety and depression (Lafrance Robinson et al., 2014), bulimia nervosa (Wnuk, 2015), self-criticism (Shahar, 2012) and unresolved feelings to a significant other (Paivio & Greenberg, 1995). Two of these trials might be considered additive studies, where in one arm EFT interventions were added to the relationship conditions of client-centred therapy. Greenberg & Watson (1998) compared client-centred therapy to client-centred therapy with the addition of two-chair, empty-chair and systematic evocative unfolding interventions. Goldman et al. (2006) replicated this trial comparing EFT to client-centred therapy. Two further additive trials are included: Newman et al. (2011) supplemented CBT with techniques from EFT and interpersonal therapy for generalised anxiety disorder, while Grosse Holtforth et al. (2019) added EFT techniques and exposure to CBT for depression.

Grosse Holtforth (Grosse Holtforth et al., 2011) also conducted a dismantling study comparing general psychotherapy, an integration of CBT with process-experiential techniques, with and without motivational clarification. Motivational clarification is employed where the client is understood to be experiencing conflicting approach and avoidance motivations, and involves interventions to produce emotional activation and change, including two-chair exercises.

Dornelas et al. (2010) tested the effectiveness of a brief affect-focused treatment for pregnant women with depression (antepartum depression).

Table 4.6

Study characteristics of the 11 included quantitative trials of emotion focus

Study	Intervention	Method	Problem	Format	Comparator	*N*	Measure	Drop out	Follow-up
Dornelas et al., 2010	Affect-focused psychotherapy	Pre-post	Antepartum depression	Individual	N/A	10	BDI	N/A	N/A
Goldman et al., 2006	Emotion focused therapy	RCT	Depression	Individual	Client-centred therapy	42	BDI	4	N/A
Greenberg & Watson, 1998	Two-chair, empty-chair, systematic evocative unfolding	RCT	Depression	Individual	Client-centred therapy	34	BDI	4	6 months
Grosse Holtforth et al., 2011	General psychotherapy	RCT	Various emotional problems	Individual	GPT – clarification	92	GSI	25	N/A
Grosse Holtforth et al., 2019	Exposure-based cognitive therapy-adapted	RCT	Depression	Individual	CBT	149	BDI-II	22	3-, 6- & 12-month
Lafrance Robinson et al., 2014	Emotion focused therapy	Pre-post	Anxiety and depression	Group	N/A	6	BDI-II	2	1-year
Newman et al., 2011	CBT + EFT & interpersonal therapy	RCT	GAD	Individual	CBT + Supportive listening	83	HRSD	13	6-month, 1-& 2-year

Table 4.6 continued

Study characteristics of the 11 included quantitative trials of emotion focus

Study	Intervention	Method	Problem	Format	Comparator	*N*	Measure	Drop out	Follow-up
Paivio & Greenberg, 1995	Empty-chair dialogue	RCT	Unresolved feelings to a significant other	Individual (Control = group)	Psychoeducation about 'unfinished business'	34	SCL-90-R	8	4 months
Shahar et al., 2012	Emotion focused therapy	Pre-post	Self-criticism	Individual	N/A	10	BDI-II	1	2-, 4- & 6-month
Watson et al., 2003	Process-experiential	RCT	Depression	Individual	CBT	93 (ITT)	BDI	27	N/A
Wnuk et al., 2015	Emotion focused therapy	Pre-post	Bulimia nervosa	Group	N/A	12	BDI	N/A	N/A

Abbreviations: GPT General psychotherapy; GSI Global severity index; HRSD Hamilton depression rating scale; ITT Intention to treat; SCL-90-R Symptom checklist-90-revised

Analysis of Quantitative Trials

Experiential Specificity

Figure 4.3 shows the pre- post-treatment effect sizes for the nine trials of

experiential specificity. These had a large overall effect size of g = 0.87, 95%CI [0.43, 1.31],

p <0.001, indicating that interventions developed to improve memory specificity and

concreteness may also improve depression symptoms. Figure 4.4 shows the smaller and

nonsignificant effect size for the five comparisons between experiential specificity

interventions and active controls (g = 0.31, 95%CI [-0.02, 0.63], p = 0.06). No additive studies

for experiential specificity interventions were identified by the database searches.

Figure 4.3

Experiential specificity: pre- post-treatment effect sizes and forest plot showing depression outcomes of trials

Study or Subgroup	Pre-treatment			Post-treatment			Weight	Std. mean difference	
	Mean	SD	*N*	Mean	SD	*N*		IV, Random, 95% CI	
Watkins et al., 2009	24.89	6.29	19	11.68	6.29	19	10.2%	2.06 [1.25, 2.86]	
Watkins et al., 2012	32.90	10.03	40	13.88	12	25	12.1%	1.74 [1.15, 2.32]	
Serrano et al., 2004	30.70	6.76	20	20.45	7.25	20	11.1%	1.43 [0.73, 2.14]	
Eigenhuis et al., 2017	32.20	9.90	26	25.40	12.3	26	12.4%	0.60 [0.04, 1.16]	
Moradi et al., 2014	19.08	9.06	12	15.25	4.03	12	10.1%	0.53 [-0.29, 1.34]	
Maxwell et al., 2016	26.13	11.31	8	20.25	16	8	8.6%	0.40 [-0.59, 1.39]	
Serrano et al., 2012	17.30	5.20	9	14.10	9.8	9	9.1%	0.39 [-0.55, 1.32]	
Werner-Seidler et al., 2018	30.80	12.81	31	25.80	12.4	29	12.8%	0.39 [-0.12, 0.90]	
Kleijn et al., 2018	6.10	4.10	55	4.90	3.7	44	13.7%	0.30 [-0.10, 0.70]	
Total (95% CI)			**220**			**192**	**100.0%**	**0.87 [0.43, 1.31]**	

Heterogeneity: Tau^2 = 0.33; Chi^2 = 32.98, df = 8 (*p* < 0.0001); I^2 = 76%
Test for overall effect: Z = 3.86 (*p* = 0.0001)

Figure 4.4

Experiential specificity: Effect sizes and forest plot showing depression outcomes of comparative trials (positive effects favour experiential specificity intervention)

| Study or Subgroup | Active control | | | Experiential specificity intervention | | | | Std. mean difference | |
	Mean	SD	N	Mean	SD	N	Weight	IV, Random, 95% CI	
Watkins et al., 2009	18.53	10.89	19	11.68	6.29	19	20.30%	0.75 [0.09, 1.14]	
Watkins et al., 2012	19.61	11.91	27	13.88	11.98	25	27.30%	0.47 [-0.08, 1.02]	
Serrano et al., 2012	4.10	3.00	8	3.10	3.4	9	10.40%	0.29 [-0.66, 1.25]	
Werner-Seidler et al., 2018	27.04	13.36	31	25.8	12.8	31	32.20%	0.09 [-0.4, 0.59]	
Maxwell et al., 2016	14.75	10.99	8	20.25	16.03	8	9.80%	-0.38 [-1.37, 0.61]	
Total (95% CI)			**93**			**92**	**100.00%**	**0.31 [-0.02, 0.63]**	
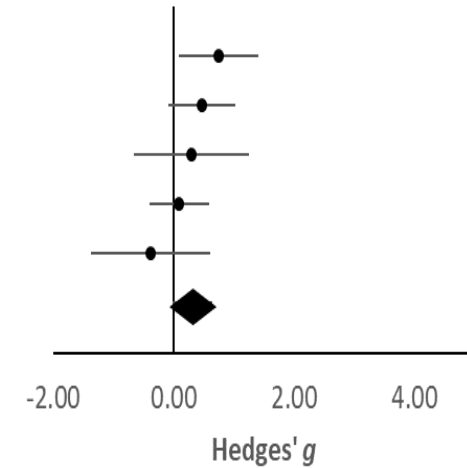
Heterogeneity: Tau^2 = 0.02; Chi^2 = 4.65, df = 4 (p = 0.33); I^2 = 14%
Test for overall effect: Z = 1.86 (p = 0.06)

Emotion Regulation

Table 4.7 shows the pre- post-treatment effect sizes and Figure 4.5 shows the forest plot for 28 comparisons within 27 trials. In their investigation of skills training in affect and interpersonal regulation (STAIR), Cloitre et al. (2010) included two intervention groups, STAIR followed by prolonged exposure, here labelled Cloitre 2010a, and STAIR followed by supportive counselling, labelled Cloitre 2010b. The aggregated results for 28 outcomes show a large overall effect size of g = 1.00, 95% CI [0.84, 1.15], $p < 0.001$, indicating that interventions aiming to improve emotion regulation may also improve depression symptoms. The effect size for the seven comparisons between emotion regulation interventions and active controls was small and nonsignificant (g = 0.07, 95%CI [-0.15, 0.30], p = 0.52; Figure 4.6).

Figure 4.7 shows results for the two additive trials (three comparisons of therapy plus an added emotion regulation component with therapy without the component). They have a mean Hedges' g of 0.22, 95% CI [-0.05, 0.50] in favour of the emotion regulation intervention, but nonsignificant at p = 0.11.

Table 4.7

Emotion regulation: Pre- post-treatment effect sizes for depression outcomes of trials

Study or Subgroup	Pre-treatment			Post-treatment				Std. mean difference
	Mean	SD	N	Mean	SD	N	Weight	IV, Random, 95% CI
Renna et al., 2018	26.71	9.41	31	8.03	6.88	31	3.50%	2.24 [1.59, 2.88]
Sauer-Zavala et al., 2020	13.83	3.71	12	5.67	3.39	9	1.50%	2.19 [1.05, 3.32]
Gilbert & Procter, 2006	10.33	2.67	6	4.30	2.37	6	0.90%	2.06 [0.55, 3.58]
Cloitre et al., 2002	25.00	10.60	22	8.00	7.80	22	3.10%	1.79 [1.08, 2.5]
Mennin et al., 2018	19.80	9.90	28	5.80	5.80	28	3.60%	1.70 [1.08, 2.32]
Khakpoor, Bytamar & Saed, 2019	15.91	6.96	11	5.27	6.36	11	1.90%	1.54 [0.56, 2.51]
Mennin et al., 2015	16.90	9.97	21	6.20	6.97	21	3.30%	1.22 [0.56, 1.88]
Mahmoodi et al., 2020	23.77	9.19	22	15.14	5.68	22	3.50%	1.11 [0.47, 1.75]
Cloitre et al., 2010b	18.80	10.01	33	8.90	7.64	33	4.40%	1.10 [0.58, 1.62]
Koch, Ehring & Liedl, 2020	48.51	12.38	22	33.00	15.72	15	3.10%	1.10 [0.39, 1.81]
Cancian et al., 2019	15.80	9.70	14	6.70	6.10	14	2.60%	1.09 [0.29, 1.89]
Afshari & Hasani, 2020	13.63	5.87	32	8.35	3.38	32	4.30%	1.09 [0.56, 1.62]
Cloitre et al., 2010a	21.10	8.80	38	11.90	8.54	38	4.70%	1.05 [0.57, 1.53]
Mohsenabadi et al., 2018	23.75	6.41	32	17.31	6.27	32	4.30%	1.00 [0.48,1.53]
Carmody et al., 2009	13.09	8.68	309	7.33	0.38	309	7.80%	0.94 [0.77, 1.10]
Safer, Robinson & Jo, 2010	17.94	9.37	50	9.10	9.21	50	5.30%	0.94 [0.53, 1.36]
Bryant et al., 2013	26.06	6.85	36	17.08	11.54	36	4.60%	0.94 [0.45, 1.42]
Bacon et al., 2018	-30.64	6.73	47	-38.79	10.89	47	5.20%	0.89 [0.47, 1.32]
Telch et al., 2000	11.50	6.40	11	7.00	5.10	11	2.30%	0.75 [-0.12, 1.62]
Wright et al., 2020	18.44	4.77	39	14.31	6.38	39	4.90%	0.73 [0.27, 1.18]
Juarascio et al., 2017	20.37	11.60	19	11.25	13.72	17	3.20%	0.71 [0.03, 1.38]
Kivity et al., 2020	23.50	14.30	13	13.30	15.40	9	2.30%	0.67 [-0.21, 1.54]
Bullis et al., 2015	7.00	4.58	11	4.09	4.23	11	2.30%	0.64 [-0.23, 1.50]
Boyle et al., 2017	14.67	8.19	39	10.06	7.06	35	4.80%	0.59 [0.13, 1.06]

Table 4.7 continued

Emotion regulation: Pre- post-treatment effect sizes for depression outcomes of trials

| Study or Subgroup | Pre-treatment | | | Post-treatment | | | Weight | Std. mean difference |
	Mean	SD	*N*	Mean	SD	*N*		IV, Random, 95% CI
Clyne & Blampied, 2004	17.90	15.54	11	10.80	12.25	11	2.40%	0.49 [-0.36, 1.34]
Graser et al., 2016	24.40	10.68	10	19.70	9.00	10	2.20%	0.46 [-0.43, 1.35]
Telch, Agras & Linehan, 2001	12.80	7.40	18	9.90	10.00	18	3.40%	0.32 [-0.34, 0.98]
Schanche et al., 2020	13.20	8.50	31	10.40	9.10	31	4.50%	0.31 [-0.19, 0.82]
Total (95% CI)			**968**			**948**	**100%**	**1.00 [0.84, 1.15]**

Heterogeneity: $Tau^2 = 0.07$; $Chi^2 = 53.31$, df = 27 ($p < 0.002$); $I^2 = 49\%$
Test for overall effect: Z = 12.67 ($p < 0.00001$)

Figure 4.5

Emotion regulation: Forest plot showing pre- post-treatment effect sizes for depression outcomes of
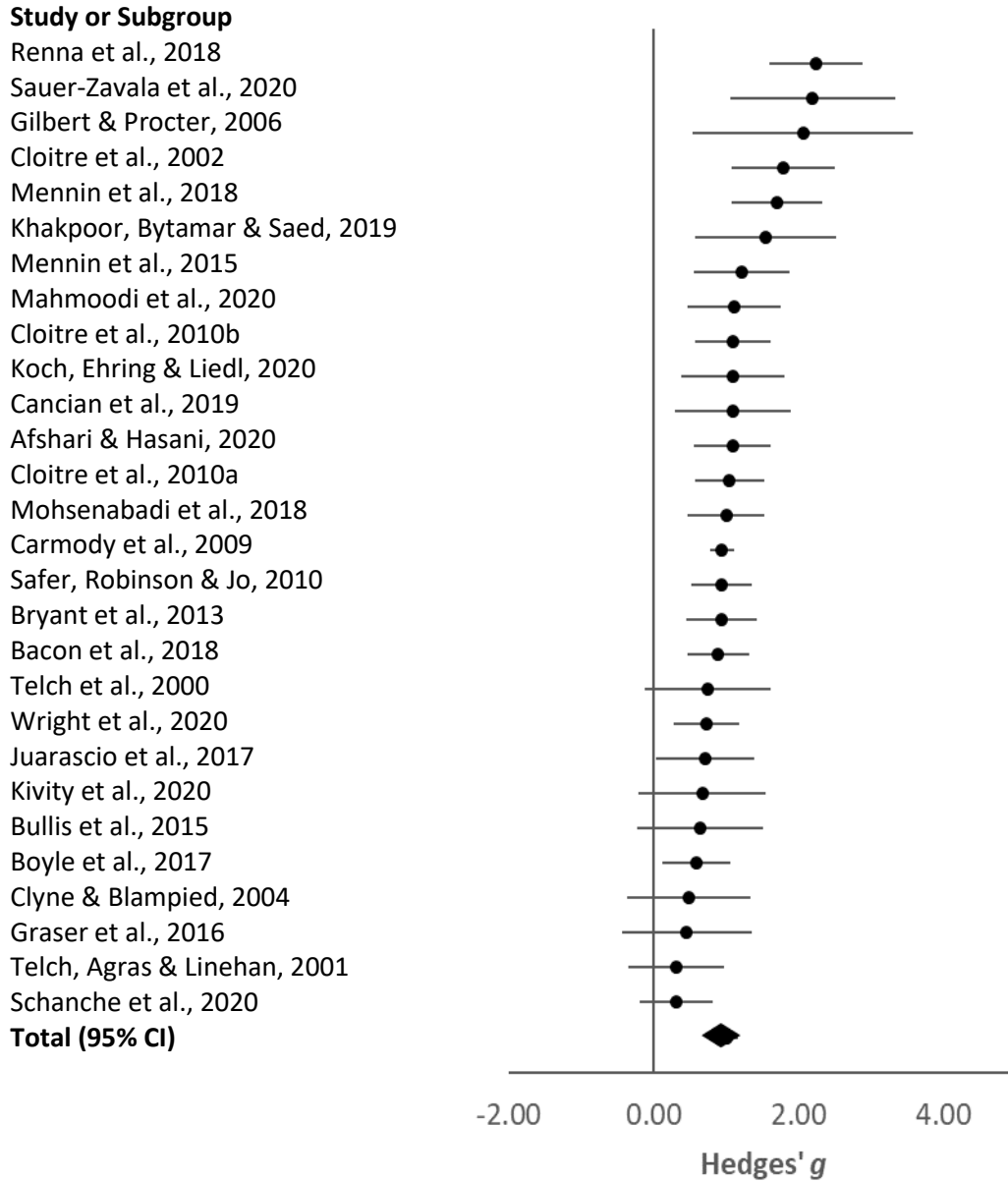
trials

Figure 4.6

Emotion regulation: Effect sizes and forest plot showing depression outcomes of comparative trials (positive effects favour emotion regulation intervention)

Study or Subgroup	Active control			Emotion regulation intervention			Weight	Std. mean difference IV, Random, 95% CI
	Mean	SD	N	Mean	SD	N		
Cloitre et al., 2010a	12.9	9.41	16	8.90	7.64	33	11.80%	0.48 [-0.13, 1.08]
Safer, Robinson & Jo, 2010	10.84	6.86	51	9.10	9.21	50	23.20%	0.21 [-0.18, 0.60]
Mahmoodi et al., 2020	16.35	5.82	23	15.14	5.68	22	12.50%	0.21 [-0.38, 0.79]
Cloitre et al., 2010b	12.9	9.41	17	11.90	8.54	38	13.00%	0.11 [-0.46, 0.68]
Bryant et al., 2013	18.21	7.86	34	17.08	11.54	36	17.80%	0.11 [-0.36, 0.58]
Sauer-Zavala et al., 2020	4.22	3.87	9	5.67	3.39	9	5.50%	-0.38 [-1.31, 0.55]
Afshari & Hasani, 2020	6.28	5.63	31	8.35	3.38	32	16.10%	-0.44 [-0.94, 0.06]
Total (95% CI)			**181**			**220**	**100.00%**	**0.07 [-0.15, 0.30]**

Heterogeneity: $Tau^2 = 0.02$; $Chi^2 = 7.42$, df = 6 ($p = 0.28$); $I^2 = 19\%$
Test for overall effect: Z = 0.64 ($p = 0.52$)

Figure 4.7

Emotion regulation: Effect sizes and forest plot showing depression outcomes of additive trials without and with emotion regulation component (positive

effects favour emotion regulation component)

Study or Subgroup	Without emotion regulation component			With emotion regulation component			Weight	Std. mean difference	
	Mean	SD	N	Mean	SD	N		IV, Random, 95% CI	
Cloitre et al., 2010a	12.9	9.41	33	8.9	7.64	33	31.40%	0.46 [-0.03, 0.95]	
Cloitre et al., 2010b	12.9	9.41	33	11.9	8.54	38	34.50%	0.11 [-0.35, 0.58]	
Bryant et al., 2013	18.21	7.86	34	17.08	11.54	36	34.10%	0.11 [-0.36, 0.58]	
Total (95% CI)			**100**			**107**	**100%**	**0.22 [-0.05, 0.5]**	
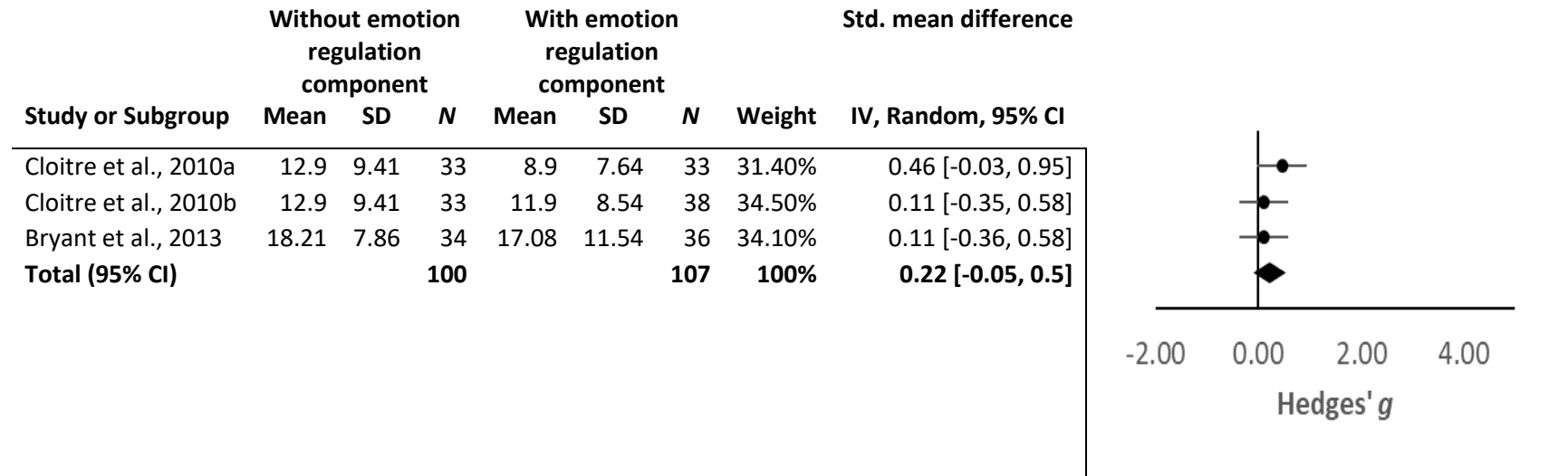
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 1.35$, df = 2 ($p = 0.51$); $I^2 = 0\%$
Test for overall effect: Z = 1.58 ($p = 0.11$)

Emotion Focus

Figure 4.8 shows the pre- post-treatment effect sizes for the 11 trials, with a very large overall effect size of g = 1.55, 95% CI [1.17, 1.93], p <0.001, indicating that emotion focus interventions may improve depression symptoms. The effect size for the comparison between emotion focus interventions and active controls was nonsignificant (g = 0.21, 95%CI [-0.03, 0.45] p = 0.08, Figure 4.9). For one study of EFT the comparator (CBT) was slightly more effective (g = -0.04, Watson, 2003).

Results for the five trials comparing therapy with an added emotion focus component with therapy without the component (Figure 4.10) give a Hedges' g of 0.16, 95% CI [-0.06, 0.37] in favour of the emotion focus intervention, but nonsignificant at p = 0.15.

Figure 4.8

Emotion focus: Pre-post-treatment effect sizes and forest plot showing depression outcomes for trials

Study or Subgroup	Pre-treatment Mean	SD	N	Post-treatment Mean	SD	N	Weight	Std. mean difference IV, Random, 95% CI
Goldman, 2006	26.21	7.10	19	4.95	5.69	19	7.30%	3.24 [2.24, 4.23]
Greenberg & Watson, 1998	25.38	6.85	17	8.39	5.69	17	7.70%	2.63 [1.69, 3.58]
Dornelas, 2010	25.40	6.80	10	11.30	7.60	10	6.60%	1.87 [0.78, 2.96]
Grosse Holtforth, 2019	24.66	8.75	76	9.39	7.78	60	12.60%	1.82 [1.42, 2.22]
Lafrance Robinson, 2014	36.00	4.56	6	25.17	7.60	6	5.00%	1.60 [0.22, 2.97]
Newman, 2011	17.30	7.93	43	6.91	5.09	34	11.60%	1.51 [0.99, 2.02]
Paivio & Greenberg, 1995	0.80	0.53	16	0.29	0.20	16	9.20%	1.24 [0.48, 2.01]
Watson, 2003	24.50	8.39	40	13.05	11.91	40	12.00%	1.10 [0.63, 1.57]
Shahar, 2012	24.20	11.37	10	11.30	12.61	10	7.70%	1.03 [0.08, 1.98]
Grosse Holtforth, 2011	1.15	0.67	35	0.61	0.46	35	11.80%	0.93 [0.43, 1.42]
Wnuk, 2015	22.75	9.16	12	14.58	10.23	12	8.50%	0.81 [-0.03, 1.65]
Total (95% CI)			**284**			**259**	**100.00%**	**1.55 [1.17, 1.93]**

Heterogeneity: $Tau^2 = 0.25$; $Chi^2 = 31.82$, df = 10 ($p = 0.0004$); $I^2 = 69\%$
Test for overall effect: Z = 8.04 ($p < 0.00001$)
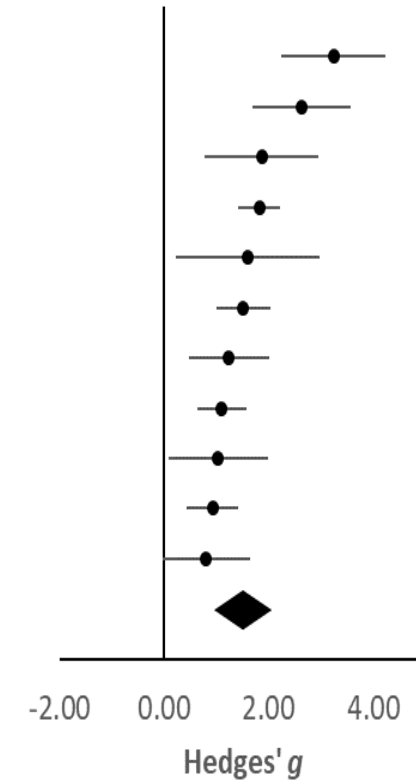
Figure 4.9

Emotion focus: Effect sizes and forest plot showing depression outcomes of comparative trials (positive effects favour emotion focus intervention)

Study or Subgroup	Active control			Emotion focus intervention			Weight	Std. mean difference IV, Random, 95% CI
	Mean	SD	N	Mean	SD	N		
Paivio & Greenberg, 1995	0.65	0.43	17	0.29	0.2	16	8.50%	1.04 [0.3, 1.77]
Goldman, 2006	9.89	9.1	19	4.95	5.69	19	10.20%	0.64 [-0.02, 1.29]
Newman, 2011	8.44	7.56	35	6.91	5.09	34	15.90%	0.23 [-0.24, 0.71]
Greenberg & Watson, 1998	9.12	5.38	17	8.39	5.69	17	9.70%	0.13 [-0.54, 0.80]
Grosse Holtforth, 2011	0.67	0.69	32	0.61	0.46	35	15.70%	0.10 [-0.38, 0.58]
Grosse Holtforth, 2019	9.51	8.69	63	9.39	7.78	60	22.00%	0.01 [-0.34, 0.37]
Watson, 2003	12.56	10.7	45	13.05	11.91	40	18.10%	-0.04 [-0.47, 0.38]
Total (95% CI)			228			221	100.00%	0.21 [-0.03, 0.45]
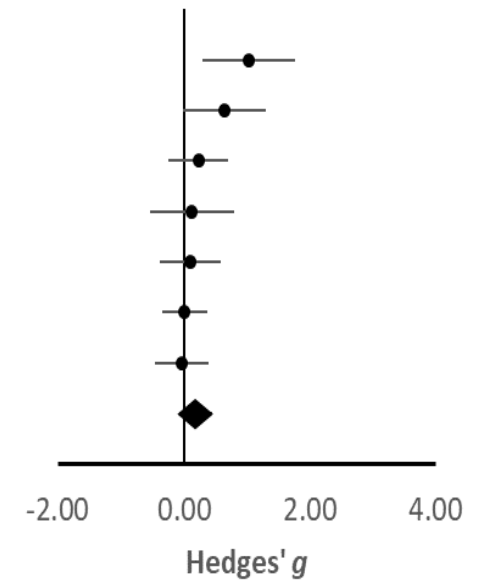
Heterogeneity: $Tau^2 = 0.04$; $Chi^2 = 9.20$, df = 6 ($p = 0.16$); $I^2 = 35\%$
Test for overall effect: Z = 1.75 ($p = 0.08$)

Figure 4.10

Emotion focus: Effect sizes and forest plot showing depression outcomes for additive trials without and with emotion focus component (positive effects favour emotion focus component)

Study or Subgroup	Without emotion focus component			With emotion focus component			Weight	Std. mean difference IV, Random, 95% CI
	Mean	SD	N	Mean	SD	N		
Goldman, 2006	9.89	9.1	19	4.95	5.69	19	11.00%	0.64 [-0.02, 1.29]
Newman, 2011	8.44	7.56	35	6.91	5.09	34	20.90%	0.23 [-0.24, 0.71]
Greenberg & Watson, 1998	9.12	5.38	17	8.39	5.69	17	10.30%	0.13 [-0.54, 0.8]
Grosse Holtforth, 2011	0.67	0.69	32	0.61	0.46	35	20.40%	0.1 [-0.38, 0.58]
Grosse Holtforth, 2019	9.51	8.69	63	9.39	7.78	60	37.50%	0.01 [-0.34, 0.37]
Total (95% CI)			**166**			**165**	**100.00%**	**0.16 [-0.06, 0.37]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 2.86$, df = 4 ($p = 0.58$); $I^2 = 0\%$
Test for overall effect: Z = 1.43 ($p = 0.15$)

-2.00 0.00 2.00 4.00
Hedges' *g*
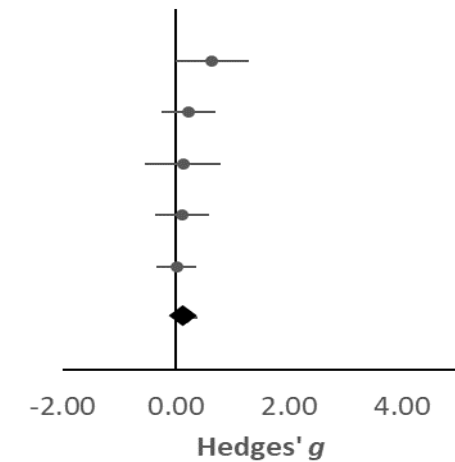
Figure 4.11

Funnel plots for publication bias for experiential specificity, emotion regulation, and emotion focus

(a) Experiential Specificity

(b) Emotion Regulation
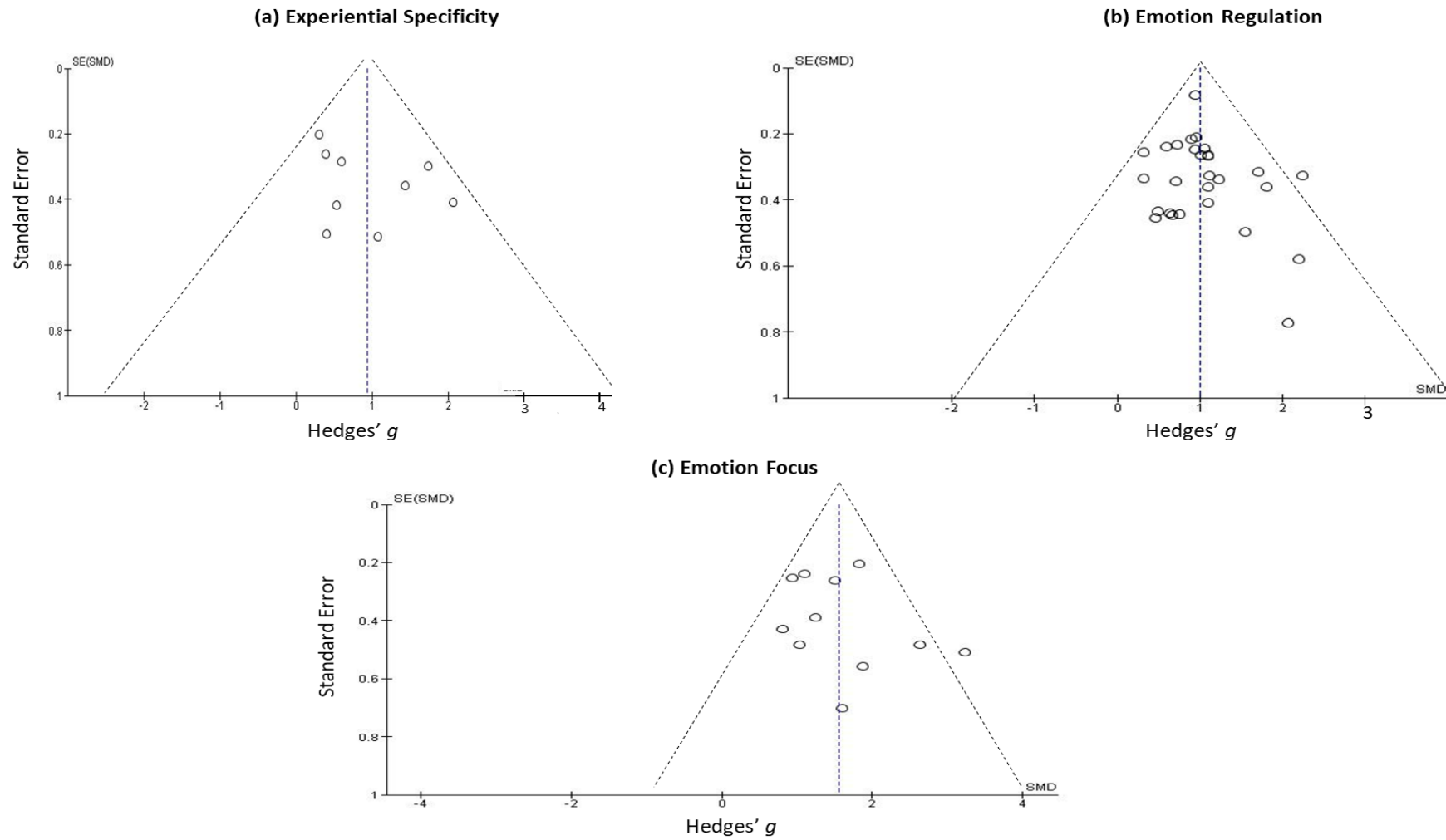
(c) Emotion Focus

Test for Publication Bias

Visual inspection of the funnel plots for experiential specificity and emotion focus (Figure 4.11 (a) and (c); RevMan 5) shows sufficiently symmetrical patterns for the trials reported here, suggesting that the risk of publication bias is avoided for the review of these components. The funnel plot for the 27 emotion regulation trials however (Figure 4.11 c), shows some asymmetry, suggesting that there is a risk of publication bias for this review, with a lack of small studies (i.e., studies with low precision, reporting a small or negative effect).

Assessment of Methodological Quality of Trials

Results of the assessment of methodological quality of the included trials are given below, with a summary in Table 4.8. Full results are given in Appendix C, Tables 4.4C to 4.9C.

Experiential Specificity. Two of the eight randomised controlled trials were given a score of 8/8. The median score was 7/8. The one non-randomised study was given a score of 4/4.

Emotion Regulation. Five of the 15 randomised controlled trials were given a score of 8/8. The median score was 5. Two trials of emotion regulation were given a score of 4/8: Boyle et al. (2017) reported that there was a chance baseline imbalance between intervention and control groups on several variables; and Khakpoor et al. (2019) did not provide any detail of how the control group in their randomised controlled trial were treated. One of the 12 non-randomised studies was given a score of 4/4, and the median score was three.

Emotion Focus. Three of the seven randomised controlled trials were given a score of 8/8. The median score was 7. One trial (Watson, 2003) specifically addressed the issue of researcher or therapist allegiance. All four non-randomised studies were given a score of 3.

Table 4.8

Summary of results for assessment of methodological quality of trials

	Randomised										Non-randomised					
	1	2	3	4	5	6	7	8	Total	Median	1	2	3	4	Total	Median
Experiential specificity					2	1	3	2	8	7				1	1	N/A
Emotion regulation				2	6	1	1	5	15	5			11	1	12	3
Emotion focus					1		3	3	7	7			4		4	4

Discussion

Stage 1: Reciprocal Translation

The process of reciprocal translation (Table 4.3 and Appendix C) found that the three psychotherapy components under review here, experiential specificity, emotion regulation and emotion focus, are transtheoretical and transdiagnostic constructs. According to the definitions provided in the PCEPS, these constructs are shared with PCET. Although in PCET practice these components are not offered in isolation, for the purposes of this review the three components have been isolated, using the definitions given in the PCEPS.

In the CBT tradition these components have been isolated, and training programmes and research underpinned by theory have been elaborated to address specific psychological problems. This is most evident for experiential specificity, where over-general autobiographical memory is seen as a cognitive bias causing a vulnerability to depression, and emotion regulation, where training helps to counteract emotional dysregulation. For emotion focus, researchers have added individual techniques such as chair-work to conventional CBT (e.g., Newman, 2011).

In psychodynamic practice, and in humanistic practices such as EFT and PCET, these components are not isolated, but are closely related constructs working in concert. Therapy as a whole is emotion focused and requires emotion regulation sensitivity on the part of the therapist to progress (Greenberg & Paivio, 2003). Specific emotion focus interventions such as working with self-configurations help to deepen the client's emotional experience. Experiential specificity interventions also help the client to identify and differentiate emotions. As seen in the component logic model (Figure 4.1), most interventions in fact serve to operationalise more than one component.

Much of the wider literature from humanistic, CBT, and psychodynamic traditions, especially theory papers and process research, reinforces that these therapy components are overlapping constructs. For example, emotion differentiation has been identified and researched as an element of both experiential specificity and emotion regulation in EFT and CBT (Fresco et al., 2013; Watson & Rennie, 1994). This review has identified many more such examples, as demonstrated through reciprocal translation (Table 4.3) and analysis of qualitative research (Appendix C). Many more studies identified in the search process were excluded from this review because two or more of the components were treated together and could not be isolated (Table 4.2 & Figure 4.2).

The following two sections use the results of this literature review to answer the questions formed in the introduction to this chapter, namely, (1) Are experiential specificity, emotion regulation, and emotion focus interventions effective in their own right for the treatment of depression? (2) Do experiential specificity, emotion regulation, and emotion focus interventions improve the effectiveness of psychotherapy for adults experiencing depression?

Stage 2:

Are Experiential Specificity, Emotion Regulation, and Emotion Focus Interventions

Effective in Their Own Right for the Treatment of Depression?

Trials of Standalone Interventions

To answer the first question addressed in Stage 2 of this literature review, the studies reporting pre-post treatment change in depression for standalone interventions are most relevant. Pooled effect sizes for the efficacy of the three components were: (a) 0.87, 95% CI [0.43, 1.31] for experiential specificity interventions; (b) 1.00, 95% CI [0.84, 1.15] for emotion regulation interventions; and (c) 1.55, 95% CI [1.17, 1.93] for emotion focus interventions, all significant at $p < 0.001$. These results compare with those of Elliott et al. (2021) who found an effect size of 0.86 for pre-post change in depression in their meta-analysis of humanistic-experiential studies. The results also suggest that these interventions are effective for the treatment of depression even where depression is not the primary target, a finding matching the meta-analysis of component studies by Bell et al., (2013), where results for secondary outcomes were similar to those for primary outcomes.

Comparative Trials

Two studies of experiential specificity (Watkins, 2009; Watkins, 2012), three studies of emotion regulation (Afshari, 2020; Mahmoodi, 2020; Safer, 2010) and one study of emotion focus (Watson, 2003) met the criteria for an efficacious and specific treatment (Chambless & Hollon, 1998). That is: (a) the interventions under investigation were compared with bona fide control treatments; (b) sample size in each group was > 25; and (c) specific symptom measures were used. In addition, for these six trials, researcher allegiance was taken into account.

150

When the effect sizes for all the comparative studies were pooled, results indicated that for emotion regulation there was no difference between the experimental group and the control group (g = 0.07, 95% CI [-.15, .30], p = 0.52). This matches the findings of other reviews that there is no difference in effectiveness between modalities for the treatment of depression (Barth et al., 2018; Cuijpers et al., 2008; Elliott et al., 2021). Previously published meta-analyses of emotion regulation interventions (e.g., Moltrecht et al., 2020; Sloan et al., 2017) report only data from measures of emotion regulation, so that comparisons with the outcomes for depression in the current review are not possible.

For experiential specificity and emotion focus interventions the pooled effect sizes calculated in this analysis were greater than those found by other reviews of treatment for depression, but comparable to those in reviews of the specific components. For experiential specificity, the pooled effect size of g = 0.31, 95% CI [-.02, .63], p = 0.06 was very similar to the results of the meta-analysis of experiential specificity interventions by Hitchcock et al. (2017) of d = 0.32, 95% CI [.13, .52], though less significant. For emotion focus interventions versus active controls, the pooled Hedges' g of 0.21, 95% CI [-.03, .45], p = 0.08 was higher than the effect size of d = -.07, 95% CI [-.21, .07] found by Elliott et al. (2021) for humanistic-experiential interventions compared with other active therapies. Elliott and colleagues, however, included treatments such as supportive counselling used as controls in trials of other therapies (i.e., interventions without an active emotion focus).

Conclusion for Efficacy of Experiential Specificity, Emotion Regulation, and Emotion Focus Interventions

Overall, the findings of these meta-analyses suggest that, according to the criteria for efficacy set by Chambless and Hollon (1998), standalone interventions based on these three components are efficacious and specific for the treatment of depression. The results of each

of the studies included in this analysis suggest that the three components are possibly

efficacious. The finding of multiple studies by different research teams for each of the

components suggests that the components are efficacious in their own right. However, the

small number of comparative studies and relatively small sample sizes for the three meta-

analyses in the current review mean that results should be interpreted with caution

(Cuijpers et al., 2016).

Do Experiential Specificity, Emotion Regulation, and Emotion Focus Interventions Improve the Effectiveness of Psychotherapy for Adults Experiencing Depression?

To answer the second question addressed in this review, additive studies are more

relevant. In additive trials, a therapeutic intervention is tested against the same intervention

with an added component. Effect sizes for comparisons between therapies with and without

the component for the few additive studies identified in this review are smaller than those

for pre-post measures.

Experiential Specificity

As yet, no additive study has been conducted to test whether existing therapy is

more effective with the addition of experiential specificity interventions, although

qualitative studies (e.g., Singer et al., 2013; Watson & Rennie, 1994; Appendix C) report that

experiential specificity enhances the client's focus on emotional experiencing, suggesting

that such research would be promising.

Emotion Regulation

Two studies, yielding three comparisons, tested whether a preparatory emotion

regulation intervention would make exposure therapy for PTSD more tolerable for clients

(Bryant et al., 2013; Cloitre et al., 2010a & b;). The overall Hedges' g for the three

comparisons was 0.22, 95% CI [-.05, .5] $p = 0.11$.

Emotion Focus

Five studies compared therapy with and without an emotion focus component, giving an overall Hedges' *g* of 0.16, 95% CI [-.06, .37], *p* = 0.15. These results are comparable to those of Cuijpers et al. (2019) who found an effect size of *g* = 0.21, 95% CI [.03, .39] for therapies with an additional component.

Conclusion for Experiential Specificity, Emotion Regulation, and Emotion Focus Interventions as Additional Components of Therapy

Wampold (2015b) estimated that an effect size of 0.20 in favour of a treatment would mean that one in nine people receiving that treatment would have a better outcome than people receiving an inferior treatment. Although the effect sizes found in this analysis are small, when multiplied over the large number of clients seen by PCET therapists in NHS Talking Therapies, they suggest that in the year 2021-22 (NHS Digital, 2023), 5,520 people receiving interventions operationalising these components would have had an improved outcome.

Limitations

Several limitations must be considered which may affect the validity of the meta-analyses reported here, and their applicability to PCET (CASP, 2018b). Potential sources of bias were:

a) Database searches, screening of papers, and data extraction conducted by a single researcher.

b) Database searches limited to English language studies.

c) No search of unpublished grey literature, which is more likely to report studies with findings unfavourable to the three components.

d) Inclusion of studies with small sample sizes, which may be underpowered, and may result in larger effect sizes. Sample sizes ranged from $N = 6$ to $N = 309$, median $N = 44$.

While establishing evidence for the components as mechanisms of change is important to support PCET theory, the findings of the analyses reported here cannot be applied directly to the practice of PCET. The quantitative studies included in the current analyses isolated each of the three experiential components in order to examine their efficacy. In PCET practice the components are not offered in isolation, but are integrated into the therapeutic flow.

Conclusions

The findings of the meta-analyses conducted for this systematic review suggest that experiential specificity, emotion regulation, and emotion focus are efficacious as standalone interventions. For PCET, this means that experiential specificity and emotion regulation interventions may be helpful in their own right at the same time as helping to facilitate the client's emotional processing. Findings from analysis of additive trials of emotion regulation and emotion focus, as well as descriptions of therapy gathered from the process of reciprocal translation, reinforce the function of emotion focus interventions in deepening the client's emotional experiencing and the function of experiential specificity and emotion regulation in enhancing this process.

The search of three databases conducted for this review found hundreds of studies on emotion regulation and emotion focus across modalities and for different client problems, including trials, process and qualitative research (Figure 4.2). Some trials and process research studies have been conducted on experiential specificity, but no additive or dismantling studies were found in the current review. Such studies are now needed to

explore its usefulness as an added therapy component. As a new model of therapy, PCET

has not yet been widely researched, and the effectiveness of these three constructs

specifically as components of PCET has yet to be established.

Chapter 5

How Do Person-Centred Experiential Therapists Use Experiential Specificity,

Emotion Regulation Sensitivity, and Emotion Focus in Practice?

Introduction

The results of the literature review and meta-analysis presented in the last chapter

provide evidence for the efficacy of the three psychotherapeutic components: experiential

specificity, emotion regulation sensitivity, and emotion focus. This chapter presents a study

which examines how PCE therapists in the PRaCTICED trial operationalised these

components as interventions offered to clients during therapy sessions.

Background

Quantitative process-outcome research, such as that reviewed in the systematic

literature review in this thesis (Chapter 4), provides evidence for the effectiveness of the

experiential components of PCET, specifically experiential specificity, emotion regulation

sensitivity, and emotion focus, in reducing clients' depression at the end of therapy. A

different type of research is needed to investigate how therapy achieves this change. 'Little

o outcome research' (Greenberg & Pinsof, 1986), or microprocess research (Elliott, 2010),

focuses on more proximal client outcomes. A wealth of research within the field of

humanistic and experiential therapy has explored relationships among client emotional

processes and successful therapy outcome (Elliott et al., 2013; Elliott et al., 2021; Watson,

2018).

There has been less research on therapist response modes and interventions aimed

at eliciting and deepening such client emotional processes. Stiles (1979) proposed a

taxonomy of verbal response modes in psychotherapy, where both the form and intent of a

therapist utterance were coded, and applied the taxonomy to three schools of therapy: client-centred, gestalt, and psychoanalytic. The author found that the taxonomy was able to "articulate the relationship between the strategy of therapy, embodied in the theory, and the tactics of therapy, manifested in the verbal responses of the therapist to the client" (p.60). Elliott et al. (1982) asked both clients and counsellors to rate the helpfulness of therapist responses using interpersonal process recall (Elliott, 1986; Kagan & Kagan, 1990). Therapist interpretations received the highest ratings for helpfulness from both therapists and clients, while questions were rated as slightly less helpful. A qualitative analysis of the IPR sessions suggested that helpful questions were open-ended and aimed at exploring the client's emotional process and meaning, while unhelpful questions were irrelevant to the client or confrontational.

Elliott (1985) described another taxonomy of helpful and nonhelpful events in therapy, focusing on the "immediate therapeutic impact" (p.307) of therapist responses. The author again used IPR to elicit clients' assessment of the helpfulness of therapist responses in one-session helping interviews with volunteer students. Two 'superclusters' of helpful events were found, incorporating responses classed as task or interpersonal events. Unhelpful events included therapist misperception and negative reactions.

Sachse (1990) described a programme of research examining the influence of therapists' processing proposals on clients' intrapersonal exploration in client-centred therapy. Results showed that therapist responses had a significant impact. When the client was at a 'shallow processing' level of exploration, the therapist response could move them to a deeper level. Where the therapist response was at the 'constant level', matching the level of processing of the client, the client sometimes moved deeper into their emotional process, but was more likely to move away. When the client was already at a deep level of

157

exploration, they were most likely to accept a 'flattening' proposal from the therapist, moving them away from their emotional process. This research highlights the difficulty of the PCE therapist's task to guide the client towards a deepening of their self-exploratory and emotional processes, and avoid flattening them by maintaining an awareness of the client's emotion regulation at each moment.

Process-Guiding Interventions in PCET

While person-centred and emotion theory provide the 'strategy', therapist interventions constitute the 'tactics' of PCET (Stiles, 1979). In contrast to emotion focused therapy (EFT), where the principles of emotion theory are operationalised through discrete tasks such as systematic evocative unfolding and working with conflict splits, PCET puts a greater emphasis on nondirectiveness. PCE therapists are less likely to propose tasks to the client, but rather to weave responses and interventions intended to facilitate the client's emotional experiencing and exploration into a therapeutic relationship based on empathic listening and reflecting (Murphy, 2019).

As described in Chapter 2, the Person-Centred Experiential Psychotherapy Scale (PCEPS-10; Elliott & Westwell, 2012) is central to the training and assessment of PCE therapists. The scale provides a definition of the therapeutic aim of each component or item, in terms of therapist intentions and client process, with examples of therapist behaviours which demonstrate competence in that component. As proposed in the opening chapters of this thesis, experiential specificity, emotion regulation sensitivity, and emotion focus are the active, process-guiding components described in the PCEPS which distinguish PCET from traditional person-centred therapy. In keeping with person-centred philosophy, these definitions and examples are descriptive rather than prescriptive (Sanders & Hill, 2014), allowing for the individual style of each therapist and their responsiveness to the

unique needs of each client. This means that there are many ways for therapists to interpret the components and put them into practice (i.e., to operationalise them), and a margin for interpretation and subjectivity for those assessing therapist competence.

Process research is needed to investigate the ways in which PCE practitioners navigate these processes and operationalise the theoretical components of the model, with the eventual aim of identifying more and less helpful therapist behaviours (Elliott, 1985; Elliott et al., 1982). While empirical evidence has shown that the method of operationalising emotion theory through therapeutic tasks is effective in EFT (Elliott et al., 2021), there is currently no research to investigate how PCE therapists weave such interventions into the person-centred relationship. It is recognised that qualitative studies are valuable in augmenting the findings of quantitative research (Bager-Charleson et al., 2021), helping to build a more detailed understanding of the processes of psychotherapy.

Using qualitative research, the current study proposes an investigation of responses and interventions offered by PCE therapists to facilitate experiential specificity, emotion regulation and emotion focus, and how such interventions are incorporated into sessions within the context of the working alliance (Haake et al., 2020; Nye et al., 2018). Such research is needed to provide a foundation for deeper understanding of the in-session processes which lead to better outcomes for clients, and to contribute to PCET practice, supervision, and training.

Aims of the Study

This study comprised an analysis of transcripts of PCET sessions to identify themes which capture and describe how therapists operationalised the three experiential components in routine PCET practice. By including all the PCE therapists who had session recordings sampled for assessment of therapy integrity in the PRaCTICED trial, the emerging

themes captured the range of ways in which different therapists interpret and apply the three PCET components.

The aim of the study was to build a rich description of how therapists operationalised experiential specificity, emotion regulation sensitivity, and emotion focus to work with the client's emotional process in current PCET practice. The study also aimed to capture the essential principles of interventions which operationalise these components, so that they can be generalised to other therapeutic contexts. The objective was to achieve this by synthesising multiple examples of verbatim exchanges between client and therapist from real therapy sessions into fictionalised but representative exemplars.

Methods

Ethics

Ethics approval was granted as part of the submission for the PRaCTICED trial (Health Research Authority, Research Ethics Committee 14/YH/0001; Barkham et al., 2021).

In line with ethical practice in qualitative research (Levitt et al., 2021), clients' and therapists' own words were not used, but were distilled and synthesised by the researcher to create representative exemplars of real rather than ideal practice. This procedure gives total protection for clients' anonymity. This is important since, although all clients gave consent at the time of the PRaCTICED trial for their data to be used for research, they may subsequently change their minds, or prefer not to have verbatim text cited in the thesis.

Context

This study draws on the large database of PCET session recordings made for the assessment of treatment integrity and process research during the PRaCTICED trial. Details of the trial and participating PCE therapists are available in Chapter 2.

Participants

Details of the PCE therapists who participated in the PRaCTICED trial are given in the thesis introduction.

Sample

Fifteen PCE therapists had session recordings submitted for assessment of therapy integrity. Sampling for the current study involved selecting one recording for each therapist. For one therapist there was only one recording, but for therapists who had more than one recording, the session where the three therapy components were best represented was selected. This was achieved by finding the mean of the PCEPS scores awarded for the three components by the expert raters in the PRaCTICED trial, and selecting the session with the highest mean score for each therapist. Recordings were therefore sampled according to competence in the three therapy components being investigated. This procedure resulted in a sample of 15 recordings for analysis, representing 15 therapists. One of the sampled sessions was a calibration recording, rated by all four raters; the remaining 14 were rated by two raters.

Unit of Analysis

The unit of analysis for this study was a therapist intervention, using as many therapist-client speaking turns as necessary to capture each example of an intervention (Elliott, 1991; Hill & Lambert, 2004). The length of each unit therefore varied between interventions and between therapists and clients. Longer meaning units might also contain differently coded sub-units within them (i.e., interventions were counted even if they also appeared within a more complex intervention; Timulak & Creaner, 2010). For this reason, some parts of excerpts with several speaking turns met the description for two or more

themes. The unit of analysis included the client speaking turn following the last therapist speaking turn of the identified intervention.

Analysis

Qualitative analysis was chosen as appropriate for this study, which investigates and interprets the internal meanings and intentions of therapists as suggested by their spoken language (Levitt et al., 2021). Epistemologically, this research was positioned within a critical realist paradigm, with the belief that human experience is an aspect of the real world, but that it is not accessible to be observed and measured, and must be interpreted. This position is a recognition of the place of this qualitative study alongside and enriching the positivist quantitative research in the thesis. The research also adopted a dialectical constructivist paradigm, acknowledging that qualitative research is tentative and cumulative, with the researcher creating meaning in 'dialogue' with the data (Elliott & Timulak, 2021; Levitt, 2021). The study was descriptive and exploratory (Llewelyn & Hardy, 2001), taking an observer perspective (i.e., that of the researcher) with a focus principally on the therapist but also on the therapeutic dyad (Elliott, 1991; Hardy & Llewelyn, 2015).

The method used was framework analysis (Ritchie & Spencer, 2002), described in Chapter 3. As described in that study, framework analysis involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation. The framework method facilitated the systematic and visible charting of each participant's contribution within each theme.

Procedure

The familiarisation stage involved immersion in the material, beginning with transcribing the 15 recordings, with duration ranging from 42 minutes to 1 hour 19 minutes. These transcripts were uploaded to QSR International's NVivo 12 (2018) for coding. The

three therapy process-guiding components defined in the PCEPS (experiential specificity, emotion regulation sensitivity and emotion focus) provided the *a priori* themes which formed the basis of the thematic framework. Themes and sub-themes were generated inductively from the process of searching for similarities between the verbal behaviours of different therapists within the *a priori* themes.

Indexing involved a deductive process of reading through each transcript and highlighting all segments which illustrated the use by the therapist of one of the three components. As the commonalities between the verbal behaviours of different therapists were identified, segments which shared these features were clustered together into codes. For each code a summary was written, describing a therapist intervention. A recursive process of cross-checking between transcripts and codes continued to refine the descriptions until saturation was reached and no new codes emerged.

For the charting stage of the framework analysis, the final summary versions of all the codes/interventions were printed out, and placed on a table where they could be viewed and rearranged to reflect different groupings. This inductive process facilitated the identification of broad themes. Within these themes, codes/interventions which captured therapist behaviour at a greater level of detail were clustered together into sub-themes. A framework matrix was created within NVivo, with one column for each therapist, and one row for each sub-theme, where each cell contained one or more of the segments of therapist speech which had been coded from the transcripts.

From these quotations an exemplar was created for each code/intervention. This was achieved by imagining a scenario similar to a real scenario described by a client in a session transcript, but changed sufficiently to be non-identifiable. Similarly, fictionalised

therapist responses were invented to capture the essence of each intervention, synthesised from multiple real therapist responses, without using any direct quotations.

Trustworthiness

A second researcher (GEH) was consulted to provide an independent perspective, providing a broader overview of psychotherapeutic concepts, and detached from the specific details of PCET. The first researcher's initial clustering of codes into themes and sub-themes was reviewed by the second researcher, who offered an alternative reading. Themes and sub-themes were refined and compared between the researchers three times, until a shared interpretation was reached.

Reflexivity

The issue of researcher reflexive practice is addressed in the thesis introduction, and in a personal statement (Appendix A). Reflexive awareness was especially important for this qualitative study, based on an interpretative process which introduces subjectivity into the findings. For the initial coding of therapist speech segments which demonstrated experiential specificity, emotion regulation sensitivity or emotion focus, I continually referred to the definitions of the components given in the PCEPS-10. For the process of clustering similar segments to create descriptions and exemplars I set aside the PCEPS-10 definitions to focus on the therapist speech. During this process, I also needed to bracket my own understanding of the PCET model, which could lead to making assumptions about the therapist's intentions in making an intervention. For the identification of commonalities within the codes, the focus on the descriptions produced for each code/intervention meant that they were further separated from the original PCEPS-10 definitions, and from the therapist speech segments, so that the themes found were new while still meaningfully reflecting the original material.

Results

Sessions Sampled for Thematic Analysis

The maximum PCEPS rating for each of the three components is 6. For the 15 session recordings represented in this study, the mean ratings awarded by the expert raters ranged from 3 to 5.5, with median 4.3. Three of the sessions were from the early phase, nine from the middle phase, and three from the late phase of therapy (see Chapter 7 for details of the procedure for calculating phase). Raters were unaware of the phase of therapy.

Thematic Analysis

Repeated searching through the 15 transcripts resulted in 336 segments of therapist speech which met the definition of one of the experiential components of PCET. From the clustering of these segments, 26 codes were identified and 26 summary descriptions of interventions written. Four themes which describe therapist behaviours were identified from the inductive process of grouping the codes/interventions: reflecting, intensifying feelings, understanding, and active guiding. Within each theme a number of sub-themes were identified (Table 5.1). Tables 5.2 to 5.5 show each overarching theme, with the descriptions and exemplars for the interventions grouped within sub-themes.

The following sections will present the results of the analysis for each theme in turn.

Table 5.1

Themes and sub-themes

Themes	Reflecting	Intensifying feelings	Understanding	Active guiding
Sub-themes	Using client's words	Questioning	Summarising	Containing emotion
	Using therapist's words	Focusing on here and now feelings	Questioning to gain a fuller perspective	Facilitating dialogue between parts
	Reflecting client's non-verbal presentation	Using images and vivid language	Offering a new perspective	Guiding the client's imagination

Reflecting

The theme of reflecting brought together interventions where the therapist acted as a mirror for the client's emotional experience. Three sub-themes were found within the theme of reflecting. The sub-theme *using the client's words* described the therapist simply repeating the client's words. The sub-theme *using the therapist's words* described interventions where the therapist used their own words to feed back their understanding of the client's narrative. This understanding could include observations of the client's emotional process, such as conflicting parts of self. *Reflecting the client's non-verbal presentation* described interventions where the therapist used their own words to describe what they observed of the client's physical presentation. For all the interventions, the emphasis of the therapist's reflection was on the emotional content of the client's narrative or physical presentation.

