A Small Scale Empirical Study Exploring Counsellors' Perceptions of Client Monitoring and Feedback

By

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Synopsis

This small scale empirical study explored counsellors' perceptions of Client Monitoring and Feedback (CMF). The study took place in the Cognitive Behavioural Therapists' offices in England. Five CBT counsellors, three male and two female, participated in digitally-recorded interviews. Although the research sample was small, it provided some insight into counsellors' perceptions of CMF.

The findings demonstrate that the Cognitive Behavioural Therapists were positive about the implementation of the CMF paradigm in their daily practices but not all of them were supportive of its formal administration. It was interesting that the participants with senior management roles were already implementing formal CMF in their routine practice, while the private CBT practitioners expressed mixed feelings towards the formal implementation of CMF. All of them stated that they are trying to remain client focused and outcome informed in many and different ways.

Further longitudinal research on counsellors' perceptions of Client Monitoring and Feedback (CMF) is definitely warranted. Perhaps the fields of counselling and psychotherapy would benefit if the perceptions of counsellors of different orientations were also explored in the future. It is also necessary to examine how CMF is being implemented in the U.K. and to compare the outcomes of counselling and psychotherapy centres where CMF is formally administered with those where CMF is informally applied.

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Declaration

I declare that the work in this dissertation was carried out in accordance with the regulations of the University of Bristol. The work is original except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other degree.

Any views expressed in the dissertation are those of the author and in no way represent those of the University of Bristol.

The dissertation has not been presented to any other University for examination either in the United Kingdom or overseas.

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List of Abbreviations used:

BACP The British Association for Counselling and Psychotherapy

BERA British Educational Research Association

CBT Cognitive Behavioural Therapy

CMF Client Monitoring and Feedback

EBP Evidence Based Practice

ETR Expected Treatment Response

GSoE Graduate School of Education

OQ The Outcome Questionnaire-45

ORS The Outcome Rating Scale

PCOMS The Partners for Change Outcome Management System

SSR The Session Rating Scale

Chapter 1 Introduction

1.0 Reflexive Preface

This chapter will briefly outline the aims of the research study and introduce the substantive area. The rationale for the selection of the research topic and its relevance and importance to the researcher will also be illustrated. The concluding paragraph will provide an overview of the research project.

This study's epistemological position was that of exploring and understanding the recently emerged field of Client Monitoring and Feedback (CMF), a research paradigm which is synonymous with the client-focused research or the evidence-based practice (Barkham *et al.*, 2001). The theoretical field under exploration, the field of CMF, is situated in the broader fields of counselling and psychotherapy. The specialized problem within this theoretical field was 'Counsellors' Perceptions of Client Monitoring and Feedback (CMF)'. The empirical setting of this research was situated in the practices of a small sample of Cognitive Behavioural Therapists in Britain.

The general conceptual framework for the particular piece of research was informed by the existing theory, the prior research and by the personal experience of the researcher. The idea occurred after discussion with another colleague in the Graduate School of Education (GSoE) in Bristol, as well as after the engagement of the researcher with the relevant literature. This project is clearly a manifestation of the researcher's personal interest in the fields of counselling and psychotherapy. Having been acquainted with the bibliography, the researcher realised that Client Monitoring and Feedback (CMF) is a fascinating area to delve into and an under-researched one. After an extensive search of the literature, studies having explored counsellors' perceptions of Client Monitoring and Feedback (CMF) were not detected. Therefore, besides satisfying the researcher's particular interest, this small scale

empirical study was conducted in order to offer hopefully new and promising insights to the counselling and psychotherapy research community.

1.1 Research Questions

In this small scale empirical study the problem of the Cognitive Behavioural Therapists' perceptions of Client Monitoring and Feedback (CMF) was addressed, which in turn informed the decisions regarding the project's empirical setting.

The research questions devised were:

- Counsellors' understanding of the phrase 'Client Monitoring and Feedback' (CMF),
- Counsellors' perceptions of the benefits of implementing Client Feedback (CF),
- Counsellors' perceptions of the challenges of implementing Client Feedback (CF) and
- Counsellors' suggestions of how the challenges of implementing Client Feedback can be overcome

1.2 Positioning the Research

> *Counselling is a purposeful, private conversation arising from the intention of one person to reflect on and resolve a problem in living, and the willingness of another person to assist in that endeavour.*
>
> *(McLeod, J., 2009, p. 6)*

> *Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his disorder, problem, or complaint.*
>
> *(Wampold, 2001, p. 3)*

The distinction between counselling and psychotherapy has always been a pervasive issue causing much controversy and confusion for all the parties concerned, something which is reflected in the lack of any conclusive definitions in the relevant literature. The different and alternative definitions that have been applied in order to describe the two terms will not be discussed here due to space constraints and because it will be beyond the scope of this project. However, the definitions that have been selected were chosen on the basis of their relevance to an updated conceptualization of the terms counselling and psychotherapy respectively and are, therefore, as recent as possible. Cooper (2008) suggests that the terms 'psychotherapy' and 'counselling' can be used interchangeably especially *"given the lack of any reliable evidence indicating a difference between [their] practices"* (Cooper, 2008, p. 9). For the purposes of this dissertation, therefore, Cooper's example will be espoused and the two terms will be used conversely. Still, it has to be clarified that the research took place in the United Kingdom and the research sample was constituted of British counsellors, who did not refer to themselves as psychotherapists.

The fields of counselling and psychotherapy have proliferated significantly. The practitioners, the individuals who are seeking therapy, the diagnoses and the therapeutic orientations being implemented have been expanded widely with the emergence of more than 400 psychotherapeutic approaches having been described in over 10,000 books

(Wampold, 2001, Duncan *et al.*, 2004). In accordance with the World Health Organisation statistics, 10% of the overall healthcare budget of the United Kingdom is consumed on mental health (WHO, 2005) and as reported by Layard (2004), even disregarding its social dimensions, mental health literally costs the UK 2% of its GDP, since *"there are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's Allowance"* (Layard, 2005, p. 2).

Counselling and psychotherapy have been scientifically verified as remarkably effective practices, more effective than multiple popular medical therapies (Duncan *et al.*, 2004). Evidence form hundreds of meta-analyses throughout the last thirty years have found that the moderate treated person is psychologically better than the 80% of the untreated sample and that 60-65% of the clients experience symptomatic relief within the first seven therapeutic sessions (Duncan *et al.*, 2004; Cooper, 2008; Duncan *et al.*, 2010). The outcome research also reports that the generic trajectory of change in effective counselling and psychotherapy is highly anticipated, with most change happening sooner rather than later (Howard *et al.*, 1996; Brown *et al.*, 1999; Haas *et al.*, 2002; Hansen & Lampert, 2003; Whipple *et al.*, 2003).

Although counselling and psychotherapy are consistently efficacious, premature terminations of therapeutic sessions are substantial, many clients do not improve, clinicians vary in effectiveness and even very effective therapists are poor at distinguishing deteriorating clients. Even if a course of therapy is deemed to be successful, clients are frequently not symptom free after the completion of the therapy (Taylor *et al.*, 2010) and relapse rates remain high (Boschen *et al.*, 2009).

In a study of more than 2000 clinicians and thousands of clients, Brown and colleagues (1999) discovered that therapeutic relationships in which no differentiation was indicated by the third session did not generally lead to a clinically significant change by the end of therapy

(Duncan *et al.*, 2004) . The same study also found that clients who deteriorated by the third encounter were twice as likely to quit therapy than clients who demonstrated improvement (Duncan, *et al.*, 2004; Miller *et al.*, 2006).

A newly emerged research paradigm called client-focused research or practice-based evidence (Barkham *et al.*, 2001) promises to address these issues. Johnson and Shaha (1996) were the first to report the significance of outcome and process tools on the quality and efficiency of counselling and psychotherapy. Various recent studies have documented significant improvements in both retention in and outcome from mental health services when clinicians adapt formal, on-going Client Monitoring and Feedback (CMF) (Duncan *et al.*, 2004; Duncan *et al.*, 2010).

1.3 Overview of the Study

Chapter 1 has briefly outlined the aims and introduced the substantive area of this small scale empirical study. It has also discussed the rationale for this research project describing the motives behind the project's selection as well as its importance and relevance to the researcher. In Chapter 2, an overview of the cognitive behavioural approach will be presented, since cognitive behavioural therapy constituted the research sample's theoretical approach, and then some important findings regarding the fields of counselling and psychotherapy will be reported. The biggest part of the literature review will present evidence for the efficacy of the Client Monitoring and Feedback (CMF) paradigm. In Chapter 3, the research design of the project and what informed its choice will be demonstrated. The development of the research tools and the role of piloting will be also discussed along with a reflection on the strengths, limitations and implications of the research. In Chapter 4, the findings of the research and their analysis with regard to the literature will be presented. In Chapter 5, the key elements of the research will be pulled together and implications for practice and avenues for future research will be drawn out.

Chapter 2 Literature Review

2.0 Introduction

The objective of this section is to denote, comment and critique on the most important empirical findings regarding the focus of this study (CMF). This theoretical elaboration of the theoretical field can be referred to as the problematic within which the researcher worked before having come closer with the particularities of the study's empirical setting (Dowling & Brown, 2010).

In order to be put into context and become, thus, meaningful, the theoretical field of this study had to be framed by some inter-related themes, which are situated in the fields of counselling and psychotherapy. The literature review will begin, therefore, with an overview of the cognitive behavioural approach, which constituted the research sample's theoretical orientation. Then, a review of some basic findings on the counselling and psychotherapy research, which illustrate the necessity for a client-focused outcome-directed clinical practice, will be provided. These findings in turn lead to the emergence of the Client Monitoring and Feedback (CMF) paradigm, which will constitute the biggest part of and will complete the literature review.

2.1 An Overview of the Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is a psychotherapeutic approach which aims at solving problems involving dysfunctional cognitions, emotions and behaviours via a direct, goal-oriented and consistent procedure in the present (http://www.babcp.com/Public/What_is_CBT.aspx). The term 'cognitive behavioural therapy' (CBT) is used variously to mean cognitive therapy, behaviour therapy and therapy grounded in the cognitive and behavioural research. Cognitive behaviour therapy (CBT) is one of the main approaches in counselling and psychotherapy and among others it

incorporates theorems of normal and abnormal human development, and theorems of emotion and psychopathology (http://www.babcp.com/Public/What_is_CBT.aspx).

Pioneered by the psychologist Aaron Beck in the 1960s, cognitive therapy, often labelled as cognitive behavioural therapy (CBT), posits that maladaptive behaviours and disturbed emotions or disposition stem from unrealistic or unhelpful thinking patterns, named automatic thoughts (Beck, 1995). Instead of reacting to the reality of a situation, an individual reacts to his or her own distorted perspective of this situation. This is the main reason why cognitive behavioural therapy (CBT) is frequently manualized and entails 'homework', where clients are assigned to monitor their thoughts and behaviours regarding their symptoms. The mechanism of homework assignments allows clients to practise the skills taught in the therapeutic sessions and to transfer them to their natural settings so that the prolonged symptom improvement can be accomplished (http://www.babcp.com/Public/What_is_CBT.aspx).

There has been a quick aggregation of evidence fostering the efficacy of CBT especially for conditions such as anxiety, depression and substance use disorders (Hofmann & Smits, 2008). Some other researchers have even advocated that CBT is superior to other kinds of therapies (Eysenck, 1994). In Britain, the National Institute for Health and Clinical Excellence (NICE) recommends cognitive behavioural therapy (CBT) as the most effective psychological therapy for a wide variety of mental health conditions, including anxiety, panic phobias, post-traumatic stress disorder, obsessive compulsive disorder (OCD), bipolar disorder, bulimia nervosa, clinical depression and psychosis (National Institute for Health and Clinical Excellence, 2007).

2.2 From the Medical Model to the Evidence-Based Practice (EBP)

Duncan and colleagues (2004) criticize the proliferation of particular psychological interventions or evidence-based practices (EBP) for certain types of mental issues and argue that this clinical practice is the psychological equivalent of the pill for the emotional distress. They also add that although it is quite enticing, it is the psychology's response to the psychiatry's historical predominance on mental health care. Following on the same path, Wampold (2001) maintains that the origins of counselling and psychotherapy are situated in the medical model, which postulates that the positive outcomes of the 'talking therapies' depend largely on the certain ingredients of the particular psychological therapies, that the technical expertise of the clinician accounts for the variability in his/her effectiveness and that there are particular 'treatments' for particular 'disorders'. Duncan and colleagues (2010) maintain that attempts to administer evidence-based practice depend mainly on training practitioners in specific treatment models which are frequently diagnostic specific.

Various governmental, policy-making and funding institutions worldwide, like the UK's National Institute of Health and Clinical Excellence (NICE), have set diverse criteria in order to determine which psychological therapies should be funded, recommended and/or implemented for the treatment of specific forms of psychological distress, a movement which emanates from the concept of 'evidence-based medicine' (Cooper, 2008). The findings are applied to develop an inventory of effective approaches, named evidence-based treatments (EBTs), empirically supported treatments (ESTs), or empirically validated treatments (EVTs) (Duncan *et al.*, 2010). These specific manualized treatments are administered within a research protocol but their operationalization in healthcare clinical settings is totally different because more complicated problems can emerge (Lambert, 2011).

In 1967, Paul raised a fundamental issue, which still remains relevant in clinical psychology:

> *"What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances?"*

(Paul, 1967, p.111)

Specific therapies may prove inadequate in order to resolve a target issue or to prevent future relapse. They might even leave clients more impaired after the intervention and as they can be disseminated to novel settings and populations, additional challenges regarding efficacy could appear (Dimidjian & Hollon, 2010). A client-directed, outcome-informed approach stresses the effectiveness of the therapeutic service delivery when clinicians adopt the clients' frame of reference rather than when they adhere on their expertise or/ and on the fixed techniques of a particular theoretical approach (Duncan *et al.*, 2004).

2.3 What works in Therapy? Evidence from the Counselling and Psychotherapy Outcome Literature

2.3.1 The Dodo Bird Conjecture- Do distinct theoretical approaches produce distinct outcomes?

Duncan and colleagues (2004; 2010) argue that there is no differential efficacy among different therapies. In 1936, the founder of common factors (see 2.4), Rosenzweig, speculated that *"all methods of therapy when competently used are equally successful"* (as cited in Wampold, 2001, p.413).

The evidence for the equivalence of all approaches has been accumulating since when researchers deliberately examined the outcomes of counselling and psychotherapy and the preponderance of the evidence argues that the dodo bird conjecture or the dodo bird verdict (Rosenzweig, 1936), as it has been commonly termed, is the most replicated evidence in the psychological literature; all bona fide therapeutic approaches work about equivalently well and when competently conducted, there is no differential efficacy among theoretical orientations (Duncan *et al.*, 2010).

> *Bona fide therapy is a therapeutic practice delivered in 'good faith'; i.e. one that the practitioner is trained in and committed to, and is based on sound psychological principles. (Cooper, 2008, p. 51)*

Duncan and colleagues (2004) contend that therapy works, but people's understanding of how it works cannot be traced in the insular answers of the distinct theoretical approaches, but in the common factors (see 2.4) that transcend all orientations and they conclude that attaining Client Feedback (CF) is an effective means to mobilize the common factors in the 'talking therapies' (Duncan *et al.,* 2010), since the basis for a clinically significant change depends on the degree of clients' utilization of the therapeutic resources available to them (Cooper, 2008).

2.3.2 What is the Impact of Therapists' Training and Experience on Clients' Outcomes?

Another striking yet interesting and consistent finding in the counselling and psychotherapy literature is that there is little difference in the therapeutic efficiency among experienced professionals and degreed practitioners (Stein & Lambert, 1995), with some studies demonstrating better outcomes for paraprofessional and trainees (Lambert & Ogles, 2004). Researchers have failed to provide evidence that professional training, experience, licensure, and/or certification affect their efficiency (Beutler *et al.,* 2004).

Duncan and colleagues (2004) suggest that there is only one way to know if therapists are learning from experience and that is to monitor outcome. Lambert and Ogles (2004) add that increasing the amount and type of training and experience that the majority of therapists receive might reduce their therapeutic effectiveness.

2.4 The Contextual Model and the Common Factors Approach

In complete opposition with the medical model and the evidence-based practices in counselling and psychotherapy (see 2.2), the meta-analysis by Miller and colleuagues (2008) found that allegiance effects accounted for the 100% of the variability in outcome among orientations, which implies that a clinically significant change happens because there is a

single theory or rationale that is respectable and reasonable for both the therapist and the client.

> *Researcher allegiance effects is the tendency for researchers to 'find' results that support their own beliefs, expectations or preferences.*
>
> *(Cooper, 2008, p. 48)*

Duncan and colleagues (2004) add that with over 400 therapy models and techniques to select from, there no reason for a blind allegiance to a certain approach if it is not effective and argue that models and techniques provide a frame for delivering therapeutic services and, more importantly, alternate modes of addressing client concerns, when the latter do not seem to benefit.

The earliest mention that the fundamental elements for a clinically significant change are a set of non-specific and unrecognized ingredients common to all approaches was proposed by Saul Rosenzweig (1936) in the 1930s. Wampold (2001) coined the phrase 'contextual model' of counselling and psychotherapy to illustrate a therapeutic setting which incorporates this set of common factors found across high-quality therapies. Part of the empirical evidence in favour of the contextual model of common factors in has been accumulated through meta-analyses (Lambert, 1999; Wampold, 2001; Duncan *et al.*, 2010).

Lambert's meta-analytical studies (1999) detected four factors for better therapeutic outcomes: extra-therapeutic variables (40%); common factors (30%); hope, expectancy, and placebo (15%); and model or technique (15%), which is a bold challenge of the frequent reverence which several clinicians and researchers place on their preferred models of working (Duncan *et al.*, 2010).

The common factors model of 'the helping professions' is a superordinate meta-model which accepts that all theoretical orientations and all types of healing in general are equally effective due to their common factors, which are a healing setting, a conceptual framework/

myth/ rationale that accounts for the client's present problematic situation and the approach for resolving it, a good therapeutic alliance between the healer and the client and a ritual/ procedure which requires the engagement of both the clinician and the client for the successful resolution of the problematic issue (Wampold, 2001).

Wampold's (2001) meta-analytical study assigns only 13% of the overall outcome variability to therapy including its components such as the clinician, the therapeutic alliance, the model or technique, the allegiance and the placebo (in 2008, Cooper described the placebo as a procedure that although remaining trustworthy to the research's subjects, lacks the apparently effective components), with 87% of the variability due to the client or extra-therapeutic aspects as well as unexplained and/ or error variance. These extra-therapeutic elements are the most prevailing in the common factors and consist of client strengths, resources, aspirations, and even events due to chance. The amount of variance attributed to clinician aspects is estimated six to nine times more than any therapy delivered, making them the second most important determinants of an effective therapeutic mix (Beutler *et al.,* 2004).

Wampold (2001) makes the distinction, though, that embracing the contextual model does not minimize the necessity of training in certain techniques; on the contrary, models and techniques are vital components of successful outcomes. Accepting and believing in a myth and a ritual within a specific social context might reinforce effective practice and therefore, therapists should be able to administer various distinct therapies in order to guarantee a good fit with the individual seeking therapy (Wampold, 2001).

2.5 The Therapeutic Alliance (TA)

In the constant debate between the treatment methods and the therapeutic relationships, Norcross and Lambert wonder:

Do treatments cure disorders or do relationships heal people?

(Norcross & Lambert, 2011, p.4)

The concept of the therapeutic alliance (TA) among the healer and the client originates from the psychoanalytic and psychodynamic psychotherapy and is conceptualized as the conscious 'therapeutic bond' or 'working alliance', in contrast to the unconscious, transferential and/ or countertransferential relationship, as it was first outlined by Freud (1958). The current definitions of the 'therapeutic alliance' or the 'helping alliance' vary slightly, but the simplest one may be the *"quality and the strength of the collaborative relationship between client and therapist" (Horvath & Bedi, 2002: 41)*. Bordin (1979) was the first one to provide a definition of the alliance that could be employed across distinct theoretical approaches. He defined it as consisting of the relational bond among the therapist and the client as well as their agreement on the goals and tasks of therapy, which includes among others, the frequency of sessions, the topics of discussion, managing cancellations and the payment.