Table 5.2

Reflecting: sub-themes, descriptions and exemplars of therapist interventions

	Reflecting	
Sub-themes	**Intervention description**	**Exemplar**
Using client's words	The therapist echoes the client's own words, usually those words suggesting emotion.	C It's weird how I never plan to go there, but I just somehow end up there. Maybe I'm punishing myself or something, but it happened again on Monday, "Oh, here I am again."
		T Punishing myself.
		C Well, I hate how I feel when I'm there, but it's almost as if I deserve to feel bad.
Using therapist's words	The therapist responds, using the therapist's own words, to let the client know that they understand what the client is saying, but without expanding on it or introducing any images or further interventions.	T I can hear that you've had a lot of really difficult experiences in quite a short space of time.
	The therapist reflects the most emotionally poignant aspect of the client's description of their experience.	C She's getting really bad now, it's so sad. She can still recognise me, but she thought my son was my brother, calling him by my brother's name. And we know she's going to get worse, but we don't know how we're going to find care for her, which is really stressful. She's been such a good Mum, she doesn't deserve this.
		T What's happening with your Mum now is really sad and really stressful.

Table 5.2 continued

<div align="center">Reflecting</div>

Sub-themes	Intervention description	Exemplar	
Using therapist's words continued	The therapist reflects the client's process using the metaphor of 'a part of you', or 'something in you', or reflects an internal conflict as different parts of the client.	T	It sounds as though part of you knows what you want, and what you need to do to get there, but there's another part of you putting up barriers somehow.
Reflecting client's non-verbal presentation	The therapist expresses their observation of the client's physical presentation in that moment, which may reflect the client's here and now emotion.	C	It was the right thing to do, we were no good for each other. But it's the kids really.
		T	And I can see the tears coming as soon as you mention the kids.

T = therapist C = client

Intensifying Feelings

The theme *intensifying feelings* captured therapist interventions which focused on and highlighted the client's emotional experience. Three sub-themes were identified within this theme. *Questioning* included interventions where the therapist asked a direct question about the client's emotions outside the session, as a response to a familiar event, or at the time of the event the client was describing. *Focusing on here and now feelings* included questions from the therapist about the client's emotional experience in the session. Other interventions within this sub-theme described moments where the therapist noticed and verbalised physical changes in themselves or in the client that suggested an immediate emotional experience. Where the change was in themselves, the intervention took the form of a therapist self-disclosure. A further intervention within this sub-theme described a therapist activity of offering a conjecture to the client about what they might be experiencing emotionally in that moment. The third sub-theme was *using images and vivid language,* where the therapist reflected the sense of the client's words, but offered an image, or used emotionally heightened language to highlight the emotional content of the client's narrative.

Table 5.3

Intensifying feelings: sub-themes, descriptions and exemplars of therapist interventions

<div align="center">

Intensifying feelings

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Sub-themes	Intervention description	Exemplar	
Questioning	The therapists asks directly about the emotional aspect of the client's narrative.	T	How does it feel when that happens?
	The therapist asks about the client's emotion at the time of the events they are recounting.	C	He just suddenly lost it, started ranting and raving and pointing his finger.
		T	How did you feel when he started going off like that?
Focusing on here and now feelings	The therapist asks the client how they are feeling in the moment, in response to their narrative.	T	Can you say a bit about what's happening inside you right now, as you're telling me this?
	The therapist makes a tentative guess at an experience the client may be having, based on the therapist's empathic understanding of the client's here and now process and narrative.	C	I don't like it when they're all together like that. They all know each other so well, and have sort of in-jokes. Maybe I'm being over-sensitive, but sometimes it seems like some of the jokes are about me.
		T	It feels as though when they're together they sort of gang up on you, and you feel very alone and helpless. I'm wondering if there might be some anger in there as you're talking?

Table 5.3 continued

Intensifying feelings

Sub-themes	Intervention description	Exemplar
Focusing on here and now feelings continued	The therapist asks directly about the client's physical sensations associated with an emotion, or observes a physical change in the client, and asks about internal feelings associated with this change. This leads to exploration of the emotional meaning of the sensations, and further exploration of the client's experience.	T I noticed that there was a sigh as you began to talk about your son. Can you describe what happens inside you when you think about him? C It's like my heart sinks. I just feel so empty. T You feel empty inside. Can you say any more about what that emptiness is like? C I don't know. Maybe I don't want to think about it. T It's an emptiness, and it's painful at the same time. It's hard even to look at it. C Yeah. It feels like an abyss, and if I looked over the edge I could fall in. T If you let yourself look down into the abyss you could just fall down and down. As if those feelings are bottomless. C [Whispers] Yes. I'll try everything to distract myself, not to have to think about it. T They're such painful feelings, you'll do anything to avoid them.

Table 5.3 continued

Intensifying feelings

Sub-themes	Intervention description		Exemplar
Focusing on here and now feelings continued	The therapist expresses their observation of their own immediate physical or emotional response to the client's narrative.	C	It's the greatest regret of my life. I was just so young and naïve, and made such a stupid decision.
		T	It's really touching me inside to hear what you're saying. I have such a strong sense of sadness, of a young person on their own.
Using images and vivid language	The therapist finds language or images to capture the emotional essence of a narrative that is literal or abstract.	C	I was just getting a few bits, bread and milk and stuff, and it was hard enough to go into the shop in the first place, but when I saw she was there I just didn't know what to do with myself. I just turned right back round and went home. It was her day off, but I'm meant to be off sick, and I just couldn't stay there while she was there. It's not that there's anything wrong with her, I just didn't want her to see me.
		T	As if you were so scared of what she would think if she saw you out when you were off work sick, and you just needed to drop everything and run.
	The therapist reflects what the client says, conveying understanding, but using more vivid or intense language than the client, or introducing images which heighten the emotional aspect of the client's narrative.	C	It does get me down sometimes.
		T	It sounds as though you feel completely battered by it.

T = therapist C = client

Understanding

The theme of *understanding* captured a therapist's efforts either to convey their own understanding of the client's narrative and process, or to help the client to make sense of their experience. Three sub-themes were identified within this theme, shown in Table 4.4. *Summarising* describes the therapist activity of succinctly reflecting the sense of the client's narrative in the therapist's own words, with an emphasis on the emotional content. Within the sub-theme of *questioning to gain a fuller perspective* the therapist offered a range of interventions in the form of questions or reflections which elicited an increasing amount of detail from the client about their experience. This included physical, cognitive, and emotional experiences, remembering past events as well as experiencing within the session. The sub-theme of *offering a new perspective* described therapist responses where they offered the client an alternative understanding or way to make sense of their experience. One intervention captured therapist communication where this understanding was based on a view of the client or their story built up over previous sessions.

Table 5.4

Understanding: sub-themes, descriptions and exemplars of therapist interventions

	Understanding	
Sub-themes	**Intervention description**	**Exemplar**
Summarising	The therapist sums up in their own words a long client narrative from the session or more than one session, emphasising the emotional aspects.	T So, just to make sure I haven't missed anything, you've told me you grew up down South, and your family are still there, and you miss them. Now that you and your husband aren't getting on, it feels like he's got his family locally to support him, but you're feeling very isolated. Going to your brother-in-law's barbecue made you feel lonelier than ever. Have I got the most important things?
Questioning to gain a fuller perspective	The therapist uses reflections and questions to help create a full description of the client's embodied experience of emotion, either here and now or remembered.	T I'm wondering if you're feeling something right now, as we're talking about this?
		C I can feel the churning in my stomach a bit.
		T There's something about talking about this that makes your stomach churn. Can you say any more about that churning?
		C When it gets bad it makes me feel sick.
		T And you're starting to feel sick now?
		C No, it's just down there now, sort of just on the edge of getting going.
		T So it's not quite a full-on churning just now, something a bit less intense?
		C More like butterflies at the moment, but not so nice!

Table 5.4 continued

	Understanding	
Sub-themes	**Intervention description**	**Exemplar**
Questioning to gain a fuller perspective continued		T Not butterflies - a different sort of insect maybe?
		C It's more like something that gets heavier and heavier, like someone starting on tiptoe and then building up to stamping in my insides. That's when I start feeling sick.
	The therapist invites the client to recall a specific experience, or a specific instance of a recurring experience, often the most recent example. The therapist offers reflections and questions to build a detailed account of the experience. The therapist may refer to this as 'freeze framing', using the metaphor of slowing a video to examine it frame by frame.	T How would it be to talk through a recent time when you felt like this? It might help us to understand more clearly what happens inside you at these moments.
		C Oh, I've felt like this for years, it gets me so down.
		T Can you think of the last time you felt like this? Perhaps it's happened just in the last week or so?
		C Um, I suppose maybe Monday. I was talking to my sister then, but it could be anybody.
		T Could you set the scene for me a bit? Maybe where you were with your sister, what was going on?
		C I'd gone round to my parents, and she was there like she always is, going on and on and on about her job this and her kids and that. It drives me mad.
		T So you went round, and you sort of expected that she'd be there, but when you went in and there she was, something happened inside you?

Table 5.4 continued

Understanding

Sub-themes	Intervention description	Exemplar
Questioning to gain a fuller perspective continued		C It's like all the strength just drains out of me. I just shrivel down to nothing.
		T You shrivel down to nothing, you feel small and weak. And on Monday, can you remember how you were feeling before you realised your sister was there?
		C That's the annoying thing, I wasn't feeling too bad before. I was pleased with myself that I'd got out of the house.
	The therapist uses reflections and questions to elaborate a client's recurring experiences. Includes emotional, embodied, cognitive and behavioural patterns.	C And when that person is around I just can't focus on my work any more.
		T Every time they're around you lose your concentration.
		C I'm looking at my screen but my head's just a mess.
		T Do you think it might be helpful if we take a moment to look at what's going on for you there?
		C It's anxiety I suppose, cos I'm just so scared they're going to pull me up again.
		T So as soon as you're aware that that person is there –
		C Yeah. The door to their office is behind me, so I hear the door go, and my friend opposite looks up from their screen; [pause] it's awful.
		T Can you describe what happens in your body in that moment?

Table 5.4 continued

Understanding

Sub-themes	Intervention description	Exemplar	
Questioning to gain a fuller perspective continued		C	It's like I just freeze, I can't move my fingers on the keyboard any more, I can't think –
		T	It's like you're a rabbit in the headlights.
		C	Yeah! I just want to run out of the office, but my legs won't move!
		T	And the person starts off behind you, but then comes round into view?
		C	And I'm there thinking "Don't stop, don't stop, don't look at me."
		T	So what happens inside you if they do look at you?
	The therapist asks questions or offers reflections that guide both the client and the therapist in an effort to understand a client experience that seems puzzling or new, either to the client, the therapist, or both.	T	It sounds like there's something that stops you from talking to him about it?
		C	I guess I don't want to hurt him.
		T	The issue is burning inside you, but there's a part of you that is even more afraid of hurting him.
		C	I know he's loud and always joking, but I'm realising that I see him as so vulnerable.

Table 5.4 continued

<div style="text-align:center">

Understanding

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Sub-themes	Intervention description		Exemplar
Offering a new perspective	The therapist responds, reflecting the client's narrative, and introducing a new perspective or way of understanding the client's emotional process.	C	It just seems to come out of the blue, like I can never predict a trigger or anything. And it's horrible; I can't breathe, I can't think straight, and I just want to get out of there. It feels like I'm going crazy.
		T	It sounds almost like there are different levels to what's happening to you. Your body is going through this horrible experience, and at the same time your head is thinking "What's happening to me? This doesn't make sense!"
	The therapist makes an empathic conjecture based on an understanding of the client built up over previous sessions.	T	This seems so painful for you. I keep noticing that you're a really kind person, and I wonder if that makes it even harder for you.

T = therapist C = client

Active Guiding

The theme of *active guiding* encapsulated segments where the therapist went beyond reflections and questions to offer interventions which guided the client's emotional process within the session. Three sub-themes were found within this theme (Table 4.5). The sub-theme of *containing emotion* described an intervention where the therapist guided the client through overwhelming feelings. When the client's distress made them want to leave the session, the therapist checked their safety on leaving, how they could comfort themselves once they'd left, and their wishes for continuing the therapy. The second sub-theme within this theme was *facilitating dialogue between parts*. The interventions described in this sub-theme involved the therapist inviting the client to talk about their experience in terms of parts of themselves, or to inhabit different parts to talk from the emotional experience of each part separately. Included within this sub-theme were interventions where the therapist guided the client in identifying and acknowledging a positive or comforting part of themselves. The sub-theme *guiding the client's imagination* captured interventions where the therapist invited the client to picture an imaginary event, in order to experience and talk through the associated emotions. Imaginary events included talking to a person who was not present, or imaging places or people that raised anxiety for the client in real life.

Table 5.5

Active guiding: sub-themes, descriptions and exemplars of therapist interventions

Active guiding

Sub-themes	Intervention description	Exemplar
Containing emotion	The therapist observes a change in the client, and that the client seems uncomfortable. The therapist uses reflections and questions to elicit the client's feelings here and now, and to work out together if the client wishes to change the topic, or to end the session altogether. The therapist offers interventions to contain the client's emotion, to check their safety, and to make it possible for the client to continue, or to return for another session of therapy.	T I can see from your face that this is really hard for you. Can you say a bit about what's happening inside you right now? C I can feel the panic rising. T It's ok, you're safe here. Can you look at me? Or just look around you, feel your feet on the floor? C I think I just need to go. T Of course, you need to do whatever will help you to feel ok. Can I just check, did it feel as if maybe we were going a bit too far, too soon? C It's really hard for me to talk about all this. It brings it all back and I struggle to cope. T It's really hard, you've been through so much. I can see that it's a struggle for you just to keep sitting there just now, but do you think we could meet again, and think together about how we could make it a bit easier to talk about these things? C I know I've got to, if I want it to change. T Ok, let's leave it there for today, and make another appointment. Can I also just check how you're going to look after yourself when you leave here today?

Table 5.5 continued

	Active guiding	
Sub-themes	**Intervention description**	**Exemplar**
Facilitating dialogue between parts	The therapist uses questions and reflections to guide the client in exploring and working towards understanding different parts of themselves, and the relationship between them.	C I do know what I want, but every time I try it feels as if there's another reason not to go for it. T And this part of you that puts up barriers, can you describe what sort of reasons it comes up with? C Usually it's something about not having good enough qualifications, or not being as clever as everyone else. T Every time that one part of you is feeling as if you're ready to try, this other part somehow tells you you're not good enough, or undermines your confidence?
	The therapist uses questions and reflections to help the client express feelings on behalf of each part of themselves, and sometimes towards another part.	T Can you maybe say out loud the sort of thing that that undermining part of you might say? C It would be like "Who do you think you are? You'll never manage it, better not to try, you'll only humiliate yourself." T So quite harsh, "You'll humiliate yourself." What's it like for the other part of you, the part that really wants to try, to hear that? C I just feel crushed.

Table 5.5 continued

Active guiding

Sub-themes	Intervention description	Exemplar	
Facilitating dialogue between parts continued	The therapist helps the client to identify and give expression to an encouraging or affirmative part of themselves.	C	Mostly it feels like everything I do is rubbish, but sometimes I can be pleased with what I've done.
		T	It sounds as though there is a part of you that can feel proud of what you've done. Can you say a bit more about that part?
Guiding the client's imagination	The therapist invites the client to say in the session things they wish they could say, or could have said, to someone in their life.	C	I go over it and over it in my head, I can't seem to stop.
		T	And if he were here now, what would you like to say to him?
		C	I'd probably just smile and keep my mouth shut, like I always do.
		T	And if there was nothing stopping you, you could tell him everything that you're keeping bottled up, could you put that into words here?
	The therapist guides the client through an exploration of an emotional experience that is hypothetical, but relevant to the client's concerns.	C	It sounds as though all of it is churning around inside you whenever you see him. Could you describe what would happen inside you if he walked into this room right now?

T = therapist C = client

Discussion

This study presented a thematic analysis of interventions which operationalised the skills of experiential specificity, emotion regulation sensitivity, and emotion focus, offered by 15 PCE therapists in the PRaCTICED trial. The sample comprised transcripts of sessions that demonstrated the greatest competence in the three experiential components for each therapist, as assessed by the expert raters in the PRaCTICED trial. However, the analysis involved only identifying types of interventions offered by therapists, with no assessment of the level of competence in delivering these interventions (Stiles, 1979). Exemplars were therefore composed as an illustration of therapist behaviour for each intervention, in order to contribute to defining the intervention, rather than proposing an ideal example.

By definition, the themes which were identified involved the therapist's active focus on the client's emotional experience, since the three experiential components were chosen as *a priori* themes. The analysis identified examples of PCE therapists finding nondirective interventions which oriented or 'nudged' clients towards their emotional experience while remaining in the client's frame of reference (Elliott, 2022). These interventions were labelled under the theme of *reflecting*. Interventions where the therapist used language and images which highlighted and strengthened the emotional content of the client's narrative were labelled as *intensifying feelings.* Interventions which elaborated the client's experience in the service of insight were labelled as *understanding*. Other interventions were identified under the theme of *active guiding.* These interventions were process-guiding, but were not directive in the same way as EFT task proposals. The PCE therapists in this sample did not formally propose activities such as working with parts of self, but instead noticed when opportunities for such interventions arose naturally within the client's narrative. They were then able to weave process-guiding interventions seamlessly into the person-centred

therapeutic relationship. These findings suggest that (in the words of Stiles, 1979) the 'strategy' of each therapist demonstrated their understanding of PCET as an integration of nondirective person-centred and experiential theory, and their 'tactics' operationalised the theory in the form of the interventions identified here.

Having identified the four themes, a possible ordering was observed where *reflecting, intensifying feelings, understanding,* and *active guiding* suggested a parallel with the process-guiding spectrum described in Chapter 1. In that chapter, the process-guiding spectrum was described as a way of capturing the range of possible therapist directiveness, from the strict nondirectiveness of classical person-centred therapists, to the process-directiveness of EFT therapists.

Reflecting

In the current study, the theme of *reflecting* captured interventions where the therapist adhered to the person-centred principle of remaining in the client's frame of reference without adding anything from the therapist's frame of reference. Within this theme, the sub-themes also suggested a spectrum, from simply echoing the client's words to offering observations using the therapist's words that privileged the emotional content of the client's narrative, including client self-configurations (Murphy, 2019; Mearns & Thorne, 2000; Sanders & Hill, 2014). These interventions served to orient the client to the emotional content of their narrative, similar to Elliott's idea of offering a "nudge" (Elliott, 2022; Sachse, 1990). These simple orienting-type interventions were also offered within more complex interactions identified within the following themes (Timulak & Creaner, 2010).

Intensifying Feelings

The theme of *intensifying feelings* combined elements of both emotion regulation sensitivity and emotion focus. The identification of the sub-theme of *questioning* suggested

184

that although questions are sometimes discouraged in classical person-centred practice

(Renger, 2021; Schmid, 2005), in the current sample the PCE therapists used questions in

the service of orienting the client to the emotional aspects of their story. The therapist

questions identified from the transcripts were open and aimed at deepening the client's

experiential exploration. It is interesting to note that due to this interpretation of the

therapists' intention, the questions identified in this sample corresponded to the theme of

intensifying feelings, rather than *understanding*. For the same reason, they also conformed

to recommendations for helpful as opposed to hindering questions (Elliott et al., 1982;

Renger, 2021; Williams, 2023).

The sub-theme of *focusing on here and now feelings* captured interventions which

helped the client to focus on and experience their emotional process in the moment. These

interventions represented ways of operationalising PCET theory, which emphasises the need

for the client to bring feelings into awareness, to make them available for exploration and

transformation (Elliott et al., 2004; Greenberg, 2004). The interventions included direct

questions about emotions, empathic conjectures (Elliott et al., 2004; Elliott & Westwell,

2012) and questions and observations about embodied feelings (Murphy, 2019). One of the

interventions, which involved the therapist making a self-disclosure about their own

physical or emotional experience in the moment, corresponds to the person-centred

concepts of immediacy and congruence (Mearns & Cooper, 2005; Mearns & Thorne, 2000).

A qualitative meta-analysis by Hill et al. (2018) found that overall therapist self-disclosure

was helpful in psychotherapy, improving the therapeutic relationship and the client's mental

health. The researchers found that immediacy helped the client to open up and be more

immediate. However, in the Hill analysis immediacy was defined as a discussion of the

therapeutic relationship, i.e., more specific than the person-centred definition of immediacy suggested here.

The sub-theme of *using images and vivid language* captured interventions where the therapist reflected the client's narrative using the therapist's own words, images or metaphors. These interventions were offered when the client's presentation lacked emotion, demonstrating the therapist's emotion regulation sensitivity by working to bring the client into a productive level of emotional arousal (Elliott et al., 2004; Elliott & Westwell, 2012).

Understanding

While coding for this study was based on the three experiential components of the PCEPS-10, the emergent theme of *understanding* also seemed to capture elements of the PCEPS-10 item 'Core meaning'. This item describes the requirement for a PCE therapist to "show an understanding of the client's central/core experience or meaning" (Elliott & Westwell, 2012). The sub-theme of *summarising* described interventions where the therapist checked that their understanding of the client's narrative and emotional process were accurate, matching those of the client. The interventions described within the sub-theme of *questioning to gain a fuller perspective* showed the therapist eliciting detail and specificity from the client around their experience. These interventions therefore demonstrated ways in which the therapists operationalised the skill of experiential specificity. An intervention which focused on the client's embodied experience incorporated elements of focusing-oriented therapy (Gendlin, 2003; Haake, 2018; Weiser Cornell, 2013). Here the therapist encouraged the client to look inside themselves to explore the experience and meaning of their 'felt sense'.

One intervention offered by several therapists was named by one therapist as 'freeze framing'. Here the therapist actively guided the client through a memory to help the client to become aware of and express emotional experiences that were previously out of awareness. These interventions shared characteristics with the EFT task of systematic evocative unfolding (Elliott et al., 2004; Greenberg & Watson, 1998; Murphy, 2019; Sanders & Hill, 2014), and also demonstrated the collaborative nature of the PCET relationship, where the therapist and client jointly endeavoured to make sense of the client's experience (Murphy, 2019; Sanders & Hill, 2014).

The sub-theme of *offering a new perspective* comprised interventions where the therapist offered an observation or conjecture from their own frame of reference, rather than that of the client. Interventions such as these could be seen as 'interpretations' (Elliott et al., 1982). Like questions, interpretations are controversial in the classical person-centred approach, being seen by some theorists as directive (Schmid, 2005). Similarly, the first item of the PCEPS-10 (Tracking/Client's frame of reference) captures the person-centred principle that the therapist should remain within the client's frame of reference without adding meaning from their own frame of reference. The interventions identified here were offered tentatively and sensitively, remaining within "the client's own train of thoughts/feelings" (Elliott & Westwell, 2012) in the service of the collaborative exploration and understanding of the client's emotional experience. Elliott et al. (1982) found that in a sample of dyads from client-centred and psychoanalytic therapy, interpretations were rated as the most helpful therapist verbal response mode by both clients and therapists. Further research is necessary to determine how effective interventions that offer a new perspective are in PCET.

Active Guiding

The sub-themes which emerged within the theme of *active guiding* could be viewed as approaching the directive end of the imagined process-guiding spectrum. The first sub-theme, *containing emotion* depicted an emotion regulation intervention, where the therapist used techniques to help the client to moderate overwhelming feelings, and checked on their safety (Sanders & Hill, 2014). The sub-theme of *facilitating dialogue between parts* identified interventions where the therapist went beyond helping the client to become aware of conflicting configurations of self, to exploring and describing them, and giving voice to one or both of the parts. An intervention where therapists helped the client to inhabit one part of themselves and give voice to that part was parallel to the EFT task of two-chair work for conflict splits (Elliott et al., 2004). In the current PCET sample however, therapists did not invite the client to move between chairs, but instead guided the client through an internal dialogue spoken out loud (Haake, 2018). In some of the segments identified in this sample, the therapist helped the client to recognise an affirmative part of themselves which could boost their self-esteem or provide comfort. This is similar to the idea of self-soothing offered as an emotion regulation task in EFT (Elliott et al., 2004).

The first intervention described within the sub-theme of *guiding the client's imagination* was also similar to an EFT task, that of unfinished business (Elliott et al., 2004; Murphy, 2019; Sanders & Hill, 2014). In EFT this intervention involves the therapist inviting the client to imagine a significant other person in an empty chair in the therapy room, and to say to the empty chair the things that would help to resolve their feelings towards the other person. In the current PCET sample, therapists invited clients to see the significant person in their imagination, and to say out loud, or complete in imagination the things they felt they needed to say or do (Haake, 2018). The second intervention, guiding the client

through a hypothetical experience, was very similar to the 'freeze framing' intervention, but the therapist suggested working through a hypothetical experience rather than a memory. The intervention was used by therapists to evoke the client's emotional experience, bringing feelings into the client's awareness, and making them accessible for exploration (Greenberg & Paivio, 2003). This use of hypothetical experience is not described in PCET or EFT literature, but the intervention described within this theme has been elaborated as a cognitive therapy technique (Newman, 2002). In cognitive therapy, the purpose of 'what if' questions is to highlight and counter the client's irrational thoughts. In the current sample, the purpose was to evoke the client's emotional response to the hypothetical but relevant situation in the therapy session, to make it accessible for exploration and possibly resolution.

A Taxonomy of PCET Emotion Focused Therapist Interventions

The thematic analysis reported in this study demonstrated that although the style of individual PCE therapists can be quite different, there are commonalities in their practice which reflect the theoretical components of PCET. From these commonalities it is possible to draw out and define specific interventions intended to operationalise the theoretical mechanisms of change. The themes that emerged from this analysis suggested that these interventions could be organised as a taxonomy which reflects a process-guiding spectrum between nondirective and actively process-directive. The themes, sub-themes and interventions identified here reflect the real-life practice of therapists in the PRaCTICED trial. The creation of a taxonomy of ideal interventions would require further research into the effectiveness of each intervention to investigate its relationship with enhanced emotional experiencing for clients, and ultimately with improved outcomes for clients.

Strengths and Limitations

The major strength of this study is that it is rooted in real-world PCET practice, delivered in a routine setting by therapists who were trained and qualified, but not necessarily expert. Although the sampled therapy sessions were identified using the highest mean rating for the three active components, the large number of 15 sessions from 15 different therapists means that a wide range of competence levels was represented, again reflecting real-world conditions. Similarly, the session recordings included a wide range of client in-session presentations. The session recordings revealed that some clients dominated the session, allowing little space for the therapist to offer interventions, while others were very collaborative, engaging with the therapist's interventions and deepening their experience within the session.

The study is limited by relying on the perception and interpretations of the observer-researcher. The data available for the current study meant that therapist intentions had to be interpreted by the principal researcher from their verbal behaviour, in contrast to methodologies which include post-session reporting by participants (Elliott, 2010).

The use of the *a priori* themes of experiential specificity, emotion regulation sensitivity, and emotion focus, and the subjectivity described here, may have introduced confirmation bias to the results. The emergent themes relied on the interpretation of the two co-researchers, meaning that other researchers may identify different themes, or classify the therapist interventions identified for this study differently. Analysis of other therapy sessions would probably reveal more interventions that wouldn't fit within the themes identified in this study. Indeed, although the sample of 15 session recordings for the current study is large, no sample would be sufficiently large to reveal all possible interventions that would be adherent to the PCET model.

The recordings and transcripts also reflected a range of therapist activity, with some therapists offering very few interventions, and others offering interventions within every theme. The current study does not offer any analysis of which interventions were used most frequently, or which might be most effective in guiding clients through their emotional experience.

It is important to acknowledge some aspects of the experience of PCE therapists and clients within the PRaCTICED trial, to provide contextual information for the study (Levitt et al., 2021). Most of the PCE therapists in the trial were newly qualified and inexperienced in PCET, and in particular in working with the emotion focused components of the model. This means that their delivery of these interventions may be different from that of more experienced therapists. The presence of a recording device may also have affected performance, although there is evidence to suggest that this is soon forgotten by therapists and clients within sessions (Brown et al., 2013). During the PRaCTICED trial, segments from recordings for sessions 2, 6 and 12 for each client were played in group supervision, and a Session Adherence and Competence form completed by the supervisor. It is possible that this knowledge affected the performance of some therapists, positively or negatively.

Conclusions

The findings of the qualitative analysis in Chapter 5 showed that PCE therapists operationalised experiential specificity, emotion regulation sensitivity, and emotion focus in a range of ways in the PRaCTICED trial. Therapists actively promoted the client's awareness and focus on their emotional process, while honouring the client's frame of reference and the person-centred principle of nondirectiveness. Future process research is needed to look at the effect and effectiveness of specific interventions, and the effect of therapists being more or less active within the session. The findings need to be confirmed by research which

includes the client's perspective. Such research could contribute to a taxonomy of PCE therapist process-guiding interventions.

The sample of session recordings for this study was selected according to the highest mean competence rating for the experiential components for each therapist. The study in the next chapter examines the relationship between competence in one session (overall and in the person-centred, proscribed, and experiential clusters of components) and change in depression at the next session.

Chapter 6

The Effect of PCE Therapist Competence on

Next-Session Client Outcomes

Introduction

Chapter 5 presented a qualitative thematic analysis of interventions through which PCE therapists operationalised experiential specificity, emotion regulation, and emotion focus in practice. The data analysed in Chapter 5 were transcripts of real PCET sessions, so that the exemplars derived from the analysis reflected real rather than ideal practice, with no reference to therapist competence. Chapter 6 presents the first of two studies examining the role of therapist competence in PCET.

Chapter 6 investigates the relationship between the competence of PCE therapists in the PRaCTICED trial (as assessed by the expert raters) and change in clients' depression between the rated therapy session and the next session. Previous research has found that therapist adherence and competence are associated with symptomatic improvement during therapy, but not with the outcome at end of therapy (Barnicot et al., 2014; Strunk et al., 2010). Greenberg and Pinsof (1986) recommended that process research should consider psychotherapy action and outcome at different levels for the development of 'microtheory' of the mechanisms of change, contrasting the "Big O" of the final outcome of therapy with "a series of 'little o's'" (p.7). Perepletchikova and Kazdin (2005) used the term 'session integrity', recognising that even if the overall integrity of a course of therapy is high, the therapy may have a poor outcome if the integrity of the treatment components within one session is low. The current study focuses on session integrity and 'little o' outcomes, that is,

changes in clients' depression during therapy, and specifically between one PCET session and the next.

Relationship Between Patterns of Change and Outcome of Therapy

Studies of patterns of change within different therapy modalities can contribute evidence towards understanding their mechanisms of change, including processes such as model-specific interventions in the therapy under examination. Research across multiple therapy modalities has shown that both within and across sessions, progress is more likely to be discontinuous, having a 'two steps forward, one step back' pattern, a curvilinear pattern, or a pattern of change unique to the client (Bone et al., 2021; Hayes et al., 2007; Pascual-Leone, 2009; Watson, 2018).

In his research, Pascual-Leone (2009) drew on dynamical systems theory (Hayes et al., 2007), recognising its relevance to emotion focused therapy. This theory proposes that change within any natural system is often nonlinear, and that "critical fluctuations" or "perturbations" frequently precede change. The moments of emotional perturbation that clients experience in therapy may be a necessary aspect of the transition to a healthier reorganisation. Dynamical systems theory implies that symptomatic deterioration during therapy may be helpful, or even necessary. This idea is captured in the traditional wisdom that "it has to get worse before it gets better". On the other hand, research has shown that early improvement is associated with good outcomes (Beard & Delgadillo, 2019), including in PCET (Duffy et al., 2022).

Relationship Between Therapist Competence and Proximal Outcome

Measures of adherence and competence provide indirect methods of gauging the effect of therapeutic interventions, as long as the intervention is sufficiently well defined (Perepletchikova & Kazdin, 2005). In other words, the effectiveness of an intervention can

only be reliably measured if the therapist delivers the intervention competently and adheres to the prescribed definition. A study by Strunk and colleagues (2010), for example, explored therapists' competence in cognitive therapy techniques as a predictor of change in clients' depression symptoms. Depression symptoms were measured at every session, and competence was measured at the first four sessions for every client. Results indicated that therapist competence ratings predicted session-to-session symptom change in sessions 2 to 5 as measured by observer on the Hamilton Rating Scale for Depression and self-reported by the client using the Beck Depression Inventory. At end of therapy however, competence ratings were only significantly associated with outcome on the Hamilton Rating Scale for Depression.

Person-Centred Therapeutic Components

A wealth of research has shown that a positive therapeutic relationship is not only vital to facilitate the delivery of the specific technical components of any model of therapy, but contributes to therapy outcome in itself (Norcross & Lambert 2019). According to classical person-centred theory, the core conditions of empathy, genuineness and unconditional positive regard are not only necessary but are sufficient to create a relationship that will lead to therapeutic personality change for the client (Rogers, 1957). Norcross and Lambert (2019) concluded that empathy and positive regard are demonstrably effective, each with an estimated effect size of .28, and genuineness is probably effective, with an estimated effect size of .23.

Studies by Zuroff et al. (2010) and Barnicot et al. (2014) investigated therapists' effectiveness in offering the person-centred core conditions as assessed by clients using the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). Zuroff et al. (2010) found that clients who rated their therapists more highly for empathy, positive regard and

genuineness improved more rapidly on measures of maladjustment and self-critical perfectionism. The results for a similar study by Barnicot et al. (2014) suggested that clients' perception of clinicians offering greater empathy, genuineness, and positive regard was significantly associated with lower depression during treatment, though not with recovery.

Experiential Therapeutic Components

A substantial body of research has investigated the change process in experiential and emotion focused therapy, concentrating on the client's emotional experiencing and processing. A review by Watson (2018) stated that studies have used "bottom-up analysis, observation, and in-depth description of psychotherapeutic processes in the session and across treatment" (p.392).

Pascual-Leone (2009) tested Pascual-Leone and Greenberg's emotional processing model of change (2007), exploring patterns of improvement in clients' emotional resilience within emotion focused therapy. The author coded and analysed emotion-processing events from 34 sessions, confirming the 'sawtoothed' nature of clients' progression within one session, involving steps forward into positive emotional experience interspersed with steps backward into distress. Pascual-Leone and Kramer (2019) built on this research by conducting mixed methods analyses of two good outcome cases of emotion focused therapy across sessions. Again, the authors identified different but non-linear patterns of change in emotional processing and the building of emotional resilience across sessions.

Relationship Between Baseline Severity and Competence

Studies and literature reviews have confirmed that higher initial severity predicts poorer outcomes (Amati et al., 2018; Saxon & Barkham, 2012; Stoch et al., 2022), including for PCET (Bauer-Staeb et al., 2023). A recent study found that although initial severity predicted poorer outcome, it was also associated with a greater rate of change, where

patients who were more depressed at baseline improved more rapidly (Stoch et al., 2022). A study of therapist effects found that a therapist effect of 6.6% for average patient severity rose to 10% as baseline severity increased, but that initial severity had less of an impact on the outcome of clients of more effective therapists (Saxon & Barkham, 2012). Together these findings raise the question of the role of therapist competence in the associations among the client's baseline severity of depression, trajectory of change and final outcome.

The Current Study

For the PRaCTICED trial the integrity of both therapy modalities being examined (PCET and CBT) was validated by assessing therapists' adherence to and competence in the model they were delivering. For the PCET arm of the trial, competence was assessed by raters using the PCEPS-10 (Elliott & Westwell, 2012). The data afforded by these competence ratings, together with the comprehensive outcome data from both the trial and routine outcome monitoring in IAPT, offer an opportunity to investigate the contribution of therapist competence to change in clients' depression.

By separating the 10 items of the PCEPS into clusters of person-centred, proscribed, and experiential components, it is possible to assess the association between competence in each cluster and outcome. In the light of research findings that outcomes for more effective therapists are less impacted by clients' greater baseline severity, the dataset available for this study also offers an opportunity to investigate the relationship between clients' baseline severity and therapist competence.

The aims of this study were:

1. To examine the relationship between participants' baseline severity and PCE therapist competence.

2. To examine the relationship between therapist competence overall, and in the different clusters of components, and next-session outcome.

3. To examine the relationship between low, medium, and high rated competence and next-session outcome.

Methods

Information about trial participants, PCET segments recorded and rated for the PRaCTICED trial, raters, and use of the PCEPS to assess therapist competence, is available in Chapter 2.

Ethics

Ethics approval was granted as part of the submission for the PRaCTICED trial (Health Research Authority, Research Ethics Committee 14/YH/0001; Barkham et al., 2021).

Clients Who Had Recording Segments Rated for Competence

As described in Chapter 2, all therapy sessions during the PRaCTICED trial were audio recorded, and a random sample rated for competence by expert raters (Barkham et al., 2021). For the PCET arm of the trial, 65 recordings were submitted for rating using the Person-Centred Experiential Psychotherapy Scale (PCEPS-10; Elliott & Westwell, 2012), representing 65 clients.

Table 6.1 shows the number included in the sample of rated recording segments, with reasons for exclusion. One recording segment was inaudible and not rated for competence. Ratings for the recording segments of five therapists who saw ≤4 clients in the PRaCTICED trial were excluded from the current study, leaving data for 59 segments. Four further recording segments were excluded from the dataset: two rated recording segments were final sessions, and therefore had no outcome data for the following session; one segment had missing outcome data for the session following the rated session; one client

subsequently switched therapy to CBT. Data for the recording segments of two other clients who switched to CBT were retained for the current study, as the session following the recorded session was still PCET. The final data set therefore comprised 55 recording segments where competence and outcome scores were matched.

Table 6.1

Number included in the sample of recording segments rated for competence, with reasons for exclusions

Sample of recording segments

Reason for exclusion	Excluded	*N*
Recording segments sampled for competence rating		65
Recording failed	1	64
Therapists saw ≤4 clients	5	59
Switched to CBT	1	58
Rated session was final session	2	56
Missing PHQ-9 data for next session	1	55
Total		55

PCE Therapists

Fifteen of the 16 therapists who delivered PCET in the PRaCTICED trial had at least one therapy segment rated for competence by the expert raters. Data for five of these therapists who saw four clients or fewer have been excluded from this study, leaving data for ten therapists. One of the 10 therapists was male. All therapists were experienced primary care counsellors. Six of the 10 therapists had previously qualified in PCET, and the remainder were trained and achieved their qualification in order to participate in the PRaCTICED trial.

The number of segments rated for each therapist ranged between 0 and 15, median = 8, mode = 1, reflecting the number of clients seen by them in the trial.

Outcome Measure

The outcome measure of depression used in routine practice as part of the NHS Talking Therapies minimum data set is the PHQ-9 (Kroenke & Spitzer, 2002). All NHS Talking Therapies clients are expected to complete the minimum data set at every therapy session (NCCMH, 2023). For participants in the PRaCTICED trial this data was incorporated into the trial data set. Data extracted from the PRaCTICED trial data set for this study were PHQ-9 scores at first PCET session, at the session rated for therapist competence, and at the next session for participants randomised to PCET who had recording segments submitted for competence rating.

Procedure

Outcome Variable: Next-session PHQ-9 Change

PHQ-9 score at the first PCET session (first PHQ-9) was used as the measure of baseline severity. The difference score, i.e., change on the PHQ-9 from the rated session to the next session (next-session PHQ-9 change), was calculated for each participant by subtracting the PHQ-9 score at the next session from the PHQ-9 score at the rated session. Improvement in a client's depression is measured by a decrease in PHQ-9 score, i.e., a negative change score.

Competence Variables: Total PCEPS, and Person-Centred, Proscribed, and Experiential Clusters

Competence ratings for the rated sub-sample were calculated using the means of the expert raters' ratings. Mean ratings were calculated for the total PCEPS ratings (maximum 60 marks), the person-centred cluster (five items, maximum 30 marks), the proscribed

cluster (two items, maximum 12 marks) and the experiential cluster (three items, maximum 18 marks). A description of each of the clusters is given in Chapter 2. For ease of comparison, percentages were calculated for the total PCEPS rating, the three competence clusters, and their standard deviations.

Variable names and descriptions are shown in Table 6.2.

Table 6.2

Names and descriptions for all variables

	Variable name	Description
Baseline severity	First PHQ-9	PHQ-9 score at first PCET session
Outcome	Next-session PHQ-9 change	PHQ-9 score at next session - PHQ-9 score at rated session
Competence variables	Total PCEPS	Mean of raters' ratings for all PCEPS items (10 items, max score = 60)
	Person-centred cluster	Mean of raters' ratings for person-centred items (5 items, max score = 30)
	Proscribed cluster	Mean of raters' ratings for proscribed items (2 items, max score = 12)
	Experiential cluster	Mean of raters' ratings for experiential items (3 items, max score = 18)

Normality of Population Distribution, Outliers, and Descriptive Statistics

SPSS for Windows v.26 (IBM Corp., 2019) was used to compute all statistics. Outliers were identified using box and whisker plots, defined in SPSS as more than 1.5 but less than 3 inter-quartile ranges from the end of the box. Tests for correlation were carried out with outliers excluded. (Results of sensitivity analyses performed by repeating correlations including outliers are given in Appendix D). Shapiro-Wilk tests for normal population distribution were applied for all variables. A sample is deemed to come from a normal

distribution if the *p* value of the Shapiro-Wilk test is ≥.05. Descriptive statistics (means, standard deviations, medians, range, and distribution defined by inter-quartile range) were calculated for all variables.

Classification into Low, Medium, or High Competence Groups

The modal number of ratings per therapist was one, rendering any results of an analysis of associations between competence ratings and client outcomes for each therapist unfeasible. In order to discern possible differences between levels of competence therefore, instead of ranking therapists, rated recording segments excluding outliers were ranked from lowest to highest according to competence ratings for each of the four competence variables (total PCEPS, person-centred cluster, proscribed cluster, and experiential cluster). The clusters were ranked separately to take account of segments where the level of competence varied between the different clusters. Each of the four sets of ratings was then divided into three samples labelled as low, medium, and high scoring groups. The number in each sample was equal as far as possible, but since all segments with identical ratings were included in the same sample, numbers varied slightly. The range of ratings for each cluster is shown in Table 6.3.

Table 6.3

Range of ratings for low, medium, and high groups for four competence variables

	n	Low	*n*	Medium	*n*	High
Total PCEPS (Max = 60)	17	18 – 34.25	17	34.5 – 44.5	17	45 – 58
Person-centred cluster (Max = 30)	18	9 – 17.5	16	18.5 – 22	17	22.75 – 29.5
Proscribed cluster (Max = 12)	16	2.75 – 6.75	20	7.5 – 9	15	9.5 – 12
Experiential cluster (Max = 18)	17	6 – 10	19	10.25 – 13	15	13.5 – 16.5

Statistical Analysis

The PHQ-9 score at every PCET session was extracted from the PRaCTICED trial dataset for every client who had a session rated for therapist competence. The pattern of change for each of these episodes of therapy was captured by plotting PHQ-9 score against session number in Excel for Windows v. (Microsoft Corp., 2016).

A multiple regression analysis was carried out to examine baseline severity (first PHQ-9) as a predictor of competence rating. Multiple regression analyses were carried out to examine baseline severity (first PHQ-9) and competence ratings overall (total PCEPS) as predictors of next-session PHQ-9 change. Pearson's *r* correlations were conducted to investigate the relationship between initial severity and competence in each of the clusters of components.

Multiple linear regressions were conducted of next-session PHQ-9 change on (a) first PHQ-9 and total PCEPS, and (b) first PHQ-9 and the person-centred, proscribed, and experiential clusters. Improvement in a client's depression is measured by a decrease in

PHQ-9 score (i.e., a negative change score). In the results of analyses reported here, therefore, negative coefficients reflect improvement in depression.

A one-way between-groups ANOVA was conducted to test for differences in first PHQ-9 between the low, medium, and high rated groups. Relationships between the three competence groups and next-session PHQ-9 change in each of the four competence variables were investigated using Pearson's r correlations. In order to investigate possible curvilinear relationships between the four competence variables and next-session PHQ-9 change, a quadratic regression was performed for each competence variable for the full sample.

Results

Patterns of Change in PHQ-9 Scores Through a Course of PCET

The line graphs displayed in Figure 6.1 show the trajectory of change (as measured by PHQ-9 score at each therapy session) for each of the 64 participants who had a segment rated for competence. The lines depicted in different colours illustrate how clients' depression improved (orange), deteriorated (red), or remained unchanged (yellow) through therapy. Visual inspection of the line graphs suggests that the trajectory of change is unique to each client, with no discernible pattern across individuals.

Figure 6.1

Line graphs showing patterns of change for 64 participants, as measured by PHQ-9 score at each session
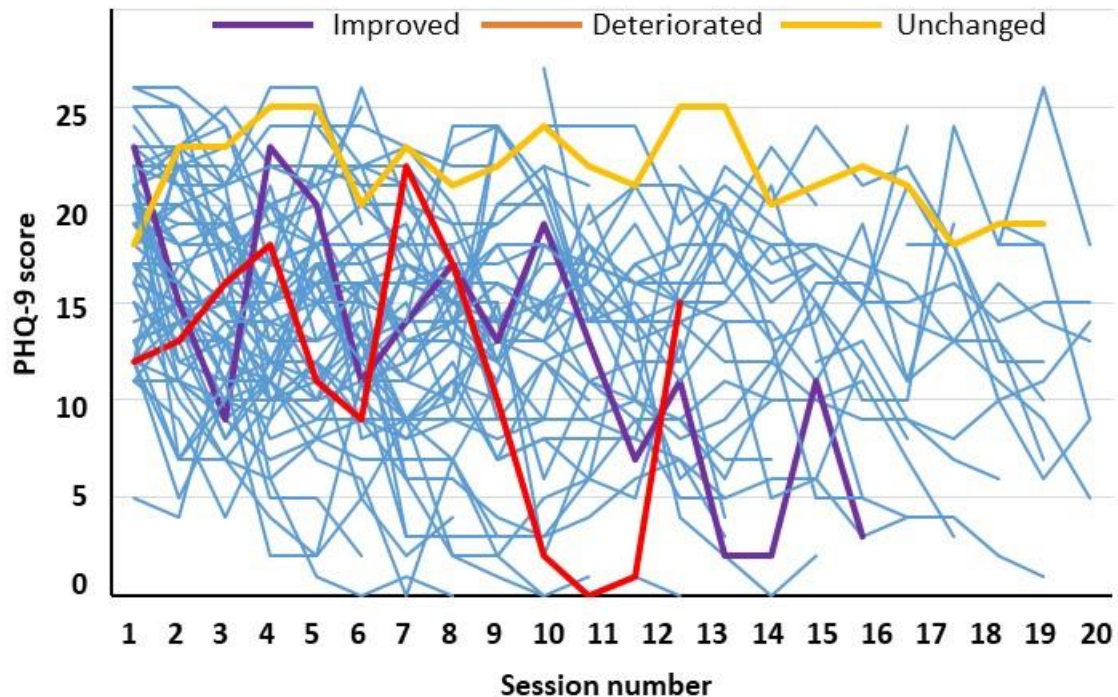
Assessment of Variables

Normality of Population Distribution and Outliers

Figure 6.2 shows box and whisker plots for baseline severity (first PHQ-9) and next-session PHQ-9 change. Results of Shapiro-Wilk tests for normality are given in Appendix D, Table 6.1D. No outliers were found for first PHQ-9. Four outliers were identified in next-session PHQ-9 change. Two high values of 13 and 8 indicated unusual deterioration in depression from the rated to the next session, and two low values of -12 and -10 indicated unusual improvement in depression. A Shapiro-Wilk test was carried out for next-session PHQ-9 change with and without outliers. When the four outliers were excluded, next-session PHQ-9 change showed a normal distribution: $W(51) = .97$, $p = .31$. Sensitivity analyses were conducted to test for differences in results when outliers were included, but

results remained broadly the same as with outliers excluded. Results are available in

Appendix D. The following analyses have been performed with the four outliers excluded (*N*

= 51).

Figure 6.2

Box and whisker plots showing median, range and interquartile range for first PHQ-9 and next-session PHQ-9 change, with outliers
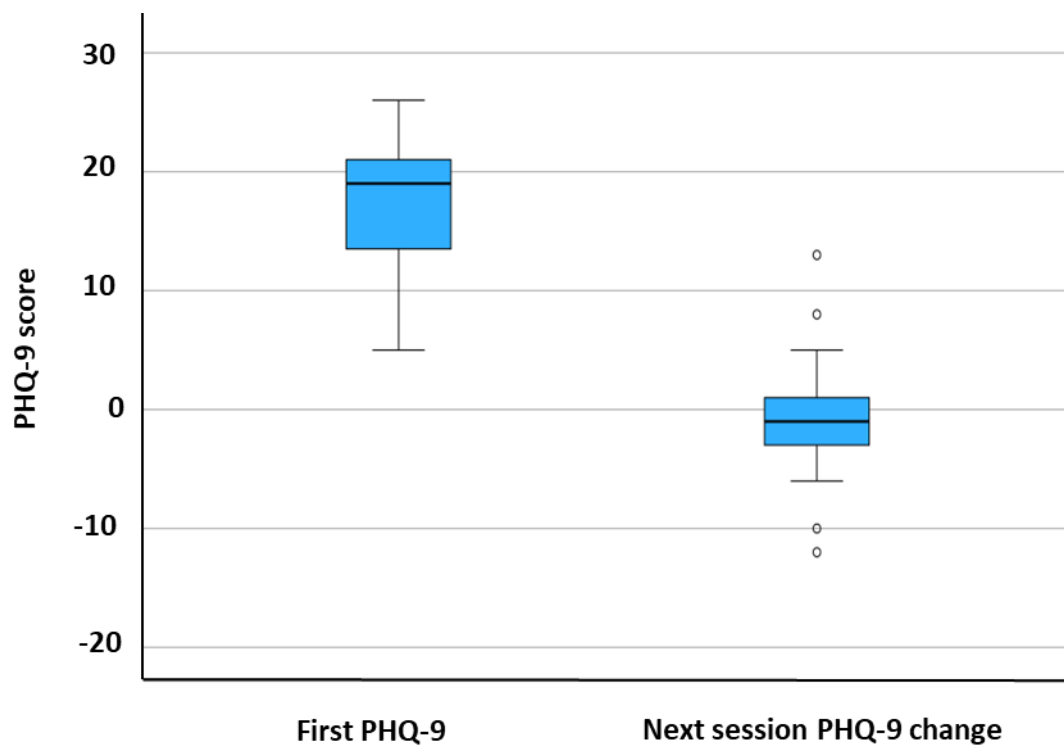
Box and whisker plots for ratings for the four competence variables, total PCEPS, the

person-centred cluster, the proscribed cluster, and the experiential cluster, revealed no

outliers (Figure 6.3).

Figure 6.3

Box and whisker plots showing median, range and interquartile range for the four competence variables
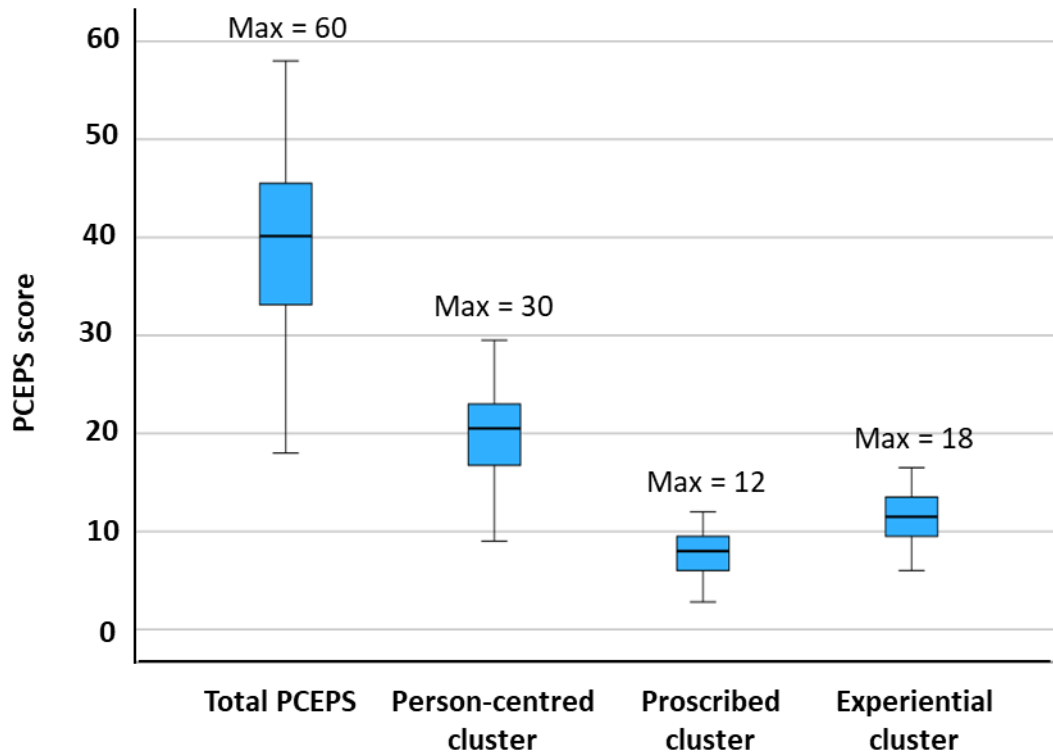
Descriptive Statistics for All Variables

Table 6.4 displays descriptive statistics for first PHQ-9, next-session PHQ-9 change, and for the competence variables, excluding outliers. The mean total PCEPS score of 39.27 was an acceptable reflection of routine practice, given that the pass mark is 40 when PCET trainees present examples of best practice for assessment. When the four competence variables were compared, the highest mean (as percentage of maximum rating) was for the person-centred cluster (66.90%), and the lowest was the experiential cluster (mean 63.33%). The greatest variation in ratings was in the proscribed cluster (standard deviation of the mean = 18.25%). Descriptive statistics including the four next-session PHQ-9 change outliers are given in Appendix D, Table 6.2D.

Table 6.4

Descriptive statistics for competence variables, first PHQ-9, and next-session PHQ-9 change

Variables	N	Mean	Mean as % of max	SD	SD as % of mean	Range	IQR
First PHQ-9	51	18.12		4.87		5 – 26	14 – 21
Next-session PHQ-9 change	51	-1.33		2.61		-6 – 5	-3 – 1
Total PCEPS (max = 60)	51	39.27	65.45	8.92	14.87	18 – 58	33 - 46
Person-centred cluster (max = 30)	51	20.07	66.90	4.50	15.00	9 – 29.5	17 - 23
Proscribed cluster (max = 12)	51	7.80	65.00	2.19	18.25	2.75 – 12	6 – 9.50
Experiential cluster (max = 18)	51	11.40	63.33	2.58	14.33	6 – 16.5	9.50 – 13.50

Relationship Between First PHQ-9 and Competence

Results of a linear regression of total PCEPS on first PHQ-9 are shown in Table 6.5. A significant relationship was found, indicating that a higher first PHQ-9 score was associated with a higher total PCEPS rating (r = .30, R^2 adjusted = .07, $F(1,49)$ = 4.72, p = .03).

Table 6.5

Linear regression of total PCEPS on first PHQ-9 (R^2 adjusted = .07, F(1,49) = 4.72, p = .03)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	t	Sig.
(Constant)	29.44	4.68	20.02 – 38.85		6.28	<.001
First PHQ-9	.54	.25	.04 – 1.04	.30	2.17	.03

Results of Pearson's *r* correlations between initial severity and competence in each of the clusters of components are shown in Table 6.6 below. Significant relationships were found between higher initial severity and greater competence in the person-centred and proscribed components (*r* = .32, *p* = .02 and *r* = .29, *p* = .04, respectively) but not the experiential components.

Table 6.6

Pearson's r correlations between first PHQ-9 and competence variables

	N	Pearson's *r*	Significance
Total PCEPS	51	.30	.03
Person-centred cluster	51	.32	.02
Proscribed cluster	51	.29	.04
Experiential cluster	51	.22	.13

The scatter plot in Figure 6.4 illustrates the relationship between first PHQ-9 and total PCEPS.

Figure 6.4

Scatter plot of Pearson's r correlation between first PHQ-9 and total PCEPS rating
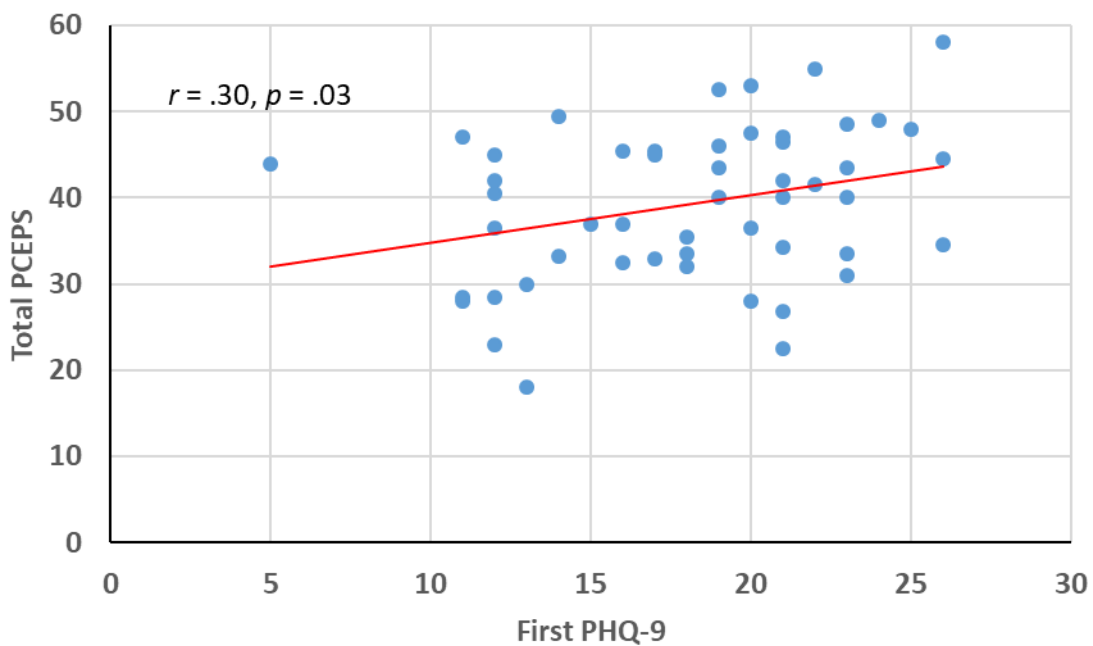
Relationship Between Competence (Total PCEPS) and Outcome (Next-Session PHQ-9 Change)

Table 6.7 shows the results of the multiple linear regression of next-session PHQ-9 change on first PHQ-9 and total PCEPS. The relationship was nonsignificant (R^2 adjusted = -.02, $F(2,48)$ = .47, p = .63).

Table 6.7

Multiple linear regression of next-session PHQ-9 change on first PHQ-9 and total PCEPS (R^2 adjusted = -.02, F(2,48) = .47, p = .63)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-1.34	1.93	-5.22 – 2.54		-.69	.49
First PHQ-9	-.07	.08	-.23 – .09	-.13	-.84	.40
Total PCEPS	.03	.04	-.06 – .12	.11	.71	.48

Results of a further multiple linear regression of next-session PHQ-9 change on first

PHQ-9, the person-centred, proscribed, and experiential clusters were not significant

(R^2 adjusted = -.08, $F(4,46)$ = 2.07, p = .10; Table 6.8). For both the person-centred cluster

and the proscribed cluster, as competence ratings increased, improvement in depression

lessened (B = .53, β = .91, p = .06 and B = .14, β = .12, p = .69 respectively). Although neither

result was statistically significant, the result for the person-centred cluster approached

significance. A statistically significant result was found for the experiential cluster (B = -.93,

β = -.92, p = .01), indicating that as competence in the experiential components increased,

improvement in depression was greater.