The alliance is the most frequently cited common factor in the counselling and psychotherapy literature (Karver *et al.,* 2006). The implementation of any agreed rationale or technique reflects the alliance in action. Several alliance measures, such as Miller's Session Rating Scale (SRS; Duncan & Miller, 2008), have been applied in many studies so far (McLeod, 2011); the graphic depiction of the alliance ratings on the therapist's computer and their sharing and discussion with clients in each session provides the latter a format for voicing their perspectives about the therapeutic direction and the desired outcome (Barth *et al.,* 2011). Two recent studies (Baldwin *et al.,* 2007; Owen *et al.,* 2010) found that clinicians who generally develop better alliances are also very effective because therapist-client collaboration and goal consensus are strongly linked with positive therapeutic outcomes (Tryon & Winograd, 2011). In fact, Owen and colleagues (2010) found that a 40% of the variance in the therapeutic outcome due to the clinician depends on the client's alliance

rating in the last visit. The process/ alliance measures and how they are used by therapists and clients in normal clinical practices will be discussed in more detail along with the progress measures in the subsequent section (see 2.6).

2.6 Client Monitoring and Feedback (CMF)

2.6.0 Introducing the Client Monitoring and Feedback (CMF) Paradigm

> *We shall not cease from exploration and the end of all our exploring will be to arrive where we started and know the place for the first time*
>
> *(T.S. Eliot as cited in Norcross & Lambert, 2011, p.98)*

Similarly to the alliance ratings scales, one of the most significant, promising and cutting edge advancements in clinical practice, which emphasizes a common factors approach, has been the design of standardised systems which monitor and provide feedback on client progress (Miller *et al.*, 2005; Lambert, 2007; Anker *et al.,* 2009). Some standardised rating scales not only measure progress and outcome but also include ratings of therapists aiming at the improvement of the overall therapy response (OQ; Lambert *et al.,* 2004; PCOMS; Miller *et al.,* 2005;). Introduced by Howard and colleagues (1996), the client-focused research paradigm is continuously increasing in popularity since it can monitor EBPs and improve overall therapy outcomes (Lambert *et al.,* 2005).

There are many and different types of outcome measurement methods such as the Outcome Rating Scale (ORS; Miller *et al.,* 2003), the Outcome Questionnaire-45 (Lambert *et al.,* 2004), the Partners for Change Outcome Management System (PCOMS; Miller *et al.,* 2005) etc. In these process and progress feedback systems, clients complete brief process and outcome measurement forms in every therapeutic session and then their ratings are processed by the computer and fed back to the clinician prior to the forthcoming session. The ongoing Client Monitoring and Feedback (CMF) to clinicians accompanied with the aid of statistical methodologies, progress graphs and predictive algorithms can enhance outcome and assist practitioners to be alert and adaptable through encouraging earlier referrals when there is a

mismatch (Lambert, 2011). If clients' outcome ratings are deviating significantly in a negative direction from what would be considered as desirable for a specific level of distress, then the feedback to the clinician is accompanied by an 'alarm signal' which alerts the therapist that there is a probability of negative or null clinical outcome. In such cases, clinicians are also advised to cautiously review each case and to devise potential plans of action for addressing the problems, such as improving the therapeutic alliance (Duncan *et al.,* 2010).

Currently, researchers have launched electronic versions of multiple well-established client questionnaires on palm held computers, which are time-saving as far as coding and analysing are concerned and allow for an immediate review of all the data sets in the therapist's computer (Clough & Casey, 2011). Such measures which can now be electronically administered are among others the PCOMs, the OQ etc.

2.6.1 Benefits regarding the Implementation of Client Monitoring and Feedback (CMF) deriving from Component and Meta-analytical Studies

Evaluating progress and providing Client Feedback (CF) is interrelated with the most robust finding of more than 40 years of counselling and psychotherapy research; that the quality of the client's engagement is the major determinant of a successful healing practice (Duncan *et al.,* 2010). Duncan and colleagues (2010) argue that the structured application of standardized outcome evaluation forms which measure client progress at every therapeutic meeting and the conscientious implementation of the findings can transform therapists' ability to influence therapy response. A growing body of evidence demonstrates that the routine Client Monitoring and Feedback (CMF) can alarm practitioners in real time about negative progress against typical and atypical therapy trajectories and, therefore, enhance their effectiveness (Cooper, 2008; Duncan *et al.,* 2010).

In a meta-analysis of three trials (Lambert *et al.,* 2001, 2002; Whipple *et al.,* 2003), the feedback pioneer Lambert and colleagues (2003) reported that Client Feedback (CF) versus

no Client Feedback led to a more cost-effective service delivery; clients who were progressing as expected attended significantly fewer sessions when Client Feedback (CF) was attained than those whose clinicians did not receive any Client Feedback (CF). The same meta-analytical study also found that clients in the feedback group who were at risk for a negative or null outcome attended more sessions and at the conclusion of therapy indicated better outcomes than 65 per cent of those in the non-feedback group (Duncan *et al.*, 2004; Miller *et al.,* 2006).

Studies by Whipple and colleagues (2003) and Harmon and colleagues (2007) reported that clients whose therapists had access to outcome and alliance data were less likely to deteriorate, more likely to continue therapy, and twice as likely to accomplish a clinical significant outcome. The same studies also found that adding ratings of the therapeutic alliance, willingness to change and perceived social support for clients who were progressing indicated incremental effectiveness over the continuous Client Feedback measurement alone (Duncan *et al.,* 2004). Two studies (Harmon *et al.,* 2007; Hawkins *et al.,* 2004) reported that applying on-going outcome ratings was beneficial to all clients, although those who were predicted as failing in therapy improved more. Baldwin and colleagues (2007) found that the therapist's variance in the therapeutic alliance ratings predicted clinical change, implying that the alliance may represent a vital element for influencing the variability due to therapist. Studies further indicate that therapies in which little, no clinically significant change or worsening of symptoms occur early in the process are at significant risk for a null or even negative outcome (Brown *et al.,* 1999).

Lambert and colleagues (2001; 2005) reported that therapists are frequently poor at assessing therapy process and outcome, a finding which has been replicated in many other studies as well. In Anker and colleagues' study (2009) 9 out of 10 clinicians reported that they were already attaining informal Client Feedback (CF) about the progress and the therapeutic alliance, but it was found that client and therapist alliance ratings did not coincide. This

empirical evidence may suggest that therapists should be mindful and humble and take actions in order to combat their collective tendency towards therapist-centricity (Norcross & Lambert, 2011).

Overall, research supports the routine measurement of outcome in everyday clinical practice and that eliciting Client Monitoring and Feedback (CMF) influences therapeutic effectiveness since it can forestall negative outcomes (Whipple *et al.*, 2003; Lambert, 2011). The aforementioned findings support conclusions documenting the superiority of real time, clinic-based utilizations of computer assisted actuarial methods over clinical judgement alone in predicting therapeutic outcome (Duncan *et al.,* 2010).

2.6.2 Challenges regarding the Implementation of Client Monitoring and Feedback (CMF) and some Arguments against CMF

Duncan and colleagues (2010) argue that the implementation of consistent Client Feedback (CF) improves outcomes irrespective of the specific approach adopted by the therapist and that whether it is elicited in person or over the phone, via paper and pencil administrations or via electronic format, it matters not. Research and clinical experience, though, suggests that many practitioners question the impact of information technology in upgrading client care (Ager, 1991). Studies have detected several clinician barriers in incorporating technological adjuncts in therapy such as lack of therapists' competence, apprehensiveness towards the importance of technology, cost of implementation, time investment and difficulty in role adaptation (Ager, 1991). Furthermore, many clients may refuse to provide formal Client Feedback (CF) via paper and pencil administrations in every therapeutic session because they may not be willing to complete forms or because they might think that it is time-consuming, impersonal or interferes with the therapeutic process. Following on the same path, in cases of illiteracy or severe physical difficulty, attaining formal Client Feedback (CF) via paper and pencil administrations is not feasible, so there should be other avenues for the therapists in order to remain client-focused.

Other evidence supports that the duration and complexity of some of the outcome measures prevent their implementation in real world clinical settings (Miller *et al.,* 2003). Indeed, Brown and colleagues (1999) found that the majority of practitioners are unlikely to apply any measure or combinations of measures that demanded more than five minutes to complete, rate and interpret because they not only require accurate and credible but also feasible tools (Miller *et al.,* 2006). Kelley and Bickman (2009) add to the previous finding that any measure designed for clinical use must be brief, psychometrically sound and functional. Duncan and colleagues (2010) on the other hand, argue that due to the widespread availability and popularity of computers, it is now possible for practitioners to obtain outcome information about clients' progress in real time.

Duncan and colleagues (2010) recognized, though, other challenges which contributed to the lack of the implementation of the Client Monitoring and Feedback paradigm (CMF), such as a 'passive resistance' of practitioners originating from a feeling of reduced independence and a perceived lack of professional worth added to the existing mechanisms for inspection of clients' progress, namely case reviews and supervisions.

Another limitation for the adaptation of Client Monitoring and Feedback (CMF) may be that seasoned clinicians may benefit more from the formal administration of CMF than less experienced practitioners, at least as far as session attendance is concerned (Lambert *et al.*, 2002). Thus, techniques of assisting trainees to deal with clients who are not differentiating from therapy could be especially vital (Lambert *et al.,* 2002). Additionally, irrespective of therapist experience therapist responsiveness might be crucial for maximizing therapy outcome via the implementation of CMF. Examining the differential effects of therapists might be an area which needs further examination.

In their now classic article on the dose-effect relationship, Howard and colleagues (1986) reported that between 60-65% of clients experienced significant symptomatic relief within

one to seven visits, a percentage that increased to 70-75% after six months and 85% after one year. The findings continue to be congruent with the dose-response literature which reports that the therapeutic benefits may have a relationship to the number of healing sessions a client attends (Lambert *et al.,* 2002). The authors and researchers suggest that Client Feedback (CF) may influence outcomes through improving the attendance of deteriorating or not differentiating cases rather than because it leads practitioners to engage in distinct activities or to make referrals (Lambert *et al.,* 2002). This aspect of therapy is not well researched and therefore, further research is definitely warranted in order to elucidate which elements constitute CMF more efficient than no CMF at all.

Soliciting Client Feedback (CF) has also been criticized as a practice driven by therapists' financial incentives. Duncan and colleagues (2010) do not deny that highly efficient clinicians can utilise the data for advertising and marketing purposes and they also suggest that the rest of the practitioners can enhance their efficiency if they implement the information conscientiously in their daily practices.

2.6.3 Limitations of the Research on the Client Monitoring and Feedback (CMF) Paradigm and Recommendations for Future Research

There are several limitations of the research on CMF which warrant further mentioning.

The fact that only a small number of studies on the CMF paradigm have been conducted so far is perhaps the most important limitation (Lambert *et al.*, 2001; Lambert *et al.,* 2002; Whipple *et al.,* 2003; Hawkins *et al.,* 2004; Harmon *et al.,* 2007; Slade *et al.,* 2008). Further limitations constitute the facts that only a small number of researchers have been involved in these studies with subjective inclusion criteria. Further replications across diverse client populations and settings should be conducted by different research groups, so that allegiance effects can be somewhat controlled.

Another weakness is the fact that different alliance measures were used in different studies (Barkham *et al.,* 2001; Lambert *et al.,* 2002; Miller *et al.,* 2006) and a noticeable issue is that the alliance may have been conceptualized and measured differently as well. The field may benefit from taking initiatives to espouse a common definition of the alliance. Of particular interest would be studies that would evaluate the convergent validity of the alliance measures in order to decide the extent to which they overlap.

Additionally, the widely used feedback systems, which process sessional alliance and outcome data, are not without drawbacks, since they normally rely on anticipated treatment response curves (ETR), which are estimated for each client and which are then compared to a reference group of previously treated clients (Lambert, 2007). The models' assumption that all clients, even those with the same symptom severity at intake, follow the same trajectory might though, be a little bit simplistic since the empirical evidence demonstrates that clients with diverse demographics, personalities, concerns and/or adaptive capabilities follow distinct trajectories during counselling and psychotherapy (Stulz *et al.,* 2007).

2.6.4 Conclusions

Although it has been underutilized in practice, CMF is a significant addition to the therapeutic toolkit and seems quite promising since deterioration rates remain high in routine care practices and since practitioners despite their confidence in their clinical intuition, are not ready to therapy failure (Barkham *et al.*, 2001; Hansen *et al.,* 2003; Duncan *et al.,* 2004). Despite the aforementioned challenges regarding its formal administration and the limitations of the research which has been conducted so far, the accrued evidence is substantial in favour of CMF's routine application.

Timely feedback allows therapists to collaboratively proactively monitor their efficiency, to detect ruptures, to tailor their approach depending on client preference about the benefit and the fit of the services provided and achieve a theoretical breadth as therapists via expanding

their repertoire to assist more clients, which leads to positive clinical outcomes through reducing significantly the rates of deterioration and the premature session terminations (Duncan *et al.,* 2010). Continuous Client Monitoring (CM) contributes to helping therapists build a strong therapeutic alliance and research repeatedly shows that clients' ratings of the alliance are far more predictive of progress than any type of intervention or the therapist's ratings of the alliance (Duncan *et al.,* 2010). The ritual of Client Monitoring (CM) also may enhance client expectancy, amplifying active engagement and guaranteeing a strong therapeutic alliance, since allegiance effects are always implicated in every research (Luborsky *et al.,* 1999).

2.7 Summary

The aim of this literature review was to frame the research under discussion within the broader fields of counselling and psychotherapy and more specifically within the theoretical filed of Client Monitoring and Feedback (CMF), through exploring CMF's background, as well as considering the arguments for and against its formal administration in clinical healthcare settings. The remaining chapters will focus on the empirical research project undertaken in order to explore counsellors' perceptions of Client Monitoring and Feedback (CMF); particularly, CBT practitioners' understanding of the CMF paradigm, their perspectives on the benefits and challenges related to its implementation and how these challenges can be overcome.

Chapter 3 Research Methods: a Description of the Research Study

3.0 Positioning the Research

Historically, the vast majority of research on counselling and psychotherapy has been predominated by the quantitative methods of inquiry such as those utilised within the fields of psychology and psychiatry (McLeod, 2011). The research on Client Monitoring and Feedback (CMF), an outcome-directed research paradigm, which is being currently implemented mostly in the United States, has employed a positivistic empirical perspective as well. Such quantitative research has been reviewed in the Literature Review (see Chapter 2) aiming at illustrating that although researchers comment on such findings, the U.K. practitioners' point of view has not yet received much attention in what these findings may mean. As a result, counsellors' perceptions of Client Monitoring and Feedback (CMF), especially in the United Kingdom, as evidenced by the lack of any published research have not been given much voice.

The focal point of the present research was counsellors' perceptions of Client Monitoring and Feedback (CMF). It was felt that this was an important phenomenon to be explored, especially since it is very efficacious, as it is suggested by the relevant evidence. Still, despite the efficacy of implementing formal Client Monitoring and Feedback (CMF), only a minority of counsellors are applying this outcome informed paradigm in their daily practice and especially in the national context of the Cognitive Behavioural Orientation in the U.K. the routine CMF is highly neglected (Duncan *et al.*, 2010). This fact was surprising and therefore, it was judged that it definitely warranted further research.

3.1 Research Design

Having got closer to the theoretical field under investigation, the *empirical field* is going to be explored and narrowed further for the specific purposes of this research.

> *The empirical field may be glossed as the broad range of practices and experiences to which the research relates.*
>
> *(Dowling & Brown, 2010, p. 147)*

The methodology used in this study provided ways to approach and answer the research questions and was informed by the epistemological stance of the study. The qualitative research questions chosen indicated a specific direction without though predicting any results and they included one process-oriented question as well. All of them were provisional because the terminology 'Client Monitoring and Feedback' (CMF) may not have been relevant to the research sample's experience. The interview schedule was constructed within the objective of the research questions, which for purposes of convenience are recapitulated below:

- What is the counsellors' understanding of the phrase 'Client Monitoring and Feedback' (CMF)?
- What are the counsellors' perceptions of the benefits of implementing Client Feedback (CF)?
- What are the counsellors' perceptions of the challenges of implementing Client Feedback (CF)?
- How can the challenges of implementing Client Feedback (CF) be overcome?

3.2 The Philosophical Perspective of the Study

This small scale empirical study's philosophical perspective was mediated by the philosophical perspectives of interpretivism (Weber, 1964), social phenomenology (Schutz, 1972) and social constructionism (Vygotsky, 1978).

The exploration of phenomena from the interviewees' mindset and the extraction of meaning from the participants' accounts constituted the focal point of this study, which can be situated within the context of the qualitative research paradigm of interpretivism (Weber, 1964). According to interpretivists, reality is a construct to which individuals attribute totally different meanings.

Similarly, due to the nature of the research questions explicitly dealing with the domain of beliefs, perceptions and meaning of participants (Denscombe, 2007) a phenomenological approach was warranted. To keep things as simple as possible, the social phenomenological approach was adopted, a model according to which people are *"creative interpreters of events who, through their actions and interpretations, literally make sense of their worlds"* (*ibid.*, p. 78). The father of phenomenology, Albert Schutz (1967), argues that the world is constituted of multiple realities and the task of the phenomenologist is to make sense of how people construct meaning, which is socially mediated and thus, created and re-created via social interaction. Research from the epistemological stance of social phenomenology sets the researcher's own conceptions as the basis for the interpretation of the participants' accounts.

The research's spirit was also mediated by the theoretical and epistemological position of social constructionism. According to social constructionism, human experience, including perception, is reflected historically, culturally and linguistically and is never an immediate representation of environmental conditions but must be seen as a particular reading of these conditions (Willig, 2008). There is no absolute 'knowledge' but multiple 'knowledges'

depending on the different ways people perceive reality (Willig, 2008). Research from a social constructionistist perspective is socially and culturally situated with the researcher is part of the researched world (Cohen *et al.*, 2011).

Following, thus, the epistemological stances of interpretivism, social phenomenology and social constructionism the objective of this research was the presentation and description of the participants' perceptions of CMF based on their subjective experiences. A report of the participants' accounts and an elucidation of how they came up with their interpretations were attempted, trying as much as possible to keep any interference with their descriptions to a minimum. The understanding of the respondents' perceptions, though, was influenced by the researcher's own assumptions and standpoint. This limitation of conducting a qualitative research is going to be addressed in a later section of this chapter (see 3.7).

3.3 The Contextual Setting and the Participants

Within the empirical field (variety of practices and experiences related to the research) of the Cognitive Behavioural oriented practices of counsellors in Britain, the practices of a small sample of counsellors originated from the social and cultural milieu of the Cognitive Behavioural Orientation based in the United Kingdom were selected to be explored. This constituted the localized empirical setting of the research, which was motivated by the theoretical field of CMF and more specifically, by the particular problem of this research, namely the exploration of counsellors' perceptions of CMF.

> *The empirical setting refers to the local region of experience about which the researcher wants to make claims- the observed position. The setting is a specified region within a broader empirical field.*
>
> *(Dowling & Brown, 2010, p.8)*

Purposive sampling was deliberately selected since it enabled the researcher to recruit respondents according to criteria which were relevant to the research and field questions (Willig, 2008). The process of interviewing occurred within the time period June- July 2011.

Five CBT counsellors, three males and two females, born between 1976-1963, and accredited by the British Association for Counselling and Psychotherapy (BACP) were interviewed. Two participants were CBT counsellors with senior management roles and three were private CBT practitioners. For purposes of convenience, they all were interviewed in natural occurring settings of their preference, namely in their offices. Still, it has to be acknowledged that there are no neutral settings when conducting research in general.

3.4 The Method of Data Collection

With an interest in conducting qualitative research and given the nature of the research questions, it was judged that exploratory, face-to-face interviews in a semi-structured arrangement as a method of data collection of a complex problem was particularly suitable. The interviews resembled a conversation with a basic pre-structuring of form and content so that the consistency across the sample could be maintained (Dowling & Brown, 2010) but the non-directive, semi-structured approach allowed the emergence of new and unanticipated themes as well as the free expression of participant-generated perspectives, which potentially may have not been part of the data in a more strict approach (Cohen *et al.,* 2011). By implementing an indirect approach as far as the field questions are concerned, the respondents were likely to produce frank and open answers (Cohen *et al.,* 2011). The instrument of the research was flexible and sufficiently open-ended to enable the contents to be re-ordered (Cohen *et al.,* 2011). In this interactional context, the same wording and order was applied in all questions.