Table 6.8

Multiple linear regression of next-session PHQ-9 change on first PHQ-9 and competence clusters

(R^2 adjusted = -.08, F(4,46) = 2.07, p = .10)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	t	Sig.
(Constant)	-.31	1.93	-4.16 – 3.54		-.16	.87
First PHQ-9	-.12	.08	-.28 – .04	-.22	-1.50	.14
Person-centred cluster	.53	.28	-.03 – 1.09	.91	1.91	.06
Proscribed cluster	.14	.36	-.57 –.85	.12	.39	.69
Experiential cluster	-.93	.37	-1.67 – -.19	-.92	-2.53	.01

The result of a further regression with the nonsignificant components first PHQ-9

and the proscribed cluster removed was R^2 adjusted = .07, $F(2,48)$ = 2.91, p = .06 (Table

6.9). Again, greater competence in the person-centred cluster was associated with less

improvement in depression (B = .49, β = .85, p = .02), and greater competence in the

experiential cluster was associated with more improvement in depression (B = -.83, β = -.82,

p = .03).

Table 6.9

Multiple linear regression of next-session PHQ-9 change on the person-centred and experiential

clusters (R^2 adjusted = .07, F(2,48) = 2.91, p = .06)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-1.83	1.65	-5.15 – 1.49		-1.11	.27
Person-centred cluster	.49	.21	.08 – .91	.85	2.40	.02
Experiential cluster	-.83	.36	-1.54 – -.11	-.82	-2.31	.03

Analysis for Low, Medium, and High Rated Competence Groups

Descriptive Statistics for Low, Medium, and High Rated Competence Groups

Table 6.10 shows the means, standard deviations and ranges for the four

competence variables (excluding outliers) in the low, medium, and high rated competence

groups. Percentage of the maximum score is shown for ratings and standard deviations.

For the low competence group, the highest mean percentage was in the person-

centred cluster, while the lowest mean percentage was for the proscribed cluster. For the

medium group, the highest mean percentage was also for the person-centred cluster, and

the lowest for the experiential cluster. For the high group the highest mean percentage was

for the proscribed sub-cluster, and the lowest for the experiential cluster.

Table 6.10

Descriptive statistics for low, medium, and high rated competence groups

		N	Mean	Mean %	SD	SD %	Range
Total PCEPS (Max = 60)	Low	17	29.19	48.65%	4.57	7.62%	18 – 34.25
	Medium	17	39.89	66.48%	3.19	5.32%	34.5 – 44.5
	High	17	48.74	81.23%	3.77	6.28%	45 – 58
Person-centred cluster (Max = 30)	Low	18	15.19	50.63%	2.34	7.80%	9 – 17.5
	Medium	16	20.43	68.10%	1.39	4.63%	18 – 22
	High	17	24.90	83.00%	1.97	6.57%	22.75 – 29.5
Proscribed cluster (Max = 12)	Low	16	5.13	42.75%	1.17	9.75%	2.75 – 6.75
	Medium	20	8.12	67.67%	0.63	5.25%	7.5 – 9
	High	15	10.23	85.25%	0.68	5.67%	9.5 – 12
Experiential cluster (Max = 18)	Low	17	8.46	47.00%	1.30	7.22%	6 – 10
	Medium	19	11.74	65.22%	0.96	5.33%	10.25 – 13
	High	15	14.28	79.33%	1.06	5.89%	13.5 – 16.5

Table 6.11 shows descriptive statistics for first PHQ-9 and next-session PHQ-9 change for the low, medium and high groups in each of the competence variables. The medium competence group included a participant with an unusually small value for first PHQ-9 of 5, with all others in the range 12 – 26. Although a Shapiro-Wilk test showed that statistically this was not an outlier ($W(17) = .94$, $p = .36$), it appeared to affect the results. Two rows have therefore been included in Table 6.11 for the medium group. The row labelled medium* shows statistics with this participant excluded.

For all competence variables the participants in the low group had the smallest first PHQ-9, and the participants in the high group had the greatest first PHQ-9. A one-way

ANOVA determined that there was no significant difference in first PHQ-9 between the three groups ($F(2,48) = 1.33$, $p = .27$).

For all competence variables except the experiential cluster, the greatest and most consistent next-session PHQ-9 change (i.e., improvement in depression) was found for the low competence group (e.g., total PCEPS mean = -1.76; SD = 2.02). The medium group achieved the least next-session PHQ-9 change, with the smallest for the experiential cluster (mean = -0.44 when the low first PHQ-9 score was excluded).

Table 6.11

Descriptive statistics for first PHQ-9 and next-session PHQ-9 change in low, medium, and high rated

competence groups

			First PHQ-9			Next-session PHQ-9 change		
		n	Mean	SD	Range	Mean	SD	Range
Total PCEPS	Low	17	16.71	4.28	11 – 23	-1.76	2.02	-6 – 1
	Medium	17	18.41	5.80	5 – 26	-0.88	2.82	-6 – 5
	Medium*	16	19.25	4.81	12 – 26	-0.75	2.86	-6 – 5
	High	17	19.23	4.32	11 – 26	-1.35	2.98	-6 – 3
Person-centred cluster	Low	18	17.44	4.73	11 – 26	-1.78	1.92	-6 – 1
	Medium	16	16.81	5.33	5 – 25	-0.87	2.96	-6 – 5
	Medium*	15	17.60	4.45	12 – 25	-0.73	3.01	-6 – 5
	High	17	20.06	4.19	11 – 26	-1.29	2.95	-6 – 3
Proscribed cluster	Low	16	15.94	4.20	11 – 23	-1.62	1.82	-6 – 1
	Medium	20	18.35	5.41	5 – 26	-1.15	2.82	-6 – 5
	Medium*	19	19.05	4.53	12 – 26	-1.05	2.86	-6 – 5
	High	15	20.13	4.03	11 – 26	-1.27	3.15	-6 – 3
Experiential cluster	Low	17	17.47	4.77	11 – 26	-1.59	2.18	-6 – 2
	Medium	19	17.84	5.00	5 - 26	-0.58	2.52	-5 – 5
	Medium*	18	18.56	4.03	12 – 26	-0.44	2.53	-5 – 5
	High	15	19.20	4.97	11 – 26	-2.00	3.07	-6 – 3

Medium*: Excluding one low value of first PHQ-9

These descriptive statistics suggest that the relationship between competence and change may not be linear, which means that linear regressions would not be the most appropriate tests for association. Correlation analyses were therefore carried out for each of the three levels of competence.

Relationship Between Low, Medium, and High Competence and Next-Session PHQ-9

Change

Table 6.12 shows correlation coefficients for the relationship between level of competence in each competence cluster and next-session PHQ-9 change, with and without controlling for participants' first PHQ-9 score. Significant results are italicised. Results for the medium group including one unusually low value of first PHQ-9 are given in Appendix D, Table 6.5D.

Table 6.12

Pearson's r correlations between low, medium, and high competence groups and next-session PHQ-9 change

		Overall		Low		Medium*		High	
		r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
	N	51		17		16		17	
Total PCEPS		.07	.63	.47	.06	-.08	.78	-.25	.34
Controlling for first PHQ-9		.10	.49	*.62*	*.01*	-.02	.95	-.26	.32
	N	51		18		15		17	
Person-centred cluster		.10	.50	.43	.07	-.04	.90	-.17	.51
Controlling for first PHQ-9		.13	.37	*.57*	*.02*	.03	.92	-.14	.60
	N	51		16		19		15	
Proscribed cluster		.13	.38	.47	.07	.32	.18	-.12	.67
Controlling for first PHQ-9		.16	.27	*.53*	*.04*	.27	.27	-.12	.69
	N	51		17		18		15	
Experiential cluster		-.03	.82	.41	.10	.01	.96	-.35	.20
Controlling for first PHQ-9		-.01	.92	.48	.06	.16	.53	-.42	.13

The positive results for the low group suggest that lower competence is associated with greater improvement in depression symptoms at the next session. At the same time, the negative results (nonsignificant) for the high group indicate that higher competence is also associated with greater improvement in depression symptoms at the next session. For the low group, where first PHQ-9 is controlled for, this relationship approaches significance, even after a Bonferroni correction (total PCEPS, r = .62, p = .01. With Bonferroni correction α = .005.). Scatter plots illustrating the relationship between total PCEPS and next-session PHQ-9 change in the low, medium, and high competence groups are shown in Figure 6.5. These scatter plots highlight the positive slope for the low competence group and the negative slope for the high competence group.

Figure 6.5

Scatter plots showing correlation between total PCEPS and next-session PHQ-9 change for (a) low, (b) medium, and (c) high rated groups

(a) Low rated competence group
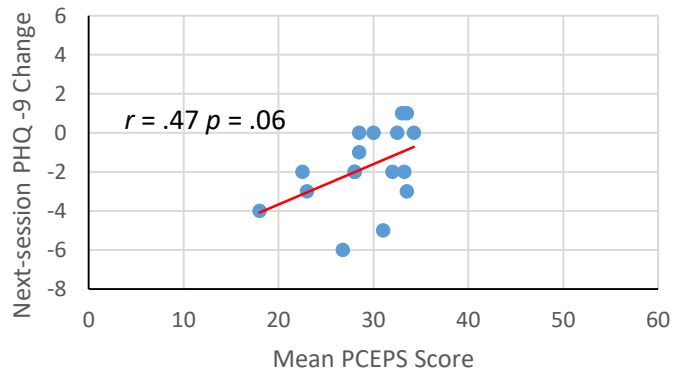
(b) Medium rated competence group
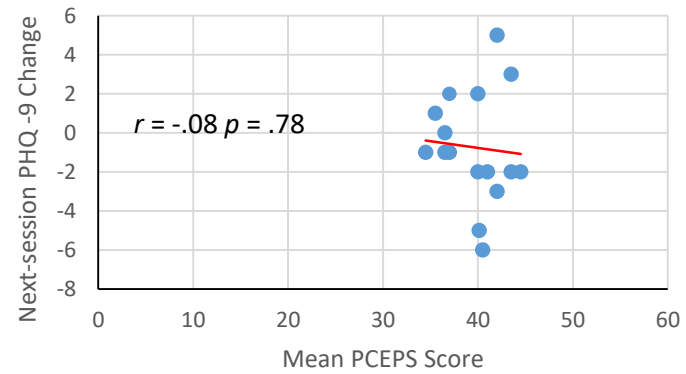
(c) High rated competence group
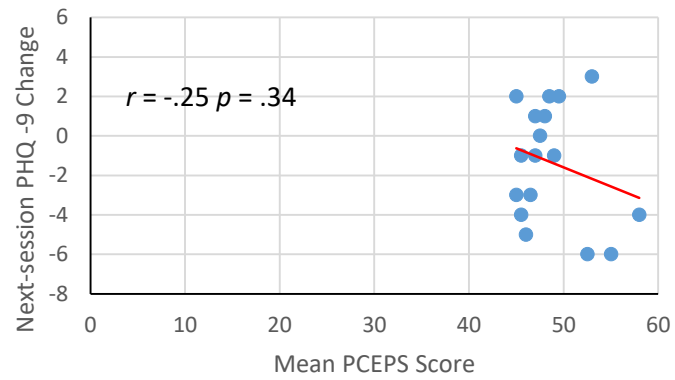
The results suggested that there may be a curvilinear relationship between competence and outcome, so quadratic regressions were performed for the full sample between the four competence variables and next-session PHQ-9 change. Results are shown in Table 6.13.

Table 6.13

Quadratic regressions of next-session PHQ-9 change on competence variables

Competence Variables		*R*	*R²*	*F*	df	*p*	Parameter estimates	
							b1	*b2*
Total PCEPS	Linear	.07	.00	0.24	1,49	.63	.02	
	Quadratic	.30	.09	2.33	2, 48	.11	.64	-.01
Person-centred cluster	Linear	.10	.01	0.46	1, 49	.50	.06	
	Quadratic	.28	.08	2.01	2, 48	.15	1.15	-.03
Proscribed cluster	Linear	.13	.02	0.78	1, 49	.38	.15	
	Quadratic	.19	.04	0.89	2, 48	.42	1.16	-.07
Experiential cluster	Linear	-.03	.00	0.05	1, 49	.82	-.03	
	Quadratic	.37	.13	3.74	2, 48	.03	2.77	-.13

The results for *R* and significance levels for all variables reported in Table 6.13 are improved from the results of linear correlations (Table 6.12). Overall competence (total PCEPS) accounted for 9% of improvement in depression, with the person-centred components accounting for 8%, and the experiential components 13%. This model suggests that segments rated the least competent and most competent achieved the greatest improvement in depression scores, while those in the middle achieved less improvement.

For the proscribed cluster, this curvilinear effect was less prominent (R^2 = .04, p = .42). While low ratings in the proscribed cluster showed a strong and significant correlation with outcome (r = .53, p = .04 after controlling for first PHQ-9, Table 6.13), high

competence ratings for this variable showed a negligible and nonsignificant relationship

with outcome (r = -.12, p = .69 after controlling for first PHQ-9).

The scatter plots in Figures 6.6 to 6.9 illustrate the relationship between each

competence variable and next-session PHQ-9 change. In order to exclude the possibility that

these findings are due to heteroscedasticity in the data, a Breusch-Pagan test was

conducted. The result indicated that the data were not heteroscedastic (p = .269). A

scatterplot of the regression of the standardised residuals on the standardised predicted

values for the relationship between competence and next-session change is shown in

Appendix D, Figure 6.1D, illustrating homoscedasticity.

Figure 6.6

Scatter plot showing curvilinear relationship between total PCEPS and next-session PHQ-9 change
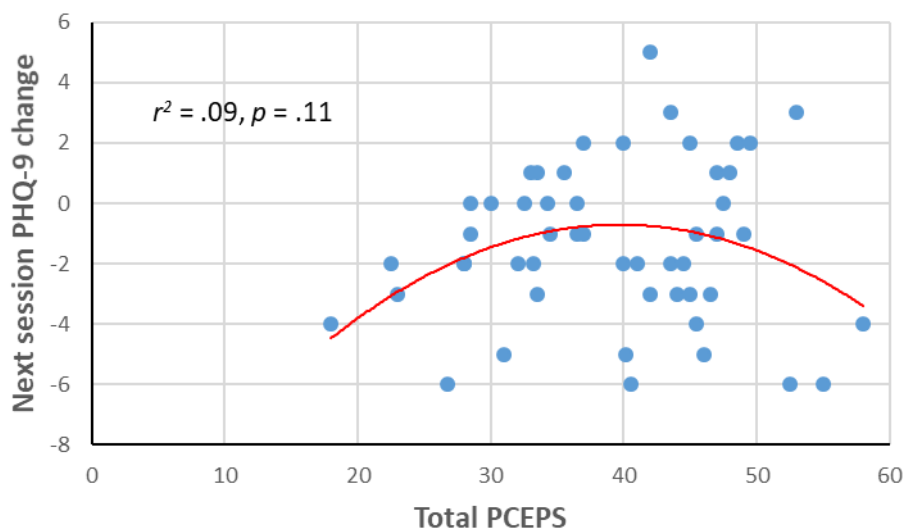
Figure 6.7

Scatter plot showing curvilinear relationship between the person-centred cluster and next-session
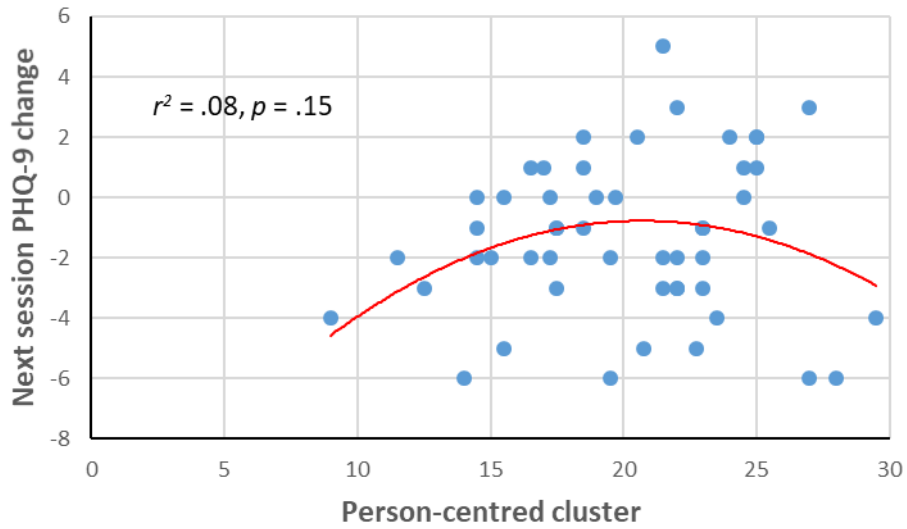
PHQ-9 change

Figure 6.8

Scatter plot showing curvilinear relationship between the proscribed cluster and next-session PHQ-9
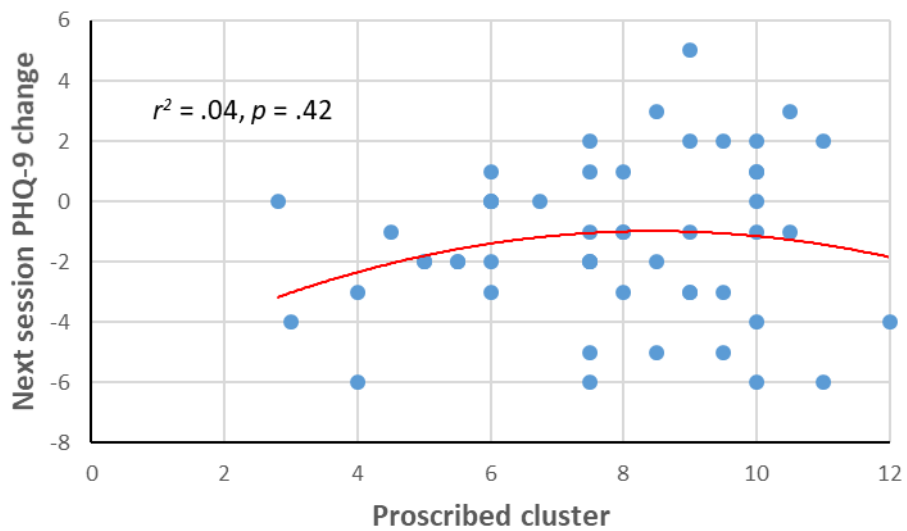
change

Figure 6.9

Scatter plot showing curvilinear relationship between the experiential cluster and next-session PHQ-9 change
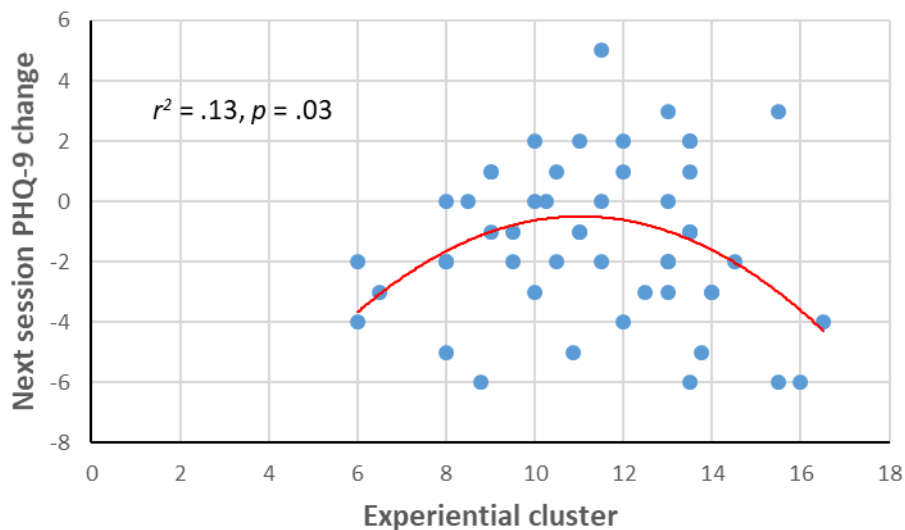
Discussion

The aims of this study were to investigate: (a) the relationship between participants' baseline severity (first PHQ-9) and PCE therapist competence, (b) the relationship between PCE therapist competence and change in participants' depression between the rated session and the next session, and (c) the relationship between low, medium and high rated competence and next-session outcome. The analysis included examinations of therapist competence overall, and in three clusters of components: person-centred, proscribed, and experiential.

Relationship Between Baseline Severity and Competence

Whereas previous research has confirmed the relationship between participants' initial severity and final outcome (Johns et al., 2019; Saxon and Barkham, 2012), no relationship was found in this study between initial severity and change in depression at the next session (β = -.13, p = .40, Table 6.7). A significant relationship was found, however,

between participants' initial severity and overall therapist competence (total PCEPS: $r = .30$, $p = .03$, Table 6.5).

It is impossible to know from the data available for this study whether this relationship is due to the perception of the rater, who after all is listening not just to the therapist, but to the therapist/client dyad, or whether there is a real tendency for more depressed clients to elicit higher competence from their therapists. When the separate PCEPS clusters were analysed, it was found that overall this relationship held for the person-centred cluster of components, but not for the experiential cluster. It may be that consciously or unconsciously, therapists' expression of the facilitative core conditions is stronger or more evident with clients who are more depressed. This echoes the finding of a study by Tschuschke et al. (2015) of a significant relationship between more severe client problems and a stronger working alliance. Although the concept of the working alliance is not identical to the facilitative relationship conditions as defined by the person-centred components of the PCEPS (Zuroff et al., 2010), the relationship conditions are an essential element in the working alliance (Bordin, 1979).

Relationship Between Competence and Next-Session Outcome

Results of a multiple linear regression showed that there was no relationship between overall competence and change in the client's depression at the next session ($\beta = -.11$, $p = .48$, Table 6.7). When the separate clusters of components were investigated within the low, medium, and high rated groups, the narrow range of percentage ratings across the competence variables reflected the internal consistency of the PCEPS (e.g., medium group: 65.22% – 68.10%, Table 6.10). This produced some collinearity between the competence variables, meaning that results should be interpreted with caution. However, when the separate clusters of the PCEPS were examined, the results of a further multiple

linear regression appeared to show that higher competence in the person-centred components was significantly associated with less improvement, and higher competence in the experiential components was significantly associated with more improvement (Table 6.9). This was an unexpected finding, given that the PCET model is founded on evidence for the effectiveness of both the person-centred and experiential components.

Relationship Between Low, Medium, and High Rated Competence and Next-Session Outcome

The results of Pearson's r correlations shown in Table 6.12 may help to explain the findings discussed in the previous paragraph. This table shows that for the experiential cluster, when initial severity (first PHQ-9) was controlled for, there were strong (nonsignificant) relationships with greater improvement for both the low ($r = .48, p = .06$) and the high ($r = -.42, p = .13$) competence groups. For the low group, lower competence ratings were associated with greater improvement, and for the high group higher competence ratings were associated with greater improvement. This led to the identification of a curvilinear relationship.

For the low competence group there was also a significant relationship in the person-centred cluster between lower competence ratings and greater improvement in depression ($r = .57, p = .02$). On the other hand, for the high competence group this relationship was nonsignificant ($r = -.14, p = .60$). These findings seem to suggest that greater competence in the person-centred components had less impact on a client's depression scores than competence in the experiential components.

The Relational Conditions and the Experiential Components

The curvilinear relationship noted above was confirmed by the quadratic regression analysis shown in Table 6.13. Although correlations such as those found in this study do not

demonstrate causation, it seems likely that low and high groups achieved similar positive outcomes through different mechanisms. For the high group, the strong correlation coefficient for the experiential components suggests that change was effected through the expected mechanisms of a focus on the client's emotional process in the context of a therapeutic relationship characterised by the Rogerian core conditions (Barnicot et al., 2014; Norcross & Lambert, 2019; Zuroff & Blatt, 2006). For the low rated group, the association was equally strong and significant but in the opposite direction. It may be that the nature of the experiential interventions offered in the low group and the high group was different, and yet equally effective. For example, where the high group may have maintained a focus on the client's emotional experiencing by consistently reflecting the most poignant aspects of the client's narrative, the low group may have been more process-directive in proposing ways to work with emotions.

The low ratings awarded to the low group for the person-centred components suggested that the raters believed the therapist was not offering adequate facilitative relational conditions, which implies that the working alliance in these client and therapist dyads would be weak. In their study of the relationship between adherence and outcome in the context of drug counselling, Barber et al. (2006) found a curvilinear relationship where, in the context of a weak working alliance, a moderate level of adherence to a skill-building therapy was associated with improved depression. In a subsequent paper, Barber et al. (2008) found a similar curvilinear relationship between adherence and outcome in supportive expressive therapy, where, in the context of a weak working alliance, a moderate level of adherence was associated with reduced drug use. In contrast to the previous study, however, in the context of a strong working alliance, higher and especially lower adherence to supportive expressive therapy techniques predicted a reduction in drug use more than

225

moderate adherence. For the study of supportive expressive therapy, however, depression

outcomes were not measured.

The similarity between Barber et al.'s 2008 study and the current study is that, like

PCET, supportive expressive therapy is a process-oriented therapy, rather than a skill-

building therapy. The analysis in the current study appears to suggest a similar curvilinear

relationship, where the experiential components are equally but differently effective in the

context of either a therapeutic relationship judged by the raters to be good, or a therapeutic

relationship characterised by a directive and dominant therapist.

The Proscribed Components

This interpretation, that the experiential components are equally but differently

effective in the context of different therapeutic relationships, would fit with the findings for

the cluster of proscribed components. For the low group, the low ratings for the proscribed

items indicate that the raters perceived these therapists as directive and acting in an expert

fashion. Nevertheless, these segments had a strong and significant association with

improvement in depression (r = .53, p = .04 after controlling for first PHQ-9, Table 6.12). On

the other hand, results of the proscribed cluster for the high group were nonsignificant

(r = -.12, p = .69 after controlling for first PHQ-9, Table 6.12).

It is possible that if the raters perceived a therapist as directive or dominant, and

therefore awarded a low rating for the proscribed cluster of components, they also awarded

low ratings for the other components. This would reflect the inter-item reliability of the

PCEPS, and explain the finding of collinearity of ratings in the three different clusters. This

suggestion reflects the debate in the field of PCET research, training and practice about

directiveness, and especially distinctions between directiveness and process-guiding (Elliott,

2011; Elliott & Freire, 2007; Murphy, 2019; see Study 1). PCET occupies an unclear and

226

possibly uneasy space between the person-centred and the emotion focused therapy positions in this area. For those in the classical person-centred tradition, only the client can be expert, as expert in their own experience. The role of the classical person-centred therapist is to offer a facilitative relationship in which the client can go through a process of self-discovery, meaning that it is unnecessary for the therapist to introduce diagnostic terms or specific techniques into the therapy (Bohart et al., 1998; Rogers, 1961). In emotion focused therapy, on the other hand, it is recognised that the therapist has expert knowledge of emotion theory, including a range of emotional processes that can result in depression, and is able to guide the client through a range of specific interventions aimed at resolving a client's 'stuck process' (Elliott, 2011; Elliott & Greenberg, 2007). The results reported from the current study suggest that while the raters in the PRaCTICED trial considered therapists who were directive or took an expert stance to be less competent in the PCET model, these characteristics did not impact the effectiveness of the therapy, and may have contributed to its effectiveness in the low group. As Perepletchikova and Kazdin (2005) put it, "Low integrity does not mean that the treatment is weak, just that it is different from that which was originally intended" (p.367).

As discussed in the introduction to this study, and illustrated in Figure 6.1, clients' symptoms fluctuate through the course of therapy. It is possible that clients who recorded a deterioration in their depression from the rated session to the next session were experiencing a 'critical fluctuation' which contributed to a successful final outcome (Hayes, 2007; Pascual-Leone, 2009). Although improvement in clients' depression between the rated session and the next session has been discussed above as if it were a measure of the effectiveness of the therapy, further analysis is needed to determine whether such proximal improvement contributes ultimately to effective therapy.

The strengths and limitations of Chapters 6 and 7 are discussed together in the next chapter.

Conclusions

The relationship found in this study between higher competence and improved outcome (as measured by the PHQ-9) appears to support the theoretical basis for the effective mechanisms of the PCET model. However, the finding of an equally strong relationship between lower competence and improved outcome demands more explanation. Since the worst rated components for the low group were the cluster of proscribed items, it may be that the raters' perception of the therapists in these segments displaying content-directiveness or dominant behaviour contributed to lower ratings in all the clusters and overall. It seems that, while therapist directiveness affects competence ratings, and may be seen as nonadherent to the PCET model, it does not reduce the effectiveness of the model. It may be that although the therapy offered in these segments is not perceived as competent by the raters in the PRaCTICED trial, it achieves successful outcomes through different mechanisms.

One interpretation of the finding in this study of a significant relationship between baseline severity and therapist competence is, that when working with more depressed, and therefore more 'cut off' clients, therapists find that they need to mobilise more of their relational and technical skills to engage the client in the tasks of therapy. This may be associated with the working alliance, which is related to outcome. However, more research is needed to establish whether in PCET greater competence leads to a stronger working alliance, or vice versa.

The current study has investigated 'little o outcomes'. The next study in this work,

Chapter 7, aims to investigate whether and how such proximal outcomes "accumulate" into

'big O' or distal outcomes (i.e., end of therapy outcomes).

Chapter 7

The Effect of PCE Therapist Competence on

Client Outcomes at End of Therapy

Introduction

Previous Research on the Relationship Between Therapist Competence and Outcome

Research investigating the association between therapist adherence, competence and integrity (ACI; Power et al., 2022) and client outcome suggests that across psychotherapeutic models this relationship is weak. Webb et al. (2010) conducted a meta-analysis of 36 studies, from which they extracted findings for 32 adherence and outcome correlations, and 17 competence and outcome correlations. Positive correlations indicated that greater adherence or competence were associated with improved outcomes. Results, $r = .02$ for adherence and $r = .07$ for competence, were both nonsignificant. The authors emphasised the heterogeneity of the studies included in the review, suggesting that the overall mean effect sizes were not necessarily informative. This is illustrated by examining the three humanistic studies included in the meta-analysis. Webb and colleagues reported a correlation of .45 for a study by Sachs (1983) investigating the effect of negative factors in brief client-centred therapy, of -.02 for EFT for adult survivors of child abuse (Paivio et al., 2004), and of -.35 for emotion-focused trauma therapy (Hall, 2007, unpublished doctoral dissertation).

Power et al. (2022) conducted a new meta-analysis to update the findings of Webb and colleagues, arguing that more recent studies offered greater rigour in the evaluation of ACI, such as the use of validated manuals for treatment and for the assessment of ACI. The

review identified 45 adherence-outcome relationships, 39 competence-outcome and seven integrity-outcome relationships. No significant relationship between adherence and outcome was found, while small and significant associations were found between competence and outcome in non-hierarchical studies ($r = .17$, $p < .001$), and between integrity and outcome in both non-hierarchical and hierarchical studies ($r = .15$, $p < .001$; $r = .23$, $p < .044$ respectively). The results of moderator analyses showed that for diagnosis, the strongest significant associations with outcome were for the treatment of anxiety and depression, and for treatment modality the strongest association was for CBT. From the finding of a moderate significant effect size for studies of treatment integrity with a hierarchical design, where individual therapist skills and attitudes were partialled out, the authors concluded that specific treatment strategies were important for clinical outcomes. However, this conclusion was based on only three studies, none of which were investigations of process-oriented therapy such as PCET.

While the studies analysed by Webb et al. (2010) and by Power et al. (2022) comprised mostly randomised controlled trials, a study by Tschuschke et al. (2015) examined therapist adherence and professional experience, the working alliance and the severity of clients' psychological problems in routine settings. Ratings for specific and common interventions and therapeutic alliance were made for 262 audio recordings, representing 30 therapists and 81 individual therapies across eight treatment modalities, which included humanistic but not specifically client-centred therapy. Interestingly, the authors found that adherence varied as much within individual therapies as between treatment modalities. Overall, the authors found a small and nonsignificant trend for adherence to predict outcome, but this relationship appeared to be indirect. Stronger associations were found across therapies between therapists' professional experience and

the severity of clients' problems, suggesting an indirect relationship among these variables and both adherence and outcome. The study also found that the quality of the therapeutic alliance was predicted by the severity of clients' problems. Although Tschuschke and colleagues did not include measures of competence in this study, they concluded that therapists across modalities are flexible and responsive to clients in their use of specific therapeutic components. Unfortunately, the authors were unable to recruit any client-centred therapists to participate in the study.

Given such ambiguous findings for a linear relationship between ACI and outcome, Barber and colleagues conducted several studies to investigate a possible curvilinear relationship. Barber et al. (2006) examined linear and curvilinear relationships among adherence, competence, working alliance and drug-use and depression outcomes in individual drug counselling in an RCT for cocaine-dependence. For depression they found a significant linear relationship between adherence and outcome, but also a curvilinear relationship, where moderate adherence predicted better outcomes. A measure of competence did not add to the model, due to collinearity with adherence, and probably as a result of the selection of the most skilled counsellors for the trial. An association was found between working alliance, adherence and outcome, suggesting that a strong alliance predicted a positive outcome regardless of the level of adherence, whereas in the context of a weak alliance, a moderate level of adherence was associated with improved outcome more than high or low levels.

A further study by Barber et al. (2008) analysed results from the supportive expressive therapy arm of the same RCT. In contrast to the results for individual drug counselling, the authors found that in the context of a strong therapeutic alliance, either a low or a high level of adherence to supportive expressive therapy techniques predicted a

reduction in drug use more than a moderate level of adherence. The study did not report

results for measures of change in depression or anxiety.

McCarthy et al. (2016) analysed results from the psychotherapy arm of a randomised

controlled trial comparing psychodynamic therapy for depression with pharmacotherapy or

pill placebo. The authors hypothesised that moderate levels of psychodynamic interventions

would be associated with symptom improvement, and that supportive interventions, and

interventions from other modalities would also contribute to outcome, but without

predicting the direction of such a contribution. Results indicated that moderate levels of

both psychodynamic and process-experiential interventions were significantly related to

improved outcome, while greater levels of common factors and person-centred

interventions were also related to symptom improvement, but nonsignificantly. As with

other studies, the authors speculated that these results may have reflected characteristics

of the therapist/client dyad, highlighting therapist responsiveness.

Competence in Different Phases of Therapy

There are two reasons for investigating therapist competence in different phases of

therapy. The first stems from research showing that across modalities, including PCET,

clients who experience an early improvement in symptoms have better outcomes (Beard &

Delgadillo, 2019; Duffy et al., 2022, Pybis et al., 2017). The second reason is that, as noted in

Chapter 6, and illustrated by the graphs of PCET clients' trajectories as measured by the

PHQ-9 (Figure 6.1), change in depression is rarely linear. Many therapy modalities, including

PCET, recommend that in the first few sessions the therapist should concentrate on building

the therapeutic relationship and working alliance, before moving into the middle, 'working'

phase (Greenberg & Watson, 2006; Murphy, 2019). The emotion-focused, experiential

interventions in PCET may be challenging for the client and need to be offered by the

therapist in the context of an established, trusting and containing relationship. As a consequence of the 'perturbation' experienced in working sessions (Hayes, 2007), symptoms may worsen for some clients. For example, Pascual-Leone and) ramer (2019) tested Pascual-Leone and Greenberg's emotional processing model of change (2007), exploring patterns of improvement in clients' emotional resilience within EFT. They conducted mixed methods analyses of two good outcome cases of EFT identifying different but non-linear patterns of change in emotional processing and the building of emotional resilience across sessions.

In another study, Auszra et al. (2013) examined the relationships among client emotional productivity, high expressed emotional arousal, the working alliance and outcome in the beginning and working phases of experiential therapy. Results indicated that both beginning phase and working phase emotional productivity, and working alliance and working phase emotional productivity were significantly correlated. Beginning phase emotional productivity, working phase emotional productivity and working alliance were all significantly associated with improved depression.

In PCET, late phase sessions are characterised by a focus on understanding and consolidating any insights and changes that the client has experienced, and preparing for ending (Murphy, 2019). In the light of these two types of evidence about client process in different phases of therapy, the current study will investigate whether there is a role for therapist competence in clients' change trajectories in PCET.

The Current Study

It is well established that clients with more severe symptoms at baseline generally have worse outcomes than those who are less symptomatic. Recent studies have confirmed this finding for clients receiving treatment in NHS Talking Therapies services, including PCET

clients (Bauer-Staeb et al., 2023; Stoch et al., 2022). At the same time, higher baseline severity has been associated with a faster rate of improvement (Stoch et al., 2022). While controlling for baseline severity is important in all outcome research (Nunes et al., 2011), it may have additional implications for the current study since it was found in Chapter 6 that higher baseline severity was significantly related to higher therapist competence. This raises the possibility that competence might be a mediator between baseline severity and end of therapy outcome. This possibility will be examined in the current study with a mediation analysis.

As well as baseline severity, clients' demographic characteristics have been found to have a role in therapy outcome. For example, a meta-analysis by Finegan and Firth (2018) investigating the association between socioeconomic status and outcomes of therapy found mixed results, but overall concluded that unemployment and relative neighbourhood deprivation as measured by the Index of Multiple Deprivation (IMD) were associated with poorer therapy outcomes. Delgadillo et al. (2020) used machine learning to predict which client demographic characteristics have most influence on the outcomes of CBT and PCET (labelled Counselling for Depression or CfD in their study). They found that CfD had better outcomes for clients living in more deprived areas and not taking antidepressant medication. The possible influence of demographic variables and baseline severity will be taken into account using regression analysis.

The chosen method of sampling recordings for adherence rating in the PRaCTICED trial was to randomly select recordings from within four therapy duration bands (Chapter 2). Together with PHQ-9 scores (Kroenke & Spitzer, 2001) measuring depression symptoms at every session for every client, the available data therefore allows analysis of competence and change in depression in the early, middle and late phases of therapy.

This study follows from Chapter 6, which looked at the relationships between competence and proximal or 'little o' outcomes (i.e., next-session client outcomes). The purpose of the current study is to investigate the relationships between competence in the various components of the PCET model and 'big O outcomes': that is, the ultimate client outcomes at end of therapy. The contribution of proximal outcomes to ultimate outcomes will be investigated by combining data from Chapter 6 with data from the current chapter to analyse the relationship between next-session PHQ-9 change and end of therapy PHQ-9 change.

The aims of the current study are:

1. To examine the relationship between overall competence and change in depression at end of therapy.

2. To examine competence as a possible mediator between baseline severity and change in depression at end of therapy.

3. To examine the relationship between competence in the person-centred, proscribed, and experiential clusters of components and change in depression at end of therapy.

4. To examine the relationship between competence assessed in the early, middle, and late phases of therapy and change in depression at end of therapy.

5. To examine the relationship between change in depression from the rated session to the next session and change in depression at end of therapy.

Methods

Information about trial participants, PCET segments recorded and rated for the PRaCTICED trial, raters, and use of the PCEPS to assess therapist competence, is available in Chapter 2, and in the Methods section of Chapter 6.

Ethics

Ethics approval was granted as part of the submission for the PRaCTICED trial (Health Research Authority, Research Ethics Committee 14/YH/0001; Barkham et al., 2021).

Full Sample of Clients Who Received PCET in the PRaCTICED Trial

Numbers included in the full sample are shown in Table 7.1. Of the 202 clients in the PRaCTICED trial randomised to PCET for whom pre- and post-therapy PHQ-9 scores were available, three switched to CBT, 14 were randomised to PCET but did not attend any PCET sessions, and 14 attended ≤2 PCET sessions. Data for these 31 clients has been excluded from this study, resulting in a sample of 171 who received PCE therapy in the PRaCTICED trial.

Sub-Sample of Participants Who Had Recording Segments Rated for Therapist Competence

Table 7.1 also shows numbers included in the sub-sample who had audio-recordings selected for competence rating. During the PRaCTICED trial all therapy sessions were audio-recorded. A sample of 65 recordings of PCET sessions was randomly selected for rating of therapist competence using the PCEPS-10. From this sample, one session was not rated due to recording failure. One client who had a session recording rated for competence attended only two sessions, and three clients switched to CBT. Three therapists saw ≤ 2 clients in the trial, each with one session rated. Competence ratings for these eight session recordings were excluded from this analysis, resulting in a sub-sample of 57.

PCE Therapists

Sixteen therapists worked with clients in the PRaCTICED trial, contributing to the trial dataset. Two therapists were male. All therapists were experienced primary care counsellors, qualified in PCET.

For this study, outcomes for the clients of three therapists who saw two trial clients or fewer were omitted (n = 3). Outcome data only was included for the clients of one therapist who participated in the later stages of the trial, and therefore had no sessions rated and no available competence data.

Table 7.1

Numbers included in the full sample and the rated sub-sample, with reasons for exclusions

Full sample			Rated sub-sample		
	Excluded			Excluded	
Randomised to PCET with pre-post therapy data		202	Session recordings sampled for competence rating		65
Switched to CBT	3	199	Switched to CBT	3	62
Did not attend	14	185	Recording failed	1	61
Attended ≤2 sessions	14	171	Attended ≤2 sessions	1	60
			Therapists saw ≤2 clients	3	57
Total		171			57
Full sample excluding rated sub-sample	57	114			

Outcome Measure

All NHS Talking Therapies clients are expected to complete a Minimum Data Set, which includes the PHQ-9, at every therapy session (NCCMH, 2023). These session-by-session PHQ-9 scores were included in the PRaCTICED trial dataset. Data extracted from the PRaCTICED trial dataset for this study were

1. PHQ-9 scores at the first PCET session;

2. PHQ-9 scores at the last PCET session;

Procedure

Demographic variables were extracted from the complete PRaCTICED trial data set for the 171 clients represented in the study. These were gender, age, IMD decile, employment status, ethnicity, and use of anti-depressant medication.

Outcome Variable: End of Therapy PHQ-9 Change

Difference scores, namely, change on the PHQ-9 from the beginning to the end of PCE therapy (end of therapy PHQ-9 change), were calculated for the full sample by subtracting the client's PHQ-9 score at the first PCET session (first PHQ-9) from PHQ-9 score at the last session. Improvement in a client's depression is measured by a decrease in PHQ-9 score (i.e., a negative change score).

Competence Variables: Total PCEPS, and Person-Centred, Proscribed, and Experiential Clusters

Competence ratings for the rated sub-sample were calculated using the means of the expert raters' ratings. Mean ratings were calculated for the total PCEPS ratings (maximum 60 marks), the person-centred cluster (five items, maximum 30 marks), the proscribed cluster (two items, maximum 12 marks) and the experiential cluster (three items, maximum 18 marks). A description of each of the clusters is given in Chapter 2. For ease of comparison, percentages were calculated for the total PCEPS rating, the three competence clusters, and their standard deviations.

Normality of Population Distribution, Outliers, and Descriptive Statistics

SPSS for Windows v.26 (IBM, 2019) was used to compute all statistics. Variable names and descriptions are shown in Table 7.2 below. Outliers were identified using box and whisker plots. An outlier is defined as more than 1.5 but less than 3 inter-quartile ranges from the end of the box. Results of sensitivity analyses performed by repeating

correlations including outliers are given in Appendix E. Shapiro-Wilk tests for normal

population distribution were applied for all variables. A sample is deemed to come from a

normal distribution if the *p* value of the Shapiro-Wilk test is ≥.05. Descriptive statistics

(means, standard deviations, medians, range, and distribution defined by inter-quartile

range) were calculated for all variables. A between groups one-way ANOVA was conducted

to assess whether the rated sub-sample was representative of the full sample.

Table 7.2

Names and descriptions for all variables

	N	Variable name	Description
Full sample	171	First PHQ-9	Baseline severity: PHQ-9 score at first PCET session
		End of therapy PHQ-9 change	Outcome: first PHQ-9 - PHQ-9 score at final PCET session
Rated sub-sample	57	Total PCEPS	Mean of raters' ratings for all PCEPS items (10 items, max score = 60)
		Person-centred cluster	Mean of raters' ratings for person-centred items (5 items, max score = 30)
		Proscribed cluster	Mean of raters' ratings for proscribed items (2 items, max score = 12)
		Experiential cluster	Mean of raters' ratings for experiential items (3 items, max score = 18)
		Next-session PHQ-9 change	Change in PHQ-9 score from the rated session to the next session

Classification of Rated Segments into Early, Middle, or Late Phase of Therapy

As a client-led modality, PCET does not prescribe a set number of sessions, and

episodes of therapy can range from two to 20 sessions according to the wishes and needs of

the client. In the rated sub-sample for this study, therapy duration ranged from four to 20

sessions. Rated segments (excluding outliers) were divided into early, middle and late

phases, classified according to the session number sampled for rating, and the number of sessions attended by the client. Early phase segments were those rated within the first quartile (all session 2 recordings were deemed to be early phase). Middle phase segments were those rated between the lower and upper quartiles. Late phase segments were those rated within the upper quartile. This procedure is illustrated in Figure 7.1, using the examples of eight-, 12- and 20-session courses of therapy. Raters were unaware of the phase of therapy when assessing recording segments.

Figure 7.1

Examples of procedure for classifying rated segments into early, middle or late phases of therapy
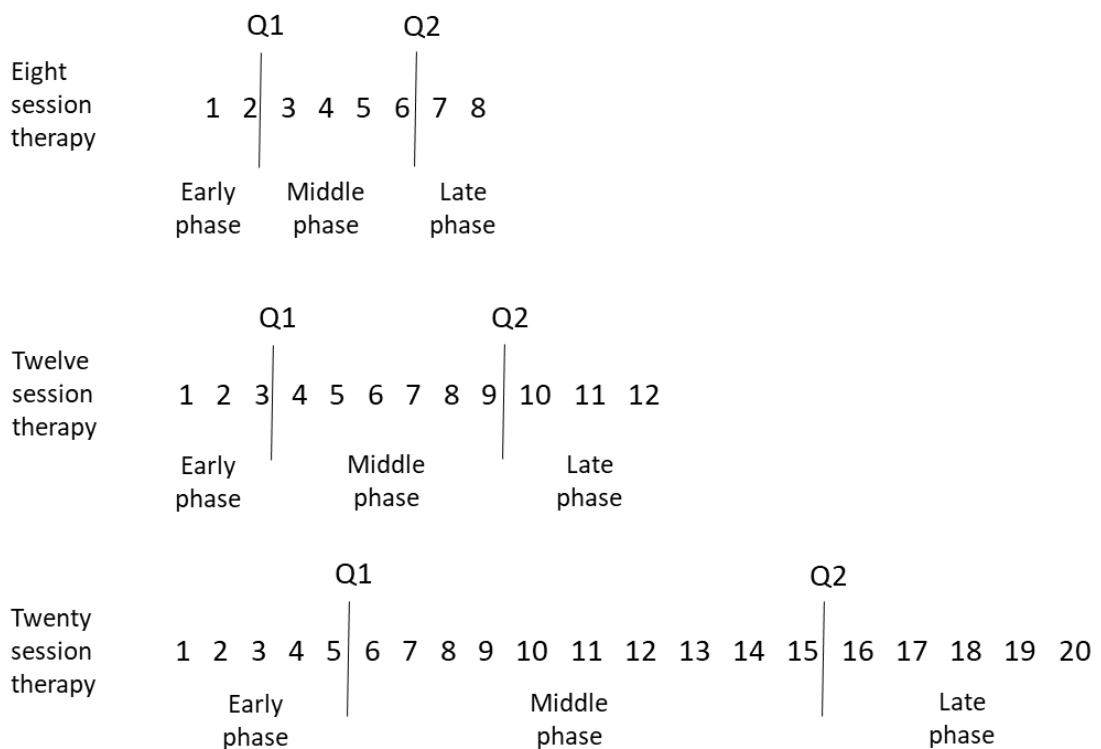
Statistical Analysis

A multiple regression analysis was conducted for end of therapy PHQ-9 change on six demographic variables (age, gender, IMD decile, employment status, ethnicity and medication) to assess these variables as possible predictors of outcome.

Improvement in a client's depression is measured by a decrease in PHQ-9 score (i.e., a negative change score). In the results of analyses reported here, therefore, negative coefficients reflect improvement in depression. Multiple linear regression analyses and Pearson's *r* correlations were conducted to investigate relationships between total PCEPS ratings, person-centred, proscribed, and experiential cluster ratings and end of therapy PHQ-9, controlling for baseline severity (i.e. first PHQ-9).

A mediation analysis was conducted to test competence as a possible mediator of the relationship between baseline severity (i.e. first PHQ-9) and ultimate outcome (i.e., end of therapy PHQ-9 change).

One-way ANOVAs were conducted to test whether there were any differences in baseline severity or competence ratings between segments rated in the different phases. Zero order and partial correlations controlling for first PHQ-9 were used to assess relationships between competence overall, and in each of the clusters of components, and end of therapy PHQ-9 change in each phase of therapy.

A multiple regression analysis was conducted to assess the contribution of change in depression from the rated session to the next session (next-session PHQ-9 change, see Chapter 6) to end of therapy PHQ-9 change in the rated sub-sample.

Results

Assessment of Variables

Normality of Population Distribution and Outliers

Using box and whisker plots, two outliers were identified in end of therapy PHQ-9 change. Two low values of -25 and -26 indicated unusual improvement in depression from the beginning to the end of therapy (Figure 7.2). Analysis was carried out with outliers excluded. With these outliers excluded the final full sample size was *N* = 169. The PHQ-9

242

change value of -25 fell in both the full sample and the rated sub-sample. With this outlier

excluded the final rated sub-sample size was *n* = 56. Results of sensitivity analyses with

outliers included are available in Appendix E, showing that there was no significant

difference between results including and excluding outliers.

Figure 7.2

Box and whisker plot for full sample showing median, range and interquartile range for first PHQ-9

and end of therapy PHQ-9 change, with outliers
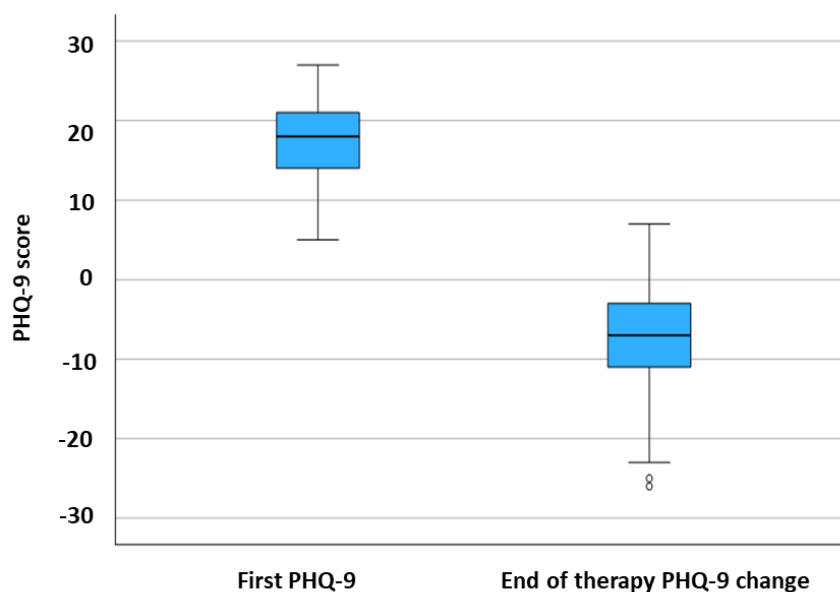
The Shapiro-Wilk statistics for first PHQ-9 (W(172) = .98 *p* = .004) indicated that the

distribution for this variable was not normal. However, the Fisher skewness coefficient

(skewness/standard error of skewness; Pett, 2015) was -.15/.19 = -.79 (i.e., within a ±1.96

range), showed that the variable was not significantly different from a normal distribution at

$\alpha \le .05$ and was sufficiently normal to permit tests for parametric data.

A Shapiro-Wilks test for normality for the competence variables indicated that none

of the four variables had distributions significantly different from normal ($\alpha \le .05$). Visual

inspection of box and whisker plots of the competence variables for the rated sub-sample

(Figure 7.3) confirmed that there were no outliers.

Figure 7.3

Box and Whisker plot showing median, range and interquartile range for competence ratings of rated

sub-sample
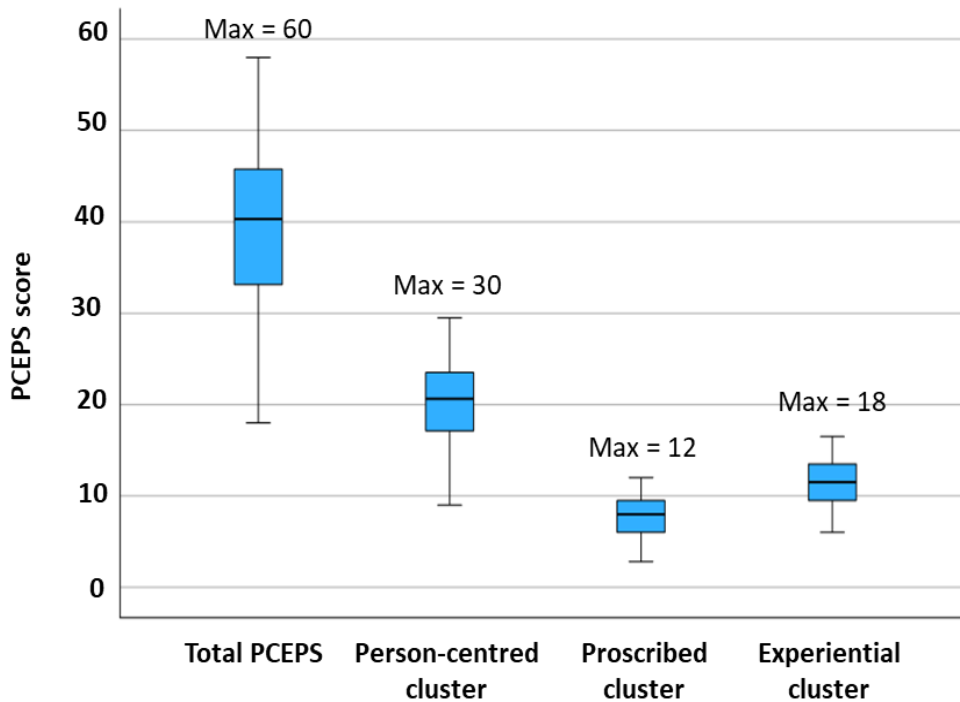
Descriptive Statistics for Full Sample and Rated Sub-Sample

Table 7.3 shows descriptive statistics for baseline severity (first PHQ-9) and end of

therapy PHQ-9 change for the full sample. It also shows descriptive statistics for first PHQ-9,

end of therapy PHQ-9 change, and for the four competence variables for the rated sub-

sample. One-way between groups ANOVAs showed no significant difference between the

rated sample ($N = 56$) and the full sample ($N = 113$) excluding outliers for first PHQ-9

($F(1,167) = .18$, $p = .67$) or end of therapy PHQ-9 change ($F(1, 167) = 1.28$, $p = .26$).

Table 7.3

Descriptive statistics for full sample and rated sub-sample

		First PHQ-9	End of therapy PHQ-9 change	Total PCEPS	Person-centred cluster	Proscribed cluster	Experiential cluster
Full sample	*N*	169	169				
	Mean	17.59	-7.06				
	SD	4.65	6.17				
	Median	18	-7				
	Range	5 – 27	-23 – 7				
	IQR	14 – 21	-11 - -3				
Rated sub-sample	*n*	56	56	56	56	56	56
	Mean	17.80	-7.82	39.38	20.16	7.74	11.48
	SD	4.72	6.35	8.54	4.36	2.13	2.44
	Median	18.50	-8.50	40.32	20.63	8.00	11.50
	Range	5 – 26	-23 – 4	18.00 – 58.00	9.00 – 29.50	2.80 – 12.00	6.00 – 16.50
	IQR	14 – 21	-12 – -3	33.06 – 45.88	17.06 – 23.50	6 – 9.50	9.50 – 13.50

Influence of Participant Demographics on End of Therapy PHQ-9 Change

Demographic information for the full sample of participants included in this study is presented in Appendix E, Table 7.2E. Demographic information for the rated sub-sample is given in Appendix D, Table 7.3D. A multiple regression analysis showed that there was no significant relationship between demographic variables and end of therapy PHQ-9 change (R^2 adjusted = -.01, $F(6,162)$ = 1.29, p = .26). There was a small but significant effect of gender (B = 2.10, β = .16, p = .03), where females experienced a greater improvement in depression than males. Results are shown in Appendix E, Table 7.3E.

Relationships Between First PHQ-9, Competence and End of Therapy PHQ-9 Change

A Pearson's *r* correlation for the relationship between first PHQ-9 and end of therapy PHQ-9 change for the full sample was r = -.33, p < .001. Table 7.4 shows the results of a multiple linear regression of end of therapy PHQ-9 change on baseline severity (first PHQ-9) and total PCEPS in the rated sub-sample. There was a statistically significant relationship, (R^2 adjusted = 0.17, $F(2,53)$ = 6.53, p = .003). The negative coefficients indicate that higher baseline severity was associated with greater improvement in depression (B = -.61, β = -.45, p <.001).

The positive coefficient for total PCEPS suggests that higher competence was associated with less improvement in depression, but this result was nonsignificant (B = .14, β = .19, p = .14).

Table 7.4

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and total PCEPS

(R^2 adjusted = 0.17, F(2,53) = 6.53, p = .003)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-2.49	4.24	-10.99 – 6.01		-.59	.56
First PHQ-9	-.61	.17	-.95 – -.27	-.45	-3.56	<.001
Total PCEPS	.14	.09	-.05 – -.33	.19	1.49	.14

Table 7.5 shows the results of Pearson's *r* correlations between the four competence variables and end of therapy PHQ-9 change. The positive coefficients suggest that higher total competence and in each of the clusters is associated with less improvement in depression. None of the relationships was found to be statistically significant, though all results were stronger when first PHQ-9 was controlled for.

Table 7.5

Pearson's r correlations between competence variables and end of therapy PHQ-9 change, controlling for first PHQ-9

	Total PCEPS		Person-centred cluster		Proscribed cluster		Experiential cluster	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
N	56		56		56		56	
Pearson's *r*	.07	.60	.07	.74	.05	.74	.09	.50
Pearson's *r* controlling for first PHQ-9	.20	.14	.17	.20	.17	.20	.19	.16

The scatter plot in Figure 7.4 illustrates the relationship between overall total PCEPS ratings and end of therapy PHQ-9 change.