After careful pre-piloting of the interview schedule with a colleague from the Graduate School of Education in Bristol and piloting with two counsellors of distinct theoretical orientations based in the U.K, the field questions were refined. The interview questions unfolded around the research questions. The interviews lasted approximately 20 minutes each, took place in private and quiet naturalistic settings, namely the counsellors' offices, which minimized any chances of disturbance from extraneous factors. As the interviews

unfolded, the researcher probed (asked further questions in order to gain insight for underlying factors which drive particular responses) for clarifications and more contextual information, while being extremely cautious not to ask any leading questions that would bias participants' responses or refer to any sensitive issues. The participants' responses were rephrased and summarized where appropriate so that validation could be achieved. The researcher's attitude was that of curiosity and genuine respect for the interviewees' perspectives. Detailed and comprehensive accounts were attempted to be collected, so ignorance was expressed since the ultimate objective was to see and report from the eyes of the participants (Cohen *et al.*, 2011). In cases when the researcher was directly asked for an understanding of the literature, it was promised that an interpretation of the literature would be shared at the end of each interview.

The respondents re-defined the phenomenon under investigation and generated novel insights for the researcher. Still, it has to be acknowledged that there were the research questions that drove the interviews. A pre-arranged set of questions administered via a paper questionnaire would be insufficient. Although using questionnaires would have allowed a larger sample, it was decided that the quality and texture of experience were more important than the quantity in this particular context.

3.5 The Method of Data Analysis

The accounts of the participants were digitally recorded via an MP3 recording device and then transcribed. Having defined the 'status of the texts' (transcriptions) as an accumulation of different themes, a thematic analytic framework at a semantic level (Braun & Clarke, 2006) was used for the analysis of what the transcribed verbatim represented. Given the research and filed questions, it was largely known from beforehand how the responses would be structured into categories and themes. To ensure that the themes expressed the participants' accurate perspectives, the results of the thematic analysis of the interview transcriptions were sent to all participants, where they were asked whether there were any

discrepancies between what they intended to say and what had been transcribed. No participants expressed any objections to the way their responses were classified, which suggests that the allocation of themes was conducted in a satisfactory manner. A letter of thanks was sent to the participants of the research and they were also thanked verbally for their time.

3.6 Ethical Considerations

The theoretical ethical field of this project were the Ethical Guidelines of the British Educational Research Association (BERA, 2004). After discussing these guidelines and the details of the project with a fellow Med student, formal e-mails were sent to the appropriate officials, namely to the heads of the counselling centres where CBT was being implemented as well as to private CBT practitioners based in the U.K. The aim of this correspondence was to request official permission from the target community before embarking on the project. The purpose, nature and methods of the project as well as the potential benefits the participants as well as the research community of counselling and psychotherapy would reap from this project were reported. Informed consent was fully gained through signing a standard form in which, specific ethical conventions were decided and honoured.

In particular, the participants were informed about their right to withdraw consent and to discontinue participation in the research at any time without being penalised. Furthermore, they were informed about their right to contact the supervisor of the researcher or the researcher via email in case they had any concerns about the procedure. It was important to assure the subjects of the research from the very beginning that their names and all identifying information would be anonymized and that the recordings would be discarded upon accurate (as possible) transcription. The intention of the researcher to store the data securely and in accordance with the Data Protection Act was asserted and accompanied by the objective to keep the scripts till the end of the academic year when they would be destroyed. Additionally, the objective to use some quotes from the interviews in the

dissertation and to share the findings within the Graduate School of Education in Bristol after all information has been made anonymous was declared. After the data collection, the participants were informed about the full objectives of the research and about how the data would be disseminated and they were asked for their systematic feedback, confirmation, cross-checking and validation on the transcripts and interpretation of the findings.

3.7 Strengths, Limitations and Implications of the Research

Due to the nature of this qualitative research, access to some novel insights was definitely gained but all the principles that were imposed throughout recording and interviewing were impossible to be obvious to the researcher and it is potent that the researcher's implication may have transformed the setting of research somewhat, making it impossible to conduct a pure naturalistic enquiry. Allegiance effects are always a possible influence in any research (Luborsky *et al.,* 1999) and the researcher's background, pre-conceptions, interests and preferences may have been brought to the data. The fact that the researcher was a supporter of the formal application of Client Monitoring and Feedback (CMF) may have positively skewed the respondents' answers to a certain extent due to a potential drive towards social desirability but any personal opinions were not revealed unless requested by the participants and shared after the completion of the interviews.

Another limitation of this study may have been the fact that Client Monitoring and Feedback (CMF) is a cross-cultural concept and it might have been possible not to have made sense to everybody, which would have led to confusion. Fortunately, this was not the case with the particular research sample. The construct 'CMF' was recontextualized in order to be relevant in the U.K. To illustrate, formal Client Monitoring and Feedback (CMF) as conceived and implemented mostly in the United States was not mentioned at all; on the contrary, the focus was on Client Monitoring and Feedback (CMF) in whatever form the counsellors made sense of it. The research questions were open, so they did not limit what was found. Still, the research design and the methods applied may have constructed the data and the findings in

some degree. With hindsight, a mixed methodological approach may have yielded more robust findings but a methodological triangulation was not pursued due to time constraints. The interviews themselves were time-consuming and placed practical limitations to the research but the fact that two participants with senior management roles were included in the research sample has to be acknowledged. This was a major advantage since these two respondents functioned as representatives of the philosophy of all the Cognitive Behavioural Therapists who were working in these particular settings and they did claim so. This definitely added to the validity of this study.

In theory generation, both confirming and disconfirming cases were incorporated with the discrepant evidence not to be so much an exception to the rule but a variation of the pre-existing theory (Cohen *et al.,* 2011). This evidence constituted a strong test of the theory; it led to the modification and elaboration of the construct under exploration and it definitely enhanced the researcher's way of thinking about the phenomenon under investigation. For example, all participants were supportive of the use of Client Monitoring and Feedback (CMF) but not all of them were in favour of its formal application; they also yielded responses of how counsellors can attain Client Feedback (CF) from a multitude of sources contributing, thus, to a more accurate and credible implementation of the phenomenon under examination. For a detailed account of the findings of the research, please refer to Chapter 4.

Even though this small scale empirical study's findings cannot be generalized to the wider population and this was not the intention of the current research, it could be supported that, if *'a given experience is possible, it is also subject to universalization'* (Haug, 1987: 44). Thus, even though the number of CBT counsellors who share the same perceptions worldwide is not known, the findings are definitely culturally and socially situated within the social and cultural milieu in which they were produced, namely the Cognitive Behavioural oriented practices in the U.K. Due to the context boundedness of the interview

generated data (Cohen *et al.,* 2011) a generalizability of the results could be only meaningful within the local empirical context of this study. It is also interesting to mention that because of the naturalistic nature of the research it may be more appropriate if the comparability and transferability of the findings were mentioned (Cohen *et al.,* 2011). Still, the readers themselves are those who will judge whether transferability was achieved in this study. Despite some elements of the research design which may have limited the validity of the findings, the project has nonetheless provided some interesting areas for reflection and Chapter 5 will refer to some possible areas that might benefit from future research.

3.8 Summary

The objective of the research design was to produce a detailed and rich account of CBT practitioners' perceptions of Client Monitoring and Feedback. An interpretive approach to the study was deemed more appropriate than a positivist one, given the focus of the small scale empirical study to shed light to the attitudes and experiences of Cognitive Behavioural Therapists regarding CMF. Ethical issues were identified and considered seriously early on in the research design process. The limitations of the research coincide with those encountered when conducting a qualitative research study and issues of validity and reliability were discussed earlier in this chapter (see 3.7) and will be referred to again very briefly in the subsequent one (see 4.0 and 4.8 respectively). Thematic analysis was selected as a method of interpreting the data, which allowed the presentation and analysis of the findings of the study, which follow in Chapter 4.

Chapter 4 Presentation and Analysis of Findings

4.0 Introduction

In qualitative research the data analysis is almost inevitably interpretive as a result of the active engagement of the researcher with the data (Cohen *et al.,* 2011). The report of the findings of this research must be seen as recontextualizing this process in order to establish

a case. As Cohen and colleagues (2011) suggest, reporting involves a double hermeneutic process since the researcher interprets the data from the subjects who have already interpreted them according to their perspectives, and then re-constructs them in his/her words. The production of the local empirical findings (data) involved an active selection on the perceived environment, since it was impossible to report all the data that were obtained through recording everything that may have occurred in a specific setting. The recording itself was an act of translation and transformation and the selecting and ordering may have imposed some personal bias, which were also addressed in chapter 3 (see 3.7). In this study, all the aforementioned weaknesses of conducting a qualitative research as well as any potential subjectivity were attempted to be kept at a minimum through taking into consideration the contextual factors of the empirical setting as much as possible.

All phenomena under exploration were categorized and ascribed codes pre-ordinately (before the data collection) as well as responsively (after the data collection) and in complete accordance with the research questions of the study, which made their analysis easier. This was a very useful approach in order to manage, analyse and present the data since it draws together all the relevant data under a particular theme of interest to the researcher, and maintains, thus, the interconnectedness and wholeness of the participants' accounts. Some respondents' accounts were particularly qualitatively rich and led to the emergence of new themes and categories. The research questions were understandable and of importance to the target group, the categories and codes were meaningful to the participants and the results were made available to the members of the target culture for review and comment, so that theoretical triangulation could be accomplished (Cohen *et al.*, 2011).The analysis concentrated on making sense of the respondents' accounts both in terms of what they said as well as how they said it, since language in a semi-structured approach of interviewing is highly indexical.

The objective of this chapter is, therefore, the presentation and illustration of the themes which emerged from the thematic analysis of the interviews' transcriptions. The themes are going to be discussed with reference to the Literature Review of Chapter 1 and to the literature on CMF and therapeutic outcomes in general. For an exhaustive list of themes, codes and quotations please refer to the Appendix 3. For purposes of anonymity participants are referred to by the use of labels (e.g. *P1*).

The categories which originated from the research and field questions and which will be discussed are:

4:1 Counsellors' understanding of the phrase 'Client Monitoring and Feedback' (CMF)

4:2 The benefits of implementing Client Feedback (CF)

4:3 The challenges of implementing Client Feedback (CF)

4:4 How the challenges of implementing Client Feedback (CF) can be overcome

4:5 Occasions when counsellors solicit Client Feedback (CF)

4:6 Counsellors' initiatives in case of bad Client Feedback (CF)

4:7 Counsellors' incentives for implementing formal Client Monitoring and Feedback (CMF)

4.1 Counsellors' understanding of the phrase 'Client Monitoring and Feedback'

There was considerable unanimity in the responses of the participants since the vast majority of the respondents were aware of the technical jargon 'Client Monitoring and Feedback' (CMF). The respondents defined 'Client Monitoring' (CM) as the *'Observation of Clients'*

Progress' and 'Client Feedback' (CF) as the *'Personal Experience Questionnaires'* clients fill at the end of the therapeutic session or in the end of the course of therapy. The interviewees also made the distinction between formal and informal Client Feedback (CF). To illustrate:

> *The word monitoring comes along with client observation (P1),*
>
> *And in the end of the course of treatment we do a patient experience questionnaire, both formal and informal (P3)*

Admittedly, the findings were quite surprising since although the respondents do not have monopoly of wisdom especially if it comes to a recently coined professional jargon, all of them were aware of the phrase 'Client Monitoring and Feedback' (CMF) and they were also applying it in their daily practice either formally through paper and pen administrations or informally through verbal interaction with the clients. It is interesting that the respondents with senior management roles were in favour of adapting formal Client Monitoring and Feedback (CMF), since they reckoned that this action would enhance their performance as counsellors and it would benefit their clients as well. This finding is in complete consistency with Lambert's (2010) prediction, namely that because of the financial incentives involved in managed care, Client Monitoring and Feedback (CMF) would be applied at increasing rates in the near future.

4.2 The benefits of implementing Client Feedback

The interviewees were unanimous in their responses, which mainly fell into four different themes. In particular, they indicated that Client Feedback (CF) enhances clients' confidence, contributes to the counsellors' reflection on their effectiveness, contributes to the counsellors' reflection on the effectiveness of the particular therapeutic approach applied and reinforces potential therapeutic adjustments:

Mostly I use it to make the client more confident about themselves, that what they are doing is worthwhile (P1),

You can justify the treatment or you can change it if it needs to be, go over the rationale, explain the model better (P3),

The benefits are that you see if you are effective or not (P5)

These findings are consistent with the available evidence on Client Directed Outcome Informed practice (CDOI); in particular, that soliciting continuous and systematic feedback is a practice-based evidence approach which individualizes the therapeutic services delivered via tailoring the therapeutic services in order to maximize therapist and client fit and that it informs practitioners about the outcomes of their performance. Client Feedback (CF) is a multicultural counselling perspective (Wampold, 2001) which enhances practitioners' intrinsic motivation to remain theoretically 'promiscuous' and to try new ideas in order to be tuned with treatment response and in order to resonate with clients' preferences, which leads to the therapist's adaptive flexibility in coping with the challenges of the clinical work (Anker *et al.*, 2009; Duncan *et al.*, 2010).

4.3 The challenges of implementing Client Feedback

There was a greater variety of comments here but there were degrees of agreement too. The interviewees indicated that the challenges of implementing Client Feedback (CF) are: the interference with the mystique of the process, the impersonal nature of the particular therapeutic practice, the compromise of clients' confidentiality, the time-consuming process of this therapeutic paradigm, the fact that clients defer and they respond traditionally to any formal form, counsellors' rigidity and their insecurity of what Client Feedback (CF) may imply for them as practitioners:

Taking the time to do it, that's about it really, the therapist may be a little bit lazy (P2),

Clients may say, this is fantastic, clients defer, people with a kind of traditional response to any formal form (P3),

Or some counsellors do not ask and do not care because they are afraid of what the client may say or because they are not being flexible, they have learned this approach and that's it, they are not responsive to the client, they do not want to be responsive (P4),

It takes away the mystique, it interferes with the process, it can disrupt the flow (P5)

These findings are congruent with previous research. Clients' deference to their therapists may derive from their desire of 'social desirability' and is a frequent phenomenon in the fields of counselling and psychotherapy since it has been mentioned by many researchers in the past (Rennie, 1998). As far as the negative client assessments of the therapeutic outcomes are concerned, they constitute a great obstacle in administering effective client focused practice and are often perceived by the clinicians as a threat to their effectiveness and to their professional prestige (Duncan *et al.,* 2010).

The fact that two participants were in favour of the application of only informal Client Feedback (CF) is interesting and it is also supported in prior research. The reliance on a self-confirming system of clinical intuition which incorporates informal feedback into the therapeutic mix as opposed to a multi-perspective informed clinical decision making is common place in the fields of counselling and psychotherapy (Worthen & Lambert, 2007). This finding adds to previous research which has found that therapists, despite their confidence in their clinical insight, are not alert to therapy failure. Hannan *et al.* (2005) compared therapist predictions of client deterioration with actuarial methods and although therapists did know about the study's purpose and were familiar with the measure applied, they accurately predicted deterioration in only 1out of 550 cases; this means that they did not recognize 39 out of the 40 clients who deteriorated as opposed to the actuarial method, which was implemented by the computer and which precisely predicted 36 of the 40 (Duncan *et al.,* 2010). These and analogous findings elucidate that without on-going Client Feedback (CF), practitioners are relatively poor at gauging clients' progress and they are less likely to

tailor the services delivered in order to hinder negative outcomes or enhance positive outcomes (Hannan *et al.,* 2005; Duncan *et al.,* 2010). Of course, if clients are not willing to complete any formal forms or if there is any special physical difficulty regarding writing, even illiteracy, there is no right or wrong method of being client-focused and Client Feedback (CF) can and should be elicited in alternative ways.

4.4 How the challenges of implementing Client Feedback can be overcome

A plurality of perspectives was indicated here depending on whether the respondents perceive the implementation of Client Feedback (CF) to be formal or informal. Obtaining informal Client Feedback (CF), not being complacent and resistant to change, triangulating Clients' Feedback (CF), via validating questions and by establishing a good therapeutic alliance were the predominant patterns. To illustrate:

> *Clients defer so we have to check that, what did you find useful about it, what are you going to take away from today and maybe in the next session we ask how have things been with you, the form is about the process but we actually go and talk to the person as well, was the therapist collaborative etc., via questions (P3),*
>
> *If you have a good relationship with the client, there is respect, and he is feeling comfortably, this is a good thing (P4),*
>
> *I would say being alert to hear what the client wants to say or being alert to non- verbal signals I guess, some kinds of behaviours signal things and you have to ask the client, I*

observe this, is this correct, sometimes therapists may be mistaken, they need to be more curious and ask, or clients may need their time in order to open up (P5)

These findings are in congruence with previous literature that found as well that the therapeutic alliance (in 1979, Bordin conceptualized the therapeutic alliance as the bond-rapport among clinician and client and their agreement on the therapeutic objectives and activities) is the cornerstone of effective therapy (Karver *et al.*, 2006). Although it can be valuable for trainee and practising therapists to trust their own insight of what clients are undergoing, it is also vital for them to be aware of the caveat that they can occasionally be mistaken, for even if their clients are telling them how impressing their collaborative work has been or how much they value a specific intervention, the tendency of clients to 'defer' to their therapists (Rennie, 1998) implies that an anonymous, autonomous examination can sometimes yield more credible results (Cooper, 2008).

It is also interesting that the participants mentioned different kinds of feedback, shedding, thus, light on a more varied and potentially more accurate and reliable client directed and outcome informed practice (CDOI) the feedback clients give to themselves about their progress, the feedback clients receive from counsellors, the feedback clients receive from the stuff of the residential setting in Client Review Meetings, the feedback clients receive from their closed ones, like family, partner, friends (although issues of confidentiality are raised here), the feedback clients receive from other clients if they are all situated in a residential setting, the feedback counsellors elicit from clinical supervisors and the feedback counsellors receive from follow-up surveys about the clients' progress:

We have group meetings, we can ask the group if they are anxious responding us individually for some reason and I get feedback from other people as well, so there is a lot of monitoring going on, there is the feedback that residents here get from each other, there is the feedback they give themselves, the feedback they get from the stuff, the kind of feedback they get from their families and partners, we follow different avenues at least (P2)

4.5 Occasions when counsellors solicit Client Feedback

The participants identified four occasions when they solicit Client Feedback (CF), which were: informal client feedback throughout therapy, at the end of the therapeutic session, in the end of the course of therapy and on a follow-up level:

> *"The biggest part is asking them how do you feel this is working, do you feel this approach is right for you, just ask them a question, do you feel that you are benefiting from this, do you feel better as a result of what we are doing, do you feel any improvements, just simple questions like that and also we try to monitor our outcomes as well, we are doing follow ups but not to the quality that I want, ideally I would like a 100% follow-up but it is kind of difficult to reach this kind of level" (P2),*

> *"We use personal experience questionnaires which is quite inadequate because the immediate person's feedback is better, we do that at the end of every session, how they found the session and in the end of the course of treatment we do a patient experience questionnaire, both formal and informal" (P3)*

4.6 Counsellors' initiatives in case of bad Client Feedback

The interviewees produced a multitude of responses, namely that in case of bad Client Feedback (CF) they try to be constructive; they review the therapeutic process with other counsellors if the client is based in a residential setting, they discuss with the client individually, they attain feedback by clinical supervisors and they adjust/ change the therapeutic model applied:

> *In a relationship it is likely that you will have a client who will not agree with you, so this is or looks like bad feedback but could be good feedback, you know (P1),*

> *We do record sessions sometimes for supervisors or solicitors, for clinical supervision and the clinical supervisor may hear the session and give feedback, via the course of supervision we get more feedback but we do not do it all the time, supervisors not only supervise trainees but qualified people as well, everyone has feedback (P3)*

The findings coincide with the literature in that the good practitioners along with other tools of monitoring client's progress such as enhanced interventions and supervision are much more likely to request and attain negative Client Feedback (CF) about the quality of their work in the beginning of therapy with the objective to take the initiative to change this to their advantage (Duncan *et al.,* 2010).