Figure 7.4

Scatter plot showing Pearson's r correlation between total PCEPS rating and end of therapy PHQ-9 change
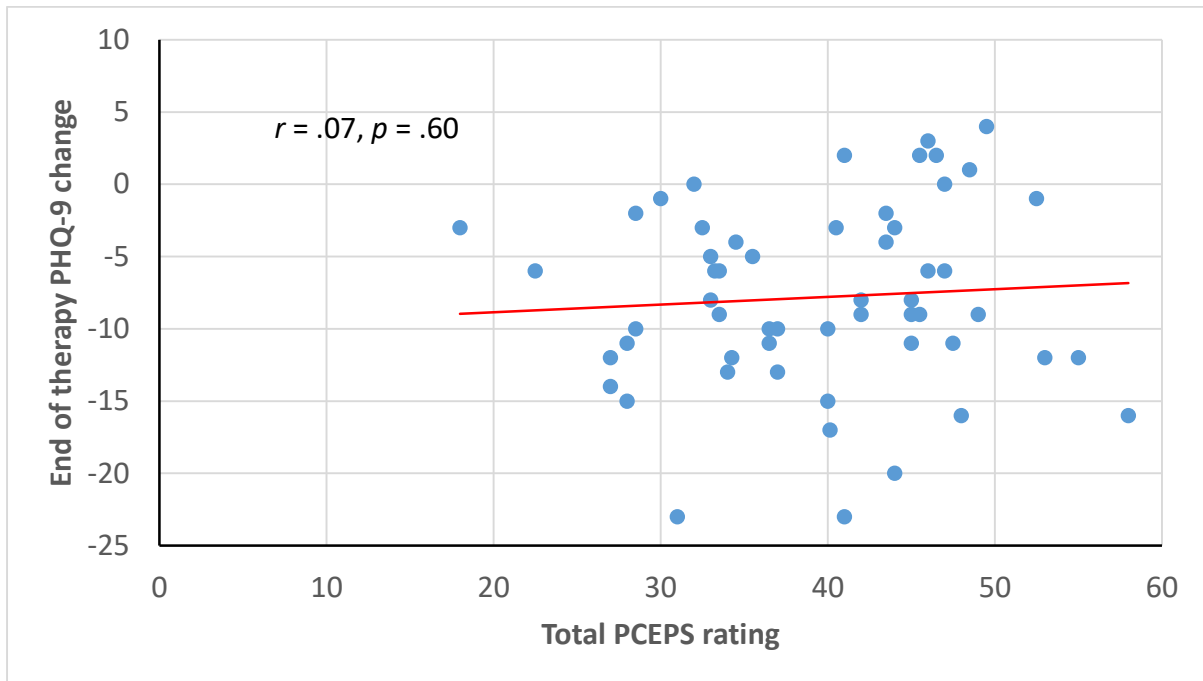
A multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and the three separate competence clusters found a significant association between first PHQ-9 and end of therapy PHQ-9 change (B = -.61, β -.45, p <.001), but no association for the competence clusters (R^2 adjusted = 0.14, $F(4,51)$ = 3.15, p = .02). Results are shown in Appendix E, Table 7.6E.

Analysis of Competence as a Mediator Between First PHQ-9 and End of Therapy PHQ-9 Change

As reported above, a significant relationship was found between first PHQ-9 and end of therapy PHQ-9 change (r = -.33, p < .001). At the same time, in Chapter 6 a significant

relationship was found between first PHQ-9 and competence, where more severe depression at baseline was associated with higher rated competence ($r = .32$, $p = .02$, Table 6.5). In the light of these findings a mediation analysis was conducted to test whether there was an indirect effect of baseline severity on end of therapy PHQ-9 change, mediated by competence (total PCEPS score).

Table 7.6 displays the result of a linear regression of end of therapy PHQ-9 change on first PHQ-9, showing that there was a significant total effect ($B = -.57$, $p = .003$). Table 7.7 displays the result of a linear regression of competence (total PCEPS) on first PHQ-9, showing that this direct effect (path A) was also significant ($B = .60$, $p = .022$). Table 7.8 displays the result of a multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and total PCEPS. The direct effect between total PCEPS and end of therapy PHQ-9 change (path B) was nonsignificant ($B = .15$, $p = .12$). In order to demonstrate competence as a partial mediator, the direct effect between first PHQ-9 and end of therapy PHQ-9 change would need to be reduced from the total effect. However, the direct effect between first PHQ-9 and end of therapy PHQ-9 change was $B = -.66$, $p = <.001$, i.e. greater than the total effect. The point estimate of the direct effect (.60 x .15) was .09. A Sobel test showed that this result was nonsignificant ($z = 1.32$, std. error = 0.07, $p = .19$), meaning that competence does not mediate the relationship between baseline severity and change in depression at the end of therapy. These results are illustrated in Figure 7.5.

Table 7.6

Linear regression of end of therapy PHQ-9 change on first PHQ-9 (total effect. R^2 adjusted = 0.14, F(1,53) = 9.92, p = .003)

	Unstandardised coefficients			Standardised Coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	2.41	3.37	-4.35 – 9.17		.71	.48
First PHQ-9	-.57	.18	-.94 - -.21	-.40	-3.15	.003

Table 7.7

Linear regression of total PCEPS on first PHQ-9 (Path A. R^2 adjusted = 0.8, F(1,53) = 5.56, p = .022)

	Unstandardised coefficients			Standardised Coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	28.51	4.71	19.07 – 37.96		6.06	<.001
First PHQ-9	.60	.25	.09 – 1.11	.31	2.36	.022

Table 7.8

Linear regression of end of therapy PHQ-9 change on first PHQ-9 and total PCEPS (Path B.

R^2 adjusted = 0.16, F(2,52) = 6.35, p = .003)

	Unstandardised coefficients			Standardised Coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-1.97	4.33	-10.65 – 6.71		-.46	.650
First PHQ-9	-.66	.19	-1.04 - .29	-.46	-3.53	<.001
Total PCEPS	.15	.10	-.04 - .35	.21	1.58	.119

Figure 7.5

Illustration of analysis of competence as mediator between baseline severity and improvement in
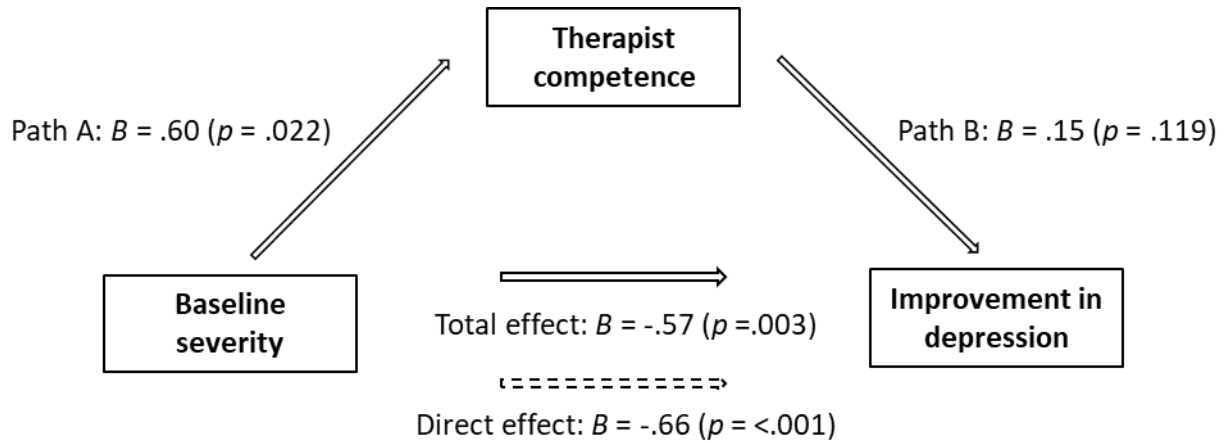
depression at end of therapy

Path A: B = .60 (p = .022)

Path B: B = .15 (p = .119)

Total effect: B = -.57 (p =.003)

Direct effect: B = -.66 (p = <.001)

Relationship Between Competence and Outcome in the Early, Middle, and Late Phases of

Therapy

Descriptive Statistics for Competence Variables, First PHQ-9, and End of Therapy PHQ-9

Change in the Phases of Therapy

Table 7.9 shows descriptive statistics for the four competence variables, overall and

in the early, middle and late phases of therapy. Table 7.9 also shows descriptive statistics for

first PHQ-9, end of therapy PHQ-9 change, and next-session change. Data for next-session

change is taken from Chapter 6 (n = 50. One client who was included in Chapter 6 has been

excluded from Chapter 7, as they switched to CBT after the session rated for competence). A

between groups one-way ANOVA determined that there was no significant difference in

competence ratings in the three phases of therapy (F(2,53) = .37, p = .69).

Visual inspection of Table 7.9 suggested that baseline severity was greater in the

early (first PHQ-9 mean = 18.35) and middle phases (mean = 18.25) than in the late phase

(mean = 16.84). As described in Chapter 6, one client had an unusually low value for first

PHQ-9. The rated session for this client fell in the late phase. The row labelled late* in Table 7.9 shows statistics with data for this client excluded. When data for this client was excluded, mean first PHQ-9 for the late phase was 17.50. A between groups one-way ANOVA indicated that there was no statistically significant difference in first PHQ-9 (F(2,53) = .59, p = .56) between the phases.

End of therapy PHQ-9 change was greatest in the middle phase (mean = -8.75). A between groups one-way ANOVA indicated that there was no statistically significant difference between the phases in end of therapy PHQ-9 change (F(2,53) = .39, p = .68).

Table 7.9

Descriptive statistics for competence variables, first PHQ-9, and end of therapy PHQ-9 change for the

rated sub-sample overall and within phases of therapy

	N	Mean	SD	Median	Range	IQR
				Total PCEPS		
Overall	56	39.38	8.53	40.25	18 – 58	33.06 – 45.87
Early phase	17	39.50	9.07	40	27 – 58	32.25 – 47.50
Middle phase	20	38.17	9.48	36.75	18 – 55	33.31 – 45.37
Late phase	19	40.55	7.15	44	22.5 – 47.5	35.50 – 45.50
Late phase*	18	40.36	7.31	43.75	22.5 – 47.5	34.87 – 45.50
				Person-centred cluster		
Overall	56	20.16	4.36	20.62	9 – 29.5	17 – 23.5
Early phase	17	20.31	4.47	19.5	14 – 29.5	16.75 – 24.75
Middle phase	20	19.29	4.91	18	9 – 28	16.25 – 22.44
Late phase	19	20.82	3.76	22	11.5 – 24.5	18.50 – 23.50
Late phase*	18	20.75	3.86	22.5	11.5 – 24.5	18.00 – 23.50
				Proscribed cluster		
Overall	56	7.74	2.13	8	2.75 – 12	6 – 9.5
Early phase	17	7.88	2.45	8	4 – 12	5.5 – 10
Middle phase	20	7.56	2.15	7.5	3 – 11	6 – 9.5
Late phase	19	7.95	1.57	8	4.5 – 10	7.50 – 9.00
Late phase*	18	7.89	1.59	8	4.5 – 10	7.12 – 9.00
				Experiential cluster		
Overall	56	11.47	2.44	11.5	6 – 16.5	9.5 – 13.5
Early phase	17	11.30	2.39	11.5	8 – 16.5	9.25 – 13.50
Middle phase	20	11.32	2.81	11	6 – 16	9.25 – 13.69
Late phase	19	11.79	2.15	12.5	6 – 14	10.50 – 13.00
Late phase*	18	11.72	2.19	12.5	6 – 14	10.25 – 13.12

Table 7.9 continued

	N	Mean	SD	Median	Range	IQR
			First PHQ-9			
Overall	56	17.80	4.72	18.5	5 – 26	14 – 21
Early phase	17	18.35	5.33	19	11 – 26	13 – 23
Middle phase	20	18.25	4.27	19.5	11 – 24	14.25 – 21.75
Late phase	19	16.84	4.71	17	5 – 25	13 – 21
Late phase*	18	17.50	3.84	17	12 – 25	13.75 – 21
			End of therapy PHQ-9 change			
Overall	56	-7.82	6.35	-8.5	-23 – 4	-12 – -3
Early phase	17	-7.71	6.70	-9	-17 – 4	-14.5 – -1.5
Middle phase	20	-8.75	5.85	-9.5	-23 – 2	-12 – -3.75
Late phase	19	-6.95	6.75	-8	-23 – 3	-10 – -3
Late phase*	18	-7.17	6.88	-8	-23 – 3	-10.25 – -2.5
			Next-session PHQ-9 change			
Overall	48	-1.25	2.67	-1.00	-6 – 5	-3 – 1
Early phase	17	-0.94	2.73	-1.00	-6 – 5	-2 – 1
Middle phase	17	-1.65	2.85	-1.00	-6 – 3	-4.50 – 0.50
Late phase	16	-1.31	2.39	-1.50	-6 – 3	-3 – 0.75
Late phase*	15	-1.20	2.43	-1.00	-6 – 3	-3 – 1

Relationship Between Competence and End of Therapy PHQ-9 Change in the Early, Middle and Late Phases of Therapy

Table 7.10 shows the results of Pearson's *r* correlations between competence rated in the different phases of therapy and change in depression at the end of therapy. The majority of coefficients were stronger and more significant when first PHQ-9 was controlled for, however no relationship was found to be statistically significant. The most significant relationships after controlling for first PHQ-9 (highlighted in italics in Table 7.10) were from the middle phase. The relationship between competence in the experiential cluster and

outcome for segments rated in the middle phase of therapy approached significance. The

positive direction of the coefficients indicated that higher competence was associated with

less improvement in depression.

Table 7.10

Pearson's r correlations between competence rated in the early, middle, and late phases of therapy and end of therapy PHQ-9 change

	Overall		Early		Middle		Late		Late*	
N	56		17		20		19		18	
	r	p	r	p	r	p	r	p	r	p
Total PCEPS	.07	.60	.12	.66	.05	.83	.01	.98	-.01	.96
Controlling for first PHQ-9	.20	.14	.20	.46	*.36*	*.13*	.03	.92	.07	.79
Person-centred cluster	.07	.62	.16	.55	.07	.77	-.08	.75	-.09	.72
Controlling for first PHQ-9	.20	.15	.24	.36	*.36*	*.13*	-.04	.86	-.01	.98
Proscribed cluster	.05	.74	.11	.68	-.08	.75	.08	.76	.05	.83
Controlling for first PHQ-9	.17	.20	.19	.48	.19	.44	.12	.64	.19	.47
Experiential cluster	.09	.50	.04	.89	.11	.63	.10	.68	.08	.74
Controlling for first PHQ-9	.19	.16	.10	.72	*.42*	*.08*	.07	.77	.10	.69

Relationship Between Next-Session PHQ-9 Change and End of Therapy PHQ-9 Change

Descriptive Statistics for First PHQ-9, Next-Session PHQ-9 Change, and End of Therapy

PHQ-9 Change

Table 7.11 shows numbers for the rated sub-sample with next-session PHQ-9 change data from Chapter 6. Two participants were identified as outliers in Chapter 6, and one client switched to CBT following the session after the rated session. Following the exclusion of these three participants, and one unusually low value of first PHQ-9, $N = 47$.

Table 7.11

Sample included in analysis of the relationship between next-session PHQ-9 change and end of therapy PHQ-9 change

Reason for exclusion	Number excluded	Number included for current analysis
Chapter 6 sample excluding outliers		51
Low value of first PHQ-9	1	50
Outliers identified in Chapter 7	2	48
Switched to CBT following rated session	1	47

Table 7.12 shows means, standard deviations, medians, range and interquartile range for first PHQ-9, next-session PHQ-9 change and end of therapy PHQ-9 change for the rated sub-sample. Data for the next-session PHQ-9 change variable is taken from Chapter 6.

Table 7.12

Descriptive statistics first PHQ-9, next-session PHQ-9 change, and end of therapy PHQ-9 change for

the rated sub-sample

	N	Mean	SD	Median	Range	IQR
First PHQ-9	47	18.21	4.73	19	5 – 26	14.25 – 21
Next-session PHQ-9 change	47	-1.25	2.67	-1.00	-6 – 5	-3 – 1
End of therapy PHQ-9 change	47	-7.79	6.18	-8.5	-23 – 4	-11.75 – -3

Table 7.13 shows the result of a multiple regression analysis of end of therapy PHQ-9 change on first PHQ-9 and next-session PHQ-9 change. The result was small but significant (R^2 adjusted = .09, $F(2,44)$ = 3.31, p = .05). As before, a significant association was found between higher first PHQ-9 and greater improvement in depression at end of therapy (B = -.47, β = -.33, p = .03), but no relationship was found for next-session PHQ-9 change.

Table 7.13

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and next-session PHQ-9

change (R^2 adjusted = .09, F(2,44) = 3.31, p = .05)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	1.02	3.82	-6.06 – 7.62		.27	.79
First PHQ-9	-.47	.20	-.82 – -.09	-.33	-2.28	.03
Next-session PHQ-9 change	.25	.33	-.39 – .90	.11	.75	.46

Relationship Between Next-Session PHQ-9 Change and End of Therapy PHQ-9 Change in

the Early, Middle, and Late Phases of Therapy

Descriptive statistics for next-session PHQ-9 change are shown in Table 7.9 (above). Box and whisker plots (Appendix E, Figure 7.1E) for end of therapy PHQ-9 change in the phases of therapy indicated that there was one outlier in the middle phase and one in the late phase. Results of Shapiro-Wilk tests for end of therapy PHQ-9 change indicated that population distribution for these samples were normal (early phase: $W(17) = .94$ $p = .28$; late phase: $W(15) = .90$ $p = .10$). The following analysis was conducted with these outliers excluded. Results with the outliers included are shown in Appendix E.

Table 7.14 shows Pearson's *r* correlations for the relationship between competence (total PCEPS) and next-session PHQ-9 change overall, and in each phase of therapy. These results (though nonsignificant) suggest that in the middle and late phases greater competence is associated with greater improvement in depression at the next session. In the early phase, however, there is an association approaching significance between greater competence and less improvement in depression at the next session ($r = .45$, $p = .09$).

Table 7.14

Pearson's r correlations between total PCEPS score and next-session PHQ-9 change overall and in the early, middle, and late phases of therapy

	Overall		Early		Middle		Late	
N	45		16		16		13	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
Next-session PHQ-9 change	.04	.79	.33	.21	-.17	.53	-.06	.84
Controlling for first PHQ-9 change	.11	.49	.45	.09	-.15	.59	-.11	.74

Table 7.15 shows the results of zero order and partial Pearson's *r* correlations (controlling for first PHQ-9) between next-session PHQ-9 change and end of therapy PHQ-9 change in the three phases of therapy. Results showed a significant association between improvement in depression in the early phase of therapy and improvement at the end of therapy (positive coefficient). This relationship approached significance. The negative coefficients in the middle phase and late phases mean that less improvement in depression from the rated session to the next session was associated with greater improvement at end of therapy. For the middle phase this result approached significance (highlighted in italics in Table 7.15).

Table 7.15

Pearson's r correlations between next-session PHQ-9 change and end of therapy PHQ-9 change overall and in the early, middle, and late phases of therapy

	Overall		Early		Middle		Late	
N	45		16		16		13	
	r	**p**	**r**	**p**	**r**	**p**	**r**	**p**
End of therapy PHQ-9 change	.07	.62	.53	.03	-.44	.09	-.16	.61
Controlling for first PHQ-9	.05	.74	.49	.06	-.50	.06	-.16	.62

The results from Tables 7.14 and 7.15 are illustrated side by side in the scatter graphs in Figure 7.6. The matching positive and negative slopes for the two correlations in each phase suggest that for each phase, lower competence was more helpful for the client at end of therapy. For segments rated in the middle and late phases, the relationship between competence and next-session change was nonsignificant, meaning that change was independent of competence. In the early phase, though still nonsignificant, lower competence was associated with more improvement in depression at the next session, and

more improvement in depression at the next session was associated with more improvement in depression at the end of therapy. In the middle phase, there was a relationship approaching significance between less next-session improvement and more end of therapy improvement.

Figure 7.6

Scatter plots showing Pearson's r correlations between competence (total PCEPS) and next-session PHQ-9 change, and between next-session PHQ-9 change and end of therapy PHQ-9 change in (a) early, (b) middle, and (c) late phases

(a) Early phase

(a) Early phase

Figure 7.6 continued

(b) Middle phase

r = -.17, p = .53

(b) Middle phase

r = -.44, p = .09

(c) Late phase

r = -.06, p = .84

(c) Late phase

r = -.16, p = .61
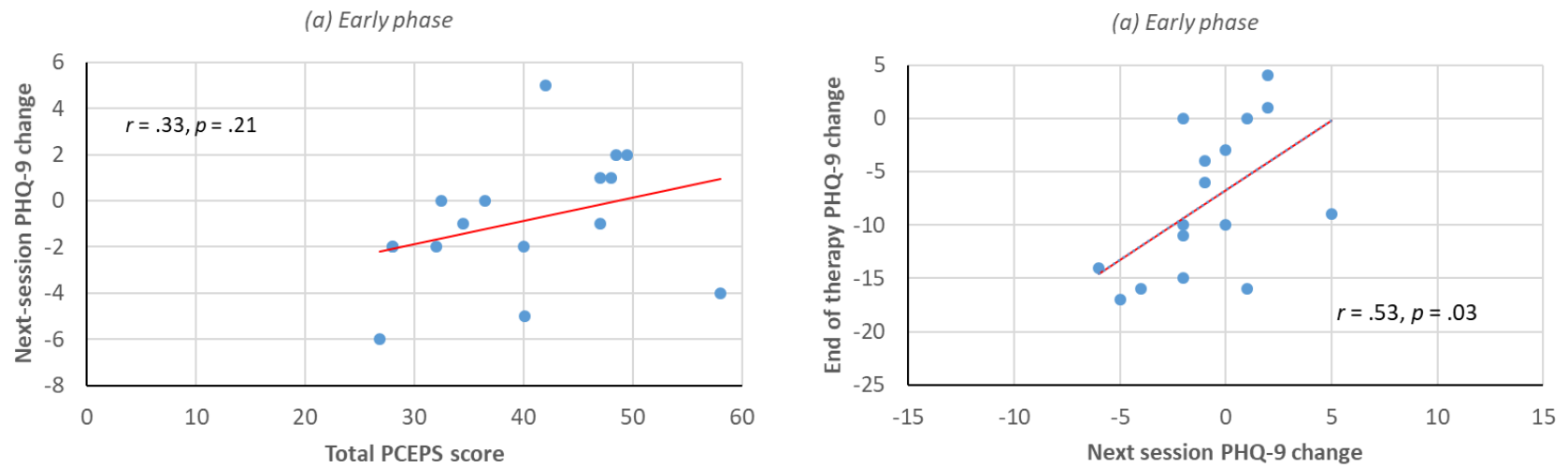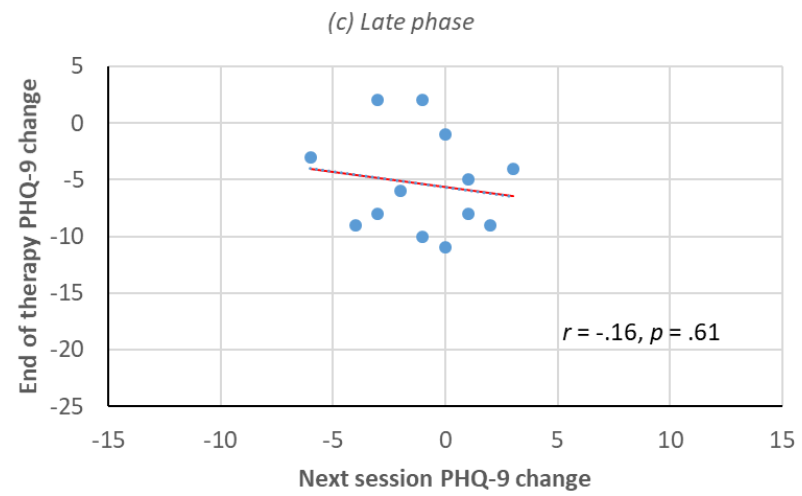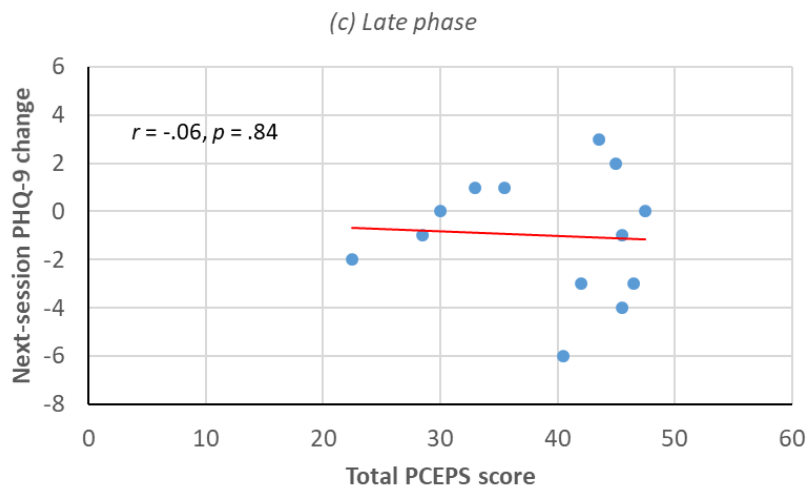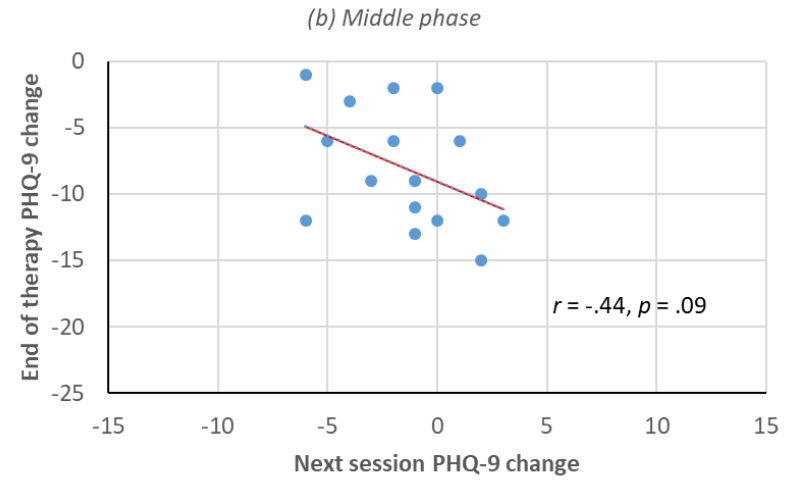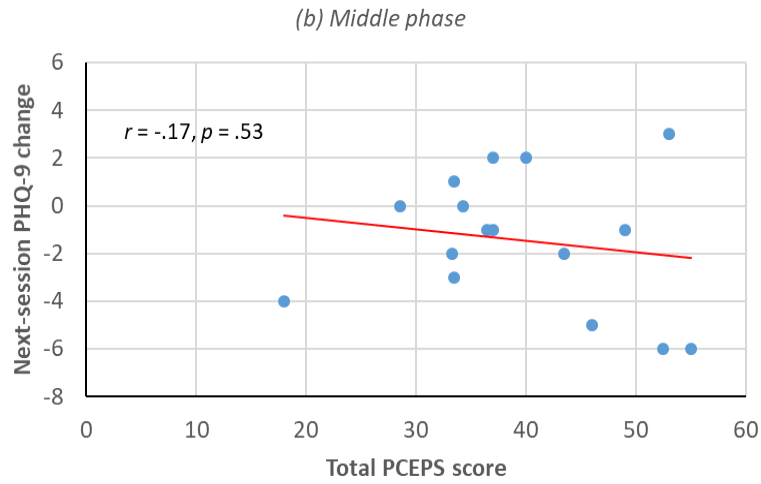
Discussion

The aim of this study was to investigate the relationship between therapist competence in the components of the PCET model and distal change (i.e., change in clients' depression at the end of therapy). This relationship was examined for the whole rated sub-sample, and also for segments rated in the early, middle and late phases of therapy. The potential impact of the proximal outcomes examined in Chapter 6 (i.e., next-session change) on outcome at the end of therapy was also investigated.

The relationship between competence and ultimate outcome was also examined for segments rated low, medium, and high for competence, to provide a parallel with the analysis in Chapter 6. Whereas in Chapter 6, a curvilinear relationship was found between therapist competence and depression change at the next session, no such relationship was found for change at the end of therapy, and results have not been reported in this chapter. The analysis is available in Appendix E.

The Influence of Baseline Severity

The results found in this study for the relationships between PHQ-9 scores at the beginning and end of therapy conform to evidence from previous research showing that higher baseline depression severity predicts greater depression at the end of therapy (Amati et al., 2018; Bauer-Staeb et al., 2023; Johns et al., 2019; Saxon & Barkham, 2012). At the same time, the results also showed that clients with higher baseline severity improved more, even if their symptoms were still worse at the end of therapy than those with lower baseline severity. This corresponds to the findings of meta-analyses across various therapy modalities (Cuijpers et al., 2022; van Bronswijk et al., 2019). Similarly, Stoch et al., (2022) found that IAPT clients with higher initial depression severity improved faster than less symptomatic clients. The authors acknowledged that clients with a higher PHQ-9 score at

the beginning of therapy had more room for improvement, but they also speculated that these clients may be more motivated to engage with therapy.

The significant relationship found in Chapter 6 between clients' greater baseline severity and higher therapist competence, especially in the person-centred cluster (r = .32, p = .02, Chapter 6, Table 6.5), can be carried forward into the current study. It was suggested in Chapter 6 that more depressed clients may elicit greater competence in the facilitative relational components of PCET in therapists. In the discussion following their meta-analysis of the relationship between adherence, competence and outcome, Webb and colleagues (2010) speculated that competence in these relationship variables would be more consistent throughout therapy than technical variables, and therefore would correlate more strongly with outcome. The collinearity of ratings for the different components in the PRaCTICED trial rating data means that a distinction between relational and technical components cannot be made for this study.

Although significant relationships were found between both baseline severity and competence, and baseline severity and outcome, a mediation analysis showed that competence was not a mediator in the latter relationship. This result was unsurprising, given the lack of a significant relationship between competence and end of therapy change in depression, discussed below.

Relationship Between Competence Overall, and Competence in the Different Clusters of Components, and Outcome at End of Therapy

As shown in Figure 7.5, no significant association was found between competence and outcome at end of therapy, overall or in any of the clusters of components. The nonsignificant overall correlation coefficient found, r = .07, corresponds exactly to the relationship between competence and outcome found by Webb et al. (2010). It is also

comparable to the findings of the meta-analysis by Power et al. (2022), where the aggregated results for non-hierarchical competence-outcome studies was r = .17, p = <.001. The findings of Chapter 6 and Chapter 7 together also parallel those of previous trials. Strunk et al. (2010), for example, found that adherence to the techniques of cognitive therapy was related to next-session change, but not final outcome. Similarly, Barnicot et al. (2014) found that clients' perception of clinicians offering greater empathy, genuineness and positive regard was significantly associated with lower depression during treatment, but not with recovery.

The important difference between previous research cited here and the current study is that in the current study the positive direction of the correlation coefficients, although nonsignificant, suggests that greater competence was associated with less improvement rather than more improvement at end of therapy. This corresponds to the results of two humanistic studies included in the Webb et al. meta-analysis (2010). The first of these studies, investigating EFT for trauma, Paivio et al. (2004), reported an r of -0.02. The second, investigating evocative empathy (Hall, 2007) reported an r of -0.35. (In the Webb et al. analysis negative correlations indicate that greater competence predicted worse outcomes.)

In discussing the findings of their meta-analysis of the relationship between ACI and outcome, Power et al. (2022) suggest that the relationship between competence and outcome could be stronger in routine clinical care than in controlled trials, where therapists receive enhanced training, supervision and monitoring. Since the PRaCTICED trial was a pragmatic trial, all aspects of therapy were delivered within routine practice except the randomisation of clients to either CBT or PCET. Nevertheless, the ACI-outcome relationship found in this study was no stronger than that found in the meta-analysis. As Baldwin and

Imel (2013) point out, "Even studies that use large data sets often have so much heterogeneity among the patients that therapist differences may be masked" (p.260). The findings appear to confirm the observation that the largest contribution to change is the client themselves, their characteristics and circumstances (Duncan, 2014). It may also be that, as suggested by previous researchers (McCarthy et al., 2015; Tschuschke et al., 2015; Webb et al., 2010), therapists' responsiveness to the uniqueness of each client in each moment introduces variability which obscures any relationship between competence and outcome. This fits with the recognition by Perepletchikova and Kazdin (2005) of the difficulty in assessing competence in process-oriented therapies such as PCET, and is illustrated by the wide spread of data points in Figure 7.5 above.

Relationship Between Competence and Outcome in the Early, Middle, and Late Phases of Therapy

When the relationship between competence and outcome was examined within the three phases of therapy, again results were all nonsignificant, and suggested that higher competence in every phase was associated with less change in depression. The strongest association was found for segments rated in the middle phase of therapy (total PCEPS, $r = .36$, $p = .13$, Table 7.10). The explanation for this finding is that segments rated in the middle phase were given the lowest ratings, and at the same time had the greatest end of therapy PHQ-9 improvement. However, one-way between group ANOVAs showed that there was no significant difference either between the groups in competence ratings, or in end of therapy PHQ-9 change, meaning that this result was found by chance.

Relationship Between Next-Session PHQ-9 Change and End of Therapy PHQ-9 Change

Overall, no relationship was found between next-session change and end of therapy change in depression. However, greater resolution was provided by examining these relationships in the early, middle, and late phases of therapy.

Improvement in depression in the early sessions of PCET, as measured by next-session PHQ-9 change, had the greatest impact on improvement at the end of therapy (r = .49, p = .06, controlling for first PHQ-9, Table 7.15). This finding is consistent with previous research on early response (Duffy et al., 2022, Haas et al., 2002; Pybis et al., 2017). Duffy and colleagues speculated that clients receiving an unstructured therapy such as PCET benefit from the relief of being able to tell their story in early sessions. The finding also conforms to the PCET theory that the therapeutic relationship is healing in itself and that the building of this relationship begins from the first session.

A negative correlation approaching significance was found between next-session PHQ-9 change in the middle phase of therapy and end of therapy PHQ-9 change, so that less change in depression (or even deterioration) was associated with more change at the end of therapy (r = -.50, p = .09, controlling for first PHQ-9, Table 7.15). This finding could support PCET theory, which postulates that a client's emotional 'perturbation' while exploring their experiential process with the help of the therapist during the working phase of therapy contributes to a positive ultimate outcome (Hayes, 2007; Pascual-Leone & Greenberg, 2007; Watson, 2018).

As found in Chapter 6, in all the phases of therapy the association between competence and next-session change was nonsignificant. The correlations appear to suggest that in each phase lower competence was more beneficial to the client at the end of therapy. The lack of significance of these results, however, means that especially in the

middle and late phases, competence and next-session change are independent. If the finding in Chapter 6 of curvilinear relationships (where segments rated low or high for competence in all the clusters achieved more next-session improvement in depression) are carried into the current study, then low or high rated competence in each phase of therapy may ultimately be most effective. This would apply especially to the early phase, where the relationships between competence and next-session change, and next-session change and end of therapy change, approach significance.

It was observed in Chapter 6 that each client had their own unique pattern of change through the course of therapy (Figure 6.1). Together however, the findings of Chapters 6 and 7 appear to support the theoretical view that the ideal pattern of change in therapy consists of an early storytelling and relationship-building phase, a middle 'working' phase, and an ending consolidation phase, where little change is expected to happen (Greenberg, 2015; Murphy, 2021). This has implications for therapist competence, suggesting that a competent PCE therapist will adjust their interventions both in response to the unique needs of the client, and also to the phase of therapy. The finding from the current study that the raters considered the therapists to be equally competent in all the phases of therapy may support this conclusion. Further research is needed to investigate whether in practice PCE therapists do adjust their interventions according to the phase of therapy. Such research would help to address the call from Duffy et al. (2022) for "understanding [of] how therapist characteristics contribute to the outcomes and improved early response effects in PCET" (p. 810).

Strengths and Limitations

A strength of Chapters 6 and 7 comes from the pragmatic nature of the PRaCTICED trial (from which the data was drawn), which collected data from routine IAPT therapy

sessions. A criticism of some research into the competence-outcome relationship based in randomised controlled trials is that the enhanced training, supervision and adherence monitoring often conducted in RCTs results in a restricted and unrepresentative range of competence ratings (Baldwin & Imel, 2013; Webb et al., 2010). Although a proportion of the therapists included in this research received their PCET training in the context of the trial, the training itself, as well as supervision, was consistent with routine practice. The wide range of total PCEPS ratings reported in this study (18.00 – 58.00) reflects the variability expected in routine practice, meaning that results of this research using the PRaCTICED trial dataset can be generalised to real-world contexts. The range of therapist competence represented makes the results generalisable to a wider population of therapists. On the other hand, the heterogeneous nature of the clients represented in the recordings means that some therapists, in being responsive to their client, may not have demonstrated their usual standard of competence in the PCET components.

The range of PHQ-9 depression scores for Chapters 6 and 7 on the other hand is restricted, since all participants in the PRaCTICED trial were assessed as experiencing moderate to severe depression at intake (Barkham et al., 2021). Both the measures used in the analysis for this study, the PCEPS-10 as a measure of competence, and the PHQ-9 as a measure of depression, are subjective instruments. Agreement between raters in scoring therapy segments using the PCEPS was inconsistent (see Chapter 7). As a client self-report measure, the PHQ-9 is also liable to client idiosyncrasies (Bendall & McGrath 2020).

The analyses reported in Chapters 6 and 7 are of an existing dataset, and post-hoc calculation of statistical power is not recommended in this case (Dziak et al., 2020). It is acknowledged that the number of rated segments for each therapist is small, providing low statistical power, and, while the number of competence ratings is comparable to similar

studies, once the sample is divided into three levels of competence or three phases, the results are less statistically meaningful. Although consequently the finding of no relationship between competence and next-session or end of therapy outcome cannot be relied on, these studies can be viewed as exploratory (Dziak et al., 2020).

While the data includes a measure of depression at every therapy session for each client, there is only one competence rating, which means that the therapist's competence when working with each client has to be assumed from this snapshot. Therapist competence is assumed on the basis of a 15-minute segment from the recording of one therapy session, which may not accurately represent their competence overall. It is probable that each therapist's competence varies in response to variations in a client's presentation at each session. The real-life setting of the therapy means that the clients of each therapist were very heterogeneous, such that within-therapist variability may outweigh between-therapist variability (Baldwin & Imel, 2013). In addition, this research does not take into account the influence on therapy of other factors such as the number of sessions attended by each client.

Research has shown that the quality of the therapeutic alliance as experienced by the client makes a significant contribution to the outcome of therapy (Norcross & Lambert, 2019). Most high quality research into the association between adherence, competence, integrity and outcome takes into account this variable. As the measures gathered for the PRaCTICED trial did not include a measure of the alliance, it has not been possible to control for the alliance in this study. It was hoped that the person-centred cluster of PCEPS items would provide an observer-rated equivalent of an alliance measure, however the collinearity of item ratings means that partialling out the ratings for this cluster would be meaningless.

Conclusions

Findings for the relationship between competence and outcome at the end of therapy in the current study were small and nonsignificant. These results are consistent with previous research, and may reflect both the heterogeneity of clients, and therapists' responsiveness to the needs of individual clients.

Analysis of the relationship between next-session change and ultimate change indicated that improvement in depression in the early phase of therapy was associated with improvement at the end of therapy. On the other hand, less change in the middle phase of therapy was associated with improvement at the end of therapy, a finding which would fit with the theoretical concept that the client's emotional 'perturbation' in the working phase of therapy is an integral aspect of the change process.

The statistical analyses in both Chapters 6 and 7 relied on average PCEPS-10 ratings from two or four expert raters. The next study (Chapter 8) presents an investigation of the interrater reliability of the PCEPS-10, reflected in the ratings of the expert raters for the PRaCTICED trial.

Chapter 8

The Interrater Reliability of the PCEPS-10

Introduction

The analysis of the relationship between PCE therapist competence and depression outcome presented in the preceding two chapters was based on the mean PCEPS ratings provided by the four expert raters in the PRaCTICED trial. Although the PCEPS-10 was developed for use in RCTs (Freire, Elliott & Westwell, 2014), its interrater reliability has not previously been tested in this context. Analysis of the levels of agreement between the raters in the PRaCTICED trial offers the opportunity to test the interrater reliability of the PCEPS-10.

The findings of the systematic literature review (Chapter 4) suggested that evidence for the effectiveness of the three active components of PCET (i.e., experiential specificity, emotion focus, and emotion regulation sensitivity) supports the theoretical underpinning for PCET interventions. The findings of the qualitative analysis in Chapter 5 elucidated some possible ways that PCE therapists may operationalise these components. Research is needed to examine whether PCET experts agree that such interventions, and the style in which they were offered by the therapists in the trial, constitute competent practice. Analysis of the level of agreement between experts may contribute to an understanding of how consistently the model is conceptualised in the PCET community. The current study aims to address these questions by analysing the interrater reliability of the expert raters who evaluated treatment fidelity in the PCET arm of the PRaCTICED trial.

Background

In developing assessment tools such as rating scales, various psychometric properties including internal consistency and interrater agreement should be tested to ensure their validity and reliability. Two of the most common statistics used to gauge interrater reliability are Cronbach's alpha and the intraclass correlation coefficient (ICC). Table 8.1 shows the criteria recommended by Cicchetti (1994) for interpretation of values for Cronbach's alpha and ICC. Although stricter interpretations exist (Trevethan, 2015), this more liberal interpretation has been chosen to reflect the complexity and subjectivity of the task of assessing competence in psychotherapy.

Table 8.1

Criteria for interpretation of Cronbach's alpha and ICC based on Cicchetti (1994)

	Cronbach's alpha	ICC
Poor	< .70	< .40
Fair	.70 ≤ alpha < .80	.40 < ICC < .60
Good	.80 < alpha <.90	.60 < ICC < .75
Excellent	> .90	> .75

In a meta-analysis of therapist competence ratings, Kühne et al. (2020) calculated the average interrater reliability of 20 studies, finding a pooled ICC of .82. The majority of included studies were of CBT-related interventions.

It has been recognised that producing rating scales and manuals for humanistic and process-oriented models such as PCET is more difficult than for skills-based models such as CBT, since in these therapies the flexible responsiveness of the therapist to the moment-by-moment experiencing of the client is emphasised over the specification of techniques and procedures to treat specific disorders (Bohart et al., 1998; Perepletchikova et al., 2007). For

example, in a review of intervention competence literature, Barber et al. (2007) found an intraclass correlation coefficient (ICC) of .93 for drug counselling, a skills-based therapy, but an ICC of .43 for dynamic therapy, a process-oriented therapy. Barlow and Brown (2020) conducted a systematic review of therapist competence measures developed for process-oriented models (i.e., psychodynamic, interpersonal, and relational therapy). Although not all included studies had tested interrater reliability, those that did employed a variety of statistical tests, reporting results ranging from poor to excellent.

Barber and colleagues (2007) suggested four reasons why interrater reliability for a given competence measure may be low, of which the first three are most relevant to process-oriented therapies:

> (a) different judges' understandings of competence, (b) differences in how much attention judges pay to different aspects of the treatment delivery (e.g., implicitly weighting certain interventions as more important to competence), (c) difficulties in operationalizing competence, and (d) the use of uniformly competent therapists in RCTs. (Barber et al., 2007, p.496)

Interrater Reliability of the PCEPS

Freire et al. (2014) investigated the interrater reliability of the original 15-item PCEPS, using Cronbach's alpha. The authors found a Cronbach's alpha of .87 (i.e., good) between six raters for the mean of the 15 items across 60 recording segments. A systematic review of measures of therapist competence (Barlow & Brown, 2020) criticised the Freire et al. study for its use of Cronbach's alpha, as this measure is less accurate than the ICC.

When the PCEPS was reduced from 15 items to 10, Westwell (2018) conducted a study to evaluate the reliability of the new instrument. The early phase of this study found a very low level of rater agreement, with a Cronbach's alpha of .06 for three novice raters and 20 recording segments. Three interventions were implemented to improve reliability:

(a) segments were reduced from 15-minutes to 10-minutes; (b) a notation system was devised to aid raters in specifying their rationale for each rating; and (c) a scale was devised to reflect the rater's emotional reaction to the therapist whose recording was being assessed. Following these interventions, the reliability of the three raters improved to a Cronbach's alpha of .82 for 40 segments. Westwell concluded that interrater reliability for the PCEPS-10 required intensive supervision and notation.

The PCEPS has also been adapted for use in other contexts, for example the Person-Centred and Experiential Psychotherapy Scale – Young Person version (PCEPS-YP; Ryan et al., 2021). This 9-item version of the PCEPS, adapted for person-centred therapists working with young people, was used to assess the treatment fidelity of 19 therapists who delivered person-centred therapy for young people in the ETHOS randomised controlled trial (Cooper et al., 2021). Discrepancies between ratings were resolved through discussion and further training for the rater. A study using data from this trial to test the interrater reliability of the PCEPS-YP found a Cronbach's alpha for mean rating of .50 for pairs of raters, and .58 for calibration segments rated by eight raters (Ryan et al., 2021).

Another adaptation of the PCEPS is the PCEPS-EFT (Elliott, 2016, unpublished), a 14-item scale developed for use by emotion focused therapists. In a recent RCT comparing emotion focused therapy (EFT) with CBT for generalised anxiety disorder, Timulak et al., (2022) found an average ICC of .77, and an average Cronbach's alpha of .97 for the PCEPS-EFT.

Interrater Agreement Beyond RCTs

Measures of the level of agreement between expert raters when judging competence has implications beyond therapy trials. For a relatively new model of therapy such as PCET, testing interrater agreement can also indicate the degree to which raters

share an understanding of the components of the psychotherapeutic model, and how they expect therapists to interpret the model in practice (Barber, 2007; Freire et al., 2012). The materials used in PCET training are (a) the competence framework (Hill, 2010), (b) the curriculum (Hill, 2011) and (c) the two editions of the textbook (Murphy, 2019; Sanders & Hill, 2014). These texts, as well as the PCEPS-10, all allow room for interpretation, reflecting the person-centred emphasis on being responsive to the uniqueness of both the individual therapist and client. As highlighted by the quotation from Barber et al. (2007) cited above, there is therefore a possibility that the PCEPS-10, and the PCET model itself, may be interpreted differently among the four training centres.

The Current Study

The study reported here aims to analyse the interrater reliability of the competence ratings produced for the PRaCTICED RCT. Four expert raters were employed in the trial to assess PCET treatment fidelity, two each from two PCET training centres. More information about the raters' background and expertise is provided in Chapter 2.

The results of the analysis of interrater reliability for the PRaCTICED trial may also reflect raters' practice in using the PCEPS-10 as an assessment measure for training and qualification in PCET. As tutors and assessors for PCET training courses, the raters were considered to be experienced in using the PCEPS-10, and therefore no extra training or supervision was offered. Raters rated recording segments in isolation, without the opportunity for discussion and monitoring available in other reliability studies (Freire et al., 2014; Ryan et al., 2021; Westwell, 2018). In keeping with the pragmatic nature of the PRaCTICED trial, these limitations reflect the conditions under which the PCEPS-10 is routinely used to assess PCE therapists for training and qualification. This study aims to

determine the significance for trainee therapists if variability is extrapolated to the wider population of training centres and raters.

The analysis also provides an opportunity to gauge the level of agreement between centres and individual raters in their understanding of the competences described in the PCEPS-10. For the assessment of treatment fidelity for the PRaCTICED trial, only the total PCEPS rating for each recording segment was necessary, to ensure that on average the competence of PCE therapists met the threshold of 40 out of 60 (Barkham et al., 2021). As well as analysing interrater reliability for raters' overall mean ratings, however, the study aims to investigate possible variations between interrater reliability for the person-centred, proscribed and experiential clusters of components. Analysis of interrater reliability for each of the 10 components individually will provide a further level of detail.

This study addresses the following research questions:

1. How do ratings compare between raters and between centres?

2. What was the interrater reliability for the PRaCTICED trial between raters and between centres?

3. What is the interrater reliability for the PCEPS-10 generalisable for a wider population (i.e., as used in routine training) between raters and between centres? What is the interrater reliability for the components of PCET?

4. Are there differences in the assessment practices of centres and raters?

Methods

Ethics

Ethics approval was granted as part of the submission for the PRaCTICED trial (Health Research Authority, Research Ethics Committee 14/YH/0001; Barkham et al., 2021).

Procedure

Chapter 2 gives details of (a) the therapists, centres and raters; and (b) the protocol for the random allocation of audio-recording segments to raters. To respect anonymity of participants, raters and centres are identified as follows: R1 and R2 from Centre A; R3 and R4 from Centre B.

Calculation of Competence Ratings

For every recording segment, the rating awarded by each rater for each of the 10 PCEPS-10 items was extracted from the PRaCTICED trial data set. Competence ratings were calculated as follows:

1. To produce an overall competence rating from each rater for every segment the 10 item ratings were summed. Ratings missing for single PCEPS-10 items were imputed by taking the mean of the ratings for the other nine items.

2. To compute ratings for the clusters of PCEPS-10 items for every rating, the total rating for the PCEPS items in the cluster was calculated and divided by the number of items in the cluster, giving the mean rating. The person-centred cluster comprises five items, the proscribed cluster two items, and the experiential cluster three items.

3. To compute ratings awarded by the two centres for every segment, the mean of the ratings of the two raters from that centre was calculated.

The resulting ratings indicate the levels of PCE therapist competence as assessed by the raters at three levels: (a) overall; (b) for the person-centred, proscribed and experiential clusters of PCEPS-10 items; and (c) for each of the 10 items individually.

Sixty-five recording segments were randomly selected for the assessment of PCET treatment fidelity, however one recording was inaudible. In total therefore, 64 recording

segments were rated, producing 137 ratings. Five recording segments were rated by both

raters from both centres, allowing comparisons of mean ratings between centres. Fifty-eight

segments were rated by pairs of raters, allowing comparison between individual raters.

Details are shown in Table 8.2 below, and in Chapter 2, Table 1.2.

Table 8.2

Rating numbers for calibration and non-calibration recording segments

	N	Calibration segments	Sub-total	Non-calibration segments	Ratings not submitted	Sub-total	Total
Centres	2	5	10	15	1	29	39
Individual Raters	4	5	20	30	3	117	137
Pairs of raters	6	5	30	60	2	58	88

Statistical Analysis

Means, standard deviations, medians and ranges were calculated for the following:

1. The five calibration segments for (a) each centre, (b) each rater, and (c) all 20

   calibration ratings (i.e., five ratings x four raters).

2. The non-calibration segments for (a) each centre, (b) each rater, and (c) the full

   sample of non-calibration ratings ($N = 117$).

   Graphs were produced to illustrate the correlations between PCEPS-10 ratings for

each pair of raters. SPSS v.26 for Windows was used to determine interrater reliability using

both Cronbach's alpha and intraclass correlation coefficients (ICC).

Interrater Reliability for the PRaCTICED Trial

For analysis of the interrater reliability of the PCEPS-10 in the context of an RCT (i.e.,

the PRaCTICED trial) ICCs were calculated for the two centres and four individual raters for

the five calibration segments, and for pairs of raters for all non-calibration segments. Since

therapists in the PRaCTICED trial did not need to meet a specific threshold for competence,

absolute agreement of ratings was not necessary, and a consistency definition was used.

Cronbach's alpha was calculated to allow comparison with previous literature. In addition,

95% confidence intervals for Cronbach's alpha were derived from the ICC (2,2) consistency

model reported in SPSS and described below.

Interrater Reliability for Centres and Raters Generalisable to a Wider Population

ICCs using a consistency definition were calculated for the analysis of interrater

reliability which can be generalised to the wider population of training centres and trainers

who rate PCET competence using the PCEPS-10. ICCs were calculated for the two centres

and four individual raters for the five calibration segments, and for all non-calibration

segments for each pair of raters for (a) overall PCEPS-10 ratings, (b) the person-centred,

proscribed, and experiential clusters of PCEPS components, (c) each of the 10 PCEPS

components. Additionally, overall interrater reliability was calculated for all ratings by a pair

of raters (calibration and non-calibration) for each PCEPS component (N = 88).

Four different ICC models were applied to meet different assumptions (McGraw &

Wong, 1996; Koo & Li, 2016; Shrout & Fleiss, 1979; Trevethan, 2015). These are described

here, numbered using the Shrout and Fleiss convention:

1. **Agreement between centres for the PRaCTICED trial**

    ICC (3,2) Two-way mixed effects, consistency, average measures were

    calculated for agreement between the two centres in the PRaCTICED trial for the

    five calibration segments. In this case the specific centres represented the whole

    population of interest. The 2 indicates that the means of ratings for the two

    raters in each centre were used.

2. **Agreement between pairs of raters for the PRaCTICED trial**

   ICC (3,1) Two-way mixed effects, consistency, single measures were calculated for agreement between the pairs of raters in the PRaCTICED trial rating the non-calibration segments. In this case the four raters represented the whole population of interest. Consistency between ratings can indicate reliability and absolute agreement is not necessary.

3. **Agreement between centres generalisable to a wider population**

   ICC (2,2) Two-way random effects, absolute agreement, average measures were calculated for agreement between the two centres for the five calibration segments, where the centres represented a sub-sample of a wider population of centres. This form of the ICC can be generalised to other centres which use the PCEPS-10 to assess trainees. In this case absolute agreement is relevant, since ratings determine whether a trainee will qualify or fail. The second 2 indicates that the means of ratings for the two raters in each centre were used.

4. **Agreement between pairs of raters generalisable to a wider population**

   ICC (2,1) Two-way random effects, absolute agreement, single measures were calculated to reflect conditions generalisable to other raters using the PCEPS-10, for example those assessing PCET trainees. In this case absolute agreement is relevant, since ratings determine whether a trainee will qualify or fail. This ICC model was also used to analyse interrater reliability for component clusters, and for each of the ten PCEPS components (see below).

Table 8.3 lays out the different forms of analysis performed to address each of the questions posed in this paper.

Table 8.3

Forms of reliability analysis for different questions

			Overall	PCEPS component clusters	Individual PCEPS items
PRaCTICED trial	Centres	Calibration segments	Cronbach's alpha		
			ICC (3,2)		
	Individual raters	Calibration segments	Cronbach's alpha		
			ICC (3,1)		
	Pairs of raters	Non-calibration segments	Cronbach's alpha		
			ICC (3,1)		
Wider population	Centres	Calibration segments	ICC (2,2)	ICC (2,2)	ICC (2,2)
	Individual raters	Calibration segments	ICC (2,1)	ICC (2,1)	ICC (2,1)
	Pairs of raters	Non-calibration segments	ICC (2,1)	ICC (2,1)	ICC (2,1)

The number of segments to be awarded a rating ≥ 40 (the pass threshold to qualify in PCET) was calculated and compared between raters and centres.

Results

Results are presented in the following order: (a) a comparison of ratings for centres and raters; (b) interrater reliability for the PRaCTICED trial; (c) interrater reliability for centres and raters generalisable to a wider population; and (d) differences in awarding pass and fail ratings.

Comparison of Ratings for Centres and Raters

Table 8.4 shows the mean PCEPS-10 ratings, standard deviations, medians and ranges for the five calibration ratings for the two centres and four individual raters. Table 8.5 shows the mean PCEPS-10 ratings, standard deviations, medians, and ranges for the 117 non-calibration ratings for the two centres and four individual raters. The mean rating for the calibration ratings was 39.10 compared to 39.35 for the non-calibration ratings. An independent samples Mann-Whitney U test showed no significant difference between the ratings for the calibration ratings (N = 20) and for the non-calibration ratings (N = 117; U = 1087.0, p = .654).

Table 8.4

Mean and standard deviation of PCEPS-10 ratings for calibration segments for centres and individual raters

	Centres				**Individual raters**				
	N	Mean	SD	Rater	N	Mean	SD	Median	Range
Centre A	5	36.40	2.94	R1	5	37.60	5.90	34	32 – 44
				R2	5	35.20	4.44	34	32 – 43
Centre B	5	41.80	8.08	R3	5	39.60	9.29	39	31 – 54
				R4	5	44.10	7.00	45.5	37 – 53
Overall	10				20	39.10	7.14	37	31 – 54

Table header: **Calibration segments**

Table 8.5

Means and standard deviations of PCEPS-10 ratings for non-calibration segments for centres and

individual raters

						Non-calibration segments			
	Centres					**Individual raters**			
	N	**Mean**	**SD**	**Rater**	**N**	**Mean**	**SD**	**Median**	**Range**
Centre A	20	37.19	8.17	R1	30	41.63	12.21	43	10 – 60
				R2	30	32.76	11.03	32.5	15 – 60
Centre B	19	41.62	6.20	R3	28	39.82	6.91	42.5	27 – 54
				R4	29	43.43	7.45	43	26 – 56
Overall	39				117	39.35	9.43	40	10 – 60

Visual inspection of the box and whisker plots in Figure 8.1 below shows that median ratings for raters R1, R3, and R4 were above 40, whereas for R2 it was 32.50. Ranges for R1 and R2 from Centre A are greater than for R3 and R4 from Centre B. For R2 there was one outlying rating of 60.

Figure 8.1

Box and whisker plots showing median, range and interquartile range for raters for non-calibration

segments, with outlier
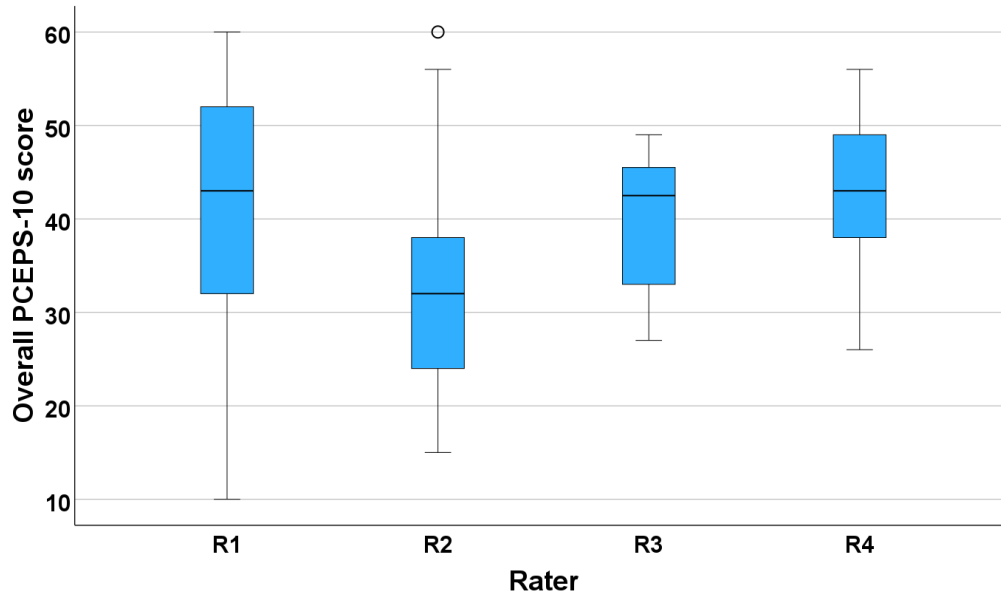
Figures 7.2 (a) to (f) shows Pearson's *r* correlations between PCEPS-10 ratings for each pair of raters including calibration and non-calibration segments. Correlations range from .36 (R1 & R2) to .83 (R3 & R4).