One participant stated that *"CBT is a very practical approach and very well evidenced, it appeals to me more, I follow the NICE guidelines and so on"* but in case of negative feedback the same respondent adds that *"I could use something slightly different"*. This finding may be more of an indication of informed choice and of a sense of humility than of blind technical adherence to a treatment protocol per se (Wampold, 2001).

As far as the Cognitive Behavioural Therapy (CBT) is concerned, by virtue of its underpinnings in basic science, it has been at the forefront when referring to evidence-based therapies (NICE, 2007) and is highly effective for a multitude of cases, but several approaches with diverse rationales and methods have also been shown to be efficacious. A recent meta-analysis comparing these approaches indicated that all of them were evenly effective, an ubiquitous and robust conclusion which is inconsistent with the specificity element of the medical model (Wampold *et al.,* 2007). Duncan and colleagues (2010) maintain fervently that specific approaches should not be mandated and that the notion of requesting clinicians to implement empirically supported treatments or evidence-based therapies is not supported by the findings.

They continue arguing that contrary to the traditional theoretical orientations which maintain that change occurs due to certain technical procedures or multiple common factors, therapeutic change occurs because there is a single theory that is respectable and believable by both the healer and client (Duncan *et al.,* 2010). Past research demonstrates that if an approach makes sense to, is accepted by, and promotes the active engagement of the client,

the specific therapy applied is insignificant, which implies that, the therapeutic techniques used are placebo delivery devices (Duncan *et al.*, 2010).

4.7 Counsellors' incentives for implementing formal Client Monitoring and Feedback

Scanning over the residual data, it was observed that there were some important themes that were not part of the pre-ordinate selection of themes but definitely needed to be addressed. One participant attributed the fact that some therapists fervently administer formal Client Monitoring and Feedback (CMF) in their daily practices due to financial reasons as well as marketing and advertising purposes:

> *People want to formalize the results of working with clients, they want to know the effect, so they can measure the cost, they do it for financial reasons, for marketing purposes, for advertising, with client monitoring and feedback you know when you have good or bad counsellors and you can tell the people who fund you that you have done all this good work, it is like advertising yourself because people who give money want to know what your outcomes are (P1)*

Duncan and colleagues (2010) refer to utilizing the formal client outcome measures' data for marketing purposes, but they counter suggest that those who fall short can seize the opportunity and improve their effectiveness.

4.8 Closing Remarks and Summary

The issues that emerged from the interview data are interesting in many ways. What characterizes the data is the widespread agreement of the interviewees on several issues and their simultaneous different perspectives on some other issues. This sample of experienced cognitive behavioural therapists was deliberately selected to provide an informed overview of counsellors' perceptions of Client Monitoring and Feedback. It should be mentioned that, though the unanimity of responses was welcome, the main objective of the interviews was to highlight a variety of perspectives and to identify important themes, irrespective of unanimity, convergence or frequency of mention (Cohen *et al.*, 2011). The fact that the

interviewees articulated similar issues in some questions, though, signifies that these themes may be significant for further elaboration.

Overall, the findings suggest that the participants of this small scale empirical study support the Client Monitoring and Feedback paradigm, although not everyone expressed their adherence to its formal administration. The research sample was aware of the CMF construct and expressed potential benefits and challenges regarding its implementation (see 4.1, 4.2 and 4.3 respectively). The interviewees also recommended ways of how the challenges of implementing CMF could be overcome. It was interesting that the participants with senior management roles were supporting and administering formal CMF in their daily therapeutic practices and that some participants recommended alternative avenues for being client-focused and outcome-informed. This implies that the CBT therapists interviewed did not conform thoughtlessly to specific therapeutic techniques and that they were really engaged in improving their outcomes.

Chapter 5 Summary, Recommendations for Future Research, Implications for Practice and Conclusions

5.0 Introduction

In concluding this dissertation, a brief summary of the key themes of this small scale empirical study will be provided and implications for practice and future research will be drawn out.

5.1 Summary

The broad aims of the current study were to research the literature regarding Client Monitoring and Feedback and to explore cognitive behavioural therapists' perceptions of this paradigm. The reasons for conducting this project and for formulating and asking the specific research questions mentioned earlier (see 1.0 and 3.0) were driven by the impression that the Cognitive Behavioural Orientation in the United Kingdom was under the influence

of the medical model. Some political motives were also implicated in asking the specific research questions since perhaps naively a contribution to the transformation of the professional practices of the counselling centres that do not implement formal Client Monitoring and Feedback (CMF) was hoped. Of course these aspirations were grounded in the fact that CMF leads to better therapy outcomes as it is suggested by the evidence reviewed in the Literature Review (see Chapter 2). It was, though, mistakenly thought that the incentives of counsellors who maintain clients without progress in therapy for prolonged periods were purely financial. This assumption is not supported by the evidence. Fortunately, the empirical field of the cognitive behavioural orientation in Britain appears not to conform to the medical model of counselling and psychotherapy and this finding is really optimistic for the future of the 'talking therapies'.

If the attention is now shifted to the theoretical and empirical debate of this study, the theoretical field set the bias in the way the empirical field could have been perceived but the empirical field challenged, questioned and asked the theory to be updated. It can be claimed, though, that the theoretical field objectified the empirical field. In this study, the findings complemented the already existing theory about Client Monitoring and Feedback (CMF). The participants were supportive of this burgeoning paradigm but not all of them encouraged its formal administration as expected. It is quite interesting that they enhanced it with their examples of effective client informed and outcome directed daily practice (CDOI), which derived by many and different sources, 'completing' the paradigm under examination and opening up the vistas for a more resourceful and conscientious counselling practice.

5.2 Recommendations for Future Research

There are several avenues for future research. It would be interesting if this study was replicated in the future and if the heads of the counselling and psychotherapy centres of different orientations were asked these or relevant research questions regarding Client Monitoring and Feedback (CMF). Provided that counsellors of distinct approaches are

trained in totally dissimilar ways, their responses would be particularly fascinating and it is probable that they would depict their approach's philosophy. Also, due to the fact that counsellors with senior management roles are more likely to implement CMF (see 4.1), it would be exciting to explore the perspectives of those who do not implement it formally and illuminate the potential reasons. A second area of future research could involve case studies, where Client Monitoring and Feedback (CMF) would be implemented formally and the therapeutic outcomes would then be measured. Alternatively, in a longitudinal level, it would be promising if counselling and psychotherapy centres adapted the Client Monitoring and Feedback paradigm for a year and then, compared their outcomes with the outcomes of previous years, when they were applying informal Client Monitoring and Feedback (CMF).

5.3 Implications for Practice and Conclusions

Overall, this newly emerging field of client focused research is a fascinating field and it definitely warrants further study for the presentation of more conclusive findings that could prove really beneficial for the 'helping professions'. The basic premise of this study is that therapy should not be 'research-directed', but 'research-informed' and not 'evidence-based' as prescribed by the medical model but, 'practice-based', which needs nothing but a paradigmatic shift (Barkham *et al.*, 2001; Duncan et al., 2004; Duncan *et al.*, 2010).

As Charles Darwin's quotation goes,

> *It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change*
>
> *(as cited in Duncan et al., 2010, p.421)*

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Appendices

Appendix 1

Informed Consent

As part of my Masters degree I am carrying out some research. I am conducting a small scale empirical study in order to explore counsellors' perceptions of Client Monitoring and Feedback (CMF).

I wish to interview the participants face to face using a semi-structured approach and I will record the interview so I can write it up afterwards.

Names and other identifying information will be anonymized and the recordings will be wiped after I have written up the content of the interview.

I will share my findings within the Graduate School of Education in Bristol but the information presented will have been made anonymous. I may also use some quotes from the interview in my dissertation. The scripts will be kept until the end of the academic year when they will be destroyed.

The participants will be shown a summary of the findings if they wish and have the right to withdraw from the process at any stage if they wish. Data will be stored in a secure manner and according to the Data Protection Act.

If you have any concerns about the procedure you can contact me at ad0364@bristol.ac.uk or my supervisor _____ at _____.

Signed Anna Dafna

Appendix 2

Research Questions:

1. What is counsellors' understanding of the phrase 'Client Monitoring and Feedback'?
2. What are the benefits of implementing Client Feedback?
3. What are the challenges of implementing Client Feedback?
4. How can the challenges of implementing Client Feedback be overcome?

Semi-structured interview questions:

1. Tell me about your experience in counselling in terms of experience and theoretical approach please.

Prompt Question: How did you come to choose your particular theoretical approach?

2. What do you understand by the phrase 'Client Monitoring and Feedback'?
3. When do you ask for Client Feedback?

Prompt Question 1: What type of client feedback are you asking for?

Prompt Question 2: What do you do instead in order to find out about how the client is progressing?

4. What actions do you take when you get bad Client Feedback?
5. What are the benefits of implementing Client Feedback?
6. What are the challenges of implementing Client Feedback?
7. How can the challenges of implementing Client Feedback be overcome?

Prompt Question: Why it is not happening in every session?

Appendix 3

Thematic Analysis (Adapted from Braun & Clark, 2006)

Category 1: Counsellors' understanding of the phrase 'Client Monitoring and Feedback'

Theme 1: Client Monitoring as the Observation of Clients' Progress (UNDERST-OBSECPROGR):

"*The word monitoring comes along with client observation" (P1),*

"I think monitoring refers to noticing client's progress and if he is better during and after treatment" (P4),

"Monitoring is observing the progress the client is making through noticing his behaviour, the way he speaks, a lot of things" (P5).