Figure 8.2

(a) Correlation of PCEPS-10 ratings between R1 and R2 (N = 20)
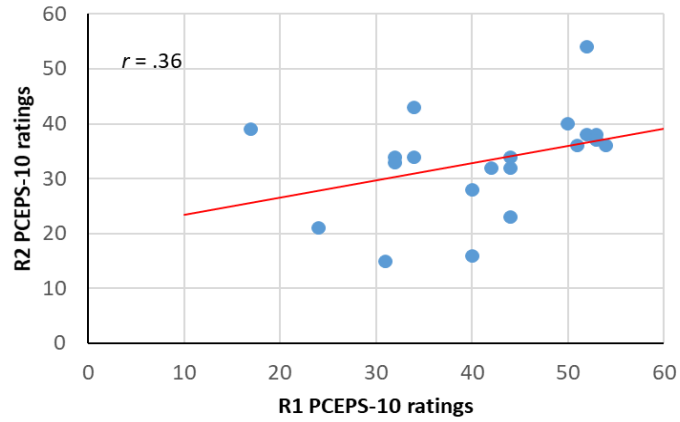
(b) Correlation of PCEPS-10 ratings between R1 and R3 (N = 17)
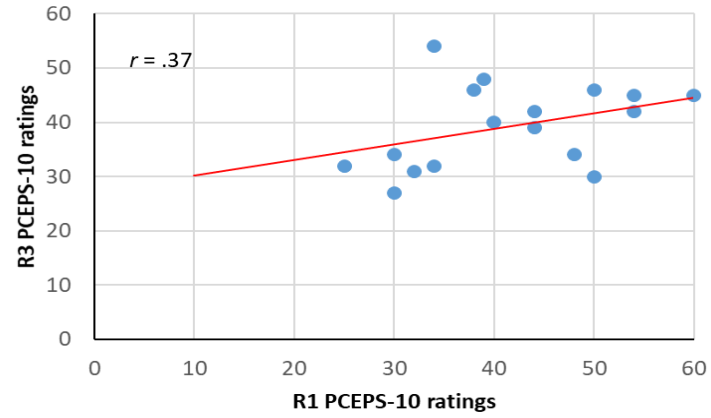
(c) Correlation of PCEPS-10 ratings between R1 and R4 (N = 7)
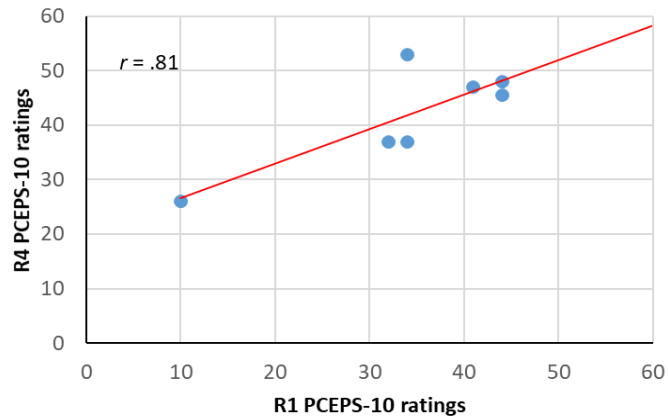
(d) Correlation of PCEPS-10 ratings between R2 and R3 (N = 7)

286
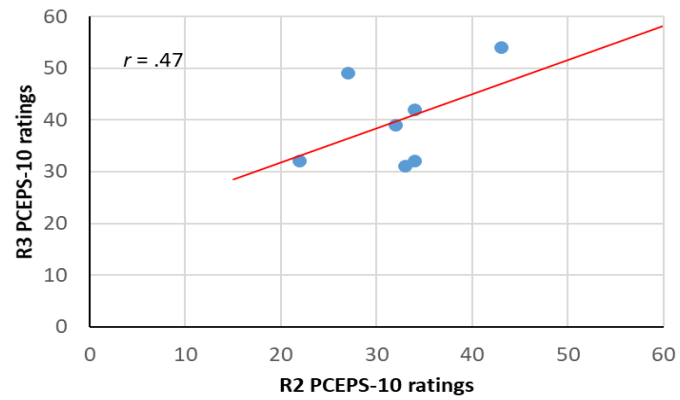
(e) Correlation of PCEPS-10 ratings between R2 and R4 (N = 18)
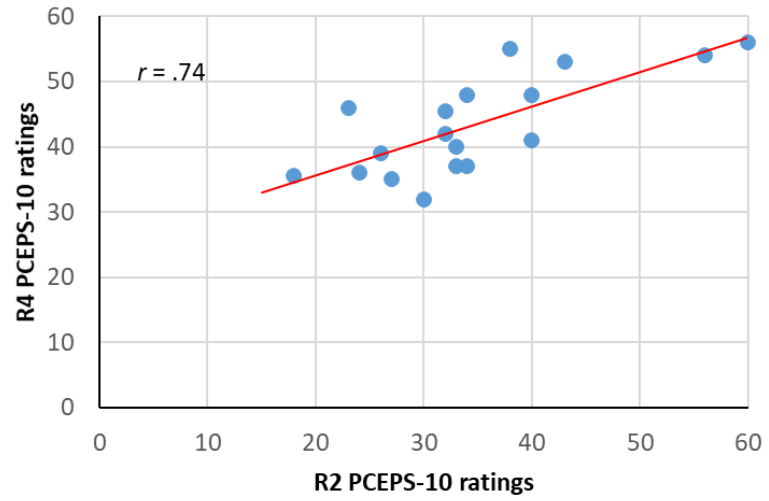
(f) Correlation of PCEPS-10 ratings between R3 and R4 (N = 19)

287
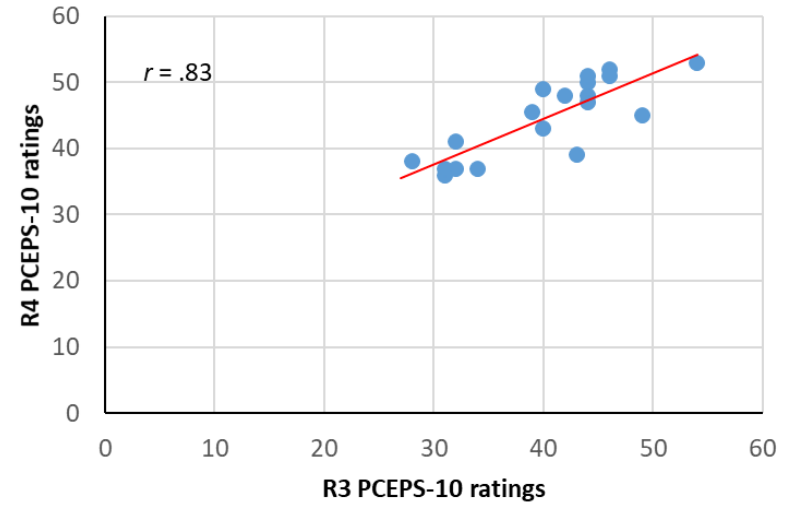
Interrater Reliability for the PRaCTICED Trial

Agreement Between Centres, Individual Raters and Pairs of Raters

Table 8.6 shows Cronbach's alpha and ICCs for interrater reliability for PCEPS-10 ratings between the two centres and between the four individual raters for the five calibration segments. The interrater reliability for the centres is .71 for both alpha and ICC (fair according to the definitions from Cichetti, 1994) though both are nonsignificant (i.e., the 95% confidence intervals bracket zero). The interrater reliability for individual raters is fair and significant using alpha (.78) and ICC (.47).

Table 8.6

Interrater reliability between centres and individual raters for the PRaCTICED trial for calibration segments (N = 5). Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

	N	Alpha	(95% CI)	ICC (3,2)	(95% CI)	ICC (3,1)	(95% CI)
Centres	10	.71	[-1.80, 0.97]	.71	[-1.80, 0.97]		
Individual raters	20	*.78*	*[0.01, 0.98]*			.47	*[0.03, 0.91]*

Table 8.7 shows results for pairs of raters for PCEPS-10 ratings of the non-calibration segments (N = 58). Alphas for pairs R1 & R2, R1 & R3, and R2 & R3 are <.70 (poor). ICC for pairs R1 & R2, and R1 & R3 are <.40 (poor), although all are nonsignificant. Conversely, alpha and ICC for R1, R2 and R3 when paired with R4 range from .82 to .90 for alpha and .69 to .82 for ICC, and all are significant. These indicate good to excellent interrater reliabilities.

Table 8.7

Interrater reliability between pairs of raters for the PRaCTICED trial for non-calibration segments

(N = 58). Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

		Non-calibration (*N* = 58)							
		R2			R3			R4	
	N	Alpha [95% CI]	ICC (3,1) [95% CI]	*N*	Alpha [95% CI]	ICC (3,1) [95% CI]	*N*	Alpha [95% CI]	ICC (3,1) [95% CI]
R1	15	.53 [-0.19, 0.81]	.36 [-0.09, 0.69]	12	.53 [-0.29, 0.83]	.36 [-0.13, 0.71]	2	*.88 [0.29, 0.98]*	*.78 [0.17, 0.96]*
R2				2	.62 [-1.20, 0.94]	.45 [-0.38, 0.88]	13	*.82 [0.45, 0.94]*	*.69 [0.29, 0.88]*
R3							14	*.90 [0.75, 0.96]*	*.82 [0.59, 0.93]*

Interrater Reliability for Centres and Raters Generalisable to a Wider Population

Agreement Between Centres, Individual Raters and Pairs of Raters

The analysis was repeated to study the generalisability to a wider population. Table 8.8 shows ICCs for interrater reliability between the two centres and the four individual raters for PCEPS-10 ratings for the five calibration segments. The interrater reliability between centres is .59 (nonsignificant) and for individual raters .40 (significant), both results showing a fair level of agreement.

Table 8.8

ICCs for calibration segments for centres and individual raters representing a wider population

(N = 5). Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

	Calibration (*N* = 5)		
	***N* ratings**	**ICC (2,2) (95% CI)**	**ICC (2,1) (95% CI)**
Centres	10	.59 [-0.58, 0.95]	
Individual raters	20		*.40 [0.03, 0.88]*

Table 8.9 shows interrater reliability between pairs of raters for non-calibration segments. Similar to Table 8.7 for the PRaCTICED trial, interrater reliability was poor (<.40) for pairs of raters R1 & R2, R1 & R3, and R2 & R3, while all pairs which include R4 were >.40 and would be considered 'good' to 'excellent'. It should be noted that only the result for one pair was significant (R2 & R3).

Table 8.9

ICCs for non-calibration segments for pairs of raters representing a wider population (N = 58). Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

	Non-calibration (*N* = 58)					
	R2		**R3**		**R4**	
	N ratings	**ICC (2,1) (95% CI)**	**N ratings**	**ICC (2,1) (95% CI)**	**N ratings**	**ICC (2,1) (95% CI)**
R1	15	.28 [-0.09, 0.61]	12	.36 [-0.12, 0.71]	2	.63 [-0.09, 0.93]
R2			2	*.32 [0.20 - 0.80]*	13	.50 [-0.08, 0.82]
R3					14	.67 [-0.01, 0.89]

Agreement for Person-Centred, Proscribed, and Experiential Clusters

Table 8.10 shows interrater reliability for the clusters of components: ICCs (2,2) for centres and ICCs (2,1) for individual raters for the calibration segments. These showed a greater level of agreement between centres for the experiential cluster (.80, excellent) than for the person-centred or proscribed clusters. Interrater reliability for the proscribed cluster was good (.60), but for the person-centred cluster it was poor (.36). All were nonsignificant. For individual raters assessing the calibration segments agreement was also greater for the experiential components than for the person-centred cluster (experiential = .35, person-centred = .28), though both were poor and nonsignificant. Only the proscribed cluster had a fair interrater reliability (.44).

Table 8.10

ICC (2,2) for centres and ICC (2,1) for individual raters, calibration segments, clusters of PCEPS-10 components. Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

	n	Person-centred [95% CI]	Proscribed [95% CI]	Experiential [95% CI]
		Calibration (N = 5)		
Centres	10	.36 [-0.35, 0.85]	.60 [-.10, .90]	.80 [-2.02, 0.98]
Individual raters	20	.29 [-0.04, 0.83]	*.44 [.06, .89]*	.35 [-0.02, 0.86]

Interrater reliability between pairs of raters for the non-calibration segments was mixed (Table 8.11), with no patterns discernible for agreement for the clusters of components. The only significant results were agreement between R2 & R4 for the experiential cluster, and R3 & R4 for the person-centred and proscribed clusters.

Table 8.11

ICC (2,1) for pairs of raters, non-calibration segments, clusters of PCEPS-10 components. Values in italics indicate significance, i.e., 95% confidence intervals that do not bracket zero

			Non-calibration (N = 58)				
		n	R2 ICC (2,1) [95% CI]	*n*	R3 ICC (2,1) [95% CI]	*n*	R4 ICC (2,1) [95% CI]
R1	**Person-centred**	15	.31 [-.11, .68]	12	*.54 [.00, .84]*	2	.85 [-.20, 1.00]
	Proscribed	15	.31 [-.11, .68]	12	.40 [-.21, .78]	2	.71 [-.09, 1.00]
	Experiential	15	.36 [-.08, .71]	12	.25 [-.18, .67]	2	.69 [-.77, 1.00]
R2	**Person-centred**			2	.33 [-.13, .10]	13	.46 [-.11, .81]
	Proscribed			2	.16 [-.01, .99]	13	.51 [-.03, .82]
	Experiential			2	.00 [-.56, 1.00]	13	*.62 [.19, .88]*
R3	**Person-centred**					14	*.65 [.13, .88]*
	Proscribed					14	*.77 [.44, .92]*
	Experiential					14	*.36 [-.11, .74]*

Table 8.12 shows the interrater reliability for the three clusters of PCEPS-10 components for every segment (calibration, *n* = 30, and non-calibration, *n* = 58. *N* = 88) rated by a pair of raters. With this larger sample it can be seen that agreement between pairs was greatest for the cluster of proscribed components (.45, fair), and least for the cluster of experiential components (.37, poor).

Table 8.12

ICC (2,1) for pairs of raters, clusters of PCEPS-10 components (N = 88). Values in italics indicate

significance, i.e., 95% confidence intervals that do not bracket zero

	ICC (2,1)	**95% CI**
Person-centred	.42	[.23, .58]
Proscribed	*.45*	*[.26, .61]*
Experiential	*.37*	*[.17, .53]*

Agreement for Individual PCEPS Components

Table 8.13 shows the interrater reliability for each of the 10 PCEPS-10 components

for every segment (calibration, *n* = 30, and non-calibration, *n* = 58. *N* = 88) rated by a pair of

raters. The components have been ranked according to the level of interrater reliability, and

all results are significant (i.e., 95% CI values do not bracket zero). The ICCs are fair for

Dominant or Overpowering Presence (.45) and Clarity of Language (.42), and poor (<.40) for

the other eight components. The lowest ICC is for Psychological Holding at .21.

Details of interrater reliability for every PCEPS-10 item are given in Appendix F: Table

8.1F shows results for Cronbach's alpha for the PRaCTICED trial. Table 8.2F shows results for

ICCs generalisable to a wider population.

Table 8.13

ICC (2,1) for pairs of raters for individual PCEPS-10 items (N = 88). Values in italics indicate

significance, i.e., 95% confidence intervals that do not bracket zero

PCEPS-10 Component	ICC (2,1)	95% CI
Dominant or Overpowering Presence	.45	[.27, .60]
Clarity of Language	.42	[.24, .58]
Core Meaning	.37	[.17, .54]
Tracking/Client Frame of Reference	.32	[.12, .49]
Experiential Specificity	.30	[.10, .48]
Content Directiveness	.27	[.07, .45]
Emotion Focus	.23	[.02, .42]
Accepting Presence	.22	[.01, .41]
Emotion Regulation Sensitivity	.22	[.01, .40]
Psychological Holding	.21	[.01, .40]

Differences in Awarding Pass and Fail Ratings

The PCEPS-10 rating required for PCET qualification is ≥40. The number of segments

rated by a pair which included one rater from each centre, including the five calibration

segments, was 34. Table 8.14 shows the number of segments where the rating awarded by

one centre reached the threshold of 40 (i.e., the segment achieved a pass) while the rating

awarded by the other centre did not (i.e., the segment failed). Figure 8.3 illustrates the 12

discrepant segments (i.e., two pass/fail and ten fail/pass ratings). If the segments rated for

the PRaCTICED trial had been submitted towards a PCET qualification, Centre A would have

passed two segments which Centre B would have failed, and would have failed nine

segments which Centre B would have passed. These differences in outcome would have

affected 12 out of 34 (35%) trainees assessed.

Table 8.14

Centres: Segments passed by one centre and failed by the other (Overall N = 34. Shaded cells indicate discrepancies.)

		Centre A	
		Pass	**Fail**
Centre B	**Pass**	10	10
	Fail	2	12

Figure 8.3

Centres: Segments passed by one centre and failed by the other (N = 12)
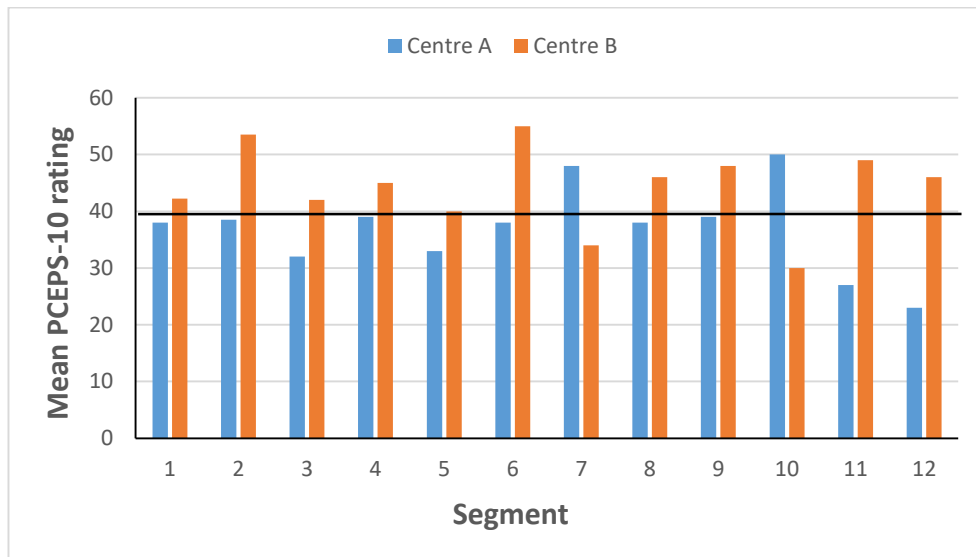
Differences between raters within the centres are displayed in Tables 7.15 and 7.16, and illustrated in Figures 7.4 and 7.5. Within Centre A, R1 would have passed 11 segments which R2 would have failed, and failed one segment which R2 would have passed. These differences would have affected 12 out of 20 (60%) of the trainees assessed. Within Centre B, each rater would have passed one segment which their colleague would have failed, affecting two out of 19 trainees (11%).

Table 8.15

Raters R1 and R2: Segments passed by one rater and failed by the other (PCEPS-10 rating >40.

(Overall N = 20. Shaded cells indicate discrepancies.)

		R1	
		Pass	**Fail**
R2	**Pass**	2	1
	Fail	11	6

Figure 8.4

Raters R1 and R2: Segments passed by one rater and failed by the other (N = 12)
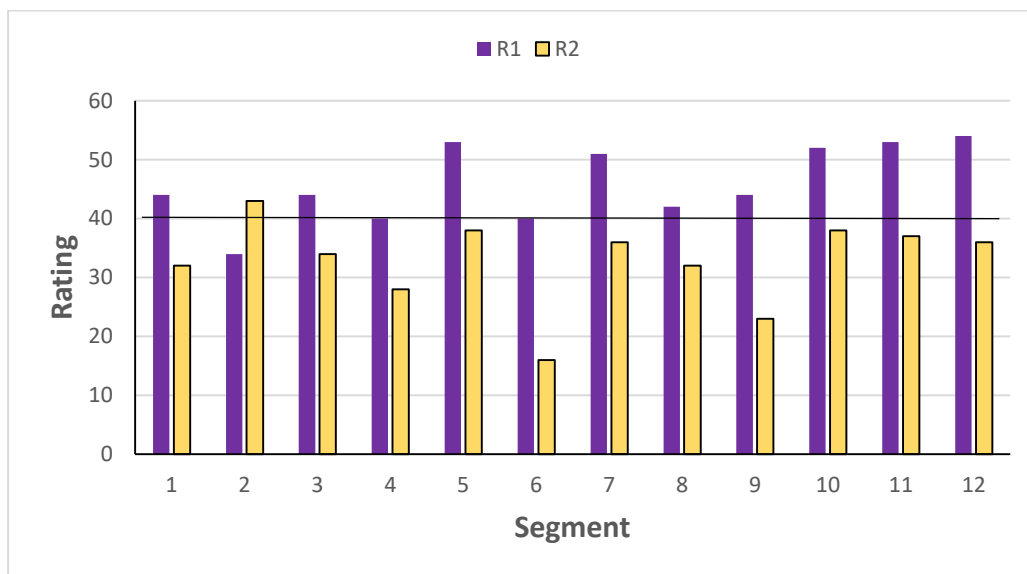
Table 8.16

Raters R3 and R4: Segments passed by one rater and failed by the other (PCEPS-10 rating >40.

N = 19. Shaded cells indicate discrepancies.)

		R3	
		Pass	**Fail**
R4	**Pass**	11	1
	Fail	1	6

Figure 8.5

Raters R3 and R4: Segments passed by one rater and failed by the other (N = 2)
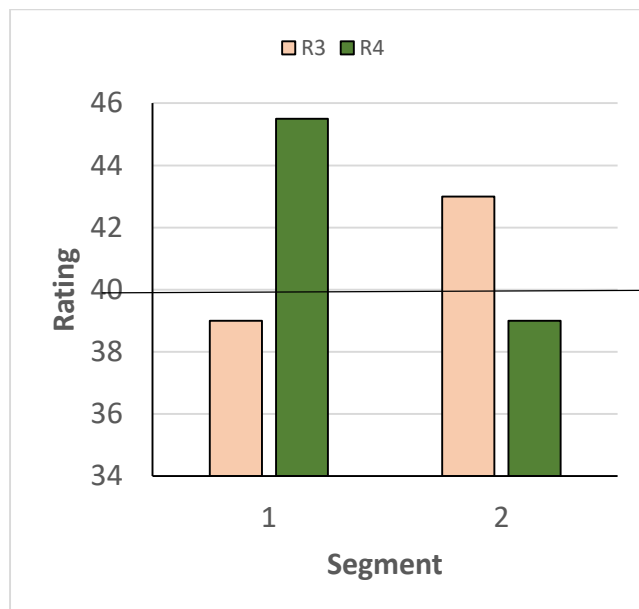
Discussion

This study analysed interrater reliability between the four expert raters from two training centres who validated the treatment fidelity of the PCET arm of the PRaCTICED trial by assessing therapists' adherence to the PCET model using the PCEPS-10. Beyond the trial, the raters also deliver training in the PCET model, and use the PCEPS-10 to determine whether therapists' competence meets the qualification threshold of 40 out of 60. The raters' ratings from the PRaCTICED trial therefore offered an opportunity to gauge the level

of agreement between raters in the context of routine PCET training, as well as for the trial itself.

Comparison of Ratings for Centres and Raters

The data shown in Tables 7.4 and 7.5, and visual inspection of the box and whisker plots in Figure 8.1 suggest that while three raters, R1, R3, and R4 awarded broadly similar ratings, R2 generally awarded lower ratings. The lower ratings from R2 influenced the results throughout the study. It is possible that some or all of the raters may have felt more freedom to award low ratings for the segments in the PRaCTICED trial than in routine practice. For PCET trainees employed by NHS Talking Therapies, continued employment may be dependent on completing the qualification. In contrast, trial therapists were already qualified, so their position was not at stake. Another reason that ratings for the PRaCTICED trial segments may have been lower overall than those awarded during routine training, is that trainees are able to select their most competent recordings for submission, whereas segments for the trial were randomly sampled. Some variability may have been introduced by the fact that raters from one of the centres represented in this study delivered the PCET training to most of the PRaCTICED trial therapists. These raters may have shared an interpretation of the PCET model with the therapists, and found more segments to be adherent than the raters from the other centre.

Visual inspection of the graphs in Figure 8.2 suggests that the most strongly correlated ratings were for the pair R3 & R4, both from Centre B. The correlation between R1 & R4 also appeared to be relatively strong, but R4's ratings were consistently higher than R1's ratings. This observation helps to explain differences between the interrater reliability of the PCEPS-10 for the PRaCTICED trial, where only consistency is required, and for generalising to the wider population of centres and trainers, where absolute agreement is

required. The weakest correlations were between R1 & R2, and R1 & R3, indicating that although on average these raters awarded similar ratings, they awarded them to different segments (i.e., their ratings were not consistent with each other).

Interrater Reliability for the PRaCTICED Trial

Barber et al. (2007, quoted at the start of this chapter) noted that one possible source of low interrater reliability in RCTs is the use of uniformly competent therapists, so that there is little variation between them to allow strong relationships to be apparent. However, as a pragmatic trial, the therapists in the PRaCTICED trial were not specially selected, but were already employed in a routine NHS Talking Therapies service, presumably providing the range of competence found in real life.

Results from the current analysis suggest that, according to the interpretation of Cicchetti (1994) there was a fair level of interrater reliability overall between Centres A and B for the five calibration segments for the purposes of the PRaCTICED trial. Cronbach's alpha and ICC (3,2) were identical at .71 (Table 8.6). However, since the 95% confidence interval included zero, this finding must be interpreted as nonsignificant. When interrater reliability was calculated for the five calibration segments rated by the four raters as individuals, the Cronbach's alpha was .78 and was significant (Table 8.8). This comes close to the alpha of .82 found by Westwell (2018) for three raters and 40 segments, and can be seen as fair reliability. This is supported by the ICC (3,1), which was also fair and significant at .47.

The results of the Mann-Whitney U test indicate that the ratings awarded by the raters for the calibration segments were representative of the ratings overall. However, the analysis of agreement between pairs of raters for the non-calibration segments (N=58) found that only pairs which included R4 were significant and achieved more than a poor level of agreement (Table 8.7). This higher level of agreement was due to R4's ratings being

consistent with those of the other raters, even though they were different in absolute terms (Figure 8.2). The generally poor agreement for the non-calibration segments, in contrast with the fair agreement for the calibration segments (rated by four raters) suggests that two raters is an insufficient number to achieve interrater reliability.

The other explanations for poor interrater reliability raised by Barber and colleagues (2007) are a lack of a shared understanding between the raters of (a) what competence means, (b) how important the various components of the model are to competence, and (c) how the components of the model should be operationalised. In this light, the excellent agreement between R3 and R4 (the two raters from Centre B) suggests that these two raters conceptualised the PCET model, its components, and its operationalisation in the same way, and rated therapists' practice (i.e., recording segments) accordingly.

Interrater Reliability for Centres and Raters Generalisable to a Wider Population

In contrast to interrater reliability for an RCT, in the context of assessing recording segments for qualification in PCET absolute agreement is required rather than consistency. Ratings determine whether a trainee will meet the threshold rating of 40 to qualify, and differences between raters could mean the difference between a trainee passing or failing. Shared understanding between raters (i.e., those working in PCET training centres) on what competence in the PCET model means, and how competence is reflected in PCEPS ratings, is therefore essential.

Results for the ICCs in this context were fair for the five calibration segments. The ICC of .59 (Table 8.8) suggests that there was a fair to good level of reliability between centres, though nonsignificant. For individual raters rating the five calibration segments, the reliability was weaker but still fair at .40.

300

As above, the poor reliability for pairs of raters rating the non-calibration segments reflected the finding that greater reliability was achieved when there were more than two raters (Table 8.9). Only the three pairs which include R4 met the ICC threshold of .40 for fair reliability. In particular, agreement between R1 and R2 for 15 segments was poor at .28. Inspection of the graph in Figure 8.2 shows that while R1's ratings were consistently higher than R2's, the points are widely scattered, meaning that for many segments there was absolute disagreement. The differences between these two raters (both from Centre A) could reflect variations in their understanding of what competence in PCET and its components means, or how it is operationalised (Barber 2007). Alternatively, it could reflect variation in their way of interpreting and using the PCEPS. Westwell (2018) found that intensive supervision and notation in the use of the PCEPS were required to resolve such differences.

Interrater Reliability for the Person-centred, Proscribed, and Experiential Clusters

For the centres rating the five calibration segments, interrater reliability for the cluster of experiential components was excellent (.80, Table 8.10), whereas for the cluster of person-centred components it was poor (.36), though both were nonsignificant. For the individual raters rating the calibration segments, interrater reliability was greatest for the cluster of proscribed components, at .44 (fair and significant).

Analysis of ratings of the non-calibration segments by the six pairs of raters (Table 8.11) suggested that R2 had greater agreement with other raters on the experiential than on the person-centred components (although R2 & R3 had an ICC of zero for two segments). R3 & R4 agreed least on the experiential components (ICC = .36), but had good agreement on the person-centred components (.65, significant) and excellent on the proscribed components (.77, significant). When ratings for all the segments were combined, giving an

overall sample of 88 segments (Table 8.12), results indicated that agreement was greatest

for the cluster of proscribed components (ICC = .45) and least for the cluster of experiential

components (ICC = .37). It is possible that the most of the raters had a greater shared

understanding of the person-centred and proscribed components than of the experiential

components, given that they came from a person-centred background (Haake et al., 2021;

Pearce et al., 2012. See also Chapter 3). It appeared, however, that R2 had a different

understanding of the person-centred components than the other three raters.

It should be noted that the high inter-item reliability of the PCEPS-10 means that

results of any statistical analysis for the three clusters are necessarily similar (see Chapter 2).

Interrater Reliability for the Individual PCEPS Components

In order to allow a further level of detail, interrater reliability was analysed for the

ten PCEPS components individually (Table 8.13). Two components, Dominant or

Overpowering Presence and Clarity of Language, achieved a fair level of agreement

(ICC = .45 and .42 respectively). It appeared that the raters shared an understanding of what

competent practice means for both of these components. Dominant or Overpowering

Presence is one of the two components in the cluster of proscribed components. In

contrast, the other proscribed component, Content Directiveness, had a poor level of

agreement (mean ICC = .27). This finding may relate to the concept of the process-guiding

spectrum (Chapter 1), suggesting that raters positioned themselves at different points on

the spectrum. While one rater may have interpreted a therapist intervention as process-

guiding (and therefore competent), another rater may have interpreted the same

intervention as content directive (and therefore proscribed).

The finding that there was relatively poor agreement on components that would be

considered core person-centred attitudes and skills was surprising. Tracking/Client's Frame

of Reference achieved an ICC of .32, while Accepting Presence and Psychological Holding were poorer (ICC = .22 and .21 respectively). Again, R2 contributed to the lowest interrater reliability for these components, reinforcing the observation that this rater conceptualised the person-centred components differently from the other raters.

The three experiential components also had relatively poor interrater reliability (experiential specificity = .30; emotion focus = .23; emotion regulation sensitivity = .22). It may be that these components are less familiar than the person-centred components to PCET practitioners, including the four raters represented here.

The inconsistencies in reliability for individual PCEPS-10 components found by this study are in contrast to the high interrater reliability (average Cronbach's alpha .87) found by Freire et al. (2014) for the 15 items of the original PCEPS. However, they are comparable to those found by Westwell (2018) in the pilot phase of his study. The findings from both this study and the study by Westwell suggest that greater clarity and improved definition of both the person-centred and experiential components of the PCEPS-10 are needed to improve interrater reliability. More precise definitions of the components within the PCEPS-10 would contribute to a greater shared understanding and conceptualisation of the model among the PCET community. At the same time, providing greater precision within the instrument used for assessing PCET competence risks restricting the flexibility and responsiveness prized by the person-centred community.

Assessment Practices of Centres and Raters

Analysis of the raters' ratings raises some concerns about differences between raters and training centres in their practice of assessing trainee PCE therapists. The two centres differed in the range of ratings they awarded, and the number of segments which would achieve a pass mark of 40. Table 8.4 shows that the ranges of ratings for R1 (10–60) and R2

(15–60) from Centre A were greater than those from Centre B (R3: 27 − 54; R4: 26 − 56). This is illustrated graphically by the boxplots in Figure 8.1. Whereas both the raters from Centre A were willing to award full marks of 60, the highest mark awarded by raters from Centre B was 56. The willingness of the raters from Centre A to award both lower and higher ratings than the raters from Centre B, while not relevant for interrater reliability in the context of the PRaCTICED trial, implies that there is an important disparity between the centres in their routine practice of assessing PCET trainees. This is highlighted by the difference in potential pass rates between the centres shown in Table 8.14, and illustrated in Figure 8.8. Based on the ratings averaged between the raters in each centre, Centre A would have failed 10 segments passed by Centre B, and passed two segments failed by Centre B.

Within Centre A, R1 would have failed one segment which R2 would have passed, but would have awarded a pass mark to 11 segments which their colleague R2 would have failed (Table 8.15 and Figure 8.9). Throughout this analysis it appears that R2 consistently awarded lower ratings for segments than the other three raters. While this difference was not problematic for the interrater reliability of the PCEPS-10 for the purposes of the PRaCTICED trial, it reflects potential variations between individual raters in the wider population in the high stakes activity of assessing the PCET competence of trainees who are trying to gain a qualification in PCET.

These differences may be moderated in everyday practice, where PCET trainers within centres are able to hold discussions to arrive at a consensus for rating segments and awarding the qualification. There is still the risk, however, that the model, despite being evidence-based, is interpreted differently in different training centres, and that procedures and standards for awarding the qualification also differ. It seems important to find a way of improving agreement on these issues between and within training centres, without

imposing rigid frameworks which would violate the person-centred philosophy of being responsive and open to experience, which is central to the PCET model.

Strengths and Limitations

A strength of this study is that it used the PRaCTICED trial data which was derived from therapy delivered in routine settings, giving it ecological validity. Therapists were already employed in the host IAPT service, representing a range of competence levels. The raters were already employed as trainers and assessors in the PCET model, and the conditions under which they rated segments for the PRaCTICED trial mirrored those of routine practice.

Limitations include the small sample sizes available, where the largest was $N = 20$ (i.e., the number of recording segments rated by one pair of raters) and there were only five calibration segments rated by all four raters. The small samples resulted in very wide 95% confidence intervals bracketing zero, implying that the true reliability value could also be zero.

It is recognised that competence varies not only between therapists, but within therapists. The competence of one therapist varies when working with different clients, and when working with one client across and even within sessions (Baldwin and Imel, 2013). In assessing PCET competence using the PCEPS-10 (including for the PRaCTICED trial, from which the data set for the current study was drawn) only one brief segment from a small number of PCET sessions is randomly selected to test for the competence of each therapist (Freire et al., 2012). Shorter or longer segments may have achieved more similar ratings from raters, resulting in different interrater reliability. If different sessions had been sampled for assessment, the ratings (and therefore reliability) may have been different. Although the findings of the current study for the interrater reliability of the PCEPS-10

appear to support those of Freire, Elliott and Westwell (2012) in their validation of the instrument, further research is needed to know if results would vary for a different sample of recording segments.

Conclusions

Overall, results suggest that the interrater reliability of the PCEPS-10 was fair for the purposes of the PRaCTICED trial, but raise concerns for centres and raters as a sample of assessors of competence for trainees in the PCET model. When reliability is calculated using a model which could be generalised to other raters and other centres, agreement in many cases was poor. This was the case for some person-centred elements of the PCET model as well as for the newer experiential components. Since the raters for the PRaCTICED trial have been recognised as experts in the PCET model, representing two training centres and the PCET community generally, it is important that they share both an understanding of the components of the model, and employ standard assessment practices. However, the results of this study suggest that there may be quite wide variations in understanding and practice between individual raters.

Chapter 9

Thesis Discussion

This thesis presents research which investigated the conceptualisation and the components of the PCET model as delivered in English NHS Talking Therapies, using data gathered in the PRaCTICED trial. Such research has national significance, given the large number of therapists delivering PCET, and the large number of clients receiving PCET in England. The research also has importance internationally, since the size and success of NHS Talking Therapies has attracted the interest of health policy makers and psychotherapy researchers around the world (Clark & Ehlers, 2023).

Figure 9.1 shows the map from Chapter 2, incorporating the key findings of the literature review and each of the five studies. The following paragraphs comprise a synthesis of the findings of the thesis overall, in order to address the research questions posed in Chapter 2.

Figure 9.1

Map showing key findings of studies and systematic literature review

Chapter 4
Systematic literature review
The experiential components are effective as standalone and added interventions.

Legend

Qualitative studies

Quantitative studies

Chapter 3
Trainers and stakeholders see PCET as coherent and effective.

There are some differences in conceptualisation of the model and assessment of practice.

Chapter 5
Therapists integrate the experiential components in a nondirective person-centred relationship.

Chapter 6
Baseline severity is related to competence.

Competence is unrelated to next-session change.

Chapter 7
Early change is related to ultimate change.

Competence is unrelated to ultimate change.

Chapter 8
Interrater reliability of the PCEPS is fair for RCTs but poor for wider practice.

Agreement is highest for the proscribed components.

Synthesis of Key Findings

The Conceptualisation of the PCET Model and the Process-Guiding Spectrum

The conclusion of the thematic analysis of interviews with PCET trainers and stakeholders in Chapter 3 was that the participants shared a conceptualisation of the PCET model. They saw the therapist's role as actively facilitating the client's exploration of their emotional experiences, in the context of a therapeutic relationship based on the Rogerian core conditions. The participants also shared an allegiance to the person-centred principles that therapy is nondirective, and the therapist is not the expert. The analysis of PCET session transcripts in Chapter 5 suggested that therapists in the PRaCTICED trial shared this conceptualisation of the model. This is perhaps not surprising, since all the therapists in the study received their PCET training from the trainers represented in Chapter 3. It was found in Chapter 5 that the therapists were able to weave experiential interventions seamlessly into a person-centred relationship. Some therapists offered interventions which actively guided their client's emotional process. These more process-directive experiential interventions would position the therapist towards the EFT end of the process-guiding spectrum.

This conceptualisation of the model, as a focus on the client's experiencing integrated into a nondirective person-centred relationship, was also reflected in the interpretation of the PCEPS used for this thesis, where the 10 PCEPS items were grouped into three clusters of components. The relational, facilitative components of the model were captured in the person-centred cluster. Therapist attitudes and behaviours seen as directive or expert were captured in the proscribed cluster. The experiential cluster captured the therapist's active focus on the client's emotional experiencing.

The analysis in Chapter 3 suggested that the components of the experiential cluster (experiential specificity, emotion regulation sensitivity, and emotion focus) were less familiar to PCET trainers and practitioners than the person-centred and proscribed clusters. This conclusion was reflected in the analysis of interrater agreement in Chapter 8, where it was found that agreement on therapist competence was lowest for the experiential components and highest for the proscribed components. The collinearity found during the analysis for Chapter 8 implied that the competence of a segment rated low in the proscribed cluster would also be rated low in the person-centred and experiential clusters.

The purpose of PCET training is to ensure the effectiveness of the model by enhancing therapists' competence in delivering its evidence-based components. The findings of the current research suggest that, at the time of the PRaCTICED trial, PCET training emphasised the nondirectiveness of the model. At assessment, therapists perceived by the raters to have a dominant or overpowering presence would receive low competence ratings in all the components. The findings of Chapters 6 and 7, however, showed that competence in the proscribed components (content-directiveness and dominant or overpowering presence) had no effect on change in the client's depression, either at the next session or at the end of therapy. Segments rated low for the experiential components were at least as effective as those rated high. One explanation for these finding is that the raters awarded low scores to segments where the therapist used active process-guiding interventions, which were perceived as content-directive or dominant. Despite low competence ratings, these therapist behaviours were associated with positive change for the client, implying that they were effective.

The results of the studies in Chapters 6 and 7 indicated that practice positioned at the classically person-centred end of the spectrum was effective, and the results of Chapters

3 and 8 suggested that this is perceived by raters as the most competent practice. The results of Chapters 6 and 7 also suggested that practice positioned towards the EFT end of the process-guiding spectrum is equally effective, which makes sense in the light of the evidence from which the PCET model was developed, (i.e., trials of emotion focused therapy, Chapter 1).

The Effectiveness of the Experiential Components

The results of the systematic literature review in Chapter 4 confirmed that the three experiential components (experiential specificity, emotion regulation, and emotion focus) are all efficacious as treatments for depression in their own right. They also showed that emotion regulation and emotion focus are effective as additional components in other therapies. Additive studies are needed to examine whether experiential specificity interventions would be effective as additional components in other therapies. Although no relationship was found in Chapter 7 between competence in the experiential components and change in clients' depression at the end of therapy, in Chapter 6 the strongest relationship between competence and next-session change was found in the experiential components. As discussed above, this association applied to both low and high competence.

The three experiential components formed the *a priori* themes of the thematic analysis in Chapter 5. Although this study did not address therapists' competence in these components, the conclusion was that experiential interventions could be woven smoothly into the therapy, in a style acceptable to clients. The results of the PRaCTICED trial and practice-based evidence available from NHS Talking Therapies data demonstrate that this style of delivering therapy is effective. Further research is necessary to determine whether weaving experiential interventions into the therapy in this way is as effective as the discrete experiential 'tasks' offered in emotion focused therapy.

The Relationship Between PCET Competence and Client Outcomes

A significant relationship was found in Chapters 6 and 7 between clients' baseline depression severity and therapists' competence, especially in the cluster of person-centred components. Two possible explanations are (a) that the therapists exhibited more relational, facilitative behaviours with clients who were more depressed, and (b) that the raters assessing recording segments were responding to a quality of the client/therapist dyad. However, this finding did not translate into a relationship between overall competence in PCET and change in clients' depression, either at the session following the rated session (next-session change), or at end of therapy. The conclusion was that therapist competence is not a mediator between baseline severity and ultimate therapy outcome.

On the other hand, curvilinear relationships were found between competence and next-session change, where both low rated competence and high rated competence showed a stronger association with improvement in depression than medium rated competence. The curvilinear relationship was strongest for the experiential cluster, which suggested that low rated and high rated therapists were equally effective but through different mechanisms.

Relationships were also found between next-session change in the early and middle phases of therapy and end of therapy change. The finding of a strong and significant relationship between next-session change in the early phase and end of therapy outcome supports the theoretical conceptualisation of PCET, where the creation of a trusting relationship and the opportunity for the client to tell their story contribute to ultimately successful therapy. The lack of a relationship between next-session change in the late phase of therapy and end of therapy outcome could support the theory that the final sessions of PCET involve consolidation rather than further change.

A negative (nonsignificant) relationship was found between change in the middle phase and end of therapy outcome, meaning that less improvement in depression in this phase was ultimately associated with more improvement. In PCET theory the middle phase is seen as the 'working phase', and the finding that less change in this phase is associated with more improvement at the end of therapy may again support this theory. Emotion theory posits that 'perturbation' in the client's emotional process is a necessary aspect of change, and ultimately successful therapy. No relationship was found however between competence and change in any of the phases.

Raters were unaware of the phase of therapy when they were assessing recording segments, and awarded competence ratings in all phases equally. This implies that therapist behaviour was similar in the three phases of therapy. Further research would be necessary to determine whether PCET would be more effective if therapists varied their behaviour according to the phase of therapy, for example offering more process-guiding interventions in the middle phase.

Consistency Between Trainers and Centres in Delivery of PCET Training and Assessment

The finding in Chapter 8 of relatively low interrater reliability for the PCEPS-10 means that the results reported in the Chapters 6 and 7 should be interpreted with caution. The correlations reported in these chapters were based on mean competence ratings, which in some cases were derived from widely varying individual ratings. While interrater reliability between the four raters in the PRaCTICED trial was acceptable for an RCT, it was poor in absolute terms between pairs of raters. One of the conclusions of Chapter 8 was that four raters are necessary to ensure interrater reliability. The only fair levels of agreement for individual components were for Dominant or Overpowering Presence and Clarity of Language. Dominant or Overpowering Presence is one of the components of the proscribed

cluster, and in Chapter 6 it was seen that it was in the proscribed cluster that the low rated competence group had their lowest ratings, and the high rated group had their highest ratings.

Due to the collinearity created by the inter-item consistency of the PCEPS-10, if a segment was rated low for one component cluster, it would be rated low in general. If it was rated high for one component cluster, it would be rated high in general. Given the consensus among the raters about therapist behaviours or attitude that were seen as dominant or overpowering, it seems that this component had a strong influence on all the ratings. The findings of Chapters 6 and 7, however, suggested that competence in this component (as rated by the PRaCTICED trial raters) had the least influence on either next-session or end of therapy outcome.

The findings in Chapter 8 of variations between training centres in their assessment practices echoed some of the findings from the interviews in Chapter 3, and raised some concerns about the consistency of training nationally. As noted in Chapter 1, and observed by participants in Chapter 3, the idea of standardisation is controversial in the person-centred tradition. However, since training is the means by which evidence of effectiveness is translated into therapists' practice, and to ensure that all PCET clients nationally receive the same quality of therapy, some standardisation in training is necessary.

The Effectiveness of PCET

The findings of Chapter 7 for outcome at the end of therapy naturally mirrored those of the PRaCTICED trial itself. Results from Chapter 7 showed that the mean PHQ-9 change at end of therapy (-7.06 for the full sample) met the definition of reliable and clinically significant improvement of a reduction of ≥6 points, and 58.5% of participants had experienced reliable change (NCCMH, 2023; Jacobson & Truax, 1991). The results of the

PRaCTICED trial indicated that improvement in depression was slightly reduced at 12-month post-randomisation (mean = -6.46; Barkham et al., 2021).

The findings of the qualitative studies in Chapters 3 and 5 also support PCET as an effective model of therapy. As described in Chapter 1, PCET was designed as an evidence-based model by people who felt allegiance to humanistic and person-centred principles. Although some of the tensions described in Chapter 1 around standardisation and nondirectiveness were reflected in the thematic analysis in Chapter 3, it was evident that the trainers and stakeholders interviewed for the study experienced PCET as an effective model, both in their personal practice and that of trainees. The findings of the qualitative analysis of experiential interventions in Chapter 5 suggested that PCE therapists find ways of weaving process-guiding interventions into a nondirective therapeutic relationship, though therapists who offered active guiding interventions would be positioned towards the process-directive end of the process-guiding spectrum. Chapter 5 did not include measures of either competence or outcome, but the results of quantitative analysis in Chapters 6 and 7 suggested that therapists at all positions on the process-guiding spectrum offered effective therapy.

Could PCET Be More Effective? Discussion and Recommendations for Further Research

The results of the PRaCTICED trial, practice-based evidence from NHS Talking Therapies data, and the results of the current research, all support PCET as an effective therapeutic modality. Multiple studies have concluded that PCET clients make the greatest gains in the early sessions (Ardern, 2023; Duffy, 2022; Pybis, 2017). It was also found in Chapter 7 of the current research that change in depression in the early phase of therapy had a strong and significant impact on depression at the end of therapy, whereas change in the middle and late phases showed no such relationship. Previous researchers have

suggested that the most significant mechanism of change in PCET is the opportunity for clients to tell their story (Duffy, 2022). A further finding from the PRaCTICED trial was that, in contrast to CBT clients, PCET clients maintained the improvement in their depression up to 12-months post-randomisation but did not improve more. Together, these observations raise the important question of how the effectiveness of PCET could be enhanced, including helping clients to maintain or increase benefits post-therapy. The following possibilities (or combination of possibilities) are discussed below, with recommendations for further research:

(a) clarifying the position of PCET on the process-guiding spectrum;

(b) clarifying the meaning of experiential specificity;

(c) clarifying the cognitive-affective focus of PCET;

(d) incorporating changes into the delivery of PCET training and assessment.

Additional sections address the issues of the effectiveness of PCET at follow-up, and the potential for personalisation of therapy.

Clarifying the Position of PCET on the Process-Guiding Spectrum

One possibility for enhancing the effectiveness of PCET might involve a rebalancing of the person-centred and experiential components, positioning the model further towards the emotion focused therapy end of the process-guiding spectrum. As described in Chapter 1, the evidence-base for the development of PCET came from five RCTs, of which three were trials of EFT. Two of these trials (Goldman et al., 2006; Greenberg & Watson, 1998) found that the effectiveness of person-centred therapy was enhanced by the introduction of specific experiential interventions. Similarly, a meta-analysis of humanistic-experiential psychotherapies by Elliott et al. (2021) found the pre-post effect of EFT to be greater than person-centred therapy (Hedges' g = 1.31 and .98 respectively).

In the light of evidence for the superiority of EFT over person-centred therapy, the developers of PCET conceptualised the new model as an integration of a particular focus on the emotional experience of the client into the person-centred relationship. However, in order to honour the nondirectiveness of the person-centred approach, and to limit the training to a 5-day course, specific EFT interventions (e.g., chair-work for a conflict split) were not included. As observed by one of the participants in Chapter 3, "that was a bit of a fudge, really, wasn't it?".

At the time of the PRaCTICED trial, all the participating PCE therapists received a pre-publication copy of the first Counselling for Depression textbook (Sanders & Hill, 2014). This book outlined various emotion focused interventions which the authors called "auxiliary techniques". The second edition of the textbook (Murphy, 2019) no longer referred to auxiliary techniques, but instead described "process-facilitation responses". The author stated: "These therapeutic tasks, processes and the facilitative techniques move fluidly, unannounced and without comment." (p.98)

This contrasts with the practice of EFT, where therapeutic tasks are introduced in response to 'task markers' in the client's narrative, and are announced and negotiated with the client (Greenberg, 2015). The qualitative analysis of PCET recordings in Chapter 5 found that the PCE therapists in the PRaCTICED trial were able to introduce interventions 'fluidly, unannounced and without comment'. At the same time, it was found that some therapists did offer more active guiding of the client's experiential process, that is, were positioned further towards the EFT end of the process-guiding spectrum (though without using chairs).

In a video describing the practice of PCET, Robert Elliott quotes Pete Sanders describing the model as "EFT without furniture" (The Counselling Channel, 2016; Haake, 2018). The question, therefore, is whether PCET would be more effective if therapists

offered more active, process-guiding interventions in response to particular markers in the client's narrative, such as a conflict split (without the use of furniture). Since such interventions are likely to take place during the middle, 'working', phase of therapy, would they strengthen the relationship between next-session change and end of therapy change in the middle phase? Would this relationship be a negative one, as suggested by experiential theory, where 'perturbation' in the client's emotional experience (possibly with a deterioration in depression during this phase) ultimately leads to a successful outcome?

Although a larger effect size was found for EFT than for person-centred therapy by the meta-analyses of humanistic experiential therapies by Elliott and colleagues (2013, 2021), only trivial differences in effectiveness were found between more and less process-guiding therapies (Elliott et al., 2013, 2021). This observation may be supported by the current research. If the interpretation that low competence ratings were awarded to the recording segments where therapists exhibited more process-guiding behaviour is correct, then the findings of the current research also suggest that both more and less process-guiding are effective.

Despite this ambiguity, there may be other reasons to clarify the position of PCET on the process-guiding spectrum. In the qualitative analysis in Chapter 3, the experience of the participants was that the theoretical coherence and clarity of the model had improved their own confidence and that of trainees as therapists. The client's confidence in the effectiveness of therapy is also important. Strengthening the client's expectation of therapy, including providing a clear rationale for therapeutic interventions, is one of the common factors of successful therapy (Wampold, 2015).

Clarifying the Meaning of Experiential Specificity

Experiential specificity is defined in the PCEPS-10 as:

> "the therapist appropriately and skilfully work[ing] to help the client focus on, elaborate or differentiate specific, idiosyncratic or personal experiences or memories, as opposed to abstractions or generalities." (Elliott & Westwell, 2012)

As observed in Chapter 4, this term has not been found in any other PCET or EFT text. The explanation used for Chapter 4 was taken from a blog by Robert Elliott (2014). Both the blog, and the process of reciprocal translation reported in Chapter 4, highlighted the role of experiential specificity in helping the client to recreate concrete, vivid memories of situations in order to counter the tendency of depressed people to have over-general autobiographical memory. The thematic analysis of interviews with trainers and stakeholders in Chapter 3, however, concluded that the participants emphasised experiential specificity as helping the client to explore and differentiate emotional rather than situational experiences. This raises the question of whether PCET practice would be more effective if training included an understanding of experiential specificity as helping the client to be concrete in all aspects of their narrative, including their situational experiences.

The meta-analysis reported in Chapter 4 found a Hedges' g effect size of 0.87 for pre-post trials of experiential specificity, and of 0.31 for comparative trials. However, the literature search found no trials of experiential specificity as an added component of another therapy. Since this is the form in which experiential specificity interventions are offered in PCET, there is a need for research to investigate whether this component does enhance the effectiveness of the model. Such research should compare experiential specificity focused solely on emotional experiencing, and in the form of interventions encouraging concreteness more generally.

Clarifying the Cognitive-Affective Focus of PCET

As described in Chapter 1, two of the trials of EFT which formed the evidence-base for PCET as an integrative therapy recognised the importance of exploring all of the client's experience (Goldman, et al., 2006; Greenberg & Watson, 1998). In particular, the therapy was described as addressing the 'depressogenic cognitive-affective processes' of clients. PCET, like EFT, aims to help the client to explore and find meaning in all of their experiencing, defined as: "thinking, perceiving, sensing, remembering and feeling, along with the inherent meanings and actions associated with these." (Murphy, 2019).

The analysis of interviews with trainers and stakeholders in Chapter 3, however, suggested that for some, their conceptualisation of PCET excluded a focus on the client's thoughts. Some participants implied that a therapist who facilitated an exploration of the client's thoughts would be assessed as nonadherent. Although the source materials do not advocate a focus on the client's thinking at the expense of their feeling, they suggest a more comprehensive understanding of the term 'experiencing'. In this light, PCE therapists would be encouraged to facilitate the client's exploration of all aspects of their experiencing. It is possible that rebalancing the understanding of experiencing in this way could help PCE therapists to be more responsive to the unique needs and styles of individual clients. Further research is needed to determine whether such a broadening of the understanding of experiencing would improve the effectiveness of PCET.

Incorporating Changes in the Delivery of PCET Training and Assessment

Modifying the conceptualisation of PCET in the ways described above would naturally lead to a broader understanding of experiential specificity and experiencing than that found in the current research, and a greater emphasis in PCET training and assessment on the experiential, process-guiding components. One of the findings from the current

research was that the proscribed cluster of components had the highest interrater reliability (Chapter 8), and the experiential cluster the lowest. One interpretation of this finding is that raters found the proscribed components the easiest PCEPS items to rate, and the experiential components the most difficult. In Chapter 6 it was found that low competence in the proscribed components had the strongest relationship with next-session improvement. The same study found that both low and high competence in the experiential cluster of components were related to next-session improvement. It is possible that the behaviour of therapists offering more active guiding interventions was perceived by the raters to be dominant, and was therefore rated low for competence. This interpretation would raise a concern that raters assess competence, using the PCEPS, according to their own conceptualisation of PCET, and the components most familiar to them, rather than on the most effective components.

Data for the research in Chapters 6, 7, and 8 came from only the four expert raters in the PRaCTICED trial. As noted in Chapter 2, the pool of trainers and assessors has since grown, and many have undertaken EFT training. Training and assessment therefore may already reflect a conceptualisation of PCET that is positioned further towards the EFT end of the process-guiding spectrum, and may incorporate more detailed teaching of experiential interventions than that represented in the current research.

Could the Effectiveness of PCET Be More Enduring?

Since NHS Talking Therapies services do not capture follow-up data for clients, no practice-based evidence is available for the effectiveness of PCET at follow-up. The results of the PRaCTICED trial however showed that while depression post-therapy continued to improve up to 12-months post-randomisation for CBT clients, it plateaued for PCET clients. This matches the findings of a meta-analysis of trials of humanistic-experiential therapies by

Duffy et al. (2023), that at end of therapy these therapies were superior to treatment as usual and comparable to other modalities, but at follow-up they were not significantly different to treatment as usual, and inferior to other modalities. While the 2013 meta-analysis by Elliott et al. (2013) found that effects for humanistic-experiential therapies were larger at 12-months or more post-therapy than at end of therapy, the updated meta-analysis (2021) found (like the PRaCTICED trial) that effects were maintained but not improved at follow-up.

It is possible that clients are able to carry forward learning from skill-building therapies such as CBT and IPT (Barkham & Lambert, 2021) more easily than from process-oriented therapies such as PCET. Emphasising the importance of helping PCET clients to review and consolidate insights and changes made during therapy may help these processes to endure beyond the end of therapy. Further research is needed to understand and address the reasons for this difference between skill-building and process-oriented therapies.

The Potential of the Personalisation of Therapy

A recent strand of psychotherapy research has focused on enhancing the effectiveness of therapy by matching clients with the most appropriate therapy (Delgadillo & Gonzalez Salas Duhne, 2020; Moggia et al., 2023). In their analysis of data from an NHS Talking Therapies service, Delgadillo and Gonzalez Salas Duhne identified a sub-group of clients (approximately 30%) receiving either CBT or PCET, for whom the outcome would be improved if they received therapy matched to their characteristics. The authors found that clients from minority ethnic groups, living in poverty, and with disabilities tended to have better outcomes in PCET than in CBT. Moggia et al. found that clients who benefited more from PCET than from CBT were more likely to be employed females or unemployed males.

322

By examining the individual items of outcome measures, these authors also found that clients were more likely to benefit from PCET if they experienced feelings of guilt and criticism from others, had a sense of purpose in life, and expected that PCET would be helpful.

Personalised matching of treatment was not relevant to the current research, which was based on the PRaCTICED trial dataset, where clients were randomised either to CBT or to PCET. The results of a multiple regression in Chapter 7 suggested that client demographics made no difference to the analysis. Personalised matching of treatment might improve the effectiveness of all therapies offered in NHS Talking Therapies services, including PCET. Treatment selection is currently based on the client's presenting problem and preference. More information about which treatment would be optimal depending on the client's characteristics could improve this process.

Implications of this Research for Mental Health Professionals

The findings of this thesis have implications for the practice of PCE therapists, and also for the wider community of mental health professionals.

For example, this work will contribute to the endeavour to clarify the experiential components of PCET, giving therapists a greater understanding of their role, and helping them to implement the components purposefully in practice. The reciprocal translation undertaken in Chapter 4 demonstrates the transtheoretical nature of the experiential components, and the thematic analysis in Chapter 5 illustrates how they may be operationalised as interventions which can be woven into a person-centred therapeutic relationship. The highlighting in Chapters 3 and 8 of differences between trainers and raters in their conception of the PCET model and how it should be operationalised will help to crystalise the arguments. This is not so that differences can be resolved, but because having

greater awareness will help those involved to hold and use these tensions resourcefully (Hanley, 2017).

The thesis will also contribute to a greater understanding of the model among colleagues from other psychotherapy modalities and other disciplines. Such understanding is especially important for referrers, within NHS Talking Therapies and more widely. Referrers need an understanding of the models of therapy that are available, in order to guide clients to the therapy that will be most beneficial for them, whether that is PCET or another model. This relates to the section above, which mooted the potential for the personalisation of therapy. Improving referrers' understanding of PCET has the potential to improve referral pathways, and ultimately to improve the experience of mental health services and outcome for clients.

Reflexivity

As stated in Chapter 2, I am an 'insider researcher' (Jamieson et al., 2023). The impetus for studying the subject of PCET came from the excitement that it created in me at different times. The first source of excitement was that PCET was (to me) a new model of therapy, offering theory which helped me to make sense of concepts that had previously seemed unclear. It felt important to do further reading into these concepts (such as the role of emotions in human functioning), to achieve a deeper understanding of them, and to communicate this with colleagues and supervisees.

The second source of excitement was the potential of PCET to strengthen the position of counselling, and humanistic and person-centred therapy in particular, in what was then IAPT. As a counsellor employed in IAPT, I shared the views and experiences of the participants in the studies by Pearce et al. (2013) and Drewitt et al. (2018), that counselling had not been understood and had been undervalued in IAPT. Like others, I hoped that the

introduction of 'IAPT approved high intensity therapies additional to CBT' in 2011 would change this. This excitement was short-lived, however. Counsellors were required to undertake additional training and qualification, but their status and pay grade within IAPT did not improve.

The third source of excitement was learning about the PRaCTICED trial, and that my colleagues and I would be central to a pragmatic, non-inferiority randomised controlled trial which would meet the requirements of NICE, with the potential to get person-centred therapy recognised in the NICE guidelines for the treatment of depression. It felt then that my colleagues and I were contributing to a project of national, and even international, importance. The trial would enhance the status of humanistic therapy in IAPT and more widely. More importantly, the findings of the trial would benefit all those clients for whom PCET worked.

This is the particular context in which the work for this thesis has been conducted (Olmos-Vega et al., 2023). The research was motivated by my curiosity about the PCET model and its components, and also by my perception that the status of humanistic therapy suffered from a lack of scientific academic research. In the current climate, dominated by authorities such as NICE which only recognise practice supported by a positivist evidence-base, such research enhances the credibility of the model.

I have no financial interest in the findings of this research, but I do have a personal interest, which may be interpreted as 'researcher allegiance' (Elliott & Freire, 2010; Jamieson et al., 2023). The research has given me the opportunity to view the PCET model through a scientific lens, and to position it in the wider contexts of psychotherapy and the study of psychotherapy. I am encouraged that the findings of the five studies and literature review described here conform to patterns seen in all therapeutic modalities, confirming

PCET as an equal participant in the race that "all have won" (Dodo bird verdict, Wampold, 2015a).

Conclusions

The efficacy of the experiential components of PCET as defined in the PCEPS-10 (experiential specificity, emotion regulation sensitivity, and emotion focus) was supported by a systematic literature review. The PCE therapists in the PRaCTICED trial operationalised these components as interventions woven seamlessly into the person-centred relationship. Both baseline severity of depression, and improvement in depression in the early phase of therapy, were significantly related with improvement at the end of therapy. However, no relationship was found between PCET competence and end of therapy outcome. An analysis of the interrater reliability of the PCEPS-10, based on competence ratings of PCET practice during the PRaCTICED trial, raised concerns about the validity of the results of correlations between competence and outcomes. However, the absence of a relationship found in the current research was comparable to previous studies. Further research is needed to investigate whether greater emphasis on the experiential components, including a broader understanding of both experiential specificity and cognitive-affective experiencing, would improve the effectiveness of the model.

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*References marked with an asterisk denote studies included in the systematic review, Chapter 4.

CReferences marked with superscript C denote studies included in the narrative review, Appendix C.

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Table of Appendices

Page

List of Tables   **Page**

List of Figures   Page

Appendix A

Chapter 2

PERSON–CENTRED & EXPERIENTIAL PSYCHOTHERAPY SCALE-10 (V. 1.2, 12/12/12)

Client ID:	Session:
Rater:	Segment:

Rate the items according to how well each activity occurred during the therapy segment you've just listened to. It is important to attend to your overall sense of the therapist's immediate experiencing of the client. Try to avoid forming a 'global impression' of the therapist early on in the session.

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1.   CLIENT FRAME OF REFERENCE/TRACK:

How much do the therapist's responses convey an understanding of the client's experiences as the client themselves understands or perceives it? To what extent is the therapist following the client's track?

> Do the therapist's responses convey an understanding of the client's inner experience or point of view immediately expressed by the client? Or conversely, do therapist's responses add meaning based on the therapist's own frame of reference?

> Are the therapist's responses right on client's track? Conversely, are the therapist's responses a diversion from the client's own train of thoughts/feelings?

1	**No tracking**: Therapist's responses convey no understanding of the client's frame of reference; or therapist adds meaning based completely on their own frame of reference.
2	**Minimal tracking**: Therapist's responses convey a poor understanding of the client's frame of reference; or therapist adds meaning partially based on their own frame of reference rather than the client's.
3	**Slightly tracking**: Therapist's responses come close but don't quite reach an adequate understanding of the client's frame of reference; therapist's responses are slight "off" of the client's frame or reference.
4	**Adequate tracking**: Therapist's responses convey an adequate understanding of the client's frame of reference.
5	**Good tracking**: Therapist's responses convey a good understanding of the client's frame of reference.
6	**Excellent tracking**: Therapists' responses convey an accurate understanding of the client's frame of reference and therapist adds no meaning from their own frame of reference.

2.   PSYCHOLOGICAL HOLDING:

How well does the therapist metaphorically hold the client when they are experiencing painful, scary, or overwhelming experiences, or when they are connecting with their vulnerabilities?

High scores refer to therapist maintaining a solid, emotional and empathic connection even when the client is in pain or overwhelmed.

Low scores refer to situations in which the therapist avoids responding or acknowledging painful, frightening or overwhelming experiences of the client.

1	**No holding**: Therapist oblivious to client's need to be psychologically held: avoids responding, acknowledging or addressing client's experience/feelings.
2	**Minimal holding**: Therapist seems to be aware of the client's need to be psychologically held but is anxious or insecure when responding to client and diverts or distracts client from their vulnerability.
3	**Slight holding**: Therapist conveys a bit of psychological holding, but not enough and with some insecurity.
4	**Adequate holding**: Therapist manages to hold sufficiently the client's experience.
5	**Good holding**: Therapist calmly and solidly holds the client's experience.
6	**Excellent holding**: Therapist securely holds client's experience with trust, groundedness and acceptance, even when the client is experiencing, for example, pain, fear or overwhelmedness

3. EXPERIENTIAL SPECIFICITY:

How much does the therapist appropriately and skilfully work to help the client focus on, elaborate or differentiate specific, idiosyncratic or personal experiences or memories, as opposed to abstractions or generalities?

E.g., By reflecting specific client experiences using crisp, precise, differentiated and appropriately empathic reflections; or.asking for examples or to specify feelings, meanings, memories or other personal experiences.

1	**No specificity**: therapist consistently responds in a highly abstract, vague or intellectual manner.
2	**Minimal specificity**: therapist seems to have a concept of specificity but doesn't implement adequately, consistently or well; therapist is either somewhat vague or abstract or generally fails to encourage experiential specificity where appropriate.
3	**Slight specificity**: therapist is often or repeatedly vague or abstract; therapist only slightly or occasionally encourages experiential specificity; sometimes responds in a way that points to experiential specificity, at times they fail to do so, or do so in an awkward manner.
4	**Adequate specificity**: where appropriate, therapist generally encourages client experiential specificity, with only minor, temporary lapses or slight awkwardness.
5	**Good specificity**: therapist does enough of this and does it skilfully, where appropriate trying to help the client to elaborate and specify particular experiences.
6	**Excellent specificity**: therapist does this consistently, skilfully, and even creatively, where appropriate, offering the client crisp, precise reflections or questions.

4. ACCEPTING PRESENCE:

How well does the therapist's attitude convey an unconditional acceptance of whatever the client brings?

Does the therapist's responses convey a grounded, centred, and acceptant presence?

1	**Explicit nonacceptance**: Therapist explicitly communicates disapproval or criticism of client's experience/ meaning/feelings.
2	**Implicit nonacceptance**: Therapist implicitly or indirectly communicates disapproval or criticism of client experience/meaning/feelings.

3	**Incongruent/inconsistent nonacceptance**: Therapist conveys anxiety, worry or defensiveness instead of acceptance; or therapist is not consistent in the communication of acceptance.
4	**Adequate acceptance**: Therapist demonstrates calm and groundedness, with at least some degree of acceptance of the client's experience.
5	**Good acceptance**: Therapist conveys clear, grounded acceptance of the client's experience; therapist does not demonstrate any kind of judgment towards client's experience/behaviour
6	**Excellent acceptance**: Therapist skilfully conveys unconditional acceptance while being clearly grounded and centred in themselves, even in face of intense client vulnerability.

5.   CONTENT DIRECTIVENESS:

How much do the therapist's responses intend to direct the client's content?

> Do the therapists' responses introduce explicit new content? e.g., do the therapist's responses convey explanation, interpretation, guidance, teaching, advice, reassurance or confrontation?

1	**"Expert" directiveness**: Therapist overtly and consistently assumes the role of expert in directing the content of the session
2	**Overt directiveness**: Therapist's responses direct client overtly towards a new content.
3	**Slight directiveness**: Therapist's responses direct client clearly but tentatively towards a new content.
4	**Adequate nondirectiveness**: Therapist is generally nondirective of content, with only minor, temporary lapses or slight content direction.
5	**Good nondirectiveness**: Therapist consistently follows the client's lead when responding to content.
6	**Excellent nondirectiveness**: Therapist clearly and consistently follows the client's lead when responding to content in a natural, inviting and unforced manner, with a high level of skill

6.   EMOTION FOCUS:

How much does the therapist actively work to help the client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit?

> E.g., By helping clients focus their attention inwards; by focusing the client's attention on bodily sensations; by reflecting toward emotionally poignant content, by inquiring about client feelings, helping client intensify, heighten or deepen their emotions, by helping clients find ways of describing emotions; or by making empathic conjectures about feelings that have not yet been expressed.
> Lower scores reflect ignoring implicit or explicit emotions; staying with non-emotional content; focusing on or reflecting generalized emotional states ("feeling bad") or minimizing emotional states (e.g., reflecting "angry" as "annoyed").

1	**No emotion focus**: therapist consistently ignores emotions or responds instead in a highly intellectual manner while focusing entirely on non-emotional content. When the client expresses emotions, the therapist consistently deflects the client away from them.
2	**Minimal emotion focus**: therapist seems to have a concept of emotion focus but doesn't implement adequately, consistently or well; therapist may generally stay with non-emotional content; sometimes deflects client way from their emotion; reflects only general emotional states ("bad") or minimizes client emotion.
3	**Slight emotion focus**: therapist often or repeatedly ignores or deflects client away from emotion; therapist only slightly or occasionally helps client to focus on emotion; while they sometimes respond in a way that points to client emotions, at times they fail to do so, or do so in an awkward manner.

4	**Adequate emotion focus**: where appropriate, therapist generally encourages client focus on emotions (by either reflections or other responses), with only minor, temporary lapses or slight awkwardness.
5	**Good emotion focus**: therapist does enough of this and does it skilfully, where appropriate trying to help the client to evoke, deepen and express particular emotions.
6	**Excellent emotion focus**: therapist does this consistently, skilfully, and even creatively, where appropriate, offering the client powerful, evocative reflections or questions, while at the same time enabling the client to feel safe while doing so.

7.   DOMINANT OR OVERPOWERING PRESENCE:

To what extent does the therapist project a sense of dominance or authority in the session with the client?

> Low scores refer to situations in which the therapist is taking charge of the process of the session; acts in a self-indulgent manner or takes over attention or focus for themselves; interrupting, talking over, silence or controlling the process; or acting in a definite, lecturing, or expert manner.

> High scores refer to situations in which the therapist offers the client choice or autonomy in the session, allows the client space to develop their own experience, waits for the client finish their thoughts, is patient with the client, or encourages client empowerment in the session.

1	**Overpowering presence**: Therapist overpowers the client by strongly dominating the interaction, controlling what the client talks about or does in the session; clearly making themselves the centre of attention; or being patronizing toward the client.
2	**Controlling presence**: Therapist clearly controls the client's process of the session, acting in an expert, or dominant manner.
3	**Subtle control**: Therapist subtly, implicitly or indirectly controls what and how the client is in the session.
4	**Noncontrolling presence**: Therapist generally respects client autonomy in the session; therapist does not try to control client's process.
5	**Respectful presence**: Therapist consistently respects client autonomy in the session.
6	**Empowering presence**: Therapist clearly and consistently promotes or validates the client's freedom or choice, allowing client space as they desire.

8.   CLARITY OF LANGUAGE:

How well does the therapist use language that communicates simply and clearly to the client?

> E.g., therapist's responses are not too wordy, rambling, unnecessarily long; therapist does not use language that is too academic or too abstract; therapist's responses do not get in the client's way.

1	**No clarity**: Therapist's responses are long-winded, tangled, and confusing.
2	**Minimal clarity**: Therapist's responses are wordy, rambling or unfocused.
3	**Slight clarity**: Therapist's responses are somewhat clear, but a bit too abstract or long.
4	**Adequate clarity**: Therapist's responses are clear but a bit too long.
5	**Good clarity**: Therapist's responses are clear and concise.

| 6 | **Excellent clarity**: Therapist's responses are very clear and concise, even elegantly capturing subtle client experiences in a few choice words. |

9.   CORE MEANING:

How well do the therapist's responses reflect the core, or essence, of what the client is communicating or experiencing in the moment?

> Responses are not just a reflection of surface content but show an understanding of the client's central/core experience or meaning that is being communicated either implicitly or explicitly in the moment; responses do not take away from the core meaning of client's communication.

1	**No core meaning**: Therapist's responses address **only** the cognitive content or stay **exclusively** in the superficial narrative.
2	**Minimal core meaning**: Therapist's responses address **mainly** the cognitive content or the superficial narrative but bring occasional **glimpses** into the underlying core feeling/ experience/ meaning.
3	**Slight core meaning**: Therapist's responses **partially but incompletely** address the core meaning/feeling/ experience that underlies the client's expressed content.
4	**Adequate core meaning**: Therapist's responses were **close** to the **core** meaning/feeling/ experience that underlies the client's expressed content, but do not quite reach it.
5	**Good core meaning**: Therapists' responses accurately address the **core** meaning/feeling/ experience that underlies the client's expressed content.
6	**Excellent core meaning**: Therapists' responses address with a high degree of accuracy the **core** meaning/feeling/ experience that underlies the client's expressed content.

10.   EMOTION REGULATION SENSITIVITY:

How much does the therapist actively work to help the client adjust and maintain their level of emotional arousal for productive self-exploration?

> Client agency is central; this is not imposed by the therapist. There are three possible situations:

> *(a)*   If the client is overwhelmed by feelings and wants help in moderating them, does the therapist try to help the client to manage these emotions? E.g., By offering a calming and holding presence; by using containing imagery; or by helping the client self-soothe vs. allowing the client to continue to panic or feel overwhelmed or unsafe.
> *(b)*   If the client is out of touch with their feelings and wants help in accessing them, does the therapist try to help them appropriately increase emotional contact? E.g., by helping them review current concerns and focus on the most important or poignant; by helping them remember and explore memories of emotional experiences; by using vivid imagery or language to promote feelings vs. enhancing distance from emotions.
> *(c)*   If the client is at an optimal level of emotional arousal for exploration, does the therapist try to help them continue working at this level, rather than deepening or flattening their emotions?)

1   **No facilitation**: therapist consistently ignores issues of client emotional regulation, or generally works against client emotional regulation, i.e., allowing client to continue feel overwhelmed or distanced.

2   **Minimal facilitation**: therapist seems to have a concept of facilitating client emotional regulation but doesn't implement adequately, consistently or well; therapist either generally ignores the client's desire to contain overwhelmed emotion or to approach distanced emotion; sometimes they misdirect the client out of a productive, optimal level of emotional arousal, into either stuck or overwhelmed emotion or emotional distance or avoidance.

3   **Slight facilitation**: therapist often or repeatedly ignores or deflects client away from their desired level of emotional regulation productive for self-exploration; therapist only slightly facilitates productive self-exploration. While they sometimes respond in a way that facilitates client productive emotional regulation, at times they fail to do so, or do so in an awkward manner.

4   **Adequate facilitation**: Where appropriate, therapist generally encourages client emotional regulation (e.g., by helping them approach difficult emotions or contain excessive emotional distress as desired by client), with only minor, temporary lapses or slight awkwardness.

5   **Good facilitation**: therapist does enough emotional regulation facilitation and does it skilfully and in accordance with client's desires, where appropriate trying to help the client to maintain a productive level of emotional arousal.

6   **Excellent facilitation**: therapist does this consistently, skilfully, and even creatively, where desired, offering the client evocative or focusing responses to help the client approach difficult emotions when they are too distant and to contain overwhelming emotions, all within a safe, holding environment.

PRaCTICED Trial:

Session Adherence & Competency Scale - CfD

Therapist: Patient:

Session Number: Date of Session:

Supervisor: Date of Rating:

Please use the following scale:

```
   0        1        2        3        4        5        6
   |--------|--------|--------|--------|--------|--------|
 None              Some          Considerable        Thorough
```
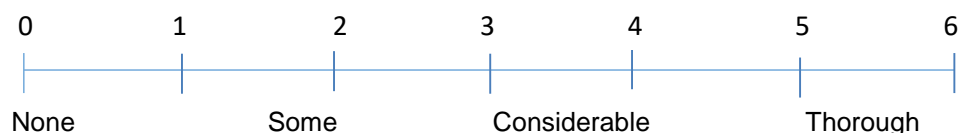
Please rate the excerpt and/or overall discussion of the session using the items below in terms of adherence to the Counselling for Depression model (i.e., to what extent were these features apparent).

Component of therapy	Adherence Rating (0-6)
1. Framework applied, including goal-setting and feedback	
2. Development and maintenance of a collaborative therapeutic relationship encompassing a central emphasis on therapist *way of being*	
3. Enabling/facilitating getting in touch with emotions	
4. Enabling/facilitating working with emotions	

Now please rate the excerpt and/or discussion of the session in terms of skilfulness of the therapist (i.e., how well the Counselling for Depression model was delivered).

5. Overall **competency** (Tick or circle one of these 3 options)	1. Very competent: An exemplar session/case 2. Competent: No concerns about the session/case 3. Concern about competence level: Targeted worked required to ensure competence

Please report these figures via email or text.

CfD Practice Manual

General principles

Counselling for Depression is a creative collaboration between client and counsellor. It can be thought of as client and counsellor together building the therapeutic edifice. The counsellor takes responsibility for the boundaries of the construction, such as time limits and outcome measures, which we can think of as the framework. The client brings their goals, their wishes for the finished building, and the materials: the narrative and emotional content. The foundation of the building is the relationship between client and counsellor. The counsellor helps to guide the client's process as they work with the materials, getting in touch with feelings and working with feelings. The mortar bringing everything together is empathy.

We will describe the model in terms of these four elements: I) Framework, II) Relationship, III) Getting in touch with emotions, and IV) Working with emotions. For II, III and IV we will distinguish two aspects, the therapeutic stance and auxiliary techniques.

The therapeutic stance

(Basic CfD competencies)

- establish the person-centred therapeutic **conditions**
- emphasise **collaboration**
- **formulate** the client's therapeutic goals by negotiation
- initiate regular **review** of progress and client's goals
- positively engage with the **time limited** nature of CfD

Auxiliary CfD techniques

(Specific CfD competencies)

- help clients **access and express** emotions
- help clients **articulate** emotions
- help clients reflect on and develop **emotional meanings**
- help clients **make sense** of experiences that are confusing and distressing[1]

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[1] See page 6, *Counselling for Depression Competency Framework*. Improving Access to Psychological Therapies, retrieved 20/05/13 http://www.iapt.nhs.uk/silo/files/counselling-for-depression-competency-framework.pdf.

We will also link these to the relevant criteria of the PCEPS. You will notice that certain criteria are relevant for all elements of the therapeutic model:

5. Content directiveness

The therapist does not intend to direct the client's content, and does not introduce explanation, interpretation, guidance, teaching, advice, reassurance or confrontation.

7. Dominant or overpowering presence

The therapist does not project a sense of dominance or authority in the session, does not take charge of the process or act in a lecturing or expert manner.

8. Clarity of language

The therapist uses language that communicates simply and clearly to the client.

9. Core meaning

The therapist's responses reflect the core, or essence of what the client is communicating or experiencing in the moment.

10. Emotion regulation sensitivity

The therapist actively works to help the client adjust and maintain their level of emotional arousal for productive self-exploration

The 4 elements of delivering CfD

	Element	Components	PCEPS-10
I	Framework	This comprises the following: • Practical components of explaining the limited time and any other practical elements regarding the arrangements. • Check that the client has completed the necessary outcome measures.	
II	Relationship	This comprises the following: • Therapeutic conditions • Collaboration • Formulate and review the client's therapeutic goals	1, 2, 4, 5, 7, 8, 9, 10

III	Getting in touch with emotions	This comprises the following: • Access and express emotions • Regulate emotions • Articulate emotions	2, 3, 5, 6, 7, 8, 9, 10
IV	Working with emotions	This comprises the following: • Articulate emotions • Reflect on and develop emotional meanings • Identify the need of the emotion • Find new adaptive emotions	3, 5, 6, 7, 8, 9, 10

I   FRAMEWORK

In CfD, the counsellor agrees the usual contract with the client in the first session, explaining the limits of confidentiality, working with risk etc. Arrangements are discussed for making appointments, and DNA and cancellation policies. The Minimum Data Set is administered at the ? of every session

Assessment is an on-going process, and does not follow any formal structure. It is about the counsellor getting a sense of the problem from the client's own point of view, and a sense of the client's process, ways in which feelings might be blocked, or might be overwhelming. Establishing the client's goals and focus for the work is a collaborative effort, and is also an on-going process, allowing for new goals and focus to emerge. For this reason, CfD does not require that a contract be made at the outset for a particular number of sessions. Up to 20 sessions are offered, and client and counsellor collaboratively work towards an ending within this limit.

In order to assess progress in meeting goals and working towards an appropriate ending, and to make sure that the client is finding the therapy as helpful as possible, regular, brief, reviews are offered. FIT, Feedback Informed Treatment, is recommended, where the counsellor constantly checks, and then adjusts and adapts to feedback about the client's changing goals and focus. The MDS can be incorporated in an informal way as a useful source of feedback.

II   RELATIONSHIP

Offering a relationship that is warm and trusting enough for the client to work

Therapeutic Stance

Counselling for Depression is founded on the therapeutic relationship, where the therapist offers and the client experiences the core conditions of empathy, acceptance and positive regard, and genuineness. These conditions are necessary for any work to be therapeutic.

Empathy

Empathy is the effort to understand the client's internal world with as much accuracy as possible, and to communicate and check that understanding with the client.

Acceptance and unconditional positive regard

By offering acceptance and unconditional positive regard, also known as prizing, the counsellor creates a warm and safe relationship, where the client can begin to allow themselves to trust another person enough to share and explore their inner world, however dark or frightening that world might seem.

Genuineness

The counsellor tries to create a real, human relationship by being themselves, and not 'professional' or 'expert'. When the counsellor allows themselves to experience and recognise their real, immediate response to the client and the client's story, this is known as congruence. There are occasions when it can be helpful to the client to share this response, for example:

- "As I listen to what you're describing, I'm beginning to feel quite angry. I wonder if that's how you're feeling?"

Auxiliary Techniques

In the sections on Getting in Touch with Emotions, and Working with Emotions, we look at auxiliary techniques as interventions that can enhance the therapeutic work. In this section on the Relationship, it is the other way around, so it is the warm and safe relationship that makes using the auxiliary techniques possible.

Auxiliary techniques are proposed to the client gently and tentatively, in a spirit of collaboration, not imposed. They are offered in the moment, where the suggested intervention feels useful and

appropriate. The counsellor briefly describes the intervention, and the rationale for offering it at that moment. Possible ways of introducing an intervention might be:

- (Clearing a space) "You seem to have a lot going on at the moment, and it feels hard to know what to focus on. I wonder if it would be helpful to do something to work out what's most important just now. There's something we could do called 'clearing a space' …"

- (Systematic evocative unfolding) "You sound quite puzzled by this feeling of being so deflated yesterday. I wonder if it would be helpful to go through what happened in some detail, almost to freeze frame it, to see if we can spot the feelings as they arose?"

These interventions are described under Getting in Touch with Emotions, below.

The counsellor always respects the client's wishes and feelings if they decline the proposal. CfD doesn't recognise the idea of 'resistance', since every decision the client makes is part of their self-actualizing process, and makes sense in the context of their individual striving for survival, maintenance and enhancement. The counsellor also relies on their empathic attunement to gauge if the client is being compliant or deferring to the counsellor, and to address this. Staying with the client's frame of reference or track means the counsellor needs to have the ability to "turn on a sixpence", to follow the client and not have any investment in any particular proposals or techniques.

PCEPS-10

In the PCEPS-10, the relationship and the core conditions are considered in items 1, 2, 4, 5, 7, 8, 9 and 10.

1. Client frame of reference/track

The counsellor follows and tries to understand moment by moment the material and emotional content of the client's narrative. They communicate and check their understanding with brief reflections and paraphrases. Questions are used only to check understanding, and especially to check accurate perception of the client's emotional process. Care should be taken that questions don't divert the client from their own track. Some interventions are:

- Repeating single words, such as "angry", "numb", "ecstatic".

- Tentative paraphrases:

  "So you're really angry?" "All this was happening, and yet you felt quite numb." "It felt really intense, ecstatic."

2. Psychological holding

The counsellor communicates verbally and non-verbally that within the safety of the counselling relationship the experiencing and expression of all forms of emotion are accepted and welcomed. Empathy is essential to follow the client's moment by moment emotional process, to offer psychological holding consistently. Examples of helpful phrases might be:

- "I can see how hard this is for you."
- "I wonder if we can stay with this feeling for a minute?"

4. Accepting presence

The counsellor communicates to the client, verbally and non-verbally, that they accept without judgement whatever the client brings in their narrative or emotionally. Empathy helps to understand the client's underlying feeling. This can be conveyed with calm and open reflections and paraphrases, for example:

- "You hate your mum."
- "It's hard knowing that refugees can find housing when you can't."

5. Content directiveness

This item relates to all the other items in this section. The counsellor avoids intentionally or unintentionally diverting the client from their track. Questions about content can unintentionally divert the client. The counsellor should also avoid the temptation to offer solutions, or to reassure the client by generalizing or by changing the subject. Where the counsellor feels that it would be helpful for the therapy to gather more information, for example to look at childhood experiences, rather than saying "Tell me about your childhood", the counsellor can keep the focus on emotions by saying:

- "I wonder if this is a feeling you've experienced at other times in your life?"
- "I wonder if this feeling is familiar to you?"

7. Dominant or overpowering presence

As with No 5, the counsellor avoids taking over the session, or acting in a distant, 'professional' or expert way. The counsellor is there to guide the client's process, but this is achieved at all times in a gentle, tentative manner. Counsellors should be genuine in their presence, for example humour can be part of the creative process, and can contribute to the relationship, but empathy is important to gauge where it is appropriate and respectful.

8. Clarity of language

The counsellor should use their empathic understanding of the client to choose language which will be clear and acceptable to that client. They should be genuinely themselves, using language which feels natural and not stilted. They should avoid technical language which might suggest expertise or superior knowledge. Reflections and paraphrases should be clear and brief, and wherever possible offered in the client's own words. Counsellors should have an awareness of balance in the session, where the great majority of talking is done by the client.

9. Core meaning

Empathy, and checking of understanding, is essential in helping the client to identify their own core meaning. The counsellor's responses can help the client to deepen and differentiate their emotional experience. Some helpful phrases might be:

- "You felt quite deflated at that moment. I wonder if you can say anything else about that feeling?"
- "You sound very proud as you talk about your children. There's something about the experience of being a mother …" (an invitation to say more)

10. Emotion regulation sensitivity

In terms of the therapeutic stance, this item relates to No 2, psychological holding. The counsellor needs to try at all times to achieve an empathic attunement with the client's emotional level. If the client is beginning to feel overwhelmed by their feelings, the counsellor needs to pick this up, to contain the client psychologically, and to offer ways to help the client feel safe as they experience their emotions. If the client seems to be out of touch with their feelings, the counsellor again needs to use their empathic attunement to understand the client's fear or reluctance to express or even to experience strong emotions.

Some interventions to help clients to regulate emotions are described under Auxiliary Techniques for Getting in Touch with Emotions, below.

III   GETTING IN TOUCH WITH EMOTIONS

Helping the client to access and stay in touch with their feelings at the right level to work

Therapeutic Stance

Counselling for Depression has been developed from the knowledge that emotions provide motivation and guide behaviour, which can be towards growth and enhancement of the individual, or, as in depression, can become stuck and unhelpful. Each person's individual and unique pattern of experiencing emotion is called their 'process'.

Good psychological health means being free to experience and express emotions as they change constantly in response to the changing environment, helping us to navigate that environment. These are known as primary adaptive emotion responses.

In depression, emotions are often stuck and unresolved. They may be kept out of awareness because they are too frightening, or because the client has been taught that they are unacceptable. Or the client may be aware of them, but unable to express them, and therefore resolve them, because they believe they are unacceptable. Sometimes, without the client being aware of it, emotions are replaced by alternative responses which seem more acceptable, for example fear or sadness replaced by anger, or anger replaced by tears. These are known as secondary reactive emotion responses.

Emotions might have been vital for survival at some time in the client's experience, but have outgrown their usefulness, and are now inappropriate for the current situation. An example might be a client who has been abused, who now fears intimacy rather than seeking it. These are known as maladaptive emotional responses.

Emotions might be used to influence other people, in order to get the client something they want or need, especially if their needs have not been met naturally within their important relationships. This can become a habit, so that the client isn't even aware of it, and as with maladaptive emotions, can be unhelpful in new situations. These are known as instrumental emotional responses.

These terms are theoretical constructs, and don't need to be shared with the client. They have been described here to help provide the counsellor with greater insight into what might be happening in a client's process, and possibly to discuss in supervision.

In Counselling for Depression, the counsellor helps the client to get in touch with their range of emotions, and to experience them in the session in order to work with them. They help the client to feel them in their body, and to express them non-verbally, for example with tears, sighs, clenched fists, or hugging themselves. They help them to articulate emotions, putting them into words, finding metaphors and images. They help the client find the meanings behind the emotion, and where they might have come from. The Counselling for Depression therapist is more interested in the client's emotional process, than in the content of the client's story.

An important aspect of getting in touch with emotions is helping the client to regulate their emotions. The client needs to feel the emotion within the session, in order to be able to work with it. The client may be over-regulated and out of touch with their emotions, for example, as we suggested above, if emotions are too frightening or feel unacceptable. Or a client may be under-regulated, and overwhelmed by their feelings to the extent that they cannot work with them. The auxiliary techniques described below can be used to help the client to regulate their emotions, and to become more aroused or less aroused within the session, in order to work productively.

Auxiliary Techniques

The following techniques are especially helpful where a client is over-regulated and out of touch with their feelings:

<u>Empathic attunement</u> helps the counsellor to identify feelings that are on the edge of awareness, and to bring them into awareness. One way of thinking about this is to imagine a 'pain compass', where the needle is pulled magnetically towards the client's pain. Examples of helpful phrases might be:

- "I noticed there was a sigh as you talked about your son."
- "You seemed to clench your fists just then; I wonder what that's about?"

<u>Empathic conjectures</u> are used where the counsellor's empathic understanding helps them to imagine how the client might be feeling, even though they are struggling to express it. These are offered very tentatively and without defensiveness, giving the client the freedom to reject them or to disagree. Often, even if the conjecture is not quite right, the client is helped to find a more accurate expression. Examples of empathic conjectures might be:

- "You've been talking about some very difficult experiences. I wonder if there might be some anger there?"

- "So you feel as though your emotions are all over the place; it's almost like you're feeling out of control?"

Working with blocks to expression of feelings

Sometimes, as described above, a client can block their expression of emotions, with or without awareness of what is happening. The counsellor can help simply by noticing this. A possible intervention might be:

- "You seem very sad, but I notice that it seems hard for you to cry."

If the client replies, for example, that to cry betrays weakness, the counsellor can choose from a range of responses, using empathy to decide what is most appropriate at that moment:

- Empathic conjecture - "Perhaps it feels too scary to show weakness just now."
- Seeking meaning – "I wonder what it would mean to you to show weakness?"
- Working with the split – "It's as if part of you needs to cry, but another part says 'no, that would be weak'."

Auxiliary techniques for working with splits are described below, in the Working with Emotions section.

Exploring bodily sensations

The counsellor can help the client to focus on the bodily sensations associated with emotions as they arise. Some clients do this spontaneously, perhaps putting a hand on their abdomen and saying "I can feel it in my gut", or bowing their head and saying "It's like I have the weight of the world on my shoulders". Other clients benefit from some encouragement, such as:

- "You're talking about so much sadness. I wonder if you can feel it inside you somewhere? Can you almost put your hand on it?"
- An empathic conjecture could be useful, such as "It sounds as though it feels quite cold/heavy/sharp?"
- Metaphors can also be helpful, such as "Sharp like a knife?"
- If it feels appropriate, bodily sensations can be explored further by asking: "I wonder if there's anything this feeling is trying to tell you?"

Systematic evocative unfolding

This intervention is used particularly when a client seems puzzled by a reaction to an event. It involves guiding the client through an event systematically, in as much detail as possible. Re-experiencing an event like this can help a client to evoke the emotions that were present or arose at the time. The counsellor maintains the focus on emotions, using empathic attunement, or the 'pain compass', to spot the moment when a feeling arises, in order to explore what might have been the trigger in that moment. It might sound something like:

- "So you were sitting at the table after tea, feeling quite relaxed, not thinking about anything in particular. But as soon as you heard the phone ring something happened inside you …"

The following techniques are helpful where a client is under-regulated and overwhelmed by their feelings:

Grounding can be used when a client is very overwhelmed, and perhaps feeling as though they might panic. The counsellor can help the client to focus on objects in the room, on their breathing, on the feeling of their body in the chair, their feet on the floor.

Pacing can help the client feel safe enough to approach a feeling, by managing the expression of emotions in a very slow, gradual way, a little at a time.

Self soothing

If the client is feeling overwhelmed within the session, the counsellor can help the client to feel in imagination the soothing, comforting presence of another protective person, or even a comforting object from their memory. We will describe a slightly different self soothing intervention in the next section on Working with Emotions.

Clearing a space

This intervention is helpful if it seems that the client is overwhelmed either by a particular emotional trigger, or by so many different problems that they don't know where to begin. The counsellor invites the client to imagine a container for each feeling or problem, and to imagine putting the container in a place where it can stay until it is needed, or the client is ready to look at it. The client can then choose which container to take the lid off, and work with in the session. Clients are often very creative, describing images such as a magazine file on a shelf in the corner, to a pirate's chest bound in chains on a desert island.

PCEPS-10

In PCEPS-10, the skills needed to help a client to access and articulate feelings are considered in items 2, 3, 5, 6, 7, 8, 9, and 10.

2. Psychological holding

With the techniques described above, particularly interventions intended to help an overwhelmed client to regulate their emotions, the counsellor's skill in psychological holding, being a calm, gentle and unphased presence, is essential.

3. Experiential specificity

The counsellor helps the client to stay with their immediate, moment by moment experience, encouraging the client to deepen and differentiate feelings. This can be seen in Systematic evocative unfolding, where the counsellor helps the client to re-create an event with sights, sounds and smells helping to evoke feelings. If a client tends to describe emotions very broadly, for example "It felt horrible", the counsellor can help the client to explore this further. Phrases might be:

- "It felt horrible. I wonder if you can say any more about what that's like for you?"
- "Horrible. You almost have a look of disgust as you talk about it."
- "It felt horrible. It sounds as though it could have been quite a scary moment?"

We have discussed the following items in the context of the Therapeutic Relationship, above. As before, the counsellor helps to guide the client's process using clear and straightforward language, but is not directive of content or dominant in any way:

5. Content directiveness

7. Dominant or overpowering presence

8. Clarity of language

6. Emotion focus

The counsellor adopts the therapeutic stance and uses the auxiliary techniques described above with the intention of helping the client to focus on the emotional content of their story, to put feelings into words, and to experience the emotions in the session at the right level of intensity to work with them.

9. Core meaning

The counsellor not only helps the client to access and articulate emotions, but also to explore the meaning of those emotions for the client, for example what the feeling is telling the client, how the feeling influences the client's behaviour and experience of the world.

10. Emotion regulation sensitivity

The counsellor adopts the therapeutic stance and uses the auxiliary techniques described above with the intention of helping the client to regulate their emotions, and to experience their emotions within the session at the right level of intensity to work with them.

IV   WORKING WITH EMOTIONS

Helping the client to work through and resolve problematic emotions

Therapeutic Stance

In Counselling for Depression, emotions are seen as problematic and contributing to depression if they are unresolved or 'stuck'. The counsellor helps the client to become aware of these unhelpful emotions, to articulate them and to feel them within the session. Once the client is in touch with specific feelings, they can be worked with. They can be explored, so that the need underlying them can be identified and understood. These feelings hopefully then can be transformed into something more 'adaptive', allowing the client to find ways of getting their needs met, and the feelings can be resolved.

An example of unresolved feelings is when someone needs to express their feelings to another person, but has not had the opportunity to do so. In CfD this is called 'unfinished business'. It can be helpful, and even transformative, to express these feelings to that person in imagination, with the help of the counsellor. Occasionally this can be a rehearsal for doing so in real life, but often this is not possible or desirable. The person may have passed away, or may be an abuser, and it would be dangerous for the client to confront them in person. The client can be reassured of this when such work is proposed.

Another example of unresolved emotion is when a life event leads to feelings of injustice, anger, helplessness and betrayal that seem out of proportion to the event itself. The counsellor may be able to help the client identify a cherished belief, perhaps a belief that they didn't even know they held until it was challenged or shattered by the life event. This is also known as a 'meaning protest'. The counsellor can then help the client to explore this belief, perhaps identify where it comes from, and transform it into a more adaptive, flexible understanding.

Counselling for Depression recognises that people are made up of different parts, 'configurations of self', each with its own voice. Each part has its own contribution to make to the person's growth - CfD does not consider that any part is destructive or needs to be eliminated. However, sometimes parts can become dominant, or can become hurtful to other parts. For example, a voice that means to be protective can produce paralysing anxiety. Or a voice that means to be motivating, an 'inner critic' can lead to guilt and misery in other parts. The counsellor can help the client to have these internal dialogues out loud, so that each voice can be heard and understood. In this way the 'inner critic', for example, might come to understand the effect it has on other parts of the self, and could soften and find more successful ways to motivate.

Auxiliary Techniques

Unfinished business

When it becomes apparent that the client is experiencing difficult and unresolved feelings towards another person, the counsellor can help the client to work with these feelings. This intervention can raise very strong feelings, and the counsellor needs empathy and emotion regulation sensitivity to help the client to feel safe. In preparation, the counsellor might ask:

- "Talking about your mum brings up some really strong feelings for you. I wonder what it would be like for you to be able to say some of these things to her?"

Then:

- "If she were here, perhaps sitting in that chair, what would you like to say?"

Sometimes the client is able to go further, and imagine how the other person might respond, and then work with the feelings evoked by that response.

Working with a cherished belief

An example of an unrecognised cherished belief might be a man who is unemployed for the first time in his life, and who is depressed as a result. Some possible interventions are:

- "It feels really important for you to have a job. Can you say something about what it means to you to work?"
- "So it is part of being a real man to provide for your family. It's almost as though you feel they won't respect you/love you if you can't provide for them?"

- "Your dad was never out of work. I wonder how it might have changed your feelings about him if he had ever lost his job?"

Configurations of self

The counsellor can help to draw out the different parts of self for the client, with phrases such as:

- "It sounds as though part of you is angry, while another part of you feels it's not ok to be angry?"
- "So part of you is saying 'You're useless and pathetic'. I wonder if you can say how it feels to be told that?"
- "You're saying another part of you feels small and frightened when that part of you talks so harshly. How is it for the harsh part to hear that?"

Self soothing

In the Getting in Touch with Emotions section above, we described self soothing as an emotion regulation intervention, helping a client to experience in imagination the safe and protective presence of another if they are feeling overwhelmed.

Self soothing can also be used to help a client to have the experience of soothing themselves, if this is something that they are not able to do spontaneously. This is like a 'configurations of self' intervention, where one part of the client learns to soothe another. The counsellor helps the client to imagine a friend or a child having the same experiences as the client. The client then imagines what they could say and do to help that person. The counsellor can then ask:

- "I wonder if you can imagine how that friend/child is feeling, as they hear what you're saying?"
- "I wonder if you might be able to find that kind and sympathetic part of you again, when you are feeling hurt or vulnerable, or when the critical part of you is too loud?"

PCEPS-10

The skills involved in working with emotions are considered in items 3, 5, 6, 7, 8, 9 and 10 of the PCEPS-10.

3. Experiential specificity

In interventions such as unfinished business, the counsellor helps the client to be clear and accurate in their feelings by encouraging the client to be specific about their experience. Possible phrases might be:

- "I wonder if you can almost see your mum? See what she's wearing? The expression on her face?"
- "Does that sound right, like the sort of thing your mum would have said?"
- "You look quite anxious as you imagine your mum here. I wonder if that's a familiar feeling for you when you're with her?"

The following items have already been discussed in other sections:

5. Content directiveness

6. Emotion focus

7. Dominant or overpowering presence

8. Clarity of language

10. Emotion regulation sensitivity

9. Core meaning

In working with emotions, the counsellor helps the client to explore and find the meaning of their emotions, for example what the feeling is telling the client, the needs that the emotion is trying to communicate, and how to find adaptive ways to get these needs met.

Table 2.1A

Sampling of recordings: Number of cases selected per therapist according to number of clients seen

Number of clients per therapist	Number of cases selected
2 – 5	1
6 – 10	2
11 – 15	3
16 – 20	4
>20 – 30	5
>30	6

Table 2.2A

Sampling of recordings: Number of recordings needed to reflect distribution of therapy duration

Therapy duration (sessions)	Distribution of therapy duration for sample (%)	Required N of audio files per therapy duration
2 – 5	29	19
6 – 10	36	23
11 – 15	16	10
16 - 20	19	12
	100	64

Personal statement

My own PCET story

1996. I gained my advanced diploma in person-centred counselling.

1997. I became a counsellor in primary care, employed directly by the GP practice. I paid for my own supervision, and was able to choose my own supervisor. I worked with anyone in psychological distress who was referred by the GPs, practice nurses, or attached staff such as midwives and health visitors. There was no limit on the number of sessions I could offer, so for many clients I offered long-term support as well as working towards change. There were no outcome measures and no targets to meet.

2001. My contract was taken over by the local primary care trust. I continued to work in the same GP practice, but was also offered more counselling hours in other practices. For the first time I belonged to a team of counselling colleagues, and a manager who was also a counsellor.

2002. I gained my postgraduate certificate in counselling supervision, and began to offer supervision to colleagues, with the title of senior counsellor.

2004. I was involved in the NHS Agenda for Change (AfC) grading and pay process. The local outcome was that counsellors in one third of our city of Sheffield were awarded Band 7, with senior counsellors awarded Band 8, while those in the other two thirds were awarded Band 5, with supervisors, including myself, awarded Band 6.

2008. My contract was taken over by the local NHS mental health foundation trust, under the new Improving Access to Psychological Therapies (IAPT) programme. All counsellors were awarded AfC Band 6, with no distinction between counsellors and supervisors. I was now a Step 3 high intensity therapist, working in a stepped care model, with a Step 2 Psychological Wellbeing Practitioner, a counsellor and a cognitive behavioural

therapist (Step 3 high intensity) in every GP practice in the city. There were now outcome measures to administer at every therapy session, and a target of 50% of clients moving to recovery.

2011. I was chosen along with three colleagues, all supervisors with a person-centred background, to attend one of the first two five-day trainings in counselling for depression (CfD). Four of the five days were devoted to an introduction to IAPT, and recapping our understanding of depression and the person-centred approach. Half a day was for assessment, leaving half a day to introduce concepts for working with clients' emotional processes. At this training I was introduced to EFT for the first time.

2012. A colleague and I travelled to Strathclyde University at our own expense, to participate in both the four-day level 1 EFT training, and the three-day level 2 EFT training. These training days gave me a grounding in EFT emotion theory and process-guiding interventions. For me, these concepts and ways of working were a revelation. They enabled me to make sense of humanistic theory in a way that I hadn't before, and provided me with a rationale and sense of direction with clients that I had lacked. At the same time, I recognised I was not suited to the process-directiveness required of an EF therapist. The PCET model therefore seemed ideal for my own style, as a therapist who strives to track the client, alongside but not leading, and at the same time actively guiding the client's emotional process when appropriate and helpful.

2013. I gained accreditation as a PCET supervisor. This meant that I could supervise qualified colleagues, and also in a private capacity offer supervision to counsellors who were undertaking the PCET training.

2014. Researchers at the University of Sheffield launched a randomised controlled trial (RCT) called the PRaCTICED trial to be conducted within the Sheffield IAPT service, to

compare the efficacy of PCET with CBT. With a counsellor and a CB therapist in every GP surgery in the city, there was natural equipoise. With therapy in both arms of the trial offered as part of routine care, the trial was pragmatic and had external validity. I was very excited to have this opportunity, to be part of an endeavour which would provide evidence for the effectiveness of the model which would be recognised by NICE, and would cement the place of humanistic counselling within the NHS. At this point only a minority of counsellors within the service had qualified in PCET, and therefore the trial team undertook to provide training for all the counsellors, who would then be able to offer PCET to clients taking part in the trial in all GP surgeries. My colleague and I tried to enthuse, encourage and support our colleagues, offering extra training sessions with experiential learning. I came to understand that PCET doesn't suit every therapist, and that a five-day training plus some extra continuing professional development sessions are inadequate to offer a thorough grounding in the model. With support and advice from experts in the model, I wrote the PCET manual for the the PRaCTICED trial trial. I offered counselling to approximately 20% of the PCET clients in the trial, and represented the counsellors on the trial working group.

2018. I plucked up the courage to ask the two principal investigators for the the PRaCTICED trial trial, Professors Michael Barkham and Gillian Hardy, if they would consider taking me on as a PhD student, despite not having a psychology degree, and very little research experience. With their backing, I was awarded a studentship by the British Association for Counselling and Psychotherapy (BACP), and embarked on a part-time PhD, while still counselling and supervising with Sheffield NHS Talking Therapies.

Appendix B

Chapter 3

Ethics Application Text v.2

Aims and objectives

PCET (Person Centred Experiential Therapy) is a relatively new model of psychotherapy, consisting of an integration of humanistic and Person Centred principles with therapeutic interventions drawn from Emotion Focused Therapy (EFT) (Greenberg, 2002). PCET has been approved for delivery by counsellors within the Improving Access to Psychological Therapies service (IAPT), offering psychotherapy in primary care settings for people experiencing depression (NHS England, 2019). In this setting the model is labelled Counselling for Depression (CfD). Training in CfD has been available since 2011 for counsellors employed in IAPT, who are already qualified and experienced in humanistic therapy. This training is currently delivered at four university centres in England: Metanoia, London; University of Nottingham; UCLan and York St John, based on a curriculum (Hill, 2011) and a Competences Framework (Hill, 2010). Trainees' competence is assessed according to the Person-Centred and Experiential Psychotherapy Scale (PCEPS) (Elliott & Westwell, 2012). For the practice element of the training counsellors receive supervision from CfD-qualified supervisors.

While there has been research into the experience of counsellors undertaking training in CfD (Drewitt et al., 2018; Nye et al., 2018; Pearce et al., 2013), as yet there has been no research into the experience of those delivering the training and supervision. As the provision of PCET has become established in IAPT, it is important to investigate the factors that facilitate trainees' competence in the model from the point of view of trainers and

supervisors. It is also important to determine aspects of conformity and difference between training centres.

The research questions for this study therefore are:

1. How do trainers and supervisors view the balance between nondirective Person Centred therapist skills, and Emotion Focused Therapy skills intended to guide the client's emotional process?

2. How are therapy manuals, specifically the Person-Centred and Experiential Psychotherapy Scale (PCEPS) and Competences Framework, used in assessing trainees? And

3. What are trainers' and supervisors' perceptions of the difficulties faced by trainees as they progress through training and assessment?

The study proposes to gather the views and experiences of trainers (N=8, two from each training centre) and supervisors (N=8, two from each centre). As professionals in this field, participants will already be familiar with the concepts and language of the PCET model. Participants' experiences will be elicited through semi-structured interviews, audio-recorded, transcribed, and analysed using framework analysis (Ritchie & Spencer, 2002). This will elicit rich data, enabling the individual and unique voices of participants to be heard, at the same time as allowing themes and commonalities to be identified. These themes can then be brought together to inform developments in PCET training in the future.

Methodology

In order to encompass the subjective and constructed nature of participants' views, where there are expected to be dense layers of meaning rather than 'truth', qualitative research has been chosen for this study grounded in a humanistic and phenomenological methodology.

For this purpose, the framework analysis method described by Ritchie and Spencer will be employed. framework analysis was developed as a method within applied policy research, to capture and map the experiences of people affected by the issue under investigation, seeking associations and explanations for experiences, attitudes and behaviour, and so contributing to the formulation of new theories and strategies which could benefit the same people in the future. This approach is appropriate to the present study, where the views of different groups of people are sought, who are sharing an experience, but from different vantage points, and where the findings of the study may help to inform decisions around training in the future. It allows the researcher to take a deductive approach, taking into account *a priori* concepts, such as those underpinning PCET theory. The method does not aim to build theory from the development of themes, but is able to focus on implications that emerge from the qualitative data, such as potential recommendations for improving the training experience, as well as the subjective experience of the participants.

Personal safety

The trainers who will be interviewed are already known to the researcher. Interviews will be conducted at the trainers' place of work (i.e., at a university, a secure and accessible location).

Supervisors are known to the trainers, and will be recruited with their assistance. Interviews with supervisors will be conducted by telephone or Skype, and therefore will not require face to face contact with the researcher.

Participants

Trainers from each of the four training institutions will be invited to participate, representing 100% of the trainers currently offering PCET training in England (N=8?).

Trainers are academics who carry out research in their own right, as well as teaching on a range of counselling courses at their institution and maintaining counselling practice.

PCET supervisors are therapists who are already trained and experienced counselling supervisors, and have successfully completed PCET training, followed by a two-day PCET supervisor training. Two supervisors from each of the four training institutions, Metanoia, Nottingham, UCLan and York St John, will be selected to participate in interviews. This sample will aim to capture a range of experiences of supervising on behalf of the different training institutions, as well as variations in background experience and approach to the PCET model.

Recruitment

There are currently nine or ten trainers offering training in PCET on behalf of NHS Education, at four university centres in England. In response to email contact from the research supervisor (Prof. Michael Barkham), nine trainers have already agreed via email to participate in interviews.

The assistance of each training institution will be sought to recruit two participants from their list of approved supervisors. The training centres will be asked to send information sheets and contact details for the researcher to all the supervisors on these lists, with a request for anyone willing to be interviewed to reply directly to the researcher. The information sheets will include the option that should there be more than two volunteers from any of the institutions, a brief questionnaire will be sent to respondents to elicit information about age, gender, original theoretical background and the extent of their counselling experience generally, and PCET experience specifically. On the basis of these responses, a sample of participants will be chosen to capture a variety of profiles (i.e., older

and younger, male/female/other, differing theoretical backgrounds and professional experience).

Consent

Information sheets and consent forms will be sent as email attachments to all participants. Consent forms will invite participants to confirm that they have read and understood the information provided about the research. Consent forms will invite participants to confirm their understanding that their involvement in the research is voluntary, and will have no material benefit to them. They will invite participants to confirm their understanding that they can withdraw from the research at any time without any consequences, and any data they have provided can be destroyed, up to the point where data is pseudonymised. Consent will be sought for pseudonymised data to be included in any potential future publication. Participants will be requested to complete the consent form, and to retain one for their own records, with one to be returned to the researcher to be kept securely at the University of Sheffield with project notes.

Potential harm to participants

Contact details for the researcher, research supervisor and head of department will be included in information sheets in case participants wish to withdraw from the research, or give feedback or make a complaint at any stage of the interview process.

Due to limited size of the community of Person Centred Experiential Therapy practitioners and trainers in England, the researcher already has professional relationships two of the participants, and potential professional and research relationships with others. Given these relationships, it is particularly important for the researcher to agree boundaries of confidentiality with participants before proceeding with interviews. Before beginning interviews and at the debrief, the researcher will emphasise the participant's right to

384

withdraw from the study, or to delete all or part of the data they provide, up to the point where data is pseudonymised. Participants will be offered a time-limited opportunity to review and redact the transcript of their own interview before analysis.

No formal debrief will be necessary, as participants will be made aware of all the aims and objectives of the research prior to interview. However, an informal debrief will be offered at the end of interviews, to recap the aims and objectives of the research and boundaries of confidentiality, and to offer the opportunity to withdraw from the research, or delete or redact any part of the interview.

Data Confidentiality

Any identifying information will be removed from transcripts, or pseudonymised. Participants will be identified in the qualitative analysis by pseudonyms. Trainers will be asked to confirm their understanding and consent that due to the importance for the project of naming the training centres, and the small number of trainers at each site (N=2), it may be possible for some readers of the research to identify contributors.

Data storage and security

The researcher, research supervisors and professional transcriber will have access to original identifiable data. For analysis, data will be pseudonymised.

Interviews will be audio recorded on an encrypted voice recording device, and recordings transferred to encrypted USB memory devices immediately following the interview. Such encrypted USB memory devices will be necessary as the most secure way to deliver recordings to transcribers. When not in use, recording devices and USB memory devices will be stored securely at the University of Sheffield, and recordings deleted immediately once interviews have been transcribed. Only the researcher and professional

transcriber will have access to passwords. Transcripts will be linked to individual participants using pseudonyms, and, for trainers, the name of the training centre where they work.

Amendments

- I have amended Aims & Objectives to clarify technical terms.

- Under Potential Harm to Participants, I have added sentences about agreeing the limits of confidentiality with participants with whom I (the researcher) have existing or potential professional and/or research relationships. I have described the debrief after each interview as an informal opportunity to reinforce the aims of the project, and an opportunity to withdraw from the research, or delete or redact anything the participant may wish. Formal debrief is not necessary, since all aspects of the research will be transparent to participants from the beginning.

- Under Data Security, I have added that the recording device will be encrypted, and that encrypted USB memory devices will be necessary for transferring data to transcribers, but recordings will be deleted as soon as transcription has been completed.

Researcher Safety Form

<table>
<tr><td>

RESEARCHER SAFETY

This form must be completed and submitted in Section F of the online ethics application form ("Supporting documentation"). No research must be conducted until after the Research Ethics Committee has considered both the ethical implications of the research and the safety of the researcher and given permission for the research to go ahead.

</td></tr>
</table>

Background

Psychological research typically involves researchers collecting data from participants. These participants could include, for example, students, friends and acquaintances, or members of the public. The research might take place on University premises, or in other organisations (e.g., schools, hospitals, companies), or might be conducted in public places. Researchers must, therefore, consider the risks that they might encounter conducting the research. In particular, supervisors and students must be familiar with the guidance and advice provided by Safety Services http://www.sheffield.ac.uk/hs/index

Please complete the following (please answer all questions that are relevant):

Title of research project: ___ **The Perceptions of PCET Trainers and Supervisors**_____

Name of lead researcher / applicant: ____Merinda Haake_____

Will the project be conducted on University of Sheffield premises?   YES <u>NO</u>

Will the researcher conduct research on other <u>premises</u>?   <u>YES</u> NO

    If YES please specify by ticking box(es) below and give details:

  Other University premises   ☒ Please specify where Metanoia Institute, London;

                                        University of Nottingham; York St John University; UCLan

  School/Educational premises   ☐ Please specify where _____

  Hospital/Clinic   ☐ Please specify where _____

Company/Business ☐ Please specify where _____

Prison/Offenders institution ☐ Please specify where _____

Social/bar premises ☐ Please specify where _____

Private houses/flats etc. ☐ Please specify where _____

Other premises ☐ Please specify where _____

Will the researcher conduct research in other <u>places</u>? YES <u>NO</u>

If YES please specify by ticking box(es) below and give details

Camps/playgrounds ☐ Please specify where _____

Sports facilities ☐ Please specify where _____

Public spaces/malls ☐ Please specify where _____

Streets ☐ Please specify where _____

Other ☐ Please specify where _____

Might the participants pose any risk to the researcher? YES <u>NO</u>
If YES please give details of the potential risk:
Where necessary, please describe below the measures that have been put in place to ensure the safety of the researcher. Please refer to the Safety Services web pages for examples of appropriate measures.

Please note. Undergraduate researchers must **never** work alone in the following environments: participants' homes, social/bar premises, or any other environment that may pose a risk to the experimenter.

Researchers should tick the following boxes and sign below (an electronic signature is fine)**:**

☒ I have read the information from Safety Services.

☒ I have fully considered any potential risks that the proposed research might have.

☒ I will inform my line manager or supervisor immediately should the research alter in such a way that the level of risk becomes greater than stated above.

☒ If, at any time, I am concerned about the risks entailed in my research I will stop the research and discuss my concerns with my line manager or supervisor.

Signed   **Student:**   **Date:**

Student applicants should also ask their supervisors to tick the following boxes and sign below:

☐ I have read the information from Safety Services.

☐ I have discussed any potential risks with the student.

☐ I am satisfied that measures outlined above are the most appropriate ones to minimise risk to the researcher.

Signed   **Supervisor:**   **Date:**

Please submit this form alongside your application for ethical approval in Section F of the online form: Supporting documentation

Participant Invitation Letter

Dear (Name),

The Perceptions of PCET Trainers and Supervisors

I am carrying out this study as part of my BACP funded PhD research into 'The role of competences in Person Centred Experiential Therapy and their impact on the effectiveness of counsellors'. I aim to expand on existing research on the experiences and perceptions of PCET trainees by capturing the experiences of trainers and supervisors, and so building a picture of PCET training from the points of view of all those involved. As a member of the small workforce of PCET trainers, your participation will be invaluable.

You are invited to take part in a face to face interview, lasting no more than an hour, at a time and place convenient to you. The interview will be semi-structured, based on a topic guide, around your experience of the PCET competences, IAPT services, and training issues.

Your responses will be kept confidential, and anonymity will be preserved by assigning codes to respondents, in order to protect personal information.

My hope is also to organise an event where trainers from all the PCET training institutions can meet together, to facilitate a group discussion around the same questions, and to identify areas of agreement and difference between the courses.

Should it be possible to write up the results of this work as an article for publication in advance of completing the PhD research, I would welcome your collaboration.

I attach an information sheet and two consent forms for your signature, one to be kept by you, and one to be returned to me to be kept with project notes.

 With thanks and best wishes,

Rinda Haake

mjhaake1@sheffield.ac.uk

Participant Information Sheet

The Perceptions of Person Centred Experiential Therapy (PCET) Trainers and Supervisors

Aims of the study

This study aims to capture the experiences and views of Person Centred Experiential Therapy (PCET) trainers and supervisors, in order to gain a better understanding of the benefits and challenges of a model of therapy that is relatively new, and yet is being widely used with patients within the NHS.

Why have I been invited?

As one of a small number of trainers and supervisors in the PCET model you have considerable influence on counsellors working within IAPT, and therefore on the clients of IAPT counsellors. It is important to gain an understanding of your experiences as a vital element in the roll-out of PCET within the NHS.

Is participation voluntary?

Participation in the study is voluntary, and you will be free to withdraw at any stage by contacting the researcher or the research supervisor (details below). Once the results have been written up and pseudonymised, however, and in the event of data being used for future research, it will not be possible to remove your data.

What will participating involve?

You will be invited to meet the researcher at a time and place convenient to you, where you will feel comfortable to speak freely and expect no interruptions. The interview is expected to take no longer than an hour, and is based on a number of questions focused on your experience of delivering training in the PCET model. The interview will be recorded, and later transcribed either by the researcher, or by a professional transcriber. Any excerpts later used in analysis will be pseudonymised, and any identifying information removed.

You will also be invited to participate in a group discussion with trainers from other training institutions, organised and facilitated by the researcher. This discussion will also be recorded and transcribed for later analysis.

What are the benefits of taking part?

This will be an opportunity to share experiences and express views with colleagues and the wider IAPT and counselling community, and to influence the training and practice of PCET in the future, as the intention is to seek to publish the results of this study. In the event of this research being published, you will be invited to participate as a named contributor.

There is no reimbursement for taking part in the study.

Confidentiality

All recordings will be transferred to an encrypted memory stick, and then deleted from the recording device. The only access to recordings will be by the researcher and transcriber. Following transcription, recordings will be destroyed. Transcripts will be kept on an encrypted memory stick, which will be kept securely at the University of Sheffield, and destroyed as early as possible following their use for quality control and potential subsequent research. Consent will be sought from you for

further research using your data. Transcripts will be pseudonymised, and any identifying information removed from excerpts later used in analysis.

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (General Data Protection Regulation, Article 6(1)(e)). Further information can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general.
The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

What will happen to the results of the study?

The study will be written up as part of a BACP funded PhD thesis investigating the role of competences in Person Centred Experiential Therapy, and their impact on the effectiveness of counsellors. The results of the study will also be written up as an article for publication.

Ethics

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Psychology Department.

Problems and complaints

If there is a problem at any time, please the get in touch with the researcher using the contact details below.

If you wish to make a complaint about the way the study has been carried out, please contact one of the research supervisors whose contact details are also found below.