Theme 2: Client Feedback as Personal Experience Questionnaires (UNDERST-PERSONEXPEQUEST):

"I suppose normally means get people fill in a form at the end of the session" (P1),

"People can write or fill out a questionnaire, which they do at the end of the treatment period, but this is only a small part" (P2,)

"We use personal experience questionnaires which is quite inadequate because the immediate person's feedback is better, we do that at the end of every session, how they found the session" (P3),

"And in the end of the course of treatment we do a patient experience questionnaire, both formal and informal" (P3),

"By feedback, I understand the self-completed questionnaires clients fill at the end of all therapeutic sessions, if the therapist was helpful, if they gained something from the process" (P4),

"Feedback is the form they fill in the end of therapy, it is about what worked for them, what didn't etc. or after every session, it depends on the rationale of the therapist really" (P5)

Category 2: The benefits of implementing Client Feedback (CF)

Theme 3: Client Feedback as Confidence Enhancement (BEN-CONFENHA):

"Yes, there are benefits, but mostly I use it to make the client more confident about themselves, that what they are doing is worthwhile, I obviously want to see how my clients are getting on and I notice big changes" (P1),

"And it makes the client more confident as well, it makes him realize that he is changing, it is not only about the therapist" (P5)

Theme 4: Client Feedback as Reflection on Counsellors' effectiveness (BEN-EFFECTIV):

"If we are actually doing any good, that's the benefit, that's the advantage, you cannot treat people like a car, you take your car to the garage because it is broken down and the mechanic fiddles with it and gives it back to you, it's not like that, it's human beings we are dealing with here, it is a very interactive process, it's almost, symbiotic, there is a huge amount of transference going on with therapist and service user" (P2),

"The benefits are that you see if you are effective or not" (P5)

Theme 5: Client Feedback as Reflection on Therapy's Effectiveness (BEN-THEFFECTIV):

"You can use technical terms; review your process" (P2,)

"It helps you have a better understanding about what's going on in therapy, it helps you be more attentive to clients' needs" (P4)

Theme 6: Client Feedback as Therapy Adjustment (BEN-THEADJUST):

"Implement new strategies and whatever" (P2),

"You can justify the treatment or you can change it if it needs to be, go over the rationale, explain the model better" (P3)

Category 3: The challenges of implementing Client Feedback (CF)

Theme 7: Challenges and Protection of Clients' Privacy (CHALL-PROTECT):

"Yes, there are challenges because one thing I have learned is that your notes can be used in a legal case, they can ask for your notes, they can take them into court, so I protect the client, I don't write things down" (P1)

Theme 8: Challenges and Difficulty in Verbalising (CHALL-VERBAL):

"Sometimes it is difficult to verbalise the progress that the client is making" (P1)

Theme 9: Challenge as being impersonal (CHALL-IMPERS):

"When you do counselling with somebody the first thing you do is to meet them, not fill forms" (P1)

Theme 10: Challenges and Interference with Process (CHALL-INTERFER):

"It interferes with the process" (P1),

"I am not in favour of asking for formal feedback because it takes away the mystique, it interferes with the process, it can disrupt the flow" (P5)

Theme 11: Challenge as time-consuming (CHALL-TIMECONS):

"Taking the time to do it, that's about it really, the therapist may be a little bit lazy but other than that it is easy, just ask them, give them a form to fill out" (P2),

"If you want to formalize feedback it requires some time and it depends on how often you do it" (P5)

Theme 12: Challenge as Insecurity (CHALL-INSEC):

"Or some counsellors do not ask and do not care because they are afraid of what the client may say" (P4)

Theme 13: Challenge as Rigidity (CHALL-RIGID):

"Or because they are not being flexible, they have learned this approach and that's it, they are not responsive to the client, they do not want to be responsive" (P4)

Theme 14: Challenges as Traditional Responses and Deference (CHALL-TRADITIONDEFER)

"Clients may say, this is fantastic, clients defer, people with a kind of traditional response to any formal form" (P3),

"When the patients are not being completely honest because they do not want to hurt my feelings or because they are bored to be specific, the accuracy of their responses" (P4)

Category 4: How the challenges regarding the implementation of Client Feedback (CF) can be overcome

Theme15: Overcoming via Attaining Informal Feedback (OVERCOM-INFORMAL):

"By getting informal feedback I suppose" (P1),

"Doing that informally" (P2),

"You can find other ways to elicit information if you want to, talking to people is better than trying to be formal" (P5)

Theme 16: Overcoming via Good Counsellors' Qualities (OVERCOM-QUAL):

"Not being lazy" (P2),

"But the counsellors themselves should be open and flexible" (P4),

"I would say being alert to hear what the client wants to say or being alert to non- verbal signals I guess, some kinds of behaviours signal things and you have to ask the client, I observe this, is this correct, sometimes therapists may be mistaken, they need to be more curious and ask, or clients may need their time in order to open up" (P5)

Theme 17: Overcoming via Feedback Triangulation (OVERCOM-FEEDTRIANG):

"We have group meetings, we can ask the group if they are anxious responding us individually for some reason" (P2),

"And I get feedback from other people as well, so there is a lot of monitoring going on, there is the feedback that residents here get from each other, there is the feedback they give themselves, the

feedback they get from the stuff, the kind of feedback they get from their families and partners, we follow different avenues at least" (P2),

"Due to confidentiality issues we do not ask other people, only in cases of a close relationship with a parent or partner we may ask if they feel there is a change or improvement" (P3),

"We do record sessions sometimes for supervisors or solicitors, for clinical supervision and the clinical supervisor may hear the session and give feedback, via the course of supervision we get more feedback but we do not do it all the time, supervisors not only supervise trainees but qualified people as well, everyone has feedback" (P3)

Theme 18: Overcoming via Validation Questions (OVERCOM-VALID):

"Clients defer so we have to check that, what did you find useful about it, what are you going to take away from today and maybe in the next session we ask how have things been with you, the form is about the process but we actually go and talk to the person as well, was the therapist collaborative etc., via questions" (P3)

Theme 19: Overcoming via Forming a Good Therapeutic Alliance (OVERCOM-ALLIA):

"Believe the client in what he is saying, if they say things in order to please me, it is not useful" (P3),

"If you have a good relationship with the client, there is respect, and he is feeling comfortably, this is a good thing" (P4)

Category 5: Occasions when counsellors solicit Client Feedback (CF)

Theme 20: Occasions throughout Therapy (OCCAS-THROUGHOUT):

"Most of the time I notice how the client is progressing by the behaviours they do, by the way they respond about what we are talking about and usually I give feedback to them and say that the way you are looking at things now is different from when you first came in, I have informal feedback and I might ask a client how they feel we are getting on, I ask them, is there anything troubling you or clients may come back to me and say I am feeling a lot better than when I first started to come and see you, or I could manage this better or sometimes they make a different kind of progress, it depends on what the client wants to make, most of the time I do alcohol counselling, if people reduce their drinking, this is my result, this is my outcome measurement and I do very well on that, I don't have any problem, so this is a performance management" (P1),

"The biggest part is asking them how do you feel this is working, do you feel this approach is right for you, just ask them a question, do you feel that you are benefiting from this, do you feel better as a result of what we are doing, do you feel any improvements, just simple questions like that" (P2),

"But as well as throughout through monitoring, also through observation as well because it is a residential setting, I observe them around the place, you know, so I can see their behaviours a lot, not all of the times but most of the time, we don't have cameras or anything" (P2),

"And I get feedback from other people as well, so there is a lot of monitoring going on, there is the feedback that residents here get from each other, there is the feedback they give themselves, the feedback they get from the stuff, the kind of feedback they get from their families and partners, we follow different avenues at least" (P2),

"And we make sure that we get informal feedback as we get along" (P3)

Theme 21: Occasions at the End of the Therapeutic Session (OCCAS-ENDSESS):

"We use personal experience questionnaires which is quite inadequate because the immediate person's feedback is better, we do that at the end of every session, how they found the session" (P3)

Theme 22: Occasions at the End of Therapy (OCCAS-ENDTHE):

"People can write or fill out a questionnaire, which they do at the end of the treatment period, but this is only a small part" (P2),

"Just ask them informally as well as formally at the end of the treatment" (P2),

"Also they fill in a written questionnaire" (P2),

"And in the end of the course of treatment we do a patient experience questionnaire, both formal and informal" (P3)

Theme 23: Occasions at Follow-ups (OCCAS-FOLLOW):

"And also we try to monitor our outcomes as well, we are doing follow ups but not to the quality that I want, ideally I would like a 100% follow-up but it is kind of difficult to reach this kind of level" (P2)

Category 6: Counsellors' initiatives in case of bad Client Feedback (CF)

Theme 24: Initiatives as Client Review Meetings (INITIAT-REVMEET):

"We review what we are doing, you know, and we review with them, we have regular weekly meetings, which we call client review meetings, where we discuss how we feel the person is doing as a team" (P2)

Theme 25: Initiative as Individual Review with Client (INITIAT-INDIVREV):

"In a relationship it is likely that you will have a client who will not agree with you, so this is or looks like bad feedback but could be good feedback, you know" (P1),

"But the main thing is to discuss it with the person, what do you feel needs to change, do you think you are benefiting from this, and if not, what do you think you would benefit from, they get homework as well, you know, because in CBT homework is a critical part of it, sometimes they feel that the homework is irrelevant, maybe they misunderstood it or they don't benefit in the way they thought they would be, that they can bring it back and discuss it informally outside of the session, so, you know, we can work with them and try find what does work for them basically and usually this works" (P2),

"We review to see what is going on, I am not getting it, I find it too distressing, some find the treatment to be very difficult to go through, traumatic events" (P3)

Theme 26: Initiative as Clinical Supervision (INITIAT-SUPERVIS):

"And then, we have clinical supervision as well, we discuss how we feel the person is doing" (P2)

Theme 27: Initiative as Therapy Adjustment (INITIAT-THERADJ):

"In this case we might change our model of working, Trauma Focused Therapy, Exposure Base Behavioural Model, Metacognitive Model (they are under the umbrella of CBT) etc., but I could use something slightly different" (P3)

If they respond negatively, it gives you a lot of things to think about. I try to adjust my approach depending on the person and I am responsive to what the client wants to keep from therapy or what he wants to change. (P4)

"It doesn't happen very often I would say. I want to help clients; this is the greatest pleasure for me, to see that what we are doing is working, I try to do something differently" (P5)

Category 7: Counsellors' incentives for implementing formal Client Monitoring and Feedback (CMF)

Theme 28: Incentives as Financial and Marketing (INCENTIV-FINANCEMARKET):

"People want to formalize the results of working with clients, they want to know the effect, so they can measure the cost, they do it for financial reasons, for marketing purposes, for advertising, with client monitoring and feedback you know when you have good or bad counsellors and you can tell the people who fund you that you have done all this good work, it is like advertising yourself because people who give money want to know what your outcomes are" (P1)