Should you feel that your complaint has not been handled to your satisfaction, you can contact the Head of Psychology, Professor Glenn Waller, at g.waller@sheffield.ac.uk.

Thank you for reading this information sheet and for considering taking part in this research.

Contact information

Rinda Haake	Prof. Michael Barkham	Prof. Gillian Hardy
University of Sheffield	University of Sheffield	University of Sheffield
Department of Psychology	Department of Psychology	Department of Psychology
Cathedral Court	Cathedral Court	Cathedral Court
1 Vicar Lane	1 Vicar Lane	1 Vicar Lane
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Consent Form v.3

The Perceptions of Person Centred Experiential Counselling for Depression (PCE-CfD) Stakeholders

Please tick the appropriate boxes	Yes	No
Taking Part in the Project		
I have read and understood the project information sheet dated 10/3/20 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. I understand that taking part in the project will include participating in a semi-structured interview, which will be audio-recorded and transcribed.	☐	☐
I understand that my taking part is voluntary and that I can withdraw from the study at any time up until the point where the data I provide is pseudonymised; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	☐	☐
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

Name of participant [printed]   Signature   Date

Name of Researcher [printed]   Signature   Date

Contact details for further information, or in the case of complaint:

Rinda Haake	Prof. Michael Barkham	Prof. Gillian Hardy
University of Sheffield	University of Sheffield	University of Sheffield
Department of Psychology	Department of Psychology	Department of Psychology
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Should you feel that your complaint has not been handled to your satisfaction, you can contact the Head of Psychology, Professor Glenn Waller, at g.waller@sheffield.ac.uk

Interview Schedule v.6

Trainers   (Probes in blue)

Introduction

- Tell me a bit about your career. How did you get into PCE-CfD training?
- Can you tell me how many PCE-CfD courses you have delivered?
- Do you find that PCE-CfD training is different to your other training work? In what ways?

Differences (organisational)

- How do you find the PCE-CfD training and assessment fits in with your other university work?
  (For example, do you have competing priorities in terms of time? Do you have competing priorities in terms of funding?)
- Do you find that you have adapted the PCE-CfD curriculum over the years that you have been delivering this training?
  (Could you give me an example?)
- (As another example, have you added any suggestions to the reading list?)

Differences (model)

- PCE-CfD was developed as an integration of person-centred principles with emotion theory and focused interventions from EFT. Can you describe your understanding of the model?
- The provisional title of my research is 'The role of competences in Person-Centred Experiential Therapy and their impact on the effectiveness of counsellors'. Could you say something about how you feel the model impacts the effectiveness of counsellors?
- As you see it, are there pros and cons of the model?

Industrialisation

- As I'm sure you're aware, there are controversies around the PCE-CfD model, and around the place of counselling within IAPT in general, including recent articles in Therapy Today and HCPJ. Can you say something about these tensions from your point of view?

Trainees

- It's probably fair to say that the interventions drawn from EFT are new concepts for most trainees. Can you describe your teaching methods for these techniques?
- Can you say something about how you use the PCEPS and Competences Framework in assessing trainees?
  (To me it seems possible to score highly on the PCEPS without employing any active components. What is your view?)
  (Have you ever given full marks for a recording?)
- In your experience, are there particular barriers for trainees learning the model?
  (For example, their original modality?)
- Is there anything you wish could be different in PCE-CfD training?

If there's time

- Are there any other questions that you think I should have asked?
- How would you like to see PCE-CfD develop in the future?
- Some counsellors say they integrate the model with other theories. Do you have a view on that?
- One reason therapists give for integrating theories or techniques from other models is that PCET doesn't seem to be suitable for all clients. Do you have any views on this?
- Who do you believe has the right to define what the model is and is not?
- Do you have any views on the name for this model?

I will be using pseudonyms when I write up the interviews. Is there a name you would like me to use?

ORIGINAL ARTICLE

WILEY

Person- centred experiential therapy: Perceptions of trainers and developers

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Abstract

Background: Top- up training in person- centred experiential therapy (PCET) was developed in 2011 and is offered, through four university centres, to counsellors working in Improving Access to Psychological Therapies (IAPT) services in England. Research into PCET training has now gained more importance, with the implementation of the IAPT Data Set Version 2.0 in September 2020, which requires IAPT services to report on the qualifications of care personnel. Previous research has explored the experiences of PCET trainees, but there is a need to investigate similarities and differences in the views and experiences of other stakeholders in the PCET initiative.

Method: Ten trainers and developers of the model were interviewed, including the full population of those personnel currently delivering the training. The framework method was used in the analysis of transcripts.

Findings: Tensions were identified between the individualism of the person- centred approach and the standardisation expected by IAPT. Participants recognised that manualisation of the PCET model was controversial, but welcomed the coherence of the model and the ability to articulate theory and practice. Practical differences between centres were identified in the delivery of training, raising the question of whether such differences reflect the individualism of the person- centred approach and the flexibility of the model, or reveal a lack of consistency in the understanding and delivery of PCET nationally.

Conclusions: PCET training is an opportunity to improve the consistency of PCET therapists' theoretical understanding and practice, enhancing their status and opportunities for research. Differences between training centres may compromise this consistency.

KEYWORDS

counselling for depression, IAPT, person- centred experiential therapy, training

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397

1 | INTRODUCTION

The Improving Access to Psychological Therapies (IAPT) programme was rolled out nationally in late 2008 to increase the availability of talking therapies in primary care for common mental health problems, particularly anxiety and depression. The plan was to expand capacity by building on an existing workforce and re- training therapists where necessary to meet specified, evidence- based competencies, and to train a new workforce of low- and high- intensity practitioners (Turpin et al., 2009). While only cognitive behavioural therapy (CBT) was initially offered, from 2011, 5- day 'top-up' training courses in other high- intensity therapies were rolled out for therapists from the pre- IAPT workforce.

For therapists working in the humanistic tradition, which includes person- centred therapy (PCT), the training offered is person- centred experiential therapy (PCET), known at the time as Counselling for Depression (CfD). The model is also known as PCE- CfD, to avoid confusion in IAPT services (Murphy, 2019). PCET is an integration of person- centred therapy with emotion theory and process- guiding components derived from emotion- focused therapy (EFT; Elliott et al., 2004). This approach was informed by evidence for the effectiveness of counselling from randomised controlled trials (RCTs) cited in the NICE Guideline for Depression (National Institute for Health & Clinical Excellence, 2009; Sanders & Hill, 2014). Of the five RCTs cited by NICE, three were trials of EFT, including two showing PCT with the addition of experiential process- guiding interventions to be more effective in reducing depression than PCT alone (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003).

According to participants in the current study, over 1,000 therapists have undertaken PCET training since 2011. Although PCET is the second most frequently delivered form of high- intensity therapy in IAPT after CBT, PCET therapists constituted only 6% of the IAPT high- intensity workforce in 2015, while non- IAPT- trained counsellors constituted 11% (NHS England, 2016). In 2018– 2019, CfD, delivered by both PCET- qualified and non- PCET- qualified IAPT counsellors, achieved a recovery rate of 49.3%, compared with

48.0% for CBT (NHS Digital, 2019).

PCET training involves five days of face- to- face teaching and experiential learning. The curriculum is based on the Counselling for Depression Competence Framework developed by the Centre for

Outcomes Research and Effectiveness (CORE) at University College London (Hill, 2010, 2011). This is followed by 80 hr of supervised practice within the trainee's usual client work. Up to six session recordings can be submitted to the trainers for assessment, of which four must be assessed as adherent to successfully complete the training. Adherence to the model is assessed according to the Person- Centred Experiential Psychotherapy Scale (Freire et al., 2014).

An evaluation of the first phase of CfD training was conducted by the developers of the model and the curriculum, and those who delivered the first three training courses (Pearce et al., 2013). The evaluation comprised questionnaires, followed by telephone interviews with six trainees, two from each course. Results suggested that trainees viewed the Competence Framework and the adherence scale as helpful, being 'descriptive rather than prescriptive', and they hoped that completing the training would enhance their status and job security within IAPT. Sixty per cent of respondents said that the training had changed their practice, but did not necessarily make them more adherent to the CfD model. The authors noted that anxiety around submitting recordings for

assessment was understandable, especially since a number of trainees struggled to meet adherence. Participants felt that the input on EFT was insufficient, and supervisors were not familiar enough with CfD. They also found that IAPT services often did not permit them to offer the maximum of 20 sessions.

A further report investigating the experience of CfD trainees also used a questionnaire and follow- up interviews, with a sample drawn from the British Association for Counselling and Psychotherapy (BACP) CfD Practice Research Network (PRN) (Drewitt et al., 2018). Similar results were obtained: participants were positive about the model and the 5- day training but felt there was a lack of support and understanding from IAPT services during the period of assessed practice. Participants stated that their initial hope that the training would enhance the status of counselling in their IAPT services was not fulfilled. A limitation of this study was that, in being PRN members, the participants had already demonstrated interest in the PCET model.

Nye et al. (2019) addressed this limitation by investigating the experiences of therapists from one IAPT service who were required to undertake PCET training in- house, thereby reducing the level of personal motivation. By asking participants about their previous theoretical orientation, and whether they had completed or dropped out of the training or training was ongoing, the authors were able to investigate whether differences in orientation contribute to success in PCET training. They concluded that theoretical orientation and choice play less of a role in completion than intrapersonal characteristics such as flexibility and resilience.

Taken as a whole, this research utilising practitioners' perspectives found that over the six years covered by these studies very little changed for trainees, especially with regard to the status and understanding of counselling within IAPT services. The PCET training programme continues to offer IAPT- approved training to all humanistic IAPT counsellors, and supports the expansion of the workforce required by the NHS Mental Health Implementation Plan 2019/20– 2023/24. There is an increased emphasis on training in the light of the implementation of the IAPT Data Set Version 2.0 in September 2020, which requires IAPT services to report on the qualifications of care personnel. Yet despite the importance of the PCET initiative and training, while the experiences of PCET trainees have been studied, there is to date no research investigating the experiences and views of trainers and developers of the model, or consistency between training courses.

To address this evidence gap, we present data from the perspective of the people who developed the PCET model and the national trainers who have delivered the training since 2011. We ask whether the original aims of the training as set out by Pearce et al. (2012) are being delivered consistently, in line with the aspiration 'to train counsellors in the CfD competences [and] to ensure the link [is] made between counselling practice and evidence of effectiveness' (p.20). In order to explore the issue of consistency between training centres, which might affect the robustness of the link between evidence of effectiveness and counselling practice, we focused on the context for the training, on potential differences between the participants in their understanding of the PCET model, and between the four training centres in their delivery of training and assessment. We interviewed all national PCET trainers and two stakeholders from the BACP who developed the model, and authors of both editions of the PCET textbook.

2 | METHOD

2.1 | Design and setting

The design comprises a qualitative study, involving all trainers currently delivering PCET training nationally, based in four universities covering the whole of England. Trainers were interviewed face-to- face at their place of work, between May and July 2019, by RH. Participants were interviewed individually, apart from two from one training centre, who were interviewed together. Two stakeholders employed by the BACP to develop and roll out the Competence Framework and PCET training were also interviewed by RH, one by telephone in October 2018 and one by videoconference in March 2020.

2.2 | Ethics

Ethical approval for this study was granted by the University of Sheffield ethics review panel, Application Reference Number 026096.

2.3 | Participants and roles

Of the ten participants, two were employed by BACP in 2010/11, when IAPT called for training to be developed in various non- CBT modalities. One of these had been a member of the Expert Reference Group that developed the Humanistic Competence Framework for Skills for Health (Roth et al., 2009) and subsequently designed the Counselling for Depression Competence Framework (Hill, 2010), as well as being a co- author of the first edition of the PCET textbook (Sanders & Hill, 2014). The other is still involved in the accreditation of PCET courses. Two participants were members of the team who developed the curriculum for the 5- day training, and a programme for assessment and qualification (Hill, 2011; Pearce et al., 2012). They later trained the trainers and are currently trainers themselves. Five other participants are currently trainers, and one participant has been a trainer in the past and is still closely involved in the PCE- CfD project, including writing the second edition of the textbook (Murphy, 2019). All participants consented for quotes from their interviews to be reproduced, and quotes have been anonymised.

2.4 | Materials

A schedule was used to guide interviews, based on the following topics:

1. Context
1.1 Participant's original orientation
1.2 Workload
1.3 IAPT
2. Model
2.1 Integration of person- centred therapy and EFT

400

3. Training

3.1 Adaptation of the curriculum

3.2 Use of PCEPS

3.3 Barriers to learning

Follow- up probes were suggested to aid in the further exploration of themes (Appendix S1).

2.5 | Procedure

Written consent was obtained from all participants to conduct, record and transcribe interviews. Interviews were between 50 min and one hour and 38 min long. They were transcribed by RH and anonymised, and an encrypted version of their own transcribed interview was emailed to each participant, giving them the opportunity to amend or redact any part. Transcripts were then uploaded to QSR International's NVivo 12 for analysis (Nvivo qualitative data analysis software, 2018).

2.6 | Framework analysis

Data were subjected to framework analysis (Ritchie & Spencer, 2002), which is a pragmatic method for analysing qualitative data in the field of public policy. This method was selected because the systematic charting of themes across cases allows transparency, with each participant's contribution being visible within each theme, and within the context of their contribution as a whole. Issues of generalisability do not arise as the whole target population of trainers is represented.

Framework analysis involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 1994). The identification of a thematic framework began with the a priori themes outlined in the interview schedule. Themes were also identified inductively, beginning at the familiarisation stage, and continuing with a process of reading each transcript and noting where participants' ideas seemed to group together, revealing similarities and differences (Gale et al., 2013). Potential themes were clarified and defined by combing through all the transcripts multiple times. This resulted in an index of themes, with subject headings and subcategories. The index was then applied systematically to each transcript through the QSR International's NVivo 12 coding facility.

The charting stage was achieved by creating a framework matrix, enabling comparisons to be made between participants' contributions for each of the identified themes, and facilitating a process of defining concepts as described by the participants, mapping the range of participants' views and developing new ideas based on these insights. A link to this matrix in Excel can be found here (Supporting Information).

2.7 | Trustworthiness

In order to ensure the integrity of the analysis, the lead author, who is a practitioner– researcher, wrote her own responses to the interview topics, which are available alongside the responses of the participants (Bolam et al., 2003).

The trustworthiness of the interview transcripts was firstly established by sending each one back to the interviewee via encrypted email, giving participants the opportunity to amend or redact any part, and thus providing a form of member checking for their validity (Brinkmann & Kvale, 2015). A further validation stage was included, called synthesised member checking (SMC; Birt et al., 2016), where the themes that had been developed were submitted to participants to confirm that they had resonance, and to invite additional comments (Appendix S2). The study conforms to the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research, and recommendations for publishing qualitative research (Elliott et al., 1999).

3 | RESULTS

Three themes were identified, with nine subthemes, as shown in Table 1. Every theme is referred to by at least eight of the ten participants. Precise numbers of participants commenting within each theme have not been stated. Such numbers would be misleading, since not all participants expressed views within every theme.

3.1 | Individualism

The responses of participants highlighted several areas where individualism can result in tensions, or a lack of coherence. For example, the valuing of individualism in initial person- centred counselling training can result in diverse, even idiosyncratic understanding of the model. Likewise, the acceptance and apparent valuing of diversity in therapy by the professional body presented tensions for some participants. Participants' moral and philosophical values were **TABLE 1** Emergent themes and subthemes

Themes	Subthemes
Individualism	Values
	Training
	Organisational context
Standardisation	Service delivery
	Manualisation
	Adherence
Coherence	Articulating the model
	Flexibility
	Effectiveness

sometimes challenged in the course of training and working with IAPT.

3.1.1 | Values

Some of the participants in this study found that the medical model of IAPT and the NHS clashes with the ontology, values and principles of the person- centred tradition. One of the participants recognised that this caused resistance from some people from the very beginning of the PCET project:

a lot of Person- Centred people would rather avoid working in the NHS, because they don't agree with the sort of scientific, evidence- based, medical- model type approach.

(P1)

The trainers from one centre particularly struggled with the compromises needed to work in a person- centred way in a health service:

I'm not even sure that I, you know, I think about Person- Centred therapy as a form of health practice. … Because in our systems, health and mental health really are aligned much more with mental illness, pathology, dysfunction, diagnosis. And that [PCET] as an approach, we're based in a different paradigm, which is about growth, and human development and human potential.

(P7)

Other participants saw PCET as a welcome opportunity to preserve the person- centred values, and to offer a non- medical alternative within the NHS:

one [trainee] said "You know, when I - I was Person- Centred trained, and then I joined IAPT. And I was kidnapped." They used this term, "I was kidnapped. And doing this training, and just doing this check- in, it's as though I've been released to come back to where, and what feels right about why we do the work that we do." And I thought it was such a powerful thing to say, when it was quite small.

(P10)

3.1.2 | Training

Nearly all the participants commented that many trainees who identified themselves as person- centred were disadvantaged by having no 'clear, theoretical underpinning' (P2).

the kind of understanding of Person- Centred is often quite narrow, and quite shallow.

(P6)

One participant, in the initial interview, and again through the synthesised member checking, described their dismay when listening to practice recordings that trainees claimed to be person- centred:

I listen to their work, and actually it's quite sort of problem- solving. Quite cognitive and problem- solving. And sometimes avoids emotion.

(P10)

therapy sessions reflected the relatively superficial, almost conversational, approach.

(P10, from SMC)

Participants attributed this to drift, to being immersed in the CBT- influenced culture of IAPT, or 'the IAPT effect' (P3), and also to trainees' original training courses. Participants believed that some courses were of low- quality:

> they'd be training people in their own personal philosophy, along with a bit of, you know, a bit of philosophy taken from other people. … I'm exaggerating now, but they could be like little cults, where strong personalities would lead the training programme.

(P1)

Integrative trainings were also considered problematic by some trainers:

> they're always called integrative, but really what they're talking about is eclectic, there's no integration.

(P6)

Participants observed that counsellors often had a 'toolbox approach' (P5) to continuing professional development (CPD), which was inconsistent with the person- centred approach. Some trainers indicated that this might reflect counsellors' own doubts about the effectiveness of PCT:

> there's a real feeling amongst a lot of people that you can't work in a person- centred way in a time- limited frame … and therefore you have to incorporate other things in.

(P4)

3.1.3 | Organisational context

The interviews revealed a lack of consistency in the conditions under which participants worked and delivered PCET training in the institutions that employed them. There were also different attitudes among the participants to BACP's accommodation of diverse philosophies and therapeutic models. Responses reflected a common feeling that the person- centred approach was under- valued in many areas, including the NHS and BACP.

At one training centre, a team of supervisors and assessors had been created, and at a different centre, a trainer was employed specifically to deliver PCET training. Another trainer said:

> Now, I work a 60- hr week, [my colleague] works a 60- hr week, we cannot add anything else in. … Short of not having holidays, we do not have time to put [a different] system in place. I know other institutions do do it. They have their workloads completely differently. We cannot do it.

(P3)

Participants' attitudes to BACP varied from appreciation to feelings of being neglected or misunderstood:

> BACP are a broad membership body with therapists of differing orientations … umbrella organisations have to make compromises and hold competing assumptions and practices with equal respect.

404

(P9 from SMC)

> So I don't think we're in the right home. And I don't know what the home is for PCE- CfD. I don't know where it resides. Because it's certainly not being championed by BACP.

<p align="right">(P5)</p>

3.2 | Standardisation

Against this background and history of individualism and diversity in the person- centred tradition, including person- centred training courses and counselling institutions, the participants observed that the advent of IAPT has brought an expectation of standardisation.

They observed that PCET therapists working within IAPT are expected to meet IAPT rules and targets, and to adhere to the PCET manual when delivering therapy. Participants also reflected on the trainers' adherence to the PCET curriculum.

3.2.1 | Service delivery

Participants identified disadvantages for person- centred therapists working in IAPT, including examples of inequality in pay, sometimes zero- hours contracts or payment by results. Where a service had lone counsellors, or very small numbers, there was no opportunity for mutual support, and often, modality- specific supervision was unavailable.

Participants also observed that there are various ways in which processes in IAPT conflict with person- centred philosophy. Trainers reflected the experience of some trainees that case managers expected clients' scores on outcome measures to improve consistently, which is unlikely to fit with a counselling process:

> it was like, "Well, if the scores are going up and down, that's not a very good sign, is it?" You know, people should be approaching, you know, kind of health, in a consistent way or something. … So there's something about the lack of understanding of the principles that underpin it. And the fact that the system is slightly out of sync, or the system of measuring or gauging how effective something is doesn't fit with those principles.

(P8)

The participants pointed out that the outcome measures comprising the Minimum Data Set themselves represent the medical model, being 'symptom removal forms' (P9).

Some trainers had the experience of counsellors being expected to complete multiple IAPT-approved top- up trainings:

> I can think of a commissioner who wanted to send somebody who hadn't got a humanistic training [background], but "I need her to do this training, because all of the counsellors have got to be able to work in all of the modalities".

(P4)

Disadvantages for person- centred counsellors within IAPT also became barriers for trainees undertaking their 80 supervised practice hours. One problem is that although during training trainees receive specialist PCET supervision, there is often no modality- specific supervision in their services, meaning that therapists may drift from the model:

> how will the fidelity of the model be maintained, if you haven't got a supervisor that understands what you're doing?

(P2)

The other problem recognised by trainers as a barrier to trainees' learning is when services put a limit on the number of sessions they are allowed to offer clients. PCET is designed to be offered in up to 20 sessions, but some trainees were told that, even during training, they could only offer six:

> They're trying to manage a waiting list by arbitrarily putting a number on it.

(P9)

Although IAPT is seen as imposing standardised practices nationally, participants observed that there are still many inconsistencies:

> I think it makes something of a mockery about this idea that IAPT was supposed to provide a level playing field from John O'Groats to Land's End in terms of treatment choice, non- variability of options for care and therapy. It's just not the case.

> (P10)

3.2.2 | Manualisation

The Counselling for Depression Competence Framework (Hill, 2010) was originally understood as a manual for PCET, and as being descriptive rather than prescriptive:

> the idea is that you start off with research of effectiveness, and then you try and draw from the research studies' descriptions of practice which you can then train people in.

(P1)

The Person- Centred Experiential Psychotherapy Scale (PCEPS), an adherence measure for PCET therapists, and the two editions of a PCET textbook were also referred to as manuals by some participants. Several participants described the tensions in the person- centred world, and for themselves, around the concept of a manualised model of therapy:

> it's being vilified. It's been described as a manual. … You know, as manualised therapy. And I don't see the PCEPS as a manual.

(P5)

Many of the trainers recognised the value of a manual:

The antipathy towards the manual is, I think, not well- grounded. To be taken as credible we have to have a model which is generalisable, albeit broadly. This does not mean that the manual is treated slavishly, nor is it an a + b = c either.

<div align="right">(P10, from SMC)</div>

3.2.3 | Adherence

Some of the participants observed that consistent, adherent practice in the PCET model would facilitate future research:

> if we are going to find out what works in therapy, we're never going to be able to do it unless we know that people are doing what we think they're doing.

<div align="center">(P6)</div>

This trainer also spoke about consistency in terms of the theory of common factors for effectiveness in psychotherapy:

> the common factors (inaudible), it seems to suggest that the coherence of practitioners' approaches matters. … To be able to explain what you're doing. … I guess it gives confidence if the practitioner knows what they're doing.

<div align="center">(P6)</div>

The interviews suggest that there are differences between the training centres in their interpretation of some items of the PCEPS, and in their rating schemes, and therefore in the standards they expect of trainees. One trainer acknowledged how rating can be subjective:

> it feels like it's a very subjective process, that is supposed to be objective.

<div align="center">(P4)</div>

A clear difference between centres emerged on the question of whether it is possible to achieve full marks on the PCEPS. Trainers from two centres expressed the view that it is very rare to award full marks to students in any context. A trainer from another centre was clear that they have awarded full marks, whereas at a third centre, the view was:

> We've given people 56/57, but for me, if you, if you are tracking somebody at a 6, and then you use some of the process- guiding elements, you've got to sacrifice some of the tracking. … Because you're not totally within their frame of reference. You're pulling something in from outside, maybe, of their, or, or on the edge of their frame of reference.

<div align="center">(P3)</div>

Such discrepancies were not seen as problematic by one participant, but a reflection of the flexibility of the model:

Does there need to be some sort of moderation? (Pause). I'm not sure actually. I'm not sure, because I think, I think there's risks in trying to define something too rigidly, and trying to put too tight a set of constraints around what something might be.

(P7)

There was agreement between trainers from several centres that trainees are more likely to drop out during the assessment stage of the training than fail to qualify.

The interviews revealed that adherence is also relevant for the trainers themselves, who deliver PCET training according to a standard curriculum. At one centre, trainers' workloads affected their ability to offer time outside the 5- day training. Another centre incorporated two extra days of training some weeks after the initial five days, to provide 'some theoretical shoring up' (P10). This centre had also introduced a system of providing audio feedback on trainees' recordings, to be more 'experience- near'.

It was acknowledged that some elements of the original curriculum had become 'obsolete' (P2), and therefore:

we've re- jigged it. And everybody's re- jigged it differently.

(P3)

Trainers delivered the curriculum more or less strictly, according to their own understanding of the model. For example, one trainer said that, in order to be consistent with the person- centred approach, the course was 'facilitated' rather than taught:

It's not taught modules in our - You know, things come through, things come up.

(P5)

3.3 | Coherence

The experience of the participants expressed in the interviews is that PCET training provides a new coherence for person- centred therapists working in IAPT, fostering greater confidence and consistency in practice, an increased sense of belonging, and creating possibilities for future research. Participants saw the model as flexible and effective. A new, clear articulation of the model was seen as an important element contributing to understanding and confidence for counsellors.

3.3.1 | Articulating the model

Participants observed that trainees' original training courses sometimes did not give them the theoretical foundation to describe their work. They believed that training in the PCET model, and emotion theory, provided language for therapists to understand the theory, and to communicate the model to colleagues from other disciplines:

I don't think they were adequately able to describe what they were doing and how they were doing it, and how it might work and benefit clients. And this gave them the language to do that.

(P2)

For some participants personally, the way the model enabled them to articulate humanistic principles was very positive:

> it's enabled me to name elements of my practice. So it's been a personal, um, joy, really.

(P3)

Participants from different training centres highlighted different aspects of the model. At one centre, the person- centred ontological foundation of the model, and therefore non- directivity, was emphasised:

> And for me in the ontology of the approach. Just, you know, trusting the client's direction. Not believing that it's worthwhile following my direction, or maintaining my direction. I don't think it's worthwhile, I don't think it's meaningful. It doesn't fit really with what the, with my understanding of the person, from the Person- Centred Experiential perspective. So that will always take precedence.

(P6)

At another centre, the process- guiding element of the model was given more emphasis:

> it's a dance between being directive and non- directive. And if all you do is follow the client, you can be ineffective, but if all you do is lead them you disempower them.

(P4)

These views reflect participants' varying views about whether PCET should be seen as a contemporary, integrative humanistic model, or as no different to person- centred therapy. Three participants used the term 'contemporary' to describe it, for example:

> a sort of contemporary, dialogic sort of Person- Centred frame, which, you know, the sort of focusing experiential arm leads towards.

(P9)

One centre understood the model as humanistic:

> these are Humanistic competencies, or Humanistic philosophies, or Humanistic principles, not just
>
> Person- Centred

(P4)

whereas participants from another training centre saw no differ-
ence between PCET and classical person- centred practice:

> the attentiveness to the emotion, listening to the emotion, engaging with the feelings. … Which I just still think is the Person- Centred Approach (laughs). I don't see it as any, I don't see it as any different!

3.3.2 | Flexibility

Participants observed that the flexibility of the model allows therapists to adapt practice in their own style, as well as adapting to the needs of the client:

> I do feel one of the things we offer on the five days is a space where you, students can go "What makes sense to me?" And we overtly say that. "What makes sense to you? What of this framework do you feel fits? Where might you need to
>
> adapt if - ?"

(P3)

They described the model as non- directive, client- led, moment- by- moment and creative work, with the theoretical underpinning ensuring coherence:

> what I'm doing is working at the edge of experience of the client. And so, if I'm there, I trust in that process. That's what I really trust in. And so, what comes from that, then sometimes you don't have to direct, sometimes you do.

(P10)

The participants' view was that, although the model was originally named Counselling for Depression, therapy is matched to the client's needs, rather than a diagnosis:

> even though the client is coming with a diagnosis, the counsellor doesn't need to diagnose them. And that the counsellor themselves, they don't need to do anything specific based on the diagnostic label that the client is bringing to them. And our theory demonstrates that that's the case.

(P7)

3.3.3 | Effectiveness

One of the reasons given by several participants for the importance of coherence in theory and practice was the connection with the evidence for effectiveness, acknowledging that the status of humanistic therapy within IAPT depends upon this evidence:

> it's kind of the prestige and the status and the value is still given to specific 'techniques', even though they're not the things that are getting the evidence- base.

(P6)

The model was developed on the foundation of empirical evidence:

the whole idea was to… build a workforce who could be properly trained, training would be approved by IAPT, and who would be delivering, hopefully, evidence- based versions of their therapy, which had been tested in trials.

(P1)

Two participants commented that research into person- centred therapy up to now has been difficult, because:

with the integration and eclecticism that's out there, we have no idea what people are doing.

(P6)

They believed that having a workforce of therapists consistently delivering this well- defined model could contribute to further evidence of effectiveness:

it feels quite good that people need to be licenced so that we can actually, you know, be collecting relevant research about its efficacy, and so on, rather than clumping it all together under the title of counselling.

(P8)

Another participant reflected that, although evidence from trials of EFT had contributed significantly to the development of the PCET model, important components of EFT had been left out:

one of the things that never actually happened in the original manual was that they did bring those things from EFT…. that was a bit of a fudge, really, wasn't it?

(P7)

Some participants commented on their own and trainees' experience of PCET being effective with clients in their own practice:

I think the thing that really comes through is that if they've really got it, and they work well with the clients, they just are thrilled … to see the impact.

(P8)

4 | DISCUSSION

The interviews conducted for this study capture the experiences of PCET trainers and developers of the model over the nine years of the PCET programme. They confirm the findings of Pearce et al. (2013) and Drewitt et al. (2018) around trainees' difficulties in adjusting to a new model, and a perceived lack of support from employing IAPT services. They also extend previous research by revealing important similarities and differences between training centres in the participants' views about the PCET model and training. The overarching themes of individualism and standardisation reflect various sources of tension around person- centred experiential therapy and the place of PCET therapists within the NHS. The overarching theme of coherence offers the hope that these tensions can be resolved.

One practical source of tension agreed by all the participants was the lack of support for trainees, or even obstacles to success, offered by IAPT services. Examples given were inappropriate supervision, and a limit on the number of client sessions allowed. Another tension emerged around values, in participants' reflections that people who adhere to a classical person- centred approach are resistant to the compromises needed for person- centred therapy to fit with a perceived medical model for delivery in the NHS, and the standardisation implied by a manual. At the same time, they observed that some of the trainees they worked with did not believe that person- centred therapy is evidence- based or effective enough to be offered as a specific modality, and therefore integrated it or supplemented it with other techniques. The interviews also confirmed previous research, which identified gaps in counsellors' original person- centred training (Pearce et al., 2012). While a 2010 survey of BACP members revealed that 72% identified as having trained in person- centred or humanistic therapy (Sanders & Hill, 2014), the experience of the participants in this study suggests that the clinical practice of some counsellors could not be described as adherent to person- centred principles.

Against this background, the participants unanimously welcomed the PCET model and training as an opportunity to strengthen, or even restore, the theoretical coherence of therapists' practice. The Competence Framework and the PCEPS, whether described as a manual or not, were seen as providing a language to clarify the trainees' understanding of the model and to communicate with colleagues from other modalities. The participants witnessed the growth in trainees' confidence in the model and in their practice.

Despite this unanimity, the differences revealed by the interviews suggest that, in some important ways, trainees' experiences may vary between training centres. On a practical level, the working conditions provided by the trainers' host universities, in terms of time and personnel, mean that not all have the capacity to offer extra support to trainees, such as regular follow- up training days.

On a philosophical level, the individualism of participants from different training centres was demonstrated in their diverging views about the definition of PCET, and in their approach to the training. Those who viewed PCET as exactly the same as person- centred therapy (PCT) considered that PCT is already an experiential model and did not seem to see process- guiding as a new skill for trainees. Those who viewed PCET as a contemporary form of PCT, or principally as a humanistic model, placed more emphasis on process- guiding, and therapists being active in therapy sessions. These differences were reflected in the criteria that trainers applied in assessing recordings, according to their interpretation of the PCEPS, and the importance they gave to active process- guiding.

Such differences raise questions about the consistency of the trainers' approach to the model. While participants stated that flexibility is an important aspect of PCET, it is unclear where the boundary lies between valuable flexibility and unhelpful inconsistency. Lack of consistency between the training centres may have consequences for the original aim of linking evidence of effectiveness with training and ultimately with offering evidence- based therapy to clients (Pearce et al., 2012). While several participants noted that, in the past, trainees were more likely to drop out of the training than to fail, this option will no longer be available with the requirement under IAPT Data Set Version 2.0 for all therapists to hold an IAPT- approved qualification.

There may also be consequences for future research. While practice- based evidence confirms that counselling in IAPT is effective in reducing depression (Pybis et al., 2017), further empirical research is needed to assess which aspects of PCET contribute to its effectiveness. There is already

extensive evidence for the effectiveness of the relational elements of therapy (Norcross, 2002), and future research will build on existing evidence for the addition of experiential process- guiding elements (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). Several participants expressed the hope that PCET training would encourage consistent practice to facilitate such research. This hope may be undermined, however, by the apparent inconsistencies among the training centres in their approach to the model, to the delivery of training and to rating adherence.

4.1 | Limitations of the current study

This study captures participants' impressions of trainees' experiences in IAPT, and the participants' own relationships with IAPT services, that they have accumulated over more than nine years, including in undertaking their own research. While synthesised member checking was carried out, the author also shares many of the experiences and perspectives of the participants, and there remains a risk that participants' reports and the analysis are subject to confirmation bias (Nickerson, 1998).

5 | CONCLUSION

The current study has highlighted similarities and differences between the four centres delivering PCET training to IAPT counsellors in England. All the stakeholders interviewed recognised the significance of their role in strengthening the voice and status of humanistic counsellors in IAPT, as the effectiveness of counselling is increasingly recognised, and the counselling workforce grows. The IAPT Data Set v.2.0, implemented since these interviews were conducted, gives even greater importance to PCET training.

The participants agreed that theoretical coherence is vital in understanding and delivering a model of therapy, for the benefit of clients, and in contributing to further evidence of effectiveness. They agreed that a major aspect of their role is to clarify the PCET model for trainees, to ensure that theory and practice are consistent. The question remains whether the inconsistencies among the centres in their understanding of the PCET model, and especially around interpretation of the assessment tool, the PCEPS, translate into variations in the effectiveness of PCET practitioners. Further research is needed into the specific elements of PCET which contribute to its effectiveness, and how best to incorporate the findings into PCET training.

6 | IMPLICATIONS

6.1 | Practice

- More resources are needed for delivering the training, for example extra days being standard rather than optional, which would improve retention and consistency of trainees' practice.
- All the training centres' host universities need to recognise the workload capacity needed to deliver PCET training, beyond the 5- day face- to- face course, in particular listening to recordings, offering feedback and extra support for trainees.

- More support is needed from trainees' employing IAPT services to complete the training, in particular the availability of modality- specific supervision and ability to offer each client up to 20 counselling sessions.

6.2 | Policy

• Consensus is needed between the training centres on interpretation and application of the PCEPS.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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Appendix C

Chapter 4, Systematic Literature Review

Table 4.1C

Reciprocal translation: Experiential Specificity

Study	Theoretical basis	Terms
		Experiential specificity
Eigenhuis et al., 2017	Cognitive	Reduced autobiographical memory specificity (rAMS); Overgeneral memory (OGM); Memory specificity training (MEST); psycho-education; memory retrieval practice; positive and negative memories; spatio-temporal, contextual and sensory perceptual details
Kleijn et al., 2018	Cognitive	Retrieving specific and positive autobiographical memories; coming to terms with memories
Maxwell et al., 2016	Cognitive	Memory specificity and reconsolidation with new information; Over-generalisation of memories; Enrich the memory specificity with visual, spatial and temporal recall
Moradi et al., 2014	Cognitive	Over-general memory as cognitive avoidance of negative affect; Special attention to spatio-temporal, contextual and sensory-perceptual details; Abandon focus on prototypical and generic elements of memories
Serrano et al., 2004	Cognitive	Overgeneral recall; Level of specificity; Effortful; Autobiographical retrieval practice for specific events; Emotional processing of events
Serrano et al., 2012	Cognitive	Over-general memories: categorical or extended
Singer, 2013	Emotion Focused Therapy	Narrative identity; Narrative script; Memory specificity; Meaning-making; Imagery; Metaphor; Emotional handle; Three modes of recollected experience: external, reflexive, internal; Emotionally evocative memories; New information for future experiences

Table 4.1C continued

Reciprocal translation: Experiential Specificity

Study	Theoretical basis	Terms
		Experiential specificity
Watkins et al., 2009	Cognitive	Abstract over-general processing as a cognitive bias; Categoric summaries of repeated events; Decontextualised mental representations; Concreteness training involves sensory focus, mental imagery, recall of specific autobiographical memories, focusing attention on experience, distinctive details
Watkins et al., 2012	Cognitive	Concrete thinking in response to difficulties; Mental imagery focusing on sensory details; Specifics of event and context; Process and sequence of event unfolding; How did it happen? How to move forward?
Watson & Rennie, 1994	Emotion Focused Therapy	Systematic evocative unfolding for problematic reaction; Concrete, vivid, imagistic, evocative language; Vivid recreation of the situation; Re-evoking the experience; Meaning bridge; Symbolising affective reactions accurately in awareness; Agential processes; Articulating clearly external and internal world; Accurate labelling; Visualising a situation and re-experiencing feelings; Problem-solving task; Concretely felt experiencing
Werner-Seidler et al., 2018	Cognitive	Over-general retrieval of autobiographical memory; summary categories of repeated events

Table 4.2C

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Afshari & Hasani, 2020	CBT	Emotion regulation; Mindfulness, Distress tolerance; Interpersonal relationships; Experiencing the present moment non-judgementally

Table 4.2C continued

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Bacon et al., 2018	Theory of constructed emotion	Emotional arousal as a meaningful experience; Emotional reappraisal; Arousal management; Regulating intensity of emotional experience; Window of Tolerance; Emotional awareness 'abilities': acceptance, understanding and tolerance; Mind, body, behaviour; Body grounding; Safe space imagery
Boyle et al., 2017	Mindfulness	Self-kindness; Mindfulness; Reduction of rumination; Increase in self-kindness; Self-compassion; 'Stepping back' and avoiding entrenchment with thoughts; Breath awareness; Gentleness; Attention to the present; Loving Kindness Meditation; Caring, warm and positive feelings for self; 'Dis-identifying' with thoughts; Use of metaphor
Brubacher, 2017	EFT	Co-regulation of emotion; Secure connection; Attachment-based emotion regulation; Safe haven of comfort, secure base for exploration; Deepening underlying emotion; Internal regulation and compassion; Reducing suppression
Bryant et al., 2013	CBT	Emotion tolerance skills (emotional labelling, mindfulness); Breathing retraining; Progressive muscle relaxation; Control of emotional reactions
Bullis 2015	CBT	Willingness to experience emotions and decrease avoidance; Present-focused, non-judgemental emotion awareness; Cognitive appraisal; Interoception; Emotion-focused exposure
Cancian et al., 2019	CBT	Mindfulness; Body sensations; Distress tolerance; Observing, describing and participating in the present moment experience; Letting go of judgements
Carmody et al., 2009	Mindfulness	Mindfulness skills; Self-regulation; Observation of moment-to-moment experience; Acceptance, kindness, compassion, openness, patience, non-striving, equanimity, curiosity and non-evaluation; Reperceiving; Decentering, defusion, distancing; Willingness to remain in contact with unpleasant internal experiences

Table 4.2C continued

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Cloitre et al., 2002	CBT	Reducing fear of experiencing and expressing anger; Reducing difficulty tolerating the interpersonal nature of therapy; Therapeutic alliance; Labelling and identifying feelings; Emotion management; Distress tolerance; Acceptance of feelings
Cloitre et al., 2010	CBT	Identifying and labelling feelings; emotion management; distress tolerance; Acceptance of feelings
Clyne & Blampied, 2004	Psycho-education	Enhancing emotional intelligence; Attending to emotions; Emotional repair; Differentiating between emotional states; Emotion recognition; Attending to physiological changes; Facial expressions; Relaxation; Venting
Esplen et al., 1999	Object relations	Self-soothing; Self-comforting; Maternal primary process presence; Validation of subjective experience; Internalization of soothing representations; Inner sanctuary; Relaxation; Solace; Warmth; Soothing receptivity; Therapist presence
Fosha, 2001	AEDT	Fully experiencing emotions; Dyadic regulation of affect; Emotional communication; Experiencing, expressing and adaptively making use of emotions; Feeling safe to feel; Reducing avoidance; Affective attunement; Modelling
Fresco et al., 2013	CBT	Attentional flexibility; Allowance and acceptance of emotion; Meta-cognitive distancing and decentering; Mindful awareness and understanding of emotion; Interoceptive awareness; Awareness of emotional conflict; Differentiation; Clearing the air; Evocative unfolding; Personal emotional meaning

Table 4.2C continued

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Gilbert & Procter, 2006	CBT/DBT	Reducing shame; Reducing self-criticism; Self-warmth; Self-acceptance; Ability to reveal painful information; Reducing avoidance; Therapeutic ruptures; Soothing or calming the self; Reducing sense of threat, increasing a sense of safeness; Self-compassion; Inner warmth; Positive affect system; Safeness; Self-nurture; Acceptance; Forgiveness; Kindness; Being gentle; Ability to detect and process distress; Sympathy; Empathy; Non-judgement; Self-to-self relating; Normalizing; Exposure; Decentering; Replacing avoidance; Re-evaluating basic beliefs; Breathing to re-focus attention; Imagining the ideal of caring and compassion
Graser et al., 2016	CBT	Moment-to-moment awareness of mental and affective states, physical sensations and perceptions; Feelings of kindness and warmth; Self-compassion; Soothing; Less suppressing affective style; Breathing
Juarascio et al., 2017	'Third wave' CBT	Psychological acceptance; Distress tolerance; Emotion regulation skills; Affective triggers; Willingness to experience distress; Acceptance of experiential distress;
Khakpoor et al., 2019	CBT	Cognitive reappraisal; Preventing emotional avoidance; Interoceptive exposure; Present-focused non-judgemental awareness; Relationship with emotions; Reducing intolerance of uncertainty; Experiential avoidance
Kivity et al., 2020	CBT	Promoting awareness and tolerance of emotions; Reducing suppression of emotions; Awareness of bodily sensations; Information contained in emotions; Decrease in avoidance and fear of emotions; Mindfulness; Breathing; Emotional acceptance; Interoceptive exposure; Experiential flexibility
Koch et al., 2020	CBT	Identifying, labelling and understanding emotions; Distress tolerance; Attentional regulation; Deep breathing; Biofeedback; Experiencing sadness and grief
Mahmoodi et al., 2020	CBT	Emotional awareness; Cognitive reappraisal; Prevention of emotional avoidance; Interoceptive exposure

Table 4.2C continued

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Mennin et al., 2015	CBT	Mindful attending/acceptance; Meta-cognitive regulation; Decentering; Cognitive reappraisal; Emotional intensity; Somatic and emotional cues; Exposure
Mennin et al., 2018	CBT	Mindful attentional, metacognitive emotion regulation; Decentering; Cognitive reappraisal; Exposure
Miles et al., 2016	CBT	Optimal range of emotion regulation; Reducing fear, avoidance and suppression of emotion; Awareness of cognitions, physiological changes and affective experience; Breathing; Muscle relaxation; Changing thoughts; Mindfulness; Grounding; Normalising emotional experiences
Mohsenabadi et al., 2018	CBT	Emotional exposure; Emotion awareness; Cognitive reappraisal; Emotion avoidance; Tolerance of physical sensations; Interoceptive exposure; Expressive suppression
Renna et al., 2018	ERT	Mindful emotion regulation skills; Decentering; Cognitive reappraisal; Exposure; Metacognitive regulation skills; Imaginal exposure; Experiential dialogue
Richards et al., 2016	CBT + Psychodynamic	Reducing difficulty in experiencing and expressing emotions; Reducing avoidance of negative affect; Recognising, accepting and tolerating emotions; Reappraisal; Tolerating uncertainty; Acceptance of feelings; Self-soothing; Support from the therapist
Safer et al., 2010	DBT	Affect regulation; Mindfulness; Distress tolerance; Non-judgemental observation; Describing moment-to-moment emotional experiences
Sauer-Zavala et al., 2020	CBT	Approach-oriented stance toward emotions; Cognitive reappraisal; Non-judgemental awareness; Mindful emotion awareness; Cognitive flexibility; Awareness and tolerance of physical sensations; Emotion exposure

Table 4.2C continued

Reciprocal translation: Emotion Regulation

Study	Theoretical basis	Terms
		Emotion Regulation
Schanche et al., 2020	CBT	Mindfulness; Relating to thoughts, emotions and bodily sensations with mindful awareness; Present-moment experience; Acceptance, openness and non-judgement; Reducing avoidance; Being decentered; Self-compassion and kindness; Self-relatedness; Curiosity, openness and compassion
Telch et al., 2000	DBT	Emotion regulation skills; Distress tolerance skills; Mindfulness; Recognizing and labelling emotional responses; Chain analysis of problem behaviour; Observing emotional experiences, thoughts and action urges; Identifying emotional triggers; Bodily responses; Self-soothing; Acceptance strategies
Telch et al., 2001	DBT	As Telch et al., 2000.
Wright et al., 2020	CBT	Increasing distress tolerance; Acceptance of feelings; Reducing avoidance of feelings; Recognising and labelling emotions; Becoming mindful of emotions; Self-soothing and relaxation

Table 4.3C

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Boterhoven de Haan, 2019	Schema Therapy	Emotion-oriented and experiential techniques; Processing aversive memories; Unmet core emotional needs; Rigidity; Stimulating affect in the session; Imagery; Chair-work; Corrective emotional experiences; Self-compassion; Tolerating affect; Noticing self-critic; Understanding on an emotional level

Table 4.3C continued

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Brennan, 2015	EFT	Self-criticism; Accessing and accepting previously avoided feelings; Identifying unmet needs; Emotions as part of adaptive meaning-making system; Core problems; Chair-work; Dramatising internal conflicts; Self-interruptive split; Blocked part of self; Aversion to emotions; In-the-moment experiencing of emotion; Interacting with emotions; Bodily sensations; Experiencing voice; New way of relating with oneself; Processing emotions; Making automatic reactions conscious; Accessing primary emotions
Bridges, 2006	EFT	Processing of painful emotional conflicts; Accessing, expressing and processing emotions; Corrective emotional experience; Transformation of painful emotional conflicts; Working through conflicts; In-session experiencing and processing; Unresolved emotions; Emotional arousal; Physiological aspects of emotion; Felt sense; Emotional processing: meaningful integration of emotion and cognition; Emotional insight
Coughlin della Selva, 2006	Intensive Short-Term Dynamic Psychotherapy	Emotional processing; Experience and express feelings; Interrupt defensive processes; Facilitate direct experience; Mind-emotion-body connection; Experiencing one's basic emotions; Conscious processing of emotion; Rework unresolved feelings in the here and now; Optimal level of emotional activation; Ability to tolerate feelings; Visceral experience; Resolution of intrapsychic conflicts
Dornelas et al., 2010	Affect-focused therapy (Short-term dynamic therapy)	Conflicted feelings; Restructuring; Exposure to avoided emotion; Tolerating feelings; In vivo experience of emotion; Technique from gestalt; Healthy expression of adaptive emotion; Raising awareness of physiological signs of emotion; Emotional arousal; Eliciting motivation; Building compassion for the self; Ability to self-soothe

Table 4.3C continued

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Friedlander et al., 2012	STDP	Corrective emotional experience; Emotional flexibility; Overcoming resistance to emotional experience and expression; Emotional and intellectual understanding; Facilitating emotional experiencing; Fostering insight; Exploration of affectively charged material; Imaginal exposure; Experience disavowed affect; Resolution of unfinished business; Working through; Metaphors; Vivid images; Imagined dialogue; Emotional attunement; Cognitive and emotional change
Goldman et al., 2006	EFT	Process-guiding interventions; Emotional processing difficulties; Self-criticism; Accessing adaptive emotions; Emotion-focused experiential and gestalt techniques; Resolving affective-cognitive problems; Accessing and restructuring maladaptive emotional states; Transforming emotions; Two-chair dialogue; Unresolved feelings; Focusing; Implicit experience; Systematic Evocative Unfolding
Greenberg & Watson 1998	EFT	Process-directive gestalt and experiential interventions; Cognitive-affective problems; Integrative experiential model; Access and restructure the underlying emotion based schemes; Two-chair dialogues to resolve self-criticism; Empty-chair dialogues to resolve unfinished business; Systematic evocative unfolding to identify and better understand shifts into depression; Experiential responding and focusing; Felt sense; Accessing primary adaptive feelings; Softening of harsh critic; Creating a meaning bridge; Empathic attunement to affect
Grosse Holtforth et al., 2011	General Psychotherapy	Motivational background of unpleasant emotions; Re-evaluating negative primary appraisals; Resolution of motivational conflicts; Two-chair exercises; Emotional activation; Raising of awareness; Verbal expression and change of behaviours, emotions and cognitions

Table 4.3C continued

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Grosse Holtforth et al., 2019	CBT + EFT & Exposure	Emotional processing; Overcoming avoidance of disturbing emotions and experiences; Reducing avoidance, increasing engagement with emotions; Activating and processing entrenched depressive memories and emotions; Imaginal exposure; Two-chair dialogue
Harte et al., 2020	EFT	Focusing; Unclear felt sense; Reprocessing emotional pain; Unresolved painful events; Felt shift; Activation of a felt sense; Bodily felt sensations; Corrective experiences; Internal processing; Accessing internal emotional experiences; Systematic Evocative Unfolding; Imaginal exposure and reprocessing; Unmet needs; Emotional arousal; Moment-by-moment; Processing, restructuring and integrating painful memories; Emotional productivity; Action tendency of primary emotion; Symbolization; Entitlement to having needs met; Staying with the experience; Flow of emotion, arousal and memories
Lafrance Robinson et al., 2014	EFT	Emotion in construction of the self; Emotional intelligence; Experiential exploration; Access and experience adaptive emotion; Transforming emotions; Bodily felt sense; Emotional evocation; Chair-work; Resolution of affective-cognitive problems; Corrective emotional experience; Emotional interrupter; Emotional processing; Moment-by-moment processing; Emotional attunement
Newman et al., 2011	CBT + EFT & IPT	Identification and processing of avoided emotions; Emotional learning; Deepening of affective experience; Emotionally corrective experiences; emotion-focused techniques

Table 4.3C continued

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Paivio & Greenberg 1995	EFT	Accessing emotion for exploration and restructuring; Re-experiencing; Cognitive-affective processing difficulties; "Unfinished business"; Unresolved anger and sadness; Accessing restricted feelings; Changed perceptions of self and other; Active process-directive intervention; Expression of unresolved feelings; Shift to greater understanding; Self-empowerment; Explicit focus on accessing emotion; Accessing emotion memory
Palvarini, 2010	Experiential-dynamic psychotherapy	Corrective emotional experience; Unresolved conflict; Emotional activation; Re-experience emotional incident in the here and now; Activation of conflicting emotions; Reparative, self-soothing feelings; Guided visual imagination; Maladaptive emotional experience of shame
Shahar et al., 2012	EFT	Emotion-focused intervention; Two-chair dialogue; Self-criticism; Self-compassion; Expression of unresolved feelings; Processing, transforming and resolving feelings; Conflict split; Healthy needs; Experiencing self; Empathic guidance; Needs of each part; Intrapsychic transactions; Integration of the self; Enacting and experiencing; Adaptive and authentic needs; Visceral experience; Internal dialogue between self-aspects
Shahar, 2014	EFT	Improving emotional awareness; Reducing experiential avoidance; Activation and transformation of shame; Access, evoke and transform emotion; Working directly with emotions; Emotional processing; Resolving lingering painful feelings; Emotionally evocative; Using emotions adaptively; Making sense of emotions; Restructuring maladaptive cognitive-affective schemes; Promoting experiencing; Attending to internal experiences; Symbolising experiences; Constructing new meanings; Emotions are connected to basic needs; Emotions contain information; Organising for adaptive action; Familiar emotional pain; Transforming emotion and integrating it into autobiographical memory; Accessing previously constricted primary adaptive emotions

Table 4.3C continued

Reciprocal translation: Emotion Focus

Study	Theoretical basis	Terms
		Emotion Focus
Shahar, 2014 continued	EFT	Mirroring moment-by-moment emotional states; Bodily felt sense; Focusing principles; Two-chair dialogue; Interruption of experience; Being entitled to experience and needs; Meta-cognitive awareness; Imaginary dialogue
Smith et al., 2014	Person-centred	Emotion processing; Metaphor; Exploring previously denied aspects of self; Therapist sensitivity to implicit emotional meaning; Making connections with unexpressed feelings; Exploring new emotions and memories; Assimilation of emotional experience; Expressing painful emotion; Accepting suppressed aspects of emotions; Stopped process; Symbolisation; Bodily felt sense; Moment-by-moment process; Experiential processes
Timulak & McElvaney, 2016	EFT	Restructuring and transformation of problematic emotion schemes; Emotional processing; Overcoming emotional avoidance; Core painful feelings; Articulation of unmet need; Emotional response to feelings and needs; Processing emotional experience; Adaptive information present in emotional experience; Restructuring/transforming in-session emotional processing problems; Activating adaptive emotional experiences; Accessing core pain; Emotional flexibility and resilience
Watson et al., 2003	Process-Experiential	Integration of client-centred and gestalt techniques; Two-chair; Empty-chair; Systematic evocative unfolding; Focusing; Cognitive-affective problems; Processing difficulties
Wnuk et al., 2015	EFT	Changing problematic emotions; Emotions are innately adaptive; Emotion schemes; Transforming maladaptive emotions schemes; Activating adaptive emotions; Focusing on moment-by-moment experience; Chair-work; Resolving internal conflicts; Self-interruptive splits; Experiencing painful emotions; Allowing and learning from emotions

Table 4.4C

Experiential specificity: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Watkins, Baeyens & Read, 2009	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Watkins et al., 2012	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Serrano et al., 2012	Y	Y	Y	Y	Y	Y	N	Y	7/8
Maxwell et al., 2016	Y	Y	Y	Y	N	Y	Y	Y	7/8

Table 4.4C continued

Experiential specificity: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equivalent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Werner-Seidler et al., 2018	Y	Y	Y	Y	Y	Y	N	Y	7/8
Serrano et al., 2004	Y	Y	Y	Y	N	N	Y	Y	6/8
Moradi et al., 2014	Y	Y	Y	Y	N	N	N	Y	5/8
Kleijn et al., 2018	Y	Y	Y	Y	N	N	N	Y	5/8

Table 4.5C

Experiential specificity: Assessment of methodological quality of non-randomised trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Eigenhuis et al., 2017	Y	N	Y	N/A	N/A	N/A	Y	Y	4/4

Table 4.6C

Emotion regulation: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Safer, Robinson & Jo, 2010	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Bryant et al., 2013	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Afshari & Hasani, 2020	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Mahmoodi et al., 2020	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Sauer-Zavala et al., 2020	Y	Y	Y	Y	Y	Y	Y	Y	8/8

Table 4.6C continued

Emotion regulation: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equivalent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Cloitre et al., 2010	Y	Y	Y	Y	Y	Y	N	Y	7/8
Mohsenabadi et al., 2018	Y	Y	Y	Y	N	N	Y	Y	6/8
Telch, Agras & Linehan, 2001	Y	Y	Y	Y	N	N	N	Y	5/8
Cloitre et al., 2002	Y	Y	Y	Y?	N	N	N	Y	5/8
Mennin et al., 2018	Y	Y	Y	Y	N	N	N	Y	5/8
Cancian et al., 2019	Y	Y	Y	Y	N	N	N	Y	5/8

Table 4.6C continued

Emotion regulation: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equivalent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Koch, Ehring & Liedl, 2020	Y	Y	Y	Y	N	N	N	Y	5/8
Schanche et al., 2020	Y	Y	Y	Y	N	N	N	Y	5/8
Boyle et al., 2017	Y	Y	Y	N	N	N	N	Y	4/8
Khakpoor, Bytamar & Saed, 2019	Y	Y	Y	Y	N	N	N	N	4/8

Table 4.7C

Emotion regulation: Assessment of methodological quality of non-randomised trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Mennin et al., 2015	Y	N	Y	N/A	N/A	N/A	Y	Y	4/4
Telch et al., 2000	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Clyne & Blampied, 2004	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Gilbert & Procter, 2006	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Carmody et al., 2009	Y	N	Y	N/A	N/A	N/A	N	Y	3/4

Table 4.7C continued

Emotion regulation: Assessment of methodological quality of non-randomised trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Bullis et al., 2015	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Graser et al., 2016	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Juarascio et al., 2017	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Bacon et al., 2018	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Renna et al., 2018	Y	N	Y	N/A	N/A	N/A	N	Y	¾
Kivity et al., 2020	Y	N	Y	N/A	N/A	N/A	N	Y	3/4

Table 4.7C continued

Emotion regulation: Assessment of methodological quality of non-randomised trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equivalent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Wright et al., 2020	Y	N	Y	N/A	N/A	N/A	N	Y	3/4

Table 4.8C

Emotion focus: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Watson, 2003	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Goldman, 2006	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Grosse Holtforth 2019	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Greenberg & Watson 1998	Y	Y	Y	N	Y	Y	Y	Y	7/8
Grosse Holtforth 2011	Y	Y	Y	Y	Y	Y	N	Y	7/8

Table 4.8C continued

Emotion focus: Assessment of methodological quality of randomised controlled trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Newman 2011	Y	Y	y	y	Y	Y	N	Y	7/8
Paivio & Greenberg 1995	Y	Y	Y	Y	N	N	N	Y	5/8

Table 4.9C

Emotion focus: Assessment of methodological quality of non-randomised trials

Study	Did the study address a clearly focused issue?	Was the assignment of patients to treatments randomised?	Were all of the patients who entered the trial properly accounted for at its conclusion?	Were the groups similar at the start of the trial?	Aside from the experimental interventions, were the groups treated equally?	Was there an equival-ent therapy control?	Was researcher allegiance accounted for?	Have potential confounding factors been taken into account?	Total
Dornelas 2010	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Shahar 2012	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Lafrance Robinson 2014	Y	N	Y	N/A	N/A	N/A	N	Y	3/4
Wnuk 2015	Y	N	Y	N/A	N/A	N/A	N	Y	3/4

Narrative review of qualitative studies

Experiential Specificity

In a study of psychotherapy process by Watson & Rennie (1994), eight anxious and mildly depressed clients were given 12-16 sessions of individual psychotherapy, and in sessions three and eight were asked to describe a problematic emotional or behavioural reaction to an event they had experienced. Therapists used systematic evocative unfolding (SEU) to help clients re-create the experience and find meaning in their affective reaction. Watson and Rennie cited Rice & Sapeira's description of successful SEU (1984) as having four phases: i) clients observe a problematic reaction; ii) therapists and clients work together to evoke the triggering situation through "concrete, vivid and imagistic language" (p.500); iii) clients identify the triggering aspects, and explore their perceptions and emotions about the situation; iv) clients broaden this exploration to help self-understanding.

Interpersonal Process Recall interviews were conducted less than two days after each SEU session (Elliott, 1986). Fourteen interview transcripts were analysed using grounded theory (Glaser & Strauss, 2017). The authors described the resulting core category as 'an enquiry into self', with sub-categories of 'client operations' and 'session momentum'. The category of 'client operations' contained further sub-categories of 'symbolic representation of experience' and 'reflexive self-examination', which led to 'making new realisations' and 'revisioning self'. The categories of 'symbolic representation of experience' and 'revisioning self' are most relevant to the concept of Experiential Specificity. Watson and Rennie drew quotes from the transcripts to illustrate categories.

Analysis of the interviews revealed both cognitive and affective aspects of the symbolic representation of experience. For example, participants talked about visualising or

creating a picture of the situation, and re-experiencing the feelings from the original

situation. The act of putting an experience into words to share with the therapist made it

more concrete and real. The authors also found that some participants checked with their

internal subjective sense that they had accurately labelled their experiences, or felt that the

therapist had supplied a label that was a 'perfect fit' with the experience.

The authors defined 'revisioning self' as the client formulating alternative ways of

being and behaving. In order to further understand this process, as the final step towards

resolution of a problematic reaction, the categories that appeared to distinguish sessions

where revisioning occurred were quantified. The acts of recollecting and visualising a

situation, and recollecting and re-experiencing feelings, appeared to lead to revisioning in

five out of six sessions. Clients also reported that their mood was elevated in four out of five

sessions where these processes helped them to gain a fresh perspective.

From the categories that they identified, Watson and Rennie described a model of

the client's process during these sessions, concluding that the representation of external

events as well as internal experiences promotes insight and reflexivity leading to

behavioural change. Accurate labelling of internal and external experiences heightens

awareness of inner emotional experience, and facilitates self-understanding, creating a

'meaning bridge' between clients' feelings, behaviour and environment.

The authors observed that sessions where clients were engaged in processes of

change and resolution were characterised by clients' eagerness and curiosity in

collaborating with the therapist's suggestions. From the observation that some clients found

the therapist's request to slow down and elaborate an experience frustrating or emotionally

overwhelming, the authors concluded that the therapist may need to be more enquiring

than directive, and willing to explain the rationale for their requests.

Singer et al. (2013) set out a theory of narrative identity built on a dual memory system of autobiographical episodic memory and long-term self. The authors reviewed literature from cognitive, developmental, personality, and clinical psychology research to define narrative identity and its implications for mental health. The relevance for Experiential Specificity in PCET is the authors' conclusion that healthy narrative identity requires a combination of memory specificity and meaning-making. They highlighted the importance of vivid and detailed memories to supply cognitive-affective information for healthy functioning.

The authors illustrated the theory with a case study from Emotion Focused Therapy, where the therapist encouraged the client to elaborate a forgotten and painful experience, and to use the new awareness and meaning to change current unhelpful behaviour. The therapist used imagery and metaphor to help the client to notice when he avoided painful feelings by changing his narrative from specific to general memories. The client was then able to stay with the specific experience, connecting bodily feelings, thoughts and emotions. Through recollecting and re-experiencing the feelings of a painful memory, the client was able to discern links with a subsequent pattern of behaviour.

These two qualitative studies reinforce the role of memory specificity and emotion labelling and differentiation in moving from psychological distress to healthy functioning in psychotherapy. They also illustrate the role of the therapist in encouraging Experiential Specificity, through process-directive interventions such as systematic evocative unfolding, the use of imagery and metaphor, and through nondirective but purposeful enquiring after the external and internal details of the client's experience.

Emotion Regulation Sensitivity

Three of the six identified qualitative studies focus on emotion regulation as an interpersonal process.

Esplen, Gallop and Garfinkel (1999) described the use of a guided imagery intervention to enhance self-soothing in women with bulimia nervosa. The intervention was developed from object relations theory, which understands emotion regulation difficulties in adults as a problem beginning in infancy, when soothing from a caregiver is ideally internalised by transferring the soothing effect to other objects or images. The guided imagery intervention incorporates exercises both for imagining places or people who can provide comfort and relaxation, and exercises to promote self-exploration. Exploration and processing of feelings are seen in psychodynamic and experiential therapy traditions as contributing to emotion regulation. The authors offered two case examples where participants discussed the unique images they created for themselves which enabled them to comfort themselves, and which helped to resist urges to binge eat. Using imagery and metaphor gave a third participant the courage to explore her relationship with her father, and the authors refer to "restor[ing] a working state" (p.184), similar to the concept of working distance. Esplen and colleagues also speculated that having a recording of the therapist's voice was soothing in itself, and functioned as a transitional object for internalising a feeling of comfort. One aspect of this intervention seen as important by the authors was the participants listening repeatedly to soothing recordings. This is similar to training in CBT, but such repetition is unlikely to happen in PCET.

Fosha (2001) stressed the function of the therapist's presence for affect regulation in Accelerated Experiential-Dynamic Psychotherapy (AEDP), replicating the co-ordination of emotional experience between mother and infant. Like Esplen and colleagues (1999), Fosha

saw emotion regulation difficulties as the result of unbearable aloneness when emotions become overwhelming, and thus the role of the therapist in counteracting this aloneness. The client's experiential avoidance is reduced, and emotions are available to be processed. Fosha presented a case illustration with a female client with depression and suicidal feelings, emphasising the therapist's use of her own emotional responses to the client. Fosha highlighted how the therapist bypassed the client's blocks to experiencing negative feelings or intimacy, by allowing and expressing her own feelings. She also emphasised that the therapist must help the client to recognise that they have allowed themselves to experience painful feelings and intimacy with the therapist, in order to sustain change beyond the therapy. In AEDP the therapist's use of their own emotional experience for the process of co-regulation within the session is crucial. Although this understanding is present in Person-Centred theory, and therefore in PCET, in the concept of therapist congruence, which is one of the core conditions (Rogers, 1957), it is not translated into sustained interventions as it is in AEDP. Similarly, although the therapeutic relationship is a fundamental aspect of PCET theory, the use of this relationship is implicit, rather than an explicit learning tool of the therapy.

Brubacher (2017) described emotionally focused individual therapy, a humanistic model based on attachment theory. The author viewed emotion regulation difficulties as either "anxious hyperactivation or avoidant deactivation of the attachment system" (p.53), and healthy emotion regulation as a process of co-regulation. Therapy therefore involves creating secure interpersonal and intrapsychic connections. As with the papers by Esplen (1999) and Fosha (2001), Brubacher sees the therapeutic relationship as a means of regulating the client's emotions in itself, and also as a "secure base" (p.57) from which to explore and process feelings. The author described the identification and understanding of

the client's patterns of emotion regulation as a central change process of the therapy. A clinical vignette is offered to illustrate this therapeutic process, with therapist interventions to heighten client emotional experience, including an example of 'enactment' between different parts of the client in order to reduce the suppression of feelings. In PCET, the therapist's emotion regulation sensitivity is seen as necessary to facilitate such emotion-focused interventions, rather than working explicitly on the client's emotion regulation patterns.

The remaining three identified qualitative studies present examples of psychoeducation and skills training in emotion regulation.

Fresco et al. (2013) presented the case of a client called 'William' to illustrate the theory and practice of Emotion Regulation Therapy (ERT), a manualised intervention in the CBT tradition for individuals with generalised anxiety disorder (GAD). ERT integrates the CBT principles of psychoeducation, skills training and exposure with mindfulness and emotion-focused (EFT) interventions. The treatment package is structured in four phases delivered over 16 sessions. There are similarities between ERT and the emotion regulation component of PCET, although PCET is client-led and therefore not structured, and the number of sessions varies according to the client's needs. Aspects of emotion regulation which are explicit in Phase I, the psychoeducation part of ERT, such as understanding how patterns of responding have arisen, interoceptive awareness and emotion differentiation, are implicit in PCET. Phase II is described as 'Regulation Skills Training', and again the skills of acceptance, decentering and reframing are implicit in PCET. An ERT exercise to promote decentering, called 'Gaining an Observer's Distance', is similar to a PCET intervention called 'clearing a space'. For Phase III of ERT, experiential exposure, Fresco et al. refer to emotional processing, which is the central principle of PCET. ERT and PCET share interventions derived

445

from EFT which are used to help process unresolved emotion, for example systematic

evocative unfolding and working with a motivational conflict split. Phase IV of ERT is

consolidating gains and preparing for ending, and includes normalising emotions.

Richards et al. (2016) described another integrative treatment, integrative dynamic

therapy (IDT) for bulimia nervosa (BN), with an illustrative case study with a client called

'Sara'. The intervention began with psychoeducation and self-monitoring derived from

traditional CBT for eating disorders, during which information around the client's patterns of

emotion regulation, and their connection with her eating and purging behaviour was noted.

The second psychodynamic phase explored difficulties in the client's emotional experience,

working on Sara's ability to accept and express her feelings, and to self-soothe. The

therapist elicited recent examples of Sara's eating behaviour in order to explore their

emotional content, similar to the PCET and EFT intervention of systematic evocative

unfolding. An important similarity between IDT and PCET is that it is personalised to the

client. For Sara this led to an exploration of the origins and functions of her self-criticism,

and its consequences for her emotion regulation, in a therapeutic process comparable to

PCET.

Miles et al. (2016) developed an innovative, single-session group emotion regulation

treatment to reduce aggression in combat veterans. The authors based their intervention on

the theory that PTSD could result in both the over-regulation and under-regulation of

emotion, and either of these could lead to failures in the regulation of a range of emotions

such as fear and sadness as well as anger, culminating in acts of impulsive aggression. They

noted that emotion regulation treatments had been effective with people suffering from

PTSD, but that a brief intervention acceptable to veterans was needed. The three-hour

session consisted of psychoeducation and skills training, including relaxation, grounding,

mindfulness and reappraisal. Miles et al. presented two clinical case studies. For 'Tom', who was highly motivated, the session reduced violent outbursts, increased his emotional awareness and his hope that he could regulate his feelings, and he subsequently engaged in exposure treatment for his PTSD. In contrast, during and following the session 'Clint' continued to avoid feeling anger, and reported that his aggression was not reduced. Although the treatment described by Miles et al. is very different from PCET, being a single-session group psychoeducation intervention for PTSD, there are similarities around normalising and learning to moderate emotion, and recognising that emotions are experienced and expressed in ways unique to the individual.

Emotion Focus

The 10 qualitative studies identified for inclusion illustrate the use of emotion focus skills through the presentation of case material. The studies include research in the Person- or Client-Centred tradition, the psychodynamic tradition, and EFT, with studies investigating interventions for anxiety, depression, eating disorders, trauma and health and psychosomatic problems. The analysis of the studies highlights similarities and differences with Emotion Focus in PCET.

Emotion Focused Therapy

A paper by Shahar (2014) describes the principles of EFT for social anxiety, and offers a case example. In common with PCET, the author emphasises the provision of a therapeutic relationship based on the Rogerian core conditions (Rogers, 1951), and the facilitation of the client's emotional experiencing, including emotion regulation. A difference between the two models however is the author's development of a theoretical formulation of social anxiety based on the premise that anxiety is a secondary emotion preventing the client's experience of primary maladaptive shame. A PCET therapist is unlikely to make such an overarching

447

formulation, but would track the client's moment-by-moment experience. Various

similarities and differences are also illustrated through the case of 'David' presented in the

study. Interventions described by Shahar which are shared with PCET include focusing, and

working with the client's self-critic and other unresolved feelings. Where the EFT therapist

in this study is process-directive however, including the identification of 'task markers',

leading to chair-work addressing the self-critic or unresolved feelings to another person, a

PCET therapist would not give the client instructions, and would be more likely to indicate

the two parts using hands.

Like Shahar (2014), the study by Timulak and McElvaney (2016) describes the

features and aetiology of generalised anxiety disorder (GAD) from the perspective of EFT

emotion theory. Worry, one of the principal features of GAD, is seen as a means to avoid

core pain from past experiences re-triggered in the present, and to try to control situations

and protect against self-criticism. Unlike PCET, the authors advocate the creation of a case

formulation to be shared with the client, including psychoeducation about the need to

reduce emotional and behavioural avoidance, and 'homework', where changes are

consciously consolidated outside the session. In PCET such consolidation would be implicit,

and changes discussed and reinforced when they are brought to therapy by the client. The

authors also describe a specific adaptation of chair-work for GAD, where the 'Worrier' takes

one chair, and the 'Experiencer' the other. Again, this would be achieved in PCET through

the therapist reflecting the client's inner conflict by using hands. Like PCET, self-soothing is

used as an intervention to help with the client's emotion regulation. Timulak and McElvaney

illustrate EFT treatment for GAD through the case example of 'Tina'.

Harte, Strmelj and Theiler (2020) conducted a change-process study involving a task

analysis of an expanded focusing task for working with trauma in EFT. The intervention was

developed by Harte, combining principles of memory restructuring with focusing (Gendlin, 2003), systematic evocative unfolding (Rice, 1974) and imagery rescripting, and was defined in a practitioner manual. A painful unresolved memory experienced by the client as a bodily felt sense was evoked through the focusing task. Resolution was achieved mainly through identifying a primary emotion, with the action tendency of the unmet need associated with the emotion. The authors offer an analysis of one session with a client named 'Betty', working on a 'small t trauma' from childhood. The session was assessed to be successful according to Betty's self report and a follow-up interview, and measures of experiencing. The authors observe that it was important that with the help of focusing, Betty's therapist was able to stay with her whole experience, rather than just emotion, which could be a maladaptive or secondary emotion. The intervention described by Harte and colleagues differs from PCET practice by being more directive and structured, with the expectation of completing a prescribed sequence of steps. Ecological validity of the study is weakened through the use of a session from EFT training, with Betty being an EFT trainee.

Bridges (2006) conducted research to explore the corrective emotional experience in the context of EFT. Measures were administered to participants to assess emotional experience, emotional expression, and emotional processing, defined as "the meaningful integration of emotion and cognition" (p.552). Physiological arousal was assessed using a wristwatch cardiac monitor. One aspect of the research was an interest in the role of positive emotions in transforming negative emotions. In this study, three case vignettes are presented to illustrate different client processing styles. One client is described as 'venting', where the client's expression of her experience, although externally-focused, does help her heart rate to gradually decrease over the course of each session. Her emotional processing however, as measured on the EXP (Klein & Mathieu, 1986) remains low, and the author

reports that there is minimal long-term change as a result. The second and third clients demonstrate how heart rate increases as emotion is accessed and decreases as it is processed. The third vignette describes a focusing intervention (Gendlin, 2003), leading to a shift in lingering sadness through an experience of positive emotion.

Brennan, Emmerling and Whelton (2014) used thematic analysis to investigate the experiences of six women who participated in a 12-session group EFT for eating disorders, based on the format proposed by Wnuk (2015, Chapter 4). Group participants chose their own focus for the work, which was the self-critic, with the facilitators offering chair-work at each session. As in the study of group EFT for depression by Lafrance Robinson (2014, Chapter 4), participants were allowed to voice their own responses to another person's self-critic. Qualitative data collected for analysis in this study were session feedback forms and letters which the participants were asked to write to their own self-critic between sessions 11 and 12. Six themes were identified, which were around separating from the critic, recognising the destructive impact of the critic, recognising the critic's protective function, accessing and accepting previously avoided feelings, becoming aware of and accepting unmet needs, and valuing the group. The principal difference between the intervention offered in this study and PCET is that currently PCET is only delivered to individuals. Other differences include the formal provision of psychoeducation, and the expectation of homework, including worksheets.

Person-Centred Therapy

Smith et al. (2014) analysed the case of 'Theresa', who received Person-Centred therapy for health anxiety, using a modified Hermeneutic Single Case Efficacy Design (Elliott, 2002) to examine outcome, and the Ward method (Schielke et al., 2009) to explore helpful factors and therapy process. The authors describe the client's "process of narrative

assimilation of her emotional experience" (p.122), in the course of which Theresa addressed

previously avoided feelings about a bereavement, and identified and was able to resolve an

internal conflict between feelings about her birth family and her own family. This process

appeared to help the client to take a different perspective on bodily sensations which she

had previously interpreted as catastrophic. The therapy described by Smith et al. has

similarities with PCET, in particular the emphasis on the Person-Centred relationship

conditions of empathy, acceptance and congruence, and use of metaphor. Although the

therapy offered was described as pluralistic, the authors state that no structured EFT or

CBT-type interventions were used, implying that the therapist in this case offered less

process-guiding than would typically be used by a PCET therapist.

Psychodynamic Therapy

Coughlin Della Selva (2006) presented a study of Intensive Short Term Dynamic

Psychotherapy (ISTDP) for a client experiencing psychosomatic disorders, based on the

theory that the suppression of emotional expression has significant negative implications for

physical health, and therefore "facilitat[ing] the direct experience of previously disavowed

feelings" (p.541) will improve physical symptoms. The client had suffered from ulcerative

colitis for many years, occasionally requiring hospital stays, and prior to psychotherapy had

been recommended surgery. The author reported that following therapy her disease was in

complete remission, and remained so at a 14-year follow-up interview. Similarities between

this therapy and PCET include a concern for emotion regulation to achieve a productive level

of emotional arousal, and the exploration of intrapsychic conflicts. Some interventions

described by Coughlin Della Selva seem parallel to interventions within PCET, such as

encouraging experiential specificity, and working with unresolved feelings about another

person. There are also important differences however. In the tradition of psychodynamic

therapy, the intervention described in this study works with transference feelings. While a PCET therapist might make an observation about a client's responses in the 'here and now' of the session, they would not explicitly work with the transference. Another difference between the two modalities is the assumption in ISTDP that the client has 'sadistic impulses', and that identifying and expressing them is therapeutic.

Palvarini (2010) traces the origins and controversies around the 'corrective emotional experience' in psychoanalytic theory. The term has been adopted more broadly within different psychotherapeutic traditions (cf. Bridges 2006), but in psychoanalysis, according to Palvarini, it refers to the client's repetition of old emotional experiences with the therapist which are transformed by the new and corrective experiences provided within the therapeutic relationship. The author describes the therapeutic relationship in Experiential Dynamic Psychotherapy as a "real relationship … based on authenticity" (p.181), corresponding to the view of the relationship in PCET. As with PCET, the therapist's empathy is also emphasised. Palvarini offers two case vignettes transcribed from successful work with one client named 'Laura', suffering from depression and hypochondriac symptoms. As in PCET, the therapist encourages experiential specificity, re-experiencing emotions in the session, sometimes with the help of guided imagery techniques, and the identification of emotional conflicts. The therapist's empathy helps Laura to access self-soothing and compassion to counteract shame, which the author sees as the corrective emotional experience.

Friedlander et al. (2012) investigated the corrective emotional experience using questionnaires, thematic analysis of interviews with a client and her therapist, and conversation analysis of videotaped therapy excerpts to explore a successful case of short-term dynamic psychotherapy (STDP). The authors were interested in both transtheoretical

and theory-specific aspects of the corrective experience, defining it as "a new and significant affective experience or cognitive understanding of either an event or a relationship" (p.352). They present the case of 'Ms K.', suffering from panic attacks and inappropriate angry episodes, with data collected from the later part of her therapy. Analysis of the questionnaires elicited five major themes: symptom relief; strength, self-awareness and self-acceptance; greater emotional flexibility and control; resolution of unfinished business from childhood and more adaptive interpersonal relationships. The authors focused on the last two themes as relevant to the concept of the corrective experience. They also highlighted the therapeutic relationship and accessing previously avoided feelings as mechanisms of change. A major theme explored by the authors through conversation analysis of therapy excerpts was 'resistance talk', where the client avoided painful feelings by, for example, changing the subject. Although this is similar to the intervention of identifying and exploring an interrupting part of the client in PCET, a PCET therapist would not see this in terms of 'confronting the client's defences', as in STDP.

Schema Therapy

Boterhoven de Haan et al. (2019) describe Schema Therapy (ST) and its application to the treatment of post-traumatic stress disorder (PTSD). ST is an integrative therapy rooted in CBT, and incorporating elements from psychodynamic and experiential therapies. The theory of ST is based on the concept of early maladaptive schemas (EMSs), defined as "lifelong core ideas or themes comprised of cognitions, emotions, memories, and body sensations that influence how an individual views himself/herself, his or her relationships with others, and the world" (p.55). EMSs are developed through negative experiences and unmet needs in childhood, and the authors review literature suggesting a relationship between EMSs and a vulnerability to developing PTSD. Like PCET, ST uses interventions such

as imagery and chair work to facilitate the client's re-experiencing and processing of emotion in session. Like Palvarini (2010) and Friedlander et al. (2012), Boterhoven de Haan and colleagues refer to corrective emotional experiences, in this case facilitated through 'limited reparenting', provided through a warm and safe therapeutic relationship that also challenges and sets limits for the client, described as 'empathic confrontation'. To illustrate the therapy, the authors offer the case of 'Bob', who had previously received an unsuccessful course of traditional exposure therapy for PTSD. Based on Bob's assessment, the therapy focused on childhood experiences of feeling weak and pathetic rather than on the traumatic event itself. Like a PCET intervention for working with unfinished business, the ST therapist helped the client to re-experience in imagination a childhood event with another person, and to discover his self-soothing capacity. Unlike PCET, however, the ST therapist 'entered' the imagined scene in order to protect the client as child. Another difference from PCET is behavioural work, where the therapist physically accompanied Bob to previously avoided locations.

Appendix D

Chapter 6

Table 6.1D

Shapiro-Wilk tests for normality

	Shapiro-Wilk	Degrees of freedom	Significance	Skewness	Standard error of skewness	Fisher skewness coefficient	Kurtosis	Standard error of kurtosis	Fisher kurtosis coefficient
PHQ9 change	.93	55	.01	.56	.32	1.75	3.39	.63	5.38
PHQ9 change excluding outliers	.97	51	.31	.04	.33	.12	-.41	.66	-.62

Table 6.1A: Fisher skewness coefficients are calculated as skewness/standard error of skewness and Fisher coefficients of kurtosis as kurtosis/standard error of kurtosis (Pett, 2015). All coefficients fell within the range of ± 1.96, indicating that the distribution of the variable is not significantly different from normal at $\alpha \leq .05$, except for overall PHQ9 change. The Fisher coefficient of kurtosis for this variable was 3.39/.63 = 5.38, i.e., outside the range of ± 1.96, indicating that this variable had a leptokurtic distribution.

Table 6.2D

Descriptive statistics including outliers

	N	Mean	St.Dev.	Median	Range	IQR
First session PHQ-9	55	17.69	4.78	18.00	5.00 - 26.00	8.00
PHQ-9 Change	55	-1.25	3.90	-1.00	-12.00 – 13.00	4.00
Mean total PCEPS (Maximum = 60)	55	39.09	8.81	40.13	18.00 – 58.00	12.50
Full PC Cluster (Maximum = 42)	55	27.69	6.49	29.00	12.00-41.50	10.00
PC sub-cluster (Maximum = 30)	55	19.97	4.46	20.50	9.00-29.50	6.50
Pro sub-cluster (Maximum = 12)	55	7.72	2.19	8.00	2.80-12.00	3.50
Experiential Cluster (Maximum = 18)	55	11.40	2.53	11.50	6.00-16.50	4.00

Table 6.3D

Linear regression of total PCEPS on first PHQ-9 including outliers (R^2 adjusted = -.07, F(1,53) = 5.04, p = .03)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	*β*	*t*	Sig.
(Constant)	29.55	4.39	20.73 – 38.38		6.72	<.001
First PHQ-9	.53	.24	.06 – 1.01	.29	2.25	.03

Table 6.4D

Multiple linear regression of PHQ-9 change on first PHQ-9 and total PCEPS including outliers (R^2 adjusted = -.03, F(2,52) = .30, p = .74)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-.10	2.78	-5.69 – 5.49		-.04	.97
First PHQ-9	-.09	.12	-.32 – .14	-.11	-.77	.44
Total PCEPS	.01	.06	-.12 – .14	.03	.18	.86

Table 6.5D

Pearson's r correlations between low, medium, and high rated competence groups and next-session PHQ-9 change with low value of first PHQ-9

	Overall		Low		Medium		Medium* Excluding one low value of first PHQ-9		High	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
N	51		17		17		16		17	
Total PCEPS	.07	.63	.47	.06	-.13	.61	-.08	.78	-.25	.34
Controlling for first PHQ-9	.10	.49	.62	.01	-.14	.61	-.02	.95	-.26	.32
N	51		18		16		15		17	
Person-centred cluster	.10	.50	.43	.07	-.09	.73	-.04	.90	-.17	.51
Controlling for first PHQ-9	.13	.37	.57	.02	-.09	.75	.03	.92	-.14	.60
N	51		16		20		19		15	
Proscribed cluster	.13	.38	.47	.07	.25	.29	.32	.18	-.12	.67
Controlling for first PHQ-9	.16	.27	.53	.04	.22	.37	.27	.27	-.12	.69
N	51		17		19		18		15	
Experiential cluster	-.03	.82	.41	.10	-.06	.80	.01	.96	-.35	.20
Controlling for first PHQ-9	-.01	.92	.48	.06	-.06	.81	.16	.53	-.42	.13

Figure 6.1D

Scatterplot of the regression of the standardised residuals on the standardised predicted values for

the relationship between competence and next-session PHQ-9 change
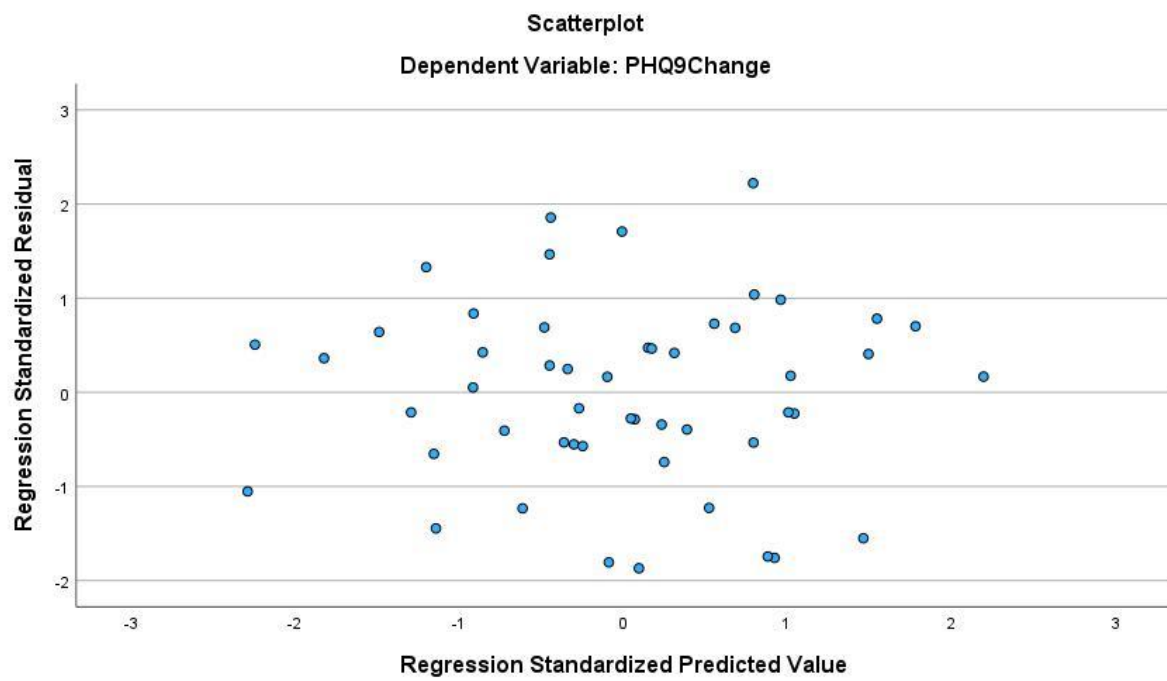
Appendix E

Chapter 7

Table 7.1E

Descriptive statistics for full sample and rated sub-sample including outliers

		First PHQ-9	End of therapy PHQ-9 change	Total PCEPS	Person-centred cluster	Proscribed cluster	Experiential cluster
Full sample	*N*	171	171				
	Mean	17.68	-7.27				
	SD	4.72	6.44				
	Median	18	-7				
	Range	5 – 27	-26 – 7				
	IQR	14 – 21	-11 - -3				
Rated sub-sample	*n*	57	57	57	57	57	57
	Mean	17.95	-8.12	39.47	20.21	7.76	11.50
	SD	4.80	6.70	8.49	4.34	2.11	2.43
	Median	19.00	-9.00	40.50	20.75	8.00	11.50
	Range	5 – 26	-25 – 4	18.00 – 58.00	9.00 – 29.50	2.80 – 12.00	6.00 – 16.50
	IQR	14 – 21	-12 – -3	33.13 – 45.75	17.13 – 23.50	6 – 9.50	9.50 – 13.50

Table 7.2E

Participant demographics for full sample

N = 171	Age	Gender	Ethnicity	IMD Decile	Employment	Anti-depressant medication
Mean	40.43					
Standard deviation	13.73					
Median	39					
Range	18 – 79					
Female		95				
Male		76				
White British			142			
White other			2			
Black or Black British Caribbean	4					
Mixed White & Black Caribbean	2					
White Irish			1			
Asian or Asian British Indian		1				
Asian or Asian British Pakistani	2					
Mixed other			1			
Not asked or Refused to answer	16					

Table 7.2E continued

N = 171	Age	Gender	Ethnicity	IMD Decile	Employment	Anti-depressant medication
1				29		
2				22		
3				9		
4				6		
5				17		
6				16		
7				13		
8				17		
9				16		
10				25		
(One missing value)						
Employed					95	
Unemployed and Seeking Work					17	
Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance					17	
Students in full or part-time education or training and who are not working or actively seeking work					9	
Retired					3	
Homemaker looking after the family or home and who are not working or actively seeking work					3	
Unpaid voluntary work					1	
Not stated					26	
Prescribed and taking						87
Not prescribed						60
Prescribed but not taking						8
Unknown						16

Table 7.3E

Multiple linear regression of end of therapy PHQ-9 change on gender, age, IMD decile, ethnicity,

employment status and use of anti-depressant medication (R^2 adjusted = -.01, F(6,162) = 1.29, p =

.26)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-4.47	2.16	-8.73 –.21		-2.07	.04
Gender	2.10	.99	.15 – 4.05	.16	2.12	.03
Age	-.05	.04	-.12 – .03	-.10	-1.26	.21
IMD decile	-.13	.15	-.43 – .18	-.06	-.82	.41
Employment status	.00	1.00	-1.98 – 1.98	.00	.00	1.00
Ethnicity	-1.15	1.32	-3.75 – 1.46	-.07	-.87	.39
Medication status	-.60	1.01	-2.59 – 1.39	-.05	-.60	.55

Table 7.4E

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and total PCEPS including

outlier (R^2 adjusted = .20, F(2,54) = 8.00, p = <.001)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-1.15	4.33	-9.83 – 7.53		-.26	.79
First PHQ-9	-.69	.17	-1.04 – -.34	-.49	-3.99	<.001
Total PCEPS	.14	.10	-.06 – .33	.17	1.40	.17

Table 7.5E

Pearson's r correlations between competence variables and end of therapy PHQ-9 change,

controlling for first PHQ-9, including outlier

	Total PCEPS		Person-centred cluster		Proscribed cluster		Experiential cluster	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
N	57		57		57		57	
End of therapy PHQ-9 change	.04	.76	.03	.81	.03	.84	.06	.66
Pearson's *r* controlling for first PHQ-9	.19	.17	.18	.18	.17	.21	.18	.19

Table 7.6E

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and competence clusters

(R^2 adjusted = .14, F(4,51) = 3.15, p = .02)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-2.68	4.53	-11.78 – 6.41		-.59	.56
First PHQ-9	-.61	.18	-.96 – -.25	-.45	-3.45	<.001
Person-centred cluster	.13	.59	-1.05 – 1.31	.09	.23	.82
Proscribed cluster	.07	.80	-1.53 – 1.67	.02	.09	.93
Experiential cluster	.22	.77	-1.33 – 1.76	.08	.28	.78

Table 7.7E

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and competence clusters with outlier (R^2 adj. = .17, F(4,52) = 3.85, p = .01)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	-1.12	4.61	-10.38 – 8.14		-.24	.81
First PHQ-9	-.69	.18	-1.04 – -.33	-.49	-3.88	<.001
Person-centred cluster	.09	.61	-1.13 – 1.31	.06	.15	.88
Proscribed cluster	.19	.82	-1.46 – 1.83	.06	.23	.82
Experiential cluster	.18	.79	-1.41 – 1.77	.07	.23	.82

Table 7.8E

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9 and next-session PHQ-9 change with outlier (R^2 adj. = .15, F(2,51) = 5.83, p = .01)

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	2.37	3.31	-4.29 – 9.02		.71	.48
First PHQ-9	-.59	.18	-.95 – -.23	-.42	-3.28	<.001
Next session PHQ-9 change	.06	.21	-.36 – .47	.03	.27	.79

Figure 7.1E

Box and whisker plots showing median, range and interquartile range for end of therapy PHQ-9

change of segments rated in the early, middle, and late phases of therapy
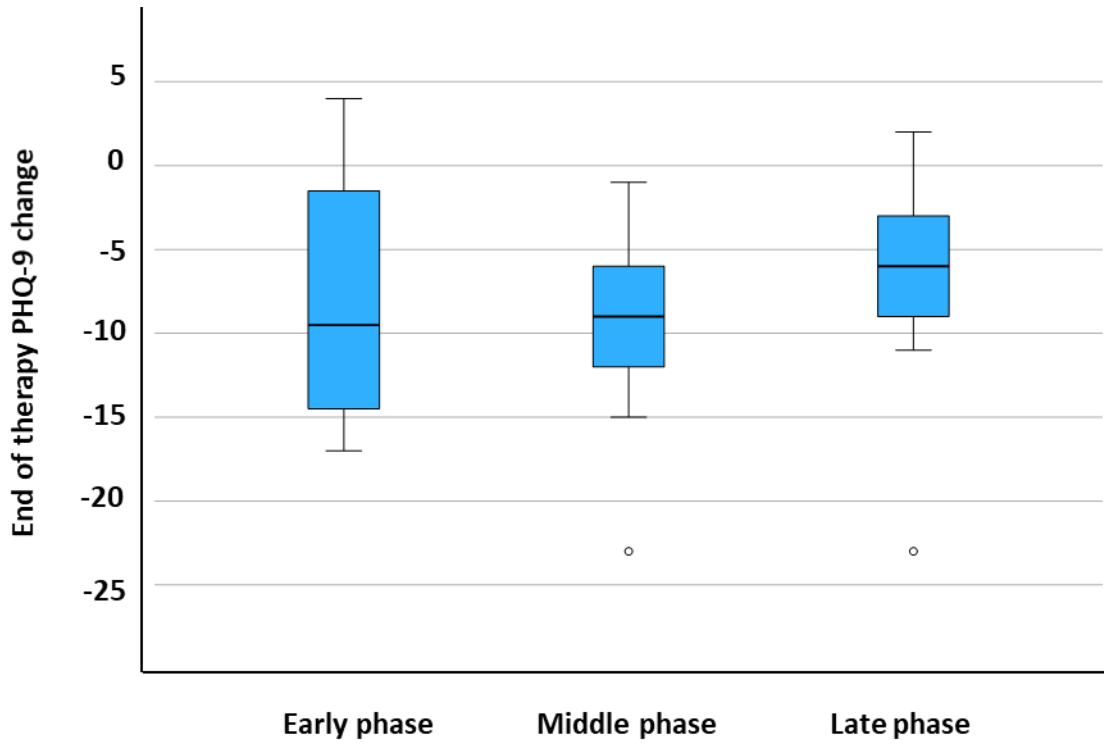
Table 7.9E

Pearson's r correlations between next-session PHQ-9 change and end of therapy PHQ-9 change

overall and in the early, middle, and late phases of therapy including outliers

	Overall		Early		Middle		Late	
N	47		16		17		14	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
End of therapy PHQ-9 change	.14	.33	.53	.03	-.12	.64	-.02	.94
Controlling for first PHQ-9 change	.10	.48	.49	.06	-.21	.43	.01	.97

These results are illustrated by the scatter plots in Figure 7.2A.

Figure 7.2E

Scatter plots showing Pearson's r correlation between next-session PHQ-9 change and end of therapy

PHQ-9 change in the phases of therapy, with outliers
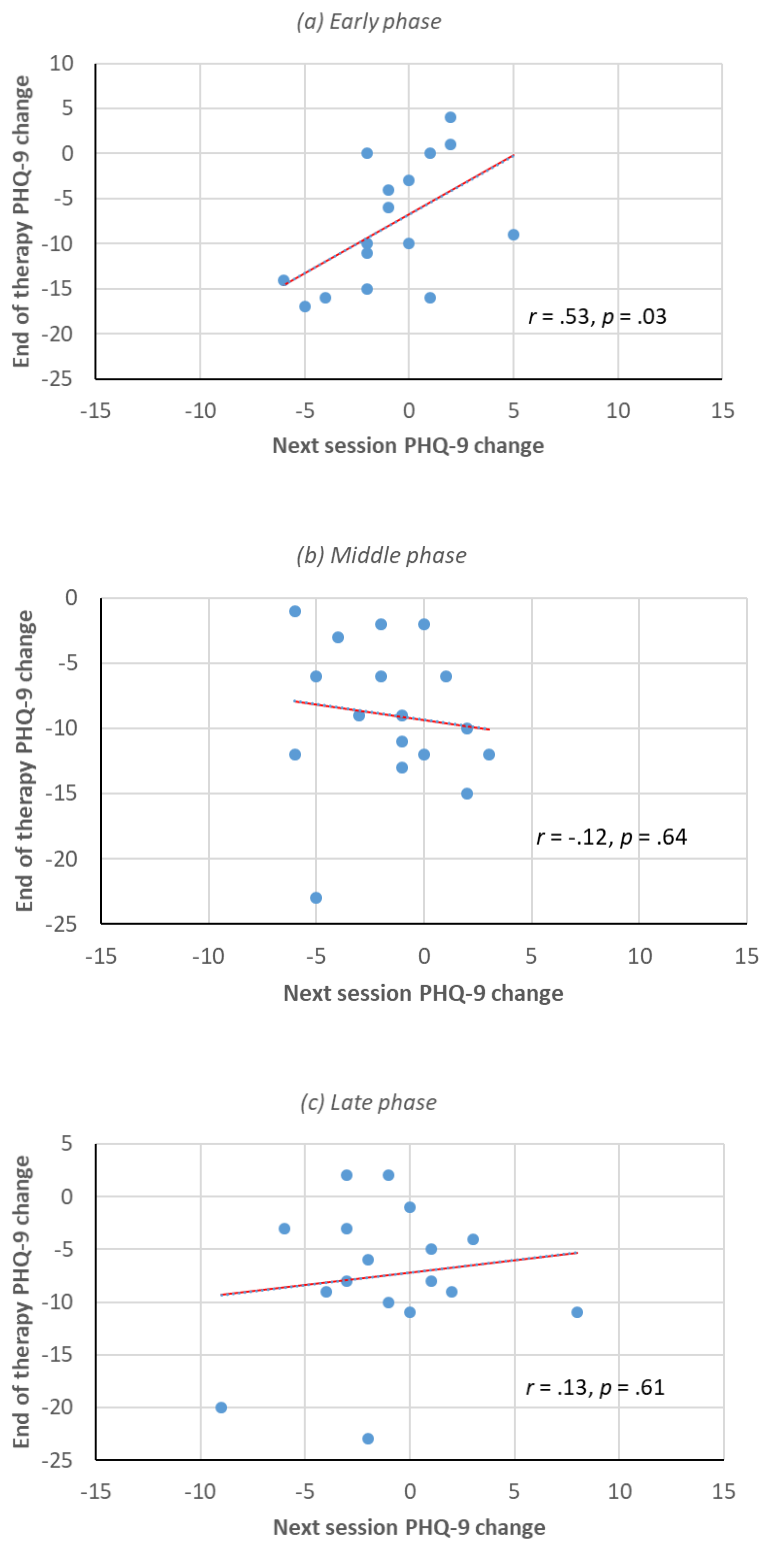
(a) Early phase

(b) Middle phase

(c) Late phase

The Relationship Between Competence and End of Therapy PHQ-9 Change for Low,

Middle, and High Rated Competence

Classification into Low, Medium, or High Rated Competence Groups

For analysis of the relationship between competence and outcome at different levels of competence, segment ratings (excluding outliers) were divided into three groups following the procedure described in the Methods section of Chapter 6. The groups were labelled low, medium, and high. The ranges of ratings for this study matched those of Chapter 6 as closely as possible. Table 7.10E shows the resulting numbers and the range of ratings for each group.

Table 7.10E

Range of ratings for low, medium, and high rated competence groups for four competence variables

	Maximum possible rating	*n*	Low	*n*	Medium	*n*	High
Total PCEPS	60	19	18 – 34.25	18	34.5 – 44	19	45 – 58
Person-centred cluster	30	19	9 – 17.50	17	18 – 22	20	22.75 – 29.5
Proscribed cluster	12	18	2.75 – 6.75	23	7.5 – 9	15	9.5 – 12
Experiential cluster	18	18	6 – 10	23	10.25 – 13	15	13.5 – 16.5

One-way ANOVAs were performed to test for differences between the three levels of competence in competence ratings and in outcomes. Correlation and multiple linear regression analyses were conducted between the low, medium, and high groups in each of the competence variables and end of therapy PHQ-9 change, controlling for first PHQ-9. Tests for a possible curvilinear relationship with outcome were conducted for each competence variable.

Descriptive Statistics for Competence Variables, First PHQ-9 and End of Therapy PHQ-9

Change in Low, Medium, and High Rated Competence Groups

Table 7.11E shows the means, standard deviations and ranges for the four

competence variables (excluding outliers) in the low, medium, and high rated competence

groups. Percentage of the maximum rating is shown for ratings and standard deviations. As

with Chapter 6, the lowest percentage ratings for the medium and high groups were in the

experiential cluster, while for the low group the lowest percentage rating was in the

proscribed cluster. A one-way ANOVA confirmed that for total PCEPS ratings the difference

between the levels of competence was significant ($F(2,53) = 117.74$, $p < .001$).

Table 7.11E

Descriptive statistics for low, medium, and high rated competence groups

		n	Mean	Mean %	SD	SD %	Range
Total PCEPS (Max = 60)	Low	19	29.86	49.77%	4.28	7.13%	18 – 34.25
	Medium	18	39.92	66.53%	3.06	5.10%	34.5 – 44
	High	19	48.39	80.65%	3.70	6.17%	45 – 58
Person-centred cluster (Max = 30)	Low	19	15.32	51.07%	2.21	7.37%	9 – 17.5
	Medium	17	20.23	67.43%	1.41	4.70%	18 – 22
	High	20	24.71	82.37%	1.87	6.23%	22.75 – 29.5
Proscribed cluster (Max = 12)	Low	18	5.17	43.08%	1.07	8.92%	2.75 – 6.75
	Medium	23	8.13	67.75%	0.59	4.92%	7.5 – 9
	High	15	10.23	82.25%	0.68	5.67%	9.5 – 12
Experiential cluster (Max = 18)	Low	18	8.63	47.94%	1.18	6.55%	6 – 10
	Medium	23	11.87	65.94%	0.95	5.28%	10.25 – 13
	High	15	14.28	79.33%	1.06	5.86%	13.5 – 16.5

Table 7.12E shows descriptive statistics for first PHQ-9 and end of therapy PHQ-9 change for the low, medium, and high groups in each of the competence variables. A one-way ANOVA confirmed that there was no statistically significant difference in first PHQ-9 scores between the segments rated low, medium and high ($F(2,53) = .94$, $p = .40$). However, as described in Chapter 6, the medium rated competence group included a participant with an unusually small value for first PHQ-9. The row labelled medium* in Table 7.12E shows statistics with this participant excluded.

In all the clusters of components, the segments awarded the highest PCEPS ratings achieved the least improvement in depression at end of therapy (end of therapy PHQ-9 change). The segments awarded the medium ratings achieved the most improvement at

end of therapy, except in the person-centred cluster where the low group achieved the

greatest end of therapy PHQ-9 change.

Table 7.12E

Descriptive statistics for first PHQ-9 and end of therapy PHQ-9 change in low, medium, and high

rated competence groups

		n	First PHQ-9			End of therapy PHQ-9 change		
			Mean	SD	Range	Mean	SD	Range
Total PCEPS	Low	19	16.74	4.16	11 – 23	-8.37	5.77	-23 – 0
	Medium	18	17.83	5.69	5 – 26	-9.17	6.63	-23 – 2
	Medium*	17	18.59	4.85	11 – 26	-9.53	6.65	-23 – 2
	High	19	18.84	4.22	11 – 26	-6.00	6.55	-16 – 4
Person-centred cluster	Low	19	17.58	4.63	11 – 26	-8.74	5.68	-23 – 0
	Medium	17	16.59	5.27	5 – 25	-8.12	6.31	-23 – 2
	Medium*	16	17.31	4.48	11 – 25	-8.44	6.38	-23 – 2
	High	20	19.05	4.21	11 – 26	-6.70	7.10	-20 – 4
Proscribed cluster	Low	18	16.06	4.09	11 – 23	-7.78	4.70	-15 – 0
	Medium	23	17.65	5.11	5 – 26	-8.35	7.31	-23 – 3
	Medium*	22	18.23	4.41	11 – 26	-8.59	7.39	-23 – 3
	High	15	20.13	4.03	11 – 26	-7.07	6.83	-16 – 4
Experiential cluster	Low	18	17.28	4.70	11 – 26	-8.00	6.09	-23 – 0
	Medium	23	17.26	4.63	5 – 25	-9.70	5.64	-23 – 2
	Medium*	22	17.81	3.87	11 – 25	-10.00	5.58	-23 – 2
	High	15	19.27	4.88	11 – 26	-4.73	6.89	-16 – 4

Medium*: Excluding one low value of first PHQ-9

Results: The Relationship Between Competence and End of Therapy PHQ-9 Change for Low, Middle, and High Rated Competence

A one-way ANOVA showed that there was no significant difference between the competence groups in end of therapy PHQ-9 change ($F(2,53) = 1.27$, $p = .29$). Results for Pearson's r correlations between the competence groups in the clusters of components and end of therapy PHQ-9 change are shown in Table 7.13E. Relationships were found for the high group between higher competence and improvement in depression in all of the clusters except the person-centred cluster. However, after controlling for first PHQ-9, no coefficient had a significance less than $p = .23$.

Table 7.13E

Pearson's r correlations between low, medium, and high rated competence and end of therapy PHQ-9 change

	Low		Medium		High	
	r	*p*	*r*	*p*	*r*	*p*
n	19		18		19	
Total PCEPS	-.08	.75	.01	.98	-.34	.15
Controlling for first PHQ-9	.06	.83	-.05	.84	-.16	.52
n	19		17		20	
Person-centred cluster	-.09	.71	-.04	.88	-.23	.33
Controlling for first PHQ-9	.05	.86	.07	.78	.01	.96
n	18		23		15	
Proscribed cluster	-.01	.97	.30	.17	-.23	.41
Controlling for first PHQ-9	.02	.92	.09	.69	-.22	.45
n	18		23		15	
Experiential Cluster	-.01	.98	.06	.78	-.48	.07
Controlling for first PHQ-9	.05	.86	.07	.76	-.34	.23

A multiple linear regression analysis was carried out for end of therapy PHQ-9 change on first PHQ-9 and competence group. Given that the medium group achieved the greatest improvement at end of therapy (Table 7.12E), this group was used as the reference group for this analysis. The overall result was significant (R^2 adjusted = .20, F(3,52) = 5.47, p = <.001), with the greatest predictor of outcome being first PHQ-9 (Table 7.13E). The results in Table 7.14E indicate that there was no difference between the low group and the medium group in predicting outcome. The result for the high group is significant at p = .05. At end of therapy, a client who participated in a PCET session which was rated high for competence would improve by 3.78 fewer points on the PHQ-9 than a client who participated in a session rated medium for competence.

Table 7.14E

Multiple linear regression of end of therapy PHQ-9 change on first PHQ-9, low and high rated total PCEPS

	Unstandardised coefficients			Standardised coefficients		
	B	Std. Error	95% CI	β	*t*	Sig.
(Constant)	1.60	3.24	-4.91 – 8.12		.49	.62
First PHQ-9	-0.60	.17	-.94 – -.27	-.45	-3.56	<.001
Low group	0.14	1.88	-3.64 – 3.91	.01	0.07	.94
High group	3.78	1.88	0.00 – 7.55	.28	2.01	.05

Discussion: Relationship Between Low, Medium, and High Rated Competence and End of Therapy Outcome

When segments were divided into groups rated low, medium, or high for competence, results of Pearson's *r* correlations suggested that only the high group showed any relationship between competence and outcome. For this group in all the clusters of

components except person-centred, higher competence was associated with improvement in depression. However, results of a multiple regression analysis (Table 7.13E) suggested that a client who participated in a PCET segment which was rated high for competence would improve by 3.78 fewer points on the PHQ-9 than a client who participated in a segment rated medium for competence, with a significance level of $p = .05$. This finding may fit with previous research which found a curvilinear relationship between adherence and outcome, where a moderate use of therapeutic techniques was associated with improved outcomes (Barber et al., 2006; McCarthy, Keefe & Barber, 2016).

The finding that medium-rated segments had better outcomes at end of therapy than the low or high-rated segments is the reverse of that found in Chapter 6, where medium-rated segments had poorer outcomes at the next session. The suggestion in Chapter 6 was that change in depression was achieved through different mechanisms in the low, medium, and high rated groups. It was suggested that in the high group, change was achieved through the theoretically supported mechanisms of a focus on emotional experience in the context of a facilitative therapeutic relationship. In the low group, low ratings in the proscribed items of content-directiveness and dominant presence suggested that the therapeutic relationship in these segments was not facilitative, but a positive next-session outcome was still achieved. Following this interpretation, the superior outcomes for the medium group in the current study could be explained if the medium group adapted both the facilitative, relational components and the active experiential components to the immediate needs of the client. Both Barber et al. (2006) and McCarthy, Keefe & Barber (2016) cite the relationship between client and therapist as a possible explanatory factor in the finding of improved outcomes with moderate adherence to therapeutic technique,

where the therapist flexibly adapts the level of therapy intervention that they offer in response to the client's needs.

When the results for Chapter 6 and Chapter 7 are considered together, it appears that PCET therapists are able to help clients to achieve positive outcomes through various mechanisms. One interpretation of the findings of the current study is that the segments rated low for competence achieve beneficial outcomes through the delivery of process-directive experiential interventions, and the high rated segments through nondirective reflections oriented towards the client's emotional experience. The beneficial outcomes found for the medium-rated segments in this study may be perceived by the raters as less competent than the high rated segments, and yet reflect the therapist's responsiveness to the needs of the individual client for more or less process-directiveness. Although this is an appealing explanation, which would fit with both PCET theory and previous research literature, the finding of this study was that the outcomes at end of therapy for the three levels of competence were not significantly different.

Chapter 8

Table 8.1F

Cronbach's alpha for centres, individuals and pairs of raters for each PCEPS item for the PRaCTICED trial

	Centres	Calibration segments for individual raters	R1 & R2	R1 & R3	R1 & R4	R2 & R3	R2 & R4	R3 & R4	Range
N	5	5	20	17	7	7	18	19	
Item 1	-.13	.51	.44	.52	.77	.30	.64	.72	.30 -.77
(95% CI)	[-9.83 - .88]	[-1.02 - 0.94]	[-0.42 - 0.78]	[-0.32 - 0.83]	[-0.34 - 0.96]	[-3.09 - 0.88]	[0.05 - 0.87]	[0.29 - 0.89]	
Item 2	.43	.48	.13	.58	.67	.58	.76	.73	.13 - .76
(95% CI)	[-4.52 - .94]	[-1.13 - 0.94]	[-1.20 - 0.65]	[-0.17 - 0.85]	[-0.89 - 0.94]	[-1.42 - 0.99]	[0.35 - 0.901]	[0.31 - 0.90]	
Item 3	.34	.59	.46	.46	.51	0	.78	.65	0 - .78
(95% CI)	[-5.31 - .93]	[-0.69 - 0.95]	[-0.37 - 0.78]	[-0.50 - 0.80]	[-1.87 - 0.91]	[-4.82 - 0.83]	[0.40 - 0.92]	[0.09 - 0.86]	
Item 4	.81	.70	.42	.49	.65	.50	.81	.76	.42 - .81
(95% CI)	[-.83 - .98]	[-0.24 - 0.97]	[-0.46 - 0.77]	[-0.42 - 0.81]	[-1.05 - 0.94]	[-1.91 - 0.91]	[0.48 - 0.93]	[0.38 - 0.91]	
Item 5	.80	.83	.20	.59	.85	.34	.67	.73	.20 - .85
(95% CI)	[-.88 - .98]	[0.28 - 0.98]	[-1.03 - 0.68]	[-0.13 - 0.85]	[0.12 - 0.97]	[-2.83 - 0.89]	[0.09 - 0.88]	[0.31 - 0.90]	

Table 8.1F continued

Cronbach's alpha for centres, individuals and pairs of raters for each PCEPS item for the PRaCTICED trial

	Centres	Calibration segments for individual raters	R1 & R2	R1 & R3	R1 & R4	R2 & R3	R2 & R4	R3 & R4	Range
N	5	5	20	17	7	7	18	19	
Item 6	.65	.61	.55	.07	.62	.53	.71	.72	.07 - .72
(95% CI)	[-2.37 - .96]	[-0.60 - 0.96]	[-0.14 - 0.82]	[-1.58 - 0.66]	[-1.20 - 0.93]	[-1.72 - 0.92]	[0.20 - 0.90]	[0.26 - 0.89]	
Item 7	.88	.90	.74	.43	.93	.76	.77	.92	.43 - .93
(95% CI)	[-.19 - .99]	[0.61 - 0.99]	[0.35 - 0.90]	[-0.57 - 0.79]	[0.62 - 0.99]	[-0.39 - 0.96]	[0.40 - 0.92]	[0.78 - 0.97]	
Item 8	.37	.62	.66	.67	.84	.19	.65	.92	.20 - .93
(95% CI)	[-5.03 - .93]	[-0.56 - 0.96]	[0.13 - 0.86]	[0.10 - 0.88]	[0.05 - 0.97]	[-3.68 - 0.86]	[0.07 - 0.87]	[0.80 - 0.97]	
Item 9	.58	.59	.42	.62	.83	.72	.76	.80	.42 - .83
(95% CI)	[-3.06 - .96]	[-0.69 - 0.95]	[-0.46 - 0.77]	[-0.05 - 0.86]	[-0.01 - 0.97]	[-0.60 - 0.95]	[0.35 - 0.91]	[0.49 - 0.92]	
Item 10	.81	.69	.23	.50	.57	.51	.67	.72	.23 - .72
(95% CI)	[-.85 - .98]	[-0.27 - 0.96]	[-0.94 - 0.70]	[-0.38 - 0.82]	[-1.49 - 0.93]	[-1.86 - 0.92]	[0.12 - 0.88]	[0.28 - 0.89]	

Item 1   Tracking/Client Frame of Reference   Item 6   Emotion Focus
Item 2   Psychological Holding   Item 7   Dominant or Overpowering Presence
Item 3   Experiential Specificity   Item 8   Clarity of Language
Item 4   Accepting Presence   Item 9   Core Meaning
Item 5   Content Directiveness   Item 10 Emotion Regulation Sensitivity

Table 8.2F

ICC (2,2) for centres and ICC (2,1) for individuals and pairs of raters for each PCEPS item for a wider population

	Centres ICC (2,2)	Calibration recordings for individual raters	R1 & R2 ICC (2,1)	R1 & R3 ICC (2,1)	R1 & R4 ICC (2,1)	R2 & R3 ICC (2,1)	R2 & R4 ICC (2,1)	R3 & R4 ICC (2,1)	Mean for pairs of raters ICC (2,1)	Range
N	5	5	20	17	7	7	18	19		
Item 1	-.06	.12	.22	.32	.59	.05	.28	.58	.34	.05 - .59
(95% CI)	[-.81 - .79]	[-.07 - .69]	[-.13 - .56]	[-.11 - 0.67]	[-.08 - .91]	[-.10 - .47]	[-.11 - .64]	[.18 - .81]		
Item 2	.27	.15	.05	.42	.45	.19	.30	.58	.33	
(95% CI)	[-.62 - .88]	[-.11 - 0.74]	[-.23 - 0.40]	[-.08 - .75]	[-.20 - .87]	[-.13 - .70]	[-.11 - .68]	[.19 - .81]		.05 - .58
Item 3	.28	.23	.28	.21	.37	0	.66	.40	.32	0 - .66
(95% CI)	[-1.52 - .91]	[-.08 - .81]	[-.13 - .62]	[-.14 - .57]	[-.58 - .86]	[-.84 - .73]	[.26 - .86]	[-.02 - .71]		
Item 4	.52	.26	.19	.32	.38	.12	.40	.62	.34	.12 - .62
(95% CI)	[-.26 - .93]	[-.03 - .81]	[-.12 - .47]	[-.17 - .69]	[-.20 - .84]	[-.11 - .60]	[-.11 - .76]	[.24 - .83]		
Item 5	.51	.31	.09	.43	.45	.10	.35	.48	.32	.09 - .48
(95% CI)	[-.26 - .93]	[.01 - .83]	[-.26 - .47]	[-.06 - .75]	[-.12 - .87]	[-.17 - .61]	[-.10 - .70]	[.02 - .77]		
Item 6	.67	.25	.33	.03	.25	.40	.53	.32	.31	.03 - .53
(95% CI)	[-2.33 - .97]	[-.07 - .81]	[-.06 - .65]	[-.37 - .46]	[-.16 - .75]	[-.58 - .87]	[.11 - .80]	[-.11 - .68]		

Table 8.2F continued

ICC (2,2) for centres and ICC (2,1) for individuals and pairs of raters for each PCEPS item for a wider population

	Centres ICC (2,2)	Calibration recordings for individual raters	R1 & R2 ICC (2,1)	R1 & R3 ICC (2,1)	R1 & R4 ICC (2,1)	R2 & R3 ICC (2,1)	R2 & R4 ICC (2,1)	R3 & R4 ICC (2,1)	Mean for pairs of raters ICC (2,1)	Range
N	5	5	20	17	7	7	18	19		
Item 7	.66	.51	.49	.28	.66	.32	.45	.84	.51	
(95% CI)	[-.27 - .96]	[.10 - .91]	[.03 - .77]	[-.23 - .67]	[-.10 - .94]	[-.12 - .80]	[-.08 - .77]	[.63 - .93]		.28 - .84
Item 8	.42	.29	.37	.46	.71	.12	.29	.82	.46	
(95% CI)	[-5.65 - .95]	[-.08 - .84]	[-.06 - .69]	[.03 - .76]	[.08 - .94]	[-.75 - .77]	[-.11 - .65]	[.48 - .93]		.12 - .82
Item 9	.63	.27	.26	.36	.67	.58	.60	.42	.48	
(95% CI)	[-10.28 - .96]	[-.11 - .84]	[-.17 - .62]	[-.06 - .70]	[.04 - .93]	[-.20 - .91]	[.22 - .83]	[-.19 - .77]		.26 - .67
Item 10	.70	.30	.12	.32	.26	.32	.39	.28	.28	
(95% CI)	[-.42 - .96]	[-.03 - .84]	[-.25 - .49]	[-.14 - .67]	[-.20 - .77]	[-.37 - .83]	[-.05 - .72]	[-.11 - .65]		.16 - .39

Item 1 Tracking/Client Frame of Reference	Item 6 Emotion Focus
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